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SERVICE INTEGRATION FOR DEINSTITUTIONALIZATION (SID) REPORT OF A THREE-YEAR RESEARCH AND DEMONSTRATION PROJECT. VOLUME 4. FINDINGS

VIRGINIA SERVICE INTEGRATION FOR DEINSTITUTIONALIZATION PROJECT

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THE SID REPORT

VOLUME 4

FINDINGS

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.

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SERVICE INTEGRATION FOR DEINSTITUTIONALIZATION

A Report of a Three-Year Research and Demonstration Project

This is Volume 4 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

June 1, 1975

As new discoveries are made, new truths disclosed, and manners and opinions change with the change in circumstances, institutions must advance also, and keep pace with the times.

Thomas Jefferson

The SID Report

Volume 4: Findings Resulting from Use of the Model

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NOTE: Volume 4 Appendices are bound separately.

I. INTRODUCTION

The Service Integration for Deinstitutionalization (SID) model began as a research and demonstration project. As a result, methods for evaluating the attainment of the model's operational objective of developing a systematic, service-integrating procedure for the orderly deinstitutionalization of residents of state institutions have been continuously built-in.

The empirical questions that the SID information system seeks to answer are varied. (See Volume 2 Section VI for a discussion of empirical questions.) Both qualitative and quantitative data are gathered and provide the basis for answering these questions. Most data are collected on an individual client basis by the broker advocate (BA) assigned to the case. There is continuous monitoring and tracking of the happenings associated with the deinstitutionalization and service delivery process for each client. The quantitative data are systematically collected through data gathering forms specifically tailored to match and guide model functioning. Qualitative data are often collected via SID forms. Monthly reports by administrators in the central and field offices provide another source of data.

Volume 4 is organized into four sections. Section I, Introduction, provides data dimensions and definitions for the reader. The next two sections, Client Outcome (II) and Service Requirements, Availability, and Provision (III) are based primarily on quantitative information. The final

section, Service Integration Functioning (IV), relies primarily on qualitative information although some quantitative data are presented.

A. DIMENSIONS FRAMING THE DATA

Five dimensions frame the information presented throughout this Volume:

1. Time Span

Quantitative data collected between April 20, 1973 (date the first assessment was completed) and December 31, 1974 were analyzed along with qualitative information gathered between July 1, 1972 and early 1975.

2. Disability Group

Clients were classified as mentally ill (M.I.), mentally retarded (M.R.), or juvenile offender (J.O.) depending on the type of institution in which they were residing at the time of initial contact with SID.

3. Geographic Location

Clients were either residents of Portsmouth (Port) or Planning District #6 (PD #6). Home of record was determined at the time of initial case contact.

4. Institution of Residence

The institution wherein the client resided at the time of the first assessment was regarded as the institution of residence. The institutions included were:

a. Institutions for the M.I.

Central State Hospital (CSH)
Western State Hospital (WSH)

b. Institutions for the M.R.

Lynchburg Training School & Hospital (LTSH)
Southside Virginia Training Center (SSVTC)

c. Institutions for the J.O.

Beaumont Learning Center (Beaumont)
Bon Air Learning Center (Bon Air)
Hanover Learning Center (Hanover)
Janie Porter Barrett Learning Center (Barrett)
Juvenile Vocational Institute (JVI)
Natural Bridge Forestry Camp (Nat Br)
Pinecrest Learning Center (Pinecrest)
("7TS" indicates all J.O. institutions are grouped together)

5. Client Selection

The sequence of selecting clients followed the dictates of administrative convenience. Some of the variables determining the order in which clients entered the project were: acquisition of authorization to release information; client's ward location in the institution; client's city or county of residence; recruitment and location of broker advocate; time of project entry into a specific institution. It is important to note that "readiness to leave the institution" was not a variable that determined the order of client selection. That is, there was no pre-screening or pre-sorting of clients with respect to "dischargeability."

Mentally ill and mentally retarded clients who had resided in the institution less than three months during their present institutionalization were not included in

the project. This three-month selection criterion eliminated from project consideration many of the "revolving-door" alcoholic problem persons.

B. DEFINITION OF TERMS

A number of terms used throughout require specific definitions:

1. Assessment

Assessment is the compilation and filing by a BA of information regarding the client's background, service and institutional history, family background, physical health, educational and employment history and potential, and a behavioral repertoire. (These data are entered on SID Forms #2 - #8.) This information forms a basis for the Assessment and Prescription (A&P) team's deliberations about the needs of the client.

2. Reassessment

A reassessment is any assessment subsequent to a client's initial assessment.

3. Prescription

A prescription is the specification by the A&P team of whether a given client should remain in the institution or be considered a candidate for community placement, and why, and in either event, designation of specific services (prescription elements) required by the client. (These data are recorded on SID Forms #1, #9 - #12.)

4. Resource Search

When a client is prescribed for community placement, the BA assigned begins to look for the ideal housing prescribed. If First Choice housing is found to be unavailable, he searches for Second and finally Third Choice housing (assuming these have been prescribed by the Team). If housing is found, the BA looks for a source of income to support the client in the community. Only after both housing and income are located does the BA begin to search for supportive services. (These data are entered on SID Forms #39 - #44.) Resource search, therefore, refers to the process wherein the BA attempts to locate, and develop a service plan for, each of the elements in a community placement prescription.

5. Placement

Placement is defined as the initial movement of a client from an institution to the community. (Movement is recorded on SID Form #30.)

6. Placement with Team Recommendation

Placement with team Recommendation is the initial movement of a client from an institution to the community under the terms specified and endorsed by the team in its prescription. Under this condition the team formally recommends to the director of the institution that the client be placed in the community. (Movement is recorded on SID Form #30 while the recommendation is formalized through

SID Form #15.)

7. Moved

"Moved" refers to any movement from one housing mode to another after initial placement in the community. Also, inter-institutional movement (transfer) is included. (Movement is reported on SID Form #30.)

8. SID Following

When a client is placed with a team recommendation, the BA assigned monitors the client's progress in the community through periodic consultation with the client and various service providers. The BA (and the A&P team) are also available to the client and providers if problems arise. These events constitute the "SID following" process. (Monitoring is recorded via SID Forms #19 and #20; problems are reported on SID Form #21.)

9. Fulfillment of Continued Institutionalization Prescription

All clients who receive a continued institutionalization prescription are reassessed within six months of the previous assessment. At that time, the BA asks institution staff to what extent the last prescription written by the team has been fulfilled. (The data are entered on SID Form #29.)

10. Termination

A client may conclude his/her participation with the SID project for a variety of reasons. In any case, the interaction between the client and the team and BA ends. (SID Form #32 is used to record terminations.)

11. Client Processing

All the happenings associated with a client's participation in the SID model constitute client processing.

II. CLIENT OUTCOME

The broad topic of client outcome is discussed in terms of eight sub-sections. Client data in each sub-section are patterned according to a 3-way breakdown: disability group, geographic area of residence, and institution of residence. The sub-sections, and their contents, are:

(1) Resultant Sample

Number of clients in the final sample as well as number of potential clients not participating in the project are presented. Reasons given for refusal to authorize information release are also presented.

(2) Client Characteristics

Important findings and comparisons of a demographic nature are included.

(3) Client Behavior

Aggregate behavior repertoire statistics are presented and compared.

(4) Prescription Outcome

Prescription decisions and reasons for these decisions are discussed.

(5) Community Placement Outcome

Number of clients placed in the community, blockages to community placement, and client cooperation in the placement process are included.

(6) Client Attitudes and Behavioral Changes

Client satisfaction with respect to community living versus living in the institution and data indicating whether community placement results in an expanded repertoire of behavior are shown.

(7) Recidivism

Total number of readmission events, total number of clients ever returned, and total once placed but currently in an institution are given.

(8) Terminations

Number of clients who have terminated involvement with the model and reasons for termination are indicated.

Throughout the Client Outcome section, terminated clients are included in assessment and prescription data but not in placement or outcome data. Assessment and prescription data represent a client's situation at a particular time; subsequent events do not change the validity of the information gathered in the assessment and prescription process. However, placement and movement in the community are processes for which data must be collected continuously. Once a client has been terminated, placement and movement data can no longer be updated.

A. RESULTANT SAMPLE

Data regarding 498 clients are included in this report. Table 1* presents a breakdown of clients assessed and prescribed, and the number of reassessments performed. (Since a given client may receive more than one reassessment, number of reassessments does not necessarily equal number of clients reassessed.)

63% of the clients assessed were residents of PD #6 and 88% of the reassessments involved clients from that area. This is reasonable since processing of clients in PD #6 began six months before the first A&P team meeting in Portsmouth and meetings in PD #6 are held weekly while those in Portsmouth occur twice a month.

The sample contains more M.I. than M.R. clients (50% versus 42%). Only 8% of those assessed were J.O. clients.

45 clients (9% of the total) have been assessed but not prescribed. A few are awaiting their initial prescription; the majority were terminated due to movement from the institution or death prior to prescription.

Not all clients targeted for processing were actually reached by SID prior to December 31, 1974. Table 2 shows the client sample size and why some potential clients never entered the SID model.

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* Tables 1 through 19 are presented at the end of Section II, CLIENT OUTCOME.

It is expected that 86 new clients will enter SID processing between December 31, 1974 and June 30, 1975. This will increase the current sample size by 17%.

Of the total clients targeted for processing, 25% could not be reached. Nearly half of these were regarded by institution staff as medically incompetent (i.e., unable to render informed consent) and no representative could be found to authorize information release in their behalf. The fact that these clients were denied an opportunity to be considered for participation in the project is unfortunate but is perhaps less distressing than the realization for them no legal decisions of any kind are possible.

Nearly 13% of the clients targeted for processing were not included due to refusal to authorize information release. Table 3 shows the consents and refusals to authorize information release by the source of authorization.

639 potential clients or their representatives were actually approached. 85% consented to release information, while 15% refused. The proportion of consents to refusals remains fairly constant among the sources except for "Institutions" (the source of authorization for the J.O. clients). Relative/guardian consented slightly less frequently than client or committee.

Over half the clients who demurred did not give a reason for refusing to sign the release. Committees and relatives who refused information release procedures were frank in their unwillingness to have clients leave the institutions.

B. CLIENT CHARACTERISTICS

Client characteristics found in the various groups and sub-groups of clients can be studied in detail from the displays of automated Assessment Digests in Appendix A. Appendix A contains separate Assessment Digests for each disability group and for each institution (or institution grouping, in the case of the J.O.).

(Similarly, the service needs of the various groups and sub-groups of clients can be studied in detail from the displays of automated Prescription Digests in Appendix B.)

The Assessment Digests are compiled in either of two ways: (a) from information based on clients who have ever been assessed (irrespective of whether or not they have been prescribed); and (b) from information based on clients who have been assessed and prescribed.

In the case of (a), information in the Assessment Digests comes from the data gathered on each client at the time of his last (most recent) assessment. (The total number of clients so included, across all client groups, is 498.)

In the case of (b), information in the Assessment Digests comes from the assessment information that is linked to the client's most recent prescription. (The total number of clients so included, across all clients groups, is 453.)

(Prescription Digests are based on the latest, most recent, prescription received by those clients who have been assessed and prescribed--total of 453 clients.)

1. Observations and Comparisons in the Demographic Information

Some of the more important observations and comparisons made from the data in the Assessment Digests are:

-The mean age of the M.I. group is nearly 20 years younger than the mean age of the M.R. group (53.29 years versus 34.55 years).

In both the M.I. and the M.R. groups, those prescribed for community placement are older than those prescribed to remain in the institution (56.97 versus 49.25 years for the M.I. group and 39.25 versus 27.41 years for the M.R. group).

-The sample is fairly equally divided between males and females except the J.O. group is over 80% male.

-Race is clearly related to geographic area and institution rather than to client group.

-None of the J.O. or M.R. clients are married; only 11.3% of the M.I. clients are currently married.

-M.R. clients have been in the institution longest on the average (14.82 years for the M.R. group versus 10.41 years for the M.I. group versus 0.66 years for the J.O. group).

Length of time in the institution is not clearly related to the prescription decision except in the J.O. group.

-Only 12.4% of the M.I. and 4.1% of the M.R. clients have been formally adjudicated incompetent and assigned a committee.

-Institution staff stated there were already plans to move 32.8% of the M.I. clients and 12.2% of the M.R. clients, and 73.8% of the J.O. clients.

-M.I. clients have an average of 1.47 prior institutionalizations, M.R. an average of 0.61 and J.O. an average of 1.14. (The length of time spent during prior institutionalizations is not added into the average institutional stay above. If it were, the mean length of institutionalization would be much greater.)

-When asked where they preferred to live, 69.2% of the M.I. group stated a preference for community living while 7.8% preferred to remain in the institution. 52.2% of the M.R. clients preferred community living while 5.4% preferred to stay in the institution; 95.2% of the J.O. group to move to the community. The remainder of the clients either had no preference or were unable to make such a decision.

-61.1% of the M.I. clients and 46.4% of the M.R. group are "normal" in appearance. 76.5% of the M.I. group and 69.1% of the M.R. group are completely mobile.

-80.6% of the M.R. clients, 18.6% of the M.I. group and none of the J.O. clients are moderately, severely, or profoundly retarded, or are of undeterminable intelligence despite testing.

-The mean grade level completed in a regular school setting is 7.01 for M.I. clients, 1.57 for M.R. clients, and 5.63 for J.O. clients.

-Institution staff stated that 56% of both M.I. and M.R. clients were incapable of self-support. All of the J.O. clients were determined to be capable of self-support, at least potentially.

Capability of self-support seems to bear some relationship to the prescription decision. Among those prescribed for community placement, 47.9% of the M.R. and 57.3% of the M.I. clients were rated as incapable of self-support while 70.4% of the M.R. and 61.5% of the M.I. clients prescribed to continue in the institution were held to be incapable of such support.

-28.6% of the M.I., 41.8% of the M.R., and 22.5% of the J.O. clients held jobs within the institution.

-37.6% of the M.I. clients and 27.8% of the M.R. clients were evaluated as capable of using public transportation unassisted.

Of those prescribed for community placement, 39.3% of the M.I. and 39.7% of the M.R. clients were felt to be capable of using public transportation while of those prescribed to continue in the institution, 27.6% of the M.I. group and 11.0% of the M.R. group were so evaluated.

-The Commonwealth pays between 69% and 80% of the total cost of institutionalization for M.R. clients, between 71% and 86% for the M.I. clients, and 100% for J.O. clients.

There is considerable normalization potential within these individuals assessed by the project: The majority of the clients prefer to live outside the institution, are of normal appearance and completely mobile. Over one-third of the M.I. and M.R. clients were judged to be capable of some kind of employment and over one-third were felt to be capable of using public transportation unassisted.

2. Reasons Clients Still in Institution

Given this picture of the various client groups, why were so many of the clients still residing in institutions at the time the A&P team initially wrote a prescription? The teams make such a judgement for each client. Table 4 summarizes the judgements reached. 453 clients have been prescribed for by the teams. An average of 1.2 reasons for each client's residence in the institution was given, for a total of 544 reasons.

Approximately one-fourth of the reasons given for the institutional residence of M.I. and M.R. clients were that the clients' conditions warranted continued institutional care. The response indicating that the client is in danger to himself or others was selected in only a few instances. Over one-fourth of the reasons checked indicated that

clients had been dischargeable for some time but that a lack of community resources and/or institutional efforts at placement necessitated continued institutional residence.

C. CLIENT BEHAVIOR

Table 5 presents a summarization of the last behavior repertoires completed for clients while they were living in the institution. The mean scores represent points on a 5-point rating scale that ranges from 0.00 to 4.00 and has a midpoint of 2.00. Appendix C contains Behavior Repertoire Statistics reports for the same groups and sub-groups specified in the Assessment Digests. These reports provide complete scores for all items.

Behavior scores between the two institutions represented in the M.I. group are quite consistent. Scores on the two sets of LTSH clients in the M.R. group are similar to each other and the adaptive scores on the SSVTC clients are in line with those found at LTSH.

The maladaptive ratings at SSVTC are considerably higher than those at LTSH. It is not clear why this occurred. Perhaps the relative youth of SSVTC clients is contributing to the difference. Or, the score differential may suggest variations in client management procedures at the two institutions.

J.O. clients have more adaptive and maladaptive behavior than either M.I. or M.R. clients. M.R. clients show less adaptive behavior than M.I. clients while the maladaptive

scores are consistent between the two groups.

Throughout the M.I. and M.R. groups, those clients prescribed for continued institutionalization (PR-IN) have lower adaptive scores and higher maladaptive scores than those clients prescribed for community placement (PR-OUT). The J.O. group does not show much variation between those PR-IN and PR-OUT. Since length of institutional stay rather than physical or behavioral condition usually determines whether a J.O. is prescribed to the community or not, this finding is not surprising.

D. PRESCRIPTION DECISIONS

In the 20 months of processing, there have been 96 A&P team meetings at which prescriptions were written for 453 clients. Table 6 summarizes the outcome of those meetings and the prescription decisions made. It contains data on the number of clients assessed and prescribed, the number of reassessments, current prescription status, number of terminations, current outcome status, one type of recidivism, community placements pending formal team recommendations, and the counts/costs of A&P team meetings. Since it contains a summary of client processsings data, Table 6 serves as a master reference document.

Note the data under "CURRENT PR STATUS" (current prescription status). If a client has received more than one prescription, information concerning his latest is contained here.

Clearly, each of the A&P teams sees a need for institutional residence for some of the clients evaluated. 35% of the M.I. clients and 41% of the M.R. clients have been prescribed for continued institutionalization. Only 19% of the J.O. clients have been prescribed to remain in the institution. Conversely, almost two-thirds (63%) of all the clients reviewed by the joint community-institution A&P teams have been recommended for community placement.

Overall, 51% of the clients from CSH and SSVTC have been prescribed for community placement while 66% from WSH and LTSH have been so prescribed. This discrepancy is unlikely due to inter-team variation since Teams from either PD #6 or Portsmouth have prescribed community placement at LTSH more often than has the Portsmouth Team at SSVTC.

The reasons specified by the Teams in making community placement prescriptions may shed some light on this variation. If more clients from WSH and LTSH were found to be inappropriately institutionalized initially, this could explain part of the difference.

In examining Table 7, it is clear that such is the case. Although there is only a 5% difference between M.I. and M.R. groups overall with regard to the percentage of clients judged to be inappropriately institutionalized initially, the differences within groups ranges from 10% to 20%. In fact, 92% of those clients the teams felt should be so classified were from WSH or LTSH.

Differences among the institutions with respect to already existent plans for client discharge are also evident. In reviewing assessment information (Appendix A), the institution staff at CSH and SSVTC stated that plans for movement

had been made for 41.8% of those subsequently prescribed OUT while staff at WSH and LTSH made such a statement about 26.7% of their residents who received community placement prescriptions. In evaluating why clients were still in the institution (Table 4), the teams from WSH and LTSH chose the response "Client dischargeable for some time; no active attempts to place" 28.6% of the total while CSH and SSVTC teams chose this alternative 16.3% of the time.

These two phenomena of (a) more initial inappropriate institutionalizations and (b) less attempt on the part of institution staff to place clients in the community at WSH and LTSH may be partly explicable in terms of the geographic areas served by the institutions. Presumably the predominantly urban areas served by SSVTC and CSH currently have and always have had more resources available to support M.I. and M.R. residents and a more cosmopolitan attitude toward accepting such individuals in the community.

The teams also specify a reason for a decision to recommend that a client remain in an institution. Table 8 presents the reasons given.

The most frequent reason given for prescribing continued institutionalization for M.I. clients was that treatment services were still required. Among the M.R. clients, the fact that education/training services were still needed was the most frequent reason given. Since institutions for the M.I. and those for the M.R. serve different functions

corresponding to the differing needs of their residents, this difference between groups is reasonable.

E. COMMUNITY PLACEMENT OUTCOME

1. Placement Percentages

The OUT column under CURRENT OUTCOME STATUS in Table 6 indicates the number of clients living in the community. The percentages are based on the total number of active cases (i.e., the number of clients A&P'd minus the number of clients terminated). The percentages of non-terminated clients presently living in the community for the three disability groups are as follows: 24% of the M.I.; 11% of the M.R.; and 75% of the J.O.

One might also ask the question: "Of those (active) clients who were prescribed for community placement, how many are actually living in the community?" The last column of Table 9 answers this question. The percentages are: 38% of the M.I. clients prescribed OUT are now living OUT; 19% of the M.R.; and 75% of the J.O.

Using placement percentage as the criterion, it is apparent from these data that SID has been most successful in placing J.O. clients. This conclusion is tempered by the finding that terminations ran inordinately high in the J.O. group, length of institutionalization for the juvenile offender is attenuated and circumscribed even without SID, and the sample size of J.O. cases is small.

Placement rate from M.I. and M.R. institutions must be interpreted within the context of varying lengths of project operational time. The data in Tables 6 and 9 are based on 20 months of SID activity at WSH, 5 months at CSH, 16 months at LTSH (PD #6), 3 months at LTSH (Port), and 9 months at SSVTC.

If placement percentages from WSH are compared with those from LTSH, it would appear that M.I. clients are easier to place than M.R. clients. However, the Portsmouth data, even allowing for the varying operational time at SSVTC and CSH, do not confirm this finding. Obviously many variables influence placement rate.

In late 1972, the Department of Mental Health and Mental Retardation proclaimed as a policy goal the reduction of 10% per year for the next five years in the resident population of its state institutions. Although SID was developed for purposes other than accommodation of this proclamation, it is worthy of note that 18% of the total group of (non-terminated) M.I. and M.R. clients are currently in the community after a client processing duration ranging from 3 to 20 months.

2. Placement With and Without A&P Team Recommendation

Some of the 84 clients currently living in the community lack the authentication of a formal A&P team recommendation, yet they have not been terminated because a team recommendation is expected to be filed in the near future. The column in Table 6 labeled (OUT/TEAM REC PENDING) indicates that there are 15 such clients among the 84.

There were 15 other clients who were terminated at the time they were living in the community. Since SID does not continue to follow terminated clients, the status of these 15 clients is not formally known. The placement percentages already discussed would be incremented were these 15 placed-out, but terminated, clients included in the placement count. If all 15 were still living in the community (one was deceased in the community), the total would have increased from 84 to 99. Table 10 is presented to show under what conditions (i.e., with a formal team recommendation versus without a formal team recommendation) these 99 clients were placed in the community. Note that over half of the placed-out-but-now-terminated clients were placed under the authentication of a formal team recommendation and that of these the juvenile offenders are over-represented.

Table 10 also enables one to view the SID placement percentage vis-a-vis the total number of clients prescribed--a larger base than the total number of clients still active in the program. Note the data in columns 5 and 6 of Table 10. The 18% statistic reported above (the percent of all active DMH&MR clients who are now living in the community) is approximately equal to the resultant 19% (the percent of all DMH&MR clients ever prescribed who are living or assumed to be living in the community).

Clients who were placed under team recommendation and subsequently terminated ended their relationships with SID for a variety of reasons including movement from the SID areas, a decision to no longer cooperate with the program,

death, etc. Terminations are discussed in more detail below (Section II, paragraph H).

3. Blockages Encountered in Placement

Why have SID BA's been unable to place two-thirds of the clients prescribed for community placement? In arranging for the placement of a client, the BA frequently encountered several blockages. Table 11 summarizes the main placement blockage per client, as judged by the BA coordinating the case, for those clients who have not yet been placed.

"Institution Blockages" (9% over all groups) were not the result of refusal by the director of the institution to release a client for whom the team had made a formal recommendation for release. Impediments at the institution occurred at the operational level. Institution blockages included awaiting evaluation by the vocational rehabilitation department, awaiting a diagnostic evaluation, or waiting for a physical health treatment program to be completed.

The single largest blockage is the lack of adequate housing. Housing for M.R. clients is a particular problem. (Specific gaps in housing are discussed in Section III.)

Income has been a blockage in only 6% of the cases. This is a lower proportion than would be expected, although the BA's attempting to place CSH clients have encountered a greater proportion of problems in this area.

Supportive services were rarely recorded as the principal blockage to placement because of the frequent occurrence of "front-end" blockages.

Lack of cooperation on the part of the client or his representative presented the major blockage in 8% of the cases. Since the cooperation of the client and his representative are crucial to successful community placement, Table 12 presents information concerning level of client/representative cooperation for all clients awaiting community placement.

Lack of cooperation was a problem in 22% of the 172 cases observed. Active uncooperativeness on the part of the client or representative was somewhat more evident in the M.R. group. This may be in part due to the difficulty of obtaining admission to an institution for the retarded at this time. If a client is placed, the institution will be reluctant to readmit him. Committees did not register uncooperativeness once they had decided in favor of authorizing information release on their ward.

4. Placed Clients versus Clients Awaiting Placement

Demographic characteristics of active clients who have been placed outside the institution (either under team recommendation or with team recommendation pending) can be compared with the characteristics of those clients who have been prescribed for community placement but have not yet been placed. To enable this comparison, Assessment Digests on non-terminated clients in each disability group now

living in the community and on non-terminated M.I. and M.R. clients prescribed for community placement but living in an institution are at Appendix D.*

In terms of mean age, mean length of last institutionalization, and normalcy of appearance, clients prescribed to the community and placed do not differ widely from those awaiting placement. However, in both the M.I. and M.R. groups, those actually placed expressed somewhat more desire to leave the institution and were evaluated by institution staff as being able to use public transportation more often than found among those awaiting placement.

Of those prescribed but not placed, 55.0% of the M.R. and 61.1% of the M.I. stated a preference for community living. Of those actually placed, 60.0% of the M.R. and 82.5% of the M.I. voiced such a desire. Likewise, while 26.0% of the M.I. and 33.3% of the M.R. clients pending placement were evaluated as being able to use public transportation, 54.3% of the M.I. and 61.9% of the M.R. clients placed were so evaluated.

In addition, while 64.1% of the M.I. clients and 51.7% of the M.R. clients in the institution having a

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* Since only five J.O. clients are awaiting placement, no Assessment Digest for clients awaiting placement is included.

community placement prescription were evaluated as incapable of self-support, only 50.0% of the M.I. clients placed and 30.0% of the M.R. clients placed were evaluated as such. Among the M.R. clients, 81.0% of those living in the community are completely mobile while 67.4% of those awaiting placement are totally mobile.

These observed differences suggest that a natural, unintended selection or sorting process favoring those clients with more normalization potential may have occurred in the placement of clients prescribed to the community.

F. CLIENT ATTITUDE AND BEHAVIORAL CHANGE

Once placed in the community, clients overwhelmingly express a preference for community rather than institutional living. Table 13 summarizes the findings.

Overall, 72 clients (85.7% of the total) express a definite preference for community living while 3 clients (3.6% of the total) prefer to return to the institution. 90% of those living in the housing situation prescribed as ideal state a preference for noninstitutional living. This percentage decreases to 86% among those living in the second choice housing mode and to 72% among those in the third choice housing situation. This observed decline in the proportion of those preferring to live in the community is quite consistent within all three client groups.

In order to detect any behavioral changes occurring after community placement, a behavioral repertoire is completed every six months for placed clients. Someone who knows the client's current behavior serves as informant. To date, behavioral repertoires have been done for 36 of the 84 clients placed. Using each client's last repertoire before release and the latest repertoire completed in the community, mean scores are compared in Table 14.

When the ratings from all adaptive behavior items are pooled, the mean rating in the before placement condition is identical with the mean rating obtained after placement: 2.47. In the areas of work, housekeeping, and pastimes, the results suggest that some slippage occurred in the amount of behavior demonstrated as the client moved from institution to community.

There appears to be less maladaptive behavior associated with community living than with institutional living. The 36 clients had a mean score of .38 on maladaptive behaviors before deinstitutionalization compared with a mean of .19 after living in the community.*

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* Behavioral Repertoire results are vulnerable to the question of inter-rater reliability. However, the Repertoire achieves some degree of group reliability and validity from the replications and comparisons noted in Section II paragraph D, above.

Mean score differences were not subjected to formal t-tests because the statistical assumption of independent events is violated when multiple ratings on the same subject are pooled and N is incremented accordingly.

G. RECIDIVISM

Although most clients prefer community to institutional living, some do return to the institution. Table 15 presents recidivism data for clients placed under a formal team recommendation.

Since there are various definitions of recidivism, data are examined in three ways: number of clients ever returned to the institution, number of readmission events, and number of clients who were once placed in the community but who are currently residing in an institution. Using each of these three different criteria for recidivism, the findings were as follows:

(1) There was wide variation among institutional groups regarding the percentage of active clients ever returned to the institution. The range was from 0% of the CSH and LTSH placed clients to 22% of the WSH placed clients.

(2) No active client placed under a team recommendation has been admitted to the institution more than once. (The second and third columns of Table 15 have identical counts.)

(3) Currently only 8% of the clients ever placed under team recommendation are residing in an institution. Since returning to the institution, the five M.I. and M.R. clients have been re-prescribed for community placement; the J.O. client is awaiting re-prescription.

How do these rates compare with those found by other programs providing post-discharge follow-up? Baseline data for M.I. and J.O. clients returned to an institution is available; a search of the literature did not reveal similar statistics for an M.R. group.

Anthony et al. (1972) surveyed previous studies of recidivism among psychiatric patients. They found that 15% of those discharged without aftercare returned to the hospital within three months, 30% - 40% within six months, and 40% - 50% within one year. With aftercare, usually less than 20% returned to the institution after six months to one year.

Results reported by Purvis and Miskimins (1970) are similar. One study they cite found that, after nine months in the community, 28% of the clients receiving structured following versus 46% of those receiving no following had returned to the institution. The authors cite other reports showing recidivism rates ranging from 15% to 20% for clients receiving follow-up versus 31% to 39% for clients receiving no following.

All J.O.'s are regarded as receiving follow-up since aftercare from a court or probation office is standard procedure after release from a juvenile institution. Laulicht (1962) reports a 66% return rate in one New York training school while Ball and Simpson (1965) report that 60% of the boys and 48% of the girls seen by the Lexington, Kentucky court system in one year had been institutionalized previously. Alexander and Parsons (1973) attempted a variety of post-release treatment methods in an attempt to reduce recidivism. In their control groups, the rates of reinstitutionalization within one year were 48% to 50%.

With short term family behavioral treatment, this was reduced to 26% and with client-centered family groups to 47%.

It is logical to raise the question as to whether the SID 20% return rate for the M.I. and 8% rate among the J.O. were artificially low due to selective termination of clients, i.e., terminating clients who appeared to be headed for a return to the institution. Table 16 aligns termination counts with returned-to-the-institution counts in an attempt to study this possibility and what its consequences would be on a combined failure rate.

When one adds these two kinds of failures (terminations and returnees) and uses the total number of clients ever placed under team recommendation as the base, the percentages displayed in column 5 of Table 16 result. With this handicapping, the observed failure rate of 23% for the M.I. group falls within the range reported in the literature of 15% to 28% recidivism for persons receiving structured following. The failure rate for the J.O. group of 29% is at the low end of the 26% to 66% reported in the literature.

H. TERMINATIONS

It is of interest to inquire further into the phenomenon of client termination in the SID operation. Table 17 presents the total count of client terminations. The percentage is based on all clients assessed--whether or not they ever reached the point of receiving a prescription at all.

Half of those who terminated were from the largest sub-group of clients--WSH residents. The largest percentage of terminations in relation to number of assessments was in the Portsmouth J.O. group. This high rate may be related to the youth and mobility of the J.O. clients and the strictly voluntary nature of the program.

Table 18 presents data with respect to where clients were living (IN versus OUT) in relation to their prescription status at the time of termination. One-fourth of all terminations occurred before a prescription was written; all of these occurrences involved clients living in an institution. Another one-fourth occurred when the client was living in the community after a prescription had been written. The remaining one-half of the terminations occurred while the client was living in an institution after he had received at least one prescription.

Reasons why clients terminated their association with SID are shown in Table 19. Action taken by the institution was responsible for over half of the terminations of J.O. clients: The institution moved the client before SID processing was complete. One-fourth of the M.I. and M.R. terminations were for this reason.

One-fourth of the M.R. terminations were due to the client or his representative refusing to cooperate with SID. This finding parallels the possible earlier trend observed

in the M.R. group regarding more reluctance and constraints in community placement (Tables 10 and 11).

Only one client has died after placement in the community. This is an important finding as other studies have reported an increase in mortality immediately after community placement, especially among elderly patients.

