DOCUMENT RESUME

ED 137 563 CE 010 539

AUTHOR Horton, Gerald T.; And Others
TITLE Illustrating Services Integration from Categorical Bases. Human Services Monograph Series No. 3.
INSTITUTION Aspen Systems Corp., Germantown, Md.; Department of Health, Education, and Welfare, Washington, D.C. Project Share.
REPORT NO DHEW-OS-76-130
PUB DATE Nov 76
CONTRACT HEW-100-75-0179
NOTE 87p.

EDRS PRICE MF-$0.83 HC-$4.67 Plus Postage.
DESCRIPTORS Community Services; *Comprehensive Programs; *Delinquency; Elementary Secondary Education; *Family Counseling; Guidance Centers; *Handicapped; *Human Services; *Interagency Coordination; Mental Health; Neighborhood Centers; Program Administration; Program Descriptions; Rehabilitation Centers; Rehabilitation Counseling; School Community Relationship; State Federal Aid; Vocational Counseling
IDENTIFIERS Georgia; Georgia (Atlanta); Kansas; New York; New York (Brooklyn); Pennsylvania (Bethlehem); Project SHARE

ABSTRACT

This report focuses on one method of human services integration--starting with a categorical funding and program base which is expanded to integrate complementary services and resources into a comprehensive service package. The four projects examined illustrate the following initial categorical bases: Community mental health services, primarily limited to counseling juveniles (East Central Kansas Mental Health Center); juvenile and family counseling in a community setting (Brooklyn Family Reception Center); traditional elementary and secondary education (Bethlehem Area Community Education Project); and employment evaluation and testing for the handicapped (Atlanta Rehabilitation Center). This report is divided into two major parts. Part I, Four Local Approaches, first presents the initial focus of each project. The reasons for initiation, how they were organized and funded, services provided, and the approach to program expansion are then discussed. Part I also describes the nature and evolution of the funding of each project in relation to the pace of growth. The experiences of the project developers in obtaining, maintaining, and expanding their financial bases are also described to provide insight into the role finances play in service integration. Part II, Four Case Studies, describes each project in depth. (The four projects were not selected based upon any set of criteria to ensure that they were typical or representative of service integration projects. Rather, they are four diverse examples of expansion from a single categorical program base.) Organizational flowcharts are included for each project. (SH)

Human Services

NUMBER 3 NOVEMBER 1976 MONOGRAPH SERIES

Illustrating Service Integration from Categorical Base

Gerald T. Horton
Victoria M. E. Carr
George J. Corcoran

PROJECT SHARE

Project Officer, WILLIAM H. PRIVETT
Office of Intergovernmental Systems
Department of Health, Education, and Welfare

PROJECT SHARE is operated by Aspen Systems Corporation, under DHEW Contract No. HEW-100-75-0179

P.O. Box 2309
Rockville, Md. 20852

DISCLAIMER

PROJECT SHARE has contracted for the preparation of monograph series in order to survey the state of the knowledge or the state of the literature in selected subject areas of importance to the human services community. The monograph series will also provide an opportunity for authors to offer their views and opinions on these topics. It is the aim of PROJECT SHARE to stimulate discussion through the publication of these monographs. The views and opinions expressed in this monograph are entirely those of the authors and are not necessarily those of the Department of Health, Education and Welfare, PROJECT SHARE or Aspen Systems Corporation.

TABLE OF CONTENTS

PART I

FOUR LOCAL APPROACHES

INTRODUCTION AND SUMMARY

Since the mid 1960's, increasing emphasis has been placed on the concept of integrating human services to respond to client needs.

The impetus for service integration has come from the Federal, State and local levels of government and from private human services providers. The Federal thrust has come through legislative proposals (e.g., the Allied Services Act); funding of integrated services research and demonstration projects, and an increased emphasis on requirements for coordination of planning and service delivery in the various legislative approaches to human service revenue sharing.

The State and local push often grew from the much more pragmatic attempt to meet increased service demand and rising costs for service provision by better utilizing revenues and facilities.

Services integration has ranged from the expansion of single categorical programs through contracts for services or referral agreements to physical collocation of multiple human services agencies in a single comprehensive service delivery center.

This report focuses on one method of services integration . . . starting with a categorical funding and program base which is expanded to integrate complementary services and resources into a comprehensive service package. The four projects examined in this case study illustrate the following initial categorical bases:

- Community mental health services, primarily limited to counseling juveniles referred by a juvenile court (East Central Kansas Mental Health Center);
- Juvenile and family counseling in a community setting (Brooklyn Family Reception Center);
- Traditional elementary and secondary education (Bethlehem Area Community Education Project);
- Employment evaluation and testing for handicapped (Atlanta Rehabilitation Center).

Each of the four projects adopted the goal of integrating services and facilities to respond effectively to the client's needs.

Each project began with a single categorical base and a specific target group. Over a period of time, other programs or services were added. The resulting integration of the initial categorical program included an expansion in programs and services, target groups and caseloads, geographic areas, and facilities. The degree and pace of the integration efforts differed according to the goals of the original project and the stability and level of funding.

FROM CATEGORICAL SERVICES TO INTEGRATED PROGRAMS: FOUR LOCAL APPROACHES

Although the basic themes of services integration and expansion were similar in the four projects, there were distinct differences in the method of integration and operation. These different approaches are described to identify key factors which affected the integration and expansion of services and resources.

TABLE 1

Summary of Four Service Integration Projects Indicating Services, Clients and Agencies Affiliated with Projects

PROJECT	SERVICES	CLIENTS	LINKAGES
East Central Kansas Mental Health Center	Diagnosis, evaluation, testing, counseling, partial hospitalization, 24-hour emergency, inpatient care, alcohol/drug abuse consultation, community education, research, screening for hospital admission	All, initially centered on juvenile offenders	*Neighboring community mental health center. *Six affiliate counties *State psychiatric hospital *Local hospital Juvenile Court Association for Retarded Children Police, Private Physicians, Youth Center, Clergy
Bethlehem Community Education Project	Health screening, social service/health referral, recreation, supplemental education, traditional education, job counseling elderly services (hot meals and referral)	All	City of Bethlehem Northampton County Board of Education United Fund Eastern Michigan University Public/private social service agencies
Family Reception Center	Psychological/psychiatric testing, juvenile evaluation, group/individual counseling, crash pad residence, referral **Mini School **Children and Youth Development Services **Group Home	Family, especially juveniles	Department of Public Welfare *Board of Education Police, Clergy, Public/private service agencies Social Clubs (Lions) YMCA, Block Associations
Atlanta Rehabilitation Center	Testing, evaluation, job training, psychological/psychiatric/medical testing, sheltered workshop, referral (employment, health, social)	Handicapped and elderly	*Dept. of Labor Urban League County Welfare Departments County Health Departments *Hospital *Technical School *Community Mental Health Center *Board of Education Private physicians Numerous State Health and Social Service Departments

*Indicates a contractual relationship for funding, staff, or other services.
**Spin-off programs not directly under the Family Reception Center.

Each project is described in depth in the case studies. The four projects were not selected based upon any set of criteria to ensure that they are typical or representative of service integration projects. Rather, they are four diverse examples of expansion from a single categorical program base. The conclusions drawn from the analysis may, therefore, not be generalized to all other service integration projects. They should, however, provide some insight to persons involved in projects with a single, categorical orientation who seek to expand and integrate additional services and resources. Also, the examples and analysis may assist local, regional and State human service planners to approach service integration from existing services rather than, or in addition to, the multi-service, comprehensive restructuring of the service system.

The four case studies, the East Central Kansas Mental Health Center, the Bethlehem Area Community Education Project, the Family Reception Center, and the Atlanta Rehabilitation Center, provide the basis for a discussion on service integration from a categorical or program base. Each of the projects studied has successfully expanded from a single categorical service or client base and is currently offering a host of human services. The success of each project can be measured not only on meeting the client's multitude of needs but also in the linking of agencies to provide complementary services. Table 1 illustrates for each project the services, clients, and linkages with other human service providers.

To acquaint the reader with the major factors of the four integration projects, they are compared in the following chapters. First, the initial focus of each project is presented. The reasons for initiation; how they were organized and funded; services provided; and the approach to program expansion are discussed. Then, the nature and evolution of the funding of each project are described in relation to the pace of growth. The experiences of the project developers in obtaining, maintaining and expanding their financial bases provide the reader insight into the role finances play in service integration.

Although the projects range in size and organizational structure, from a division within a multi-purpose State human services umbrella agency to a private, nonprofit corporation, common components either assisted the integration of services or detracted from a smooth operation. Facilitators, such as strong leadership, staff commitment, and community receptivity are discussed. Other administrative factors, such as a lack of a legal governing board which hinder the service integration efforts are described.

PROJECT SUMMARIES

EAST CENTRAL KANSAS MENTAL HEALTH CENTER. In 1960, a group of Kansas residents succeeded in their efforts to gain State enabling legislation for community mental health centers. Subsequently, the East Central Kansas Mental Health Center was established in Emporia as a non-profit corporation and was supported by a .25 mill levy appropriated by the Lyon County Board of Commissioners.

Although the originators of the Center envisioned a wide range of mental health services, limited staff (initially, a part-time psychiatric social worker) confined the Center to consultation with the local probate (juvenile) judge to enable appropriate placement of juveniles. In addition, counseling services were offered on a limited basis.

Affiliation agreements with adjacent counties permitted gradual expansion of the Center's financial base, number and types of staff, geographic area, and clientele.

By 1974, it was apparent to staff and local residents that the Center could not adequately deliver a broad range of mental health services. The lack of available local resources forced the Center Director to seek Federal funds. To comply with Federal requirements, the Center had to expand its target area and facilities.

Affiliation agreements with another mental health center and a local hospital, and the Federal staffing grant made it possible for the East Central Kansas Mental Health Center to integrate partial hospitalization, in-patient, and emergency 24-hour treatment, with a broad spectrum of complementary mental health services including community education, evaluation, and specialized counseling.

During a period of 15 years, the Center's services were transformed from part-time, crisis-oriented consultation (primarily juveniles) to full-time comprehensive mental health treatment. The strength of the project rests on the stability of its initial funding and the incremental addition of staff and services. After functioning as a cohesive unit and after exerting a strong influence on the community, the Center experienced a smooth expansion in area, clients, and staff while integrating additional services and facilities.

BETHLEHEM COMMUNITY EDUCATION PROJECT. The Bethlehem Community Education Project evolved from a traditional elementary and secondary education program. Recognizing the low utilization of school facilities and the duplication of services, the City, County, School Board, and United Fund developed a community education concept that integrated existing educational programs and facilities with social and health services, recreation programs, and supplemental educational courses.

Four schools were chosen to house the Community Education Project because of their specialized facilities (e.g., cafeteria, auto mechanics shop, gymnasium, baseball field). The schools designated Neighborhood Centers were located in four quadrants of Bethlehem which were identifiable neighborhoods.

The availability of local resources (augmented by long-term Federal block grants) enabled the proposers of the Community Education Project to transform the four schools from typical six-hour, five-day/week youth facilities into eleven-hour, seven-day/week bustling activity centers for all ages.

The strong commitment of the City and County governments, School Board, and United Fund to the project prevented many start-up problems characteristic of newly integrated projects.

BROOKLYN FAMILY RECEPTION CENTER. The Brooklyn Family Reception Center is a multi-service neighborhood facility which evolved from a juvenile evaluation-counseling center. Established in 1972 to offer juvenile court intervention at the community level, the focus of the Center expanded as a result of additional needs identified by staff and clients.

Currently, in addition to the Family Reception Center, the Sisters of the Good Shepherd operate the following programs in adjacent buildings:

- Mini School which offers alternative education;
- A Children and Youth Development Services program which established a network of public and private youth-related resources; and
- A group home.

By integrating these programs with the counseling, socialization, legal advocacy, psychological/psychiatric testing and referral services of the Center, the Sisters of the Good Shepherd are able to provide community-based complementary services for the entire family.

Strong community participation in program design has resulted in a high utilization of services. An unstable financial base on the other hand, has generated many problems. Typically, the Center Director must scramble for funds from numerous sources and often programs must be geared toward the program scope or restrictions of the grant. This haphazard financial situation has resulted in sporadic, short-term planning and program implementation. It can be hypothesized that long-term, stable, open-ended grants would

enable the Sisters of the Good Shepherd to develop comprehensive long-term plans to meet the many needs of Park Slope residents.

ATLANTA REHABILITATION CENTER. Originally a pilot project for employment evaluation and testing, the Atlanta Rehabilitation Center was initiated in 1965 through an Office of Economic Opportunity grant. Previously, numerous public and private service agencies (e.g., county welfare departments, State Department of Labor, Atlanta Urban League, and a public hospital) had provided limited evaluation. These agencies recognized that such duplicate and fragmented evaluation was not adequate to meet the needs of their clients. Therefore, the Atlanta Rehabilitation Center was established to accept referrals from these agencies and to provide comprehensive employment evaluation services.

Although the Center was operating on a time-limited demonstration grant, the program developers and operating agency (the State Division of Vocational Rehabilitation) were not prepared to assume financial responsibility when the Federal grant ended.

After a resource identification trip to Washington, the facility operators were successful in joining several small categorical grants and limited State appropriation to enable continuation of the Center. Following transition to a State facility, the Center expanded services to include job counseling and referral and workshop training.

Although the piecemeal funding approach created some operational problems, the Center is now operating effectively due to the efforts of the Director and other State administrators and the good rapport with service agencies.

FACTORS FACILITATING SERVICES INTEGRATION

An analysis of the four projects studied indicates that many factors including funding, project philosophy, operation and staffing patterns, and community climate are important to the expansion of service delivery.

Among the factors identified in the case projects as most conducive to facilitating services integration are:

- Stable, adequate funding;
- A strong project director who can mobilize resources, merge conflicting opinions or groups, plan effectively, and relate to a broad cross-section of community residents, leaders, and service providers;
- Community receptivity to the need for services and the desire to effectively deliver services through an integrated mechanism;
- An administrative structure which allows an individual (director) or group (Board of Directors) to plan and implement programs;
- A staff which exhibits a strong desire to increase service delivery effectiveness through services integration; and
- Long term planning which considers project goals or purpose, methods to integrate service delivery (e.g., case conference, single funding source, etc.), and current and future funding sources.

Funding seems to be the major determinant to services integration. The amount and type of funding shapes the initial implementation and integration of services.

Projects such as the East Central Mental Health Center and the Family Reception Center, which began with small funding bases, grew in small increments. On the other hand, the Bethlehem Community Education Project and Atlanta Rehabilitation Center were initiated on a large scale with large sums of money. In addition, projects like the Family Reception Center, which rely on short-term demonstration grants, must frequently change programs, thus reducing the possibility of long range planning and service continuation.

Other factors, such as a strong Director and dedicated, qualified staff, can mitigate the problems encountered with short-term or inadequate funding. Community receptivity, which assists in implementation of a services integration project, seems to be less important in the smooth operation of a project than an administrative structure which allows an individual or governing group to make and carry out decisions.

A comprehensive and long-range plan will assist the proposers of an integration project to identify key factors to a successful operation and will hopefully provide a framework for the project administrators (Director, Board, and staff). The absence of a detailed plan at the beginning of the services integration will probably result in administrative or funding problems. However, an able administrator and staff could partially diminish the effects of a lack of prior planning.

To assist the human service planner, provider, or administrator contemplating a services integration effort, the four case studies describe in detail the process of services integration. By reading the case studies the person contemplating a services integration project will become familiar with the positive and negative factors of such an undertaking. Hopefully, the discussions in the case studies will help the reader avoid similar pitfalls and emulate the successes of the four projects studied.

For the person who desires to coordinate a single service or program with another program, the first case study involving the East Central Kansas Mental Health Center will be particularly helpful. The method of increasing the geographic delivery area (and hence number of clients) through affiliation agreements with adjacent County Boards of Commissioners might be of special interest to the reader. In addition, the necessity of expanding facilities in the face of an inability to construct new specialized facilities (e.g., for hospitalization), is common to many service providers. However, the reader can learn how the East Central Center surmounted this problem through affiliation agreements with a local hospital to allow a portion of that facility to house the in-patient treatment services.

The description of the Bethlehem Area Community Education Project, should assist persons desiring to integrate services provided by numerous human services agencies. Of particular aid to the reader is the discussion on the multi-agency Community Education Commission, which was organized to provide overall administration of the Project. The problems associated with the lack of real power within this group should caution services integration proposers to consider the best administrative structure for their project.

The scarcity of stable, open-ended funding could obstruct a proposed services integration project. Readers faced with this dilemma should gain insights from the financial resource process undertaken by the Director of the Family Reception Center, discussed in the third case study. This case study also amplifies the role of identification of needs in the services integration process.

If an individual desires to integrate services at a State departmental level, the fourth case study, Atlanta Rehabilitation Center, should provide guidance. The importance of long-term planning (especially in the area of funding) is also illustrated.

An analysis of one case study, or a comparison of two or more projects, will hopefully assist the human services planner and practitioner in planning and implementing a successful services integration project. The difference in scale and scope of the case studies should help the implementor of a small scale, narrowly focused project or a large scale project.

COMPARISON OF PROGRAM DEVELOPMENT

Project rationales, such as response to a service need or better utilization of services and facilities, were the major determinants of program initiation, organization, operation and subsequent expansion. The projects studied exhibited differences in implementation and operation including services provided, the pace and sequence of expansion, the type of expansion, and the stability of programs and funding. Each of these factors is described in this section. Funding is presented in this section but discussed in detail later on.

PROJECT INITIATION

The reasons for the initiation of these four projects greatly influenced how they were organized, the level of funding and services, and the approach to program growth and development.

The initial impetus for the four projects followed the theme of meeting an identified community need by initiating or expanding services and existing facilities. There were significant differences as to whether the motivation was to design a new program to alleviate a need or to consolidate existing services or programs.

In two cases, Bethlehem and Atlanta, the focal point for services integration was to use existing resources more efficiently and eliminate duplication of programs. These reforms, in turn, benefited the client population. Both of these projects started with a large, relatively stable funding and resource base and achieved high levels of initial expansion by integrating available services and resources. In Bethlehem, the basic service locations were existing school facilities that were only being operated during school hours. In Atlanta, a service that was handled separately on a fragmented basis by a number of agencies was consolidated into one well-equipped and well-funded facility to provide comprehensive evaluation services.

In the other two cases, Brooklyn and Emporia, the focus was on generating programs to meet identified needs. The initiative for the program was not from public agencies but from the community, (i.e., private citizens and church groups). The programs were not initially funded on a large scale and grew at a moderate and careful rate. The pace of growth was largely a function of the level of funding and the community acceptance of the new programs. In both cases, the program evolution was shaped by the identification of additional needs of the original client group.

KANSAS

In the case of the East Central Kansas Mental Health Center, a clear need for community mental health services was apparent but no local services or facilities existed to meet that need. The distances to available mental health services as well as the inability of local officials to properly screen potential committees to the State mental hospitals or evaluate juvenile offenders led to the initiation of the East Central Kansas Mental Health Center. The Center was the only facility within a 65-mile radius which offered mental health counseling and evaluation.

The East Central Kansas Mental Health Center was initiated in 1960 in Lyon County when private citizens formed a coalition to lobby for State legislative support for community mental health service. Following the passage of enabling legislation, a corporation was established with a board of directors composed of five citizens of the county. Professional staff, including a psychiatric social worker (counselor) and part-time psychologist and psychiatrist, was hired to provide mental health services.

Initial services included individual and group counseling and evaluation of juvenile offenders and potential admissions to the State Mental Health Hospital. The clinical services were supplemented by a community education program. The services were not as broad in scope as originally envisioned. The initial funding for the mental health center was primarily provided by a county tax levy of .25 mill supplemented by fees and donations. This was subsequently revised to .5 mill and supplemented by a similar levy in adjacent counties which were added to the project. Major expansion occurred in 1974 when a Federal staffing grant enabled integration of the Center's services with those provided by a neighboring center, the State Mental Health Hospitals, and a local hospital.

BETHLEHEM

In contrast, the Bethlehem Community Education Project grew out of an effort to minimize the duplication of services. The representatives of several agencies including the city, county, School Board, and United Fund recognized that they provided similar services to address similar problems and causes. However, the services and facilities of each agency were often underutilized.

A committee was formed to develop integrated programs that would maximize the use of facilities and deal with the total family and the total need rather than a piecemeal approach.

The Bethlehem Community Education Project integrated supplemental education courses, health and social services counseling and referral, and recreation within four existing schools. The basic cause for the program integration was the desire to coordinate and more efficiently use existing city, county, Board of Education and private (United Fund) resources. The programs were designed to use the school facilities during non-school hours to provide educational, recreational, and social service programs. The initial program was well planned and started on a large scale using existing resources and a Federal financial match. After the initial major expansion, the emphasis was on program refinement rather than additional expansion or integration of other available resources or services.

BROOKLYN

The Brooklyn Family Reception Center grew out of the refocusing of existing youth programs from a detention facility to a crisis intervention-diagnostic center. A new facility, the Family Reception Center, was developed to address the total family problems with emphasis on youth. As in Emporia, previously unidentified needs which were perceived

when treating a specific target group (primarily youth) caused a new program to be developed to treat more comprehensively the existing target area and service population. This new program, in turn, was supplemented by additional services and programs in a continual expansion and integration.

When the additional needs were identified, a program was planned to meet them and additional funding was sought. The resources were often generated from private sources within the community. Some of the financing used was in the form of time-limited Federal grants which have the built-in pressure of generating program continuation money after the grants run out.

ATLANTA

The Atlanta Rehabilitation Center initiation resembled the Bethlehem Community Education Project in that a number of public and private agencies providing diagnosis and services to the elderly and handicapped recognized that these services should be consolidated and handled at one central diagnostic and evaluation facility. The central facility would have the staff and equipment to provide comprehensive diagnostic and evaluation services to persons referred by those agencies. Economies of scale would enable more comprehensive services to be provided at the main center. In addition, this would allow better use of existing staff in the agencies currently poviding these services.

