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ABSTRACT

Since the advent of institutional care in the nineteenth century, there has been extensive discussion concerning the relative merits and constraints inherent in such service provision. In the twentieth century, the trend toward institutionalization began to be reversed. Patients or clients were released or returned to communities and community care through increasingly available medical and social resources. The impetus toward the use of alternatives to institutionalization has come from federal legislation and from a continuing loss of institutionalized clientele since the 1950's. These occurrences have caused a great deal of discussion and prompted an examination of the present-day patient or client population's use of state and public institutions and community support services. Possible sources of documented information are presented. (KA)

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BIBLIOGRAPHY SERIES

Issues in Deinstitutionalization

PROJECT SHARE

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ALTERATIVES TO INSTITUTIONALIZATION

Since the advent of institutional care in the 19th century, there has been extensive discussion concerning the relative merits and constraints inherent in such service provision. In the twentieth century, the trend toward institutionalization began to be reversed. Patients or clients were released or returned to communities and community care through increasingly available medical and social resources.

A further impetus toward the use of alternatives to institutionalization was enacted and implemented through the 1963 Federal legislation entitled, the Community Mental Health Centers Construction Act, which called for the development of and funding of community-based services. This landmark legislation was designed to aid in the reduction by 50 percent of the U.S. institutionalized populations.

This impetus allied with the fact that institutions had continuously (since the 1950's) been 'losing' their clients in large numbers brought about the current situation. These occurrences have caused a great deal of discussion and prompted a prolonged and varied examination of the present-day patient or client population's use of State and public institutions and community support services.

It is hoped this bibliography, comprised of selected annotated citations of documents within the PROJECT SHARE collection, will help direct readers toward possible sources of documented information on this frequently discussed topic. It is additionally hoped that it will aid in broadening the perspective on the issues this type of social services delivery raises.

Advocacy: A Role for DD (Developmental Disabilities) Councils.

James L. Paul, Ron Wiegerink, and G. Ronald Neufeld.
North Carolina Univ. at Chapel Hill. Developmental Disabilities / Technical Assistance System.
1974, 245p
Executive Summary available from PROJECT SHARE.
SHR-C001518 Available from NTIS, PC$ 9.50/MF$ 3.00.

Materials developed as part of the National Conference on Initiative Functions of Developmental Disabilities Councils, held in Winter Park, Colorado, in June 1974, are presented. Topics covered in the monograph include advocacy potential, the State council as advocate, the consumer as advocate, planning and evaluation, consumerism, regionalism, revenue sharing, public awareness, legal developments, legal issues, and deinstitutionalization. A conceptual basis on which councils can build their policies concerning comprehensive planning for developmental disability services is outlined, as is a model for council use in planning and evaluation. Consideration is given to the use of staff members from a variety of State agencies in the planning and implementation of council programs. The council's role in assuring consumer accountability in regional programs, such as councils on government, is discussed. Ways in which councils can act in behalf of disabled applicants for Supplemental Security Income program benefits are suggested. Steps in developing and implementing a public information campaign on developmental disabilities are outlined. Legal issues concerning the rights of developmentally disabled persons are considered, and avenues open to councils to assist disabled persons in gaining and asserting their legal rights are described. Council actions in developing a program of deinstitutionalization for developmentally disabled persons are suggested. A list of conference participants, several bibliographies, and the conference agenda are included.

After Release: The Volunteer's Role in Social Readjustment of Elderly Patients.

Majid Al-Khazraji, Hyman L. Cohen, Rutherford E. Everest and Richard Stratton.
Saint Francis College, Loretto, Pa.
1973, 13p
Pub. in Massachusetts Journal of Mental Health V4 n2 p32-44 Winter 1974.

Where other societal alternatives are lacking, many older persons are being admitted to mental hospitals simply because there is no other place for them. Role flexibility, basic to social adjustment of the elderly, disintegrates into a patient/institution role set aggravating the isolation of old age. When deinstitutionalization becomes a goal, hospital administrators fear that the elderly patient will no longer be able to readjust to community life without assistance. Intimate contact with nonprofessional volunteers can aid in removing the elderly person's dependence on mental health professionals by removing the "patient" image. There is a danger that volunteers may lose motivation and develop feelings of inadequacy necessitating skillful, if minimal supervision of volunteers by professionals. Community resources should be pooled so that they are readily accessible to both volunteers and clients. An experiment conducted in the spring and summer of 1970 tested the above assumptions from the perspective of the agency, the volunteer, and the patient. Data indicating behavioral changes undergone by patients as perceived by volunteers is presented in tabular form. Two factors emerge as essential to the successful utilization of lay volunteers: (1) volunteers must visit their friends regularly to provide consistent support contact; and (2) professional consultants must maintain high standards in screening volunteers and have sufficient knowledge of aging and mental illness to be able to guide volunteers. bibliography is included in the paper.

Alternatives to Institutionalization for the Aged: An Overview and Bibliography.

Liz Karnes.
Nebraska Univ. at Omaha. Coll. of Public Affairs and Community Services.
Sep 75, 29p
SHR-0001460 Available from Mrs. Mary Vance, Editor, Council of Planning Librarians, P.O. Box 229, Monticello, IL 61856, Exchange Bibliography No. 877.

Literature relevant to alternatives to institutionalization for the aged is cited in a bibliography accompanied by an overview of the subject and by definitions of the various levels of care that may be required by an older person. The bibliography is in nine sections: (1) general problems of the elderly; (2) relocation (problems encountered by older persons forced to move from their homes); (3) alternatives (the need for options to institutional care); (4) nursing homes (descriptions, criticisms, and recommendations); (5) home care (homemaker and home health aide programs for the elderly); (6) day care (day care centers and day hospitals); (7) community care (how the community can help its older citizens); (8) alternative living arrangements (options for people who do not want to live in an institution but cannot remain at home); and (9) cost factors (the cost of alternatives to institutionalization). Approximately 330 books, articles, reports, and other materials, most published in the 1960's or 1970's, are cited.

Community Corrections: A Reader.

Burt Galaway, C. David Hollister, and Joe Hudson.
Minnesota Univ., Duluth. School of Social Development.
1976, 309p
SHR-C002013 Available from Charles C. Thomas, Publisher, 301-327 E. Lawrence Ave., Springfield, IL 62703.

This compilation of articles on community-based corrections is intended for use by students and correctional practitioners and administrators. The articles pertain to the deinstitutionalization of correction programs, the variety of correctional programs and services that have been developed and operated within a community context, and major issues relevant to the development of community-based correction programs. Contributors to the book are administrators, practitioners, scholars, and researchers both from within and outside the field of corrections and criminal justice. Specific topics addressed by the articles are institutional programming, diversion, probation, programming for short-term offenders, residential community corrections, parole and aftercare, the organization of correctional programs and services, citizen involvement, the rights of offenders, and evaluation research. An index is provided.

Community Placement of the Mentally Retarded. A Handbook for Community Agencies and Social Work Practitioners.

Richard A. Mamula and Nate Newman
Kern Regional Center for the Mentally Retarded and Developmentally Disabled, Bakersfield, Calif.
1973, 142p
SHR-0002556 Available from Charles C. Thomas, 301-327 E. Lawrence Ave., Springfield, IL 62717.

The recent efforts of political leaders, the acts of Congress and the involvement of parents have resulted in the emergence of community placement programs for the mentally retarded at Federal, State and local levels. This handbook, created for social work practictioner in the field of community placement, attempts to: examine the basic components of the community placement concept; discuss its historical development; and offer suggestions and practical guidelines for the development of effective community placement programs to meet the particular requirements of the individual communities and agencies involved. The succinct review of a variety of community programs offered here will allow individual agencies and communities to extract from the material, the information which is germane to their particular situation. An indepth discussion of the patient, the careproviders, and the community takes past and current experiences into account, and offers critiques and practical suggestions. Since such a variety of types of community - facilities exist, the scope of the survey in limited to facilities which offer the most personal interaction. Hence, in defining community placement, the book limits discussion to smaller facilities which most closely approximate the family living situation. Current trends in program development, described as 'closed system approach', are based on the view of the mentally retarded as incurable, organically diseased, and primarily a problem of subnormal intellect. Program development evolves from diagnosis and symptomatology of a physical condition, while social and cultural factors are ignored. An 'open system approach', which views mental retardation as a social problem, is proposed for the future. This approach will allow the retarded the opportunity to realize his full potential. Appendices include: (1) an outline of an 8 - week careproviders training program; (2) an outline and prospectus of an adult education training program; (3) a sample developmental plan; (4) a self - help evaluation inventory; (5) guidelines for programming; (6) a patient evaluation scale; and (7) a careprovider's handbook. A bibliography is included.