Table 1

CLIENT SAMPLE USED IN SID FINAL REPORT
(May 11, 1973 through December 31, 1974)

Cl Group	Inst	Cl A'd		Cl A & P'd		Re-A's	
		n	%	n	%	n	%
M.I.							
PD #6	WSH	176	35.3	165	36.4	90	55.2
PORT	CSH	73	14.7	56	12.4	1	0.6
Sub-Tot		249	50.0	221	48.8	91	55.8
M.R.							
PD #6	LTSH	135	27.1	131	28.9	53	32.5
PORT	LTSH	18	3.6	17	3.8		
PORT	SSVTC	54	10.8	52	11.5	10	6.1
Sub-Tot		207	41.6	200	44.2	63	38.7
J.O.							
PD #6	7TS	5	1.0				
PORT	7TS	37	7.4	32	7.1	9	5.5
Sub-Tot		42	8.4	32	7.1	9	5.5
TOTAL		498	100.0	453	100.1	163	100.0

Table 2

CLIENT SAMPLE SIZE

Cl Group	Inst	Clients Reached By SID: 1 A'd Bet. 5/11/73 & 12/31/74 n	%	2 To Be A'd By 6/30/75: Have Info Release n	%	No Contact Yet n	%	3 Total Cl A'd By 6/30/75* (C.1 + C.2) n	%	Potential Clients Missed By SID: 4 Refusals n	%	5 Medically Incompetent Cl: No Relative or Committee n	%	Relative or Committee Unreachable n	%	6 Total Missed (C.4+C.5) n	%	7 Total Cl Targeted for Processing (C.3 + C.6) n
M.I.																		
PD#6	NSH	176	35.3	3	8.1	28	57.1	207	35.4	38	13.5	34	12.2			72	25.8	279
Port	CSH	73	14.7	34	91.9	17	34.7	124	21.2	30	17.6	16	9.4			46	27.0	170
Sub-Tot		249	50.0	37	100.0	45	91.8	331	56.7	68	15.1	50	11.1			118	26.3	449
M.R.																		
PD#6	LTSH	135	27.1			1	2.0	136	23.3	26	13.8	14	7.4	12	6.4	52	27.7	188
Port	LTSH	18	3.6			3	6.1	21	3.6	1	3.2	9	29.0			10	32.3	31
Port	SSVTC	54	10.8					54	9.2	3	4.4	11	16.2			14	20.6	68
Sub-Tot		207	41.6			4	8.1	211	36.1	30	10.5	34	11.8	12	4.2	76	26.5	287
J.O.																		
PD#6	TTS	5	1.0					5	0.9									5
Port	TTS	37	7.4					37	6.3									37
Sub-Tot		42	8.4					42	7.2									42
TOTAL		498	100.0	37	100.0	49	99.9	584	100.0	98	12.6	84	10.8	12	1.5	194	24.9	778

*Assumes that all clients who have not yet been contacted will sign release of information authorization.

NOTE: Percentages in Columns 1, 2, and 3 are based on TOTAL row.
Percentages in Columns 4, 5, and 6 are based on Column 7.

Table 3

CONSENTS AND REFUSALS TO AUTHORIZE INFORMATION RELEASE
(Total Client Sample)

Source of Authorization	Approached	Consents		Refusals		Reasons for Refusals*											
						No Reason Given		Unwilling to Release Personal Information		Didn't Want (Cl) to Leave Institution		Release Would Deplete Cl's Resources		SID Not Needed/Were Firm Plans to Move Client		Other	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Client	442	374	84.6	68	15.4	40	58.8	6	8.8	12	17.6	1	1.5	5	7.4	4	5.9
Committee	42	35	83.3	7	16.7					7	100.0						
Relative/ Guardian	107	84	78.5	23	21.5	2	8.7	2	8.7	18	78.3					1	4.3
Instn	48	48	100.0														
Total	639	541	84.7	98	15.3	42	42.9	8	8.2	37	37.8	1	1.0	5	5.1	5	5.1

*Percentages based on number of refusals.

Table 4

SUMMARY OF REASONS CLIENT STILL IN INSTITUTION

Reason	M.I. FD #6 n	M.I. FD #6 WSH %	M.I. Porta n	M.I. Porta CSH %	M.I. Sub-Tot n	M.I. Sub-Tot %	M.R. FD #6 n	M.R. FD #6 LTSH %	M.R. Porta n	M.R. Porta LTSH %	M.R. Porta n	M.R. Porta SSVTC %	M.R. Sub-Tot n	M.R. Sub-Tot %	J.O. FD #6 n	J.O. FD #6 JTS %	J.O. Port n	J.O. Port JTS %	J.O. Sub-Tot n	J.O. Sub-Tot %	TOTAL N°	TOTAL %
Client is under legal restraints			8	10.5	8	3.2					1	1.3	1	0.4			29	49.2	29	49.2	38	7.0
Client's behavioral/physical/overall cond. is such that institu. care will be nec. for foreseeable future	33	19.1	25	32.9	58	23.3	40	30.1	6	23.1	23	29.8	69	29.2			6	10.2	6	10.2	133	24.4
Client is danger to self or others	1	0.6	1	1.3	2	0.8	2	1.5			1	1.3	3	1.3							5	0.9
Client has been dischargeable for some time; no active attempts to place	41	23.7	9	11.8	50	20.1	46	34.6	8	30.8	16	20.8	70	29.7							120	22.1
Client has been dischargeable for some time; attempts to place have been made but resources unavailable	13	7.5	4	5.3	17	6.8	2	1.5	3	11.5	5	6.5	10	4.2			2	3.4	2	3.4	29	5.3
Client only recently dischargeable	35	20.2	6	7.9	41	16.5	10	7.5			8	10.4	18	7.6			16	27.1	16	27.1	75	13.8
Family members indicate they are no bridge to placement	10	5.8	11	14.5	21	8.4	6	4.5	8	30.8	20	26.0	34	14.4			1	1.7	1	1.7	56	10.3
Client placed out at least once but returned	13	7.5	6	7.9	19	7.6	2	1.5			1	1.3	3	1.3			1	1.7	1	1.7	23	4.2
Client serving a "useful purpose" for institution																						
Client has refused to leave institu.	5	2.9	4	5.3	9	3.6	3	2.3	1	3.8			4	1.7							13	2.4
Other	22	12.7	2	2.6	24	9.6	22	16.5			2	2.6	24	10.2			4	6.8	4	6.8	52	9.6
TOTAL	173	100.0	76	100.0	249	99.9	133	100.0	26	100.0	77	100.1	236	100.0			59	100.1	59	100.1	544	100.0

*Some clients were assigned more than one reason

Table 5

BEHAVIOR REPERTOIRE STATISTICS:
LAST BEHAVIOR REPERTOIRE WHILE LIVING IN

Cl Group	Inst.	All/ Last PR	N*	Adaptive Behavior X̄	Adaptive Behavior s.d.	Maladaptive Behavior X̄	Maladaptive Behavior s.d.
M.I.							
PD #6	WSH	ALL	176	2.10	1.83	0.47	1.11
		PR-IN	49	1.99	1.82	0.60	1.25
		PR-OUT	116	2.15	1.84	0.41	1.05
PORT	CSH	ALL	73	2.26	1.79	0.41	1.02
		PR-IN	29	1.91	1.78	0.48	1.14
		PR-OUT	27	2.51	1.76	0.26	0.81
SUB-TOTAL		ALL	249	2.15	1.82	0.45	1.09
		PR-IN	78	1.96	1.81	0.55	1.21
		PR-OUT	143	2.22	1.83	0.38	1.01
M.R.							
PD #6	LTSH	ALL	135	1.76	1.87	0.39	1.05
		PR-IN	52	1.43	1.80	0.57	1.25
		PR-OUT	79	1.99	1.88	0.29	0.89
PORT	LTSH	ALL	18	1.86	1.88	0.37	1.03
		PR-IN	6	1.62	1.86	0.65	1.32
		PR-OUT	11	1.98	1.87	0.24	0.84
PORT	SSVTC	ALL	54	1.71	1.84	0.54	1.18
		PR-IN	24	1.18	..70	0.74	1.37
		PR-OUT	28	2.16	1.83	0.40	0.98
SUB-TOTAL		ALL	207	1.76	1.86	0.43	1.09
		PR-IN	82	1.37	1.78	0.62	1.29
		PR-OUT	118	2.03	1.87	0.31	0.91
J.O.							
PD #6	7TS	ALL	5	3.32	1.30	0.24	0.75
PORT	7TS	ALL	37	2.93	1.48	0.54	1.08
		PR-IN	6	2.86	1.53	0.62	1.15
		PR-OUT	26	2.91	1.46	0.61	1.12
SUB-TOTAL		ALL	42	2.96	1.46	0.51	1.05
		PR-IN	6	2.86	1.53	0.62	1.15
		PR-OUT	26	2.91	1.46	0.61	1.12

*N = number of clients, not the number of observations upon which the x̄ and s.d. are based.

Table 6

CLIENT PROCESSING SUMMARY

PROJECT OPERATIONAL FOR 1 YEAR(S) AND 6 MONTH(S) (AS OF 12/31/74)

CL GROUP	INST	NO.CL A&P'D	NO. RELEASES	CURRENT PR STATUS IN #	CURRENT PR STATUS IN %	CURRENT PR STATUS OUT #	CURRENT PR STATUS OUT %	(NO. TERM.)*	CURRENT OUTCOME STATUS IN #	CURRENT OUTCOME STATUS IN %	CURRENT OUTCOME STATUS OUT #	CURRENT OUTCOME STATUS OUT %	(WAS OUT NOW IN)	(OUT/ TEAM REC PENDING)	A&P YEAR NO. MINS	A&P YEAR MAN HOURS	A&P YEAR PERSNL COST
M.I.																	
PD#6	MSH	165	90	49	30%	116	70%	(25)	94	70%	43	30%	(4)	(6)	56	1,574	$ 13,977
PORT	CSH	56	1	29	52%	27	48%	(2)	49	91%	5	9%		(1)	10	319	$ 3,014
SUB-TOT		221	91	78	35%	143	65%	(25)	146	76%	48	24%	(4)	(7)	46	1,893	$ 16,991
M.R.																	
PD#6	LTSH	131	53	52	40%	79	60%	(8)	111	90%	12	10%		(1)	28	1,016	$ 8,518
PORT	LTSH	17		6	35%	11	65%		17	100%					2	106	$ 1,001
PORT	SSVTC	52	10	24	46%	28	54%	(1)	42	82%	9	18%	(1)	(4)	10	343	$ 3,241
SUB-TOT		200	63	82	41%	118	59%	(9)	170	89%	21	11%	(1)	(5)	40	1,465	$ 12,756
I.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	163	166	37%	287	63%	(46)	323	79%	84	21%	(6)	(15)	96	3,727	$ 32,403

* 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 A&P'D"
3) "CURRENT OUTCOME STATUS" PERCENTAGES ARE BASED ON ("NO.CL A&P'D" MINUS "(NO. TERM)")

Table 7

REASONS FOR COMMUNITY PLACEMENT PRESCRIPTION DECISION

Reason	M.I. PD#6 WSH n	M.I. PD#6 WSH %	M.I. Port CSH n	M.I. Port CSH %	M.I. Sub-Tot n	M.I. Sub-Tot %	M.R. PD#6 LTSH n	M.R. PD#6 LTSH %	M.R. Port LTSH n	M.R. Port LTSH %	M.R. Port SSVTC n	M.R. Port SSVTC %	M.R. Sub-Tot n	M.R. Sub-Tot %	J.O. PD#6 7TS n	J.O. PD#6 7TS %	J.O. Port 7TS n	J.O. Port 7TS %	J.O. Sub-Tot n	J.O. Sub-Tot %	Total N	Total %
Inappropriately Institutionalized Initially	16	13.8	1	3.7	17	11.9	15	19.0	3	27.3	2	7.1	20	16.9							37	12.9
Insti Deleterious							2	2.5					2	1.7							2	0.7
No Further Improvement Expected	52	44.8	2	7.4	54	37.8	20	25.3			9	32.1	29	24.6			18	69.2	18	69.2	101	35.2
Alternative Living Preferable	46	39.7	24	88.9	70	49.0	42	53.2	8	72.7	17	60.7	67	56.8			6	23.1	6	23.1	143	49.8
Other	2	1.7			2	1.4											2	7.7	2	7.7	4	1.4
TOTAL	116	100.0	27	100.0	143	100.1	79	100.0	11	100.0	28	99.9	118	100.0			26	100.0	26	100.0	287	100.0

Table 8

REASONS FOR CONTINUED INSTITUTIONALIZATION PRESCRIPTION DECISION

Reason	M.I. PD#6 WSH n	M.I. PD#6 WSH %	M.I. Port CSH n	M.I. Port CSH %	M.I. Sub-Tot n	M.I. Sub-Tot %	M.R. PD#6 LTSH n	M.R. PD#6 LTSH %	M.R. Port LTSH n	M.R. Port LTSH %	M.R. Port SSY/TC n	M.R. Port SSY/TC %	M.R. Sub-Tot n	M.R. Sub-Tot %	J.O. PD#6 YTS n	J.O. PD#6 YTS %	J.O. Port YTS n	J.O. Port YTS %	J.O. Sub Tot n	J.O. Sub Tot %	Total N	Total %
Treatment Services Needed	27	55.1	17	58.6	44	56.4	19	36.5			5	20.8	24	29.3			5	83.3	5	83.3	73	44.0
Education/Training Services Needed	12	24.5			12	15.4	16	30.8	4	66.7	10	41.7	30	36.6							42	25.3
Evaluation Services Needed	4	8.2	3	10.3	7	9.0	8	15.4	2	33.3	2	8.3	12	14.6			1	16.7	1	16.7	20	12.0
Maintenance Services Needed	6	12.2	8	27.6	14	17.9	8	15.4			7	29.2	15	18.3							29	17.5
Other			1	3.4	1	1.3	1	1.9					1	1.2							2	1.2
TOTAL	49	100.0	29	99.9	78	100.0	52	100.0	6	100.0	24	100.0	82	100.0			6	100.0	6	100.0	166	100.0

Table 9

CURRENT PRESCRIPTION AND OUTCOME STATUS FOR NON-TERMINATED CLIENTS

Client Group	Inst	Current Pr Status IN n	IN %	CUT n	CUT %	Current Outcome Status IN n	IN %	OUT n	OUT %	Total N	Total %	% of Clients Pr OUT Actually OUT
M.I.												
PD #6	WSH	41	28.9	101	71.1	99	69.7	43	30.3	142	34.9	42.6
Port	CSH	29	53.7	25	46.3	49	90.7	5	9.3	54	13.3	20.0
Sub-Tot		70	35.7	126	64.3	148	75.5	48	24.5	196	48.2	38.1
M.R.												
PD #6	LTSH	51	41.5	72	58.5	111	90.2	12	9.8	123	30.2	16.7
Port	LTSH	6	35.3	11	64.7	17	100.0			17	4.2	0.0
Port	SSVTC	24	47.1	27	52.9	42	82.4	9	17.6	51	12.5	33.3
Sub-Tot		81	42.4	110	57.6	170	89.0	21	11.0	191	46.9	19.1
J.O.												
PD #6	7TS											
Port	7TS			20	100.0	5	25.0	15	75.0	20	4.9	75.0
Sub-Tot				20	100.0	5	25.0	15	75.0	20	4.9	75.0
Total		151	37.1	256	62.9	323	79.4	84	20.6	407	100.0	32.8

Table 10

COUNT OF ACTIVE AND TERMINATED CLIENTS PLACED IN THE COMMUNITY
(May 11, 1973 through December 31, 1974)

		Placement of Active Clients						Placement of Terminated Clients								
		1				2		3				4		5		6
Cl Group	Inst	W/Team Rec		W/O Team Rec		Sub-Total		W/Team Rec		W/O Team Rec		Sub-Total		Total Placed in Community		No. Cl A & P'ed
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	
M.I.																
PD #6	WSH	37	86.1	6	13.9	43	84.3	3	37.5	5	62.5	8	15.7	51	30.9	165
Port	CSH	4	80.0	1	20.0	5	100.0							5	8.9	56
Sub-Tot		41	85.4	7	14.6	48	85.7	3	37.5	5	62.5	8	14.3	56	25.3	221
M.R.																
PD #6	LTSH	11	91.7	1	8.3	12	80.0	1	33.3	2	66.7	3	20.0	15	11.5	131
Port	LTSH															17
Port	SSVTC	5	55.6	4	44.4	9	100.0							9	17.3	52
Sub-Tot		16	76.2	5	23.8	21	87.5	1	33.3	2	66.7	3	12.5	24	12.0	200
J.O.																
PD #6	7TS															
Port	7TS	12	80.0	3	20.0	15	78.9	4	100.0			4	21.1	19	59.4	32
Sub-Tot		12	80.0	3	20.0	15	78.9	4	100.0			4	1.1	19	59.4	32
TOTAL		69	82.1	15	17.9	84	84.8	8	53.3	7	46.7	15	15.2	99	21.9	453

NOTE: Percentages in Column 1 are based on Column 2. Percentages in Column 3 are based on Column 4.
Percentages in Columns 2 and 4 are based on Column 5.
Percentages in Column 5 are based on Column 6.

Table 11

BLOCKAGES ENCOUNTERED BY BA IN COMPLETING RESOURCE SEARCHES FOR CLIENTS PRESCRIBED TO AND AWAITING PLACEMENT IN THE COMMUNITY

Client Group	Inst	Institution		Housing		Income		Supporting Services		Client/ Representative		No Specific Block Yet		Total	
		n	%	n	%	n	%	n	%	n	%	n	%	N	%
M.I.															
P.D. #6	WSH	3	5.2	28	48.3	3	5.2			3	5.2	21	36.2	58	33.7
Port	CSH			10	50.0	4	20.0			2	10.0	4	20.0	20	11.6
Sub-Tot		3	3.8	38	48.7	7	9.0			5	6.4	25	32.1	78	45.4
M.R.															
PD #6	LTSH	11	18.3	38	63.3	1	1.7			5	8.3	5	8.3	60	34.9
Port	LTSH			7	63.6	2	18.2			1	9.1	1	9.1	11	6.4
Port	SSVTC	1	5.6	11	61.1			1	5.6	2	11.1	3	16.7	18	10.5
Sub-Tot		12	13.5	56	62.9	3	3.4	1	1.1	8	9.0	9	10.1	89	51.7
J.O.															
PD #6	7TS														
Port	7TS			1	20.0							4	80.0	5	2.9
Sub-Tot				1	20.0							4	80.0	5	2.9
Total		15	8.7	95	55.2	10	5.8	1	0.6	13	7.6	38	22.1	172	100.0

Table 12

COOPERATION OF CLIENT/REPRESENTATIVE IN CLIENTS AWAITING PLACEMENT IN THE COMMUNITY

Client Group	Inst	Client/ Representative Cooperative		Client Actively Uncooperative		Client Unaware/ At Times Uncooperative		Committee Uncooperative		Relative/ Guardian Uncooperative		Total	
		n	%	n	%	n	%	n	%	n	%	N	%
M.I.													
PD #6	WSH	48	84.5	3	5.2	4	6.9			2	3.4	57	33.7
Port	CSH	16	80.0	1	5.0	2	10.0			1	5.0	20	11.6
Sub-Tot		65	83.3	4	5.1	6	7.7			3	3.8	78	45.4
M.R.													
PD #6	LTSH	47	78.3	7	11.7	2	3.3			4	6.7	60	34.9
Port	LTSH	11	100.0									11	6.4
Port	SSVTC	15	83.3			1	5.6			2	11.1	18	10.5
Sub-Tot		73	82.0	7	7.9	3	3.4			6	6.7	89	51.7
J.O.													
PD #6	7TS												
Port	7TS	5	100.0									5	2.9
Sub-Tot		5	100.0									5	2.9
Total		143	83.1	11	6.4	9	5.2			9	5.2	172	100.0

Table J*

MOST RECENT LIVING PREFERENCE OF CLIENTS PLACED IN COMMUNITY

Client Group	Inst.	Living in Ideal Housing: N.R./D.K.* n	%	Prefer Out of Inst. n	%	Prefer In Inst. n	%	No Pref. n	%	Living in 2nd Choice Housing: N.R./D.K. n	%	Prefer Out of Inst. n	%	Prefer In Inst. n	%	No Pref. n	%	Living in 3rd Choice Housing: N.R./D.K. n	%	Prefer Out of Inst. n	%	Prefer In Inst. n	%	No Pref. n	%	TOTAL N
M.I.																										
PD #6	WSH	2	7.7	23	88.5	1	3.8					5	83.3			1	16.7			8	72.7	2	18.2	1	9.1	43
Port	CSH			4	100.0															1	100.0					5
Sub-Total		2	6.7	27	90.0	1	3.3					5	83.3			1	16.7			9	75.0	2	16.7	1	8.3	48
M.R.																										
PD #6	LTSH	1	14.3	6	85.7							1	100.0					1	25.0	3	75.0					12
Port	LTSH																									
Port	SSVTC			5	100.0					1	25.0	3	75.0													
Sub-Total		1	8.3	11	91.7					1	20.0	4	80.0					1	25.0	3	75.0					21
J.O.																										
PD #6	7TS																									
Port	7TS	1	10.0	9	90.0							3	100.0					1	50.0	1	50.0					15
Sub-Total		1	10.0	9	90.0							3	100.0					1	50.0	1	50.0					15
Total		4	7.7	47	90.4	1	1.9			1	7.1	12	85.7			1	7.1	2	11.1	13	72.2	2	11.1	1	5.6	84

* N.R./D.K. = No report or client could not decide.

Table 14

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

* BEHAVIORAL REPERTOIRE *

* GROUP STATISTICS *

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

NUMBER OF CLIENTS PROCESSED: 36

"BEFORE" AND "AFTER" BEHAVIORAL REPERTOIRE RESULTS ON 36 DEINSTITUTIONALIZED CLIENTS

ADAP BEHAVIORS	N/TOTAL	BEFORE MEAN	AFTER MEAN	MALAD BEHAVIORS	N/TOTAL	BEFORE MEAN	AFTER MEAN
ALL	5344/ 5544	2.47	2.47	ALL	2405/ 2448	0.38	0.1
MOBILITY/LOCOMTN	604/ 612	3.00	3.05	FAULTY SOCIALZTN	1042/ 1044	0.48	0.25
EATING	463/ 468	3.44	3.45	ASSAULTIVE	178/ 180	0.17	0.0
DRESS/GROOMING	671/ 684	3.29	3.40	SELF DESTRUCTIVE	250/ 252	0.46	0.2
WRITING SKILLS	350/ 360	2.21	2.29	PHOBIAS	307/ 324	0.25	0.04
READING SKILLS	345/ 360	2.58	2.65	DISORIENTATION	213/ 216	0.31	0.2
TALKING SKILLS	246/ 252	2.89	2.97	COMPLAINTS/SYMPT	415/ 432	0.33	0.16
AURAL	175/ 180	3.26	3.38				
SOCIALIZATION	320/ 324	2.59	2.50				
MONEY MANAGEMENT	274/ 288	2.33	2.36				
INTELLECT/COGNTV	377/ 396	2.64	3.16				
AFFECT	141/ 144	3.13	3.28				
WORK	173/ 180	1.50	1.29				
HOUSEKEEPING	340/ 360	2.22	1.89				
PASTIMES	865/ 936	0.83	0.59				

Table 15

RECIDIVISM AMONG ACTIVE CLIENTS UPON WHOM THE A&P TEAM HAS FILED A FORMAL RECOMMENDATION FOR COMMUNITY PLACEMENT

(May 30, 1973 through December 31, 1974)

Cl Group	Inst	Total Community Placements Under Team Rec N	%	Ever Returned To Inst n	%	Readmission Events* n	Once Out/ Now In n	%
M.I.								
PD#6	WSH	41	54.7	9	22.0	9	4	9.8
Port	CSH	4	5.3					
Sub-Tot		45	60.0	9	20.0	9	4	8.9
M.R.								
PD#6	LTSH	11	13.3					
Port	LTSH							
Port	SSVTC	6	8.0	1	16.7	1	1	16.7
Sub-Tot		17	22.7	1	5.9	1	1	5.9
J.O.								
PD#6	7TS							
Port	7TS	13	17.3	1	7.7	1	1	7.7
Sub-Tot		13	17.3	1	7.7	1	1	7.7
TOTAL		75	100.0	11	14.7	11	6	8.0

*Percent not appropriate as there can be more than one readmission event per client.

Table 16

COMMUNITY PLACEMENTS UNDER TEAM RECOMMENDATION WHO HAVE TERMINATED OR RETURNED TO AN INSTITUTION

Client Group	Inst.	1 Active n	1 Active %	2 Terminated n	2 Terminated %	3 Total n	3 Total %	4 Returned to Inst. n	4 Returned to Inst. %	5 Returned or Terminated n	5 Returned or Terminated %
M.I.											
PD #6	WSH	41	95.3	2	4.7	43	52.4	9	22.0	11	25.6
Port	CSH	4	100.0			4	4.9				
Sub-Tot		45	95.7	2	4.3	47	57.3	9	20.0	11	23.4
M.R.											
PD #6	LTSH	11	91.7	1	8.3	12	14.6			1	8.3
Port	LTSH										
Port	SSVTC	6	100.0			6	7.3	1	16.7	1	16.7
Sub-Tot		17	94.4	1	5.6	18	22.0	1	5.9	2	11.1
J.O.											
PD #6	7TS										
Port	7TS	13	76.5	4	23.5	17	20.7	1	7.7	5	29.4
Sub-Tot		13	76.5	4	23.5	17	20.7	1	7.7	5	29.4
TOTAL		75	91.5	7	8.5	82	100.0	11	14.7	18	22.0

NOTE: Percentages in Columns 1 and 2 are based on Column 3.
Percentages in Column 4 are based on Column 1.
Percentages in Column 5 are based on Column 3.

Table 17

TOTAL TERMINATIONS COMPARED WITH TOTAL ASSESSMENTS

Client	Inst	Total Assessments n	Total Assessments %	Total Terminations n	Total Terminations %	% of Assessments Who Terminated
M.I.						
PD #6	WSH	176	35.3	30	50.0	17.0
Port	CSH	73	14.7	3	5.5	4.1
Sub-Tot		249	50.0	33	55.0	13.3
M.R.						
PD #6	LTSH	135	27.1	9	15.0	6.7
Port	LTSH	18	3.6			0.0
Port	SSVTC	54	10.8	3	5.0	5.6
Sub-Tot		207	41.6	12	20.0	5.8
J.O.						
PD #6	7TS	5	1.0			0.0
Port	7TS	37	7.4	15	25.0	40.5
Sub-Tot		42	8.4	15	25.0	35.7
TOTAL		498	100.0	60	100.0	12.0

Table 18

COUNT OF TERMINATED CLIENTS BROKEN DOWN BY
RESIDENCE STATUS AND PRESCRIPTION STATUS AT TIME OF TERMINATION

Cl Group	Inst	Terminated Before Pr Written: 1 Living IN n	%	1 Living OUT n	%	2 Sub-Total n	%	Terminated After Pr Written: 3 Living IN n	%	3 Living OUT n	%	4 Sub-Total n	%	5 Total Terminated N	%
M.I.															
PD#6	WSH	7	23.3			7	23.3	15	50.0	8	26.7	23	76.7	30	50.0
Port	CSH	1	33.3			1	33.3	2	66.7			2	66.7	3	5.0
Sub-Tot		8	24.2			8	24.2	17	51.5	8	24.2	25	75.8	33	55.0
M.R.															
PD#6	LTSH	1	11.1			1	11.1	5	55.6	3	33.3	8	88.9	9	15.0
Port	LTSH														
Port	SSVTC	2	66.7			2	66.7	1	33.3			1	33.3	3	5.0
Sub-Tot		3	25.0			3	25.0	6	50.0	3	25.0	9	75.0	12	20.0
J.O.															
PD#6	7TS														
Port	7TS	3	20.0			3	20.0	8	53.3	4	26.7	12	80.0	15	25.0
Sub-Tot		3	20.0			3	20.0	8	53.3	4	26.7	12	80.0	15	25.0
TOTAL		14	23.3			14	23.3	31	51.7	15	25.0	46	76.7	60	100.0

NOTE: Percentages in Columns 1, 2, 3, and 4 based on Column 5.
Percentages in Column 5 based on TOTAL row.

Table 19

REASONS FOR TERMINATIONS

Reason	M.I. PD#6 WSH n	M.I. PD#6 WSH %	M.I. Port CSH n	M.I. Port CSH %	M.I. Sub-Tot n	M.I. Sub-Tot %	M.R. PD#6 LTSH n	M.R. PD#6 LTSH %	M.R. Port LTSH n	M.R. Port LTSH %	M.R. Port SSVTC n	M.R. Port SSVTC %	M.R. Sub-Tot n	M.R. Sub-Tot %	J.O. PD#6 7TS n	J.O. PD#6 7TS %	J.O. Port 7TS n	J.O. Port 7TS %	J.O. Sub Tot n	J.O. Sub Tot %	Total N	Total %
Cl Death While in Comm.	1	3.3			1	3.0															1	1.7
Cl Death While in Inst	8	26.7			8	24.2	1	11.1					1	8.3			1	6.7	1	6.7	10	16.7
Cl/Rep Refuses to Co-op	5	16.7			5	15.2	3	33.3					3	25.0			2	13.3	2	13.3	10	16.7
Cl Moved from SID Area	7	23.3	1	33.3	8	24.2	4	44.4					4	33.3			3	20.0	3	20.0	15	25.0
Cl Assessed; Inst. Moved Cl Out Before Pr Written	3	10.0	1	33.3	4	12.1					2	66.7	2	16.7			2	13.3	2	13.3	8	13.3
Cl A&P'd; Inst. Moved Cl Out Not Under SID Pr	4	13.3	1	33.3	5	15.2					1	33.3	1	8.3			6	40.0	6	40.0	12	20.0
Other	2	6.7			2	6.1	1	11.1					1	8.3			1	6.7	1	6.7	4	6.7
TOTAL	30	100.0	3	99.9	33	100.0	9	99.9			3	100.0	12	99.9			15	100.0	15	100.0	60	100.1

III. SERVICE REQUIREMENTS, AVAILABILITY, AND PROVISION

In developing human services designed for a given target population, three associated questions are relevant:

(1) What services does the target population need?

(2) What services currently exist to meet these needs?

(3) To what extent are the available services actually meeting these needs?

Planning and development of services often proceed without an adequate answer to any of these questions. The result is the current delivery system with its overlaps among services and gaps between them. Documentation accompanying three aspects of client processing in the SID model systematically provides data to answer the questions and facilitates planning to meet future needs of institutionalized mentally ill, mentally retarded, and juvenile offender clients.

(1) The answer to what services are required is produced on an individual client basis by the A&P teams. After making the initial prescription decision regarding a client's readiness for community placement, the team writes a detailed and individually-tailored prescription for him. If the client is determined to be capable of community living, then housing, income, job training/placement, physical health, social/psychological health, and educational services required for successful community residence are prescribed. If the client is held to require continued institutional care, a prescription detailing institutional services needed to aid in fully developing his potential is written. In either case, individualized objectives are assigned by the team to each element prescribed.

(2) If the prescription is for community placement, a resource search (see IB4 for definition) is conducted and services found to be available or reasons for unavailability are noted. If the prescription is for continued institutionalization, a resource search is not carried out since it is assumed that the institution exists to meet the needs of its residents. The prescription is transmitted to institution personnel for their consideration in working with the client.

(3) The extent to which available services are actually being provided is monitored by the BA. When a community placement prescription is filled and the client moves to the community with a team recommendation (IB6), the BA follows the client (IB8) and reports on the client's status with regard to each element prescribed. The BA determines if the service has been provided, if the service provider believes the specified objective is being met, if the client believes the service should be continued, and if the client valued the service. The degree of fulfillment of continued institutionalization prescriptions (IB9) is periodically reported by the BA assigned.

The following discussion of the service needs of non-terminated SID clients, the availability of services to meet their needs, and the actual provision of services is divided into two major sections: data for clients currently prescribed for community placement and data relating to clients currently prescribed to continue in the institution. Client data presented throughout are further broken down by disability group, geographic area of residence, and institution of residence.

A. SERVICE REQUIREMENTS, AVAILABILITY, AND PROVISION FOR CLIENTS CURRENTLY PRESCRIBED FOR COMMUNITY PLACEMENT

1. Service Requirements

a. Housing. The A&P team prescribes an ideal (first choice) housing arrangement for each client prescribed for community placement. Appendix E contains Prescription Digests for non-terminated clients in each disability group and each institution (or institution grouping, in the case of the J.O., clientele.) Table 20 (1)* summarizes the ideal housing selections made on the 256 clients currently prescribed for community placement.

20% of the M.I. clients were prescribed to reside ideally in a group home, 20% to reside in a nursing home, and 14% to live with a relative or guardian. Among the M.R. clients, 30% were prescribed to live ideally in a group home, 31% to live with a relative or guardian, and 14% to live with a foster family. 40% of the J.O. clients were prescribed to return to their families as the most preferable living arrangement.

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* Tables 20 through 40 are presented at the end of Section III, SERVICE REQUIREMENTS, AVAILABILITY, AND PROVISION.

These findings suggest that family linkages were least intact in the M.I. group of clients, perhaps because of their high mean age. The J.O. group apparently had the greatest amount of remaining family linkage, again perhaps due to their relative youth.

In addition to making an ideal housing selection, the team may prescribe one or two alternative housing situations for a given client. These second and/or third choice housing elements are searched for by the BA if the ideal housing situation has proven to be unavailable.

Table 20(2) and (3) present the second and third choices in housing respectively. Foster care is prescribed as a viable alternative to ideal housing more often than any other single modality. 38.5% of the second choices and 24.6% of the third were for some type of foster care. Home for adults is prescribed more frequently as a third choice (20%) than as a first choice (9%).

Table 21 pools and summarizes all housing prescribed. A total of 600 housing prescriptions were written for the 256 clients currently prescribed for community placement. This yields an average of 2.3 housing choices per client made by the A&P teams.