In essence, the initiation of the Atlanta Center was an attempt to meet an existing client need effectively by consolidating existing services and resources. The program later expanded to provide more comprehensive services to its target groups by integrating staff of other State agencies into the project. This expansion occurred after the demonstration grant terminated and the State assumed financial and operational responsibility.

CONCLUSIONS

Based upon the experiences of the four projects in initiating their programs these conclusions may be drawn:

- Projects which are starting from a limited base directed at an unmet need require extensive, long-range planning which is realistic within funding constraints. This was evidenced in both the Emporia and Brooklyn projects.
- Projects which are designed to consolidate existing resources and start at a high level of operation require acceptance by involved agencies. The Bethlehem and Atlanta projects illustrated this point. In addition, the operational planning necessary for this large scale implementation was demonstrated by the smooth start at Bethlehem as opposed to Atlanta's initial problems.
- The nature of the initial impetus and funding is a major determinant of the growth pattern of each project.

PROGRAM EXPANSION AND GROWTH

The nature of program expansion and growth in the four projects was largely a function of the philosophy and framework which initially led to the project.

In the two projects which started on a large scale by integrating existing services (Bethlehem and Atlanta), the post program-initiation period was characterized by program refinement and "consolidation of gains." The changes in the Bethlehem project have continued to be refinement and modification of the existing program based upon a well-defined planning-evalution process. In Atlanta, the initial problems caused by a rapid start-up and lack of long-range planning were resolved and the funding was solidified by the State takeover and Federal grants. The program was refined and improved by

integrating some service personnel from other State agencies to provide comprehensive evaluation and training services.

In Emporia and Brooklyn, where the program started off on a much smaller scale to meet demonstrated or perceived needs of a limited client group, the program grew at a moderate pace. The growth and expansion were tied to funding sources and constraints and followed a well-defined plan. New programs were developed and existing services expanded to meet additional needs of the target group.

KANSAS

The East Central Kansas Mental Health Center initially expanded geographically to add adjacent counties lacking mental health services. In 1963, in response to a proposal from Coffey County, a contractual agreement was signed between the East Central Kansas Mental Health Center Board and the Coffey County Board of Comissioners. The Center staff provided counseling and evaluation services to Coffey County residents. In return, the County donated .5 mill of county taxes for staff salaries.

Between 1967 and 1973, four more counties joined the East Central Center on a contractual basis. The Center staff provided limited mental health counseling and evaluation. Services were provided based on the availability of staff rather than a negotiated number of clinic hours per county allocation.

The Board subsequently expanded to include representatives of the new geographic areas and facilities which were utilized within later expansions. The East Central Center case differed from the other three studies because these projects did not involve geographic expansions and the resulting consequent need for expanded community participation on that basis.

Expansion of the Kansas Center was moderately paced to retain the community based concept while remaining within the constraints of a stable but limited funding base. This expansion included increased funds, staff, and geographic area and clients, but not significant widening of the scope of services. The increased need for services and the desire to offer a comprehensive mental health program made it apparent that a major expansion, requiring Federal funding, and necessitating a deviation from the community based approach, was necessary.

The Center staff followed a cautious approach to expansion. Three years of discussion with other comprehensive mental health clinics and medical practitioners resulted in the development of a realistic, comprehensive program plan which was included in the Federal grant application. The plan included an additional expansion in geographic coverage, as well as an increased scope of services provided by means of the Federal grant as well as affiliations with the existing State hospital, a local hospital, and adjacent community mental health center.

As a result of the integration of services and facilities, the Center increased its geographic coverage, caseload, and scope of services and now provides a truly comprehensive community mental health program. The project appears to have a stable funding base and the future outlook seems favorable.

BROOKLYN

The Brooklyn Family Reception Center began with the long-term involvement of the Sisters of the Good Shepherd in a detention program for troubled youth and developed into a community based support program for the entire family. The original program was funded by church funds, private contributions, and a Federal grant. Subsequent expansion involved identifying additional needs of the target population in the community and

developing programs and obtaining resources to meet them. Sources of expansion funds have included foundations, Federal grants, State and city social services money, and private financial institutions.

As a result of the expansion approach, a series of incremental programs has been added to enable the Sisters of the Good Shepherd to provide comprehensive community-oriented help to troubled youth and their families. The approach closely parallels the experience in Kansas of incrementally building towards a comprehensive program focused on a specific target group. It differs in that it stayed within one geographic area and utilized whatever funds could be developed.

As a consequence, some of the resources are demonstration grants with limited-period funding. This has caused the Sisters to seek new funds to continue the programs once the initial demonstration period was over. They have been remarkably successful to date but it may be more difficult in the future because of tight economic conditions in New York City and the State.

BETHLEHEM

In contrast to the Kansas and New York experiences, the Bethlehem Community Education Project was developed from a desire to utilize more fully the existing resources of traditional education programs which were not currently used at full capacity on a full-time basis. These resources were available as in-kind match to generate continuing Federal support through social services, community development and education programs to provide expanded services to an expanded client group.

The holistic approach to service delivery, in which an agency provides a multitude of services, characterized the Bethlehem Project. Starting from the tradtitional educational stucture, the Project implementors added new educational programs to serve the entire family rather than the 5-18 year old age group. In recognition of the inter-related nature of educational and other problems, the Project integrated existing community services such as child guidance, job counseling, elderly assistance, congregate meals, etc. Although the impetus of the Project was to provide a wide range of services to aid residents, the desire to utilize resources more fully and thereby maximize investments also influenced the decision to expand educational services.

A human services committee was developed to plan the project and secure funds. When the project was initiated, a Community Education Commission was formed from among elected officials and representatives of project participants. The Commission provides overall program coordination, but has no real implementation powers and members frequently need to recommend actions to their agencies (City Council, United Fund Board, etc.). Each participating Board must approve an action such as resource allocation. A Community Education Coordinator provides overall supervision of the project and each Neighborhood Center has a Community Education Director who provides day-to-day supervision of the programs and staff.

Funding is provided by a variety of sources and is funneled through the School District. These sources include:

- State Department of Education,
- State Department of Community Affairs,
- State Department of Public Welfare,
- Bethlehem City Council,
- State University, and
- United Fund.

These funds provide staffing (program and coordination staffs) and operating costs.

Program changes result from suggestions by Commission members which emanate from assessment of community desires or recommendations from neighborhood advisory councils in each of the areas where the program operates.

The program is successful and has a very stable funding base. Community support is generated through involvement in the planning process and design of programs which would have a high utilization rate. The differences between this program and the two previous examples are that the Bethlehem program was designed to respond to under-utilized resources and the program changes are a function of refinements reflecting community interest rather than responses to an identified need.

Also, the program started from a single categorical base but did not have the limited client group that characterized the other two programs. It began with a major expansion and stable funding, and subsequent changes have been in the area of program refinement rather than program expansion.

ATLANTA

The Atlanta Rehabilitation Center was originally developed to respond to a need cited by numerous health and social services agencies for a diagnostic center. Previously, many agencies provided limited diagnosis of client problems. The diagnosis was limited in terms of staff capabilities and equipment and was also oriented toward each particular agency's program. Therefore, it was decided to set up a central facility to handle diagnosis and assessment by accepting referrals from all area services agencies. The project would provide specially trained evaluation staff and facilities to complete a more comprehensive diagnosis and assessment than was possible at each of the agencies. By delegating evaluation to a central facility agency staff could concentrate on delivering services.

The Center was initiated by an OEO demonstration grant through Economic Opportunity Atlanta, the community action agency. The State Division of Vocational Rehabilitation accepted a contract to set up and administer the Center, which was then operated by professional State staff.

The original funding, which was in excess of $1 million, allowed the program to gear up very quickly with only limited time for planning. Problems occurred because of the client selection process, organization and responsibilities of staff, and misunderstanding about the Center's scope. Consequently, the initial operation was limited to basic diagnosis and evaluation of selected clients.

When the OEO demonstration grant ended, the State took over the facility with additional Federal support. The organizational structure and client selection philosophy were revised and the Center began operating more efficiently. The program initially expanded by providing more comprehensive diagnosis and evaluation services. Soon these were supplemented by job referral and other referral services. Next, cooperative agreements were made with various agencies to provide staff at the center site for specialized services. During this expansion process, State support and funding increased as Federal support decreased. The program now has very stable funding and provides comprehensive diagnosis, evaluation and training services to its clients.

The evolution of this project was a hybrid compared to the other three projects. The Atlanta Rehabilitation Center was similar to Bethlehem in that it grew out of a consolidation of existing resources and had very high initial stable funding. However, it did not have the planning that any of the other projects had prior to its initial implementation, and therefore, suffered operational problems. Like the Brooklyn Family Reception Center, it expanded according to a determination of additional needs of existing clients within a given geographic area to provide comprehensive services to its target group. However, the

expansion largely involved affiliations with existing agencies, similar to the major expansion of the Kansas project. Other than service agencies and the Department of Human Resources Advisory Board, community involvement has been limited. The funding, while evolutionary, has remained constant and stable and the future outlook for the project is good.

CONCLUSIONS

In projects such as the Family Reception Center and East Central Mental Health Center where community advisory boards were utilized to help in the planning and administration of the project, citizens helped significantly in continuing expansion in programs and caseloads. However, in the two projects (Bethlehem Community Education Project and Atlanta Rehabilitation Center) where community advisory boards were not used, the integration was a basic function of consolidation of existing programs. Rather than strong reliance on the citizens of the area, the agencies involved in services integration appeared to provide the greatest impetus to consolidation.

It can be hypothesized that if a new project is being structured, extensive community support is essential in planning and implementation. If existing programs and resources are being consolidated for more efficient use, the agencies which are being integrated into the comprehensive project will be the effective agents of change.

In every case but Kansas, significant Federal grant money was used to start the programs. The funding base represented by the Federal grants, however, varied from continuing education block grant money in Bethlehem to short-term demonstration grants for the Sisters of the Good Shepherd who had to constantly worry about program continuation.

From the experience of the four projects it can also be hypothesized that continuing stable sources of funding are required whether it be the county millage in Kansas or Department of Education funding in Bethlehem. As illustrated by the Brooklyn project, however, this can be overcome with considerable effort.

In all program integration from a single categorical base, it is critical to assess the environment, develop goals and objectives, and a rational and well panned approach, and secure stable sources of funding. The concept of expansion from a single categorical base is a very viable one as indicated by these projects. However, the above factors are necessary to improve the chances of the program's success.

The role that funding played in the four projects is discussed in more detail in the next section. Finally, it can be stated that the nature of the initial program, either response to unmet needs or consolidating existing resources, is a major determination of the rate and type of expansion and integration that will occur.

COMPARISON OF FUNDING

The nature and evolution of the funding of the four projects had a major impact on the nature and pace of expansion that occurred.

The key factors with regard to the funding included:

- Amount of funding;
- Sources of funding;
- Stability of funding;
- Restrictions on the use of the funding; and
- Paperwork necessary to acquire and maintain funding.

DIFFERING FUNDING APPROACHES

The differing experiences of the four projects in developing, maintaining and expanding their financial bases provide insight into the role of funding in program development.

The key to successful operation of any program is the financial base. In addition to financing staff, facilities, and services, the funding can provide the impetus to service expansion and integration as in the case of the East Central Kansas Mental Health Center. On the other hand, lack of stable or adequate funding can hinder effective, ongoing programs as illustrated by the Atlanta Center and the Brooklyn Family Reception Center. In Bethlehem, the absence of a large anticipated Federal grant brought about an effective local coalition of funding sources.

KANSAS

The East Central Kansas Mental Health Center evolved as a result of local action. Citizens dissatisfied with the current mental health system, which consisted of three State mental hospitals, petitioned the State Legislature for enactment of community based facilities. A compromise bill allowed the establishment of local, private, non-profit corporations for mental health services but did not provide State funds.

Relying on local tax dollars, the East Central Center was limited in the scope of services and number of clients. However, the local tax dollars provided stable, continuing funding. The absence of other State or Federal funds to augment the local resources forced several neighboring counties to contract with the Center, thus slowly expanding the geographic area, the number of staff, and number of clients. The major expansion was made possible by a large Federal staffing grant which provided the funds necessary to offer a comprehensive mental health services program. The massive paperwork necessary to obtain and

maintain the grant was a major problem for the Center to handle, however, and led them to have some questions as to whether it was worth the trouble to get the grant. In fact, they have several full-time administrative staff just to meet the reporting requirements.

The Kansas staff discussed expansion potentials for several years with other community mental health centers and mental health professionals. In addition, good rapport with the community existed as a result of several years of effective service delivery and community contact with civic associations, other service providers, and residents. The director also "laid the groundwork" for expansion by continually discussing the issues of expansion, effective service delivery etc., with the existing staff. Therefore, the expansion into a comprehensive in-patient and out-patient mental health facility progressed smoothly.

ATLANTA

Limited financial resources in Kansas can be contrasted to the sudden availability of funds to implement the Atlanta Rehabilitation Center. Through an Office of Economic Opportunity demonstration grant, a local CAP agency (Economic Opportunity Atlanta) initiated a comprehensive testing and evaluation facility for handicapped clients. The grant, in excess of $1 million was sufficient to buy and renovate a building, hire 151 staff, and provide evaluation services. Although the large grant allowed the provision of services to many clients, the Center lacked adequate long-range planning and start-up time.

The elimination of previously available funding can devastate a program. When the demonstration grant for the Atlanta Rehabilitation Center ended, State personnel operating the facility were faced with dropping the needed program and eliminating 151 State personnel slots or finding an alternative funding source. The State personnel marshalled local support and applied for several Federal categorical grants to cover different components of the operation. Subsequent Federal grants allowed the State to assume responsibility for the Center which became part of the new Department of Human Resources' umbrella agency. The restrictions inherent in the categorical grants and the lack of stability of the Federal monies led the Director of the Center and the Commissioner of the State Department of Human Resources to request increased State funds.

Although the Atlanta Center does have fairly secure funding, the program is hampered by restrictive categorical Federal grants. This problem is increased by the fact that State funding of rehabilitation projects rests on disability criteria that often excludes borderline clients in need of services.

BROOKLYN

Lack of stable funding and narrow categorical grants are generally seen as inhibitors to effective service integration and delivery. For example, the Director of the Brooklyn Family Reception Center spends a considerable amount of time locating financial resources and applying for grants. Within a five-year period the Director of the Center secured an LEAA Project Outreach demonstration grant, Title XX funds, two additional short-term LEAA grants, an HEW Office of Youth Development grant, three private foundation grants, a local financial institution grant, and numerous private gifts. This constant search for funds reduces the effectiveness and coordination of the programs developed by the Sisters of the Good Shepherd.

BETHLEHEM

The mobilization of local resources resulted in the Bethlehem Area Community Education Project. Based on the concept of maximization of resources, the Project participants (City

of Bethlehem, United Fund, Bethlehem Area School Board, and Northampton County Commissioners) coordinated the funding for shared staff and facilities. For example, the Community Education Coordinator is paid by Federal monies through the School Board, local county and city tax dollars, and private donations through the United Fund. Thus, no one agency or funding source has to bear the full financial cost of this individual.

The necessity of combining financial resources rather than relying on comprehensive Federal grants has enhanced coordination among the City, County, School Board and United Fund. The role of these participants in funding the Community Education Project has eliminated domination by one agency and has fostered the concept of sharing resources for a more effective service delivery system. It has led, however, to some operational problems, as discussed in the next section, with regard to project administration.

Another financial asset to the Community Education Project is the stability of funding. Continuing block grant Elementary and Secondary Act funds, and local tax dollars enable the Community Education Coordinator and Commission to engage in long-term planning and concentrate on service delivery rather than hunting for financial resources.

Although Bethlehem does not have the problem of constantly searching for funds like the Family Reception Center, the myriad of funding sources results in problems. The project is funded by seven separate sources: the Pennsylvania Department of Education, the Pennsylvania Department of Public Welfare, the United Fund, Eastern Michigan University, Bethlehem City Council, Northampton Board of Commissioners, and the Bethlehem School District. To further confuse the accounting procedures, the above sources utilize a variety of programs (e.g., Department of Education donates ESEA Titles I and II and Vocational Education funds) and a variety of fiscal years.

CONCLUSIONS

Although the funding bases of the four projects vary from continuing block grants (for example, Bethlehem Community Education Project) to short-term demonstration grants (for example, the programs operated by the Sisters of the Good Shepherd), certain conclusions can be drawn from the analysis of the four projects. In general, it can be hypothesized that the type of funding clearly influences the program operation and expansion philosophy. For example, small, stable local funding of the East Central Kansas Mental Health Center resulted in very gradual expansion of services, clients, and geographic area. With the influx of a large Federal staffing grant, the Center expanded the types of services to include emergency 24-hour service, in-patient and partial hospitalization services and greatly increased the geographic coverage of services.

Additional factors uncovered in an analysis of these four projects should be considered in any attempt to expand from single categorical program to a comprehensive integrated program. These factors include the following:

- Stable sources of funding are required, whether it be the county millage in Kansas or the Department of Education funding in Bethlehem to maximize program integration potential. Although this can be overcome by having an exceptional "grantsperson" as in the case of the Family Reception Center, it is not without effect on the program's longevity and comprehensiveness.
- The amount of paperwork and reporting requirements necessary to obtain the funds must be balanced against the need for the funds.
- Limiting the number of sources from which funds are obtained facilitates management, staffing and organization of the project.
- The restrictions inherent in any categorical grant must be balanced against the use to which the funds are put and the availability of alternative resources.

- Adequate program planning and laying of groundwork with complementary agencies cannot be ignored even if there is adequate and stable initial funding.
- If short-term demonstration grants form the majority of the funding base, adequate long-range planning must be undertaken to ensure a smooth funding transition for program continuation.
- The implications of integrating and consolidating existing resources must be examined in terms of the obligations to the other involved agencies and their role and involvement in project administration.

In summary, the nature and evolution of funding has a major impact on how a single categorical program expands into a more comprehensive integrated service delivery program. Therefore, all the implications of policy decisions relative to project funding must be clearly addressed in the project planning stage. If a less than desirable funding alternative must be selected, the unfavorable implications must be confronted.

COMPARISON OF IMPACT OF MANAGEMENT AND ORGANIZATION

The four projects exhibit differing organizational structures ranging from a division within a multi-purpose State human services umbrella agency in Atlanta, to a private, non-profit corporation in Emporia. However, an analysis of operational aspects of the four projects reveals common components which assisted or detracted from smooth services integration operations.

Two primary facilitators seem to be the strong leadership exhibited by the project director (and project proposers) and staff commitment and expertise. However, other administrative factors such as the lack of a legally constituted board hindered effective integration.

BROOKLYN

The extensive social service and grant experiences of the Director of the Brooklyn Family Reception Center greatly facilitated the initial program conception and the expansion into the Mini School, Barbara Blum group home, and Children and Youth Development Services Program. Personal contacts within other social services programs assisted the Director in program development and securing funding.

The Director was able to instill enthusiasm and a sense of individual responsibility in the Center staff. The stability and closeness of the staff enhanced effective coordination of client cases. Formalized case conferences or daily "shop talk" allowed a sharing of case responsibilities. Outstationing of staff (e.g., counselor in Center also provides educational counseling in the Mini School) enhanced the integration of services offered by the four auxiliary centers (Family Reception Center, Mini School, Children and Youth Development Services and Barbara Blum group home).

In addition to the Director's leadership and staff capabilities, the smooth operation of the Brooklyn Family Reception Center and other programs is facilitated by the Director's overall authority. Although three separate advisory boards oversee the operation of the Center and auxiliary programs, the Director has the authority to make decisions and carry out the programs.

BETHLEHEM

This situation can be contrasted with the situation in Bethlehem where a Community Education Commission was formed to provide administrative direction of the project. The members include representatives of the following organizations:

- School Board,
- City Council,
- County Commission,
- United Fund, and
- Each Neighborhood Center.

Although the original proposers accounted for a majority of the members, the Commission is only an appointed advisory committee without legislative, budgetary, or other powers. Therefore, each participating board must approve recommendations of the Commission or Community Education Coordinator.

Although it was able to obtain a voluntary commitment from the School Board to serve as a conduit of funds and also to facilitate personnel cooperation, the Commission had no legal integrative powers. Thus, effective coordination and integration are hampered by the lack of one policy body to make decisions.

Another impediment to effective operation is the organizational structure where the social services staff is responsible to the parent organizations instead of the Community Education Coordinator or the Community School Director. For example, the Job Placement Coordinator is funded by, and is administratively responsible to, the Lehigh Valley Manpower Program, an organizational arm of the County. Thus, the integration of services and ensuing coordination suffers not only from the absence of a single governing board, but also through complexities of the day-to-day operational structure.

Several factors assisted in service integration in Bethlehem. The stature of the Superintendent of the Bethlehem School District and the other instigators of the Community Education Project, including the Mayor, the United Fund Director, and the Director of the Department of Public Welfare, assisted in coordinating services in Bethlehem. The Superintendent's philosophy of services integration and his knowledge of the community school movement in areas like Flint, Michigan assisted in effectively coordinating the project participants and community to achieve a services integration project. The ability of the Superintendent, the Mayor, and other participants to secure funding approval from their respective boards and collectively from the Department of Health, Education, and Welfare transformed a concept into a viable project.

Staff hired (or transferred from existing programs) to implement the project included:

- A Community Education Coordinator,
- Four Community School directors,
- Support office staff, and
- Service providers (e.g., outreach workers, recreation supervisors, home economics instructors, job placement coordinator, child development specialist, and information and referral specialists).

The composition of the staff indicated a keen understanding of the broad concept of community education. Staff (under the direction of the Community Education Coordinator) provided coordination through group conferences, staff meetings, etc.

Thus, despite the administrative drawbacks, the project is successful due to personal contact and commitment to the concept of services integration.