Community Residences for Mentally Retarded Persons. A Summary of a Study of Seven Community Residences.

Kurt Wehbring and Ciele Ogren
1976, 31p
SHR-0002538 Available from National Association for Retarded Citizens, P.O. Box 6109, 2709 Avenue E East, Arlington, TX 76011.

This monograph summarizes a more extensive report by the National Association for Retarded Children on case studies of seven residential facilities for mentally retarded persons. A brief overview of the facilities, representing a cross section of sponsorship, size, organization, philosophy, and program, outlines the characteristics of the successful models. The Lori Knapp Home in Wisconsin, with eight severely and moderately retarded individuals, exemplifies State use of nonprofit homes. Six young, mildly retarded women live in the Lupine House in California, a program which demonstrates how a group of parents can overcome technical problems and community opposition to establish a group home. In Pennsylvania, the Hearth forms part of a network of group homes and is distinguished by its religious orientation. The traditional polarization of those who favor the community - based approach and those who favor large institutions falls away when one views the Manchester Group Home in Connecticut. Funded and developed by a large State hospital, it houses ten mildly and moderately retarded men. Institutionally developed residences offer: (1) practical experience in the administration of residential service; (2) an already established funding source; (3) accountability resting with a single agency; and (4) the availability of support services. In Colorado, Cheyenne Village trains fourteen men and women to live a highly structured environment, and gradually leads them to independent living. California's Community Living Program directs twenty - six retarded adults through a one and a half year rehabilitation program in independent living. The Hamilton Street Residence for Children in Nebraska, attests to the ability of severely retarded persons to live within a residential community. This house demonstrates the role of a comprehensive service system in the operation of a community residence. Following the program summaries, residences are compared in terms of the initiation, development, and operation of the residence; community resources used; costs; and funding sources. The conclusion stresses the importance of program philosophy. Outstanding characteristics of the homes and information about their residents are tabulated. A bibliography is included.

Community Residences: Some Perspectives and Issues.
Community Residences Information Services Program.

Westchester Community Service Council, Inc., White Plains, N.Y.
Jun 75, 24p
SHR-0000744 Available from Westchester Community Service Council, Inc., 713 County Office Bldg., White Plains, N.Y. 10601, $1.00.

The development and operation of community residences in Westchester County, New York are considered in relation to deinstitutionalization. As of January 1975, there were 92 community residences in Westchester, including 41 group homes, seven halfway houses, four hotels, 28 family care group homes, and 12 adult proprietary homes. In an attempt to ascertain the number of community residences to be developed through 1976, questionnaires were sent to 36 provider agencies. The 31 agencies which responded serve the following populations: aged, infirmed, and disabled; alcoholics; delinquents; dependent and neglected children; psychotic individuals; mentally retarded; and persons in need of supervision. Using the data obtained from questionnaires, it was possible to illustrate the development of community residences from 1955 through 1975 and to project their development through 1976. The status of community residences and zoning in Westchester County is examined, with emphasis on relevant court decisions and the need for updated zoning codes. Public concerns regarding community residences are noted, including fear of property value depreciation, possibility of increased danger to persons and property with a resultant increase in crime rates, fear of inappropriate behavior of atypical residents, nuisance complaints, fear of too many facilities concentrated in one neighborhood, and fear that residents will not have adequate supervision. Consideration is given to public attitudes toward mental disabilities and strategies for gaining acceptance of community residences. The Community Residences Information Services Program in Westchester County is described.

Community Treatment and Social Control. A Critical Analysis of Juvenile Correctional Policy.

Paul Lerman.
Rutgers - The State Univ., New Brunswick, N.J. Dept. of Sociology.
1975, 254p
SHR-0001715 Available from University of Chicago Press, 5801 Ellis Ave., Chicago, IL 60637.

The impact of actual practices and policies related to community treatment programs for juveniles is assessed. Data relevant to achievements claimed for the community treatment project initiated in the Sacramento - Stockton area of California in 1961 are examined. The probation subsidy program enacted by the California legislature in 1965 is analyzed. The effectiveness of these projects in reducing the confinement of juvenile offenders in institutions and in lowering recidivism rates is evaluated. Community treatment programs are discussed in relation to issues for correctional policy. Assumptions and operating criteria pertaining to probation subsidy are considered, and the social impact of probation subsidy is explored. Issues inherent in probation subsidy for correctional policies are detailed, along with fiscal aspects of probation subsidy. It is demonstrated that major goals of the community treatment strategy in California were not realized in practice. Although community treatment was proposed as an effective alternative to traditional institutionalization, the latter was found to be more effective. Proposed as a noncoercive substitute for sanctions delivered by the State, community treatment proved to be associated with increases in State and local social control. Community treatment was found to be more expensive than traditional institutionalization. Improvements to the community treatment system and alternative treatment strategies are discussed. Appendixes contain a methodological note on community treatment program analysis and tabular data. A bibliography is provided.

Comprehensive Care to the Elderly.
Annotated bibliography.

George Ybarra, Stephanie Lee Amsden, Deirdre Harris, and Lana Norwood.
Texas Univ. at Austin. Center for Social Work Research.
Feb 77, 86p
SHR-0001790 Available from University of Texas, Center for Social Work Research, Austin, TX 78712.

This annotated bibliography is devoted to the problems encountered by senior citizens. Citations primarily cover the period from 1970 to 1975. They are organized according to eight major headings: (1) the elderly and their families; (2) subpopulations among the elderly; (3) the system of delivering health care to the elderly; (4) the elderly and their environment; (5) community care of the elderly; (6) expanding roles in geriatric health care; (7) factors affecting the design and development of health care systems; and (8) additional bibliographies on the elderly. Consideration is given to subcultural and urban - rural population differences among the elderly and to blacks and Mexican-Americans. Other topics covered in the bibliography are medical and psychiatric care, client assessment, institutional settings, the relocation of elderly patients, alternatives to institutional care, protective and support services, nurses and social workers, models of planning service delivery, research, and legislation.

Comprehensive Directory of Services. A Resource for Clder Mon Valley Residents.

Mon Valley Health and Welfare Council, Inc., Monessen, Pa.
1976, 163p
SHR-C001270 Available from NTIS, PC$ 8.00/MF$ 3.00.

A compilation of resources available to older residents of the Mon Valley, Pennsylvania, area is provided by the Mon Valley Health and Welfare Council, Inc. This resource inventory is designed as a guide for older consumers so that existing resources can be fully utilized. Information is presented in a simple format for the following services: emergency listings, counseling, day care, education, employment, financial aid, health organizations, hospitals, housing, living arrangements, nursing homes, protective services, recreation, research and planning, retired person's organizations, senior citizens' centers and clubs, service organizations, and transportation. Each entry provides the name of the relevant agency, its address and telephone number, hours, director, contact person, services, eligibility, funding, fees, and other information if available. An index of services by county is included.

Comprehensive Human Services Planning and Delivery. Taunton Area. (Massachusetts).

Taunton Area Community Mental Health Program, Mass. Governance Body.
1975, 26p
SHR-0000560 Available from NTIS, PC$ 4.50/MF$ 3.00.