Of all housing prescriptions written for M.I. clients, 23% were for foster homes, 17% for group homes, 16% for homes for adults, and 12% for nursing homes. 28% of the housing prescriptions written for M.R. clients were for foster homes, 26% for group homes, and 17% for relative or guardian homes. 45% of the prescriptions written for J.O. clients were for relative or guardian homes.

Using the data in these two tables, some conclusions may be drawn:

(1) M.I. clients received over twice as many prescriptions for restrictive housing situations (nursing home and home for adults) as the M.R. client group (28% versus 13%).

(2) Over 30% of the J.O. and M.R. clients were seen to have family supports available and were prescribed to reside ideally with a relative or guardian. 14% of the M.I. clients received such an ideal prescription.

(3) Foster home placement was frequently seen as a second-best alternative. It constituted 13% of the ideal housing prescriptions but 25% of the total housing prescribed. Home for adults represents even further compromise (9% 1st, 10% 2nd, 20% 3rd).

b. Income. Table 22 contains a summary of all income suggestions made by the A&P teams. (Table 22 also summarizes the auxiliary prescription elements most frequently selected by the teams.)

Suggested source of income for the M.I. and M.R. groups were fairly evenly distributed among client or family resources, SSI and public assistance, and Medicaid and

Medicare. The major source of income suggested for the J.O. group was the client or the family's own finances.

c. Auxiliary Prescription Elements: Job Training/Placement. From Table 22 it can be seen that, on the average, slightly more than one job training/placement element was prescribed for each client.

55% of the J.O. clients were prescribed for employment counseling and 44% of the M.R. clients were prescribed for evaluation and referral. The J.O. clients were apparently viewed as more ready for job placement than the M.R. who often required further evaluation.

Over one-fourth of the M.R. clients were prescribed for placement in a sheltered workshop. While 32% of the WSH clients were held ready for employment counseling, 68% of the CSH clients were prescribed for further evaluation.

d. Auxiliary Prescription Elements: Physical Health. An average of three to four physical health elements were prescribed for each client.

Nearly all clients were prescribed for medical following in the community. The percentage of clients prescribed for dental following ranged from 27% of the WSH clients to 96% of the CSH and SSVTC clients.

Family planning/sex education was prescribed for all J.O. clients and for 45% of the M.R. clients. The fact that only 12% of the M.I. clients received this prescription

is likely attributable to the group's higher mean age.

e. Auxiliary Prescription Elements: Social/ Psychology Health. An average of three to four social/ psychological health elements were prescribed for each client.

Community Adjustment Training (C.A.T.) was prescribed frequently for M.I. and M.R. clients. J.O. clients were not seen to be so isolated from community life.

Family counseling was prescribed for more J.O. and M.R. clients than for M.I. clients (70% and 65% versus 40%). This is consistent with the finding that residing with relative or guardian was prescribed more frequently for the former groups than for the latter.

f. Auxiliary Prescription Elements: Education. Education elements were, on the average, prescribed less frequently than the other types of elements for the M.I. and M.R. clients. The J.O. clients, whose mean age is 16 years, had an average of 1.4 educational elements prescribed.

Speech therapy was prescribed for 22% of the M.R. clients.

2. Service Availability

After the team has written a community placement prescription, the BA assigned begins to look for the ideal housing prescribed. If this is unavailable, a search for the second and finally third choice housing

(assuming these have been prescribed by the team) is carried out. If housing is found, the BA looks for a source of income to support the client in the community. Once housing and income have been found, a search for auxiliary elements is conducted.

It was discovered that this was the only practical manner in which resource searches could be realistically conducted. Until service providers knew, with a high degree of probability, that a client was to return to the community, they would not enter into a service agreement with the broker advocate even if they had the service capability.

This method of searching first for housing, and only after housing becomes likely, then for income, and lastly for the auxiliary elements produces more interpretable data concerning the existent limits of availability of housing than it does about the existent limits of availability of the other elements.

Because of the search methodology employed, it is necessary to use a different measure to reflect availability of housing from that used to reflect availability of the other elements. In the case of housing, extent of availability is measured by obtaining the percentage of housing elements

CONTINUED

1 OF 4

found to be available against housing elements prescribed; in the case of the other elements, extent of availability is measured by obtaining the percentage of service elements found to be available against service elements searched. Such measures assume that the housing search has been completed for all clients and that the search for the other elements is completed only after the broker advocate has rendered a report of availability/unavailability.

It is important to observe that, given our search method and our availability measures, the existent gap between housing needs and housing availabilities can be readily detected; the discrepancy between other service needs and other service availabilities cannot be fully revealed.

Availability is reported at the time the BA requests that the team formally recommend that the client be released. If the search was not successful, availability is reported at the time the BA requests the team to review and possibly change the prescription.

Data presented on service availability are based primarily on the Cumulative Resource Search Results reports for each disability group and institution of residence at Appendix F. For each element prescribed, the following information is provided in these reports:

(1) Number of clients for whom the element was prescribed, number of clients for whom the element was found to be available, and number of clients for whom the search to fill the element is not complete.

(2) If the element has been determined to be unavailable, the reason(s) for unavailability.

(3) The total number of BA contacts made and reported in searching to fill individual client prescriptions within each element; the mean number of contacts per individual client prescription for which a search has been conducted and reported.

(4) The total number of different providers contacted in performing the searches; the mean number of different providers contacted per individual prescription search that has been conducted and reported.

a. Housing. Table 23 reflects the extent to which the ideal housing modalities prescribed were actually found to be available. The first column shows the number of times each housing modality received a first choice prescription. The second column indicates how many instances of a given modality were found--regardless of preferred choice in the prescription. In the course of searching, the BA encounters unavailabilities; columns 3 through 7 sum to the number of times the BA encountered and reported an unavailability. (The BA may have recorded "unavailable" on housing elements never filled, or he may have eventually filled the prescription at another establishment. Also the BA may be reluctant to finalize unsuccessful housing search results, in which case the reason for unavailability would not yet be reported.

Therefore, the sum of columns 3 through 7 does not necessarily equal the number of unavailabilities which is the difference between columns 1 and 2.) Column 8 records how many contacts the BA's made in attempting/succeeeding to fill the prescriptions associated with a given element/row. Column 8 also reflects the average number of contacts with respect to the number of availabilities. Column 9 lists the number of contacts without counting the same agency/provider more than once per search.

Table 23 (1) combines the housing availability data for all clients. Housing has been found for 29.1% of the 254 non-terminated clients having community placement prescriptions.*

There is clearly a data lag between the BA's locating housing and his informing the SID central office of this fact. 84 clients are currently living in the community but housing for only 74 clients has been reported as having been found. Part of this lag occurs when the institution prematurely releases a client and at least a portion of the search for services is carried out after the client has already arrived in the community.

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* See first footnote to Table 23 for explanation of why only 254 of the 256 clients prescribed for community placement appear in these data.

The gap in resources between what was prescribed by the team and found to be available ranges from 20% in the case of boarding house/residential hotel to more than 90% with regard to group homes and halfway houses.

Boarding house/residential hotel, home for adults, and relative/guardian/independent living show the least gap between prescription and availability. It may be noted that these housing types serve community residents generally rather than having been created specifically to serve the M.I., M.R., or J.O. as is the case with group homes and halfway houses.

The most frequent reasons given for housing unavailability were that there were no openings in available programs and that no such resource existed in the area being searched. Together these accounted for 61% of the reasons for unavailability.

12.6 contacts and 11.6 different contacts were made for each availability obtained. However, foster home and "other" are largely responsible for the excessive number of contacts per availability. Determination of availability of residence with a relative/guardian/independently or in a boarding home required the least amount of expenditure of BA contact effort.

Table 23 (2) shows that housing for 34.1% of the M.I. clients has been established. There is no resource gap in boarding house/residential hotels for the M.I. clients. There is a 100% gap between the requirements of the M.I. for halfway houses and the availability of this living mode, and a 92% gap with respect to group homes.

Establishment of foster care placement for M.I. clients required the greatest number of contacts.

Housing for only 13.8% of the M.R. clients has been found. See Table 23 (3). 100% gaps between need and availability existed with respect to boarding house/residential hotels, halfway houses, nursing homes, VR residential facilities, and "other" housing. The gap was greater than 80% among all modes except homes for adults (29% gap).

The largest mean number of contacts per available housing resources for M.I. clients was in relation to searches for foster homes.

Table 23 (4) shows that housing for 84.2% of the J.O. clients was available. A 100% gap between need and availability existed with respect to foster homes and group homes for this client group. Though there were several contacts made in trying to locate foster homes and group homes, none was successful.

b. Income. Tables 24 and 25 respectively reflect the extent to which searches for income sources and auxiliary elements were successful and give the reasons for unavailability of services when searches were unsuccessful.

In either table, the first column shows the number of elements prescribed. The second column indicates the number of elements for which search results have been reported. The number of elements found to be available are shown in column 3 while the number found to be unavailble are shown in column 4. (In each row, figures in columns 3 and 4 sum to the figure in column 2.) Columns 5 through 9 reflect the number of times the BA encountered an unavailability. Since more than one unavailability may be encountered per element, the sum of the figures in columns 5 through 9 may be greater than the number of elements unavailable. Column 10 shows the total BA contacts and the mean number of contacts with respect to the number of searches completed (i.e., mean equals total divided by figure in column 2). Column 11 provides the number of contacts without counting the same agency/provider more than one time per search.

Availability of income is determined either at the same time housing is being located or directly after housing is found. Table 24 shows that the proportion of searches completed parallels the availability of housing across client

groups (cf. Table 23). 46% of the sources suggested for J.O. clients were searched. 22% of the income sources suggested for M.I. clients and 9% of those suggested for M.R. clients were searched.

95% of the elements searched were found to be available and all income sources searched for the J.O. group were available. Only five income elements have been determined to be definitely unavailable.

An average of 1.6 contacts and 1.4 different contacts were made in the course of each completed search.

c. Auxiliary Service Elements. Cumulative resource search results for all auxiliary elements prescribed and for each of the four major types of elements are summarized in Table 25. As with income, the proportion of auxiliary elements for which searches were completed paralleled the availability of housing. 69% of the elements prescribed for the J.O. clients had been searched. 26% of those prescribed for the M.I. clients and 12% of those prescribed for the M.R. clients were searched.

95% of the elements for which a search had been completed were found to be available. Availability ranged from 93% of the elements searched in the M.I. group to 98% among the J.O. clients.

25 (or 5%) of the 516 elements searched were unavailable. 36% of the reasons for unavailability indicated a simple lack of the resource required. An average of 1.1

contacts and 1.1 different contacts per search were made.

Among the four types of auxiliary service elements, availability ranged from 100% of the educational elements searched to 92% of the job training/placement elements searched. The lowest proportion of availability with respect to completed searches was found in the job training/placement area among WSH clients (86% of the elements searched were available).

The local service delivery systems were apparently able to absorb the relatively small number of SID clients placed without difficulty. It is not clear how long this ability would continue if housing were more available and services for more clients were requested.

3. Services Provided

In the previous section, the low rate of availability of housing for all client groups and especially the M.R. group was established. Availability of income sources and auxiliary services were found to be high in relation to the number of searches completed but the extent of availability of these services could not be fully tested because searches for these elements could not be made until housing was established.

To look further into the service availability question and to consider the matter of service provision, data for the 84 clients now living in the community are examined and

follow-up information is used to determine whether or not services established as being available for them are actually being provided to them.

In the case of all services for these 84 clients, availability is measured by obtaining the percentage of available elements against services prescribed. (It is assumed that all searches have been completed for placed clients.) Two indices are used to measure service provision: (a) percentage of services provided against services prescribed and (b) percentage of services provided against services available.

Findings summarized in the tables presented here are based on reports at Appendices G, H, and I.

(1) Appendix G contains Client Status Update reports for each client group. This report summarizes client outcome to date, current housing and income sources available for clients in the community.

(2) Appendix H contains Cumulative Resource Search Results reports for clients living outside the institution by disability group and previous institution of residence. The content of the reports is as in Appendix F.

(3) Tables for each client group regarding provision of services in the community are at Appendix I. The clients' and service providers' assessments of aspects of these services are tabulated.

a. Housing. A comparison among housing prescribed, available, and provided for the 84 clients living in the community is shown in Table 26. Consistent with the method used in Table 23, ideal housing prescribed is used as the

base from which to derive housing availability.

The slippage in reporting noted earlier is evident. Only 76.5% of the housing prescribed is reported as available. Yet, when we examine our service provision records it is apparent that services are indeed available (they are being provided) which were not reported via the BA resource search reporting methodology. This inverse finding of greater provision than availability suggests that our availability measures are weak; or, that provision is the best criterion for availability.

Based on the Total row only, there was no apparent gap between housing prescribed and housing provided. However, closer inspection reveals that certain modes were over-represented while others were never provided. The gap between housing prescribed and provided with regard to halfway houses was 90% and with respect to group homes, the gap was 83%. Homes for adults were provided three times as often as these were ideally prescribed. In the M.I. group, homes for adults were provided over four times more often than ideally prescribed. These findings reflect the heavy reliance upon second and third housing choices in placing many of the clients residing in homes for adults.

Since it is difficult to compare the current housing modes for the various client groups from the Table 26 display, Table 27 is offered to facilitate an inspection of current housing occupied by client group.

50% of the M.I. clients were living in homes for adults or nursing homes. 42% of the M.R. clients and 93% of the J.O. clients were residing with relatives, guardians, or independently.

Table 28 presents the proportion of clients living in first, second, and third choice housing modes.

While 73% of the J.O. clients are residing in the team's first choice housing situation, the M.I. and M.R. clients are spread out across the choices. 40% of the M.I. and 48% of the M.R. clients are living in the first choice housing while 38% of the M.I. and 33% of the M.R. clients are living in the team's third choice housing.

Table 29 relates the types of community housing being utilized with the levels of housing preferability as prescribed by the team.

50% of the clients living in an ideal housing mode were residing with a relative/guardian/independent. This contrasts with an ideal prescription percentage for this modality of 23.4% (Table 20). 39% of those living in their second choice mode were with relatives while 28% were in foster care. Half of those residing in the third choice were in homes for adults.

b. Income. Table 30 summarizes the income sources providing financial support to clients in the community compared with sources reported to be available and those suggested by the teams.

The analysis in Table 30 (and Table 32 ff.) rests on the assumption that searches were completed on all elements of all prescriptions for the 84 clients living in the community. Consequently, availability is measured against prescription, as was done in examining housing availabilities for the entire group of clients prescribed for community placement (see Table 23).

Again, we find more service provision than we do availability for these 84 clients. The rate of provision of income is 157% of availability. It is not clear whether the greater provision rate is due to BA lag in reporting availability for clients in the community or whether income sources are being added after availability is reported to the team.

87% of the sources suggested were provided. 106% of the sources suggested for M.I. clients were provided while 65% and 70% respectively of the sources suggested for M.R. and J.O. clients were provided.

Table 31 compares income sources supporting the 84 clients living in the community. Almost three-fourths of the income sources supporting J.O. clients were either the client himself or his family. SSI or public assistance constitute 41% of the sources supporting M.R. clients. Sources supporting M.I. clients were primarily distributed between client or family's resources (35%) and SSI or public assistance (34%).

c. Auxiliary Service Elements. Information on the client's situation with respect to each element prescribed by the team and/or added once placement occurred is regularly gathered from both the client's and service provider's viewpoint. Information on each element is included in each report submitted. Tables 32 through 35 (and the more detailed tables at Appendix I) are based on these reports. An element was considered to have been provided if, at any time during the client's community tenure, a service related to the element was rendered. The objective of the element need not have been met for the element to be counted as provided nor did the service need to have been given on a regular or continuous basis for it to be counted.

Table 32 presents service availability and service provision data on the auxiliary service elements for the 84 clients living in the community.

Tables 32 (1) provides a summary across all auxiliary elements. For the 84 clients involved, 449 reports from clients and 161 from providers have been recorded. An average of 5.3 client reports and 1.9 provider reports have been collected for each client.

61% of the elements prescribed were available. Availability ranged from 50% of the elements prescribed for M.R. clients to 80% of those prescribed for J.O. clients.

82% of the elements prescribed were, at some point, provided. 78% of those prescribed for M.I. clients were

provided while 92% of those prescribed for J.O. clients and 83% of those prescribed for M.R. clients were provided.

134% of the elements available were provided. This finding further confirms the fact that our availability measures underestimate actual services available. Since the BA reports availability just prior to or soon after the client's placement, a percentage of provided versus available greater than 100% does not necessarily indicate simply an information lag. It may reflect the addition of services as new needs become evident and/or that some clients were placed in the community before the entire prescription was deemed fillable.

Table 32 (2), (3), (4) and (5) present summary information on service availability and service provision for each type of auxiliary element.

The percent of elements prescribed that were available ranged from 57% of the social/psychological health services to 66% of the physical health services. The percent of elements prescribed that were actually provided ranged from 74% of the social/psychological health services to 97% of the job training/placement services.

Provision ranged from 124% of availability in the physical health area to 163% of availability in the job training/placement area. By our measures, services were provided at more than 100% of availability in all cases.

d. Value/Effectiveness of Services Provided.

Table 33 summarizes the clients' assessments of the occurrence and usefulness of the auxiliary services at the time of the last report.

Services documented as having been provided at least once were not always provided during the last reporting period. Given the nature of certain kinds of services, this is quite understandable. Services not provided in the last report period ranged from 21% of the social/psychological services to 32% of the physical health services.

Across all auxiliary elements, clients reported that 36% of the services received were very useful. J.O. clients reported the lowest percentage of very useful elements in each category. Across all clients, only 9% of the elements were reported to be not useful. Among the four types of elements, "not useful" was chosen in relation to 3% of the physical health elements but 18% of the educational elements.

Table 34 presents the most recent client responses regarding whether or not the auxiliary services being provided should be continued.

Clients stated a desire to continue 78% of the services being provided. J.O. clients reported the lowest proportion of services they wished to continue. Corresponding to the data in Table 33 that showed physical health

elements were rated very useful most often and educational elements rated so least often, clients desire to continue services associated with 88% of the physical health elements and 66% of the education services.

Table 35 provides data on service provider assessment of client movement toward objectives specified in the prescription.

Clients met the objective set by the team with regard to 40% of the elements. No client progress is reported for 15% of the services rendered. Consistent with the attitudes expressed by the clients toward educational and physical health elements, the providers report that the objectives of 51% of the physical health elements and 21% of the educational elements have been met. Providers for the J.O. group report the lowest proportion of elements for which the objective has been met.

e. Service Provision Problems. Table 36 provides a summary of the data on problems reported during service provision. One or more problems in service provision was reported on 33 of the 84 clients (30.3%). There was a total of 70 problem reports on these 33 clients. Some clients had more than one problem report associated with a given service element. For example, in the second row, six different clients had a total of nine problem reports relative to second choice housing.

Clearly housing elicited the greatest number of delivery problems reported, though there were problems reported in connection with many of the other service elements as well.

Service providers made 44 of the 70 reports on problems (62.9%). Services associated with 3.3% of the elements provided were prematurely terminated due to a service delivery problem. Service with respect to 8% to 17% of the housing provided was ended prematurely.

B. SERVICE REQUIREMENTS AND PROVISION FOR CLIENTS CURRENTLY PRESCRIBED FOR CONTINUED INSTITUTIONALIZATION

Discussion of the service requirements and provision of services across institutions must be more general because specific prescription elements vary from one institution to another. This is particularly true among institutions serving different client groups but also obtains among institutions serving the same groups. The reader is referred to Appendix E for a summary of elements prescribed at each institution and Appendix J for a compilation of the fulfillment of institutional prescriptions at each institution.

1. Service Requirements. Table 37 is based on the Prescription Digests at Appendix E. The table contains data on 138 non-terminated clients prescribed for continued institutionalization at a SID-participating institution.

An average of 5.4 elements were prescribed for each M.I. client, and an average of 6.3 elements were prescribed for each M.R. client. An average of one to two more elements were prescribed for LTSH clients than for SSVTC clients.

Table 38 compares the most frequently prescribed continued institutionalization elements among client groups. No element consistently accounts for more than 11% of the total elements prescribed. Medical/dental treatment is the most frequently prescribed element overall with review of diagnosis and/or pharmaceutical intake next.

2. Service Provision. Clients prescribed to continue in the institution are reassessed by the team at approximately six months after the previous assessment. At that time, the BA determines the extent to which the institution fulfilled the last prescription written by the team and formally records same. Table 39 summarizes the results on the 93 active clients who have been reassessed.

43% of the elements were completely filled and an additional 19% were partially filled. At WSH 26% of the elements remained unfilled while at LTSH and SSVTC 37% and 42% respectively were unfilled.

Elements reported to be either completely or partially filled by institution personnel are analogous to those reported to have been provided at least once by community service providers. Table 40 provides a comparison between

fulfillment of continued institutionalization prescriptions and provision of auxiliary prescription elements to clients living in the community.

62% of the elements prescribed to be provided by institution staff were actually provided while 82% of those prescribed for provision by community service deliverers were rendered. 66% of the prescribed institutional elements were provided for M.I. and J.O. clients while 59% of those prescribed were provided for M.R. clients. In the community 78% of the elements prescribed for M.I. clients, 83% of those prescribed for M.R. clients, and 92% of those prescribed for J.O. clients were provided,

Table 20 (1)

IDEAL HOUSING PRESCRIBED

nt		Boarding Res/Res. Hotel		Foster Home								Halfway House								Group Home								Nursing Home		Home for Adults		Relative/ Guardian		Other		TOT
				M.I.		M.R.		J.O.		Other		M.I.		M.R.		J.O.		Other		L.I.		M.R.		J.O.		Other										
	Inst.	R	%	R	%	R	%	R	%	R	%	R	%	R	%	R	%	R	%	R	%	R	%	R	%	R	%	R	%	R	%	R	%	R	%	R
86	WSH	6	5.9			1	1.0			9	8.9	4	4.0	1	1.0			6	5.9	5	5.0	6	5.9			10	9.9	20	19.8	11	10.9	16	15.8	6	5.9	101	
t	CSH	1	4.0	4	16.0							2	8.0	1	4.0					1	4.0	2	8.0			1	4.0	5	20.0	4	16.0	2	8.0	2	8.0	25	1
b-Total		7	5.6	4	3.2	1	0.8			9	7.1	6	4.8	2	1.6			6	4.8	6	4.8	8	6.4			11	8.7	25	19.8	15	11.9	18	14.3	8	6.4	126	1
86	LTSH	2	2.8	1	1.4	3	4.2			3	4.2			2	2.8							19	26.4					6	8.3	6	8.3	26	36.1	4	5.6	72	1
t	LTSH	1	9.1			1	9.1			1	9.1											5	45.4			1	9.1					1	9.1	1	9.1	11	1
t	SSYTC					6	22.2			1	3.7			1	3.7							7	25.9			1	3.7	1	3.7	1	3.7	7	25.9	2	7.4	27	
b-Total		3	2.7	1	0.9	10	9.1			5	4.5			3	2.7							31	28.2			2	1.8	7	6.4	7	6.4	34	30.9	7	6.4	110	1
86	TTS							1	5.0	1	5.0					4	20.0							5	25.0							8	40.0	1	5.0	20	1
t	TTS							1	5.0	1	5.0					4	20.0							5	25.0							8	40.0	1	5.0	20	1
b-Total																																					
L		10	3.9	5	2.0	11	4.3	1	0.4	13	5.9	6	2.3	5	3.0	4	1.6	6	2.3	6	2.3	39	15.2	5	2.0	13	5.1	32	12.5	22	8.6	60	23.4	16	6.2	256	1

Table 20 (2)

SECOND CHOICE HOUSING PRESCRIBED

Inst.	Boarding Hse/Res. Hotel		Foster Home								Halfway House								Group Home								Nursing Home		Home for Adults		Relative/ Guardian		Other		TOT
			M.I.		M.R.		J.O.		Other		M.I.		M.R.		J.O.		Other		M.I.		M.R.		J.O.		Other										
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	N
WSH	9	10.8	11	13.3	1	1.2			17	20.5	1	1.2					2	2.4	5	6.0	3	3.6			8	9.6	5	6.0	15	18.1	3	3.6	3	3.6	83
CSH	3	12.5	4	16.7	2	8.3			2	8.3									6	25.0					2	8.3					1	4.2	4	16.7	24
otal	12	11.2	15	14.0	3	2.8			19	17.8	1	0.9					2	1.9	11	10.3	3	2.8			10	9.3	5	4.7	15	14.0	4	3.7	7	6.5	107
LTSH	2	3.2			27	42.9			2	3.2			4	6.3					1	1.6	11	17.5			3	4.8	4	6.3	6	9.5	1	1.6	2	3.2	63
LTSH	1	9.1			5	45.5							1	9.1			1	9.1			2	18.2					1	9.1							11
SSVTC	1	4.0			11	44.0							3	12.0			1	4.0			7	28.0									1	4.0	1	4.0	25
otal	4	4.0			43	43.6			2	2.0			8	8.1			2	2.0	1	1.0	20	20.2			3	3.0	5	5.1	6	6.1	2	2.0	3	3.0	99
TTS																																			
TTS	1	8.3	1	8.3			1	8.3									1	8.3					2	16.7							5	41.7	1	8.3	12
otal	1	8.3	1	8.3			1	8.3									1	8.3					2	16.7							5	41.7	1	8.3	12
	17	7.8	16	7.3	46	21.1	1	0.5	21	9.6	1	0.5	8	3.7			5	2.3	12	5.5	29	10.6	2	0.9	13	6.0	10	4.6	21	9.6	11	5.0	11	5.0	218

Table 20 (3)

Third Choice Housing Prescribed

at		Boarding Hse/Res. Total		Foster Home								Halfway House								Group Home								Nursing Home		Home for Adults		Relative/ Guardian		Other		TO
				M.I.		M.R.		J.O.		Other		M.I.		M.R.		J.O.		Other		M.I.		M.R.		J.O.		Other										
e	Inst.	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#
/6	MSH	8	15.0	2	3.8	2	3.8			11	20.8															1	1.9	6	11.3	13	24.5	3	5.7	7	13.2	53
t	CSH	1	7.1	1	7.1	1	7.1					1	7.1					1	7.1	1	7.1			1	7.1					4	28.6	2	14.3	1	7.1	14
>-Total		9	13.5	3	4.5	3	4.5			11	16.4	1	1.5					1	1.5	1	1.5			1	1.5	1	1.5	6	9.0	17	25.4	5	7.5	8	12.0	67
/6	LTSH	1	3.0			5	15.2			2	6.1			1	3.0							7	21.2			1	3.0	2	6.1	7	21.2	4	12.1	3	9.0	33
t	LTSH	1	20.0			1	20.5																							1	20.0	1	20.0	1	20.0	5
t	SSVTC	3	20.0			4	26.7	1	6.7					1	6.7							2	13.3									4	26.7			15
>-Total		5	9.4			10	18.9	1	1.9	2	3.8			2	3.8							9	17.0			1	1.9	2	3.8	8	15.1	9	17.0	4	7.6	53
/6	???																																			
t	???							1	16.7																							4	66.7	1	16.7	6
>-Total								1	16.7																							4	66.7	1	16.7	6
.		14	11.1	3	2.4	13	10.3	2	1.6	13	10.3	1	0.8	2	1.6			1	0.8	1	0.8	9	7.1	1	0.8	2	1.6	8	6.4	25	19.8	18	14.3	13	10.3	126

Table 21
ALL HOUSING PRESCRIBED[a]

	Inst.	Boarding Res/Res. Hotel		Foster Home								Halfway House								Group Home								Nursing Home		Home for Adults		Relative/ Guardian		Other		TOT
				M.I.		M.R.		J.O.		Other		M.I.		M.R.		J.O.		Other		M.I.		M.R.		J.O.		Other									
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	N
6	WSH	23	9.7	13	5.5	4	1.7			37	15.6	5	2.1	1	0.4			8	3.4	10	4.2	9	3.8			19	8.0	31	13.1	39	16.5	22	9.3	16	6.8	237
	CSH	5	7.9	9	14.3	3	4.8			2	3.2	3	4.8	1	1.6			1	1.6	8	12.7	2	3.2	1	1.6	3	4.8	5	7.9	8	12.7	5	7.9	7	11.1	63
-Total		28	9.3	22	7.3	7	2.3			39	13.0	8	2.7	2	0.7			9	3.0	18	6.0	11	3.7	1	0.3	22	7.3	36	12.0	47	15.7	27	9.0	23	7.7	300
6	LTSH	5	3.0	1	0.6	35	20.8			7	4.2			7	4.2					1	0.6	37	22.0			4	2.4	12	7.1	19	11.3	31	18.4	9	5.4	168
	LTSH	3	11.1			7	25.9			1	3.7			1	3.7			1	3.7			7	25.9			1	3.7	1	3.7	1	3.7	2	7.4	2	7.4	27
	SSVTC	6	6.0			21	31.3	1	1.5	1	1.3			5	7.5			1	1.5			16	23.9			1	1.5	1	1.5	1	1.5	12	17.9	3	4.5	67
-Total		12	4.6	1	0.4	63	24.0	1	0.4	9	3.4			13	5.0			2	0.8	1	0.4	60	22.9			6	2.3	14	5.3	21	8.0	45	17.2	14	5.3	262
6	77S															4	10.5	1	2.6					7	18.4							17	44.7	3	7.9	38
:	77S	1	2.6	1	2.6			3	7.9	1	2.6					4	10.5	1	2.6					7	18.4							17	44.7	3	7.9	38
-Total		1	2.6	1	2.6			3	7.9	1	2.6					4	10.5	1	2.6					7	18.4											
		41	6.8	24	4.0	70	11.7	4	0.7	49	8.2	8	1.3	15	2.5	4	0.7	12	2.0	19	3.2	71	11.8	7	1.3	28	4.7	50	8.3	68	11.3	89	14.8	40	6.7	600

[a] Includes Ideal, Second, and Third Choice Housing.

TABLE 22

INCOME SUGGESTIONS AND AUXILIARY ELEMENTS PRESCRIBED

Client Group	Inst.	Income suggestion* Cl/Fam's Finances n	%	SSI/Pub Asst. n	%	Medicaid Medicare n	%	Veterans SS/ Other Dis n	%	Other/ Unknown n	%	Job Training/Placement Prescr** Emp Counsel VR/Voc n	%	Eval & Ref VR n	%	Job Trg VR n	%	Shelt Wkshop n	%
M.I.																			
PD/6	WSH	81	35.4	80	34.9	46	20.1	15	6.6	7	3.1	32	31.7	16	15.8	10	9.9	15	14.8
Port	CSH	27	29.4	26	28.3	26	28.3	2	2.2	11	12.0	3	12.0	17	68.0	6	24.0		
Sub-Total		108	33.6	106	33.0	72	22.4	17	5.3	18	5.6	35	27.8	33	26.2	16	12.7	15	11.9
M.R.																			
PD/6	LTSH	47	23.6	71	35.7	42	21.1	29	14.6	10	5.0	16	22.2	31	43.1	7	9.7	20	27.8
Port	LTSH	8	21.0	10	26.3	11	29.0	3	7.9	6	15.8	4	36.4	7	63.6	5	45.4	4	36.4
Port	SSVTC	26	32.1	25	30.9	24	29.6	3	3.7	3	3.7	7	25.9	11	40.7	4	14.8	6	22.2
Sub-Total		81	25.5	106	33.3	77	24.2	35	11.0	19	6.0	27	24.5	49	44.5	16	14.5	30	27.3
J.O.																			
PD/6	JTS																		
Port	JTS	30	63.8	8	17.0	6	12.8	2	4.3	1	2.1	11	55.0	5	25.0			2	10.0
Sub-Total		30	63.8	8	17.0	6	12.8	2	4.3	1	2.1	11	55.0	5	25.0			2	10.0
TOTAL		219	31.9	220	32.1	155	22.6	54	7.9	38	5.5	73	28.5	87	34.0	32	12.5	47	18.4

Mean No. Income Suggestions Per Client — M.I. Clients = 2.55
M.R. Clients = 2.09
J.O. Clients = 2.35

Mean No. Job Training/Placement Elements Prescr. Per Client — M.I. Clients = 1.11
M.R. Clients = 1.29
J.O. Clients = 0.85

* Percentages based on number of income suggestions. Suggestions rather than clients are counted; a client may be included more than one time per cell.