KANSAS

The credit for establishing the East Central Kansas Mental Health Center is given to a grass roots organization of five citizens who conceived the original plan, lobbied for State enabling legislation, and implemented the original Center. The expansion of the Center resulted from the Executive Director's extensive community contacts, conferences with

other comprehensive centers and cooperative agreements with another mental health center and a local hospital. The Director compiled the comprehensive grant application and worked extensively with the members of the Board of Directors to dispel their reluctance to accept Federal funds. In addition, the strong administrative qualities of the Executive Director effectively prepared the staff for the expansion.

Staff is housed in the Center and provide outreach services through alternating clinical hours in the courthouses of the adjacent participating counties. Establishment of a home base enables staff to confer on cases and provides opportunities for staff meetings to discuss administrative policies or problem cases.

The Center staff exhibited a strong commitment to serving the community (as illustrated by late-night responses to emergency calls) and to providing comprehensive services through the integration of the hospital in-patient facility and the Center's out-patient treatment services.

Following the 1975 staffing grant expansion, a Director of Administration was hired to coordinate case reporting and overall management for the East Central Center, the South Central Center, and the in-patient facility at Newman Hospital.

ATLANTA

The Atlanta Rehabilitation Center was initiated through strong leadership of a community organizer, who was the head of the Atlanta Economic Opportunity. Mobilizing resources and coalescing different factions were two frequent roles of the EOA director and board members. As evidenced by the Federal allocation of a demonstration grant of $1 million, the instigators were successful in the development of the joint evaluation concept.

However, operational problems arose which could be attributed to the split funding-operation structure maintained by the EOA board (funding and overall administration) and State Division of Vocational Rehabilitation (operation).

Following State assumption of operation and management of the Atlanta Rehabilitation Center, the Director of the Department of Education and other key citizens marshalled efforts to secure Federal funding. Under the Director of the Department of Education's leadership, several Federal administrators became involved in the project and a series of Federal grants was secured.

A new director, hired following State assumption of the Center, reorganized it to deliver services more effectively to the client. In addition, the director's extensive contacts with other State and local human service agencies and private industry resulted in an expansion of services without extensive financial allocations. For example, at the request of the Center Director, the Department of Labor transferred a job placement counselor to the Center.

Despite the initial operational problems, the current director has been successful in obtaining cooperative agreements for staff or ancillary services. The cooperative agreements and smooth operation of the facility result from his efforts to determine another agency's "yardstick of success" and make an appeal based on benefit to the agency and client.

CONCLUSIONS

The four projects studied clearly demonstrate the necessity of a key individual or director to bring together the various elements involved in a service integration project. The director's leadership, persuasiveness, commitment to the integration concept, and contacts with the community residents, staff, political leaders, and other service agency heads

appear to have a great impact on the initial implementation and later expansion and integration of services.

In addition, the director must have authority to carry out the project. The lack of clear administrative power in the Bethlehem Community Education Project illustrates the problems associated with a conglomeration of participants without a central administrative figure.

Staff commitment has enhanced the effective operation of each of the projects studied. As one director aptly stated, ". . . An administrator is like a ship's captain, good directions are meaningless without adequate staff for implementation."

PART II
FOUR CASE STUDIES

EAST CENTRAL KANSAS MENTAL HEALTH CENTER

INTRODUCTION

The East Central Kansas Mental Health Center was organized in 1960 in response to several factors. These included:

- The desire to enable local juvenile judges to place juvenile clients appropriately and to keep track of their treatment and response;
- The growing national movement toward community mental health centers; and
- The desire to provide an alternative to commitment to the State Mental Hospital system.

The Center evolved over the succeeding 16 years to provide a broader range of services over a larger geographic area to an increasing number of clients. While the scope of services and the range has increased, however, the focus and target group have remained basically the same, i.e., "to provide community mental health services to persons of all ages."

This study describes the three major phases within the expansion:

- Establishment and initial operation of the Center (1959–1963);
- Initial expansion to adjacent counties while retaining the community-based concept (1963–1974);
- Major expansion based upon Federal support (1974–1976).

The following basic themes are explored:

- Impetus for expansion
- Nature of expansion
  - Increased staff
  - Expanded geographic coverage
  - Increased services
  - Additional income
  - Additional cooperative or contractual agreements
- Modifications in funding patterns
- Impact of expansion
  - Increased case load
  - Expanded service delivery output

The case study concludes with an analysis of the operational impacts of expansion over the life of the project and presents future plans.

ESTABLISHMENT AND INITIAL OPERATION

Prior to establishment of the East Central Kansas Mental Health Center, mental health education and consultation did not exist in Lyon County. No public or private psychiatrists practiced in the area. To obtain diagnosis, evaluation, testing or psychological or psychiatric treatment, an individual had to travel to Topeka (65 miles), Wichita (95 miles), or Kansas City (100 miles). The distance and cost, in terms of time and money, prevented many citizens from receiving mental health care. In addition individuals committed to any of the three State Mental Hospitals, located in Larned (110 miles), Oswawatomie (90 miles) and Topeka, were removed from friends and family. The distances and relationships of these locations to Emporia are illustrated in Exhibit 1.

Because probate judges and physicians could not adequately evaluate the mental condition of juvenile offenders or patients, many individuals were inappropriately referred to the State Mental Hospitals (e.g., belligerent juveniles who would benefit from counseling rather than commitment).

In light of the above conditions, in 1959 a group of five Emporia citizens, a housewife, probate judge, attorney, physician and credit union manager began planning an alternative to the State operated mental health system. This local group organized a grassroots coalition of 21 individuals representing business, education, agriculture, clergy, blue collar workers, and medicine to petition the State Legislature to provide local community mental health centers. In 1960, the State Legislature passed a compromise bill allowing local communities to establish mental health centers but did not provide State funds for implementation or operation. However, the bill allowed the establishment of a non-profit corporation which could contract with the County Boards of Commissioners to provide mental health services. The counties were limited to a maximum of a .5 mill levy to support the mental health centers.

Pursuant to this bill, the Mental Health Center of East Central Kansas, Inc., was formed in 1960. It was located in Lyon County and an initial .25 mill levy was approved by the Lyon County Board of Commissioners to support the Center.

The primary purpose of the Center was to prevent or reduce unnecessary institutionalization by providing a community alternative in the form of:

- Providing consultation services to local juvenile judges to enable appropriate placement of juveniles;
- Screening potential admittees to the State Hospital to prevent unnecessary institutionalization; and
- Providing follow-up to area patients discharged from the State Mental Hospital to reduce recidivism.

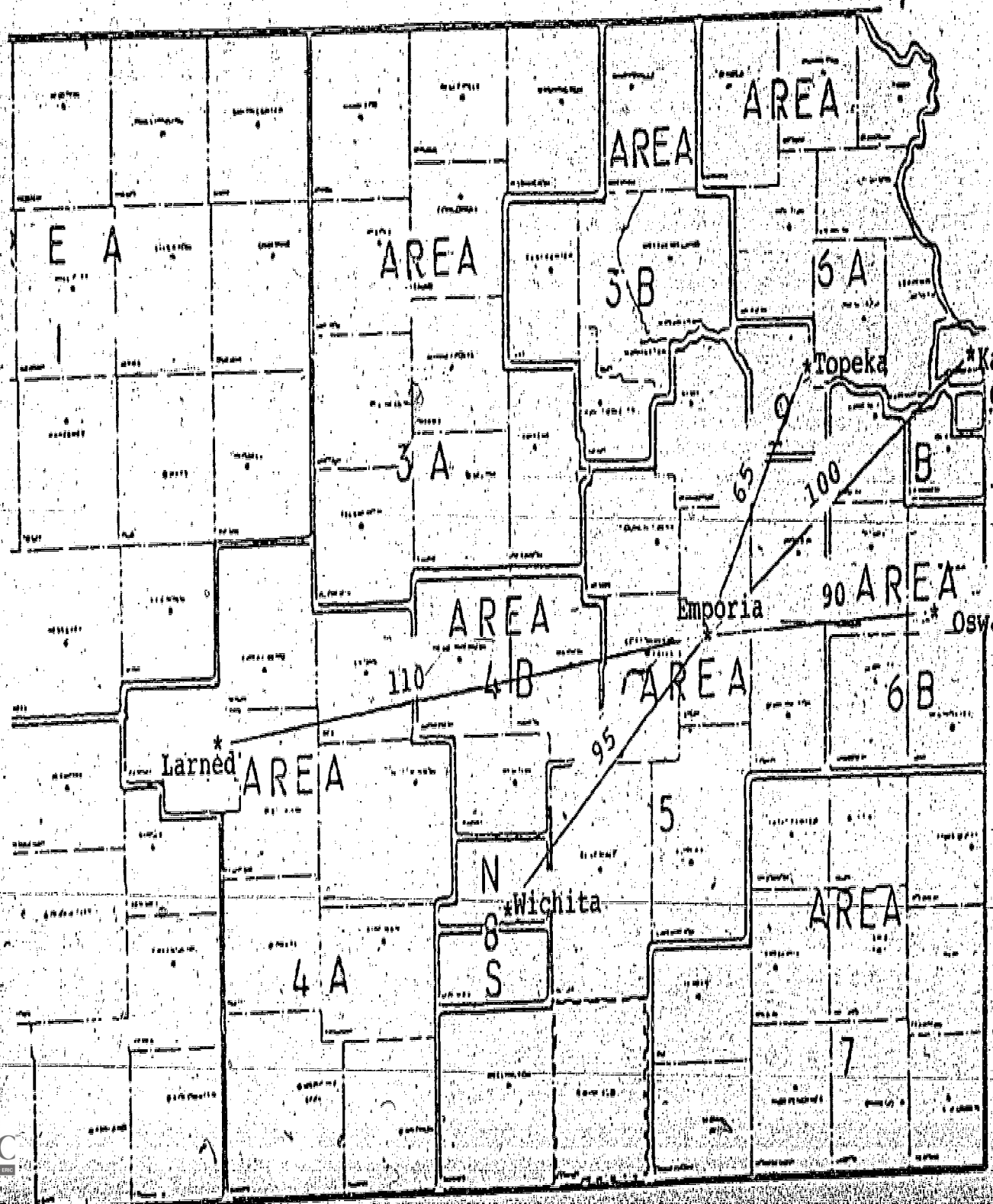
In addition, community mental health services, which were formerly available in other cities some distance away, were to be provided to people with less severe problems.

The services originally proposed (but not implemented until 1975) to be provided included:

- Consultation to schools, courts, health and welfare agencies (both public and private), ministers, physicians, law enforcement agencies, and other interested persons;
- Out-patient diagnosis and treatment;
- Educational programs;
- Casework and counseling;
- Research;

EXHIBIT 1

RELATIONSHIP IN MILES OF MENTAL HEALTH SERVICES AND HOSPITALS TO EMPORIA IN 1960



- In-service training for staff and for students entering the psychiatric profession;
- Partial hospitalization;
- In-patient services;
- Emergency 24-hour-a-day service;
- Services to the developmentally disabled;
- Screening and follow-up services to individuals being admitted to or returning from an institutional facility; and
- Mental health treatment and educational services to individuals and the community relating to alcoholism and drug abuse.

The East Central Kansas Mental Health Center began operation in early 1960 occupying the second story of a downtown commercial building. The Center was managed by a board of directors composed of citizens of Lyon County including the five initiators of the community mental health concept.

The Center was originally staffed by one part-time psychiatric social worker who primarily provided consultation to the juvenile judge. Several months later, two part-time clinical psychologists and a full-time receptionist-secretary were hired. The core staffing was completed with two additions later in 1960. An additional part-time clinical psychologist, who specialized in child psychological testing and psychotherapy was hired. Finally, the part-time social worker was replaced with a full-time psychiatric social worker who was hired as the Executive Director of the Center. His duties included administration, staff supervision, and provision of outpatient services and community education. This core staff remained constant through the period of initial operations until 1963 when expansion into adjacent counties began.

During the initial three years of operation, the Center provided the following services:

- Diagnosis, evaluation, testing and treatment (e.g., out-patient counseling);
- Education (staff appearances before service organizations, school groups, etc., to explain what the center is, what services are provided, what mental illness entails, and preventive aspects of mental health);
- Consultation (school teachers, juvenile judges, or policemen work with clients with behavior problems);
- Combined treatment and educational services (e.g., working with families of individuals committed to the State Hospital).

The level of services increased throughout the three year period as illustrated in Exhibit 2.

Since key staff was not hired until late 1960, the service provision levels are lower for that year. The levels in subsequent years increased due to having fully staffed years of operation, increased funds, and community recognition of the availability of the community mental health services. The increased awareness and resultant use of the Center by patients was a result of a vigorous community education program by the Center.

The increased funds in the second and third year came as a result of three factors:

- Slight increase in the amount received from the millage assessment;
- Marked increase in fees due to increased caseload; and
- Carry-over into second year of unexpended first year funds due to late staffing of the Center.

The level of income and source of funds is illustrated in Exhibit 3.

This pattern of expansion had a limited horizon and the services had just about leveled off when the second impetus for expansion occurred in 1963.

EXHIBIT 2

SERVICE PROVISION CHARACTERISTICS (1960-1962)

LEVEL OF SERVICES RENDERED

	1960	1961	1962
Cases Opened	80	99	179
Cases Closed	55	96	143
Cases Carried	23	28	68
No. of Individuals Seen	375	545	497
No. of Interviews	606	1,097	1,216
No. of Interview Hours	436	937.5	1,116

TYPE OF CLINICAL SERVICES RENDERED

	1960	1961	1962
Diagnosis & Evaluation	19	47	84
Treatment	42	59	73
Referral Service	17	33	21
Brief Service	27	28	43

EXHIBIT 3

BASIC FUNDING PATTERNS (1960-1962)

Year / Funding Source	1960	1961	1962
County .25 Mill Levy	13,488.73	14,368.44	14,960.00
Fees	2,481.75	6,684.75	8,143.00
Donations	1,277.42	77.95	—0—
Balance Carried Over From Prior Year	—0—	5,437.69	2,497.00
TOTAL Income	17,247.90	26,568.83	25,600.00
TOTAL EXPENDITURES	$11,810.12	$21,197.40	$25,025.00

INITIAL EXPANSION INTO ADJACENT COUNTIES WHILE RETAINING THE COMMUNITY BASED CONCEPT (1963-1974)

In 1963, several key individuals in the neighboring county of Coffey, which had no community mental health facilities, contacted friends in Lyon County to ascertain the possibility of obtaining services from the East Central Kansas Mental Health Center. Following board and staff recognition of the need for expanding services to adjacent

counties, a contract was signed by the Coffey County Board of Commissioners and the East Central Kansas Mental Health Center Board. The contract stated that the Center would provide services to the County by making its facilities available to the residents of Coffey County and by providing staff on a rotating on-site basis. The staff was scheduled to provide services at a specified time and location in Coffey County.

In return for the services provided, Coffey County instituted a .5 mill levy which provided approximately $10,000 which was paid to the Center in 1963. This additional funding enabled the Center to add one full-time psychiatric social worker to the Center staff.

Between 1963 and 1974, four additional counties, which were unable to support their own mental health center, joined the East Central Kansas Mental Health Center on a contractual basis. The counties and the year of their affiliation are as follows:

- Greenwood (1967)
- Chase (1970)
- Morris (1973)
- Osage (1973)

Contracts were signed on the same basis as the Coffey County contract.

The additional counties and the resultant increase in staff, case load, and funding are illustrated in Exhibit 4.

EXHIBIT 4

SUMMARY OF INITIAL EXPANSION OF ADJACENT COUNTIES

County	Date of Service Initiation	Professional Staff Hired	Millage Rate	Total Allocation First Year
Coffey	1963	1 Full-Time	.5	$10,000
Greenwood	1967	2 Full-Time 1 Part-Time	.5	$18,000
Chase	1970	3 Part-Time	.5	$12,000
Morris	1973	2 Full-Time	.5	$12,000
Osage	1973	1 Full-Time	.5	$10,000

The additional staff hired as a result of the county affiliation, became part of the Center staff and not staff persons related to the individual counties. The Center, in turn, provided the needed services to the counties by drawing from its entire staff. Staff time was provided to the counties on the basis of need and not on the basis of their contribution.

The Mental Health Center Board of Directors was expanded to include representatives of the participating counties. By 1974, the Board consisted of 35 members reflecting a wide range of occupations including: a nurse, several ministers, two attorneys, a building contractor, two physicians, and several housewives.

Through the additional funding from the participating counties, one of the additional Center staff members hired was the current Executive Director.

By 1974, the Center had increased to four part-time and ten full-time staff members. The staffing pattern is displayed in Exhibit 5. The staffing pattern in 1963, the beginning of the initial expansion phase, is also presented to show the extent of expansion achieved by the end of the phase.

EXHIBIT 5

STAFFING PATTERNS (1963–1974)

Type of Staff	Number of Staff 1963		1974		Total Change	
	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time
Psychologist	3	—	2	3	−1	+3
Psychiatric Social Worker	—	—	—	3	—	+3
Psychiatrist	—	—	1	—	+1	—
Executive Director	—	1	—	1	—	—
Clinical/Office Management	—	1	1	3	+1	+2
TOTAL	3	2	4	10	+1	+8

In addition, in 1974, an alcohol/drug abuse grant from HEW funded an alcoholism consultation and treatment staff of three full-time professionals. The staff operates out of a separate facility in Emporia and does not provide outreach services in the other counties.

The large expansion was primarily a result of increased funds due to the participation of the adjacent counties increased client fees, some grant and contract support, and an increase in the Lyon County millage rate from .25 to .5 mill in 1963. The income level and source of funds of 1962 and 1974 are compared in Exhibit 6 to illustrate this change.

The substantial increase in caseload from 1962 to 1974 which was made possible by the expanded funding is presented in Exhibit 7.

The nature of the expansion and consequent staffing and types of services delivery were beginning to cause acute problems in the Center's operation due to the limited number of staff. Due to the part-time employment of key staff members, services were primarily directed toward immediate short-term clinical treatment rather than extended consultation or education. The staff handled crisis situations rather than systematically dealing with behavior problems. Also, the clients who received services were the ones who came to the center or county satellites since there was no effective outreach to serve specific target groups. Therefore, although the Center originally was established with a focus on treating juveniles, only 30 percent of the client load was under 18.

In addition, the staff felt the limited services, and especially the paucity of preventive mental health services, constrained the Center from adequately reaching many citizens in need of mental health services. During several periods, a waiting list was instituted because of the high demand for clinical services.

EXHIBIT 6

BASIC FUNDING PATTERNS (1962 AND 1974)

Funding Pattern	Years 1962	1974
Receipts		
Lyon County Appropriation	$14,960.00	$ 41,354.00
Coffey County Appropriation	–0–	12,120.00
Greenwood County Appropriation	–0–	18,075.00
Chase County Appropriation	–0–	12,940.00
Morris County Appropriation	–0–	12,350.00
Osage County Appropriation	–0–	20,322.00
Patient Service Fees	8,143.00	16,203.00
Social & Rehabilitation Services (Welfare)	–0–	11,873.00
Reimbursed Grant Expenses	–0–	8,371.00
Consultation Contracts	–0–	1,982.00
Reimbursed Expenses	–0–	509.00
Grant Receipts	–0–	8,958.00
Donations	–0–	411.00
Interest	–0–	972.00
Miscellaneous	–0–	143.00
TOTAL RECEIPTS	23,103.00	166,583.00
Carry Over	2,497.00	17,528.00
Cash Balance	25,600.00	184,111.00
TOTAL EXPENDITURES	25,025.00	176,033.00
Cash Balance	575.00	8,078.00

EXHIBIT 7

LEVEL OF SERVICES RENDERED

	1962	1974
Cases opened	179	1,199
Cases closed	143	939
Cases carried	68	539
No. of individuals seen	497	N/A
No. of interviews	1,216	5,147
No. of interview hours	1,116	7,999

The lack of comprehensive services including 24-hour emergency service, in-patient care, and the inability of current staff (many of whom were part-time) to adequately handle the

case loads prompted the Executive Director to request that the Board apply for a Federal staffing grant. This marked a movement away from the local community-based concept that the Center had begun with and functioned under for its 14 years of operations. However, the problems were compelling and provided sufficient impetus for the program's major expansion.

MAJOR EXPANSION BASED UPON FEDERAL SUPPORT (1974-1976)

By 1974, heavy staff load and lack of comprehensive services were becoming very apparent and the need for additional funding and expansion was clear. However, in 1974, no local alternatives were available. Therefore, in response to the Executive Director's suggestion, the Board instructed the Executive Director to prepare a grant application for funds from the Department of Health, Education, and Welfare. The Executive Director was informed by the Department of Health, Education, and Welfare that to be eligible for a comprehensive mental health services staffing grant, and to be designated a "catchment area," the East Central Kansas Mental Health Center would have to expand its service area and facilities. Therefore, the Board, upon recommendation of the Executive Director, approached the South Central Mental Health Counseling Center. The South Central Mental Health Center was started in 1963 as a result of a citizen action (with leadership by the Kiwanis Club). The Center offered the same type of services as the East Central Mental Health Center to the neighboring counties of Butler and Sumner and was governed by a similar citizen board.

The boards and executive directors of both centers signed an affiliation agreement and combined population of the two areas into the HEW designated catchment area. Under the agreement, the two centers would retain service delivery responsibility to the residents of their respective participating counties. However, greater administrative control would be granted to the East Central Center. The Executive Director of the South Central Center would employ or dismiss personnel in consultation with the Executive Director of the East Central Center.

This agreement marked the final geographic expansion of the Center to date. The counties covered and the year that they initially received services from the Center is illustrated in Exhibit 8. The individual service areas were combined to form Catchment Area 5 for the purpose of obtaining the Federal grant.

A Joint Coordination Committee composed of four members from each Center's Board of Directors (including the Board chairpersons) was formed to review the affiliation agreement, consider future needs for mental health services for the entire area, and resolve conflicts that might arise between the two Executive Directors. If necessary, as administrator of the HEW grant, the East Central Board would resolve any conflicts.