The organization and accomplishments of the human service delivery system in the Taunton, Massachusetts area are described and the development of the Taunton management and services integration model is discussed. The Taunton Area Governance Body's accomplishments include: establishment of eight human service centers, development of an integrated service program for the mentally and physically disabled, improving the quality of nursing and rest home care, and deinstitutionalization. The Taunton model involves a stacked matrix which brings together the separate processes of individual categorical services and crosscutting integration at each of four geographic scales (community / neighborhood, area, region, and State). In such a matrix, most agency staff have two supervisors -- a categorical director and an integrating director. On one side of the matrix are community human service coordinators, and area specialties are on the other side; the result is the combination of specialty services delivered in a coordinated manner. A discussion of research and development goals and objectives is included. Portions of this document are not fully legible.

Costs of Homemaker-Home Health Aide and Alternative Forms of Service. A Survey of the Literature.

Nancy Robinson, Eugene Shinn, Ester Adam, and Florence Moore.
National Council for Homemaker-Home Health Aide Services, Inc., New York.
1974, 57p
SHR-C002042 Available from National Council for Homemaker-Home Health Aide Services, Inc., 67 Irving Place, New York, NY 10003.

A survey of the literature on the costs of homemaker and home health aide services and alternative types of care was conducted. Data were obtained for the period between 1971 and 1973. The average cost for homemaker and home health aide services per hour per family unit was $3.98 in 1971-1972. The average cost per case per year was $467.79. The average revenue per day per patient in short-stay hospitals was $95 to $100 in 1973. The average cost per day per patient in extended care facilities was $13 to $19 in 1972. For elderly persons in Maryland in 1972, the average cost per day per patient was $39 for chronic care, $32 for skilled care, and $24 for intermediate care. Reimbursement from the State of New York and New York City to voluntary institutions for children averaged $30 per day per child, or $915 per month per child, in 1972-1973. For foster home care during 1973, reimbursement in New York to voluntary institutions averaged $12 per day per child, or $360 per month. It was determined that homemaker and home health aide services are usually less costly than out-of-home alternatives when provided alone or as an array of in-home services. Annotated and supplementary bibliographies and the addresses of bibliographic sources are provided.

Decarceration. Community Treatment and the Deviant: A Radical View.

Andrew T. Scull
Pennsylvania Univ., Philadelphia. Dept. of Sociology.
1977, 184p
SHR-0002571 Available from Prentice-Hall, Inc., 301 Sylvan Ave., Englewood Cliffs, NJ 07632.

Decarceration for deviants is designated as an ineffective process for closing down State asylums, prisons, and reformatories. There exists a significant lack of knowledge about what community treatment actually involves and the likely effects of abandoning institutional controls. There is little solid evidence to support the claim that leaving deviants at large 'cures' or 'rehabilitates' them. Decarceration results in suffering for both the deviant and society. An adequate sociological understanding of the nature and sources of decarceration is an urgent necessity in view of the clustering of deviants after release from institutions into ghettos and inner cities. Subjects discussed in the book include: deviance and the dynamics of control, capitalism and the social control apparatus in the 1970's, the decarceration of criminals and delinquents, the demise of asylums, psychoative drugs and community treatment, social policy, structural sources of the failure of the 19th century decarceration movement, and success in the 20th century with respect to welfare capitalism and the changing exigencies of domestic pacification and control. A bibliography and an index are provided.

Deinstitutionalization: Accomplishments, Issues and Directions.

LeRoy P. Levitt.
Illinois State Department of Mental Health and Developmental Disabilities, Springfield.
Jun 1976, 14p
SHR-0002167 Available from National Conference on Social Welfare, 22 West Gay Street, Columbus, OH 43215.

Social, cultural, political, economic, and professional issues pertaining to deinstitutionalization in the field of mental health are explored. A brief background discussion of trends in the provision of mental health services is presented. A definition of deinstitutionalization is presented encompassing three interrelated processes: the process of preventing unnecessary or inappropriate admission; the process of returning to the community all patients or clients who have been prepared, through programs of rehabilitation, to function adequately in local settings; and the process of establishing and maintaining a responsive community environment which protects human and civil rights. Major issues considered with respect to deinstitutionalization are the fate of State hospital staff and facilities, the fate of discharged or transferred patients, and community services and acceptance. Guidelines to facilitate entry into the community, integration into the community, and community education are presented. A bibliography is included.

Deinstitutionalization: An Analytical Review and Sociological Perspective.

Leona L. Bachrach
National Inst. of Mental Health, Rockville, Md.
Div. of Biometry and Epidemiology.
1976 48p
SHR-0002451 Available from ERIC Document Reproduction Service, P.O. Box 190, Arlington, VA 22210 as ED 132 758

This document outlines a theoretical framework with which to view the multitude of narratives produced recently concerning deinstitutionalization of the emotionally disturbed. An analytical review of the literature and a theoretical synthesis of issues in deinstitutionalization is provided. A fundamental assumption is that many problems related to deinstitutionalization result from a failure to understand the unique position of the mental hospital in American culture, and consider this uniqueness during the process of planning for social change. A discussion of definitions of deinstitutionalization shows a division between those specifying what the word describes and those specifying what the word ought to describe. For the purposes of the article, the term implies shunning traditional institutional settings and expanding a continum of community - based treatment alternatives. The maturation of views on deinstitutionalization is presented, sequentially, according to the assumption that four distinct periods characterize any humanitarian movement: innovation, peaking, criticism, and retrenchment. The paper considers issues such as: (1) the selection of patients for community care; (2) the treatment course of patients in the community; (3) the quality of life of patients in the community as a whole; (4) the relation between deinstitutionalization programs and the community as a whole; (5) financial problems; (6) legal and quasi - legal issues; and (7) accountability. The concepts of functionalist approach taken and their application to the functions of asylum and custody are described. Finally, reaching the goal of deinstitutionalization requires the avoidance of territorial arguments and requires the use of such programs as hospital - based outpatient care, brief hospitalization, and community outreach. An extensive bibliography supplements the article.

Deinstitutionalization - Delinquent Children.

Jeffrey Koshel.
Urban Inst., Washington, D.C.
Dec 73, 74p
Executive Summary available from PROJECT SHARE.
SHR-C001831 Available from Urban Institute, 2100 M St., NW, Washington, DC 20037.

Studies that have been made about various institutional and noninstitutional arrangements for treating and controlling delinquents are assessed. Custodial institutions, semicustodial institutions (group residences, halfway houses), specialized group homes, specialized foster homes, probation/parole, and correctional daycare are among the available facilities that are evaluated. Deinstitutionalization refers to emptying custodial institutions, and Massachusetts is the only State in the U.S. with the first total deinstitutionalization program for delinquents. Probation has been an effective noninstitutional alternative, but it appears that only certain selected delinquents benefit from such a program. More reliable information is needed on recidivism of juveniles handled under the various alternatives. Costs of institutional and noninstitutional care programs are considered. The programs in Massachusetts, the District of Columbia, Wisconsin, and Minnesota are described in an appendix, and the research limitations of each program are analyzed. California has developed treatment strategies for delinquents based largely on their different levels of personal maturity, and this classification scheme is described in an appendix. Charts show various characteristics of custodial institutions in 1970.

Deinstitutionalization - Dependent and Neglected Children.

Jeffrey Koshel.
Urban Inst., Washington, D.C.
Dec 73, 60p
SHR-C001833 Available from Urban Institute, 2100 M St., NW, Washington, DC 20037.

An analytical framework is presented for evaluating the deinstitutionalization of dependent and neglected children. Terms associated with the concept of deinsitutionalization are defined, and background statistics on the problem of dependent and neglected children are provided. Tabular data are included. An overview of the foster care system is presented in graphic and narrative form. The system encompasses prevention, preplacement, foster care (out-of-home placement), and postfoster care. Equations are given for assessing the costs of foster care. Significant issues concerning the deinstitutionalization of dependent and neglected children are discussed. They relate to the absence of 'universe of need' data, the benefits of alternative placement, the incidence of costs, cost savings from further deinstitutionalization, and the assessment of deinstitutionalization techniques. Priority areas of research on residential insitutions and alternatives are indicated. Various types of studies that Federal research agencies should undertake in conjunction with State and local child welfare agencies are suggested. The issue of whether wholesale deinstitutionalization policies are in the best interest of children is questioned. Additional data on dependent and neglected children are appended.