** Percentages based on number of clients receiving community placement prescription (see total column, Table 20)

TABLE 22 (Continued)

INCOME SUGGESTIONS AND AUXILIARY ELEMENTS PRESCRIBED

Client Group	Inst.	Physical Health Prescr**						Social/Psychological Health Prescr**												Education Prescr**					
		Dental Care		Medical Care		Fam Plg/ Sex Ed		Activity Ctr/Day Care		C.A.T.		Family Counsel		Continuum of M.H. Services		Prob Officer		Social Club		Adult Ed		Regular Class		Speech Therapy	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
M.I.																									
PD#6	WSH	27	26.7	100	99.0	6	5.9	19	18.8	50	49.5	40	39.6	88	87.1			45	44.6	3	3.0			1	1.0
Port	CSH	24	96.0	25	100.0	9	36.0	12	48.0	19	76.0	10	40.0	18	72.0	1	4.0	9	36.0	6	24.0			4	16.0
Sub-Total		51	40.5	125	99.2	15	11.9	31	24.6	69	54.8	50	39.7	106	84.1	1	0.8	54	42.9	9	7.1			5	4.0
M.R.																									
PD#6	LTSH	52	72.2	71	98.6	29	40.3	14	19.4	58	80.6	54	75.0	62	86.1	1	1.4	45	62.5	7	9.7			13	18.1
Port	LTSH	10	90.9	11	100.0	6	54.5	3	27.3	10	90.9	8	72.7	1	9.1			9	81.8	3	27.3			4	36.4
Port	SSVTC	26	96.3	27	100.0	15	55.6	11	40.7	15	55.6	10	37.0	10	37.0			10	37.0	9	33.3			7	25.9
Sub-Total		88	80.0	109	99.1	50	45.4	28	25.4	83	75.4	72	65.4	73	66.4	1	0.9	64	58.2	19	17.3			24	21.8
J.O.																									
PD#6	7TS																								
Port	7TS	16	80.0	20	100.0	20	100.0	1	5.0	2	10.0	14	70.0	2	10.0	18	90.0	6	30.0	5	25.0	9	45.0		
Sub-Total		16	80.0	20	100.0	20	100.0	1	5.0	2	10.0	14	70.0	2	10.0	18	90.0	6	30.0	5	25.0	9	45.0		
TOTAL		155	60.6	254	99.2	85	33.2	60	23.4	154	60.2	136	53.1	181	70.7	20	7.8	124	48.4	33	12.9	9	3.5	29	11.3

Mean No. Physical Health Elements Prescr Per Client — M.I. Clients = 3.32
M.R. Clients = 3.92
J.O. Clients = 3.10

Mean No. Soc/Psych Health Elements Prescr Per Client — M.I. Clients = 3.34
M.R. Clients = 4.00
J.O. Clients = 3.00

Mean No. Education Elements Prescr Per Client — M.I. Clients = 0.13
M.R. Clients = 0.73
J.O. Clients = 1.40

TABLE 23 (1)

HOUSING SEARCH RESULTS FOR ALL CLIENTS

Community Housing	1 Ideal Pr By Team*	2 Avail. n	2 Avail. %	Reason Unavailable: 3 Openings n	3 Openings %	4 Not Eligible n	4 Not Eligible %	5 Not Fit Needs n	5 Not Fit Needs %	6 No Such Resource n	6 No Such Resource %	7 Other n	7 Other %	8 # Contacts Tot	8 # Contacts Per Avail.	9 # Diff. Contacts** Tot	9 # Diff. Contacts** Per Avail
Boarding House/ Res. Hotel	10	8	80.0	1	100.0									12	1.5	11	1.4
Foster Home	32	7	21.9	13	28.3	8	17.4	4	8.7	14	30.4	7	15.2	115	16.4	104	14.9
Halfway House	21	2	9.5	2	33.3					3	50.0	1	16.7	8	4.0	8	4.0
Group Home	62	5	8.1	4	19.0	4	19.0			11	52.4	2	9.5	34	6.8	32	6.4
Nursing Home	32	8	25.0	3	50.0	1	16.7	1	16.7	1	16.7			44	5.5	41	5.1
Home for Adults	22	14	63.6	8	50.0	3	18.8	1	6.2	1	6.2	3	18.8	76	5.4	68	4.9
Relative/Guardian/ Indep.	61	27	44.3	2	20.0			1	10.0	3	30.0	4	40.0	42	1.6	39	1.4
Trg. School for Blind																	
VR Resident Facility	7	1	14.3					1	33.3	1	33.3	1	33.3	4	4.0	3	3.0
Other/Unknown	7	2	28.6	2	40.0	1	20.0			1	20.0	1	20.0	31	15.5	30	15.0
Total	256	74	29.1	35	30.7	17	14.9	8	7.0	35	30.7	19	16.7	336	12.6	336	11.6

* If a BA reports that a search for a prescribed housing element has been made but the client's record does not show that the element was prescribed, neither the prescription nor search records for the client are included. Thus figures in column 1 may not equal those in the total rows of Table 20.

** 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.

NOTES: 1) Percentages in column 2 are based on corresponding figures in column 1.
2) Percentages in columns 3 through 7 are based on the total number of contacts in the row resulting in a determination that service cannot be provided (sum of columns 3 through 7).

TABLE 23 (2)

HOUSING SEARCH RESULTS FOR MI CLIENTS

Community Housing	1 Ideal Pr By Team*	2 Avail. n	2 Avail. %	Reason Unavailable 3 Openings n	3 Openings %	4 Not Eligible n	4 Not Eligible %	5 Not Fit Needs n	5 Not Fit Needs %	6 No Such Resource n	6 No Such Resource %	7 Other n	7 Other %	8 # Contacts Tot	8 # Contacts Per Avail.	9 # Diff. Contacts** Tot	9 # Diff. Contacts** Per Avail
Boarding House/ Res. Hotel	7	8	114.3	1	100.0									12	1.5	11	1.4
Foster Home	14	6	42.9	8	30.8	3	11.5	3	11.5	7	26.9	5	19.2	84	14.0	73	12.2
Halfway House	14									1	50.0	1	50.0	2		2	
Group Home	25	2	8.0	2	33.3					3	50.0	1	16.7	9	4.5	9	4.5
Nursing Home	25	8	32.0	2	40.0	1	20.0	1	20.0	1	20.0			40	5.0	37	4.6
Home for Adults	15	9	60.0	4	50.0	1	12.5	1	12.5	1	12.5	1	12.5	50	5.6	42	4.7
Relative/Guardian/ Indep.	19	8	42.1	2	33.3			1	16.7	1	16.7	2	33.3	17	2.1	15	1.9
Trg. School for Blind																	
VR Resident Facility	4	1	25.0									1	100.0	3	3.0	2	2.0
Other/Unknown	3	1	33.3	1	20.0	1	20.0			2	40.0	1	20.0	25	25.0	24	24.0
Total	126	43	34.1	20	33.3	6	10.0	6	10.0	16	26.7	12	20.0	242	5.6	215	5.0

* If a BA reports that a search for a prescribed housing element has been made but the clients's record does not show that the element was prescribed, neither the prescription nor search records for the client are included. Thus figures in column 1 may not equal those in the total rows of Table 20.

** 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.

NOTES: 1) Percentages in column 2 are based on corresponding figures in column 1.
2) Percentages in columns 3 through 7 are based on the total number of contacts in the row resulting in a determination that service cannot be provided (sum of columns 3 through 7).

TABLE 23 (3)

HOUSING SEARCH RESULTS FOR MR CLIENTS

Community Housing	1 Ideal Pr By Team*	2 Avail. Avail. n	2 Avail. %	Reason Unavailable 3 Openings n	3 Openings %	4 Not Eligible n	4 Not Eligible %	5 Not Fit Needs n	5 Not Fit Needs %	6 No Such Resource n	6 No Such Resource %	7 Other n	7 Other %	8 # Contacts Tot	8 # Contacts Per Avail.	9 # Diff. Contacts** Tot	9 # Diff. Contacts** Per Avail
Boarding House/ Res. Hotel	3																
Foster Home	16	1	6.2	5	31.2	3	18.8	1	6.2	5	31.2	2	12.5	27	27.0	27	27.0
Halfway House	3									2	100.0			4		4	
Group Home	32	3	9.4	2	18.2	1	9.1			7	63.6	1	9.1	18	6.0	16	5.3
Nursing Home	7			1	100.0									4		4	
Home for Adults	7	5	71.4	4	50.0	2	25.0					2	25.0	26	5.2	26	5.2
Relative/Guardian/ Indep.	38	6	17.6							2	50.0	2	50.0	12	2.0	11	1.8
Trg. School for Blind																	
VR Resident Facility	3							1	100.0					1		1	
Other/Unknown	4			1	100.0									1		1	
Total	109	15	13.8	13	29.5	6	13.5	2	4.5	16	36.4	7	15.9	93	6.2	90	6.0

* If a BA reports that a search for a prescribed housing element has been made but the client's record does not show that the element was prescribed, neither the prescription nor search records for the client are included. Thus figures in column 1 may not equal those in the total rows of Table 20.

** 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.

NOTES: 1) Percentages in column 2 are based on corresponding figures in column 1.
2) Percentages in columns 3 through 7 are based on the total number of contacts in the row resulting in a determination that service cannot be provided (sum of columns 3 through 7).

TABLE 23 (A)

HOUSING SEARCH RESULTS FOR JO CLIENTS

Community Housing	1 Ideal Pr By Team*	2 Avail.		Reason Unavailable 3 Openings		4 Not Eligible		5 Not Fit Needs		6 No Such Resource		7 Other		8 # Contacts		9 # Diff. Contacts**	
		n	%	n	%	n	%	n	%	n	%	n	%	Tot	Per Avail.	Tot	Per Avail
Boarding House/ Res. Hotel																	
Foster Home	2					2	50.0			2	50.0			4		4	
Halfway House	4	2	50.0	2	100.0									4	2.0	4	2.0
Group Home	5					3	75.0			1	25.0			5		5	
Nursing Home																	
Home for Adults																	
Relative/Guardian/ Indep.	8	13	61.5											13	1.0	13	1.0
Trg. School for Blind																	
VR Resident Facility																	
Other/Unknown		1												5	5.0	5	5.0
Total	19	16	84.2	2	20.0	5	50.0			3	30.0			31	1.9	31	1.9

* If a BA reports that a search for a prescribed housing element has been made but the clients's record does not show that the element was prescribed, neither the prescription nor search records for the client are included. Thus figures in column 1 may not equal those in the total rows of Table 20.

** 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.

TABLE 24

CUMULATIVE RESOURCE SEARCH RESULTS FOR INCOME

		1	2		3		4		Reasons Unavailable 5		6		7		8		9		10		11	
ient oup	Inst.	Sugg. By Team*	Search Completed n	%	Avail. n	%	Unavail. n	%	No Openings n	%	Not Eligible n	%	Not Fit Needs n	%	No Such Resource n	%	Other n	%	Tot & Mean Contacts Per Search Tot	X	Tot # Diff. & Mean Contacts Per Search** Tot	X
06	WSH	197	50	25.4	47	94.0	3	6.0	1	33.3	1	33.3	1	33.3					83	1.7	75	1.5
rt	CSH	71	10	14.1	9	90.0	1	10.0			1	100.0							13	1.3	12	1.2
ub-Total		268	60	22.4	56	93.3	4	6.7	1	25.0	2	50.0	1	25.0					96	1.6	87	1.5
06	LTSH	178	15	8.4	14	93.3	1	6.7									1	100.0	26	1.7	21	1.4
rt	LTSH	35																				
rt	SSNTC	75	11	14.7	11	100.0													16	1.5	14	1.3
ub-Total		288	26	9.0	25	96.2	1	3.8									1	100.0	42	1.6	35	1.3
06	7TS																					
rt	7TS	39	18	46.2	18	100.0													24	1.3	23	1.3
ub-Total		39	18	46.2	18	100.0													24	1.3	23	1.3
TOTAL		595	104	17.5.	99	95.2	5	4.8	1	20.0	2	40.0	1	20.0			1	20.0	162	1.6	145	1.4

NOTES: 1) Percentages in column 2 are based on corresponding figures in column 1.
2) Percentages in columns 3 and 4 are based on corresponding figures in column 2
3) Percentages in columns 5 through 9 are based on the total number of contacts in the row resulting in a determination that service cannot be provided (sum of columns 4 through 8).

* Table 22 is based on Prescription Digests (Appendix E) in which the total number of income suggestions made are tabulated. Table 24 is based on Cumulative Resource Search Results reports (Appendix F). In these reports, a given client is counted only one time in each category. The total number of suggestions shown in Table 22 is greater than that shown in Table 24.

** 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.

TABLE 25 (1)

CUMULATIVE RESOURCE SEARCH RESULTS FOR ALL AUXILLIARY ELEMENTS

		1	2		3		4		Reasons Unavailable 5		6		7		8		9		10		11	
Client Group	Inst.	Pr By Team	Search Completed n	%	Avail. n	%	Unavail. n	%	No Openings n	%	Not Eligible n	%	Not Fit Needs n	%	No Such Resource n	%	Other n	%	Tot & Mean Contacts Per Search Tot	X	Tot # Diff. & Mean Contacts Per Search* Tot	X
M.I.																						
PD#6	WSH	750	219	29.2	200	91.3	19	8.7	2	10.5	3	15.8	4	21.0	7	36.8	3	15.8	243	1.1	231	1.1
Port	CSH	246	44	17.9	44	100.0													47	1.1	47	1.1
Sub-Total		996	263	26.4	244	92.8	19	7.2	2	10.5	3	15.8	4	21.0	7	36.8	3	15.8	290	1.1	278	1.1
M.R.																						
PD#6	LTSH	733	80	10.9	77	96.2	3	3.8	1	20.0			1	20.0	1	20.0	1	20.0	91	1.1	90	1.1
Port	LTSH	117																				
Port	SSNTC	243	57	23.5	57	100.0													62	1.1	60	1.1
Sub-Total		1093	137	12.5	134	97.8	3	2.2	1	20.0			1	20.0	1	20.0	1	20.0	153	1.1	150	1.1
J.O.																						
PD#6	7TS																					
Port	7TS	169	116	68.6	114	98.3	2	1.7			1	50.0			1	50.0			127	1.1	127	1.1
Sub-Total		169	116	68.6	114	98.3	2	1.7			1	50.0			1	50.0			127	1.1	127	1.1
TOTAL		2258	516	22.8	492	95.4	24	4.6	3	12.0	4	16.0	5	20.0	9	36.0	4	16.0	570	1.1	555	1.1

NOTES: 1) Percentages in column 2 are based on corresponding figures in column 1.
2) Percentages in columns 3 and 4 are based on corresponding figures in column 2.
3) Percentages in columns 5 through 9 are based on the total number of contacts in the row resulting in a determination that service cnnot be provided (sum of columns 4 through 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.

TABLE 25 (2)

CUMULATIVE RESOURCE SEARCH RESULTS FOR JOB TRAINING/PLACEMENT ELEMENTS

		1	2		3		4		Reasons Unavailable 5		6		7		8		9		10		11	
Client Group	Inst.	Pr By Team	Search Completed n	%	Avail. n	%	Unavail. n	%	No Openings n	%	Not Eligible n	%	Not Fit Needs n	%	No Such Resource n	%	Other n	%	Tot & Mean Contacts Per Search Tot	X	Tot # Diff. & Mean Contacts Per Search* Tot	X
M.I.																						
PD#6	WSH	111	35	31.5	30	85.7	5	14.3	1	20.0	1	20.0	1	20.0	2	40.0			40	1.1	37	1.1
Port	CSH	29	5	17.2	5	100.0													5	1.0	5	1.0
Sub-Total		140	40	28.6	35	87.5	5	12.5	1	20.0	1	20.0	1	20.0	2	40.0			45	1.1	42	1.1
M.R.																						
PD#6	LTSH	90	16	17.8	15	93.8	1	6.2	1	50.0			1	50.0					17	1.1	17	1.1
Port	LTSH	21																				
Port	SSVTC	31	9	29.0	9	100.0													9	1.0	9	1.0
Sub-Total		142	25	17.6	24	96.0	1	4.0	1	50.0			1	50.0					26	1.0	26	1.0
J.O.																						
PD#6	7TS																					
Port	7TS	19	18	94.7	17	94.4	1	5.6			1	100.0							19	1.1	19	1.1
Sub-Total		19	18	94.7	17	94.4	1	5.6			1	100.0							19	1.1	19	1.1
TOTAL		301	83	27.6	76	91.6	7	8.4	2	25.0	2	25.0	2	25.0	2	25.0			90	1.1	87	1.0

NOTES: 1) Percentages in column 2 are based on corresponding figures in column 1.
2) Percentages in columns 3 and 4 are based on corresponding figures in column 2.
3) Percentages in columns 5 through 9 are based on the total number of contacts in the row resulting in a determination that service cnnot be provided (sum of columns 4 through 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.

TABLE 25 (3)

CUMULATIVE RESOURCE SEARCH RESULTS FOR PHYSICAL HEALTH ELEMENTS

		1	2		3		4		Reasons Unavailable 5		6		7		8		9		10		11	
Client Group	Inst.	Pr By Team	Search Completed n	%	Avail. n	%	Unavail. n	%	No Openings n	%	Not Eligible n	%	Not Fit Needs n	%	No Such Resource n	%	Other n	%	Tot & Mean Contacts Per Search Tot	X	Tot # Diff. & Mean Contacts Per Search* Tot	X
M.I.																						
PD#6	WSH	302	87	28.8	83	95.4	4	4.6	1	25.0			1	25.0			2	50.0	95	1.1	89	1.0
Port	CSH	116	23	19.8	23														23	1.0	23	1.0
Sub-Total		418	110	26.3	106	96.4	4	3.6	1	25.0			1	25.0			2	50.0	11	1.1	112	1.0
M.R.																						
PD#6	LTSH	280	29	10.4	28	96.4	1	3.4							1	100.0			32	1.1	32	1.1
Port	LTSH	39																				
Port	SSVTC	112	30	26.8	30	100.0													31	1.0	31	1.0
Sub-Total		431	59	13.7	58	98.3	1	1.7							1	100.0			63	1.1	63	1.1
J.O.																						
PD#6	7TS																					
Port	7TS	62	42	67.7	41	97.6	1	2.4							1	100.0			47	1.1	47	1.1
Sub-Total		62	42	67.7	41	97.6	1	2.4							1	100.0			47	1.1	47	1.1
TOTAL		911	211	23.2	205	97.2	6	2.8	1	16.7			1	16.7	2	33.3	2	33.3	228	1.1	222	1.1

NOTES: 1) Percentages in column 2 are based on corresponding figures in column 1.
2) Percentages in columns 3 and 4 are based on corresponding figures in column 2.
3) Percentages in columns 5 through 9 are based on the total number of contacts in the row resulting in a determination that service cnnot be provided (sum of columns 4 through 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.

TABLE 25 (4).

CUMULATIVE RESOURCE SEARCH RESULTS FOR SOCIAL/PSYCHOLOGICAL HEALTH ELEMENTS

Client Group	Inst.	1 Pr By Team	2 Search Completed n	2 Search Completed %	3 Avail. n	3 Avail. %	4 Unavail. n	4 Unavail. %	Reasons Unavailable 5 No Openings n	5 No Openings %	6 Not Eligible n	6 Not Eligible %	7 Not Fit Needs n	7 Not Fit Needs %	8 No Such Resource n	8 No Such Resource %	9 Other n	9 Other %	10 Tot & Mean Contacts Per Search Tot	10 Tot & Mean Contacts Per Search $\bar{X}$	11 Tot # Diff. & Mean Contacts Per Search* Tot	11 Tot # Diff. & Mean Contacts Per Search* $\bar{X}$
M I.																						
PD#6	WSH	332	96	28.9	86	89.6	10	10.4			2	20.0	2	20.0	5	50.0	1	10.0	107	1.1	104	1.1
Port	CSH	89	12	13.5	12	100.0													15	1.3	15	1.3
Sub-Total		421	108	25.6	98	90.7	10	9.3			2	20.0	2	20.0	5	50.0	1	10.0	122	1.1	119	1.1
M.R.																						
PD#6	LTSH	322	34	10.6	33	97.1	1	2.9									1	100.0	41	1.2	40	1.2
Port	LTSH	46																				
Port	SSVTC	72	12	16.7	12	100.0													16	1.3	14	1.2
Sub-Total		440	46	10.4	45	97.8	1	2.2									1	100.0	57	1.2	54	1.2
J.O.																						
PD#6	7TS																					
Port	7TS	60	39	65.0	39	100.0													44	1.1	44	1.1
Sub-Total		60	39	65.0	39	100.0													44	1.1	44	1.1
TOTAL		921	193	21.0	182	94.3	11	5.7			2	18.2	2	18.2	5	45.4	2	18.2	223	1.2	217	1.1

NOTES: 1) Percentages in column 2 are based on corresponding figures in column 1.
2) Percentages in columns 3 and 4 are based on corresponding figures in column 2.
3) Percentages in columns 5 through 9 are based on the total number of contacts in the row resulting in a determination that service cnnot be provided (sum of columns 4 through 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.

TABLE 25 (5)

CUMLATIVE RESOURCE SEARCH RESULTS FOR EDUCATIONAL ELEMENTS

		1	2		3		4	Reasons Unavailable 5		6		7		8		9		10		11	
Client Group	Inst.	Pr By Team	Search Completed n	%	Avail. n	%	Unavail. n	%	No Openings n	%	Not Eligible n	%	Not Fit Needs n	%	No Such Resource n	%	Other n	%	Tot & Mean Contacts Per Search Tot	$\bar{X}$	Tot # Diff. & Mean Contacts Per Search* Tot	$\bar{X}$
M.I.																						
PD#6	WSH	5	1	20.0	1	100.0													1	1.0	1	1.0
Port	CSH	12	4	33.3	4	100.0													4	1.0	4	1.0
Sub-Total		17	5	29.4	5	100.0													5	1.0	5	1.0
M.R.																						
PD#6	LTSH	41	1	2.4	1	100.0													1	1.0	1	1.0
Port	LTSH	11																				
Port	SSVTC	28	6	21.4	6	100.0													6	1.0	6	1.0
Sub-Total		80	7	8.8	7	100.0													7	1.0	7	1.0
J.O.																						
PD#6	7TS																					
Port	7TS	28	17	60.7	17	100.0													17	1.0	17	1.0
Sub-Total		28	17	60.7	17	100.0													17	1.0	17	1.0
TOTAL		125	29	23.2	29	100.0													29	1.0	29	1.0

NOTES: 1) Percentages in column 2 are based on corresponding figures in column 1.
2) Percentages in columns 3 and 4 are based on corresponding figures in column 2.
3) Percentages in columns 5 through 9 are based on the total number of contacts in the row resulting in a determination that service cnnot be provided (sum of columns 4 through 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.

TABLE 26

HOUSING PRESCRIBED, AVAILABLE, AND PROVIDED FOR 84 CLIENTS LIVING IN THE COMMUNITY

Community Housing	M.I. Ideal Pr By Team	M.I. Avail. n	M.I. Avail. %Pr	M.I. Provided n	M.I. Provided %Pr	M.I. Provided %Avail	M.R. Ideal Pr By Team	M.R. Avail. n	M.R. Avail. %Pr	M.R. Provided n	M.R. Provided %Pr	M.R. Provided %Avail	J.O. Ideal Pr By Team	J.O. Avail. n	J.O. Avail. %Pr	J.O. Provided n	J.O. Provided %Pr	J.O. Provided %Avail	Total Ideal Pr By Team	Total Avail. n	Total Avail. %Pr	Total Provided n	Total Provided %Pr	Total Provided %Avail.
arding House/ es. Hotel	7	8	114.3	8	114.3	100.0				1									7	8	114.3	9	128.6	112.5
ster Home	6	5	83.3	5	83.3	100.0	3	1	33.3	4	133.3	400.0		2					9	8	88.9	9	100.0	112.5
lfway House	5						1						4			1	25.0		10			1	10.0	
oup Home	3	1	33.3	1	33.3	100.0	6	1	16.7	1	16.7	100.0	3						12	2	16.7	2	16.7	100.0
rsing Home	9	6	66.7	7	77.8	116.7				1									9	6	66.7	8	88.9	133.3
me for Adults	4	9	225.0	17	425.0	188.9	3	5	166.7	5	166.7	100.0							7	14	200.0	22	314.3	157.1
lative/Guard/ ndep.	11	8	72.7	9	81.8	112.5	8	6	75.0	9	112.5	150.0	1	12	150.0	14	175.0	116.7	27	26	96.3	32	118.5	123.1
g. School or Blind																								
. Resident. acility	3	1	33.3																3	1	33.3			
her/Unknown				1																		1		
TOTAL	48	38	79.2	48	100.0	126.3	21	13	61.9	21	100.0	161.5	15	14	93.3	15	100.0	107.1	84	65	76.5	84	100.0	129.2

TABLE 27

CURRENT HOUSING OF 84 CLIENTS PLACED IN COMMUNITY

Client Group	Inst.	Boarding Hse/Res. Hotel n	%	Foster Home n	%	Halfway House n	%	Group Home n	%	Nursing Home n	%	Home for Adults n	%	Relative/ Guardian/ Indep. n	%	VR Resident Facility n	%	Other/ Unknown n	%	TOTAL N	%
M.I.																					
PD#6	WSH	6	14.0	5	11.6			1	2.3	7	16.3	16	37.2	7	16.3			1	2.3	43	100.0
Port	CSH	2	40.0									1	20.0	2	40.0					5	100.0
Sub-Total		8	16.7	5	10.4			1	2.1	7	14.6	17	35.4	9	18.8			1	2.1	48	100.1
M.R.																					
PD#6	LTSH									1	8.3	5	41.7	6	50.0					12	100.0
Port	LTSH													3	33.3					9	99.9
Port	SSVTC	1	11.1	4	44.4			1	11.1					9	42.9					21	100.1
Sub-Total		1	4.8	4	19.0			1	4.8	1	4.8	5	23.8								
J.O.																					
PD#6	7TS					1	6.7							14	93.3					15	100.0
Port	7TS					1	6.7							14	93.3					15	100.0
Sub-Total																					
TOTAL		9	10.7	9	10.7	1	1.2	2	2.4	8	9.5	22	26.2	32	38.1			1	1.2	84	100.1

TABLE 28

PROPORTION OF 84 CLIENTS LIVING IN IDEAL, SECOND, AND THIRD CHOICE HOUSING

Client Group	Inst.	Housing Choice: Ideal n	Ideal %	Second n	Second %	Third n	Third %	TOTAL N	TOTAL %
M.I.									
PD #6	WSH	16	37.2	11	25.6	16	37.2	43	100.0
Port	CSH	3	60.0			2	40.0	5	100.0
Sub-Total		19	39.6	11	22.9	18	37.5	48	100.0
M.R.									
PD #6	LTSH	7	58.3	1	8.3	4	33.3	12	99.9
Port	LTSH								
Port	SSVTC	3	33.3	3	33.3	3	33.3	9	99.9
Sub-Total		10	47.6	4	19.0	7	33.3	21	99.9
J.D.									
PD#6	7TS								
Port	7TS	11	73.3	3	20.0	1	6.7	15	100.0
Sub-Total		11	73.3	3	20.0	1	6.7	15	100.0
TOTAL		40	47.6	18	21.4	26	31.0	84	100.0

TABLE 29

TYPE OF HOUSING BY A&P TEAM'S PREFERRED CHOICE SERVING 84 CLIENTS IN THE COMMUNITY

Community Housing	Housing Choice: Ideal n	Ideal %	Second n	Second %	Third n	Third %	TOTAL N	TOTAL %
Boarding House/ Res. Hotel	4	10.0	1	5.6	4	15.4	9	10.7
Foster Home	3	7.5	5	27.8	1	3.8	9	10.7
Halfway House	1	2.5					1	1.2
Group Home			1	5.6	1	3.8	2	2.4
Nursing Home	5	12.5	2	11.1	1	3.8	8	9.5
Home for Adults	7	17.5	2	11.1	13	50.0	22	26.2
Relative/Guard./ Indep.	20	50.0	7	38.9	5	19.2	32	38.1
Trg. School For Blind								
VR Resident Facility								
Other/Unknown					1	3.8	1	1.2
TOTAL	40	100.0	18	100.1	26	99.8	84	100.0

TABLE 30

INCOME SOURCES SUGGESTED, AVAILABLE, AND PROVIDED FOR 84 CLIENTS LIVING IN THE COMMUNITY.

	M.I						M.R.						J.O.						Total					
	Sugg. By	Avail.		Provided			Sugg. By	Avail.		Provided			Sugg. By	Avail.		Provided			Sugg. By	Avail		Provided		
Income Source	Team	n	%Pr	n	%Pr	%Avail.	Team	n	%Pr	n	%Pr	%Avail.	Team	n	%Pr	n	%Pr	%Avail	Team	n	%Pr	n	%Pr	%Avail.
Cl/Family's Finances	31	22	71.0	30	96.8	136.4	15	6	40.0	9	60.0	150.0	13	10	76.9	14	107.7	140.0	59	38	64.4	53	89.8	139.5
SSI/Public Assistance	29	19	65.5	29	100.0	152.6	19	9	47.4	14	73.7	155.6	5	4	80.0	3	60.0	75.0	53	32	60.4	46	86.8	143.8
Medicaid/ Medicare	10	6	60.0	13	130.0	216.7	12	4	33.3	7	58.3	175.0	3	1	33.3	1	33.3	100.0	25	11	44.0	21	84.0	190.9
Unearn SS/ Other Dis	8	5	62.5	8	100.0	160.0	6	2	33.3	4	66.7	200.0	2						16	7	43.8	12	75.0	171.4
Other/ Unknown	2			5	250.0								4			1	25.0		6			6	100.0	
TOTAL	80	52	65.0	85	106.2	163.5	52	21	40.4	34	65.4	161.9	27	15	55.6	19	70.4	126.7	159	88	55.3	138	86.8	156.8

TABLE 31

INCOME SOURCES SUPPORTING 84 CLIENTS LIVING IN THE COMMUNITY

Client Group Inst.	Cl/Fam's Finances n	%	SSI/Public Assistance n	%	Medicaid/ Medicare n	%	Unearn SS/ Other Dis n	%	Other/ Unknown n	%	Total N	%
M.I.												
PD #6 WSH	25	33.3	27	36.0	12	16.0	6	8.0	5	6.7	75	100.0
Port CSH	5	50.0	2	20.0	1	10.0	2	20.0			10	100.0
Sub-Total	30	35.3	29	34.1	13	15.3	8	9.4	5	5.9	85	100.0
M.R.												
PD #6 LTSH	4	20.0	9	45.0	3	15.0	4	20.0			20	100.0
Port LTSH												
Port SSVTC	5	35.7	5	35.7	4	28.6					14	100.0
Sub-Total	9	26.5	14	41.2	7	20.6	4	11.8			34	100.1
J.O.												
PD #6 7TS												
Port 7TS	14	73.7	3	15.8	1	5.3			1	5.3	19	100.1
Sub-Total	14	73.7	3	15.8	1	5.3			1	5.3	19	100.1
TOTAL	53	38.4	46	33.3	21	15.2	12	8.7	6	4.4	138	100.0

TABLE 32 (1)

ALL AUXILIARY ELEMENTS PROVIDED TO 84 CLIENTS LIVING IN THE COMMUNITY

Client Group	Inst.	Clients	Client Reports	Provider Reports	Elements Pr By Team	Elements Avail. n	Elements Avail. % Pr	Elements Provided n	Elements Provided % Pr	% Avail.
M.I.										
PD#6	WSH	43	294	75	300	172	57.3	227	75.7	132.0
Port	CSH	5	10	6	56	44	78.6	51	91.1	115.9
Sub-Total		48	304	81	356	216	60.7	278	78.1	128.7
M.R.										
PD#6	LTSH	12	61	37	116	53	45.7	79	68.1	149.1
Port	LTSH									
Port	SSVTC	9	29	15	84	48	57.1	87	103.6	181.2
Sub-Total		21	90	52	200	101	50.5	166	83.0	164.4
J.O.										
PD#6	7TS									
Port	7TS	15	55	28	126	101	80.2	116	92.1	114.8
Sub-Total		15	55	28	126	101	80.2	116	92.1	114.8
TOTAL		84	449	161	682	418	61.3	560	82.1	134.0

TABLE 32 (2)

JOB TRAINING /PLACEMENT ELEMENTS PROVIDED TO 84 CLIENTS LIVING IN THE COMMUNITY

Client Group	Inst.	Clients	Client Reports	Provider Reports	Elements Pr By Team	Elements Avail. n	Elements Avail. % Pr	Elements Provided n	Elements Provided % Pr	% Avail.
M.I.										
PD#6	WSH	43	294	75	52	24	46.2	48	92.3	200.0
Port	CSH	5	10	6	9	5	55.6	8	88.9	160.0
Sub-Total		48	304	81	61	29	47.5	56	91.8	193.1
M.R.										
PD#6	LTSH	12	61	37	15	9	60.0	16	106.7	177.8
Port	LTSH									
Port	SSVTC	9	39	15	10	7	70.7	12	120.0	171.4
Sub-Total		21	90	52	25	16	64.0	28	112.0	175.0
J.O.										
PD#6	7TS									
Port	7TS	15	55	28	18	17	94.4	17	94.4	100.0
Sub-Total		15	55	28	18	17	94.4	17	94.4	100.0
TOTAL		84	449	161	104	62	59.6	101	97.1	162.9

TABLE 32 (3)

PHYSICAL HEALTH ELEMENTS PROVIDED TO 84 CLIENTS LIVINC IN THE COMMUNITY

Client Group	Inst.	Clients	Client Reports	Provider Reports	Elements Pr By Team	Elements Avail. n	Elements Avail. % Pr	Elements Provided n	Elements Provided % Pr	% Avail.
M.I.										
PD#6	WSH	43	294	75	122	76	62.3	98	80.3	129.0
Port	CSH	5	10	6	27	23	85.2	24	88.9	104.4
Sub-Total		48	304	81	149	99	66.4	122	81.9	123.2
M.R.										
PD#6	LTSH	12	61	37	43	23	53.5	28	65.1	121.7
Port	LTSH									
Port	SSVTC	9	29	15	40	26	65.0	41	102.5	157.7
Sub-Total		21	90	52	83	49	59.0	69	83.1	140.8
J.O.										
PD#6	7TS									
Port	7TS	15	55	28	45	35	77.8	36	80.0	102.9
Sub-Total		15	55	28	45	35	77.8	36	80.0	102.9
TOTAL		84	449	161	277	183	66.1	227	82.0	124.0

TABLE 32 (4)

SOCIAL/PSYCHOLOGICAL HEALTH ELEMENTS PROVIDED TO 84 CLIENTS LIVING IN THE COMMUNITY

Client Group	Inst.	Clients	Client Reports	Provider Reports	Elements Pr By Team	Elements Avail. n	Elements Avail. % Pr	Elements Provided n	Elements Provided % Pr	% Avail.
M.I.										
PD#6	WSH	43	294	75	124	72	58.1	80	64.5	111.1
Port	CSH	5	10	6	15	12	80.0	14	93.3	116.7
Sub-Total		48	304	81	139	84	60.4	94	67.6	111.9
M.R.										
PD#6	LTSH	12	61	37	55	21	38.2	33	60.0	157.1
Port	LTSH									
Port	SSVTC	9	29	15	23	9	39.1	23	100.0	255.6
Sub-Total		21	90	52	78	30	38.4	56	71.8	186.7
J.O.										
PD#6	7TS									
Port	7TS	15	55	28	44	34	77.3	44	100.0	129.4
Sub-Total		15	55	28	44	34	77.3	44	100.0	129.4
TOTAL		84	449	161	261	148	56.7	194	74.3	131.1

TABLE 32 (5)

EDUCATIONAL ELEMENTS PROVIDED TO 84 CLIENTS LIVING IN THE COMMUNITY

Client Group	Inst.	Clients	Client Reports	Provider Reports	Elements Pr By Team	Elements Avail. n	Elements Avail. % Pr	Elements Provided n	Elements Provided % Pr	% Avail.
M.I.										
PD#6	WSH	43	294	75	2			1	50.0	
Port	CSH	5	10	6	5	4	80.0	5	100.0	125.0
Sub-Total		48	304	81	7	4	57.1	6	85.7	125.0
M.R.										
PD#6	LTSH	12	61	37	3			2	66.7	
Port	LTSH									
Port	SSVTC	9	29	15	11	6	54.5	11	100.0	183.3
Sub-Total		21	90	52	14	6	54.5	13	92.9	216.7
J.O.										
PD#6	7TS									
Port	7TS	15	55	28	19	15	79.0	19	100.0	126.7
Sub-Total		15	55	28	19	15	79.0	19	100.0	126.7
TOTAL		84	449	161	40	25	62.5	38	95.0	152.0

TABLE 33 (1)

ASSESSMENT BY 84 PLACED CLIENTS OF USEFULNESS OF ALL AUXILIARY SERVICES AT TIME OF LAST REPORT

Client Group	Inst.	N.R/ D.K.* n	N.R/ D.K.* %	No Service In Per n	No Service In Per %	Very Useful n	Very Useful %	Somewhat Useful n	Somewhat Useful %	Not Useful n	Not Useful %	Total n	Total %
M.I.													
PD#6	WSH	17	7.5	56	24.7	120	52.9	13	5.7	21	9.2	227	100.0
Port	CSH	46	90.2	5	9.8							51	100.0
Sub-Total		63	22.7	61	21.9	120	43.2	13	4.7	21	7.6	278	100.1
M.R.													
PD#6	LTSH	18	22.8	15	19.0	38	48.1	4	5.1	4	5.1	79	100.1
Port	LTSH												
Port	SSVTC	23	26.4	30	34.5	24	27.6	6	6.9	4	4.6	87	100.0
Sub-Total		41	24.7	45	27.1	62	37.4	10	6.0	8	4.8	166	100.0
J.O.													
PD#6	7TS												
Port	7TS	22	19.0	40	34.5	21	18.1	14	12.1	19	16.4	116	100.1
Sub-Total		22	19.0	40	34.5	21	18.1	14	12.1	19	16.4	116	100.1
TOTAL		126	22.5	146	26.1	203	36.2	37	6.6	48	8.6	560	100.0

* No report on usefulness or respondent could not decide.