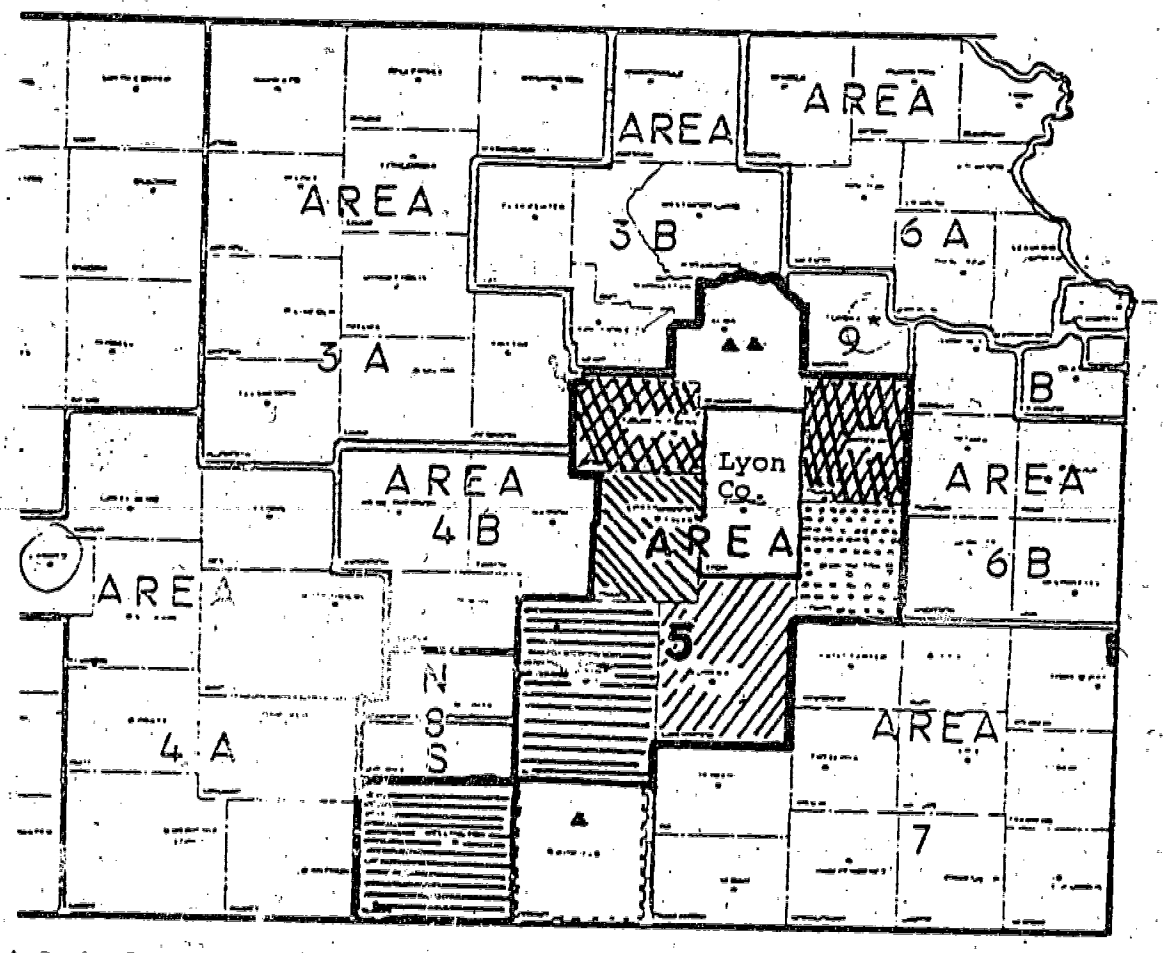
Additional provisions of the affiliation agreement include:

- Sharing of client information with various program elements,
- Disbursement of Federal staffing monies by the East Central Center to the South Central Center, which will arrange for the necessary equipment, supplies and office personnel,
- The medical/clinical director of the South Central Center will have clinical authority over staff members employed by that facility and the medical/clinical director of the East Central facility plus the in-patient facility (Newman Hospital).

Having expanded its geographic coverage area by means of affiliation agreement with the South Central Center, the East Central Center next turned to expanding its facilities. An alliance was formed with the Newman Memorial County Hospital to provide in-patient,

EXHIBIT 8

GEOGRAPHIC EXPANSION THROUGH AFFILIATION AGREEMENTS WITH THE EAST CENTRAL CENTER



▲ Cowley County which is affiliated with a comprehensive center in Oklahoma might be brought into Area 5 in 1977.

▲▲ Wabaunsee County has been placed (by Federal Government) in Catchment Area 5 but has not signed affiliation agreements with East Central Center

KEY: Year of affiliation of adjacent counties with East Central Center
1963 1967 1970 1973 1974

partial hospitalization and 24-hour emergency services to residents of the counties participating in the East Central Center.

This agreement was established to achieve three fundamental goals:

- To provide local hospitalization for persons who would otherwise need to leave their immediate community for care,
- To provide services to restore an individual to ambulatory functioning in the shortest time possible,
- To provide a linkage in services that will maximize community resources so that persons will not only have immediate and appropriate care but also move easily to less intensive care services.

In addition, the agreement outlines the specific areas of responsibility illustrated in Exhibit 9.

The final linkage was forged by means of an agreement with the Topeka State Hospital. To ensure a "free movement of patients among all elements of (in-patient and out-patient) services" and to enable transfer of client information from one facility to another, the East Central Center and the Topeka State Hospital signed a cooperative agreement indicating the basic roles, responsibilities and linkages of the East Central Center and the Topeka State Hospital in the areas of out-patient and short term in-patient care vs. long term specialized care.

As a result of these three affiliations, a comprehensive Mental Health Services delivery system was developed in Area 5. An organizational chart indicating the lines of cooperation among the three affiliates comprising the Area 5 comprehensive mental health services delivery system is illustrated in Exhibit 10.

Through these affiliate agreements, the East Central Center accrued the population and facilities necessary for a comprehensive community mental health program. Therefore, the Board instructed the Executive Director to prepare the grant application. With the assistance of his secretary, the Executive Director wrote the application in two months.

No structured needs assessment was conducted. However, at board meetings requested by the Executive Director, the Board discussed community needs. Based on current and potential caseloads as identified by Board members and staff and an analysis of

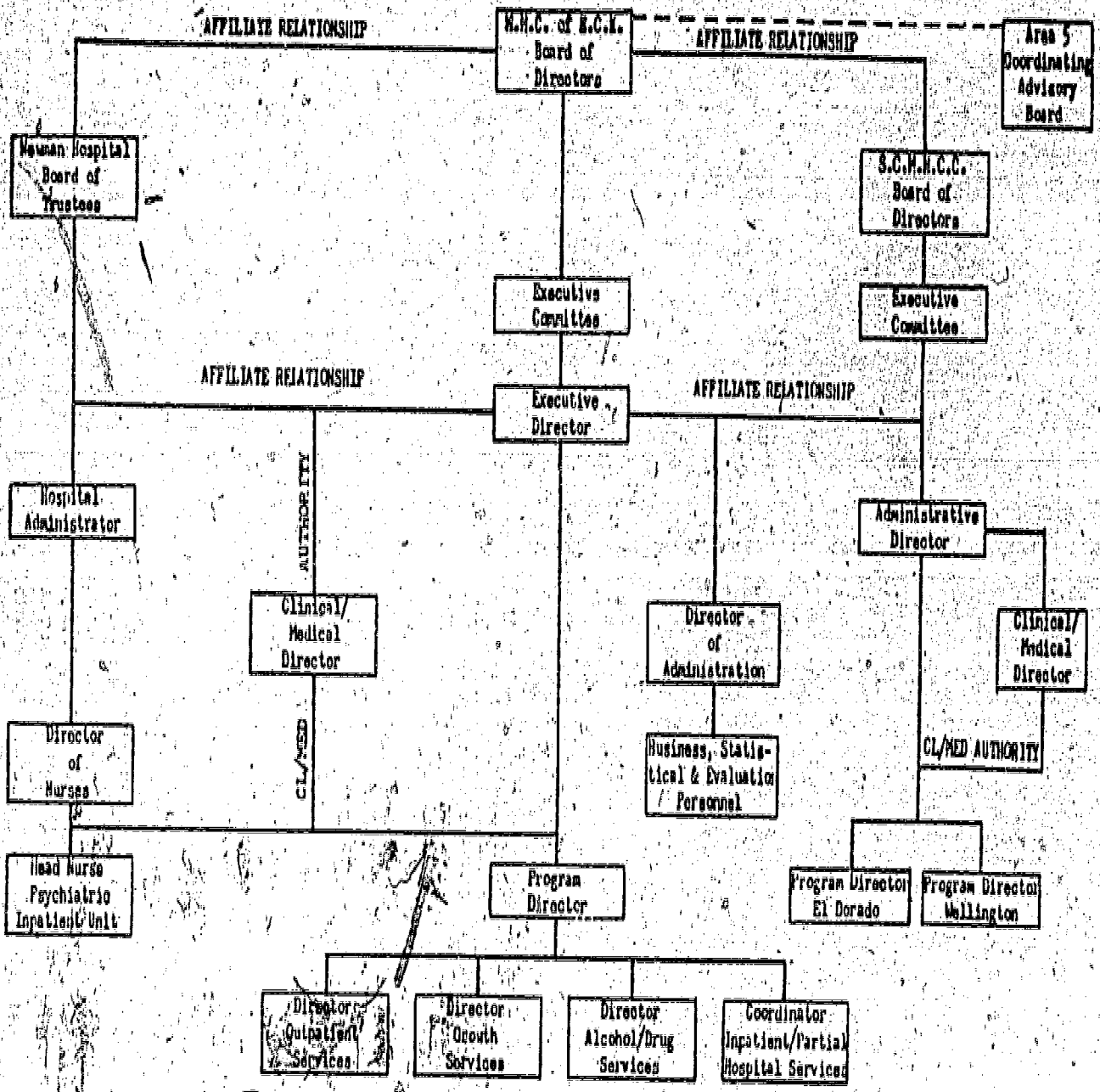
EXHIBIT 9

BASIC PROVISIONS OF AGREEMENT WITH NEWMAN HOSPITAL

- The grant will provide the salaries for the nursing personnel and Newman Hospital will recruit and staff the nursing positions. The nursing personnel will be supervised by the Director of Nursing of Newman Hospital and will be given consultation in clinical work by accredited staff members of the Mental Health Center Staff,
- Administrative matters and salaries will be determined by policies developed by Newman Hospital,
- The Mental Health Center will provide professional clinical staff as outlined in the grant. Professional clinical staff will be paid by and administratively responsible to the Mental Health Center,
- The basic team for developing the treatment program, maintaining the therapeutic atmosphere, and setting internal procedures will be the head nurse, psychiatric social worker, psychiatrist, activity therapist, and administrative assistant/records coordinator,
- Final responsibility for patient care and treatment will rest with the Mental Health Center psychiatrist responsible for in-patient and partial hospitalization services,
- Physicians from seven county area may admit and follow their patient in the psychiartic services unit, however, the chief of staff of the service will be the psychiatrist,
- The Mental Health Center will provide appropriate training in the beginning as well as ongoing in-service training to hospital personnel in the two units.

EXHIBIT 10

ORGANIZATIONAL CHART INDICATING LINES OF COOPERATION AMONG THREE MENTAL HEALTH AFFILIATES



ORGANIZATIONAL CHART

EXHIBIT 11

COMPARISON OF 1974 AND 1975 CASELOAD INFORMATION

	1974	1975
Self, Family or Friend	48%	50%
Physicians	15%	7%
Clergy	1%	1%
Public Schools	5%	6%
Police & Courts	17%	15%
Social or Community Agency (SRS, Youth Center, etc.)	8%	17%
Others (Voc. Rehab., Nursing Homes, Inst. for Retarded Children, Attorneys, Public Health Depts., etc.)	6%	4%
TOTAL	100%	100%
STAFF WORKLOAD PERCENTAGES		
Clinical (Fee & non fee) (14,832 hours)	58%	*61%
Consultation	16%	9%
Administration	15%	15%
Staff Training (Other & own agency)	7%	7%
Public Education	2%	3%
Community Planning	2%	2%
Other	—%	3%
TOTAL	100%	100%
CLINICAL REPORT		
Cases Referred: a) Outpatient	1,099	1,299
b) Inpatient	0	215
c) Partial Hospitalization	0	190
Cases Carried from Previous Year	465	593
Total Cases Served	1,564	2,297
Patients Terminated	939	1,301
Total Individual Interviews	4,720	6,566
Total Group Interviews	427	588
Total Family Interviews	—	439
Total Interviews	5,147	7,593
AGE DISTRIBUTIONS OF CASELOAD (Male and Female)		
Age		
15 & under	10%	14%
15–17	20%	13%
18–24	32%	22%
25–44	21%	36%
45–64	16%	13%
65 & over	1%	2%
TOTAL	100%	100%

census information (e.g., number of elderly), the Executive Director approximated needs and anticipated potential clients to be served by the expanded clinical staffs of the East Central and South Central Centers and Newman Hospital.

Although structured planning techniques were not utilized in grant preparation, the "planning process" was a continuation of a two to three year discussion on the merits of

expansion. Through the Association of Directors of Community Mental Health Centers, the Executive Director talked with directors of other Kansas centers which had expanded their mental health services. Talks centered on type of staff needed for expanded services, services to be offered in a comprehensive center, and data system requirements to meet Federal regulations. In addition to meeting with staff from other centers, the Executive Director discussed the potential expansion with local hospital and mental health center staffs to ensure continuity of services.

The Executive Director of the East Central Center reviewed the grant application with the two affiliates . . . the South Central Center and the Newman Hospital. Following approval of the application by the three boards (East Central and South Central Centers and Newman), the Executive Director met with local human service agencies to explain the concept of the expanded services and to generate support for the grant application. A series of endorsements from the related human services agencies were obtained and attached to the grant application.

Examples of the endorsing agencies included the following:

- Lyon County Juvenile Court,
- Flint Hills Area Health Planning Council, and
- Lyon County Association for Retarded Children.

EXHIBIT 12

BASIC FUNDING PATTERNS (1962, 1974, AND 1975)

	1962	1974	1975
Receipts			
Lyon County Appropriation	$ 14,960.00	$ 41,354.00	$ 45,613.00
Coffey County Appropriation	—0—	12,120.00	15,318.00
Greenwood County Appropriation	—0—	18,075.00	17,500.00
Chase County Appropriation	—0—	12,940.00	13,373.00
Morris County Appropriation	—0—	12,350.00	13,300.00
Osage County Appropriation	—0—	20,322.00	21,437.00
Patient Service Fees	8,143.00	16,203.00	33,770.00
Social & Rehabilitation Services (Welfare)	—0—	11,873.00	20,849.00
Reimbursed Grant Expenses	—0—	8,371.00	—0—
Consultation Contracts	—0—	1,982.00	6,334.00
Reimbursed Expenses	—0—	509.00	6,153.00
Grant Receipts	—0—	8,958.00	—0—
Donations	—0—	411.00	4,448.00
Interest	—0—	972.00	466.00
Miscellaneous	—0—	143.00	404.00
State Grants	—0—	—0—	9,276.00
Federal Grants	—0—	—0—	293,487.00
State Funding (SB 175)	—0—	—0—	27,071.00
TOTAL RECEIPTS	$ 23,103.00	$166,583.00	$528,799.00
Carry Over (Reserve)	2,497.00	17,528.00	8,078.00
TOTAL REVENUES	$ 25,600.00	$184,111.00	$536,877.00
TOTAL EXPENDITURES	$ 25,025.00	$176,033.00	$490,599.00
Cash Balance	$ 575.00	$ 8,078.00	$ 46,278.00

The completed application was received by HEW, reviewed and approved and the comprehensive mental health services program began in 1975.

The impact of the expansion based upon the Federal support is clearly evident in a comparison of the caseload statistics of 1974 and 1975. These statistics are presented in Exhibit 11, and show a marked increase in clinical services provided based upon an increase of total clinical hours from 7,999 in 1974 to 14,832 in 1975.

The reduction in admissions to the State Hospital indicates the utility of the newly installed in-patient services at Newman Hospital. From July 1974 to July 1975, 180 people were admitted to the State Hospital. From July 1975 to May 1976 only 119 were admitted. During 1975, 185 residents of the East Central Center area were discharged, died, or placed on long term leave from the State Hospital; of this total, 88 persons utilized the East Central facilities for follow-up treatment.

Total staff increased from 14 to 37. Six of the additional staff were business office staff who were required to complete the increased paperwork required by the grant. The clinical staff now includes two full-time psychiatrists and 11 in-patient staff (Newman Hospital).

The major reason for the increase in program and staff was the Federal staffing grant which was received in 1975. A comparison of the 1962, 1972, and 1975 funding patterns, which is illustrated in Exhibit 12, confirms this point. It clearly illustrates the dramatic growth of the program throughout the three phases. It should be noted that initial State financing was provided under a legislative act passed in 1974 but the funds are only a fraction of what might be provided in future years.

FACILITATORS AND INHIBITORS

Although the transition to a comprehensive center was cited by staff as fairly smooth, the following factors inhibited the growth of the East Central Mental Health Center:

- The rural areas need mental health services but residents are often reluctant to use the facilities. The Center staff had to change the image of serving "crazy" people to a rational view of the potentials of the mental health program;
- Several senior staff members resisted the transition because they had to switch from primarily clinical to supervisory capacity;
- The Federal reporting requirements were cumbersome and time-consuming. One person spends almost 100% of his time ensuring informational requirements are met. One staff member felt they had switched from serving people to meeting requirements;
- The two affiliates (Newman Hospital and South Central Center) were reluctant to reduce their individual powers or jurisdictions;
- Many board members viewed the grant as a Federal bureaucratic hassle;
- The business office staff had to switch from one form to a myriad of forms; additional computer-trained staff had to be hired;
- The Federal requirement to increase the geographic area to encompass the South Central Center area resulted in a very large catchment area; and
- Adequate facilities did not exist in the area to allow for expanded services. Currently, the East Central Center main office is in a building rented from the adjacent Association for Retarded Children & Sheltered Workshop. The satellite offices are temporarily housed in donated space in county courthouses.

The most influential factor in the expansion of the mental health program was the tremendous demand for services and the lack of other adequate resources. The Central Center staff caseload far exceeded the norm. Clinical staff felt that they were not adequately meeting the needs of their clients or the many individuals who were on waiting

lists. The problems with the distance and physical set up of the State Hospital facilitated the inclusion of Newman Hospital in the expanded program.

Growing community and professional support for the concept of moving clients from the State Hospital for more appropriate care at the local level also assisted the expansion of mental health services. The Executive Director characterized the expansion as the result of natural growth. As more people demanded services, the mental health program grew.

Grant application assistance from groups other than the Emporia Board or East Central Center staff was minimal. The regional office of the Department of Health, Education, and Welfare did assist in refining the mechanics of instituting the grant. Following a gradual "educational" campaign by the Executive Director, the Kansas Congressmen did assist the Center in obtaining the grant.

FUTURE PROJECT CHANGES

Several changes in the East Central Center are envisioned by the Executive Director. Under a new State bill, the Center will be receiving additional funds for mental health services. Hopefully, this source of funds will redirect state dollars formally supporting the State Mental hospitals to local communities.

In response to needs identified by staff and citizens, the Center is proposing additional services and treatment techniques. The staff hopes to increase the number and scope of workshops, especially in rural areas. Through workshops on parent education, marriage counseling, and individual growth, the staff hopes to reach more individuals suffering from a greater variety of problems.

The Center may contract with the Halfway House, a private residential facility for disturbed patients.

Hopefully, new facilities can be constructed to meet the particular physical needs of a mental health program. An in patient psychiatric unit could be built to replace the "loaned" space at Newman Hospital. Additional office space is also needed.

CONCLUSION

The overall benefits of the expanded mental health program are the ability to provide treatment to additional clients especially children and the ability to respond to mental disorders in a total manner through a comprehensive program of evaluation, education, counseling, in-patient treatment, and crisis intervention.

Initiation of the project, in the form of part-time psychiatric counseling and evaluation, allowed gradual growth in terms of staff, geographic area, clients and services. The efforts of the Executive Director and Board members to expand the financial base through affiliation agreements with the surrounding counties and the Federal staffing grant has allowed the Center to meet the original goals of providing community based mental health care and allowing adequate testing and screening to appropriately place citizens (especially juveniles) exhibiting maladaptive behavior.

BETHLEHEM AREA COMMUNITY EDUCATION PROJECT

INTRODUCTION

The Bethlehem Area Community Education Project was initiated in 1974 through the cooperative efforts of the City of Bethlehem, Northampton County, the Bethlehem Area School District, and the United Fund. The Project goals are:

- Maximum utilization of school and community facilities,
- Expanded educational interests (relevancy) for children,
- Equal educational opportunity for adults,
- Coordination of community resources,
- Community participation in decisionmaking.

This case study describes the transition from a traditional education elementary school program to a community education concept in order to achieve the above goals. Specifically, the case study outlines the participation in the planning and implementation processes, the rationale for the Project, the services delivered, the funding, and the success of the community education effort.

The factors are discussed in the following sections:

- Project Planning
- Implementation
  - Programs
  - Administration
  - Funding
- Community Participation
- Evaluation
- Project Changes
- Anticipated Changes
- Facilitators and Inhibitors
- Conclusion

PROJECT PLANNING

The inital impetus for the project was the realization by several providers that service duplication existed in Bethlehem. In 1974, representatives of the United Fund, the Director of the Department of Public Welfare, the Mayor of Bethlehem and the Superintendent of the

Bethlehem School District met to discuss mutual services and service needs. The group decided each agency dealt with problems which had similar causes. Yet, despite numerous services available in the community, many problems still existed. Therefore, the group looked to the service delivery system to identify areas of needed improvement. Overlapping services and fragmented services were identified as inhibitors to a comprehensive, effective social service system.