Deinstitutionalization in Oregon. A Review of Services within the Human Resources System.

Edward Burling, Dennis Heath, Tim Jacobs, and Sharyn Kaplan.
Oregon Dept. of Human Resources, Salem.
1 May 75, 122p
Executive Summary available from PROJECT SHARE.
SHR-C000671 Available from NTIS, PC$ 6.50/MF$ 3.00.

Services are reviewed that are available to adults who have been released from State institutions in Oregon for the mentally and emotionally disturbed and developmentally disabled. The following target services are evaluated in terms of their availability: preplacement planning and followup services, community living options, community health services, community education and training, employment, mobility, and community leisure time activities. Three major issues are identified as crucial to the successful deinstitutionalization of the mentally retarded, developmentally disabled, mentally and emotionally disturbed, and alcohol and drug clients: (1) followup services (i.e., a plan for monitored, consistent, and continuous followup services), made prior to a client's departure from an institution and which involves staff of the institution, staff of several community agencies, and the client; (2) day plans (i.e., a workable plan for the client to have recreation, work, or training available in the community); and (3) living facilities (i.e., the return to a client's natural home or, when needed, an appropriate range of supervised living arrangements suited to the needs of each client). The facilities visited during the evaluation of available services for deinstitutionalized adults are listed in an appendix.

Deinstitutionalization. Initial Report.

William Duke Morton, and Robert B. Muse.
Oregon Dept. of Human Resources, Salem. Program Evaluation and Development.
Jan 75, 72p
Executive Summary available from PROJECT SHARE.
SHR-0000670 Available from NTIS, PC$ 5.25/MF$ 3.00.

Factors involved in the release of clients from State-supported institutions in Oregon are discussed. Deinstitutionalization is viewed as a process and not as a single event, and definitional considerations associated with the deinstitutionalization process are presented. Programmatic considerations involved in this process are also examined. The problem of community readiness for released clients is addressed in terms of community attitudes and financial resources and the possibility of counterproductive efforts from community programs. The problem of overextension is considered. Processes by which a client can be served are noted along with factors that determine the costs of deinstitutionalization. Overall policies of Oregon's Department of Human Resources are reviewed that support a deinstitutionalization program. Specific actions taken by the department to ensure the successful implementation of these policies are noted: (1) formation of a Human Resources Facilities Advisory Committee; (2) formation of an interdivisional task force to describe community support systems; (3) a commitment to continue evaluating the effectiveness of the program; (4) an intent to ensure maximum Federal funds without a total dependence on them; and (5) the continued refinement of a model by which department budgets and programs can be presented in an understandable manner. An appendix provides information on semi-independent living services for the developmentally disabled.

A related document is available as SHR-0000671.

Deinstitutionalization: Problems and Opportunities.

Patricia Massey Reveley.
Maryland Dept. of State Planning, Baltimore.
Mar 76, 164p
Executive Summary available from PROJECT SHARE.
SHR-C000806 Available from NTIS, PC$ 8.00/MF$ 3.00.

Research on deinstitutionalization in Maryland is reported and based on a review of State agency plans and a series of interviews with individuals involved in the deinstitutionalization process. It is noted that deinstitutionalization results from a change to a philosophy of care and treatment that discourages reliance and dependence upon institutional care and encourages the development of alternatives to institutionalization. Deinstitutionalization efforts in Maryland's Department of Health and Mental Hygiene, Department of Human Resources, Department of Education, and Department of Public Safety and Correctional Services are reviewed. Conflicting State regulations that could impede deinstitutionalization efforts are noted along with conflicting State policies, staffing problems, problems associated with the re-use of buildings vacated by deinstitutionalization, financial problems, lack of supportive services for deinstitutionalized clients, and community issues in the implementation of deinstitutionalization policies and programs. Recommendations are made for solving problems associated with deinstitutionalization in Maryland. Interviews conducted with Maryland agency officials are listed in an apperdix.

Deinstitutionalization: Program and Policy Development. Edition Number One.

James L. Parel, Donald J. Stedman, and G. Ronald Neufeld
North Carolina Univ. at Chapel Hill. Div. of Special Education.
1977, 297p
SHR-0002544 Available from Syracuse University Press, 1011 E. Water St., Syracuse, NY 13210.

This anthology provides an orientation to issues surrounding deinstitutionalization of the mentally and physically handicapped. Three major factors enter into the process of normalizing an institutionalized person. First, the person undergoing the transition must overcome the social shock of the changed environment. Second, both he and his family must overcome economic and attitudinal resistance by the community. Third, the family must orient itself to reversing the painful decision to institutionalize. The first section provides a framework for defining and understanding deinstitutionalization. The second section presents major aspects of the theory and issues involved in deinstitutionalization, including labeling and stigma, policy and politics, production roles of consumers, and the transformation of organized caregiving. The final section covers basic topics involved in the structure of the institutional change, such as accountability and the legal, organizational, and programmatic aspects of deinstitutionalization, which are necessary in making services more responsible to clients. In reference to these last issues, program planning, monitoring, and evaluation at local, regional, and State levels are discussed. Practical deinstitutionalization programs, explicated separately and indepth, include judicial, legislative, and several citizen advocacy approaches. In addition, two chapters concern the integration of these approaches into a schematic training design. A bibliography follows each article.

Deinstitutionalization: The Case of the Disappearing Hospitals.

Max Silverstein
Pennsylvania Univ., Philadelphia. School of Social Work.
March 1977, 21p
SHR-0002553 Available from National Conference on Social Welfare, 22 W. Gay St., Columbus, OH 43215.

This paper outlines the major issues in the current effort of State and local governments to divest themselves of responsibility for operating health care facilities and services. Although the overt motive for this effort is financial, public officials attempt to justify such action by claiming that it is better for patients not be institutuionalized in public hospitals. Public general hospitals have been allowed to become run down across the country, and there exists a systematic effort to close them entirely in spite of the crucial roles that they play in the lives of more than 22 million Americans. Closing these institutions removes valuable outpatient and short term inpatient facilities from community access. Those who keep the traditionally underfunded and understaffed instututions short of money are those who complain of the resulting low quality of care and then use the quality excuse for closing the 'private sector'. The movement to deinstitutionlize the mentally ill is also being interpreted as justification for eliminating public mental hospitals. In most cases, however, attempts to provide appropriate alternative settings offering personal restorative services have fallen short of meeting the need. This situation has, at times, resulted in chaotic community conditions in areas, where patients have been discharged, often creating backlash. In conclusion, although deinstitutionalization focuses upon the need for sound community based services, the long range view must take into account the continuing and projected need for appropriate institutions for the seriously disabled mentally ill. There is an obligation on the part of professional social workers to bring the facts to the public's attention.

Developing Day Care for Older People.

Helen Padula.
Maryland Dept. of Health and Mental Hygiene,
Baltimore. Services to the Aged.
Sep 72, 79p
SHR-0001321 Available from NTIS, PC$ 6.00/MF$ 3.00.

The establishment of adult day-care programs is discussed in a technical assistance monograph. Adult day care is defined as a program of care during the day for impaired adults in a group setting away from home. Historical developments in psychiatric day hospitals are reviewed, and a distinction is made between day-care centers and day hospitals. Basic services involved in the provision of adult day care include a protective environment, one meal, social activities, a rest period, emergency medical arrangements, and liaison with the home situation. Additional service components of adult day care are personal care services, family counseling, legal services, health education, a program of planned functional restitution, skilled nursing services, physical therapy, and the treatment resources of a hospital that include diagnostic and medical consultation. Target populations of adult day care are confused older persons, persons with difficult behavior, institutionalized older persons, and families of older persons. The activities and services involved in an adult day-care program are described. Consideration is given to the following additional aspects of adult day care: transportation, center size and hours, physical standards, comfort, safety, space, staffing, records, evaluation, and planning. A list of suggested readings is provided. Information on the financing of adult day care, operational day-care centers, and community services for the aged is included. Patient and home evaluation forms are presented.

Effectiveness of Homemaker - Home Health Aides.