TABLE 33 (2)

ASSESSMENT BY 84 PLACED CLIENTS OF USEFULNESS OF JOB TRAINING/PLACEMENT SERVICES AT TIME OF LAST REPORT

Client Group	Inst.	N. / D.K.* n	N. / D.K.* %	No Service In Per n	No Service In Per %	Very Useful n	Very Useful %	Somewhat Useful n	Somewhat Useful %	Not Useful n	Not Useful %	Total n	Total %
M.I.													
PD#6	WSH	2	4.2	13	27.1	23	47.9	5	10.5	5	10.4	48	100.0
Port	CSH	7	87.5	1	12.5							8	100.0
Sub-Total		9	16.1	14	25.0	23	41.1	5	8.9	5	8.9	56	100.0
M.R.													
PD#6	LTSH	5	31.2	3	18.8	8	50.0					16	100.0
Port	LTSH												
Port	SSVTC	5	41.7	4	33.3	1	8.3	2	16.5			12	100.0
Sub-Total		10	35.7	7	25.0	9	32.1	2	7.1			28	99.9
J.O.													
PD#6	7TS												
Port	7TS	3	17.6	5	29.4	3	17.6	2	11.8	4	23.5	17	99.9
Sub-Total		3	17.6	5	29.4	3	17.6	2	11.8	4	23.5	17	99.9
TOTAL		22	21.8	26	25.7	35	34.6	9	8.9	9	8.9	101	99.9

* No report on usefulness or respondent could not decide.

TABLE 33 (3)

ASSESSMENT BY 84 PLACED CLIENTS OF USEFULNESS OF PHYSICAL HEALTH SERVICES
AT TIME OF LAST REPORT

Client Group	Inst.	N.R/ D.K.* n	N.R/ D.K.* %	No Service In Per n	No Service In Per %	Very Useful n	Very Useful %	Somewhat Useful n	Somewhat Useful %	Not Useful n	Not Useful %	Total n	Total %
M.I.													
PD#6	WSH	7	7.1	24	24.5	59	60.2	3	3.1	5	5.1	98	100.0
Port	CSH	22	91.7	2	8.3							24	100.0
Sub-Total		29	23.8	26	21.3	59	48.4	3	2.5	5	4.1	122	100.1
M.R.													
PD#6	LTSH	4	14.3	9	32.1	13	46.4	1	3.6	1	3.6	28	100.0
Port	LTSH												
Port	SSVTC	11	26.8	15	36.6	14	34.2	1	2.4			41	100.0
Sub-Total		15	21.7	24	34.8	27	39.1	2	2.9	1	1.4	69	99.9
J.O.													
PD#6	7TS												
Port	7TS	6	16.7	22	61.1	6	16.7	1	2.8	1	2.8	36	100.1
Sub-Total		6	16.7	22	61.1	6	16.7	1	2.8	1	2.8	36	100.1
TOTAL		50	22.0	72	31.7	92	40.5	6	2.6	7	3.1	227	99.9

* No report on usefulness or respondent could not decide.

TABLE 33 (4)

ASSESSMENT BY 84 PLACED CLIENTS OF USEFULNESS OF SOCIAL/PSYCHOLOGICAL HEALTH SERVICES AT TIME OF LAST REPORT

Client Group	Inst.	N.R/ D.K.* n	N.R/ D.K.* %	No Service In Per n	No Service In Per %	Very Useful n	Very Useful %	Somewhat Useful n	Somewhat Useful %	Not Useful n	Not Useful %	Total n	Total %
M.I.													
PD#6	WSH	8	10.0	19	23.8	38	47.5	5	6.2	10	12.5	80	100.0
Port	CSH	13	92.9	1	7.1							14	100.0
Sub-Total		21	22.3	20	21.3	38	40.4	5	5.3	10	10.6	94	99.9
M.R.													
PD#6	LTSH	7	21.2	3	9.1	17	51.5	3	9.1	3	9.1	33	100.0
Port	LTSH												
Port	SSVTC	4	17.4	10	43.5	4	17.4	2	8.7	3	13.0	23	100.0
Sub-Total		11	19.6	13	23.2	21	37.5	5	8.9	6	10.7	56	99.9
J.O.													
PD#6	7TS	9	20.4	7	15.9	10	22.7	9	20.4	9	20.4	44	99.8
Port	7TS	9	20.4	7	15.9	10	22.7	9	20.4	9	20.4	44	99.8
Sub-Total													
TOTAL		41	21.1	40	20.6	69	35.6	19	9.8	25	12.9	194	100.0

* No report on usefulness or respondent could not decide.

TABLE 33 (5)

ASSESSMENT BY 84 PLACED CLIENTS OF USEFULNESS OF EDUCATIONAL SERVICES AT TIME OF LAST REPORT

Client Group	Inst.	N.R/ D.K.* n	N.R/ D.K.* %	No Service In Per n	No Service In Per %	Very Useful n	Very Useful %	Somewhat Useful n	Somewhat Useful %	Not Useful n	Not Useful %	Total n	Total %
M.I.													
PD#6	WSH									1	100.0	1	100.0
Port	CSH	4	80.0	1	20.0							5	100.0
Sub-Total		4	66.7	1	16.7					1	16.7	6	100.1
M.R.													
PD#6	LTSH	2	100.0									2	100.0
Port	LTSH												
Port	SSVTC	3	27.3	1	9.1	5	45.4	1	9.1	1	9.1	11	100.0
Sub-Total		5	38.5	1	7.7	5	38.5	1	7.7	1	7.7	13	100.1
J.O.													
PD#6	7TS												
Port	7TS	4	21.0	6	31.6	2	10.5	2	10.5	5	26.3	19	99.9
Sub-Total		4	21.0	6	31.6	2	10.5	2	10.5	5	26.3	19	99.9
TOTAL		13	34.2	8	21.0	7	18.4	3	7.9	7	18.4	38	99.9

* No report on usefulness or respondent could not decide.

TABLE 34 (1)

CLIENT DESIRE AS REPORTED BY 84 PLACED CLIENTS TO CONTINUE RECEIVING ALL AUXILIARY SERVICES AT TIME OF LAST REPORT

Client Group	Inst.	N.R. D.K.* n.	N.R. D.K.* %	Continue n	Continue %	Discontinue n	Discontinue %	Total n	Total %
M.I.									
PD#6	WSH	5	2.2	179	78.9	43	18.9	227	100.0
Port	CSH	1	2.0	43	84.3	7	13.7	51	100.0
Sub-Total		6	2.2	222	79.9	50	18.0	278	100.1
M.R.									
PD#6	LTSH	6	7.6	58	73.4	15	19.0	53	100.0
Port	LTSH								
Port	SSVTC	5	5.8	76	87.4	6	6.9	48	100.1
Sub-Total		11	6.6	134	80.7	21	12.6	101	99.9
J.O.									
PD#6	7TS								
Port	7TS	7	6.0	79	68.1	30	25.9	116	100.0
Sub-Total		7	6.0	79	68.1	30	25.9	116	100.0
TOTAL		24	4.3	435	77.7	101	18.0	560	100.0

* No report on meeting objective or respondent could not decide.

TABLE 34 (2)

CLIENT DESIRE AS REPORTED BY 84 PLACED CLIENTS TO CONTINUE RECEIVING JOB TRAINING/PLACEMENT SERVICES AT TIME OF LAST REPORT

Client Group	Inst.	N.R. D.K.* n.	N.R. D.K.* %	Continue n	Continue %	Discontinue n	Discontinue %	Total n	Total %
M.I.									
PD#6	WSH	2	4.2	34	70.8	12	25.0	48	100.
Port	CSH			7	87.5	1	12.5	8	100.0
Sub-Total		2	3.6	41	73.2	13	23.2	56	100.0
M.R.									
PD#6	LTSH	2	12.5	11	68.8	3	18.8	16	100.1
Port	LTSH							12	100.0
Port	SSVTC	2	16.7	10	83.3				
Sub-Total		4	14.3	21	75.0	3	10.7	28	100.0
J.O.									
PD#6	7TS								
Port	7TS			13	76.5	4	23.5	17	100.0
Sub-Total				13	76.5	4	23.5	17	100.0
TOTAL		6	5.9	75	74.3	20	19.8	62	100.0

* No report on meeting objective or respondent could not decide.

TABLE 34 (3)

CLIENT DESIRE AS REPORTED BY 84 PLACED CLIENTS TO CONTINUE RECEIVING PHYSICAL HEALTH SERVICES AT TIME OF LAST REPORT

Client Group	Inst.	N.R. D.K.* n.	N.R. D.K.* %	Continue n	Continue %	Discontinue n	Discontinue %	Total n	Total %
M.I.									
PD/6	WSH	2	2.0	88	89.8	8	8.2	98	100.0
Port	CSH			23	95.8	1	4.2	24	100.0
Sub-Total		2	1.6	111	91.0	9	7.4	122	100.0
M.R.									
PD/6	LTSH	1	3.6	23	82.1	4	14.3	28	100.0
Port	LTSH								
Port	SSVTC	2	4.9	36	87.8	3	7.3	41	100.0
Sub-Total		3	4.4	59	85.5	7	10.1	69	100.0
J.O.									
PD/6	7TS								
Port	7TS	3	8.3	29	80.6	4	11.1	36	100.0
Sub-Total		3	8.3	29	80.6	4	11.1	36	100.0
TOTAL		8	3.5	199	87.7	20	8.8	227	100.0

* No report on meeting objective or respondent could not decide.

TABLE 34 (4)

CLIENT DESIRE AS REPORTED BY 84 PLACED CLIENTS TO CONTINUE RECEIVING SOCIAL/PSYCHOLOGICAL HEALTH SERVICES AT TIME OF LAST REPORT

Client Group	Inst.	N.R. D.K.* n.	%	Continue n	%	Discontinue n	%	Total n	%
M.I.									
PD#6	WSH	1	1.2	57	71.2	22	27.5	80	99.9
Port	CSH	1	7.1	9	64.3	4	28.5	14	100.0
Sub-Total		2	2.1	66	70.2	26	27.7	94	100.0
M.R.									
PD#6	LTSH	3	9.1	22	66.7	8	24.2	33	100.0
Port	LTSH								
Port	SSVTC			21	91.3	2	8.7	23	100.0
Sub-Total		3	5.4	43	76.8	10	17.9	56	100.1
J.O.									
PD#6	7TS								
Port	7TS	2	4.5	27	61.4	15	34.1	44	100.0
Sub-Total		2	4.5	27	61.4	15	34.1	44	100.0
TOTAL		7	3.6	136	70.1	51	26.3	194	100.0

* No report on meeting objective or respondent could not decide.

TABLE 24 (5)

CLIENT DESIRE AS REPORTED BY 84 PLACED CLIENTS TO CONTINUE RECEIVING EDUCATIONAL SERVICES AT TIME OF LAST REPORT

Client Group	Inst.	N.R. D.K.* n	N.R. D.K.* %	Continue n	Continue %	Discontinue n	Discontinue %	Total N	Total %
M.I.									
PD#6	WSH					1	100.0	1	100.0
Port	CSH			4	80.0	1	20.0	5	100.0
Sub-Total				4	66.7	2	33.3	6	100.0
M.R.									
PD#6	LTSH			2	100.0			2	100.0
Port	LTSH								
Port	SSVTC	1	9.1	9	81.8	1	9.1	11	100.0
Sub-Total		1	7.7	11	84.6	1	7.7	13	100.0
J.O.									
PD#6	7TS								
Port	7TS	2	10.5	10	52.6	7	36.8	19	99.9
Sub-Total		2	10.5	10	52.6	7	36.8	19	99.9
TOTAL		3	7.9	25	65.8	10	26.3	38	100.0

* No report on meeting objective or respondent could not decide.

TABLE 35 (1)

SERVICE PROVIDERS' ASSESSMENT OF CLIENT MOVEMENT TOWARD OBJECTIVES OF ALL AUXILIARY PRESCRIPTION ELEMENTS AT TIME OF LAST REPORT IN THE CASE OF 84 PLACED CLIENTS

Client Group	Inst.	N.R./* D.K. n	N.R./* D.K. %	Obj Met /Serv Ended n	Obj Met /Serv Ended %	Obj Met /Serv Contin n	Obj Met /Serv Contin %	Moving To Obj n	Moving To Obj %	No Progress n	No Progress %	Has Regressed n	Has Regressed %	Total n	Total %
M.I.															
PD#6	WSH	53	23.4	18	7.9	109	48.0	27	11.9	20	8.8			227	100.0
Port	CSH	7	13.7	17	33.3	12	23.5	10	19.6	3	5.9	2	3.9	51	99.9
Sub-Total		60	21.6	35	12.6	121	43.5	37	13.3	23	8.3	2	0.7	278	100.0
M.R.															
PD#6	LTSH	10	12.7	7	8.9	31	39.2	12	15.2	19	24.0			79	100.0
Port	LTSH														
Port	SSVTC	34	39.1	3	3.4	18	20.7	12	13.8	19	21.8	1	1.2	87	100.0
Sub-Total		44	36.5	10	6.0	49	29.5	24	14.5	38	22.9	1	0.6	166	100.0
J.O.															
PD#6	7TS														
Port	7TS	63	54.3	2	1.7	9	7.8	17	14.7	24	20.7	1	0.9	101	100.1
Sub-Total		63	54.3	2	1.7	9	7.8	17	14.7	24	20.7	1	0.9	101	100.1
TOTAL		167	29.8	47	8.4	179	32.0	78	13.9	85	15.2	4	0.7	418	100.0

* No report on meeting objective or respondent could not decide.

TABLE 35 (2)

SERVICE PROVIDERS' ASSESSMENT OF CLIENT MOVEMENT TOWARD OBJECTIVES OF JOB TRAINING/PLACEMENT PRESCRIPTION ELEMENTS AT TIME OF LAST REPORT IN THE CASE OF 84 PLACED CLIENTS

Client Group	Inst.	N.R./* D.K. n	N.R./* D.K. %	Obj Met /Serv Ended n	Obj Met /Serv Ended %	Obj Met /Serv Contin n	Obj Met /Serv Contin %	Moving To Obj n	Moving To Obj %	No Progress n	No Progress %	Has Regressed n	Has Regressed %	Total n	Total %
M.I.															
PD#6	WSH	14	29.2	5	10.4	14	29.2	9	18.2	6	12.5			48	100.1
Port	CSH			2	25.0	2	25.0	2	25.0	1	12.5	1	12.5	8	100.0
Sub-Total		14	25.0	7	12.5	16	28.6	11	19.6	7	12.5	1	1.8	56	100.0
M.R.															
PD#6	LTSH	3	18.8			6	37.5	3	18.8	4	25.0			16	100.1
Port	LTSH														
Port	SSVTC	4	33.3					2	16.7	6	50.0			12	100.0
Sub-Total		7	25.0			6	21.4	5	17.9	10	35.7			28	100.0
J.O.															
PD#6	7TS														
Port	7TS	9	52.9	2	11.8	2	11.8	4	23.5					17	100.0
Sub-Total		9	52.9	2	11.8	2	11.8	4	23.5					17	100.0
TOTAL		30	29.7	9	8.9	24	23.8	20	19.8	17	16.8	1	1.0	101	100.0

* No report on meeting objective or respondent could not decide.

TABLE 35 (3)

SERVICE PROVIDERS' ASSESSMENT OF CLIENT MOVEMENT TOWARD OBJECTIVES OF PHYSICAL HEALTH PRESCRIPTION ELEMENTS AT TIME OF LAST REPORT IN THE CASE OF 84 PLACED CLIENTS

Client Group	Inst.	N.R./* D.K. n	N.R./* D.K. %	Obj Met /Serv Ended n	Obj Met /Serv Ended %	Obj Met /Serv Contin n	Obj Met /Serv Contin %	Moving To Obj n	Moving To Obj %	No Progress n	No Progress %	Has Regressed n	Has Regressed %	Total n	Total %
M.I.															
PD#6	WSH	17	17.4	5	5.1	64	65.3	5	5.1	7	7.1			98	100.0
Port	CSH	3	12.5	10	41.7	4	16.7	6	25.0	1	4.2			24	100.1
Sub-Total		20	16.4	15	12.3	68	55.7	11	9.0	8	6.6			122	100.0
M.R.															
PD#6	LTSH	2	7.1	3	10.7	12	42.9	3	10.7	8	28.6			28	100.0
Port	LTSH														
Port	SSVTC	14	34.2	2	4.9	12	29.3	6	14.6	7	17.1			41	100.1
Sub-Total		16	23.2	5	7.2	24	34.8	9	13.0	15	21.7			69	99.9
J.O.															
PD#6	7TS														
Port	7TS	20	55.6	1	2.8	3	8.3	3	8.3	9	25.0			36	100.0
Sub-Total		20	55.6	1	2.8	3	8.3	3	8.3	9	25.0			36	100.0
TOTAL		56	24.7	21	9.2	95	41.8	23	10.1	32	14.1			227	99.9

* No report on meeting objective or respondent could not decide.

TABLE 35 (4)

SERVICE PROVIDERS' ASSESSMENT OF CLIENT MOVEMENT TOWARD OBJECTIVES OF SOCIAL/PSYCHOLOGICAL HEALTH PRESCRIPTION ELEMENTS AT TIME OF LAST REPORT IN THE CASE OF 84 PLACED CLIENTS

Client Group	Inst.	N.R./* D.K. n	N.R./* D.K. %	Obj Met /Serv Ended n	Obj Met /Serv Ended %	Obj Met /Serv Contin n	Obj Met /Serv Contin %	Moving To Obj n	Moving To Obj %	No Progress n	No Progress %	Has Regressed n	Has Regressed %	Total n	Total %
M.I.															
PD#6	WSH	21	26.2	8	10.0	31	38.8	13	16.2	7	8.8			80	100.0
Port	CSH	3	21.4	4	28.6	4	28.6	2	14.3	1	7.1			14	100.0
Sub-Total		24	25.5	12	12.8	35	37.2	15	16.0	8	8.5			94	100.0
M.R.															
PD#6	LTSH	5	15.2	4	12.1	13	39.4	6	18.2	5	15.2			33	100.1
Port	LTSH														
Port	SSVTC	9	39.1	1	4.4	4	17.4	4	17.4	4	17.4	1	4.4	23	100.1
Sub-Total		14	25.0	5	8.9	17	30.4	10	17.9	9	16.1	1	1.8	56	100.1
J.O.															
PD#6	7TS	24	54.5	1	2.3	3	6.8	10	22.7	6	13.6			44	99.9
Port	7TS	24	54.5	1	2.3	3	6.8	10	22.7	6	13.6			44	99.9
Sub-Total															
TOTAL		62	32.0	18	9.3	55	28.4	35	18.0	23	11.9	1	0.5	194	100.1

* No report on meeting objective or respondent could not decide.

CONTINUED

2 OF 4

TABLE 35 (5)

SERVICE PROVIDERS' ASSESSMENT OF CLIENT MOVEMENT TOWARD OBJECTIVES OF EDUCATIONAL PRESCRIPTION ELEMENTS AT TIME OF LAST REPORT IN THE CASE OF 84 PLACED CLIENTS

Client Group	Inst.	N.R./* D.K. n	N.R./* D.K. %	Obj Met /Serv Ended n	Obj Met /Serv Ended %	Obj Met /Serv Contin n	Obj Met /Serv Contin %	Moving To Obj n	Moving To Obj %	No Progress n	No Progress %	Has Regressed n	Has Regressed %	Total n	Total %
M.I.															
PD#6	WSH	1	100.0											1	100.0
Port	Con	1	20.0	1	20.0	2	40.0					1	20.0	5	100.0
Sub-Total		2	33.3	1	16.7	2	33.3					1	16.7	6	100.0
M.R.															
PD#6	LTSH									2	100.0			2	100.0
Port	LTSH														
Port	SSVTC	7	63.6			2	18.2			2	18.2			11	100.0
Sub-Total		7	53.8			2	15.4			4	30.8			13	100.0
J.O.															
PD#6	7TS														
Port	7TS	10	52.6	1	5.3	2	10.5	5	26.3	1	5.3			19	100.0
Sub-Total		10	52.6	1	5.3	2	10.5	5	26.3	1	5.3			19	100.0
TOTAL		19	50.0	2	5.3	6	15.8	5	13.2	5	13.2	1	2.6	38	100.1

* No report on meeting objective or respondent could not decide.

TABLE 36

PRESCRIPTION ELEMENTS ON WHICH SERVICE PROVISION PROBLEMS WERE REPORTED FOR CLIENTS RESIDING IN THE COMMUNITY

	1	2		3				4	
Prescription Element	Provided	Clients with Problems n	Clients with Problems %	Problem Reported By Client	By Provider	By SID	Total	Service Prematurely Terminated n	Service Prematurely Terminated %
Ideal Housing	40	9	22.5	1	6	2	9	6	15.0
Second Housing	18	6	33.3	4	4	1	9	3	16.7
Third Choice Housing	26	2	7.7		2		2	2	7.7
Income	138	9	6.5	2	10	4	16	1	0.7
Elderly Activity Ctr.	20	1	5.0	1			1	1	5.0
Eval. & Ref thru VR	26	2	7.7		2		2		
Employment Counsel-VR/VEC	25	2	8.0	1	1		2		
Sheltered Workshop	11	2	18.2		1	1	2		
Other Employment	6	2	33.3	1	3		4		
Family Plg/ Sex Ed	25	2	8.0	1	1		2	1	4.0
Personal Physician	74	2	2.7	1	1		2		
Pharm.w/ Supervision	37	3	8.1	2	1	1	4	1	2.7
Hearing Aid	1	1	100.0		1		1		
Behavior Mod Program	4	1	25.0			1	1		
Individual Psychotherapy	6	1	16.7	1			1		
Continuum M.H. Services	59	4	6.8	1	7		8	1	1.7
Social Club	36	1	2.8		1		1	1	2.8
Alcoholics Anonymous	2	1	50.0		2		2	1	50.0
Family Counseling	26	1	3.8		1		1	1	3.8
TOTAL	580			16	44	10	70	19	3.3

Number of clients = 33
WSH clients = 28
LTSH clients = 4
JO client = 1

NOTE: Percentages in columns 2 and 4 are based on corresponding figures in columr

TABLE 37

TOTAL AND MEAN NUMBER OF CONTINUED INSTITUTIONALIZATION PRESCRIPTION ELEMENTS PRESCRIBED

Client Group	Inst.	No. Clients	No. Elements Prescribed	Mean No. Elements Prescribed Per Client
M.I.				
PD#6	WSH	37	201	5.43
Port	CSH	27	144	5.33
Sub-Total		64	345	5.39
M.R.				
PD#6	LTSH	48	331	6.90
Port	LTSH	3	18	6.00
Port	SSVTC	23	114	4.96
Sub-Total		74	463	6.26
J.O.				
PD#6	7TS			
Port	7TS			
Sub-Total				
TOTAL		138	808	5.86

TABLE 38

MOST FREQUENTLY PRESCRIBED CONTINUED INSTITUTIONALIZATION ELEMENTS

Client Group	Inst.	1 Clients	2 Elements Prescribed	3 Behavior Modification n	%	Medical/Dental Treatment n	%	Recreational Program n	%	Review Diagnosis and/or Pharmaceuticals n	%
M.I.											
PD#6	WSH	37	201	15	7.5	19	9.5	13	6.5	24	12.0
Port	CSH	27	144	5	3.5	20	13.9	16	11.1	15	10.5
Sub-Total		64	345	20	5.8	39	11.3	29	8.4	39	11.3
M.R.											
PD#6	LTSH	48	331	33	10.0	32	9.7	31	9.4	30	9.0
Port	LTSH	3	18	1	5.6	3	16.7	2	11.1	3	16.7
Port	SSVTC	23	114	14	12.3	13	11.4	12	10.5	8	7.0
Sub-Total		74	463	48	10.4	48	10.4	45	9.7	41	8.9
J.O.											
PD#6	7TS										
Port	7TS										
Sub-Total											
TOTAL		138	808	68	8.4	87	10.8	74	9.2	80	9.9

TABLE 39

SUMMARY OF FULFILLMENT OF CONTINUED INSTITUTIONALIZATION PRESCRIPTIONS

Client Group	Inst.	Clients	Elements Prescribed	Completely Filled n	Completely Filled %	Partially Filled n	Partially Filled %	Unfilled n	Unfilled %	Other/ N/A n	Other/ N/A %
M.I.											
PD#6	WSH	46	206	91	44.2	45	21.8	53	25.7	17	8.2
Port	CSH										
Sub-Total		46	206	91	44.2	45	21.8	53	25.7	17	8.2
M.R.											
PD#6	LTSH	37	231	100	43.3	38	16.4	85	36.8	8	3.5
Port	LTSH										
Port	SSVTC	6	37	15	40.5	5	13.5	16	43.2	1	2.7
Sub-Total		43	268	115	42.9	43	16.0	101	37.7	9	3.4
J.C.											
PD#6	7TS										
Port	7TS	4	3			2	66.7	1	33.3		
Sub-Total		4	3			2	66.7	1	33.3		
TOTAL		93	477	206	43.2	90	18.9	155	32.5	26	5.4

TABLE 40

FULFILLMENT OF CONTINUED INSTITUTIONALIZATION PRESCRIPTION VERSUS PROVISION OF AUXILIARY PRESCRIPTION ELEMENTS TO CLIENTS LIVING IN THE COMMUNITY

Client Group	Inst.	Continued Institutionalization				Community Placement			
		Clients	Elements Prescribed	Elements Completely or Partly Filled n	Elements Completely or Partly Filled %	Clients	Elements Prescribed	Elements Provided n	Elements Provided %
M.I.									
PD#6	WSG	46	206	136	66.0	43	300	227	75.7
Port	CSH					5	56	51	91.1
Sub-Total		46	206	136	66.0	48	356	278	78.1
M.R.									
PD#6	LTSH	37	231	138	59.7	12	116	79	68.1
Port	LTSH								
Port	SSVTC	6	37	20	54.0	9	84	87	103.6
Sub-Total		43	268	158	59.0	21	200	166	83.0
J.O.									
PD#6	7TS								
Port	7TS	4	3	2	66.7	15	126	116	92.1
Sub-Total		4	3	2	66.7	15	126	116	92.1
TOTAL		93	477	296	62.0	84	682	560	82.1

IV. SERVICE INTEGRATION FUNCTIONING

Service integration is a difficult concept to define, to say nothing of the amorphousness encountered in attempting to evaluate the extent to which it was actualized during SID model application.

The first task, therefore, is a conceptual one: What is service integration? (Or, if you prefer, services integration.)

We are heavily indebted to a former DHEW services integration study* for delineating and defining the key variables in service integration. From the conceptual framework proffered in the former DHEW study, we have constructed Table 41. (All tables cited in this section appear at the end of Section IV.)

Table 41 contains a conceptual overview of what service integration is. In the first column is listed a series of service integration variables or functions. The second column gives a brief definition of each function. The third column goes on to indicate whether or not the SID model, as it has practiced to date, performs the particular service integration function and, if so, by what SID component the function is performed. The fourth

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* "Integration of Human Services in HEW: An evaluation of Services Integration Projects," prepared by The Research Group, Inc. and Marshall Kaplan, Gans and Kahn in August 1972 for the Department of Health, Education, and Welfare, Social and Rehabilitation Service, Washington, D.C.

column offers suggestions as to how the non-operative service integrating functions in SID could become operative.

Table 41, then, provides a summary evaluation of the service integration status in the present application of the SID model. It is quite apparent, for example, that in the case of the administrative support services variables the SID model as it is now known is deficient. On the other hand, in the case of those service integration variables having to do with direct service linkages the SID model is well developed.

But what have the actual, empirical results been in the course of "demonstrating" several service-integrating mechanisms? What effects upon the service delivery system have the five socio-technical, service-integrating components embodied in the SID model had?

The empirical question, in this instance, is extremely complex and cannot be answered in any kind of clean, direct fashion. It is necessary to resort to basic sensory data, since we have no theory (except perhaps what is borrowed from social and organizational psychology) and no accompanying instrumentation in the service integration area.

The observations which follow are in the form of simple frequency counts of nevertheless fairly important happenings (e.g., participation in service integration meetings), narrative accounts, identification of issues

encountered, and commentary on service delivery happenings and developments.

But we are in unchartered waters: There is no independent variable and no experimental controls of any sort. Save for an undergirding of scientific values (and science has been known at times to be notoriously handicapped by observational biases), we are at the mercy of selective perception.

The SID model embodies five service-integration mechanisms: committee of commissioners; assessment and prescription team; broker advocate; quality control team; and automated information system. It has been postulated that each of these components bring about service-integrating effects. The evaluative question becomes, in terms of column 1 of Table 41 to what extent are the functions listed therein promoted by one or more of these five services-integrating mechanisms?

We shall not belabor an evaluation of two of the components in the model: quality control team and automated information system.

Evaluating the quality control team leads into the problem of evaluating the evaluators and ultimately into infinite regress. Besides evaluation, the quality control team is charged with coordinating, developing and maintaining the model. The SID report in its entirety is a

description of all of these functions (evaluation, coordination, development, maintenance) and it is left for the reader to "evaluate the evaluators."