The group realized that the recreation, health and social services, and education programs provided by the city, county, United Fund agencies, and the school board has similar goals. For example, city and YMCA (United Fund) recreation programs had goals of maintaining self sufficiency and enabling a child to develop into a social and intellectual adult. Although they were funded by separate sources, the city, school board and the United Fund agencies often provided similar programs. For example, the schools had basketball teams, the Young Men's Christian Association (a United Fund Agency) provided supervised recreation, and the city Bureau of Recreation provided basketball facilities.

Despite this plethora of recreation programs, school facilities often went unused while YMCA programs lacked adequate facilities. In recognition of these problems and the opportunities existing in the community, the group decided to emphasize unifying programs and dealing with the total family or the total need rather than a piecemeal approach.

Discussions on coordinated service delivery were not new to the Bethlehem area. Previously, a Joint Study Committee was established to research the social service delivery system in the Bethlehem area. The Joint Committee was composed of representatives of the Bethlehem area, Forks of the Delaware, and Lehigh County United Funds, the Lehigh Valley Community Council and a team of consultants. The Committee analyzed budgets of social service agencies (particularly those in the United Fund), interviewed service providers and elected public officials, and reviewed reports on social services and coordination attempts.

The Joint Study Committee Report concluded that there was a great deal of duplication in services and recommended numerous coordination or consolidation actions including:

- Adoption of a uniform classification system for budgeting for all United Fund agencies,
- County-wide programming for recreation programs,
- Sharing of expensive equipment, and
- Joint YMCA and YWCA facilities.

The Human Services Committee reviewed the Joint Committee Report and agreed with many of the findings and recommendations. For example, the recognition of duplication of recreation programs led to the proposal for placing three city recreation counselors in the Neighborhod Centers to coordinate recreation activities of the City and United Fund agencies.

The Director of the Department of Public Welfare suggested the 1970 Social and Rehabilitation Service Act as a potential funding source to improve Bethlehem's social service delivery system. The school district volunteered an in-kind match if the Department of Public Welfare would provide start-up funds.

Following the identification of the potential SRS funding, the group formed a Human Services Committee under the guidance of the Lehigh Valley Community Council. The Committee consisted of two school board members, two City Council members, two representatives from the United Fund Board, two community residents, and the Chief Clerk of the County Board of Commissioners.

The city, school board, and United Fund each delegated a staff member to research the potential Federal funding sources, prepare a grant application, and assist in developing a concept for the improvement of the service delivery system.

Following numerous meetings, the Human Services Committee and staff began formulating a "community education" concept. As defined in a project brochure, community education "is a concept which supplies a wide range of activities and services to meet the needs of the people within the community by using existing school buildings as Neighborhood Centers."

The Human Services Committee and several other community residents visited the Flint (Michigan) Community School System to view an established community school, to encounter the concept in action, and to ascertain the applicability of the concept to the Bethlehem area. Committee members interviewed numerous educators and community people instrumental in establishing the Flint Project and learned from them the basic details concerning the establishment and successful operation of a community school.

Following the trip to Flint, approximately 30 community meetings were held in Bethlehem to ascertain community receptivity to the project. The problems of duplication and fragmentation were discussed and the community education concept was proposed by the Committee.

In addition to the community meetings, a general population survey was conducted to assess community views on community education and to determine high priority goals or needs. The type of information collected is illustrated in an excerpt of the questionnaire presented in Exhibit 13 below.

Results of the questionnaire indicated high community interest in the community education concept and willingness to participate in the project. Adult respondents were especially enthusiastic about the educational extension courses (e.g., woodworking, wills and estates, yoga).

EXHIBIT 13

COMMUNITY EDUCATION QUESTIONNAIRE

DIRECTIONS FOR COMPLETING QUESTIONNAIRE

Indicate how you feel about each possible Community School Activity or Program listed below by circling the number which best describes how you feel about this activity or program.

The numbers are defined according to the following scale:

1. Regardless of cost, activity *definitely should not* be done.
2. Regardless of cost, activity *probably should not* be done.
3. If there is no cost to the taxpayer, activity *probably should* be done.
4. If there is no cost to the taxpayer, activity *definitely should* be done.
5. Even if it requires additional cost to the taxpayer, activity *probably should* be done.
6. Even if it requires additional cost to the taxpayer, activity *definitely should* be done.

1. Assist residents in securing needed services (such as transportation or housing) from the appropriate agency.	1	2	3	4	5	6
2. Establish public schools as centers for learning for all.	1	2	3	4	5	6
3. Provide organized physical, recreational activities for the community.	1	2	3	4	5	6
4. Provide adults the opportunity to complete their formal high school education.	1	2	3	4	5	6
5. Offer leadership training programs for lay and professional persons.	1	2	3	4	5	6

As a result of the tabulations indicating the activity should be initiated, the Committee began finalizing proposed courses, activities, and services for incorporation in the community education project.

The Committee visited the State capital in Harrisburg to discuss the proposed project with the State Secretary of Education, Secretary of Community Affairs, and Secretary of Public Welfare. The three department heads were enthusiastic about the community education concept and the fact that the local group could coordinate to effect such a project.

A liaison from each of the three state departments was designated to assist the Committee in securing financial resources and to keep the Secretaries informed on the projects.

The Committee also visited the Region III Department of Health, Education and Welfare Office in Philadelphia. Although HEW officials expressed keen interest in the project, the Committee was informed that SRS regulations had changed, thus limiting the possibility of funds. Nevertheless, the Committee persisted in developing a basic proposal of instituting a community education project in Bethlehem.

A coalition of funding sources including ESEA Title I and Title III, school board, city and county funds was compiled to establish the Community Education Project in four sites . . . three junior high schools and one elementary school.

IMPLEMENTATION

The Community Education Project, which was initiated in 1974 in four public schools, envisioned the following categories of services:

- Education,
- Recreation,
- Social and health services.

A total of 15 agencies are involved in the Community Education Project and provide the following types of programs and services:

- Basic Education
- Languages
- Reading Improvement
- High School Completion
- Consumer Education
- Home Arts
- Music and Dance
- Health Programs and Services
- Employment and Vocational Services
- Hobby Activities
- Public Forum
- Social Gatherings
- Youth Activities
- Senior Citizen Activities
- Field Trips
- Counseling Services
- Graduate Equivalency Diploma
- Comprehensive Sports and Physical Fitness Programs

The four schools, three junior high schools and one elementary school, were chosen on a geographic basis. The schools were designated Neighborhood Centers and were to provide a focal point for the four "neighborhods" (quadrants of the Bethlehem area).

PILOT PROGRAM The Bethlehem Area Community Education Program began on a limited scale during the summer of 1974 at two junior high schools. A wide variety of classes were offered in the areas of recreation, leisure time, and educational enrichment. All age groups, pre-school through adult, were invited to participate in 29 programs ranging from Open Gym and Pottery to Financial Management for the Family, Home Repair and the Science of Creative Intelligence. In addition, an Elderly Nutrition Program was provided through utilization of two school cafeterias.

The success of the summer program is illustrated by the high enrollment (over 400) in courses requiring registration and additional untabulated utilization of the schools. For example, one school reported a "head count" exceeding 13,000 during the summer session.

PROGRAMS

Following the high utilization of the two pilot schools, the Community Education Project was fully instituted in the fall in the two additional previously designated sites. A total of 139 courses were offered during an eight-week session (approximately 50 percent were implemented) and approximately 2,000 people enrolled in the courses.

The following list illustrates some of the courses offered to all age groups in Bethlehem:

SHORTHAND II
For those with more experience. Brush up on shorthand skills. Free use of text.
Nitschmann: Thurs. 7:00–9:00—Fee $8—10 weeks

SIGN LANGUAGE
Communicate effectively with friends and relatives who may be deaf.
Expert instruction in the basic skills of silent communication.
Nitschmann: Wed. 7:00–9:00—Fee $16—16 weeks

SINGLE PARENT SURVIVAL
A four week course for those single parents interested in an indepth discussion about problems and successes. Taught by family counseling staff.
Donegan: Tues. 7:00–8:30—Fee$4—4 weeks
Northeast: Mon. 7:00–8:30—Fee $4—4 weeks

SINGLE SURVIVAL (BEAT FOOD COSTS)
For men and women (especially college bound). Survive on more for less. Be your own cook.
Nitschmann: Thurs. 7:00–9:00—No Fee—8 weeks

Existing educational programs were integrated into the Community Education Program. For example, Adult Basic Education, General Education Development, English as a Second Language, and the Standard Evening School Programs were coordinated by the Community School Coordinator (and directors in each center).

Courses are taught by professional educators and residents with expertise or certification in a subject area (e.g., auto mechanics). Approximately 15 to 20 percent of the courses are taught by professional teachers and approximately 80 to 85 percent by community residents.

HEALTH AND SOCIAL SERVICES COMPONENT. In addition to enrichment courses, the Community Education Program offers health screening and diagnostic assessment, home and family living instruction, direct and in-kind health and social services. The in-kind services are offered through the regular day school program. Direct services are provided by four Information and Referral Specialists, four Elderly-Service workers, a Child Development Specialist, and four Outreach Workers. Direct Services include information and referral, counseling and guidance, community outreach, job placement, and nutrition services.

The information and referral program was developed to improve the delivery of health and social services and to ease citizen access to health and social services. The I&R program consisted of the following four phases:

- Phase 1—Preliminary assessment. Included establishing the lines of communication between case worker and client, establishing credibility, and assessing the client's need(s).
- Phase 2—Problem/resource identification. Included determining the cause of the client's identified needs and identifying appropriate resources.

- Phase 3—Referral. Included making necessary arrangements with client so he can avail himself of identified resource(s).
- Phase 4—Follow-up. Included contacting the client to determine if the identified need has been met.

Elderly Service Workers provide counseling and referral services related to health, housing and financial needs of the elderly.

The director of the Parent Information Center is responsible for the delivery of information and guidance to parents regarding their child's behavior, emotional growth and normal child development.

The Outreach Workers assist community residents and service agencies to identify community needs and resources. They also assist the Community School Director and other staff members to plan needed programs and activities.

The Lehigh Valley Manpower Program and Department of Vocational Education also provide support staff including a Job Placement Coordinator to provide recruitment, placement and training services and two Home Economists who teach classes as part of the education component.

The social service staff assigned to family counseling provided services to more than 1,000 community residents between July 1, 1974, and December 31, 1974. The Outreach workers averaged nearly sixty community contacts weekly.

An additional site was added to the original two sites for the Elderly Nutrition Program. Hot lunch meals are served for 200 to 300 senior citizens daily.

Existing health services (e.g., School Nurses and Visiting Nurses) are utilized for a community outreach program to encourage community use of existing resources, to initiate referrals to the Neighborhood Centers, and to provide supportive counseling services.

RECREATION COMPONENT Through the City of Bethlehem's Bureau of Recreation, three Recreation Supervisors set up a wide range of recreation programs for all age groups. Yoga, ballet, and dance courses are offered. A Dominoes Club meets regularly and conducts tournaments. Basketball, baseball and other team sports are organized using the school gyms. Senior citizen activities are offered. The recreation program offers the opportunity to fully utilize expensive recreation/athletic equipment and space and, thus, strongly implements the goal of better utilization of community facilities.

ADMINISTRATION The Community Education program is administered by the Bethlehem area school district.

A Community Education Commission was established to coordinate the Project, and to recommend an annual program and budget plan, including staff and resource allocations among the project participants. The Commission is composed of two School Board members, two members of the City Council, two members of the United Fund Board, one representative from each of the four Community School Neighborhood Councils, and the County Commissioner's Chief Clerk.

The duties of the Commission, as outlined in the joint enabling resolution/ordinance, include:

- To determine the annual program and activities of the Community Education Program from the interests and requests of the participating Community School Neighborhood Councils and local staff in the districts.
- To prepare an annual operating budget and staffing plan on the basis of program requests that include recommendations for the allocation of expenses and resources among the city, school district, United Fund and others and patterns of donated and volunteer services related to the program.

- To present its budget and recommendations (e.g., interorganizational agreements and contracts) at appropriate times during the year for formal action by the funding and sponsoring organizations.
- To develop long-range plans for community education programs including the availability of new facilities, areas to be served and improvement of existing programs . . . (and to) review and evaluate the program as to its overall impact and its impact within each of the districts.
- To initiate and encourage the development of community school neighborhood councils within each of the districts.

The Commission makes a recommendation to the various funding sources for formal action. The Commission also makes recommendations about sub-contracts between agencies, sponsors, and the school districts.

Although an integral force in the Community Education Project, the Commission has no real power. Members, who are appointed by the city council, United Fund Board, school board, and County Commission, are liaisons rather than decisionmakers. The recommendations of the Commission must be voted on and approved by the above entities for action.

Each Neighborhood Center has a Neighborhood Council composed of residents of the area surrounding the center. The neighborhood representatives for each council are appointed by the applicable Community School Director. One member from each council is appointed to also sit on the Community Education Commission. The duties of the Neighborhood Council, as outlined in the resolution creating the Community Education Commission, are:

- The (annual) formulation of program interests, needs and recommendations for the operation of the Community School.
- On-going review of programs and activities in the District to ensure that these services fulfill the intent of the program and needs and interests of the community.
- Active seeking out of new needs and concerns at the local level and encouragement of full participation by residents in the programs available.
- Consideration of operation questions concerning the on-going performance of the program including consultation with staff and Commission on such issues as fees, memberships, scheduling and developing neighborhood volunteers."

A Coordinator of Community Education was hired by the School District's Division of Instruction to provide overall professional leadership and administration. He is responsible for coordination of planning, program development, resource allocation, and evaluation.

The Community Education Coordinator has a Ph.D. in Education and several years teaching and educational consulting experience.

At the upper decisionmaking levels, the Coordinator of Community Education works with the Commission in the formulation of policy and overall programs. He also provides coordination between the participating agencies by working with the Directors of the manpower, counseling, recreation and education programs in the implementation of sub-contractual agreements.

In each community center, a community school director is administratively responsible to the school principal. The Community School Director coordinates the various components of the project within his school and provides a link between the facility and the community school coordinator.

The community school director supervises an outreach worker, home economics instructor, and secretary.

Additional staff includes:

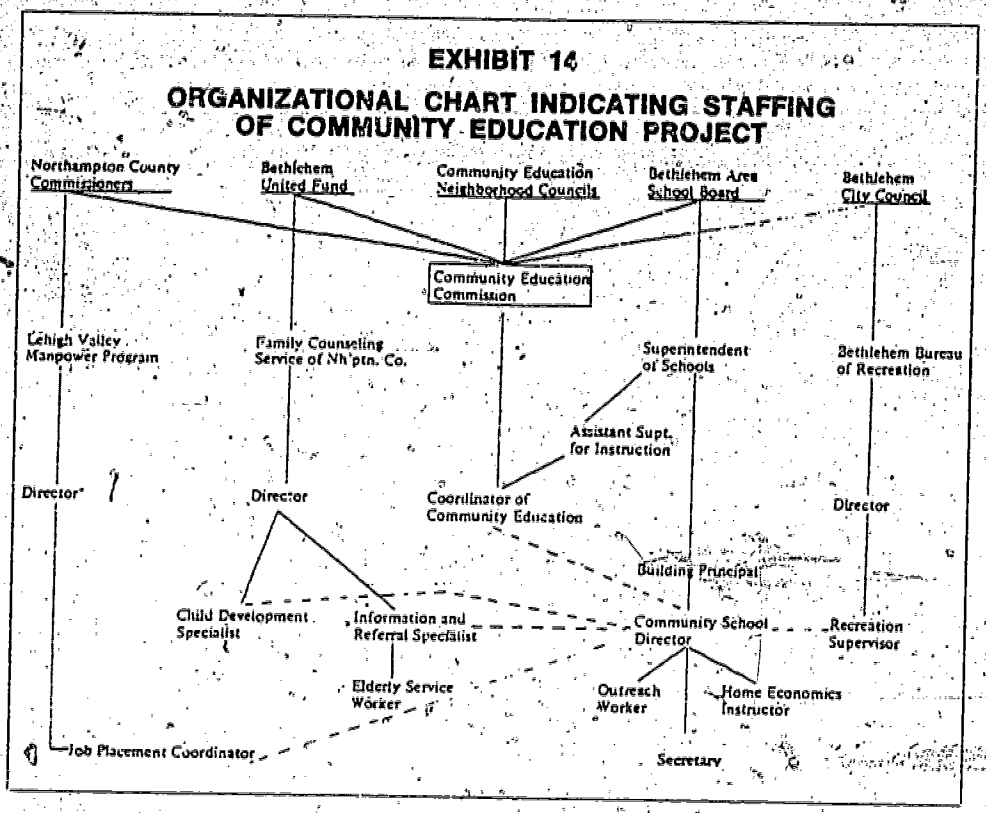
- One job placement coordinator (funded by and administratively responsible to the Lehigh Valley Manpower Program Director),
- One child development specialist (funded by and responsible to the United Fund),
- Four information and referral specialists (funded by and responsible to the United Fund),
- Four elderly service workers (funded by and responsible to the Director of the Family Counseling Service—United Fund),
- Three recreation supervisors (funded by and responsible to the Director of the Bethlehem Bureau of Recreation).

The economics instructors, child development specialists, and recreation supervisors share their time among the four facilities. The remaining personnel are allocated full time to each facility.

The Community Education Project organizational chart (Exhibit 14) illustrates the participating agencies, direct and coordinating lines of communication, and staff involved in the project.

EXHIBIT 14

ORGANIZATIONAL CHART INDICATING STAFFING OF COMMUNITY EDUCATION PROJECT



FUNDING

The Community Project budget is divided into two staffing components:

- Community education staff (coordinator (1), directors (4), outreach workers (4), secretary (4), and home economics instructors (2)).
- Program area staff (recreation supervisor, child development specialist (1), information and referral specialists (4), elderly service workers (4), job placement coordinator (1)).

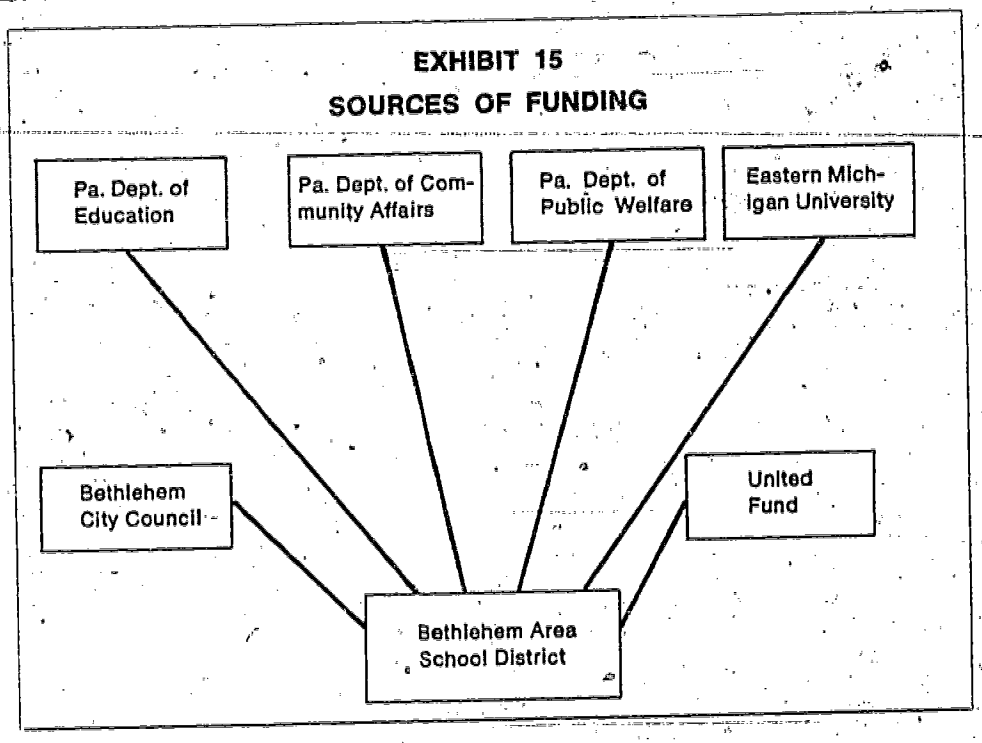
As the conduit for funds, the school district receives funds from the following sources:

- Pennsylvania Department of Education,
- Pennsylvania Department of Public Welfare,
- Pennsylvania Department of Community Affairs,
- United Fund,
- Eastern Michigan University,
- Bethlehem City Council, and
- Bethlehem Area School District.

Exhibit 15 illustrates the sources of community education funds:

EXHIBIT 15

SOURCES OF FUNDING



The Pennsylvania Department of Education allocates monies from two programs (Titles I and III of the Elementary and Secondary Education Act and Vocational Education).

The 1975 sources and amounts of community education funds and the fiscal year of each program are indicated in Exhibit 16.

Exhibit 17 illustrates the organizational structure of the educational component of each community school.

These individuals are financed through the sources listed in Exhibit 16.

The 1976–77 Community Education budget including project coordination personnel (coordinator, 3 directors, 3 secretaries, 2 bus drivers), travel, salaries for instructors and supplies totals $268,289. This amount does not include personnel on loan from United Fund, Manpower Program, Family Counseling, and Bureau of Recreation. The budget has been fairly constant since the inception of the program.

TRAINING

In response to the Commissions recommendations, the coordinator conducted several in-service training sessions to enhance staff and community effectiveness and to foster similar activities in each community center.