Gary A. Fashimpar and Richard M. Grinnell, Jr.
Mexia State School, Texas.
1977, 19p
SHR-0002521 Pub. in Health and Social Work, v3 n1 p147-165
Feb 78.

An empirically based research project, involving the evaluation homemaker/home health aides (H/HHA's), the quantity and quality of their services, and their roles as perceived by clients, is reported. The project was conducted in a large visiting nurse association located in a southwestern metropolitan area. Two short opinion questionnaires were employed instead of a lengthy single questionnaire. The theoretical population for the project was a 50 percent random sample, drawn from all 286 clients, who received H/HHA services during the second week of March, 1977. The 143 randomly selected clients were assigned to two mutually exclusive groups. The first questionnaire was mailed to 73 clients, and 66 were returned. The return rate of 90.2 percent was high, and final sample included 129 clients. Both questionnaires sought information on why clients thought they were receiving H/HHA services. A total of 123 responded that they were physically ill, handicapped, or disabled. The remaining six indicated that they were mentally handicapped or under psychiatric care. In response to a question which asked how payment was made for H/HHA services, sixty people indicated Medicare, 22 indicated the State department of public welfare, 11 indicated Medicaid, and the remaining 36 did not know. H/HHA possess a wide array of objectives when working with clients. They are perceived to be effective in improving the quantity and quality of home care for their clients. Clients viewed the H/HHA's more as professional people than as servants. Supporting tabular data are provided.

Emotionally Disturbed Children: A Program of Alternatives to Residential Treatment.

Linda Bedford and Larry D. Hybertson.
Boston Children's Service Association, Mass. Treatment Alternatives Project.
1974, 7p
SHR-0002152 Pub. in Child Welfare v54 n2 p109-115 Feb 1975.

A program providing alternatives to residential treatment of emotionally disturbed children is detailed. The Treatment Alternatives Project (TAP) is a service and demonstration program that was formed in August, 1972 through a contract between the Massachusetts Department of Public Welfare and the Boston Children's Service Association. TAP clients are children between 4 and 16 years of age who live in the greater Boston area. They cannot receive treatment unless the welfare department has obtained legal custody, by parent designation or involuntarily. The Informed Consent Form, signed at the time of formal admission by a parent or guardian, is described. Five areas that merit special consideration in the selection of feasible treatment alternatives for emotionally disturbed children are examined in relation to the experience gained in TAP: (1) medical screening (TAP's comprehensive medical and psychological evaluation and care program is sketched); (2) delineation of case management and treatment issues; (3) supportive alliances; (4) staffing and caseload levels; and (5) cost and service accounting. The fiscal soundness of the program is demonstrated by the fact that only 3 of 41 clients are in a residential treatment program.

Evaluation of Personal Care Organizations and Other In-Home Alternatives to Nursing Home Care for the Elderly and Long-Term Disabled. Interim Report No. 1. Identification of Alternative Programs to Institutionalization: Methods and Results.

Pauline R. Charpentier and Robert Soliz.
Applied Management Sciences, Inc., Silver Spring, Md.
26 Sept 74, 130p
Executive Summary available from PROJECT SHARE.
PB-256 010 Available NTIS, PC$7.25/MF$3.00.

Procedures followed in a study of alternatives to nursing home care are described. The first task was an exhaustive search of the literature. Ten indices and abstracting services and several major journals relating to health care and the elderly were consulted. More than 200 documents were ultimately selected for review. A telephone survey was conducted to contact individuals, organizations, and governmental agencies having knowledge about health care for the elderly and especially health care which represents an alternative to institutional placement. Nine projects were identified as a result of the literature search (three in New York, one in Colorado, two in Maryland, one in Ohio, and two in Massachusetts). Summaries of each project are provided, along with an enumeration of services offered. A form for use during site visits to evaluate the projects was devised, and screening and classification criteria for the selection of evaluation parameters were developed. A tentative interview format was prepared. Appendices contain abstracts describing the projects and a bibliography.

Evaluation of Personal Care Organizations and Other In-Home Alternatives to Nursing Home Care for the Elderly and Long-Term Disabled. Interim Report No. 2 (Revised). Critical Evaluation of Reported Research Involving Alternatives to Institutionalization and Cost/Efficiency-Effectiveness.

Applied Management Sciences, Inc., Silver Spring, Md.
30 Apr 75, 97p
Executive Summary Available from PROJECT SHARE
PB-256 011 Available NTIS, PC$6.00/MF$3.00.

A critical review of eight projects was undertaken to evaluate the effectiveness and/or cost efficiency of alternatives to institutionalization for the elderly. It appeared that stroke patients may benefit from home care programs following inpatient treatment. With regard to rehabilitation care in the home as an alternative to outpatient clinic care, patients seemed to prefer the clinic environment where visits were longer. Two emerging forms of noninstitutional care appeared to be worthwhile in terms of patient care and satisfaction. Adult day care for the infirm elderly was related to higher levels of life satisfaction than for patients in an institutional milieu. Congregate living arrangements combined social aspects of group living with readily available supportive services. The impact of a socially-oriented club setting on the physical and mental functioning of patients was demonstrated. Weaknesses inherent in the evaluation of the projects are noted, and guidelines for the critical evaluation of research documents are appended.

Evaluation of Personal Care Organizations and Other In-Home Alternatives to Nursing Home Care for the Elderly and Long-Term Disabled. Interim Report No.3 (Revised). Assessment of the Feasibility of Conducting a Prospective Study of Clients Served by Alternatives to Institutional Care. Volume I.

Douglas E. Skinner, Kenneth G. Wissman, Pauline R. Charpentier, Alan C. Foose, and Robert Soliz.
Applied Management Sciences, Inc., Silver Spring, Md.
30 Apr 75, 123p
Executive Summary available from PROJECT SHARE.
PB-256 012 Available NTIS, PC$6.50/MF$3.00.

The feasibility of conducting a prospective study of elderly clients served by alternatives to institutional care was assessed. Literature in the fields of aging, long-term institutionalization, and alternatives to institutionalization was reviewed, and a telephone survey of individuals and organizations concerned with alternatives to institutionalization was conducted. A site visit information file was designed to guide the site visits. Areas of discussion for projects to be evaluated were general program information, client information, data collection, financial information, sources of revenue, staff information, services provided, physical plant, research activities, and organization. Twenty-three projects offering noninstitutional services for the elderly in six states (Kentucky, Michigan, Minnesota, Pennsylvania, Rhode Island, and South Carolina) were visited. Issues analyzed with respect to feasibility were supplemental services, client population, selection criteria (eligibility), barriers to the expansion of services, service evaluation, intake forms, case folders, encounter forms, demographic and personal data, client assessment and client progress, data processing, monitoring program activities and clients, cooperation with agencies, supervisory authorization, administrative constraints, staff research skills and staff stability, research experience, limitations on research confidentiality, political and jurisdictional constraints, and project longevity.

Evaluation of Personal Care Organizations and Other In-Home Alternatives to Nursing Home Care for the Elderly and Long-Term Disabled. Interim Report No. 3 (Revised). Assessment of the Feasibility of Conducting a Prospective Study of Clients Served by Alternatives to Institutional Care. Volume II, Appendix A (Updated).

Applied Management Sciences, Inc., Silver Spring, Md.
30 Apr 75, 132p
Executive Summary available from PROJECT SHARE.
PB-256 013 Available from NTIS, PC$7.25/MF$3.00.

This appendix to a report on the feasibility of conducting a prospective study of elderly clients served by alternatives to institutionalization contains summaries of 23 project site visits and interviews with government officials in six states (Kentucky, Michigan, Minnesota, Pennsylvania, Rhode Island, and South Carolina). Information on personal care organizations and other in-home alternatives to nursing home care for the elderly and long-term disabled is included.

Evaluation of Personal Care Organizations and Other In-Home Alternatives to Nursing Home Care for the Elderly and Long-Term Disabled. Interim Report No. 4 (Revised). Major Experimental Design Considerations of a Prospective Study of Clients Served by Alternatives to Institutional Care.