The automated information system is also explicitly set forth in this report, both in terms of its technical structure (see Volume 3) and its information products (see Volume 2 and Sections II and III of this Volume). Again, the reader becomes the judge. As for the questions, "Does information have value?", the answers are so obvious as to become of trivial concern from an evaluation standpoint. None of the other four service-integrating components could function at all without a structured information system and when large amounts of information are encompassed this automatically means automation. In terms of user receptivity of the SID automated system in particular, we encountered the commonly experienced initial resistances, followed by acceptance, and finally "data hunger"--the well established pattern noted by others.*

The remainder of this section, therefore, will explore observations we have made on the service-integrating happenings and effects connected with the application of three of the SID model components: committee of commissioners, assess-

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* Personal communication from Dr. Dan Payne, Assistant Commissioner for Program Development and Evaluation, Department of Mental Health and Mental Retardation, Commonwealth of Virginia.

ment and prescription team, and broker advocate. The conceptualization presented in Table 41 provides the framework for ordering the evaluative discussion.

A. COMMITTEE OF COMMISSIONERS

The committee of commissioners is the project's "board of directors." Its primary purpose is to govern the project.

The committee of commissioners came into being as a consequence of the project grant. It had no prior existence. To grow into a viable body it was necessary that the committee of commissioners become internally organized and coordinated, assume a posture of leadership and group cohesiveness, and engage in decision-making with respect to administrative support services (funding, personnel practices, planning, programming, etc.).

This section examines the extent to which the committee of commissioners was able to accomplish its role and mission.

1. Coordination Authorization

In the SID project the authorization for coordination has been voluntary and mediated, not directed (see paragraph A of Table 41). Given these modes of coordination authorization, how effective has coordination been within the committee of commissioners?

One crude measure of coordination successfulness is extent of participation as reflected in attendance at meetings. Another indicator of coordination effectiveness

is the manner in which the committee is able to handle intrusions requiring leadership activity and group cohesiveness. Data on each of these indicators are examined.

a. Indicator of coordination effectiveness: Attendance at meetings. Table 42 presents the attendance record of SID-participating agencies at the meetings of the committee of commissioners.

A total of 18 meetings of the governing body of the project were held in the period under study. Eight of these meetings were full committee meetings; ten were executive committee meetings. The number of meetings each of the 12 participating state agencies was held accountable for was dependent upon length and status of agency membership. For example, the last three agencies listed in Table 42 did not join the project until the fall of 1974.

The chairman of the committee was the commissioner of Welfare (designated as "DWI" in the table); the vice-chairman initially was the executive director of Children and Youth, later the commissioner of Vocational Rehabilitation.

Note that attendance of the meetings by the agency head himself is in general better for executive committee members than non-executive committee members--even though there were, of course, more than twice as many meetings to attend for executive committee members.

One executive committee member had a very low attendance record which, in this instance, accurately reflected a non-participatory attitude toward the project by that agency at the state level. Two long, private discussions between the project director and this agency head did not result in increased attendance. Nor did his election to the vice chairmanship midway through the study period increase his attendance at the meetings.

Note that the agency heads of two of the original nine SID-participating agencies attended no meetings at all! These commissioners did, however, send representatives to all but one of the meetings each was held responsible for. In encounters the project director arranged, these two agency heads were each quite prone to indicate that they would attend "the next meeting" and usually expressed words of encouragement toward the project. They were known to point out that there were so many boards and commissions that it was difficult to attend them all.

So far as is known, the chairman did not exert one-to-one pressure on the reluctant members to increase their attendance rate. However, the Secretary of Human Affairs, at least on one occasion, enjoined all of the SID agency heads from the human affairs area to attend a certain meeting. Three of the six commissioners appeared.

Throughout the study period, clearly Mental Health, Children and Youth, Welfare, and State Planning were the agencies most responsive and most participative. These same agencies had the highest commissioner attendance rate at the meetings. (This is not to suggest that the SID staff felt that these agencies always dealt effectively with the issues presented.)

Going beyond the executive committee membership, Education and Visually Handicapped (again the highest in commissioner attendance at the meetings) were clearly the most supportive and sympathetic, as reflected in the attitude of the agency head, of all the other agency members. The agency head for the Visually Handicapped seemed to understand clearly the concept of service integration at the state level. The agency head of Education was responsive to SID's technical efforts and products and was the person who at a crucial time moved that the Secretary of Human Affairs take steps to maintain the project.

Some of the agencies with no or low commissioner attendance were either antagonistic toward the project or simply ignored its existence. Health quarreled frequently with the high client processing costs in the research and demonstration effort. The head of Corrections has chosen to ignore the committee even though some of the clientele in the project (the juvenile offender) fall under his domain and

even though the model has application implications for an harassed adult corrections system. The commissioner for Vocational Rehabilitation felt that the project was an unnecessary innovation: "We don't have to do things differently, we just have to do better what we are already doing."

In summary, perhaps a fair assessment is that the agency heads of six of the twelve SID-participating state agencies showed at the state level at least a minimally meaningful, personal positive involvement toward fulfilling their contractual agreement to enter into a pilot demonstration service integration arrangement. These commissioners represented: Mental Health and Mental Retardation, Children and Youth, Welfare, State Planning and Community Affairs, Education, and Visually Handicapped.*

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* During the study period the Commission for Children and Youth underwent a change in agency head. The first head was vice chairman of the committee of commissioners (and acting chairman for a brief time) until his departure on June 30, 1974.

In March of 1975 the committee elected the director of the Office on Aging as vice chairman. This agency will probably come to play a stronger role in SID.

The Secretary of Human Affairs was not a member of the committee of commissioners so his attendance record at the meetings is not included here. He was principally "on call" to the chairman and the project director to assist in coordination and to further participation of the twelve agency members. He attended meetings on request.

b. Indicator of coordination effectiveness: Leadership activity and group cohesiveness. During the evolution of the committee of commissioners, events transpired which demanded leadership and/or cohesiveness from the group. The examples cited here, with their outcomes, fall short of the heavier policy-making issues which are reserved for a later section.

(1) Item: Very early in the project (client processing had not yet begun), the Secretary of the United States Department of Health, Education, and Welfare received a letter of complaint regarding the SID project. The letter alleged that SID represented an unwise expenditure of government funds. The author of the letter was a professional person in one of the SID target areas who had participated in one of the early community meetings. The Secretary of Human Affairs responded to the resultant inquiry from the Secretary of HEW and nothing further was heard on the matter.

This untoward event happened at a phase in the project's development when none of the coordinating machinery had yet been established. (For example, the event was prior to the first meeting of the committee of commissioners.) The Human Affairs Secretary's handling of the matter effectively solved a problem which posed potentially disruptive consequences for the project.

(2) Item: At the fourth meeting of the committee of commissioners, held on October 15, 1973, the project director, in a formal statement, chided the committee for what he saw as a failure of the commissioners to live up to the terms of the original coordination agreement (i.e., the endo sed grant application): little or no support, poor attendance at meetings, lack of interest, etc.

This action precipitated a crisis out of which positive effects accrued. With the urging of the Secretary of Human Affairs the committee organized itself by electing officers and naming an executive committee. The committee began to establish its authenticity as the project's governing body.

(3) Item: Several matters having to do with committee membership are related to the emergence of leadership and cohesiveness.

- The Secretary of Human Affairs defined his role for the committee as other than that of a participating member, per se. By this action he opted in favor of a strategy designed to try to strengthen the committee as a decision-making entity.

- The committee was never able to decide satisfactorily that membership on the committee was restricted to agency heads themselves. The chairman, and others, set an example by rarely if ever sending a representative, but no pronouncement was ever made to this effect, nor any motion made. The issue was only "discussed."

-Though one of the largest of the twelve SID-participating agencies, Health was at no time named to executive committee membership. In the course of the project, three opportunities arose for the chairman of the committee to appoint Health. Each time he failed to do so. It is believed that this "oversight" represented a miscalculation in coordination judgment as far as the project's interests were concerned.

-When the question arose of expansion of committee membership (from nine to twelve agencies), little or no opposition was voiced. There was a brief discussion of whether the prospective member agencies "gave direct services" but this was quickly seen as an inconsistent criterion for already existent member agencies.

(4) Item: Mobilizing full A&P team participation was a problem in the early stages of the project's operation in Portsmouth. The committee of commissioners met this leadership challenge by inviting the Portsmouth A&P team members to join the committee members in a two-day site visit to the PD #6 A&P team activity. The visit proved to be a coordination highlight in the project inasmuch as it resulted in a much strengthened SID-Portsmouth operation.

(5) Item: There was an instance wherein one of the agencies at the local level withdrew completely its A&P team support. The support was finally restored once the chairman of the committee of commissioners wrote a formal letter to the agency head requesting same. Earlier, lower-level and less formal coordination attempts had failed.

(6) Item: A conflict developed over who was responsible for charges on a particular billing, the Division of Automated Data Processing or the SID project. The chairman eventually negotiated a compromise where a previous impasse had developed.

(7) Item: The Division of ADP gave the SID project staff only a few days' notice that the terminal SID was using would no longer be available. The chairman was able to stop this action and thereby preserve continuity in SID's data processing services.

(8) Item: A staff member of one of the SID-participating agencies (a frequent attendee at meetings of the committee of commissioners) was designated chairman of a panel at a regional professional conference conducted in Tidewater Virginia. The panel topic was "Integration of Human Service Delivery." The panel chairman did not notify the SID Richmond office of the upcoming session on service integration. That is, no attempt was made to coordinate SID input at the session in spite of the fact that the panel chairman had, in his role as an "alternate" on the committee of commissioners, been quite intimately familiar with what the project was doing. Two broker advocates from the SID Portsmouth office attended the session. Upon recognizing them, the panel chairman

apparently concluded that he could not easily ignore the presence of SID staff in a discussion directly involving service integration methodology in Virginia. He invited one of the broker advocates to make a five-minute presentation on the SID project. . . . This same SID-participating state agent at a similar conference in another section of state was heard to say: "SID is a cadillac of services integration; what we need at this time in Virginia is a push-cart."

In the absence of directed coordination authorization, the identification of committee leadership and the formation of group cohesiveness are painfully slow processes. Yet they are essential conditions before any interagency board of directors can grapple effectively with service integration policy matters.

2. Administrative Support Services

The degree to which the "integrator" (i.e., the committee of commissioners in the demonstrated SID model) provides administrative support services is perhaps the most rigorous test of whether or not administrative service integration is in fact operative.

"Administrative support services" references such activities as fiscal operations, personnel practices, and planning and programming (see column 1 of Table 41). These are broader, more comprehensive functions than the somewhat circumscribed items related to coordination development discussed above.

a. Fiscal Operations. Service integration fiscal operations include joint budgeting, joint funding, fund transfer, and purchase of service. To date, these functions have not been actualized in the SID project even though opportunities to enter into these kinds of arrangements did present themselves.

The inkind match coming from services rendered by state and local project participants is perhaps a kind of joint funding, but primarily has to do with personnel usage. At least it does not represent utilization or shifting of appropriated program monies.

The federal funds for the grant came to a single agency (the Department of Mental Health and Mental Retardation) so cannot be considered an illustration of joint receipt or joint dispersal of funds.

Moving beyond the groundrules framing the grant money itself, the question can be asked, "What were the occasions in which the participating state agencies pooled their individual fiscal resources to further the aims of the project?"

There was one instance in which this occurred. The amount of money was small (c. $500) but the effect was dramatic. The Department of Mental Health and Mental Retardation and the Division of State Planning and Community Affairs jointly paid the transportation costs of the bus trip discussed in IVA1b(4) above.

The original SID proposal envisioned that as community resource gaps became identified via project procedures the participating state agencies would follow suit by plugging the gaps. Throughout the demonstration the committee of commissioners received information on resource gaps from the quality control team and repeatedly received formal requests for additional resources from at least one of the A&P teams in the project.

The committee of commissioners was totally ineffective in dealing with such matters. Even when the request was very specific and circumscribed, such as an additional physician or physician's assistant to serve the general medical needs of SID deinstitutionalized clients, the committee was unable to mobilize the Health Department or, alternatively, tap each of their own individual agency resources to meet the need.

At one juncture, the project director asked the committee: Would it not be possible to pool funds from all the state agencies toward establishing just one halfway house in PD #6? The answer from the chairman was: Not in any kind of practical manner. None of the other agency heads picked up on the question.

Only one agency head (the executive director of Children and Youth), when he was vice-chairman, was known

to surface the question of resource development. His remarks carried the warning that unless the state complements the work of the communities, the SID method would not endure. But none of the other commissioners were ready to play out this theme.

When the issue of SID continuation arose it was automatically accompanied by the issue of joint funding. This matter is described in considerable detail in Volume 7 and is not reiterated here.

Attentiveness to filling identified resource requirements, to the extent that there was any at all, came from individual state agencies--not from the new piece of service integration machinery governing the project. For example, DMH&MR funded Chapter 10 proposals from the two pilot areas and DDA inserted seed money likewise.

But the committee of commissioners, itself, was unable to muster funds to meet a single resource requirement to further services f existent and prospective deinstitutionalized clients. Had it been able to do so it would have strengthened the model procedure tremendously. Even a single token would have changed the entire complexion of service integration at the state level. No doubt the agency heads sensed this.

Of course there were many constraints that operated against the realization of joint funding by the committee of commissioners. Such matters require planning and lead time. The Commonwealth utilizes line item budgeting. The greatest bar, however, was lack of interest or incentive. The commissioners were simply unable to wear two hats. The frame of reference for each agency head was his own agency only.

b. Personnel Practices. A&P team manpower support has been the service integration personnel practice of most major concern to the committee of commissioners. To what agency should the SID staff belong--both the central SID staff and the broker advocates--was a major issue dealt with by the committee in its adoption of the plan for extending SID. (See Volume 7.)

The committee dealt with the A&P team manpower support requirements quite effectively. When Portsmouth was having trouble getting started, the committee of commissioners very constructively intervened. A&P team manpower support has been excellent (see IVB, below), a happenstance no doubt mostly due to community interest in the project but also due to the fact that members of the committee of commissioners, individually and collectively, adopted positions of support on this matter.

There was a thread of concern running throughout meetings of the committee of commissioners that the local service providers were devoting "a lot of time to this project." But no commissioner, even those least interested in and involved in the project, took steps to withdraw local support. In fact this was the one resource area where strong commissioner support could be counted upon. This kind of support obviously represents a potent, unwritten, peer-acceptance sanction among the commissioners.

The formation and operation of local service integration machinery apparently does not threaten state agency heads to a significant degree.

c. Planning and Programming. Several issues arose in the course of the study period wherein the governing body of the project was confronted with making policy decisions in the area of planning and programming. The manner in which these issues were handled is a test of the strength of the integrator.

(1) Issue: In the early planning stages of the project a dispute arose over the optimal hardware on which to construct the SID automated information system. The project director pushed for the purchase of a "mini-computer" system of which SID would be the dedicated user. The granting agency approved the request that grant funds be used for purchase of the equipment. The commissioner of the project's housekeeping agency (DMH&MR) accepted the project director's plan. The Commonwealth's office of purchase and

supply refused to issue a purchase order until approved by the director of the Division of Automated Data Processing. The director of ADP withheld approval. The Secretary of Human Affairs supported the position taken by the ADP director. The committee of commissioners took no position (at this stage it did not yet have a chairman and had no semblance of being a "governing body"). The equipment purchase was thereby denied. The granting agency was so informed of the denial. The granting agency then took steps to inform the Commonwealth that unless the state Division of ADP entered into a specific contract with the project, thus guaranteeing data processing support, that it (the granting agency) would withdraw funding support of the project.

The end results of this controversy have been very positive. The Division of ADP, after the initial liaison and technical difficulties were overcome, has given excellent support to the SID automated information system. The SID information system, since it is now developed on the state computer system itself, can expand "indefinitely" without necessitating a lengthy and expensive conversion. One of the pilot demonstration areas receives SID automated reports via a Department of Highways terminal located near the SID field office.

The Secretary of Human Affairs made an extremely sound decision in steadfastly holding to his position in the matter.

(2) Issue: The granting agency urged the project to include a cost/benefit analysis in the research and demonstration. A contract was negotiated with the firm of Booz-Allen-Hamilton, Inc. to develop the methodology for the analysis. Booz-Allen personnel worked jointly with SID staff in developing an explicit model tailored to SID's objectives and client processing procedures. The Booz-Allen methodology was presented to the committee of commissioners for approval prior to SID implementation. One agency representative argued that the methodology should compare the cost of SID deinstitutionalization with the cost of traditional deinstitutionalization. The committee finally approved the approach as put forth in the Booz-Allen/SID staff conceptualization.

(3) Issue: Each commissioner was provided with a copy of the 1974 SID Progress Report compiled in connection with the continuation application for the final period of project funding. The executive committee formally approved the report after making one minor change in the proposed budget. All nine commissioners signed the continuation application request. Three commissioners commented that the report was of excellent quality. With one small exception, none of the commissioners took issue with the

substance of the progress report. On the other hand, little overt interest was displayed by the commissioners in the report's contents.

(4) Issue: To promote the project's image the staff engaged the services of a local public relations firm to develop a descriptive brochure. The modest cost was readily approved by the committee. The final product was pictorially bold and innovative in design. Except for the commissioners who had seen the design in its early stages, there was little or no commissioner reaction to what was quite obviously a rather striking deinstitutionalization/service integration representation. The lack of commissioner reaction again suggested considerable "distance" from the project's activities and aims.

(5) Issue: A policy issue which consumed much of the energy of several SID staff members and considerable executive committee time had to do with the question of authorization of information release in the case of prospective clients unable to give informed consent. This issue is fully described in section II paragraph L of Volume 6. The issue impacted strongly on one agency head and the committee became totally ineffective with respect to taking any action other than that recommended by the agency head directly affected. "I won't step on your toes if you

promise not to step on mine."

Inability to resolve the informed consent issue created a blockage in the project's client processing activities that still exists: A significant portion of institutionalized prospective clients simply cannot be reached. The outcome of this issue and the committee's refusal to deal with the matter of resource development represent significant failures in the attempt to build a viable administrative service integration body within the context of the project. It is important to note that in neither of these two issues did the Secretary of Human Affairs enter directly into the problem-solving process. Without the Secretary's background presence, the committee of commissioners failed the test.

(6) Issue: Though again a difficult issue, and one with potentially far-reaching implications, the committee of commissioners dealt more effectively with the question of SID continuation. This matter is reviewed in detail in Volume 7. The problem-solving process was protracted and rocky but the committee was able to reach a consensus. It issued a set of formal recommendations to the Secretary. However, it seems a likely probability that had the Secretary disengaged himself from the continuation/extension question the committee would have again faltered.

3. Comment

The process of building a viable administrative service integration body at the state level within the context of a federally funded research and demonstration project and glued together only by voluntary and mediated coordination authorization is fraught with enormous, almost insurmountable, difficulties. The basic reason for the difficulty is that the environmental contingencies attached to the participants' service-integration behaviors are of insufficient, or of negative, consequence.

The reinforcers for service-integrative behavior that were operative at all during the study period were the so-called social reinforcers (respect for the effort; the ethics of fulfilling an agreement; respect for the authority of an office and its location in the bureaucratic structure, to wit, the Office of Human Affairs; peer acceptance and peer pressure; moral code; etc.). Such social reinforcers are not enough to effect meaningful organizational change.

The aversive reinforcers attached to any given agency head's service-integrating behaviors are of greater moment and serve as powerful deterrents in any attempt to integrate or consolidate. What will an agency head tell his constituents (or even his subordinates) if he has "given away" half of his budget, or gone on record as cutting one of his own programs in preference for a "better" one that

does not "belong" to him? Little wonder that the United Nations has its problems!

The solution (for those states who do opt for administrative services integration) is simple in concept, complicated in design. A system of fiscal incentive that will constrain the non-integrative behaviors of individual departments need be constructed.

B. ASSESSMENT AND PRESCRIPTION TEAM

The principal service integration functions of the assessment and prescription (A&P) team can be found in Table 41. The A&P team is a multi-disciplinary body of service providers with joint membership from the state institution and the local community. Its primary task is to review clients targeted in the project, "diagnose" each client's service needs, and oversee the client's receipt of services through the arm of the broker advocate or case coordinator. As information accumulates across clients and as the service needs of the community and institution are brought into focus, team functions expand into matters concerned with planning and programming.

The task before us now is to attempt to evaluate the A&P team as a viable structural component in the SID model by examining its functioning and its effects during the demonstration period.

A&P team is referenced in the singular, although in the project's operations there are several A&P teams. Inter-team comparisons can be made in certain of the data, but the primary focus will be to evaluate the A&P team as a general prototype.

1. Case Team Coordination

The A&P team as embodied in the project goes beyond the sometime multiagency case conference by assuming the characteristics of an ongoing, systematized case team (see paragraph C2c of Table 41). To evaluate the realization of A&P team coordination effectiveness, we look again at the attendance-at-meetings indicator.

a. Attendance at A&P team meetings. Tables 43 through 48 are records of A&P team attendance for the project's duration through December 31, 1974.

Attendance was excellent throughout. PD #6 teams had a somewhat higher percentage of member attendance than did Portsmouth teams, but this difference evaporates when mean number of attendees is compared. Portsmouth had a larger pool of team membership from which to draw participants for any given meeting.

The mean number of agencies/members in attendance per meeting ranged across teams from 10.1 to 11.8. The percentage of membership in attendance per meeting ranged

across teams from 63% to 91%. Attendance records of individual agencies can be noted at the interest of the reader.*

In interpreting the data in Tables 43 through 48 it is particularly important to recall that A&P team meeting arrangements posed a number of logistic and coordination challenges. In many instances team members had to travel long distances. Two hours of travel time was more the rule than the exception.** Some members spent as much as three or four days a month in A&P team meetings (plus "homework"). The receiving institution accommodated the team's presence by setting aside a conference room for regular use, having its staff available on a per client basis, adjusting its cafeteria service accordingly, etc. When an agency's principal representative was unable to attend, a replacement had to be found. Familiarity with and orientation to the A&P team procedures was an on-going requirement. Meeting agendas entailed carefully scheduled

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* Portsmouth has within its boundaries no local office of the Virginia Commission for the Visually Handicapped. The VCVH regional office in Norfolk supported the Portsmouth A&P team operation for a brief time, then stopped.

** In the case of Portsmouth to LTS&H the travel time was 3½ to 4 hours one way and the meetings lasted for two days at a time.

time blocks per case. Meetings were all-day affairs, sometimes long and fatiguing. The tabulated attendance counts misleadingly oversimplify a whole host of arrangements that had to dovetail successfully in order for an A&P team meeting to accomplish its objective.

Insofar as attendance at A&P team meetings is a reflection of coordination/participation effectiveness, the records indicate that the A&P team was a feasible, workable mechanism for bringing multiple agencies together to work on a clearly specified task.

b. Participation at A&P team meetings. But, one can ask, how effective was the A&P team process? Did the members participate mutually? Was the team truly a coalition of institution and community service providers? How were decisions reached?

During the course of each case presentation at each A&P team meeting a broker advocate was given the assignment of recording "process notes." In addition to making open-ended observations on team processes and member interaction, the broker advocate followed a checklist of items to record his judgments.

Tables 49 and 50 are compilations of the checklist data. The total number of counts for any given category do not necessarily correspond to the number of client processings. Sometimes multiple check-ratings were assigned during the course of one case presentation/dis-

cussion; at other times the broker advocate did not make a judgment.

The pattern of observations throughout Table 49 suggests that there was much joint participation in the A&P team problem-solving process. The only instance in which "institution dominant" occurred more frequently than "institution-community equal" was in the category of leadership at Western State Hospital. Perhaps this was in part due to the fact that the WSH A&P team had as three of its regular members the directors of three different DMH&MR state institutions. All three of these members were physicians.

The manner in which consensus was reached on the prescription decision of IN versus OUT differed between PD #6 and Portsmouth. One area did a lot of formal voting, the other area very little. Voting seems to have been resorted to in Portsmouth only when the chairman sensed a lack of agreement among team members since more often than not in Portsmouth a vote led to a non-unanimous result. In PD #6 where voting occurred far more frequently, the voting result was more often unanimous than not.

The results in Table 50 indicate that service integration interactions arose in this order of frequency: (1) between institution and community; (2) within and/or between institutions; and (3) between community agencies.

c. Qualitacive observations on A&P team participation and interaction. Quantitative counts cannot adequately represent the nature and substance of A&P team participation and interaction. Neither can such numerous and complex happenings be summarized comprehensively in narrative form. From broker advocate process notes, from the minutes of A&P team meetings, and from all-too-fragile perception and memory, we can offer a sampling of observations and happenings to complement the frequency counts in Tables 49 and 50.

Perhaps one of the most important observations to be made is that the skill of the team chairman has been one of the most critical factors regarding functioning of the team itself. Chairpersons of A&P teams to date have come from the following local agencies: Education, Health, Planning, Welfare, Mental Health, and Association for Retarded Citizens. We have not observed agency affiliation (nor sex) to be an important consideration in chair selection; the art of chairmanship is the crucial variable.

Individual differences being what they are, some team members repeatedly contributed more than others. Representatives from some agencies were virtually non-participatory insofar as the prescription process was concerned. A considerable degree of success resulted in some instances by a change in the individual representing a particular agency. Curiously, faithfulness in attendance did not seem

to be related to amount of oral participation. We cannot say whether oral participation was related to aural participation.

Except in the case of juvenile offender processing in Portsmouth, community team members came to and were, in a sense, hosted by the institution. This arrangement did not seem to cause one-sided interchange between institution and community members. In fact, community members often seemed freer with advice and recommendations to the institution than vice versa. But this was usually a consequence of team maturation.

> The first A&P team developed contained three physician directors of institutions. Community members seemed reluctant at first to participate in client prescriptions. After a rather self-assured, verbally articulate community member joined the team, the ice was broken and community members began to challenge institution members and institution practices.
>
> The community Welfare representative announced that he saw no need for his presence at the meetings if the doctors were going to make all of the decisions. This comment led the team into a discussion of who was and who was not participating in the prescription process. The team chairman discussed the possibility of calling upon silent members.

When the A&P team operation began at one of the state institutions for the mentally retarded, the director of the institution decided to reveal rather than conceal.

> As the tour for the community members of the team ended, the director freely acknowledged the lack of facilities and programs. He welcomed any and all assistance, from articles of clothing to program design.

Sometimes community team members came down hard on the institution.

> In one instance the public health team member became very critical of institution medical services and records. The client had had exploratory thoracic surgery accomplished at another state institution. However, laboratory tests prior to the operation failed to indicate that such surgery was needed. Available records at the institution could not justify the surgery either. The same member criticized the treatment of another client at the same meeting. He felt that this second client needed visual, neurological, and auditory evaluation, plus speech therapy.
>
> In the course of writing a continued institutionalization prescription, the team prescribed the client to receive behavior modification while in the institution. Institution representatives responded that their staff limitations and structure may not allow them to fill such a prescription. A community representative resolved the issue by suggesting that the team prescribe behavior modification and thereby formally recommend to the institution staff that a viable program be developed.
>
> One team member brought to the attention of the team an observation she had made regarding apparent institutional policy. She objected to the "institutional haircuts" the male residents were given, pointing out that this practice had untoward stigmatizing effects by openly labeling any such person as an institutional case. The team concurred and it was recorded that the team had thereby notified the administration of the institution of its position on the matter.

When community team members experienced inadequate information input from institutional staff (as was frequently the case when juvenile offender processing was held in the community rather than at the institution), they pressed the institution to obtain consultation evaluations when they felt these were necessary. Community members sometimes would impose similar demands in reassessment instances when it was clear that the services prescribed

by the team had not been rendered to the client.

There were instances when institution team members reminded community team members of the latter's responsibilities.

> In the case of one forensic client, the team was apparently well along the road toward making a decision not to make a prescription decision. The director of the institution showed the rest of the team what it was doing. He pointed out that the client under discussion had been victimized by both state institutions and community agencies which either could not or would not seriously address themselves to the client's needs and if the current inclination of the team were followed, the very same thing would happen again. SID, in effect, would represent another instance of agency cop-out. This admonition helped the A&P team to consider forensic cases in a much more direct, less gun-shy manner.

> One team member (an institution director) stated that the overall responsibility for keeping tabs on the availability of housing should lie with the local Welfare department.

There were instances in which the institution, or certain staff members thereof, expressed sentiments toward the SID-A&P process in actions rather than words.

> Just as the broker advocate was beginning her presentation of the client to the team, the institution unit chief announced that the client had been discharged two days ago.

Sometimes institution team members tied the hands of community team members.

> In the case of one juvenile offender client, the juvenile institution representative announced that the institution had made definite plans for release. The team-as-a-whole prescribed release if for no other reason than the client would have at his disposal the A&P team and broker advocate coordination service to facilitate his adjustment in the community.

But agreement between institution and community was not always reached in situations where the institution had already arrived at a preordained position.

> One juvenile offender client had been institutionalized because of a very serious crime he had allegedly committed. The institution strongly believed that he was ready for return to the community. The community members of the team said "No!", pointing out to the institution contingent that more concrete evaluation evidence to justify the client's return was needed. The institution went ahead with placement plans--to a location other than Portsmouth.

In general, confrontations between institution and community occurred more frequently than between one community agency and another. The latter interactions were more gingerly approached.

> One team member became critical of a local alcoholic program. When it became obvious to him that the program was under the sponsorship of one of the other community agencies represented on the team, he quickly backed off.
>
> The local public health officer addressed the team regarding deinstitutionalization problems and asked what his agency and other local agencies could do to better serve the clients.
>
> Team members discussed the necessity for community agency input when questions of agency responsibilities came up. One member stated that it may be that agencies are not aware of the many problems people leaving institutions are faced with.

The process of writing prescriptions sometimes led agency representatives into a delineation of the kinds of services their agency provided, for the enlightenment of all concerned.

> In one case, the team prescribed both vocational training and adult education. A discussion ensued which involved a description of the services provided by the corresponding agencies.

A superintendent of a juvenile offender institution was asked: "What happens to girls who are discovered to be pregnant at your institution?" The superintendent replied that in such cases the girl is counseled as to abortion, adoption, or keeping the child herself. She is then transferred to a special cottage for pregnant girls at another state juvenile institution.

Formal and informal admission criteria for facilities at times became explicit during A&P team client processing.

One client was said to be unsuitable for admission to Woodrow Wilson Rehabilitation Center because he was mentally ill. The institution social worker had attempted such a placement in the past and was given this reason.

The team was told at one point that admission to a new MR training center was restricted to persons to whom specific, short term training objectives could be attached with the goal in mind of return to the community within a short period of time.

Institution directors were noted to utilize their role as an A&P team member to offer supervision and direction to their own staff. As a result vertical communication channels within the institution were opened.

The clinical director of one institution questioned the medication being given to one institutionalized client. He proceeded to explain major differences between various psychopharmacological treatments.

One hospital director said openly that he was unaware that certain administrative procedures in his institution were not being executed. He clarified for his staff the necessity for same.

Another director admonished his staff for failing to ensure that one client's legal commitment status be resolved.

One director told his medical staff that the possibility of acquiring a consultant from the Medical College of Virginia be explored in a particular client's case.

Interchanges between A&P team members and SID Quality Control team members usually involved procedural matters.

SID procedures encouraged the A&P team to base prescriptions on client needs--not on resource availability. This frequently led team members to the conclusion that they were writing unrealistic prescriptions. It created an intermittent dialogue between A&P team members and SID staff members. Use of the term ideal housing instead of first choice housing seemed to feed what was basically a pseudo-issue of semantics, for everyone seemed basically to realize that if prescriptions were constrained by existent resources then (a) the service requirements of many clients would go unrecognized and (b) resource gaps would be impossible to identify.

Team members were sensitive to inconsistences in the contents of assessment summaries on clients. SID staff reminded A&P team members that when information is compiled from a wide variety of sources contradictions can be expected, hence the information source code for all items on the printout. One purpose of the assessment portion of the A&P meetings was to resolve conflicting information.

The above examples indicate that A&P meeting interactions went far beyond the amenities typically associated with formal case conferences. The A&P group did in fact become a team. There was, for example, an implicit agreement that disagreement was acceptable. Confrontations and challenges occurred, often to result in greater clarification and increased group cohesiveness.

Coalition, however, does seem an apt characterization, since as one observes the interaction over a period of time the essential two-sided nature of the group is not lost. Coalition, also, because of the basic agreement and willingness to cooperate and participate toward a commonly shared objective (improved service to clients) in spite of differing perspectives.

2. Providing Core Services

The core services that are provided by a service-integration structure at the service delivery level are listed and defined in paragraph C1 of Table 41 . These core services are: outreach, intake, diagnosis, referral, and followup.

The performance of these core services in the SID model is accomplished by the A&P team with the support of the broker advocate and via the framework of SID procedures.

The outreach function occurs as a result of the project's designation and solicitation of the target group of clients. The intake function is the admission of the client's case for assessment deliberation before the team. Diagnosis is the team's written prescription, a specification of what services the client needs. Referral constitutes the search for, and service agreement with, resource agencies--actions performed by the broker advocate serving as an extension of the A&P team. The followup function is the ongoing monitoring process of a client once he has entered the system via intake.

How effectively did the A&P team perform the core services functions?

In a quantitative sense, this question is answered by the data in sections II and III of this volume since all of the data presented therein are representations of core services functions and were A&P team/broker advocate generated.

But, again, the quantitative results are divested of the subtleties and intricacies of how the team carried out the core services functions. Tables of assessment, prescription, and followup statistics do not fully answer the question of whether a multi-disciplinary body does indeed add a necessary, heretofore absent dimension to the service delivery process. Maybe individuals within a single agency could perform the core services just as effectively.