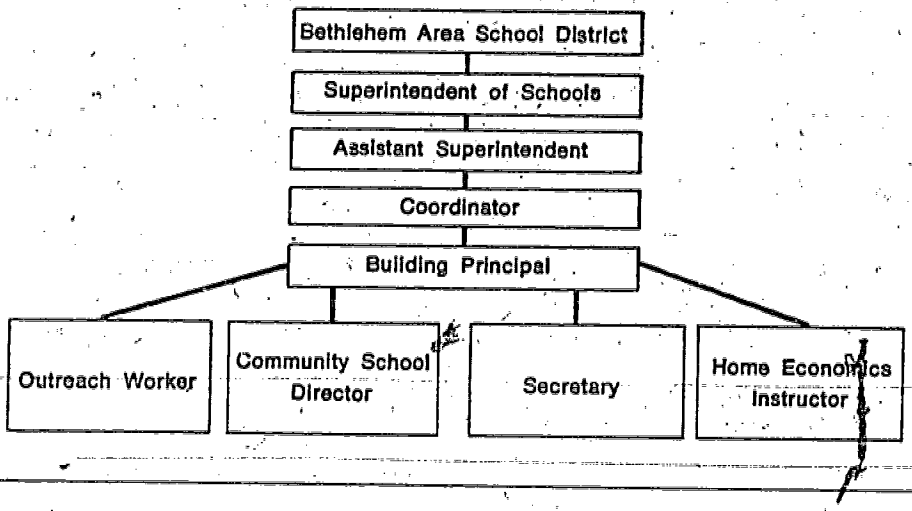
EXHIBIT 16

1975 BUDGET SOURCE, AMOUNT AND FISCAL YEAR

Source	Amount	Fiscal Year
Pennsylvania Department of Education		
• Title I, ESEA	$ 80,381	August–August
• Title III, ESEA	$ 9,000	September–September
• Vocational Education	$ 22,070	September–September
Pennsylvania Department of Public Welfare		
• Social and Rehabilitation Services Act and Older Americans Act	$177,375	February–February
United Fund	$ 17,308	January–January
Eastern Michigan University	$ 3,000	April–April
Bethlehem City Council	$ 55,835	June–June
Bethlehem School District	$167,472	July–July

EXHIBIT 17

STAFFING OF EDUCATIONAL COMPONENT



In addition to the community school directors and staff, representatives from the following community groups participated in the training sessions:

- National Association of Women,
- Solo Parents,
- American Association of University Women,
- Boys Clubs,
- YMCA,
- Senior Citizens Club,
- P.T.A.,
- Church Groups,

- School Board,
- City Council, and
- Business Groups.

Efforts were also made to include ethnic representation reflecting the neighborhoods (e.g., Blacks, Spanish Speaking, Hungarians).

Topics for discussion included:

- Neighborhood Councils' Relationship to Community Education Commission and Staff,
- Neighborhood Councils' Role in Program and Budget Development,
- Techniques of Identifying Neighborhood Needs, and
- Techniques for Establishing a Representative Neighborhood Council.

Discussions centered on alternative techniques or roles and staff recommendations.

COMMUNITY PARTICIPATION

The Community Education Project designed three channels for community participation:

- Through a broad range of educational programs and health and social services geared to the needs of the entire community,
- Through the neighborhood councils, and
- Through contact with the social services workers.

Contrary to traditional education which is geared toward the youth, the Community Education Project encompasses programs for the entire community. Special components of the project include the Elderly Nutrition Program which provides counseling and information and referral assistance to elderly persons. In addition, elderly residents are urged to take advantage of the other programs and services (e.g., educational courses). Other courses or services are directed toward youth (e.g., recreation), parents (consumer education, child development counseling) or multi-age groups (hobby activities, high school completion).

As discussed previously, the Neighborhood Council advises the Community School director on needs and desired programs and provides for dissemination of information back to the neighborhood.

The third channel for community involvement is through the social services workers who provide outreach services and act as liaisons between the school and neighborhood. The social services workers primarily work in the neighborhood, talking to residents, gathering suggestions for programs, and informing residents about the existing programs and services.

EVALUATION

Evaluation of the Community Education Program is a continuing process on several levels:

- University,
- Commission,
- Staff, and
- Community.

Bethlehem's Community Education Project is monitored by the Community Education Development Center of Eastern Michigan University. Lehigh University, which is in the City of Bethlehem, is also assisting in the evaluation of the Community Education Project by collecting baseline data.

EXHIBIT 18

RESULTS OF COMMUNITY EDUCATION COMMISSION EVALUATION OF PROJECT

	Expectations	Strengths	Weaknesses	Recommendations
Community	The Community Education Project should:	Involvement of the community,		Greater involvement of Commission in Project
	Create a sense of community or belonging, through establishment of community centers,	Efforts to reach low income residents,		
		Establishing communication among 17 different ethnic groups (as exhibited in the "International Night"),		
Programs and Services	Decentralize services,	Establishing flexible services and classes which change according to community needs/desires,	Administrative paperwork required of coordinator,	Additional summer programs.
	Coordinate and integrate community resources, specifically health and social services, and	"Integration" between school board, City Council and United Fund board,	Confusion in areas of budget and administration,	Establish measurable objectives,
		Assessment of community needs and resulting program,	Some duplication of effort between Community Education Project and other, non-participating agencies,	Additional financial resources,
				Establishment of juvenile delinquency program,
	Allow high utilization of facilities especially school buildings.	High attendance levels.		
Miscellaneous			Conflict between traditional teachers and community education teachers over method of payment.	Additional in-service training.
			Insufficient amount of in-service training for staff,	
			Confusion of job responsibilities.	

To evaluate the first year of the Community Education Project, the Coordinator interviewed the Community Education Commission members as to expectations, perceptions of the program's strengths and weaknesses and recommendations for improvement.

A synopsis of the interview results is illustrated in Exhibit 18.

Through joint center staff meetings, the Coordinator reviews program and facility utilization figures and discusses the effectiveness of the program in reaching the initial goals.

As part of the quarterly report for the Fall 1975 session, each center Director developed a set of objectives related to the five original goals. Tasks to achieve the goals were defined and progress to date in meeting the objectives was later described.

Through the outreach workers and the Neighborhood Councils, the community education directors are provided information on community assessment of the Project. In addition, resident utilization of services provides an indication of community response (e.g., if few people register for a course, it probably will be eliminated).

The Commission, staff, and community evaluation of the project results in program revisions.

PROJECT CHANGES

Due to the necessity of responding to community desires, programs in the educational component are constantly changing. The basic mixture of supplemental educational courses (e.g., G.E.D. classes, language courses, etc.), public interest courses (e.g., investment market), and hobby courses (e.g., pottery), remains fairly constant. A summer recreation program was added due to high community interest.

Due to a low utilization factor, the Child Development Specialist Program is no longer offered.

Coordination and budgetary problems resulted in the elimination of one of the neighborhood center sites (and subsequent reduction in staff). However, project staff feel the remaining three sites will adequately accommodate the residents of Bethlehem.

ANTICIPATED CHANGES

In recognition of the legal implementation problems associated with the Community Education Commission, the structure will probably be revised. It has been recommended that the Commission become an advisory committee to the school board, thereby allowing the project participants to recommend policies to the agency with fiscal control of the project.

FACILITATORS AND INHIBITORS

FACILITATORS. The major impetus to the expansion of traditional educational facilities to encompass the community education concept was the commitment of the individuals involved, especially the Superintendent of Schools. In addition, previous coordination efforts provided a precedent. The Commission members viewed the existing social service delivery system as inadequate and ineffective and implemented some of the recommendations of the previously discussed report by the Bethlehem, Forks of the Delaware, and Lehigh County United Funds and the Lehigh Valley Community Council.

Another factor which facilitated the initiation of the project was public receptivity. Initial favorable reaction to the concept and high utilization of programs assisted in the successful implementation and continuation of the Community Education Project.

Use of existing school facilities enabled the project implementors to initiate the Community Education Project without costly construction expenses. The budget can remain fairly low because new equipment (e.g., machine shop tools and home economics kitchens) is not necessary. Use of the school cafeterias for the elderly hot lunch does not interrupt the regular day school activities and allows greater utilization of space and equipment. In addition, use of school buses to transport the elderly to the neighborhood centers maximizes use of the buses.

INHIBITORS Inhibitors to smooth implementation of the community education concept include:

- Number of sites,
- Multitude of funding sources (seven) and fiscal years (five),
- Administrative structure,
- Commission's lack of power,
- Absence of computerization of client information, and
- Fear of loosing "turf."

The Community Education Coordinator thought the establishment of four sites was unwieldy in terms of staff required, number of services and programs to be offered in each facility, and overall coordination.

The reliance on seven discrete funding sources poses budgeting and auditing problems; in addition, the funding sources follow five different fiscal cycles, thus compounding budgeting problems.

The organizational structure whereby the social services staff is responsible to the parent organizations creates administration and coordination problems. For example, the job placement coordinator is funded by and administratively responsible to the Lehigh Valley Manpower Program, not the community school director or coordinator. Without a direct line of administration (except through the support (office) staff and the Home Economics staff members), the community school director has virtually no real power. In addition, he is directly supervised by the school principal rather than the community education coordinator.

Although the members of the Commission were the initiating force behind the Community School Project, they are an appointed board without legislative, budgetary, or other powers. They can make recommendations to the separate organizations which must act in concert. Other than the voluntary conduit of funds through the Board of Education, no legal administrative power exists.

The United Fund agencies in the *Joint Study Group Report* acknowledged the need for joint data processing of client information to enhance coordination of service delivery. The Community Education Coordinator echoed the need for a computerized system of maintaining information on clients, program levels, budgeting information, etc. However, the current (and anticipated) budget is not adequate for such expenditures. Therefore, client information and other data collected by each neighborhood center is fragmented and not easily retrievable.

Despite the overwhelming enthusiasm of the Community Education Commission (formerly the Human Services Committee) in developing the Community Education Project, many individual agencies or departments were reluctant to participate. Several agency heads feared they would lose their identity and individual administrative powers. Through the persuasion of the Commission members, the community education coordinator and directors, and through the documented success of the project, agency and department head reluctance has dissipated.

CONCLUSION

Through the realization of the commonality of problems in the community and services offered by numerous agencies, the school board, United Fund, Northampton County, and City of Bethlehem have successfully instituted a means of joint service delivery. The Community Education Project has resulted in greater and more efficient utilization of existing facilities in the following ways:

- Renewed community interest in schools and the community,
- Community participation in developing programs and courses,
- Increased communication between the schools and community residents (through the outreach workers),
- Central information and referral for a wide variety of community programs,
- Designation of a neighborhood center which serves as a focal point for the neighborhood,
- Coordination of some programs and services (e.g., elderly service worker can help an elderly person find decent housing, provide hot meals, and interest elderly persons in therapeutic recreation program.),
- An opportunity for whole family to participate in educational and recreation programs, and
- Maximized resources (e.g., instead of the city United Fund and other agencies each having an elderly service worker, one person can provide services to elderly).

FAMILY RECEPTION CENTER

INTRODUCTION

The Family Reception Center is a multi-service neighborhood facility established by the Sisters of the Good Shepherd. Through a variety of services, the facility attempts to divert troubled youth from the juvenile justice system and to prevent family breakdown.

The Center was a logical successor in the long-term involvement that the Sisters have had with the provision of services to juveniles in a community setting. It was designed to meet specifically identified needs (juvenile) and complementary programs have been developed to meet additionally identified needs.

This case study describes the evolution of these programs and their funding sources. It also analyzes the reasons for the expansion, specific factors which have facilitated the expansion, and what factors have inhibited the expansion or potential future expansion.

The study covers the following topics:

- Background to the development of the Family Reception Center;
- Initial development of the Family Reception Center;
- Expansion of the Family Reception Center programs;
- Summary of expansion philosophy and approach;
- Facilitators and inhibitors to expansion; and
- Conclusions.

These topics are discussed in detail below.

DEVELOPMENTAL BACKGROUND

The roots of the Family Reception Center go back to 1936 when the Sisters of the Good Shepherd responded to the need for a residence for neglected, rebellious runaway girls. Later, the mayor of New York invited the Sisters to open a detention center for delinquent teenage girls who were not eligible for child care. Thus, the Euphrasian Residence was founded in 19[illegible] by the Sisters of the Good Shepherd as an alternative to the Women's House of Detention, a State-run prison.

In 1968, the current Project Director of the Family Reception Center joined the staff of the Euphrasian Residence. She felt the scope of the Euphrasian Residence should change from a detention center because of the negative functions of detention programs which could be replaced by a more positive approach.

Juvenile courts had raised the eligibility age from 16 to 18, thereby giving the Sisters of the Good Shepherd the opportunity to leave detention services to public detention centers.

Thus, the Center's Project Director began working with the Bureau of Child Welfare to develop a crisis intervention-diagnostic center to replace the Euphrasian detention center. In 1969, a psychological-social-academic-medical evaluation program was instituted. The purpose of the program was to help a troubled child and her parents jointly reach a decision which would improve the home life. Following three weeks of extensive testing and counseling, most clients returned home. For those children needing an alternative to home, the clinical staff made recommendations to the clients and assisted them in finding a resource (e.g., group home, foster home, residential treatment). Approximately 360 girls per year were tested and counseled.

Through their experience with the clients, the staff recognized the need for additional services. The lack of foster and group homes in the neighborhood necessitated separating the child from the family thus eliminating the potential to solve parent-child problems.

In recognition of an open urban form of care, St. Helena's Residence was instituted. This center provided live-in care, psychological testing/counseling, and other services. Contact with the community and family was maintained because the center was neighborhood-based and family and friends were encouraged to visit the client.

On a suggestion of one departing client, who wanted to remain in contact with the residence, day-treatment services were instituted in 1970. Under Project Outreach, a day school, recreational and social support after school, and individual/group/family treatment services became part of the Sisters of the Good Shepherd's program.

In recognition of the necessity of working with the total family rather than providing piecemeal services to children, in 1971 the Sisters of the Good Shepherd began planning a neighborhood-based Family Reception Center.

Prior to 1971, various funding sources provided operational funds for the programs instituted by the Sisters of the Good Shepherd. St. Helena's and the Euphrasian Residence were funded through the City of New York's foster care program. The city provided 12.5 percent to match State funds (12.5%) and Federal funds (75%). The Sisters of the Good Shepherd contracted with the City to provide foster care. This contract is renewed yearly without additional applications. This funding source was characterized by the Project Director of the Center as "stable, open-ended, and secure."

The day treatment services were funded by a Federal program (Project Outreach) through the Law Enforcement Assistance Act (LEAA) as a demonstration project. Following the two year allocation, the project was continued through Title IV-A funding.

INITIAL DEVELOPMENT

In 1972, a three-year LEAA demonstration grant was secured to provide court diversion at the community level, through the Family Reception Center.

The basic concept of the Center was to render support to people in their community. In many cases, residents should not have to resort to the police for family problems; clients should not go across town to receive some social services; teenagers without a home should not have to be committed to an institution outside the community. Therefore, the community and family were the focal points of the program design.

The five goals of the program were to:

- Initiate overall community support for the total family;
- Offer intervention at the earliest, most appropriate time;
- Provide open access to socialization for families;
- Provide services without labeling individuals; and
- Maximize community resources by sharing and augmenting social services.

Following design of the program, the Sisters of the Good Shepherd began looking for a service area. Meetings with judges of the Family Court of Brooklyn, legislative leaders, clergy, and representatives of community groups resulted in the selection of the Park Slope Community. This area, composed of 120,000 residents (including 43,000 children and juveniles), was chosen because there were few social and health services and the juvenile delinquency rate had risen more rapidly than in the adjacent areas of Brooklyn.

Two graduate students under the direction of a community organizer from the Gould Foundation surveyed the area to assess the reaction of residents and business people to the establishment of the Family Reception Center. Following a very favorable reaction by the residents and business people, the Sisters of the Good Shepherd, in conjunction with the Gould Foundation, found an abandoned house which could serve as the Family Reception Center. The Gould Foundation purchased, renovated and rented the building to the Sisters of the Good Shepherd.

The Family Reception Center and the other three Park Slope facilities is governed by an interdisciplinary Community Advisory Board composed of area residents, lawyers, an anthropologist, businessmen, social workers, and other professionals. The Community Advisory Board is divided into two sub-sections: Overall Facilities (e.g., Barbara B. Blum Group Home, Family Reception Center) and Community Programs. The Community Programs Advisory Board was designed to include ⅓ parents, ⅓ youth and ⅓ professionals.

In addition to the Community Advisory Board, the Sisters of the Good Shepherd have a legal governing board for the entire agency. An Advisory Board also exists for the facilities located in Manhattan (Euphrasian Residence, Marian Hall, St. Helena's Residence and Project Outreach).

An Advisory Board for Training Programs, composed of city and State manpower professionals and officials, is consulted in the development of workshops and monitors the impact of some programs. The relationship of the advisory boards to the programs operated by the Sisters of the Good Shepherd, is illustrated in Exhibit 19.

Services were initiated in 1972 at the Family Reception Center to achieve the above goals.

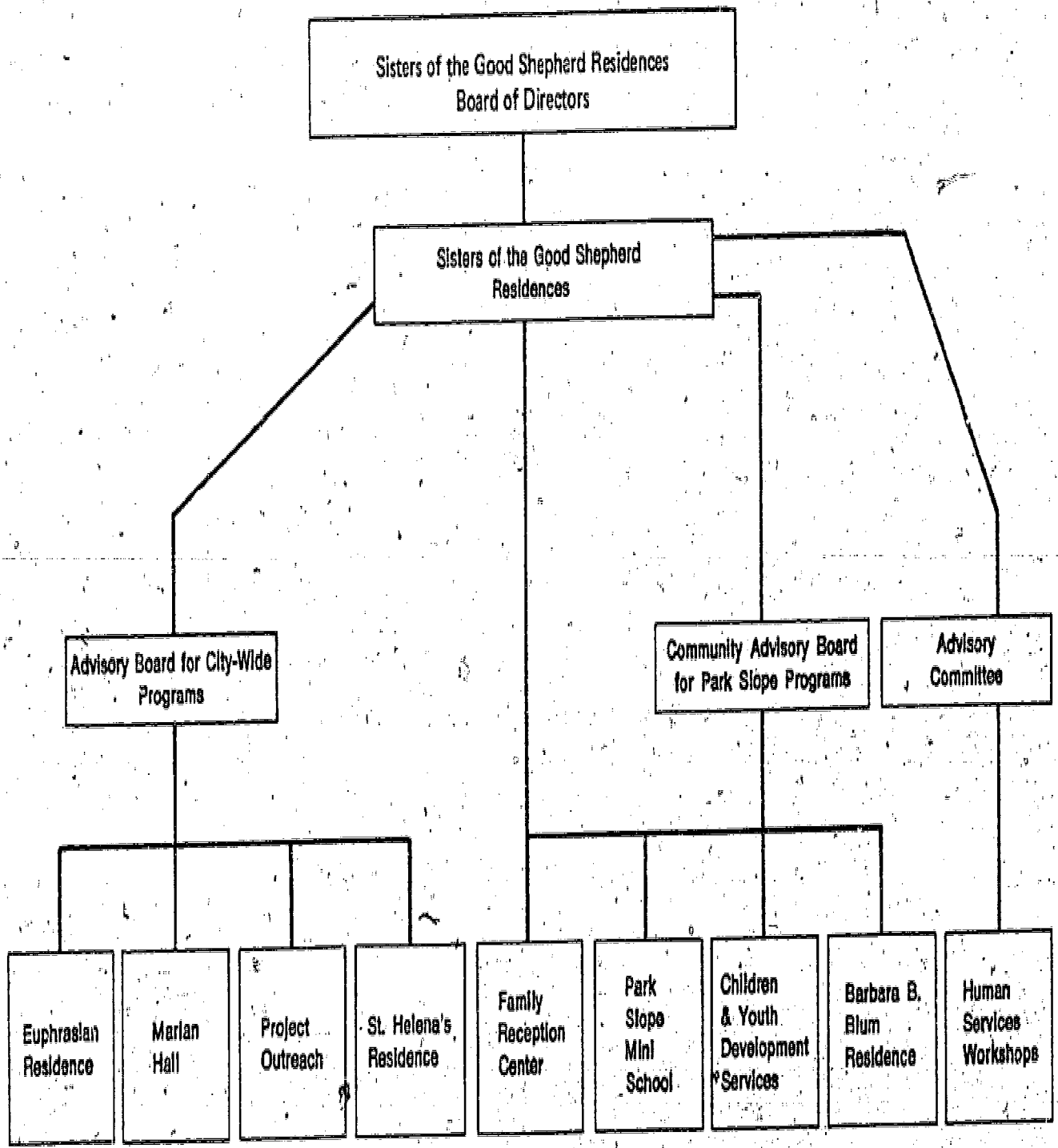
The services included the following:

- Crisis-oriented and continuing counseling for individuals, families, and groups;
- Family life education;
- Peer group therapy;
- Legal advocacy;
- "Crash pad" (dormitory brief residential care);
- Socialization;
- Referral for other social, medical, vocational and religious services; and
- Psychological/psychiatric testing.

Many referral services augment the other services provided by the Center. For example, a child with learning disabilities who is being counseled for antisocial behavior is assisted in finding appropriate educational support. In addition, an educational advocate works with the public educational system to coordinate services provided by the Center and the public schools. In essence, the Family Reception Center immediately became a community focal point for services to juveniles. The success of the program quickly led to the identification of additional unmet needs and the development of spin-off services and funding to meet those needs. Thus, the expansion was immediate.

EXHIBIT 19

ADVISORY BOARD FOR SISTERS OF THE GOOD SHEPHERD FACILITIES



EXPANSION OF SERVICES

Complementary programs grew out of the needs identified while working with the residents of the Family Reception Center.

These programs which were incrementally developed, funded, and implemented over the next several years, included:

- Mini School;
- Children and Youth Development Services; and
- Barbara B. Blum Residence.

These programs are logical extensions of the initial Sisters of the Good Shepherd activity which was to provide community oriented services to juveniles. They are also direct spin-offs of the Family Reception Center program. In addition to these programs, additional services and activities were incorporated in the Family Reception Center program as a result of needs identified by staff and residents.

Another program initiated by the Sisters of the Good Shepherd is a series of "Human Services Workshops." Although not located in Park Slope, this program indicates the continuing interest of the Sisters in the application of community resources to needs. The evolution of programs and funding is illustrated in Exhibit 20. The specific programs are discussed below.