Douglas E. Skinner, Pauline R. Charpentier, Kenneth G. Wissmann, and Alan C. Foose.
Applied Management Sciences, Inc., Silver Spring, Md.
1 May 76, 233p
Executive Summary available from PROJECT SHARE.
PB-256 014 Available NTIS, PC$9.50/MF$3.00.

Design considerations in the conduct of a prospective study involving elderly clients served by alternatives to institutional care are discussed. Available instruments for use in supporting experimentation activities are categorized as follows: (1) patient/client assessment (scales and indices and questionnaires developed by specific projects); (2) patient/client assessment (conceptual approaches to assignment, experimental requirements of a formal patient assignment protocol, and operational assignment techniques); (3) quality of care (medical and nonmedical care evaluation); and (4) cost analysis (systems and instruments). The feasibility of cost analysis is explored in relation to project costs and other levels of cost analysis. Project costs concern staff functioning and client utilization of project services. Other levels of cost analysis are total programmatic costs, Federal budget costs, taxpayer-recipient costs, and social costs.

Evaluation of the Effects of Group Home Living

Charles J. Seevers.
Aux Chandelles, Bristol, Ind.
1975, 15p
SHR-0002364 Pub. in Research Exchange and Practice in Mental Retardation v1 n1-2 p51-65 Jun 1975

An operational developmental model was designed, applied and evaluated as an alternative to the traditional custodial model of institutionalization used to meet the residential needs of the mentally retarded in Elkhart County, Indiana. Six developmentally disabled adult women were trained, in a small group home setting, to live in minimally supervised apartments. Admission criteria were to prevent probable institutionalization, to deinstitutionalize by providing a community residential placement for institutionalized women, to provide an alternative to women whose home situation was deleterious, and to provide an adult living situation for women whose home dependency was deleterious to their occupational and social growth. The group home was a nine-room split-level house with four bedrooms, a living room, dining room and kitchen, an activity room, a laundry room, a private den, and 2½ baths. Program planning for the six residents was divided into two basic parts: structured individual program plan activity, and individual choice activity. Over an 18-month period, four of the six residents were placed into various apartments. Three of the four women successfully made the transition. An evaluation of the group home training experience, examining aspects of the women's social competency prior to and following group home living, indicates that it was successful. Results are analyzed and tabulated. The key factor contributing to success in similar projects is an emphasis on developmental as opposed to custodial care.

Hartford SITO Project Documentation. The Use of Case Management and Purchase of Service Contracts in the Community Life Association.

Community Life Association, Hartford, Conn.
Mar 74, 96p
SHR-0000030 Available from PROJECT SHARE, PC$ 6.00.

The progress of the Community Life Association (CLA) System of Management and purchase of service is documented after approximately six months of operation. Two types of case managers are employed, the family service workers operating from Neighborhood Life Centers (multiservice centers), assist neighborhood residents to obtain employment or improve their existing employment making the individual fully or partially self-supporting. The case worker implements the plan through purchase of service arrangements with more than 25 public or private participating area agencies. Personal case workers provide alternatives to unnecessary institutionalization of elderly people by providing services to maintain the older person in his or her own home, in the home of a family member, foster home, or other supervised living arrangement. Appropriate health and social services are arranged or purchased according to contracts with provider agencies. Cost and effectiveness information of this mode of services delivery is not yet available due to lack of funds for an automated data system. Conclusions reached after six months operation indicate an improved accessibility of services to clients, documenting of service inadequacies, and initiation of new or improved high priority services. The initial steps in developing a case management and purchase of service model have resulted from this experience. Portions of this document are not fully legible.

Hidden Impediments to Deinstitutionalization.

Robert M. Gettings.
National Association of Coordinators of State Programs for the Mentally Retarded, Inc., Arlington, VA.
1977, 6p
SHR-0002459 Pub. in State Government v50 n4 p214-219 Autumn 1977.

This study outlines barriers to the development and implementation of deinstitutionalization of the retarded at the State level. Semantic arguments over the applicability of 'deinstitutionalization' often conceal the real ideological struggle between parties favoring total evacuation from all large facilities and those accepting 24-hour care/supervision. Recently, the Federal government assumed a large financial role in caring for the retarded, increasing its expenditures 300 percent from 1970 to 1977. The Government's expanded role includes: (1) extension of Medicaid benefits; (2) liberalization of eligibility for Federal/State social services (under Title XX of the Social Security Act); (3) enactment of the Supplementary Security Income (SSI) program; and (4) escalation of the Social Security and SSI benefits. Federal laws such as the Education for All American Children Act, the Rehabilitation Act, the Housing and Community Development Act, et al. allow the legislative basis necessary for deinstitutionalization. Funds and laws, however, cannot overcome the lack of: interagency coordination, Congressional coordination (interaction between four to five major committees involved), and clear Federal guidelines. On the organizational level, growth and diversification in community-based programs allows wider options, but complicates access and program shifts in response to client needs. Judicially, many cases safeguarding the constitutional rights of the retarded have recently dramatized their plight. Ironically, this often worsens the situation, as such fanfare obscures the need for legislative and administrative action. Moreover, litigation removes health care staff from their social service functions when they are forced to respond to litigation as defendants and witnesses. A diagram of HEW expenditures for mental retardation and bibliographic references are included.

Home - Based Programs: A Growing Alternative.

Deanna Dudzinski and Donald L. Peters
Pennsylvania State Univ., University Park
1977, 11p
SHR-0002572 Pub. in Child Care Quarterly v6 n1 p61-71
Spring 1977.

This paper discusses the advantages of operating home - based programs for young retarded or severely handicapped children. There is considerable variety among home - based programs, but the goal of all programs is to affect a lasting change in what is happening in the homes. In the home visitation model, a home visitor makes recurring visits to the home to work directly with the child, the mother, or the mother - child dyad. Home visitation has the advantage of being easily adapted to a wide range of environmental circumstances. Another model relies on parent group meeings which provide both emotional support and practical information about motivating children, making and using inexpensive home learning materials, dealing with interpersonal problems of families, and improving home management skills. Two other types of home - based programs are the home visits / group meetings in combination with preschool involvement programs. Key elements in home - based programs are as follows: the structure of the learning situation, the individualization of program activities, the focus on the mother - child dyad, the home visitor assuming a secondary role, the motivation of parents, and the comprehensiveness of the family support system. The benefits of establishing and operating home - based programs are listed. A bibliography is included.

Home Care: An Alternative to Institutionalization.

Massachusetts State Department of Elder Affairs, Boston.
Mar 76, 403p
PB-266 909 Available from NTIS
PC$13.25/MF$3.00

A home care project is evaluated as an alternative to institutionalization in Worcester, Massachusetts. The project's target population consisted of elderly persons, identified as being in a crisis situation, who would probably soon be institutionalized and elderly persons in institutions who could return to the community if the necessary support services were available. One goal of the project was to develop and test a service payment system based on a capitation concept rather than on a direct fee-for-service model. It was envisioned that public resources could be used more efficiently if home care services were provided in the community as opposed to care in institutional settings. Of particular concern were elderly persons, not needing intensive medical care, but, in need of assistance with one or more of the basic tasks of daily living, such as meal preparation, shopping, and housekeeping. Data were obtained in the course of the project on 485 individuals. The sample was randomly divided into experimental and control groups. A plan of care was devised, based on available community services. Sixty services were made available in the areas of nutrition, transportation, homemaker, housing, health, and other. Almost half of the experimental group received no services. A comparison of service recipients with nonrecipients could not explain the low participation level. The average monthly cost of home care was $28.42, much less than the monthly rate of $387.50 for institutional care. Costs for services were greater for individuals living with a spouse than for those living alone, and costs for homemaker services were greater than any other costs. Additional information on the project is appended.

Home Health: The Need for a National Policy to Better Provide for the Elderly.

Comptroller General of the United States, Washington, DC.
Dec 1977, 67p
SHR-0002276 Available from U.S. General Accounting Office, Distribution Section, P.O. Box 1020, Washington, DC 20013.