We do not have black or white answers to this most important of questions. What we do have is a wealth of existential experiences with a local, multiagency body, the SID A&P team. The capsules to follow are a feeble attempt to share but a few of these experiences with the reader.

In many cases the sheer exposure to the A&P team of the tragedy of lengthy and unnecessary institutionalization resulted in a prompt deinstitutionalization prescription and placement.

The team questioned the appropriateness of institutionalization because the client's only problem was epilepsy (i.e., no severe retardation nor behavior management problem). Explanation by institution representatives indicated that the institution had been an epileptic colony at the time of the client's admission 23 years ago. Had the community not become aware of this situation the person may well have remained in the institution many more years for no substantial reason. The client is presently living in the community under SID monitoring procedures.

Community team member knowledgeability about facility capability made for sounder placements.

A specific home for alcoholics became the subject of discussion. It was ascertained that the facility would not be able to provide the kind of supervision required for the particular client in question, so the broker advocate was instructed by the team to look elsewhere.

From her knowledge of the local school system and from the assessment facts in the case, the Education team member told the broker advocate to ensure that the client attended school X and not school Y.

The A&P team mechanism ought theoretically to make it easier to extend services begun in the institution into the community. Sometimes this was the case, sometimes not.

In one MR case, the team recommended that the client be tied in with the Bureau of Crippled Children so that he could receive a service similar to one he was being provided within the institution. This was accomplished.

The broker advocate for one client was told that the client could not be enrolled in the local school system until his records arrived from the state juvenile institution. The broker advocate went to the Education representative on the A&P team, who said such a policy was indefensible since "We frequently accept out-of-state students before their records arrive." The Education representative immediately removed the obstacle to service provision in this instance.

In another juvenile offender case, the community Vocational Rehabilitation team member emphasized the importance of having the VR institution office immediately transfer the client's records to the community VR office. This was not done.

The A&P team process stimulated concurrent services, i.e., services for the client while in the institution and services for (or preparation by) those agencies expecting the client's return.

In the institution the client was offered training in sign language, fitted with a hearing aid, and trained in its use. Simultaneously, the client's family was offered training in sign language and counseling regarding acceptance of the client's status as a participating family member.

A videotape of the client's aberrant behavior was shown at an A&P team meeting. The team prescribed continued institutionalization with emphasis on self-care training. One of the team members showed and discussed the tape with the client's family so as to increase the family's understanding of the behavior modification approach that had been prescribed by the team. Resources from this team member's agency agreed to assist the institution in developing a treatment plan. Prior to A&P team intervention, both the family and the institution were at a loss in dealing with the client's behavior. Now an active treatment program is underway which involves the institution, the family, the client, and another agency.

The multiagency character and strength of the team resulted in the provision of services clients may not otherwise have received.

A consultation in the medical chart of one client had recommended cataract surgery in 1972. The institution explained that it had neither the technical capability nor the finances to arrange for such. The team member from the Commission for the Visually Handicapped said that his agency could sponsor the client for corrective surgery.

A young lady at a training school suffered from a heart condition. The team prescribed that the institution refer the client to the University of Virginia medical center for evaluation and possible surgery.

A client placed in the community was getting along well except for the fact that she had still failed to receive any APTD checks and she was behind three months in payment to her landlady. Re-institutionalization loomed as a distinct possibility. The welfare representative promised to look into the matter and expedite the APTD eligibility application.

It was called to the attention of the team (by a broker advocate) that clients were leaving the hospital with only a 3-day supply of non-psychotropic medications. For clients who did not yet have approved medicaid benefits, it was impossible to obtain continuing medication. The hospital director team member immediately announced that it was the responsibility of the hospital, specifically the attending physician, to ensure that any indigent patient leaving the hospital be provided with sufficient medication, up to a 30-day supply.

The mental health member told the rest of the team that some deinstitutionalized SID clients were failing to keep appointments at his facility. The team discussed approaches to overcome this problem.

Sometimes persons not targeted for SID services received the benefit of A&P team multi-agency liaison.

A team member told the team that she had recently, in a professional capacity, called upon a person (not a SID client) who was living in a boarding home. The team member found the living conditions unsatisfactory and wondered if it would be possible to pick the person up as a SID client, return him to the state mental hospital, and then re-settle him into the community. The team recommended that the team member request the local Welfare department (representative present on the team) to move the individual to a more supervised housing facility.

A staff member from one of the juvenile offender institutions appeared before the A&P team. He requested the team to process a juvenile from his institution who had no home or relatives and had been a ward of the state for many years. Though the juvenile did not have a home of record related to the team's locale, the team accepted him as a client and prescribed placement in its own community.

Also, the team sensitized higher officials with respect to service delivery problems.

Broker advocates reported to the team that they repeatedly experienced delays in eligibility determination and that as a consequence community placements were being held up, places on waiting lists surrendered, etc. The team formally requested the state Department of Welfare to investigate the possibility of speeding up the processing of applications at both state and local levels. Similar problems were encountered with the advent of the SSI program and similar concerns voiced to the appropriate officials.

Questions regarding a particular client's access to her own trust fund were triggered by broker advocate input. The team called in a representative from the institution's reimbursement office to discuss actions taken by the institution in this case. The team decided to write a letter to the assistant attorney general serving DMH&MR requesting clarification of the client's financial entitlements.

The team registered concern that a local nursing home's policy had caused the return of a 74-year-old client to the institution because the nursing home found the client's modified acting-out behavior unacceptable.

But in spite of its multiagency character, the team did not always solve problems associated with referral, followup and service delivery.

One broker advocate pled desperately before the team that she was receiving only put-offs from two of the community agencies represented on the team and that she needed the team's help and direction. This led into a team discussion which centered around calling the client a sociopath. The institution director chastised the rest of the team for blaming the client when in reality the problem was one of deficiencies in treatment technology. "Let's be honest enough to admit it when we can't help someone rather than say its the client's fault."

A client placed in the community fell and broke her shoulder. She was taken to the local general hospital emergency room. When staff in the emergency room learned that the woman had been a patient at the nearby state mental hospital, she was returned there without treatment. Neither the general hospital nor the mental hospital notified the broker advocate of the problem. When the client was discussed at the next A&P team meeting, community team members questioned the general hospital and the mental hospital procedures in this case.

The team gave guidance and supervision to the broker advocates on matters relating to delivery of the team's core services.

To avoid possible inconsistences or omissions in recording the service elements prescribed by the team, the broker advocates were requested routinely to summarize each client's prescription at the conclusion of each case presentation

The broker advocate told the team that he was unsuccessful in getting his client to follow through on a certain prescription element. The team suggested another kind of approach for the broker advocate to take in his attempt to gain the client's cooperation.

One team member emphasized to the broker advocate the need for a family contact prior to the A&P team meeting. Such contacts may serve two purposes: (a) provide valuable diagnostic information and (b) rekindle family interest in the client.

These, then, have been examples from A&P team demonstration of its role as multiagency provider of the five core services (recruiting, assessing, prescribing for, referring, and following clients).

How effectively did the A&P team perform these core services? Perhaps all that can be stated conclusively is that it would be difficult to report similar functional happenings resulting from the activities of a case team

the members of which represented only a single agency. Paragraph C, below, is devoted to a further elaboration of A&P team performance of core services as effected via the team's "staff" of broker advocates.

3. Planning and Programming

Besides providing the five core services, the A&P team carries out planning and programming functions. These functions are listed in paragraph B3 of Table 41 and consist of: joint planning; joint development of operating policies; joint programming; information sharing; and joint evaluation.

Information sharing was a continuous, ongoing activity of the A&P team, made possible by SID central office staff serving as compilers and mediators of the information generated by the team itself, on the one hand, and by the committee of commissioners, on the other. Information generated by the team was transformed into minutes of meetings and into hand-tabulated (and later automated) reports, the latter of which identified client demography and pinpointed resource requirements in relation to client needs. Information generated by the committee of commissioners came in the form of policy decisions, issues, plans, and constraints--usually relayed to the team via SID staff.

Joint evaluation occurred in a systematic fashion at certain steps in the program's development, and also occurred

less systematically, to one degree or another, throughout all of the A&P team planning and programming activities. Two A&P team meetings in one of the geographic areas were devoted entirely to joint evaluation of the program in August and September of 1974. When the SID Plan for Continuation/Extension was submitted, there again resulted meetings concerned with joint evaluation. (See Volume 7 of this report.) Recently the A&P teams in one of the project areas have decided to invite clients who have been placed and living in the community to reappear before the team to obtain an "existential evaluation" of the results of deinstitutionalization."*

Examples of the team's activities in the three other programming and planning functions comprise the remainder of the discussion.

a. Joint development of operating policies.

Frequently the A&P team made policy decisions with respect to its own procedures. In so doing the team was constrained by the project guidelines and requirements, and later by recognition of and respect for developmental gains achieved (for example, constructions in the automated information system), but, nevertheless, there were within these limits considerable freedom and flexibility for the team to decide on many operational matters.

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* The 8-volume SID Report, itself, however, should not be construed as a product of joint (i.e., multi-agency) evaluation. It was compiled by SID staff, in fulfillment of the terms of the 3-year grant.

Prior to the first client processing meeting, several organizational meetings were held. It was during these meetings that specific agencies and representatives were designated to serve on the A&P team. Agency representatives were asked to evaluate and comment on the first draft of assessment and prescription formats. Team officers were elected.

The team decided that agency members could bring resource persons and observers with them to A&P team meetings. This would serve to strengthen the assessment/prescription function, as well as offer a means by which potential team replacements could receive training and orientation in SID procedures.

One team member suggested displaying the behavioral repertoire results in chart form in each assessment. Team agreed.

It was decided by the team to request that the client appear briefly before the team during the assessment/prescription process. The client's wishes and the attendant physician's opinion regarding client appearance would be respected.

The team decided that it was unnecessary for the broker advocate to render a detailed report to the team of his resource search in instances where the search was successful. The team chairman was given the authority by the team to sign directly recommendations for client movement in such instances. Only when the BA encountered problems, or was forced to compromise the team's prescription, would a report to the entire team be necessary before a formal recommendation for client movement be submitted.

The director of the institution questioned the appropriateness of the team's differentiating between prescribing convalescent leave versus prescribing discharge from the institution. Such distinction was eliminated from the prescription format.

In those instances where the client was physically unable to come to the team meeting, the team decided to go to the ward to meet the client.

The team decided that it could accommodate six to eight assessment/prescription client processings per meeting, and still leave room for a few followup problems and the business meeting.

The team saw a need for establishing formal definitions for each of the community placement prescription elements (housing, income, supportive services) and requested SID staff to develop same and include in the A&P team manual.

Recalling poor attendance at a previous meeting, the team chairman announced that hereafter he would determine if enough agencies were represented to enable construction of appropriate prescriptions and, if not, he would postpone the meeting. Team members were reminded to send alternates to those meetings which they themselves were unable to attend.

One team member brought to the team's attention her concern over client interviewing techniques sometimes being used at the meetings. The team decided that the broker advocate, in consultation with institution staff, should decide who would be best suited to lead the interview in each specific case. Main points to be covered in the interview were discussed.

The team established a policy enabling the relatives of clients to appear before the A&P team in appropriate instances.

The team expressed concern to have always a physician present, either as a team member or as a staff consultant, during the prescription process.

b. Joint programming.

Joint programming is defined as the joint development of programmatic solutions to defined problems in relation to existing resources. Joint programming efforts of the A&P team often came in the form of resolutions.

The team observed that some clients prescribed for community placement could probably profit from a "depressurization" program designed to assist them in their reorientation and readjustment to community life. Shortly thereafter the hospital instituted a community adjustment training (CAT) program.

The team was invited to give a live demonstration of the assessment/prescription process on a fictitious client at the annual meetings of a state professional association. Team accepted the invitation and gave the demonstration.

The team unanimously voted to send to the committee of commissioners a letter expressing continuing concern over the lack of available funds (particularly insufficiency of SSI payment) to meet housing costs for deinstitutionalized clients. The team recommended that the committee of commissioners search to find monies in the amount of 35 to 50 dollars per month per client.

The institutional staff on the forensic unit queried the A&P team as to its ability to provide funds for improving services on the forensic unit. The team indicated it had no funds itself but that it could recommend same to the committee of commissioners.

It was the feeling of the team that the broker advocate should not work up those cases, nor present them to the team, in which the institution was unable to provide much needed psychological and psychiatric evaluations. The team requested the team chairman to write a letter to the director of the Department of Corrections and to the institutional superintendent stating the team's view.

The director of the institution indicated to the other team members that his institution would develop programs based on the elements prescribed by the team for clients receiving continued institutionalization prescriptions.

The director of the institution stated his strong disapproval over the manner in which patients committed to his institution from the particular SID community were delivered--frequently after normal duty hours and in shackles. A motion was made and passed by the team that the chairman present the problem to the City

Manager, express the team's position on the matter, and offer training to the persons providing the transportation.

Two team members (physicians) volunteered to solicit the support of local medical professional organizations in an effort to increase medical service for patients discharged from the state hospital. The team recommended to the committee of commissioners that the local public health department receive the services of another physician to look after the general medical needs of deinstitutionalized SID clients.

c. Joint planning.

Joint planning is the joint determination of service delivery system needs and priorities through a structured planning process.

The team saw the need to be able to process prospective SID clients who could not be brought into the procedure because they were unable to give informed consent to the release of information on themselves. The team made a formal request to the Attorney General to render guidance as to how the team could proceed in such instances.

After examining data on the institution's placements, the team requested the chairman to draft a resolution containing two recommendations: (a) to encourage the institution to return the individuals to their specific home jurisdiction and (b) to request of the state additional funding support for those localities receiving a disproportionate number of deinstitutionalized persons.

The team divided itself into task force groups. Additional community resource people were recruited to increment membership in task forces. Each task force was assigned a specific resource problem area: housing, income, mental health aftercare, dental services, health services, special education, welfare programs, etc. Objectives are to identify resource gaps and develop plans for programs. Task force presentations are made to the team-as-a-whole monthly, on a rotating basis.

There were instances in the project where joint planning by the A&P team, often using the SID data base as a point of departure, stimulated expansion and creation of needed services and resources by single agencies. Therefore, joint planning can and did lead to non-joint programming.

> The Chapter 10 Board made grant application to Developmental Disabilities Planning and Advisory Council for a group home and supportive services for the mentally retarded.
>
> City Council approved the application for a 25-bed home for juvenile delinquents.
>
> Senior centers and several homes for adults are working to develop more programs for their clientele.
>
> The mental hygiene clinic conducts pre-screening conferences for prospective voluntary admissions to the state hospital.
>
> The institution now routinely schedules pre-admission and pre-release conferences wherein community resource people are invited to attend.
>
> The institution has begun several training and preparatory programs for residents targeted for de-institutionalization.
>
> Agencies in three cities are exploring avenues for developing day activity programs for the mentally retarded.
>
> An application for DDA monies to assist in the development of an extended residential system for the mentally retarded in the area has been submitted.

4. Comment

A&P team development during the project certainly represents one of the strongest service integration "findings" in the entire demonstration. Voluntary coordination,

mediated by SID procedures and staff, provided sufficient organizational framework to enable the team to coagulate, remain intact, perform the core services, and address itself to matters concerned with planning and programming. The record of involvement and accomplishments established by the local service-integrating body stands in marked relief against the insipid, defensive attitude toward innovative service integration observed at the state level during the demonstration period.

It is instructive to attempt to formulate the underlying factors which contributed to the success of A&P team functioning.

- There is considerable "hunger" among local service providers for an improved system of delivery of services; attempts toward improvement can be stimulating and positively reinforcing to participants.

- Local service providers are keenly aware that there is ordinarily very limited cross-talk among agencies; A&P team meetings corrected this communication deficiency.

- The structured, well-specified nature of the assessment and prescription task provided the kind of operational security necessary for a large group of participants to function smoothly and yet contribute meaningfully.

- The SID field staff, headed by the community services coordinator, were clearly designated and accepted as the role means by which A&P team coordination was effected.

- The A&P team, in effect, had at its disposal a staff--i.e., the broker advocates.

-Team members from many agencies frequently remarked that meetings provided a learning experience to themselves.

-The team received information feedback with respect to its progress and accomplishments on a regular basis (information on individual clients served, on resource requirements identified, on positions, plans and procedures adopted).

-The heads of the participating state agencies in Richmond had gone on record as having requested and received funds to implement the project; there was at least symbolic support from upper echelons.

-The client's appearance at team meetings served as an acute existential reminder to what the team was about.

C. BROKER ADVOCATE

In the language of Table 41, the broker advocate is the case coordinator (see paragraph C2b of Table 41). The broker advocate serves as an arm of the A&P team; therefore, many broker advocate activities represent extensions of A&P team functions.

The broker advocate occupies a rather unique position in the human services delivery system:

-The BA's activities and observations occur at the very "synapse" of service delivery.

-He attempts to perceive the delivery system through the eyes of his client.

-He is beholden to no one single agency; his loyalties and responsibilities are diffuse: to the client, to the A&P team, to the administrative procedures in the project.

-The BA spends his time in both the state institution and the community, yet is an agent for neither; instead he is an agent for the client.

-While he functions as an arm of the A&P team, he can also intimately witness the strengths and weaknesses of the team as these impact on his client.

-Because of his power base, i.e., the multi-agency A&P team, the BA's requests and urgings on behalf of his client are apt to be heard and acted upon.

-To fulfill his role and meet its objectives, the BA must be both a broker and an advocate. As a broker, he must cooperate, compromise, conciliate, mediate, facilitate; as an advocate, he must take stands, assume positions, point fingers, be explicit, and cry out. All of this requires a fine sense of timing and balancing.

Because of the broker advocate's unique position, it is important to attempt a documentation of his observations on service integration happenings (or non-happenings) as consequences of the operational SID model, as well as his observations on the delivery system's service (or non-service) to the client.

Again, such events are formally documented in section III of this volume--from a statistical standpoint. Therein data on the results of resource searches and on service delivery outcomes are tabulated. What is presented here is an attempt to enliven the formalized data with examples of actual experiences encountered. Much of the information is presented in raw, undigested form from the observer himself--the broker advocate.

1. State Institutions

Broker advocate interface with four large Department of Mental Health and Mental Retardation state institutions (two mental hospitals and two training schools for the mentally retarded) and seven small Department of Corrections

training schools for the juvenile offender provided a range of experiences and observations with respect to service delivery in the institution and institution responsiveness to the project's procedures and objectives.

> The integration of service delivery was a relatively slow process at both the institution and community levels and required a substantial degree of familiarity with the project concept as well as personal acceptance of the project's goals.
>
> Whenever an outside group enters a relatively closed operation, people become fearful of just what this group wishes to find out and how its activities will affect the staff.
>
> From the standpoint of the Portsmouth broker advocate, the juvenile institutions presented the most difficulties in all aspects of the SID process from assessment to follow-up. The reasons for this were numerous: newness of the deinstitutionalization concept in the juvenile area, the number of institutions involved, A&P team development problems, a green staff of broker advocates, and the nature of the juvenile cases themselves.
>
> The broker advocates found that due to the few clients at any one juvenile institution they were unable to really establish rapport or understanding between themselves and the counselors or other personnel. SID made institution people nervous because it made them justify what they had done for a child in a short period of time. Because each institution operated somewhat differently, A&P team members found the prescription process most difficult. No sooner did the team begin to become aware of the operations of one institution than SID was scheduled to present clients from another institution.
>
> Initially the roles of the broker advocate, cottage counselor, and probation officer were seen as duplicative in function. This made it difficult to justify one's goal as helping to eliminate service overlap.

Upon completion of the first round of client processing in the juvenile institutions, it was made clear to the superintendents that SID would return to their institutions upon notification that a Portsmouth client was scheduled for release in approximately two or three months. But there has been very little follow through on this offer. When it has taken place, it has been the result of individual counselors who have personal contacts with SID broker advocates. Even these referrals seemed to come from the viewpoint that SID is not a procedural system but rather an additional resource to be tapped when dealing with the more difficult cases. Sometimes probation officers would request that SID be called in but even so this was not usually done. Part of this problem stems from the personnel turnover at the juvenile institutions. New counselors who have not dealt with SID know little or nothing about it since institutional superintendents do not seem to require that contact with SID be made.

In those instances where the juvenile institutions have kept in touch with SID the results have been quite satisfactory. Over time the team has been able to get a better handle on its role and write more suitable prescriptions. Institutional personnel became able to confront the team with questions that they would never have asked in the early days. They see the team as a means for inputting their problems to community agencies that had never before listened.

Perhaps fewer problems would have occurred with the juvenile group had SID-Portsmouth processed this client group last.* By the same token, using the juveniles as a starting point seems to have made the other two client groups more successful.

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* This proved to be a most accurate evaluative comment. When the PD #6 broker advocates entered the juvenile offender institutions, they already had well over a year's experience with the other two client groups. Client processing went much more smoothly. The other crucial difference was that the PD #6 A&P team journeyed to the juvenile institutions, something which the Portsmouth A&P team never did.

By the time the broker advocates entered the second target group of clients, they found SID easier to explain and the institution staff much easier to deal with.

Although institution staff were aware that the broker advocates were coming, they were not prepared for the rather huge demand for information, and they questioned the role of the broker advocate in light of the role of the institution social worker.

One institutional director was responsible in large measure for SID ever getting off the ground at all! In the midst of one of the planning sessions SID staff held with the initial A&P steering committee, things were not going at all well. The host director rose to the occasion: "None of us may want to do this, but our bosses have all said that we will, so let's get on with it. Just give us a date when you want us to begin."

Even after the beachhead was established, SID was both positively and negatively received. Some personnel thought the role of the broker advocate was an invaluable aid in community placement, while others resorted to obstructionistic tactics to prevent SID's success. It seemed apparent to the broker advocates involved with the obstructionists that jealousy of the community base with its numerous contacts was a large part of the problem.

In an institution which served both broker advocate field staffs, an abundant amount of cooperation was encountered when the second broker advocate field staff entered. Institution staff went out of their way to do the things requested by the broker advocate without making excuses or delays. When it came time to deal with the same staff for placements, the institution social workers bent over backwards to cooperate. Telephone calls were returned almost immediately, and numerous calls were made by the institution staff to the broker advocate in the community. The hints and overtones of jealousy and turf invasion felt at other institutions were never seen at this particular one.

In its entry to one of the large DMH&MR institutions, the broker advocate staff discovered that the director was not even perfunctorily courteous in his reception of SID. It was clear from the director's opening remarks to the broker advocates that he felt them to be witch-hunting or searching for skeletons in the hospital's closet, and he was adamant in his insistence that none would be found. To community members of the A&P team he expressed the hope that people were present with sufficient authority to make decisions. It quickly became obvious to the broker advocates as they worked with other personnel in the institution that the director's opinions had filtered through the ranks. But as time wore on, the institution began to do everything possible to cooperate. When mix-ups and misunderstandings did occur, the director could be counted upon to lend his strength and support to constructive solutions.

The broker advocates had trouble getting the doctors to realize that the SID medical forms needed to be completed. Worse than a high school student trying to make excuses for not doing his homework, doctors would try anything to avoid filling out the forms. Sometimes broker advocates would have to invoke director influence to persuade these doctors that this work be done. Sometimes nursing personnel would be more cooperative, but oftentimes they begged off, not feeling as competent as the doctors. Unfortunately, the doctors proved not all that familiar with the cases, either, and medical information would prove inaccurate.

Inaccuracies in medical records were jumped on by team members and used as a spring board for long discussions on accurate record keeping. Fortunately hospital administrators were also aware of these inadequacies and were beginning to convert the entire record system to problem-oriented record keeping. The community/institutional working relationship developed rapidly in spite of some really cutting observations by community team members. Hospital staff rapidly gained confidence in voicing their opinions and team members called directly on staff for opinions and interpretations.

Institution opinion of clients was sometimes contradictory. When one client was presented at his first A&P team meeting, institutional staff present said that he was capable of performing at a self-care level. When group home representatives saw him, they received an entirely different story from the institution. At the client's reassessment more staff were present and they once again stated that he was self-care and even went so far as to say that he did not need a diabetic diet.

At times the broker advocate, in tracking down a release of information signature, was able to supply the institution with its first contact and information about a client's family that it had had in years, and the family with the first news of their relative.

As a consequence to the broker advocate assessment intervention some clients received long overdue services for the first time during their hospital stay, such as diagnostic or medication review.

One broker advocate discovered that a client's mother was also residing in the same institution as the client, without the client's knowledge.

Broker advocates found problems with some social workers who really did not know their residents. In some cases it was because the resident had been recently transferred to a new ward, and in other cases it seemed to be simply a lack of interest.

One of the most frustrating problems to occur is the release of the client by the institution after the broker advocate has gathered the assessment information but before the A&P team has met and prescribed for him.

Sometimes clients are moved from one ward to another with no notification to the broker advocate concerned.

When a client is brought to the A&P team meeting he is not always accompanied by the aide who served as informant for the behavioral repertoire. When repertoire interpretation problems occur, the aide needs to be present for clarification.

There have been repeated instances of failures by the staff of the institution to return broker advocate phone calls or to follow through with arrangements such as completion of medical forms. Reminders seem to have no impact.

The institution has not really paid much heed to team prescriptions for continued institutionalization. When reassessment data are gathered by the broker advocate, frequently it is noted that the assessment print-out is not in the folder nor is there a copy available of the prescription written by the team. At team meetings when ward staff is confronted by the information gained by the broker advocate about fulfillment of these prescriptions, the excuse of lack of available facilities is often invoked.

Many social workers at the institution bent over backwards to cooperate with the broker advocate in filling team prescriptions for community placements. When the social worker and the broker advocate pooled their efforts, amazingly quick results occurred.

A very productive meeting resulted when I met with the institution staff working with my client: unit manager, social worker, ward nurse, speech therapist, an interested teacher, and a graduate social work field placement student (working one-to-one with my client). When I reviewed my client's prescription elements, (e.g., behavior modification, community adjustment training), we realized that such formal programs were not in existence on this unit. However, various members of the staff group began to volunteer to provide informal alternatives to the prescription. Together, we were able to schedule a much more complete and goal-oriented treatment plan for this client than she had previously been provided. I felt that the workability of the final plan was due to the staff's special knowledge of what they could each offer this particular client vis-a-vis my understanding of the A&P team's recommendations and their goal of eventual placement in a community setting.

Hospital staff became better informed and more on their toes They were better able to serve SID and non-SID clients due to their participation in A&P team meetings.

2. Community Agencies

Broker advocates dealt with a host of community agencies. Many of these agencies had direct representation on the A&P team; some did not

At the beginning of the project some community agencies were not as convinced as they later became of the project's worth.

Orienting community service providers toward SID proceeded at a somewhat slower pace than in the institutions. This was because services delivered by the communities did not get tested until the project placed and followed clients.

Productive and meaningful broker advocate contacts in the community were not accomplished easily. As with the institutions, directors of community agencies were made aware of SID and asked to pass the word on to their staffs, but early months were filled with long telephone conversations by broker advocates to agency staff members prefaced by a 10-15 minute explanation of the project, the broker advocate role, and then questions and answers before the actual reason for the call could be stated. Unless one dealt with the same person in a given agency each time he called, he might find himself following the same process each time the call was made.

When the A&P team first began, the community agency representatives seemed unsure of their roles on the team and little information filtered down to the active service providing staff.

The same resentments toward SID which were present in institutional personnel were also expressed by the staffs of local community agencies.

The generally conservative community attitude was probably one of the principal factors in the slow acceptance of the SID concept and procedures.

When agencies are represented on the A&P team the broker advocates encounter fewer problems and obtain more positive results.

The Social Security Administration is not represented on the A&P team. This is most unfortunate since this agency probably holds the record for difficulties and problems it has created for the broker advocates during the project.

The policy of the Social Security Administration at the time of the first mentally retarded placement was that no application for SSI could be made until the client was already placed in the community. This state of affairs was eventually corrected by SSA policy at a very high level, but not before telephone calls from the broker advocate staff had been made first to local offices, then to state offices, then to federal offices in the Social Security Administration.

Although the local Social Security Administration office had received a memorandum detailing new procedures for SSI applications, the representatives of this office refused to make copies available to the broker advocate staff and refused to send a copy of the memorandum to the institution concerned on the grounds that it was an SSA inter-office communication.

We began to observe that the SSI operational efficiency was much improved when we entered another large DMH&MR institution. At this institution a person called a "homefinder" was the liaison with the local Social Security Administration office. Thus it was clearly understood who should be contacted in the event that any problem arose.

Delays in the processing of SSI eligibility applications continue. The Social Security Administration continues to give every evidence that the ineptitude it generally displays must be one of design rather than one of accident.

The Health Department became one of the most cooperative community agencies. Not only were its programs open to SID clients but the Health Department added additional programs to meet the requirements of SID prescriptions. At times Health provided transportation for SID clients, something many of the agencies did not have available for SID clientele. The director of the Health Department was responsive to the part of the A&P team prescription that impacted upon his services.

The public school system was very slow in facilitating the return of juvenile offender clients to the community. Often when a client returned, he was not brought before the placement commission for five to eight weeks.

During our early encounters with Education, we made frequent trips to elicit staff cooperation on the administration and principal levels. In many cases the school administrative officials were not willing to help the students returning from the juvenile offender institutions. As the project has matured and with stronger education representatives on the A&P team, the public schools have become more receptive to team recommendations.

Since a shortage of foster homes exists for non-delinquent children, it requires at least a double effort to find a foster home for a juvenile offender. Social Services did its best to find homes for juvenile offender clients, but many of these placements were unsuccessful due to the attitudes of the clients themselves.

A medicaid application sat on the desk of a supervisor for almost four months before broker advocate intervention brought to light the fact that the supervisor was waiting for an accompanying SSI application.

When the new Social Services representative joined the A&P team, the relationship between the broker advocate and Social Services improved dramatically. Social Services became an invaluable asset in facilitating applications and in willingly giving out information needed by the broker advocate.

The broker advocate staff experienced some problem in getting their clients to accept community mental health services. This was apparently due in many cases to the negative valence of psychiatry. Many clients and family members seemed reluctant to enter the agency because of the name it carried. The standard line of "I ain't crazy" or "I don't need no shrink" still occurred frequently in the clientele served.

Appointments established by the broker advocates at the mental health clinic were sometimes broken by the client. Many hard feelings from these broken appointments were directed at the broker advocates by the clinic staff. Also, the clinic staff seemed to resent the A&P team having made such recommendations in the first place. One day there was a showdown between a clinic staff member and a SID broker advocate. The mental health A&P team representative intervened and offered to become the liaison for all recommendations for mental health services--a procedure which has proven itself over the months to be most efficient and effective.

We found a reluctance by the vocational rehabilitation counselor at the juvenile institutions to transfer cases to the local community VR office because the VR facility at the institution would lose the numerical count so vital to its existence at the institutional level.

PRIDE is a vocational rehabilitation project that has a lot of good things to offer the community. However, it has been our experience that clients tend to get lost in this system. Frequent calls to the director have netted very few positive results.

Many of the counselors working for the local Department of Vocational Rehabilitation have been most effective in helping to gain jobs and training for SID clients. Vocational rehabilitation in an adjoining city has also been an important asset in the search for resources. We did find that the transfer of vocational rehabilitation cases from institution to local agency and from one community to another often encountered administrative bottlenecks.

The Employment Commission when called upon to help the broker advocate find jobs for returning SID clients was of little service. VEC counselors contacted by the broker advocates seemed to have rather standard, pat answers that did not go very far in meeting a client's needs. Even when some counselors put forth their best efforts, however, the results have been minimal. Perhaps the present state of the economy is partly the problem.

In the case of the juvenile offenders, the probation department of the juvenile and domestic relations court was the biggest resource broker advocates had for help. By the same token, the probation officers were happy to have the additional assistance in placing their probates. A very good working relationship developed between probation officers and broker advocates, unlike that between juvenile institutional staff and broker advocates.

The juvenile court gave its full support to the broker advocate staff in helping with the placement and follow-up of juvenile offender clients. The probation officers seemed to see SID staff as a means of easing their own overburdened caseloads. Probation officers and broker advocates often worked very closely on joint cases.

There seemed to be no role conflict nor turf invasion problem between probation officers and broker advocates.

3. A&P Team

In the SID model the institution and the community agencies come together in the form of a case team, the A&P team. The broker advocate serves as an arm of this team, but at the same time is positioned to observe its functioning.

As a general rule, the broker advocates seemed to agree that A&P team operation was conscientious and beneficial to clients. Cooperation was sustained throughout a long period, information from varying sources and disciplines was routinely available, problems were more often resolved than they were created, and a kind of autonomous, self-perpetuating aura developed.

But there were some problems and defects in team functioning that the broker advocates noted.

Each member was usually willing to contribute his expertise or service where needed, but a team made up of lineworkers rather than local agency heads may have been more effective in integrating the nitty-gritty in service delivery to the client.

Clients generally have received better services as a result of our present A&P team, which is made up largely of local agency heads. Attitudes toward deinstitutionalization have been changed in team members themselves, but these members do not go out of their way to educate other personnel in their agencies.

Team agencies do not always follow through on the very prescriptions they participated in formulating.

It was difficult to find a unified pattern in the team's decisions. On one day most cases would be prescribed OUT, while another time similar cases might be recommended to continue in the institution.