EXHIBIT 20

MILESTONE EVENTS
EVOLUTION OF FAMILY RECEPTION PROGRAM
(1947–1976)

Year	Event of New Program	Funding Sources
1947	Euphrasian Residence	New York City-New York State-Federal foster care
1969	Reorientation of Euphrasian Residence into a Crisis Intervention—diagnostic Center with a Psychological—Social—Academic—Medical evaluation program.	Same as above; Also Title IV-A Funds
1969	St. Helena's Residence	Same as above
1970	Project Outreach	LEAA Project Outreach Grant for two years; Currently Title XX
1972	Marion Hall	City, State, Federal
1972	Family Reception Center	LEAA Grant for 3 years; currently city-State funding
1973	Mini-School	Board of Education staff; New York Community Trust Grant
1973	Children and Youth Development Services	OYD Grant for two years; Continued with LEAA funding
1974	Barbara B. Blum Residence	City, State, Federal
1976	Human Service Workshops	Local financial institution

MINI SCHOOL PROGRAM (1973)

When the Sisters of the Good Shepherd acquired the site for the Family Reception Center, several "squatters" were discovered. The children were illiterate school dropouts. The staff of the Center recommended the establishment of an alternative educational facility for these and other community children. The Park Slope Mini School was founded for neighborhood children 10 to 14 years of age "who have not learned in other schools because of their special educational, social and emotional needs and the lack of individualized resources in the traditional school system to meet those needs."

The goals of the Mini School are:

- To instill in children a desire to learn through a school community which creates in them a sense of belonging;
- To develop an educational program which will maximize each student's potential; and
- To help redirect children whose behavior has been maladaptive and self-defeating.

The Mini School originally served 21 students in a facility several blocks from the Family Reception Center. Through a cooperative effort with the New York Board of Education, the Mini School offers instruction, casework, and group and family counseling. The Board of Education supplies one teacher per seven students and the Center supplies two child care specialists. Funding for one child care specialist is provided by a New York Community Trust grant. As the popularity of the Mini School grew, the program was expanded to include 84 students and some classes were established within the public school.

The teachers and social workers are assisted by interns from local colleges and other volunteers. The Family Reception Center provides social work services to the children and families of the Mini School.

CHILDREN AND YOUTH DEVELOPMENT SERVICES (1973)

In March, 1973, the Center was notified of a delinquency prevention grant that could be obtained through HEW's Office of Youth Development. The Director of the Center prepared a grant to coordinate civic, professional and service groups on Park Slope along with block associations, schools, churches and other community resources to increase opportunities for youth. The grant provided funds for seven to eight social service staff for the Children and Youth Development Services (CYDS) operated in a house adjacent to the Family Reception Center. The funding was $150,000 for the first year and $125,000 for the second year. The rationale behind the CYDS was to foster cooperation to share social service resources and to spur "larger societal and city systems to be a responsive presence" to the people of Park Slope

The CYDS grew out of numerous talks concerning children with block associations, store owners, churches, schools and social clubs (YMCA, Lions Club).

The CYDS directly provides job development and placement, career counseling, communications, and media projects. In addition, crisis-intervention is offered at two police precincts. In addition, the CYDS provides a network of youth services such as basic and remedial education, casework counseling, psychological testing, drug rehabilitation program, and summer recreation programs sponsored by other agencies in the community.

Although CYDS does not have legal or fiscal control over the other groups or agencies, they have instituted this network through:

- Allocating part of the OYD grant to a church group which instituted tutoring and recreation services;

- Developing neighborhood task forces for recreation, education, and youth employment;
- Holding community meetings to share information (e.g., activities offered by a youth agency) to recruit additional financial or service resources, and to foster joint utilization of facilities;
- Offering consultation to community groups to enable them to expand their resources; and
- Compiling a "Human Services Directory of Park Slope, Brooklyn."

The directory is a good example of the attempt to maximize resources through sharing of information. The directory lists the address, telephone number, service, and contact person for adult education centers, cultural institutions and groups, community action organizations, day care centers, health services and other community services.

The CYDS is currently funded by an LEAA grant of approximately $144,000 which replaced the OYD two year demonstration grant.

BARBARA B. BLUM RESIDENCE (1974)

Another program that developed out of staff perceived needs was the Barbara B. Blum Residence, a group home for neighborhood children. With financial assistance from the Gould Foundation, the Sisters of the Good Shepherd bought the house adjacent to the Center and established the only group home in Park Slope. The top floor of the house provides room for the CYDS staff.

HUMAN SERVICES WORKSHOPS (1975)

Although not located in Park Slope, the most recent addition to the myriad of programs sponsored by the Sisters of the Good Shepherd is a series of Human Services Workshops "for renewal of knowledge and skills in the helping professions." The short courses are taught by experts in various professions. This program was initiated through a small grant from a local financial institution in recognition of the need for continuing education of social workers, counselors, etc., at the Center and other social service organizations in New York City.

ADDITIONAL ACTIVITIES AT THE CENTER

As a result of residents' and Center caseworkers' "brainstorming" the Committee for Cultural Development was organized. The committee was composed of a group of neighborhood residents who organized cultural, artistic and musical programs within the Center and through outings. A neighborhood mother developed a *dance workshop* for teenagers and young children at the Center. A *drama workshop* was initiated in the same manner.

In response to the cultural and ethnic mixture of Park Slope, a group of neighborhood residents held an "International Supper Night." Music, food and films helped the neighborhood residents share their differences for greater understanding and acceptance.

The need for cheap clothing and the necessity of financial resources for the children's outings promoted by the committee for Cultural Development resulted in the establishment of a *thrift shop* operated by and for the residents of Park Slope.

Through activities like the dance and drama workshops, thrift shop, and international supper night, the Family Reception Center provides the focus of community cohesiveness and maximizing community resources.

SUMMARY OF EXPANSION PHILOSOPHY AND APPROACH

The expansion of the original general counseling/testing service to include education services (Mini School and human service seminars), Children and Youth Development Services, Committee for Cultural Development, Thrift Store, and specialized counseling and workshop sessions (e.g., Spanish speaking seminar for parents, teenager human relations workshop) reflects the Director's approach of incremental growth. The Center started as a focal point for the community. As caseworkers provided basic counseling services, they developed rapport with the clients and the community as a whole. As additional needs were identified by clients or staff, new services were instituted. The Director thought that attacking problems should be done in small increments as part of a logical plan for increasing the scope of services in response to identified needs. As the credibility of the Center grew, and as additional resources were developed, new services and programs could be smoothly implemented. The incremental growth facilitated coordination of programs. Instead of having to accommodate ten new services at the same time, staff could gradually change format and techniques (e.g., develop group counseling sessions instead of numerous individual sessions) through the initiation of one service or program at a time.

Communication with the community is considered an important element of the project. The following factors enhance staff communication:

- The "drop-in" atmosphere of the Center which increases the number of clients, allows personal dialogue, and increases the rapport between staff and community residents;
- Casework meetings with public assistance staff of the welfare office to develop procedures to facilitate service eligibility and delivery to Family Reception Center clients;
- A "Community Developer" who is involved in developing linkages between the Center and other facilities under the direction of the Sisters of the Good Shepherd and other community agencies; and
- The CYDS task forces and other advisory groups which allow citizens (including youth) to participate in program development.

Internal Center communication is maintained through regular staff meetings on policy issues, program development, and special cases. In addition, the following factors assist in coordination of programs delivered by the Sisters of the Good Shepherd:

- The Assistant Director coordinates all services provided to families (records are maintained for each family or individual);
- Out-stationing of staff (e.g., staff from the Center teach family life education courses at the public schools and remedial reading at Mini School);
- The Director divides her time among the facilities and handles overall programming and budgeting for the facilities; and
- A staff member of the Center acts as Mini School coordinator.

The use of these coordination approaches reinforces the philosophical foundation of the project as a community-based organization.

The program is further characterized by a highly qualified staff. The majority of professional caseworker staff has an MSW degree and a few staff members have a masters in counseling. The Director has a doctorate in social work and has taken specialized counseling refresher courses. The caseworker staff is augmented by a part-time psychiatrist, two part-time psychologists, and support staff (clerical, cook, maintenance, etc.).

Exhibit 21, which indicates the job classifications and number of professional and child care staff in 1974, also reflects the current staffing pattern.

EXHIBIT 21

PROFESSIONAL AND CHILD CARE STAFF POSITIONS MARCH, 1974

	Full-Time	Part-Time
Project director		1
Program coordinator (assistant director)	1	
Casework supervisor/clinical coordinator	1	
Caseworkers	5	
Child care supervisor	1	
Child care workers	1	2
Night supervisors	1	1
Family workers	2	
Community resource coordinator	1	
Family life educator	1	
Recreation/group worker	1	
Educational advocate	1	
Court social worker		1
Psychiatrist		1
Psychologist		2
TOTAL	16	8

The success of the project to date can be attributed to a specific set of facilitators which spring from the above philosophy and operational approach. A few inhibitors to existing and future expansion can also be identified. These facilitators and inhibitors are discussed in the next section.

FACILITATORS AND INHIBITORS TO EXPANSION

FACILITATORS The major facilitators to the initial establishment of the Center and the incremental growth in services and programs were:

- Experience in social services;
- Community assessment and continuing involvement of community in planning new services;
- Staff enthusiasm and expertise;
- Overall guidance and thrust of director;
- Range of complementary services;
- Established boundaries;
- Foundation backing; and
- Board membership.

The history of providing social services through the Euphrasian Residence and St. Helena's Residences assisted the Sisters of the Good Shepherd, in general, and the Director, in particular, in establishing the Family Reception Center. The Director was familiar with the mechanics of obtaining funds from a variety of sources including HEW and LEAA, knowledgeable about counseling and testing techniques, and familiar with day-to-day operations of a social service agency. The Director's capability and track record enhanced her ability to obtain financial and community support.

The unstructured assessment of community attitudes assisted in site selection and generation of community support for the Center. In addition to initially involving the community through an assessment of community receptiveness, the Center constantly

relies on residents and agencies for identification of needs and development of new programs. Spin-offs resulting from the Center staff-community contact are:

- Development of a network of community agencies dealing with juvenile gang activities to prevent a gang war;
- Publication of a Park Slope Human Services Directory;
- Development of new programs (Thrift Shop) sponsored by the Center; and
- Greater sense of "community" despite the numerous differences among residents (e.g., International Night).

The Center staff exhibits a high degree of flexibility in responding to needs and developing new programs or refocusing existing services (e.g., expansion of general counseling to include counseling for latency-age children, parent-teen communication workshops and single parents' therapy group).

In addition, the informal atmosphere and accessibility of staff enhances the high utilization of the Center. The staff exhibits stability in the job which enhances support from the community residents and service agencies.

The Director (although part-time) instills enthusiasm and individual responsibility in the staff. Her knowledge of contact people at the city, State and Federal levels enables the Center and related programs to maintain funding.

The range of services provided by the Center and the adjacent programs (Children and Youth Development Services, Mini School and Barbara Blum Residence) allows a response to the wide range of problems exhibited by the clients. The interdependence of the therapeutic (e.g., counseling) and support (e.g., "crash pad") services results in coordination of a spectrum of services and reinforcement of services provided. For example, a socially maladaptive child bunking in the "crash pad" while his mother is in the hospital may be provided counseling services.

The closeness of the staff enhances sharing of case responsibilities especially in very difficult or multi-problem cases. In addition, since several staff members are familiar with each client, a client does not have to wait until one particular caseworker is available.

The program has community boundaries. This community or target area definition has allowed services to be geared toward an identified group of people in an identified community, Park Slope. The residents identify the area as a "community" and are willing to work to improve their community.

Strong financial backing of the Gould Foundation (e.g., bought and renovated site for Center) has greatly assisted the establishment and expansion of the Center. Without the financial assistance of this local foundation, many of the programs would not have been initiated.

Multi-talented board members act as instigators and enablers (e.g., one board member, an attorney with expertise in housing, assisted in locating, through a review of building records, a site for the relocation of Project Outreach).

INHIBITORS The major inhibitor to the continuation and expansion of programs is funding, specifically the necessity to look constantly for new resources to replace one- or two-year demonstration grants. The exception to this problem is the continuing foster care funding through the City of New York.

Another problem associated with the project was the necessity to limit dependency on other established programs or agencies. Although communication is extensively maintained with community agencies (e.g., local welfare office, public school system), many agencies do not want to lose their identity by being engulfed by the Family

Reception Center or the Child and Youth Development Services Program. Often other agency eligibility requirements restrict center clients from receiving services.

A final factor which tends to hinder service is the multitude of different reporting forms required by the several sources of funds. In addition, staff cited the constant revision in forms and required information as detracting from efficient service delivery.

CONCLUSIONS

The Family Reception Center exhibits a high degree of flexibility in program modification. The growth of the Center has been characterized by new programs (e.g., Children and Youth Development Services and the Mini School), additional services (e.g., summer program of recreational, cultural, and instructional activities), and specialization of services (e.g., single parents' therapy group instead of traditional individual counseling).

The major impact of the Center on the community and residents has been the coalescing of resources to meet constantly evolving needs. The attitude among the staff is, "If you don't have a needed service, find one. If it doesn't exist, find the resources to develop it."*

The commitment of the staff and residents has enabled the Center to reach and surpass its original goals of diverting youth from the juvenile justice system and preventing family breakdown. The Center has also been highly successful in acting as a catalyst for community coordination and facilitating access of center clients to other agencies.

* *A Commitment to People: Evaluation of the Family Reception Center*, (Research Center, Child Welfare League of America, September, 1974).

ATLANTA REHABILITATION CENTER

INTRODUCTION

The Atlanta Rehabilitation Center is a State operated facility for diagnosis (medical, psychological, psychiatric skills), education, and training of handicapped persons. Originally a pilot project funded in 1965 by Economic Opportunity Atlanta (EOA—a local OEO program), the Center (formerly titled the Atlanta Employment Evaluation and Service Center) served as a model for comprehensive rehabilitation centers.

The objectives of the center include:

- To provide services to vocationally handicapped clients in an effort to make them self-supporting, to have personal independence, and to be self-determining in their own future;
- To provide evaluation for full-time employment of persons who are physically, mentally, or emotionally handicapped, culturally or socially deprived;
- To provide a comprehensive and systematic method of determining the training and work potential, capacity, attitude, and motivating factors of economically needy persons sixteen years of age or older;
- To provide a program of services designed to help persons overcome obstacles to employment—including such services as remedial education, work adjustment, training, and others necessary to secure and hold employment; and
- To coordinate the various services provided by the Center with other social and restorative agencies.

This case study follows the progression from a pilot project diagnosis center to a comprehensive rehabilitation center through a discussion of each of the phases of development in terms of participants and staff, purposes, services, and funding.

This discussion is presented in the following sections:

- Initial Development;
- Transition to State Administration; and
- Facilitators and Inhibitors to Integration and Operation.

INITIAL DEVELOPMENT

In 1965, EOA responded to the need cited by numerous health and social service agencies for a diagnostic center. Previously, many agencies, such as the Department of Labor, Veterans Administration and Atlanta Urban League, provided limited diagnosis of client problems.

Following numerous meetings with service agencies, EOA applied for a demonstration grant to establish an employment evaluation center. The concept was considered to be unique by the Office of Economic Opportunity and subsequently a grant in excess of $1 million was awarded to EOA.

The EOA Board acted as the grantee. However, the original concept outline in the grant was local assumption of the project when the Federal demonstration grant ended. Therefore, the EOA Board contracted with the State to operate the facility. Since the Division of Vocational Rehabilitation, under the Department of Education, provided services to disabled clients, that Division was designated a delegate agency for administration of the EOA (OEO) funds.

EOA located an abandoned bowling alley (approximately 50,000 square feet) and renovated the facility. Unfortunately, the space did not easily lend itself to renovation for an evaluation center.

According to the contract between the State and EOA, staff was hired under the State Merit System and the facility was operated under State policies. EOA reimbursed the State for all costs—staff, operation, etc. The staff of 151 individuals consisted of an administrator (with no previous rehabilitation experience), counselors, caseworkers and psychologists.

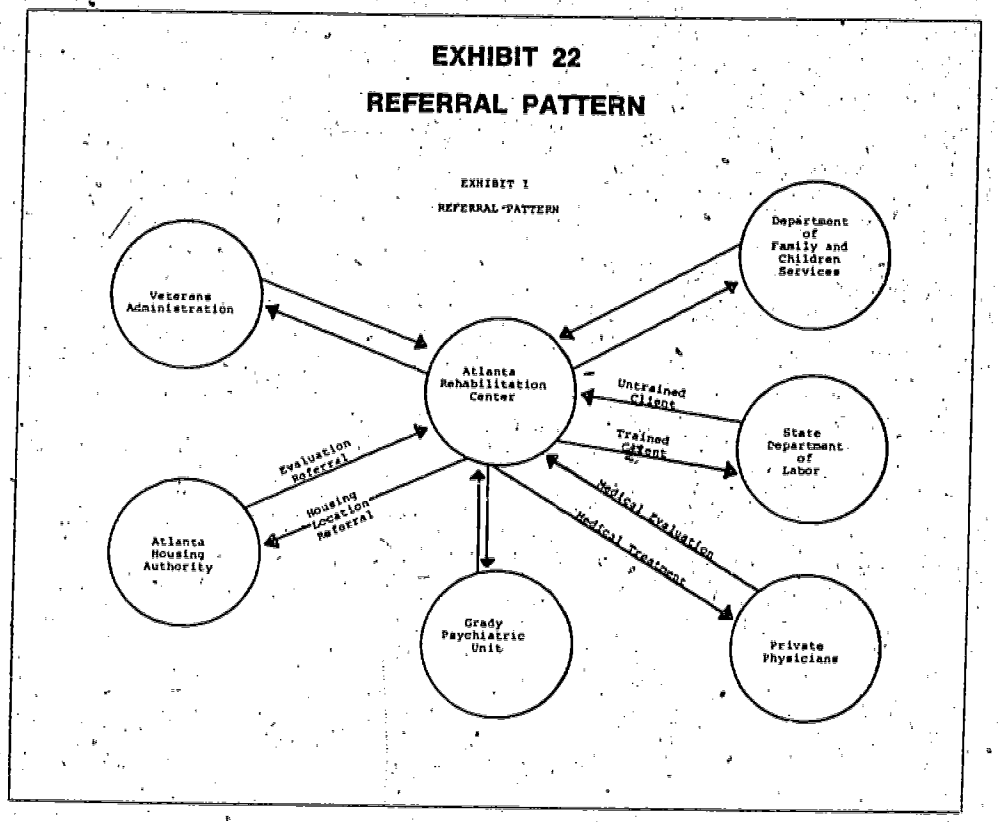
Only two counselors had authority to allocate funds and place clients on the caseload. Therefore, problems arose in certification and initial treatment of clients.

Clients were referred from the following agencies or individuals (as illustrated in Exhibit 22) which initially assisted in developing the concept of an evaluation center:

- Department of Family and Children Services (County);
- Department of Labor (State);

EXHIBIT 22

REFERRAL PATTERN



- Veterans Administration;
- Public Health Departments;
- Atlanta Urban League;
- Housing Authorities;
- Grady Hospital Psychiatric Unit; and
- Private Physicians.

The measurement of program success was the number of people "rehabilitated." Therefore, the counselors often activated only high-success potential cases and eliminated many eligible multi-problem cases.

In addition, a misleading newspaper advertisement was published indicating a multitude of services could be provided when, in actuality, the Center provided only evaluation and diagnostic services. This led to many ineligible persons seeking services which were not offered by the Center.

These operational problems hampered effective program implementation. However, during the initial three-year period the Center provided services which were valuable to clients and referral agencies.

The services primarily consisted of evaluation and testing. Clients were assessed in terms of physical and mental health and work aptitude. Any physical, emotional or mental hindrances to employment were noted on the client's record and this information was transferred to the referral agencies.

TRANSITION TO STATE ADMINISTRATION

In 1968, the OEO demonstration project funding ended and EOA urged the State to assume operation and financing.

The State Division of Vocational Rehabilitation was faced with a dilemma. If the State did not assume commitment to operating the facility, 151 Merit System personnel would be unemployed and the State's reputation as an innovator in vocational rehabilitation projects would be tarnished. In addition, the need for an evaluation center existed. Therefore, the Director of the Georgia Department of Education and a contingent of local people went to Washington to secure funding. The Federal Administrator for Rehabilitation in Washington became interested in the program and was instrumental in combining a series of Federal grants to continue operation of the Center.

Consequently, the State received the following Federal grants:

Research and Development	$ (est.) 750,000
Expansion Grant	250,000
Training Services	300,000
Total (est.) $	1,300,000

In addition, the State Legislatiure appropriated approximately $150,000 which was used as Federal match and which signified State assumption and responsibility for the facility. The director was replaced in 1969 and the staff was reduced to 97 persons.

The organizational structure was revised to allow six counselors to activate caseloads. This allowed faster eligibility determination, and allowed enough counselors to oversee the cases from in-take to discharge.

As the counselors became more involved with their clients, it became apparent that providing evaluation services did not totally assist the client in becoming self-supporting. Therefore, the staff began developing job opportunities through contacts with the Department of Labor and private industry.

The staff also contacted various groups (e.g., county welfare caseworkers, drug groups, community mental health organizations, Urban League) to explain the services available and to determine additional services needed and referral resources available to the Center staff.

As a result of the growth of the program, staff became aware of the necessity for coordinating with other agencies. Therefore, "working" or verbal agreements were arranged with the following agencies to donate staff to the Center:

- Grady Hospital — Physician (Part-Time)
- Community Mental Health Center — Psychiatric Counselor (Part-Time)
- Atlanta Adult Education Department — 3 Basic Education Teachers (Atlanta Center pays salary of one teacher)
- Atlanta Area Technical School — Instructor
- Department of Labor — Full-Time Counselor

Through these cooperative agreements the Center has been able to expand its services to include:

- General Education Development (GED) courses;
- Job Placement (full-time rather than Center staff part-time);
- Increased Medical Evaluation; and
- Sheltered workshop (subcontract with private industry).