The coordination of Federal programs offering home health benefits for the elderly is addressed, and the need for a comprehensive national policy focusing on the delivery of home health services is reported. Costs associated with the provision of home health services to the elderly, including the value of services rendered by family and friends, are examined in terms of level of impairment and are compared with costs of nursing home care. As one becomes more impaired, the costs of home services increase along with the proportion of care provided by families and friends until, at the 'greatly impaired' level, the breakeven point in cost is reached. There is a high probability that older people who live alone will eventually be institutionalized. It is proposed that 200,000 public service jobs be created to provide home health services for the elderly to help deter the need for institutionalization. Costs related to the changes in Medicare and Medicaid liberalizing home health benefits are, for the most part, not eyed as prohibitive. Difficulties in the coordination of Federal home health programs are discussed, and three recommendations are made: (1) DHEW should have intermediaries and carriers publicize the use of home health care and provide information about the availability of home health services to physicians and institutions; (2) DHEW should identify State Medicaid programs which do not provide equal treatment to eligible individuals; and (3) DHEW should develop a comprehensive national home health policy. Appendices contain additional information on home health services.

Human Services Trends in the Mid-1970s.

Harold W. Demone, and Herbert C. Schulberg.
Harvard Medical School, Boston, Mass. Dept. of Psychiatry.
1975, 12p
SHR-0001717 Pub. in Social Casework v56 p268-279 May 75.

Trends in ideologies and social values, civil rights, technology, administrative practices, and program patterns associated with the human services industry in the early 1970's are reviewed. Six contemporary ideological trends have contributed to the modeling of the human services delivery system by the mid-1970's: equity of care, personal choice, citizen participation, deinstitutionalization, decriminalization, and profitmaking. Most of these trends had their genesis at the community and State levels. Separable but closely linked civil rights trends are evident in judicial decisions, legislation, and rules and regulations. Collectively, these trends have altered human services in the areas of equal protection, privacy and confidentiality, thought control, right to treatment, and protection of human research subjects. The third major set of forces affecting human services is the level of technological sophistication available for dealing with given problems. Technological advances can enhance such social values as equity of care. However, when technological advances conflict with contemporary values, problems arise. Among the key administrative practices developing in human services organizations are accountability and evaluation techniques, management controls, planning procedures, and unionization of personnel. Purchase of service, decentralization, care-giving networks, and self-help groups are among emerging program patterns. Conclusions are drawn regarding the implications of the trends.

Identifying the Housing and Support Service Needs of the Semi - Independent Elderly: Toward a Descriptive Planning Model for Area Agencies on Aging in Illinois.

Leonard F. Heumann and Monica Lindeman
Illinois Univ. at Urbana - Champaign. Housing Research and Development Program.
1977, 135p
SHR-0002501 Available from University of Illinois at Urbana - Champaign, 1204 W. Nevada St., Urbana, IL 61801.

This report presents the findings of a 2 - year study on housing and support service needs of semi - independent elderly persons conducted for the Department on Aging of the State of Illinois. The objectives of the study were: (1) to define those elderly persons who suffer from various functional impairments and marginal social adjustments but are not so ill as to require a totally dependent environmental setting; (2) to define the housing, financial, environmental, and supportive service needs of elderly persons in Illinois; (3) to explore the possibility of enumerating this population at the local level so that the responsible local, State, and Federal agencies can plan for and create necessary housing and support service programs. The overall needs analysis model involved: (1) developing a base matrix describing the elderly submarkets by housing and household characteristics; (2) defining functional disability levels; (3) developing a disability and submarket matrix; (4) defining the marginal social adjustment indicators covering low income and housing inadequacy; and (5) developing a set of matrices crosstabulating housing and low income needs with the elderly submarket and functional disability. A subarea quality analysis was conducted to identify concentrations of elderly to determine the quality of the environments and to rank subareas in terms of desirability as places to locate housing and support services. Once housing and support service needs were identified, the model was employed to match supply with need. Tables, maps and diagrams provide supporting data, and additional information is included in the appendices.

Independent Living for the Mentally Retarded: Issues in Deinstitutionalization.

Roger M. Nooe
Tennessee Univ., Knoxville. School of Social Work.
16 May 77, 20p
SHR-0002555 Available from National Conference on Social Welfare, 22 W. Gay St. Columbus, OH 43215.

This article describes a promising approach to developing alternatives to institutional care for the mentally retarded. True alternatives to institutional care for the mentally retarded must duplicate patterns and conditions of everyday life as nearly as possible. Too often group homes, boarding homes, and other community based facilities simply reproduce institutional conditions on a smaller scale. The transitional group home, in which the institutionalized person prepares himself for permanent community residence, allows the individual and health care staff ample opportunity to evaluate and decide among community alternatives. Project Open Door was developed as a transitional living facility for mentally retarded adults. The program emphasized self - responsibility and skill development through interaction with the community. There is an element of risk involved in releasing the mentally retarded individual into the community and the employment of normal solutions is recommended in case of problems. If possible, reinstitutionalization should be avoided. The critical issue for determining degree of independence is the degree to which one is able to manage his affairs, including his financial affairs. The criteria for identifying skills should be that the skill is necessary for community living and reliance on psychological tests in this area should be minimized. The most important tasks for transitional homes involve: (1) rekindling emotional expression; (2) developing problem solving techniques; 3) solidifying the self - concept of the retarded person; and (4) directing the released individual in the use of community, rather than institutional, resources. Bibliographic information in the form of footnotes follows the paper.

Is Statewide Deinstitutionalization of Children's Services a Forward or Backward Social Movement.

George Thomas.
Regional Inst. of Social Welfare Research, Inc., Athens, Ga.
Feb 76, 93p
SHR-0001135 Available from NTIS, PC$ 6.00/MF$ 3.00.

Alternatives to the institutionalization of children are explored. Sources of pressure on States in the movement toward the deinstitutionalization of children's services are examined. These pressures derive from the assumed negative effects of institutionalization on children, social reform actions and movements, legislation, and citizen groups. Four deinstitutionalization alternatives are detailed: (1) reduce the average length of stay in institutions; (2) minimize referrals for admissions, either gradually or totally, and close institutions by attrition; (3) develop a phaseout plan that combines a more rapid release of children with a progressive decline in referrals for admission; and (4) move toward a highly differentiated system in which some institutions are maintained for treating a small percentage of extremely difficult or seriously deviant children, while eliminating others incapable of servicing such a population. The effects of institutionalization on children are assessed. Service alternatives to institutionalization are identified as foster family care, group home care, community-based services, and strengthening family life. Possible consequences of deinstitutionalization are discussed, and issues to consider in the development of a deinstitutionalization plan are cited. A bibliography is provided.

Juvenile Corrections in the States: Residential Programs and Deinstitutionalization. Preliminary Rept.

Robert D. Vinter, George Downs, and John Hall. Michigan Univ., Ann Arbor. National Assessment of Juvenile Corrections.
1976, 80p
Executive Summary available from PROJECT SHARE.
SHR-0000979 Available from Institute of Continuing Education, University of Michigan, Hutchins Hall, Ann Arbor, MI 48109.

An analysis of residential services provided by State agencies for young offenders in their care is provided for State policymakers and agency executives. The data set is composed of youth in programs that during 1974 were operated by or received some funding from State agencies charged with administrating residential services for young offenders. Data were collected during field trips to 16 sample States and reconnaissance visits to several other States, followed by interviews with officials and staff of agencies in all 50 States. It was found that some States assigned about 20 times more youth to institutions than others. The number of offenders in State camps and ranches has been stable at slightly more than 2,500 for about five years; the number of youths in State institutions declined from 41,000 to 25,000 during the same five years (1969 - 1974). States spent about $300 million for the operation of institutions, camps, and ranches during 1974. An aggregate average daily population of 5,663 was identified in State-related community-based residential programs in 1974, about one fifth the number assigned to institutions. States have undertaken community-based corrections services in two modes: one involving direct administration and operation of facilities and the other involving purchase of service funding for facilities operated under administrative auspices. The implications of the study for policy and program development are discussed.

National Deinstitutionalization Study.