There seemed to be phases of interest in certain prescription elements, as when sex education enjoyed a surge of popularity and then eventually died down.

Sometimes the team seemed to get hung up on trivial issues, debating them at length while ignoring or skimming over vital issues such as medical needs.

One or two members would frequently dominate the input while the rest of the group merely followed the tide.

One BA felt that he could control the prescription process when he became highly verbal and persuasive: "The team was supportive of my bias."

Team members sometimes dodged their responsibilities and were not confronted by other members about failure to deliver a specific service or treatment.

Have the team members informally agreed that one professional does not criticize another professional in the presence of other professionals?

Early-on some team members questioned our qualifications and backgrounds. As they became familiar with what we could and could not do, what we knew and did not know, and as we became responsive to the team's guidance, members came to trust us and overlook our shortcomings.

From time to time, some team members became so acutely aware of the absence of other members that they made comments.

Team members do not always come (sometimes they send alternates), and of those that do come, only four or five participate.

I sometimes feel that my client would have received a different prescription if team members X, Y, or Z had been present; this applies also to institutional personnel who may be absent.

Sometimes the team tends to over-prescribe.

I was very disappointed when a counselor from the Virginia Commission for the Visually Handicapped was not present at the meeting when I presented my client.

4. Coordinating and Mobilizing Services

The major thrust of the broker advocate is to coordinate the services prescribed for his client and to mobilize the service delivery system toward this end.

Broker advocates comment on their own role.

The primary function of the broker advocate is to drag the client through the maze of bureaucratic red tape.

Sometimes I am cast in the role of enforcer rather than coordinator. Here is a diary of one day's activities.

1 - Take Outreach worker and adult social worker to group home where my client lives in order to make them more aware of living conditions (poor).

2 - Nag social worker to find out why four of my clients have not yet received support checks.

3 - Deliver Nursing Home application forms to social worker; request that she complete application for institutionalized clients. (Three months later: return to same social worker to ask why forms have not been completed and received. Listen to social worker request new, blank forms, since she has misplaced original copies. Start over.)

4 - Talk landlord into transporting client to physician for physical examination.

5 - Attempt to persuade institutional Vocational Rehabilitation worker to arrange for Department of Vocational Rehabilitation to evaluate client (unsuccessful).

6 - Persuade mental health worker to contact client and arrange counseling appointment.

7 - Request special funds for two clients (unsuccessful).

8 - Request Medicaid assistance for client, from Department of Public Welfare (successful after four telephone calls).

I've noticed a "damned if you do, damned if you don't" situation regarding the BA's role. It seems the BA has to find some magic place between overt aggression and passive acceptance in attempting to mobilize services. At times, service providers resent the "interference" of the BA, and the client suffers as a result. And yet, if the BA pacifies service providers and doesn't push for service delivery, often nothing gets accomplished. As a result, the BA often gives up on mobilizing a specific service and simply provides direct services herself.

One of my most important functions in mobilizing services as a BA is to broker with agencies for client services in the community, before my client is released from the institution. I believe this pre-release work is necessary to prevent last minute confusions and cancellations.

In numerous instances, it was the broker advocate who bridged the gap between institution and community, making it possible for the client to move back into the community.

After one disastrous attempt to place a client in a foster home with SSI financial support, the institutional social worker was so discouraged she was unwilling to fill out further application forms, or even to consider another outside placement for this client. I was able to persuade the client's family to agree to provide financial support for the client until the SSI payments began. Without this interim support arrangement, I suspect this placement would have fallen through.

Two teenage clients at one institution were in need of special education in their home community before successful return to a community living situation could be effected. BA gathered information and data to present clients' cases regarding special education needs. When the placement committee met, both BA and institutional staff were present to represent clients and provide additional information. As a result of these efforts, the clients were accepted for placement in the special education department of the local public school system.

BA provided service availability information regarding the existence of a Sheltered Workshop in the community. BA arranged for WSH client to be enrolled at this Sheltered Workshop as a Vocational Rehabilitation client. Because placement in the Workshop was immediate, the client was able to return to the community as an employed citizen. Without this employment outlet, the client could not have returned to the community.

For two of my clients a community placement effort expanded beyond them to other institutionalized persons as well so that a rather large group of people were deinstitutionalized. This occurred when Liberty House Nursing Home in Harrisonburg opened its doors. Working with the WSH social worker and Liberty House staff to place my two clients there, WSH social workers became mobilized to seek placement for other WSH patients. Approximately 20 other WSH patients were also placed at the Harrisonburg Liberty House at this time.

Without a broker advocate, the family of this client would never have been able to combat the problems of applying for SSI assistance, Medicaid, and special services from the Public Health Department. The family did not know what was available to them, and without such services, they could not have kept the client at home. The institution did not send proper referrals for community followup services; nor did the community agencies eagerly accept their own responsibilities. The broker advocate became a vital link between institution, agencies, client's family, and client.

One client was placed in a nursing home. Costs were to be borne by Social Security and Welfare. However, Social Security failed to send a referral to Welfare, requesting Auxiliary Grant payment and Medicaid approval. BA contacted three Social Security offices before locating the branch handling the client's case. BA notified Welfare and requested that Social Security send Welfare a referral notification. When the Welfare payment came through, it was twice returned to the Post Office because of an incorrect address. BA notified Welfare of this situation and provided an address correction. Social Security has been behind in a $75.00 payment since September 1974. BA is still attempting to straighten out this matter. Client was placed in the nursing home with no personal toilet articles. BA obtained these for client. BA arranged services for client from Public Health Department and from local Senior Citizens program.

There were instances in which the broker advocate was unsuccessful in effecting community placement for his client.

BA attempted to coordinate service delivery plans for a client still living in the institution. Because institution staff has not cooperated with the BA in providing pre-release services, I fear that my client's housing and supportive services may fall through.

All kinds of mental health plans were coordinated for a WSH client. Community agencies and institutional staff cooperated well in arranging services. But the client refused to cooperate, so plans had to be dropped.

In another instance several weeks of community placement planning between myself and a mental health worker dissolved into nothing after the client had been in the community only six hours. Housing, financial assistance, mental health aftercare, follow-up by the health department, AA meetings, and direct assistance from an AA member had all been set up for the benefit of this client's return to the community. A contract had also been written for the client and signed which established the boundaries of what actions by the client would constitute a return to WSH. After three successive attempts to obtain alcohol, one of which was successful, the client was returned to WSH.

After the client is placed in the community, coordination services continue. Sometimes the coordination effort results in the delivery of needed services, sometimes not.

Client deinstitutionalized through SID project. Client has now remained in the community for 1½ years. This is the longest she has remained out since she was first institutionalized at age 15. BA feels this client was able to remain a part of community life only because BA kept abreast of problems and coordinated filling of service gaps.

In the cases of four clients who had already been placed in the community, it was determined that their SSI applications had been lost. Numerous calls to state officials in Richmond resulted in the information that no applications for these four clients had been received. A check with the social security office at the city where the institution was located also revealed that no record of the application had been filed. Re-application was made in October 1974 but at the time of this writing, some of these clients still have not received any SSI benefits.

One of the juvenile offender clients possessed natural artistic ability. To help him develop it, I tried to get the client enrolled in a commercial art course at the local community college. I was told that there were no prerequisites to the course. The client did not have a high school diploma. The vocational rehabilitation counselor working with the client insisted that a diploma was necessary. I checked with the community college by speaking to the representative on the A&P team from said college. This representative stated that contrary to the vocational rehabilitation counselor's statement no diploma was necessary. However, in the meantime, the counselor had made other arrangements and the opportunity for the client to take the course was lost.

As the client's BA, I worked with DVR to attempt to involve client in employment or an employment training program. After working together to arrange an employment plan, our service plans had to be dropped when a local mental health clinic told the client's family that the client should not work or be pressured into work if he was not inclined to seek employment. At times, agencies do not communicate their feelings about service plans directly to the BA.

The present BA inherited the case of a client placed in a housing situation discovered by the original BA. The local welfare agency had access to negative information regarding this housing situation, but the BA had not contacted welfare prior to the client's placement. When welfare learned of the placement, the social worker made the BA aware of the problems in the home, and the client had to be moved. This was a case where the BA failed to act as a communication link between the institution and the community agencies.

BA spent two days trying to coordinate transportation for a client. In contacting agencies, the BA received several "maybes", but no agency/resource would actually provide transportation to Charlottesville in a last-minute situation, despite the urgency of the situation.

Transportation is a principal service which frequently is difficult to obtain.

One client repeatedly failed to keep appointments with Vocational Rehabilitation and consequently that agency terminated the client. The same client also failed to keep appointments after repeatedly being reminded by the broker advocate of the time and place for (a) a neurological appointment and (b) an appointment to discuss the entire matter with the broker advocate and the vocational rehabilitation counselor.

Clients under SID were released with recommendations for program involvement. Community agency service agreements were outlined and monitored by SID BA. After placement in nursing home, client involvement and program usefulness were recorded monthly by BA, with follow-up provided as needed. Clients not released under the SID program were placed in the nursing home without benefit of the above procedure, leaving their care accountable only to the nursing home staff itself.

Department of Public Welfare has not understood the role of the BA. When BA is involved in a case, the social worker feels relieved of her duty as direct service provider. (This has been observed in four of my cases.)

I made an appointment at Social Services to assist my client in applying for food stamps. I provided transportation. We arrived promptly for our appointment, which I had earlier confirmed. Instead of a transaction that should have required only a few moments of time, it took one and three-quarter hours from the time of our punctual arrival to acquire the necessary food stamps for the client. This accomplishment would not have occurred even that soon had it not been that I called the director of the Social Services Department to attempt to expedite matters. Though the phone call to the director resulted in prompt service, serious doubt remains that any effort was made to cure the illness rather than the symptom. All of the Social Service employees in at least this particular section of the department seemingly were at liberty to arrange their own lunch hours as they saw fit. When we arrived at 1:30 p.m., no employees were to be found.

With one juvenile offender client I found myself in court a great deal of the time, giving testimony or awaiting a judgment as to whether the child would remain in the community or be returned to the institutional system.

Broker advocate intervention has prompted families of clients to once again become active service providers for their relatives. In some cases this has meant a place to live; in others, merely an occasional visit or letter. But the intangible service of kinship with others has been increased in numerous cases, even when finances have prevented families from becoming providers of tangible services.

Clients deinstitutionalized to skilled or intermediate care facilities are definitely receiving more and better services than non-SID clients. Without the SID process, former WSH patients simply sit in nursing homes, waiting to die, with the staff hoping they will die gracefully and without fuss.

Next to finances, housing reflects the largest increase in community services potentiated by the BA. Advocating for the client, the BA has refused to allow service deliverers to accept a traditional "no vacancy" answer as the final housing-availability decision. In some cases, this has meant the BA knocking on new doors; in other cases, it has involved the advocacy-

brokerage role of persuading existing homes to begin accepting the retarded and the formerly mentally ill person as a boarder.

I attempted to obtain dental care for an adult client who had been placed in the community from LTS&H. There was agreement that this service was necessary, but no specific agency was assigned to fulfill the A&P team prescription. A search of community resources proved fruitless. Most private dentists and organizations were willing to aid children, but not adults.

I can't begin to recall the number of times my clients went to agencies requesting a service and failed to receive it, and I returned with the client and he received the service.

Reinstitutionalization in one case was prevented by calling upon a major resource: the client himself.

Client had been living in the community for a year, after release from WSH. Initially placed in a rooming house, his condition had deteriorated to the point that the community mental health agency and other agencies were recommending reinstitutionalization. His landlord had served eviction notice; he was not functioning on the job; his roommate had been alienated. There were many complaints regarding this client's behavior. Public Health was very concerned about his medical conditon (i.e., an epileptic not taking his drugs regularly). Although everyone was concerned, there was general agreement that no one had talked to the client honestly about the problem, facing him with his responsibility and choices in the issue. SID coordinated a case conference with this client, giving him as much data about the situation as any agency worker. We went into the meeting feeling WSH or a VA hospital in Roanoke were perhaps necessary. The client talked a great deal in the conference (which included a mental health worker, public health nurse, SID BA, client); he took responsibility for choosing to move to a Home for Adults; he amazed everyone at the meeting with the clarity and intelligence of his thinking, and his physical symptoms of nervousness almost disappeared, temporarily. Since that time, this client has moved (by himself, with placement coordinated by SID and an Outreach worker), and his condition is much improved. He is back at work, taking his medication, and appears

to be happy. Comments he has made since then make clear that he is proud to be considered a full human being, consulted about his own future, and represented by a broker advocate whose job it is to be concerned with the client's decision-making responsibility and rights.

Comments from clients have sometimes attested to the contribution of the broker advocate.

> I wouldn't be out of the institution now if it weren't for the BA.

> I couldn't have tried to enter into community activities if I'd had no BA.

One client made the following comment in response to negative publicity SID was receiving.

> It's a shame people don't understand about SID. I like my job. I like living out here. It's too bad people don't understand what SID did for me.

5. Community Development

As an extension of the role to advocate and coordinate services for individual clients, the broker advocates became engaged in many activities of a "community development" nature. Such activities focussed on increasing community awareness of the problems and needs in the deinstitutionalization process.

In educating the community the broker advocates used several methods and approaches.

- The data base accumulated by the efforts of the A&P team and the broker advocates became extremely useful in identifying for others the demographic characteristics of institutionalized persons and the resource requirements for such persons. Periodically the broker advocates reported such information to governing bodies and professional groups.

-Broker advocates became members in or informal consultants to various local agencies, such as the Association for Retarded Citizens, Mental Health Association, Human Resources Council, Halfway Housing, Inc., local school boards, Chapter 10 boards, etc.

-Some of the broker advocates volunteered direct services to some of the local programs, such as helping to man a hotline. Others helped directly in the planning and development of new, local programs.

-Broker advocates also gained community support and acceptance by lending a hand in such things as clothing and fund drives.

-Liaison with the mass media was established. Television programs and human interest newspaper articles were used to further the understanding of the clients and the SID program.

6. Comment

In service integration functioning at the local level the broker advocate does indeed make a contribution in the service delivery process that complements and extends beyond that made by the case team itself.

Clients served by the SID project have benefited from having a broker advocate in numerous ways, the most important of which is having one central person to turn to for assistance. This effect is particularly dramatic in the cases of those clients who have dormant or non-existent linkages to services.

Often the simple process of filling out an assessment packet seemed to spark renewed interest on the part of the client and the institution with regard to the client's welfare and future. For those clients whom the A&P team recommended

remain in the institution, specific programs were outlined, receipt of services monitored by the broker advocate, and cases re-presented to the A&P team. This procedure caused institutional staff to move, where little or no movement was occurring prior to the broker advocate's arrival on the scene. Sometimes the progress was significant enough for the team to change the prescription to one of community placement.

Those clients recommended and placed in the community benefited the most from having a broker advocate. The client left the institution provided with an outline of needed services designated by the A&P team. These services were arranged by the broker advocate on behalf of the client. The client did not have to cope alone with what can be very complicated service delivery systems. The client did not always get all the services prescribed by the team, but it is safe to conclude that he received more of them than would have been the case had he had no broker advocate.

But, one may ask, what has the presence of the broker advocate done toward "integrating" the existent service delivery system? Perhaps nothing in the formal sense; that is, nothing organizationally nor fiscally. But he has moved mountains in an indirect, informal sense.

The broker advocate's formalistic contribution to integrated services delivery is found in his role as an extension of the local, service-integrating, multi-agency body: the A&P team. By his concrete actions, the broker advocate reifies the prescriptive decisions of the team. By its existence, the A&P team empowers the broker advocate.

As a contribution to service integration at the local level, what would the A&P team have to offer without the broker advocate? Similarly, what could the broker advocate accomplish without the A&P team?

Table 41

SERVICE INTEGRATION FUNCTIONS*, THEIR DEFINITIONS*, THEIR OPERATIONAL MODES AS PRACTICED IN THE SID MODEL TO DATE, AND INDICATIONS AS TO HOW THEY COULD BE FURTHER OPERATIONALIZED IN AN ADMINISTRATIVELY-STRENGTHENED SID MODEL

Service Integration Function	Definition of Function	Current SID Operational Mode	Recommended SID Operational Mode
A. Coordination Authorization			
1. Voluntary	1. Emphasis is on provision of direct service by autonomous service providers via persuasion of the "integrator". Linkages develop without a formalized structure.	1. Participating agencies at state level "request" participation of local agencies.	1. Move from voluntary to mediated and directed.
2. Mediated	2. Emphasis is on the development of linkages between autonomous service providers, usually with the help of a special coordination program or staff.	2. SID staff serve as coordination mediators; SID procedures serve as a coordination program.	2. Move from mediated to directed.
3. Directed	3. The "integrator" utilizes mandated authority for the development of linkages among service providers.	3. Not operative.	3. Give Secretary of Human Affairs authority for directed coordination.
B. Administrative Support Services			
1. Fiscal			
a. Joint budgeting	a. The "integrator" sits singly or together with all service providers to develop a budget.	a. Not operative in SID model per se; however this function is already mandated to the cabinet secretaries.	a. Secretary of Human Affairs

Table 41 (continued)

Service Integration Function	Definition of Function	Current SID Operational Mode	Recommended SID Operational Mode
b. Joint funding	b. Two or more service providers give funds to support service.	b. Not operative.	b. Secretary of Human Affairs
c. Fund transfer	c. Funds originally targeted for one service are shifted to another service.	c. Not operative.	c. Secretary of Human Affairs
d. Purchase of service	d. Formal agreements/contracts between the integrator and the autonomous service providers to render service.	d. Not operative.	d. Give this authority to A&P Team locally, to Secretary of Human Affairs at state level
2. Personnel Practices			
a. Consolidated personnel administration	a. Central provision for hiring, firing, promoting, placing, classifying, training, etc.	a. Not operative.	a. Place under the designee of the Secretary of Human Affairs
b. Joint use of staff	b. Two or more different agencies deliver service by using the same staff.	b. Staff (BA's) in executing a coordination service are guided by multi-agency body (A&P Team).	b. Formalize A&P Team usage of BA's; formalize central SID staff arrangement vis-a-vis C of C and Secretary of Human Affairs

Table 41 (continued)

Service Integration Function	Definition of Function	Current SID Operational Mode	Recommended SID Operational Mode
c. Staff transfers	c. An employee is on the payroll of one agency but is under the administrative control of another.	c. BA's are under a single agency payroll, but carry out directions of local A&P Team.	c. Continue (see 2b, above).
d. Staff outstationing	d. Placement of a service provider in the facility of another service provider.	d. Not operative.	d. Place BA's under the roof of the A&P Team Chairperson agency.
e. Co-location of staff	e. Service providers from different agencies are located in a common facility.	e. Not operative.	e. Not necessary.
3. Planning and Programming			
a. Joint planning	a. Joint determination of service delivery system needs and priorities through a structured planning process.	a. Performed by A&P Team and by C of C.	a. Continue
b. Joint development of operating policies	b. A structured process in which the policies, procedures, regulations, and guidelines are jointly established.	b. Performed by A&P Team and C of C.	b. Continue
c. Joint programming	c. The joint development of programmatic solutions to defined problems in relation to existing resources.	c. Performed by A&P Team and C of C.	c. Continue

Table 41 (continued)

Service Integration Function	Definition of Function	Current SID Operational Mode	Recommended SID Operational Mode
d. Information sharing	d. An exchange of information regarding resources, procedures and legal requirements (but not individual clients) between the integrator and various service providers.	d. Performed via AIS and QC Team	d. Continue
e. Joint evaluation	e. The joint determination of effectiveness of service in meeting client needs.	e. Performed by QC Team, A&P Team, C of C.	e. Continue
4. Other			
a. Record-keeping	a. The gathering, storing, and disseminating of information about clients.	a. Performed via AIS and BA.	a. Continue
b. Grants-management	b. The servicing of grants.	b. Operative in isolated instances only.	b. Accomplish by representative in local government, local agencies, a state government.
c. Central support services	c. The consolidated or centralized provision of services such as auditing, purchasing, consultative services, etc.	c. Not operative.	c. Designated by Secretary of Human Affairs.
C. Direct Service Linkages			
1. Core Services			
a. Outreach	a. The systematic recruitment of clients	a. BA via SID procedures	a. Continue

CONTINUED

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Table 41 (continued)

Service Integration Function	Definition of Function	Current SID Operational Mode	Recommended SID Operational Mode
b. Intake	b. The process resulting in the admission of a client to the provision of a service.	b. A&P Team	b. Continue
c. Diagnosis	c. The assessment of overall service needs of individual clients.	c. A&P Team	c. Continue
d. Referral	d. The process by which a client is directed or sent for services to a provider.	d. A&P Team; BA	d. Continue
e. Follow-up	e. The process used to determine if clients receive the services to which they have been referred and to determine if the client in general is successful in negotiating the service delivery system.	e. BA; A&P Team	e. Continue
2. Modes of Case Coordination			
a. Case conference	a. A meeting between the integrator's staff and various service providers on a given client.	a. A&P Team meetings	a. Continue
b. Case coordinator	b. The designated staff member having prime responsibility to assure the provision of services by multiple autonomous service providers to a given client.	b. BA	b. Continue

Table 41 (continued)

Service Integration Function	Definition of Function	Current SID Operational Mode	Recommended SID Operational Mode
c. Case team	c. Continuous and systematic interaction between members of a multidisciplinary group of service providers for the purpose of relating a range of services to individual clients.	c. A&P Team	c. Continue

Explanatory note:

A&P Team = Assessment and Prescription Team
C of C = Committee of Commissioners
BA = Brcker Advocate
AIS = Automated Information System
QC Team = Quality Control Team

*
After "Integration of Human Services in HEW: An Evaluation of Services Integration Projects" prepared by The Research Group, Inc. and Marshall Kaplan, Gans and Kahn in August 1972 for DHEW, SRS, Washington, D.C.

Table 42

AGENCY PARTICIPATION IN MEETINGS OF COMMITTEE OF COMMISSIONERS

April 24, 1973 through December 13, 1974

Agency	No. of Meetings Held/Responsible For	Meetings Agency Head Attended #	%	Meetings Agency Head and/or Representative Attended #	%
*DWI	18	13	72%	18	100%
*Voc Rehab	18	5	28%	5	28%
*VCCY	18	15	83%	16	89%
*MH&MR	18	17	94%	18	100%
*Planning	18	10	56%	17	94%
Health	8	0	0%	7	88%
Education	8	4	50%	6	75%
Employment	8	0	0%	7	88%
VCVH	8	4	50%	6	75%
Corrections	1	0	0%	1	100%
Deaf	1	0	0%	0	0%
Aging	1	1	100%	1	100%
TOTAL	125	69	55%	102	82%

NOTE: Eight full committee meetings were held.
Ten executive committee meetings were held.

*Executive Committee member

Table 43.

AGENCY PARTICIPATION IN A&P TEAM MEETINGS

PLANNING DISTRICT #6 A&P TEAM FOR WESTERN STATE HOSPITAL

May 11, 1973 through December 31, 1974

Agency	No. of Meetings Held Responsible For	Meetings at Least One Representative From Agency Attended: #	%
W.S.H.	37	37	100%
DeJarnette	37	33	89%
Catawba	37	33	89%
Mental Health: Chapter 10	37	28	76%
Mental Health: Clinic	35	34	97%
Education	37	33	89%
Employment	37	34	92%
Welfare	37	33	89%
Health	37	36	97%
Vocational Rehabilitation	37	37	100%
Planning	37	32	86%
Visually Handicapped	37	34	92%
*Disability Determination Division (SSI)	12	9	75%
TOTAL	454	413	91%

Mean number of agencies represented per meeting = 11.8

* Membership started June 27, 1974

Table 44

AGENCY PARTICIPATION IN A&P TEAM MEETINGS

PLANNING DISTRICT #6 A&P TEAM FOR LYNCHBURG TRAINING SCHOOL AND HOSPITAL

September 20, 1973 through December 31, 1974

Agency	No. of Meetings Held Responsible For	Meetings at Least One Representative From Agency Attended: #	%
LTSH	29	29	100%
DeJarnette-Catawba	29	24	83%
Mental Health: Chapter 10	29	22	76%
Mental Health: Clinic	29	27	93%
Education	29	17	59%
*Employment	29	23	79%
Welfare	29	26	90%
Health	29	28	97%
Vocational Rehabilitation	29	28	97%
Planning	29	22	76%
Visually Handicapped	29	23	79%
**Disability Determination Division	13	11	85%
TOTAL	332	280	84%

Mean number of agencies represented per meeting = 10.1

* Rep. was not permitted to attend from 3/21 through 6/6/74.
** Membership started June 11, 1974.

Table 45

AGENCY PARTICIPATION IN A&P TEAM MEETINGS
PORTSMOUTH A&P TEAM FOR THE MENTALLY ILL AT C.S.H.

August 14, 1974 thru December 31, 1974

Agency	No. of Meetings Held Responsible For	Meetings at Least One Representative From Agency Attended: #	%
C.S.H.	10	10	100%
City of Portsmouth (Sr. Citizens)	5	3	60%
Dept. of Social Services	10	4	40%
Dept. of Voc. Rehab.	10	8	80%
Education (DAC)	10	8	80%
Education (Special)	10	10	100%
Education (TCC)	4	4	100%
Health Dept.	10	10	100%
Mental Health Center	10	10	100%
Portsmouth MH & MR Serv. Board	10	3	30%
Probation & Parole Office	2	2	100%
S.E.V.T.C.	10	2	20%
T.A.R.C.	10	9	90%
T.A.R.C. Holiday House	10	4	40%
V.C.V.H.	10	0	0%
V.E.C.	10	8	80%
TOTAL	141	95	67%

Mean Number of agencies represented per meeting = 10.8

Table 46

AGENCY PARTICIPATION IN A&P TEAM MEETINGS
PORTSMOUTH A&P TEAM FOR THE MENTALLY RETARDED AT S.V.T.C.

April 11, 1974 thru December 31, 1974

Agency	No. of Meetings Held Responsible For	Meetings at Least One Representative From Agency Attended: #	%
S.V.T.C.	10	10	100%
City of Portsmouth (Planning - 4) (Sr. Citizens - 1)	5	1	20%
Department of Social Services	10	7	70%
Department of Voc. Rehab.	10	7	70%
Education (DAC)	10	7	70%
Education (Special)	10	10	100%
Education (TCC)	6	3	50%
Health Department	10	10	100%
H W & R Planning Council *	9	4	44%
Mental Health Center	10	8	80%
Portsmouth MH & MR Serv. Board	10	2	20%
S.E.V.T.C.	10	6	60%
TARC	8	4	50%
TARC Holiday House	10	8	80%
V.E.C.	10	2	20%
V.C.V.H.	10	4	40%
TOTAL	148	93	63%

Mean number of agencies represented per meeting = 10.1

* Resigned effective 9/30/74

Table 47

AGENCY PARTICIPATION IN A&P TEAM MEETINGS
PORTSMOUTH A&P TEAM FOR THE MENTALLY RETARDED AT L.T.S.H.

October 1, 1974 thru December 31, 1974

Agency	No. of Meetings Held Responsible For	Meetings at Least One Representative From Agency Attended: #	%
L.T.S.H.	3	3	100%
City of Portsmouth (Sr. Citizens)	1	1	100%
Dept. of Social Services	3	3	100%
Dept. of Voc. Rehab.	3	2	67%
Education (DAC)	3	3	100%
Education (Special)	3	3	100%
Education (TCC)	1	1	100%
Health Dept.	3	3	100%
Mental Health Center	3	1	33%
Portsmouth MH & MR Serv. Board	3	0	0%
S.E.V.T.C.	3	3	100%
T.A.R.C.	3	2	67%
T.A.R.C. Holiday House	3	3	100%
V.C.V.H.	3	0	0%
V.E.C.	3	3	100%
TOTAL	41	31	76%

Mean number of agencies represented per meeting = 11.3

Table 48

AGENCY PARTICIPATION IN A&P TEAM MEETINGS
PORTSMOUTH A&P TEAM FOR THE JUVENILE OFFENDERS

November 21, 1973 thru December 31, 1974

Agency	No. of Meetings Held Responsible For	Meetings at Least One Representative From Agency Attended: #	%
Beaumont	5	5	100%
Bon Air	2	2	100%
Hanover	4	4	100%
Janie Porter Barrett	1	1	100%
J.V.I.	1	0	0%
Natural Bridge	1	1	100%
Pinecrest	2	2	100%
City of Portsmouth (Planning)	10	7	70%
Dept. of Social Services	8	6	75%
Dept. of Voc. Rehab.	10	9	90%
Education (DAC)	7	5	71%
Education (Special)	2	2	100%
Education (TCC)	10	8	80%
Health Dept.	10	6	60%
H W & R Planning Council	10	8	80%
J & D R Court	10	10	100%
Mental Health Center	10	9	90%
Portsmouth MH & MR Services Board	10	6	60%
V.C.V.H.	5	3	60%
V.E.C.	10	8	80%
TOTAL	128	102	80%

Mean number of agencies represented per meeting = 11.1

Table 49

A&P TEAM DECISION-MAKING PROCESS[1]

Activity	Planning District #6				Portsmouth							
	WSH (MI)		LTSH (MR)		CSH (MI)		SSVTC (MR)		LTSH (MR)		7TS (JO)	
	#	%	#	%	#	%	#	%	#	%	#	%
Leadership												
Institution Dominant	166	48.8	42	22.5	3	5.0	3	4.9	0	0.0	4	9.5
Community Dominant	33	9.7	22	11.8	6	10.0	15	24.6	1	5.6	12	28.6
Inst.-Comm. Equal	128	37.6	117	62.6	51	85.0	43	70.5	17	94.4	26	61.9
Other	13	3.8	6	3.2	0	0.0	0	0.0	0	0.0	0	0.0
Total	340	99.9	187	100.1	60	100.0	61	100.0	18	100.0	42	100.0
Participation												
Institution Dominant	99	29.0	26	13.8	2	3.3	5	8.1	4	10.5	4	10.5
Community Dominant	12	3.5	13	6.9	3	5.0	10	16.1	9	23.7	9	23.7
Inst.-Comm. Equal	222	65.1	143	76.1	55	91.7	47	75.8	25	65.8	25	65.8
Other	8	2.3	6	3.2	0	0.0	0	0.0	0	0.0	0	0.0
Total	341	99.9	188	100.0	60	100.0	62	100.0	38	100.0	38	100.0
Consensus												
Unanimous w/o vote	119	36.0	55	29.1	56	94.9	53	86.9	13	72.2	25	62.5
Unanimous with vote	155	46.8	93	49.2	1	1.7	1	1.6	1	5.6	6	15.0
Majority with vote	45	13.6	36	19.0	1	1.7	5	8.2	4	22.2	7	17.5
No agreement	1	0.3	0	0.0	0	0.0	0	0.0	0	0.0	1	2.5
Other	11	3.3	5	2.6	1	1.7	2	3.3	0	0.0	1	2.5
Total	331	100.0	189	99.9	59	100.0	61	100.0	18	100.0	40	100.0
Source of Expertise												
Institution Mainly	83	28.2	44	27.3	6	10.5	10	16.4	0	0.0	3	7.3
Community Mainly	11	3.7	4	2.5	2	3.5	3	4.9	0	0.0	8	19.5
Both	175	59.5	102	63.4	49	86.0	48	78.7	18	100.0	30	73.2
Other	25	8.5	11	6.8	0	0.0	0	0.0	0	0.0	0	0.0
Total	294	99.9	161	100.0	57	100.0	61	100.0	18	100.0	41	100.0

Table 50

A&P TEAM DECISION-MAKING PROCESS[2]

Activity	Planning District #6				Portsmouth							
	WSH (MI)		LTSH (MR)		CSH (MI)		SSVTC (MR)		LTSH (MR)		7TS (JO)	
	#	%	#	%	#	%	#	%	#	%	#	%
Interactions Reflecting Service Integration Issues or Problems												
Institution with community	18	17.5	19	17.1	9	22.5	11	24.4	5	13.9	19	19.2
Inter-agency (community)	7	6.8	12	10.8	5	12.5	6	13.3	16	44.4	5	5.1
Intra-agency (community)	4	3.9	5	4.5	2	5.0	4	8.9	0	0.0	7	7.1
Community agency w/A&P Team	3	2.9	3	2.7	3	7.5	0	0.0	0	0.0	5	5.1
Inter-institutional	7	6.8	18	16.2	0	0.0	0	0.0	0	0.0	17	17.2
Intra-institutional	22	21.4	17	15.3	5	12.5	6	13.3	5	13.9	0	0.0
Institution w/A&P Team	2	1.9	14	12.6	5	12.5	4	8.9	0	0.0	19	19.2
SID with institution	8	7.8	4	3.6	5	12.5	2	4.4	0	0.0	14	14.1
SID with community agency	7	6.8	1	1.0	2	5.0	2	4.4	5	13.9	2	2.0
SID with A&P Team	13	12.6	5	4.5	2	5.0	6	13.3	0	0.0	7	7.1
Intra-SID	0	0.0	0	0.0	2	5.0	0	0.0	5	13.9	2	2.0
Other	12	11.7	13	11.7	0	0.0	4	8.9	0	0.0	2	2.0
Total	103	100.1	111	100.0	40	100.0	45	99.8	36	100.0	99	100.1

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