As the Center's services expanded, it was reorganized into the following program departments or units:

- Counseling Department;
  - Job Bank;
- Casework Department;
- Job Readiness Area;
- Medical Unit;
- Psychological/Psychiatric Counseling Unit;
- Work Adjustment;
- Vocational Evaluation Unit;
- Personnel and Training Department;
  - Special Education Section; and
  - Sheltered Workshop (Training Section).

The functions of these departments or units are described below, and Exhibit 23 illustrates a typical client flow through the system.

The Center contains several operational units or sections which enable the client to progress logically through the evaluation and training system.

CASEWORK DEPARTMENT Clients referred to the Atlanta Rehabilitation Center are assigned a caseworker who interviews the client to assess needs and employment desires. The Intake Section records pertinent client data such as age, address and work history.

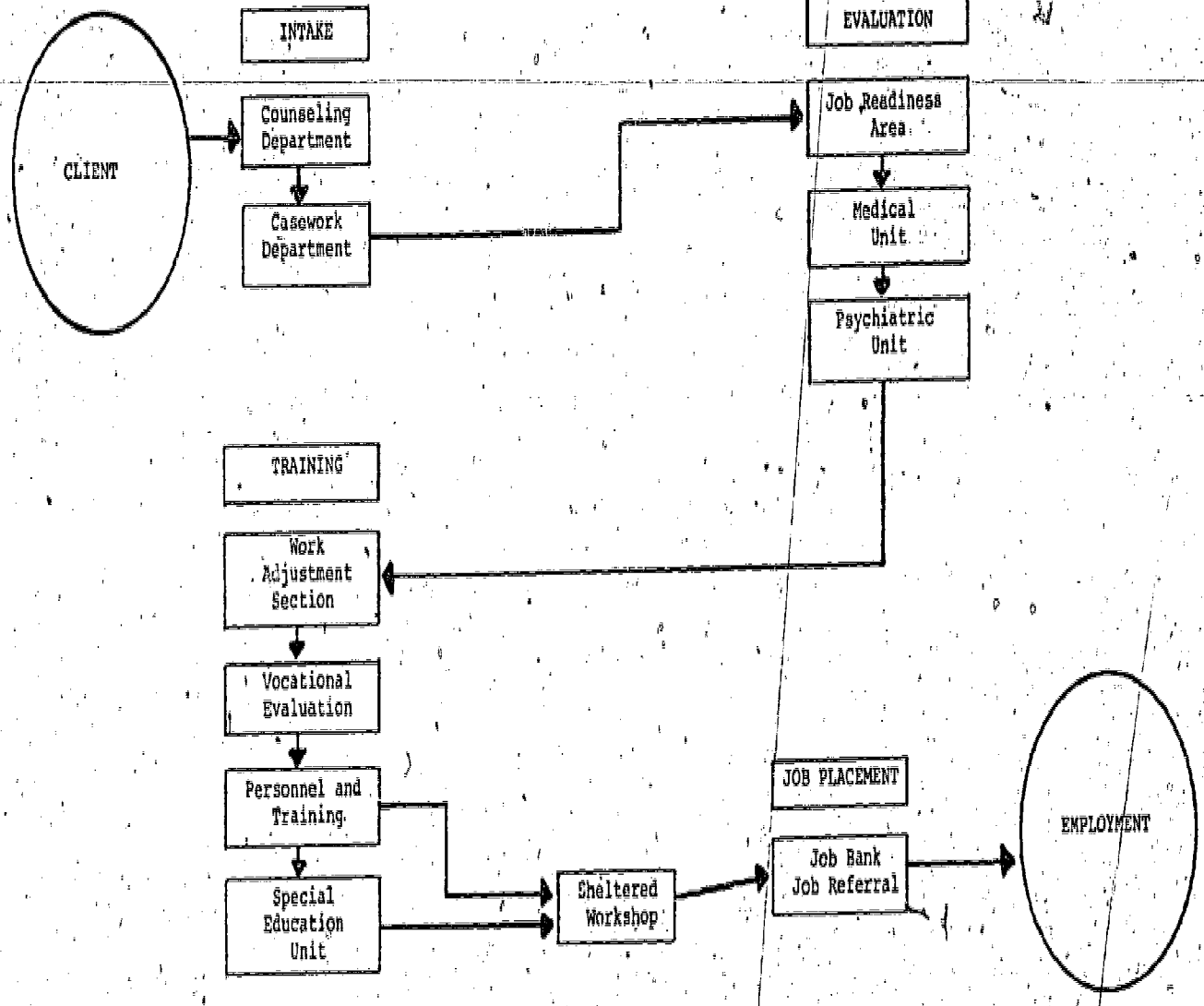
COUNSELING DEPARTMENT The client is assigned a counselor who works with the client from entry to discharge. The counselor assists the individual in assessing his strengths and weaknesses and provides overall guidance.

JOB READINESS Following initial counseling, the client is assigned to the Job Readiness Area for orientation (Center regulations, potential services, staff introductions).

MEDICAL UNIT The Center contains a complete physical examination and emergency treatment section staffed by one full-time doctor, two nurses and a physician's assistant. Clients are given a complete physical examination and if medical services are needed, arrangements are made through the counselor for treatment outside the facility.

EXHIBIT 23

CLIENT FLOW THROUGH REHABILITATION SYSTEM



PSYCHOLOGICAL UNIT A full-time psychologist and a psychiatric consultant administer numerous psychological and psychiatric tests. The test results are forwarded to the client's counselor for gearing the program to the client's abilities and needs.

WORK ADJUSTMENT Through the Work Adjustment Section, the client experiences actual job situations (i.e., time cards, supervisor, production quotas) and work adjustment assignments are made. The services provided in this section are basically therapeutic rather than training.

VOCATIONAL EVALUATION The client's skills, aptitudes, and job interests are measured in the Work Potential Section of the Vocational Evaluation Department through a series of written and manipulative (engine repair, plumbing, carpentry) tests.

SPECIAL EDUCATION SECTION All clients have access to the special education program in which teachers conduct high school completion and review classes.

At the completion of the classes, clients take the General Education Development (GED) test which, if passed, provides the equivalent of a high school diploma.

The special education teachers are provided by the Atlanta Adult Education Department. The Evaluation Center pays for one instructor and the School Board provides the other salaries.

TRAINING SECTION Some clients are trained in potential employment positions such as general clerical worker, day care attendants, and industrial power sewing. Clients accepted in the training program are provided a stipend based on family income and number of dependents. The Sheltered Workshop, through contract with a private employer, allows the client to participate in an actual work situation.

To assist in training, the Atlanta Area Technical School donates an instructor to the Center.

JOB BANK The culmination of the evaluation/training program of the Center is assistance in finding suitable employment. The Center has a computer tie-in with the Georgia Department of Labor Job Bank, and positions listed with DOL are discussed with the client. The Department of Labor also provides a full-time counselor who is assisted by several interview aides.

Exhibit 24 illustrates the departments and program sections of the Atlanta Rehabilitation Center.

In 1972, the State of Georgia passed the Reorganization Act which created the Georgia Department of Human Resources (DHR). This umbrella department combined programs dealing with five major human services. These program areas are physical health, mental health, vocational rehabilitation, income maintenance, and social services.

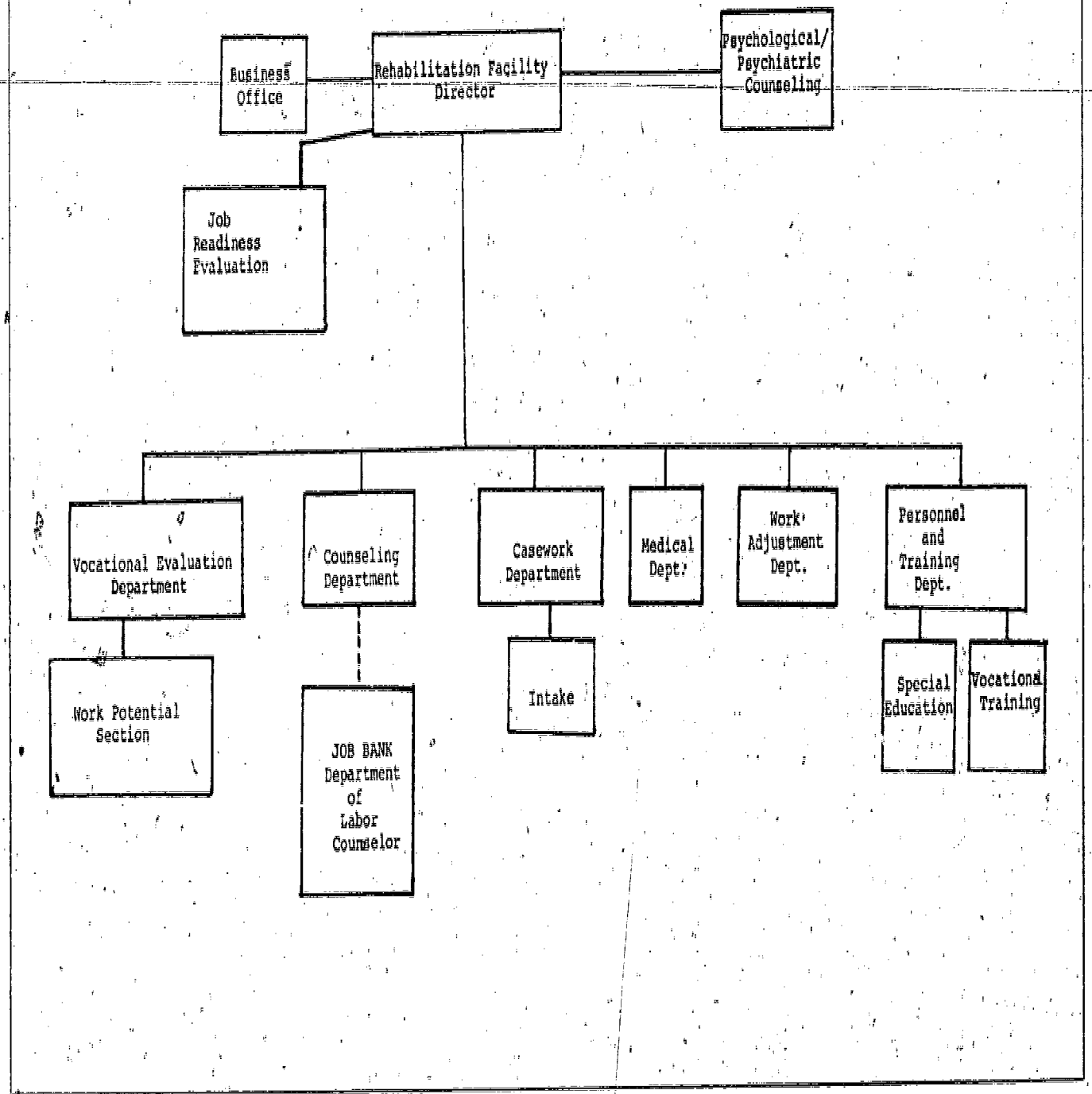
The Reorganization Act consolidated and merged into the Georgia Department of Human Resources the following agencies:

- Division of Vocational Rehabilitation (formerly under the Department of Education);
- Department of Public Health;
- Department of Family and Children Services;
- State Board for Children and Youth;
- State Commission on Aging;
- Council on Aging;
- Commission on the Status of Women;
- Georgia Factory for the Blind; and
- Radiation Control Council.

Under the Department of Human Resources, the Division of Vocational Rehabilitation continued to provide services to persons (16 years or older) with substantial mental or physical handicaps to employment. However, through the transfer of Vocational

EXHIBIT 24

ORGANIZATION CHART
ATLANTA REHABILITATION CENTER



Rehabilitation from the Department of Education to the Department of Human Resources, the Division, and subsequently the Atlanta Rehabilitation Center, was able to coordinate its activities with related human service programs such as:

- Benefits payments to handicapped clients;
- Mental health screening; and
- Physical health treatment.

Exhibit 25 illustrates the Department of Human Resources divisions with which the Center coordinates for service delivery.

PLANNING

The Department of Human Resources has created a State Development Policies Plan which compiles State policies related to human services provided by DHR agencies and local governments. The overall goal of the plan is: "For each Georgian, the fullest possible development of individual potential for self-fulfillment and for productive and responsible participation in society." This goal is subdivided into six program objectives with an identification of the appropriate program and an assessment of current and future needs (service and funding).

The six program objectives include:

- To provide financial assistance and basic services to eligible aged, blind, disabled, unemployed, needy families with dependent children, and Cuban refugees;
- To promote good mental health for all Georgians through readily accessible services in a variety of environments, community and institutional, according to need;
- To foster a uniformly satisfactory state of health for Georgia through comprehensive areas service and through surveillance and preventive measures;
- To provide comprehensive social services to meet human needs throughout the State;
- To assist the physically and mentally handicapped, public offender, and AFDC recipients to achieve self support and gainful employment; and
- To improve the management, administration, program content, and service delivery system of the Department through improvement of executive direction and administrative support.

These program objectives influence the development of coordinated services through the Atlanta Rehabilitation Center and other DHR facilities.

CITIZEN PARTICIPATION

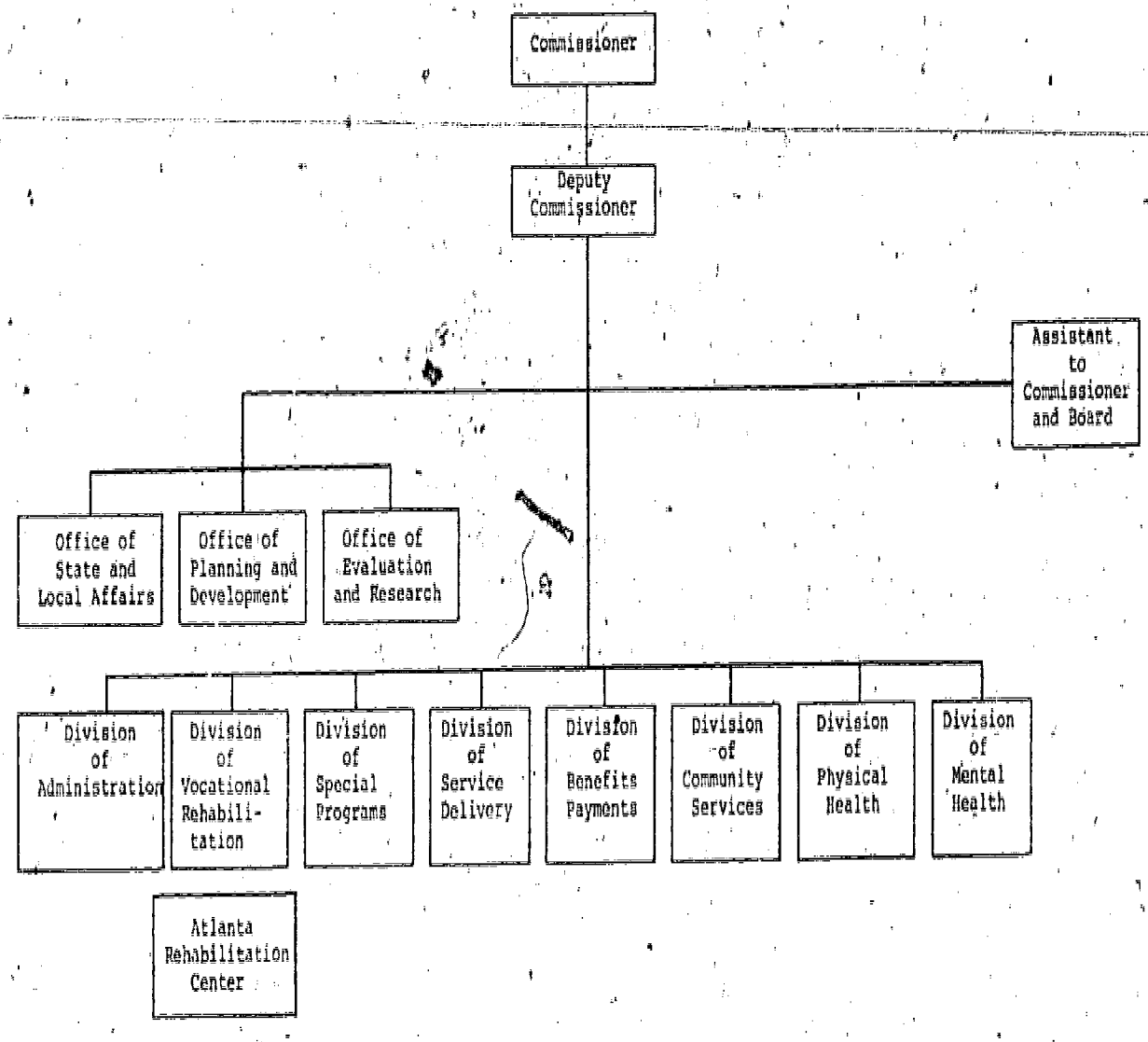
Through the Economic Opportunity Atlanta Board, citizens were provided an opportunity to review the proposed facility application and provided operational recommendations during the first three years of operation.

During the 1969 to 1972 period under State operation, there was little participation by citizens in operation or evaluation of the Center. However, citizen participation increased with the 1972 reorganization.

The Department of Human Resources has two entry points for public participation in the planning process. The first is the Department of Human Resources Board composed of 15 individuals. Board members are apointed by the Governor and are responsible for the establishment of policy for the Department. Board members are largely representative of

EXHIBIT 25

GEORGIA DEPARTMENT OF HUMAN RESOURCES—ORGANIZATION



organized professional and consumer groups. By law, five of the 15 members must be practicing physicians.

In addition, the Department has created a series of 20 advisory councils. These councils are composed of private and professional individuals appointed by the Commissioner and Board of the Department. Advisory councils exist in response to Federal funding requirements in such areas as comprehensive health planning, emergency health services, medical facilites and Medicaid.

The Vocational Rehabilitation Advisory Council assists the Vocational Rehabilitation Director in program and policy development. The Vocational Rehablitation Advisory Council is composed of 15 individuals representing business, industry, higher education, medical-psychological-psychiatric groups, and consumers (individual clients or advocacy groups). The Advisory Council reviews program proposals and current vocational rehabilitation services and makes recommendations to strengthen the program and make it more responsive to client needs.

Although the Director of the Atlanta Rehabilitation Center does not deal directly with the Vocational Rehabilitation Advisory Council, the recommendations of the Council filter down to the Center Director through the DHR Director and the Deputy Director of Facilities.

COORDINATION

Internal coordination is maintained through central intake and central information and referral by counselors, team casework, and case conferences.

The client is assigned a counselor who follows the client through the entire evaluation/education/training job development process.

If the client requires additional services (e.g., medical treatment), the counselor refers him to a resource and coordinates the transfer of pertinent client information between the Center and the other agency.

The counselor works in concert with the other staff (e.g., caseworker, job placement counselor, vocational evaluator, etc.) to ensure the client receives the full range of necessary services provided by the Center.

The staff members of the case teams jointly develop a recommended program for the client, periodically evaluate the client's progress, and share information on client background, testing results, etc.

The staff periodically meets to discuss problem cases in a case conference. Of particular benefit is the Center's position within the Department of Human Resources whereby other DHR staff can be pulled into case conferences. For example, the local Department of Family and Children Services (Welfare) caseworker dealing with the family of a client could provide insight into the client's background or problems related to his handicap.

To structure the coordination among human service delivery agencies at the State and local levels, DHR has instituted human services area coordination teams in various parts of the State. The teams provide coordination of human services through monthly meetings, a human services coordinator and joint planning staff. The Division of Vocational Rehabilitation has a representative who deals with the Atlanta Center on the the Fulton County and DeKalb County Subarea Human Services Coordinating Teams.

Until recently, the Fulton County Human Services Coordinator (head of the team) maintained an office in the Center thus facilitating day-to-day coordination between the Center and other human service agencies.

FUNDING

State appropriations initiated in 1969 have steadily increased while Federal grants have been reduced. Current funding includes:

Federal training service grant	—	$ 275,000
State appropriations	—	306,000
Title XX	—	364,000
Basic Support (Section 110)	—	471,000
TOTAL	—	$1,416,000

FACILITATORS AND INHIBITORS

The lack of comprehensive, centralized evaluation services was the major impetus to the initial development of the Center. Many public and private agencies like the Veterans Administration, Housing Authority, Department of Labor, and Urban League evaluated clients especially in relation to employment potentials. However, most agencies did not have sophisticated staff (e.g., psychologist and psychiatrist) or testing methods to adequately evaluate clients. In addition, few rehabilitation programs for handicapped (mentally or physically) clients existed. Therefore, many agencies viewed a comprehensive evaluation center as vital to their operation. Thus, as a community facilitator, the EOA submitted a demonstration grant for establishment of an evaluation center to which public and private agencies could refer clients.

The inclusion of the Center in the Division of Human Resources umbrella facilitated transfer of staff and coordination of human service components of the State. For example, the Director of the Center works closely with the human services area coordinator as discussed in the section on coordination.

Inhibitors to expansion and operation included the potential lack of funding following the culmination of the demonstration grant and restrictions imposed by Federal categorical grants. The federally required reporting process which requires a great deal of staff time reduced staff effectiveness. The lack of ownership of the facility has eliminated the potential to renovate the facility (State regulations prohibit renovation of non-State facilities) to better accommodate rehabilitation programs.

CONCLUSION

The Atlanta Rehabilitation Center comprehensively attacks the multitude of problems faced by a handicapped individual. Medical, psychiatric, and psychological evaluation, training, education, and job placement services in a single location enable the client to attain personal independence. Coordination with other human service agencies (e.g., local welfare department) enables the Center to provide a broad information and referral program to complement the services provided at the Center.

U.S. GOVERNMENT PRINTING OFFICE: 1977 241-205/5003(77) 1-3