David Braddock.
1977, 7p
SHR-0002460 Pub. in State Government v50 n4
p220-226 Autumn 1977

Problems surrounding deinstitutionalization are presented from five perspectives: (1) a literature review, (2) problems noted in state planning documents, (3) data emanating from 48 accreditation surveys, (4) trends in information and training materials, and (5) the presentation of concrete suggestions at the State level. The review of ideological, public policy, and psychosocial literature revealed that while there is great support for deinstitutionalization at the Federal level, the Federal government possesses no coherent policy in this area. Support for deinstitutionalization diminishes at the State and local level, resulting in slight population declines in most State institutions. State planning documents disclosed that while services to residents in most institutions were inadequate, there are presently not enough community-based services to risk deinstitutionalization, and the cost of upgrading existing institutions is prohibitive. The inadequacy of institutional services was found to be amplified in the survey data of the Joint Commission on Accreditation of Hospitals. Deficiencies were identified in the physical environment, personnel, program planning and in subsequent violations of constitutional rights. A marked increase of information and training materials on community reintegration was viewed as evidence of growing momentum to change from institution-dominated systems to systems based on community services. It was suggested that community-based service systems must be developed prior to deinstitutionalization. It was further recommended that future lifelong-care institutions be limited in size, and that parent education programs, pregnancy screening, abortion and infant-care programs be implemented to prevent the need for institutionalization in many cases. Finally, the possibility and financial consequences of judicially mandated deinstitutionalization were discussed.

National Perspective of Community Residential Facilities for Developmentally Disabled Persons. Home is a Good Place.

Gail O'Connor.
Oregon University, Eugene. Rehabilitation Research and Training Center in Mental Retardation.
1976, 92p
SHR-0002313 Available from American Association on Mental Deficiency, Inc., 5201 Connecticut Avenue, NW, Washington, DC 20015

The findings of a nationwide descriptive study of community residential facilities (CRF's) for developmentally disabled persons, including the mentally retarded, are reported. The study covered the period from 1972 to 1974, and information was obtained through a nationwide mail survey of facilities and interviews with CRF operators. A CRF was most commonly found to be a large older home in a residential or combined business/residential area located within walking distance to stores and shops. Most residents shared a bedroom with one or two other persons. Over two-thirds of the facilities offered residents a relatively normal home life but about one-half of the residents were living in 'non-normalized' conditions, normalization being related to facility size. The larger facility was usually staffed by a full-time administrator and direct care personnel, and the smaller facility by house parents. The average staff to resident ratio was 0.52, or one staff member to every two residents. The ratio was higher for children and adolescents than for adults. Major causes of staff turnover were low pay, long hours and little privacy. Virtually all facilities utilized some type of community services, with transportation presenting a vital problem. Detailed information was obtained on the background and characteristics of residents. Facility managers believed that 4 out of every 10 residents would eventually be able to live independently in the community. Supporting data are tabulated in an appendix, and a bibliography is included.

Opening Closed Doors: The Deinstitutionalization of Disabled Individuals.

David Braddock
Council for Exceptional Children, Reston, Va.
1977, 183p
SHR-0002542 Available from Council for Exceptional Children, 1920 Association Dr., Reston, VA 22091.

This book surveys current trends and issues pertaining to program planning for deinstitutionalization of the mentally handicapped. Each chapter can be consider as a separate module, if the reader seeks information in a specific area. The introductory chapter examines deinstitutionalization from ideological, public policy, social, psychological, and programmatic perspectives. Chapter II reports a study of trends in contemporary deinstitutionalization planning experience in 34 States. An analysis of recent data, collected from accreditation surveys of residential facilities in 21 States is provided in chapter III. Both chapters II and III concentrate on obstacles impeding deinstitutionalization. Chapter IV considers a study of available print and audiovisual information and training materials on reintegrating retarded individuals into community settings. This chapter refers to an annotated bibliography, which appears after the final chapter. Chapter V provides practical suggestions for program planners, administrators, and legislators contemplating involvement in deinstitutionalization efforts. The final chapter restates major study findings and addresses public policy questions. Based on these findings, the following changes are recommended: (1) development of supportive community mental health services; (2) provision of facilities, which provide growth and personal comfort, for severely disabled persons who require intensive treatment, and (3) development of comprehensive parent education, pregnancy screening, and maternity and infant care to reduce the frequency of many high risk factors which cause disabilities and, hence, reduce the possibility of institutionalization. During the transitional years State expenditures for the mentally handicapped may double. Appendices support the discussion.

Overview of State Human Service Activities.

Minnesota State Planning Agency, St. Paul.
11 Dec 73, 48p
SHR-0000263 Available from PROJECT SHARE, PC$ 4.50.

Human services activity in Minnesota is reviewed for a committee of the Minnesota legislature by the Director of Human Resources Planning of the State Planning Agency. Five major trends in human services in Minnesota are identified: strengthening of local delivery capability, development of alternatives to institutionalization, increased internal State agency accountability, regionalization, and increased interagency cooperation. Specific activities of State agencies as they relate to these trends are discussed, including corrections, vocational rehabilitation, allied health personnel credentialing, health manpower job descriptions, public assistance, and child development. A compilation of Federal and State level activities concerning human services is provided for a number of agencies. This compilation includes a description of the activity and its objectives, its current status, and anticipated 1974 and 1975 legislative action. Anticipated new legislative requests are included. Portions of this document are not fully legible.

Relocation of Released Mental Hospital Patients into Residential Communities.

Julian Wolpert and Eileen R. Wolpert
Princeton Univ., N.J. School of Architecture and Urban Planning.
1976, 21p
SHR-0002547 Pub. in Policy Sciences v7 p31-51 1976.

Analysis of the trend begun in the late 1950's to release mental health patients on a massive scale reveals profound changes in four areas. In the area of fiscal goals, there has been: (1) probable savings on a per patient basis; (2) some shifting of the financial burden from State to Federal and community levels and to families of the disabled; (3) some shifting of programs and funding from health to welfare and criminal justice sectors; (4) some shifting of neighborhood spillover effects to residential communities; and (5) increase in per deim costs for inpatient treatment. Concerning civil and therapeutic rights, massive release has meant: (1) reduced risks of overhospitalization or improper commitment; (2) increased risks of underhospitalization or insufficient therapeutic or social services; and (3) greater incidence of nondifferentiating release procedures. With respect to treatment goals, there has been; (1) a reduced prospect for research in State hospitals; (2) enhanced opportunities for experimentation with aftercare treatment procedures; (3) increased training opportunities in community based care; (4) enhanced prospects of performance evaluation; and (5) increased opportunity for development of functional patient classification. Concerning goals for an enclusive society, the result has been: (1) increased community awareness about mental disability; (2) increased community awareness about mental disability; (2) ghettoization of released patients; (3) increased community demand for rehospitalization overriding civil rights concerns; and (4) emergence of community volunteerism and advocacy on behalf of released patients. The crucial policy decisions necessary to master the most troubling of the above developments, ghettoization, involve the implementation of county - wide planning for residential sites for released patients. Without such action, court rulings will be necessary and forthcomming to restore freedom of residential choice for the disabled. A bibliography is included.

Service-Integrating Model for Deinstitutionalization.

William E. Datel, and Jane G. Murphy.
Virginia Service Integration for Deinstitutionalization Project, Richmond.
1975, 11p
SHR-C001977 Pub. in Administration in Mental Health p35-45 Spring 1975.

This service integration model being tested in Virginia features a coalition of institutional and community workers to assess client needs and prescribe services and a broker-advocate marshaling resources in the community to meet specific needs. The model focuses on the mentally ill and mentally retarded and juvenile offenders and is designed to be a service integration procedure for the orderly deinstitutionalization of residents in State institutions. Consideration is given in the model to some of the problems involved in the deinstitutionalization process. These problems pertain to the impermeability of organizational boundaries between State institutions and communities; high recidivism rates; a lack of communication, coordination, and followup; insufficient accountability; and inadequate resource planning. Five main structural components of the model are detailed: an assessment and prescription team, a field staff of broker advocates, a quality control team, an automated information system, and a committee of commissioners. The client processing procedure is described and illustrated in a flowchart. Target groups and areas are delineated, and program activities in the model not directly related to the client are noted.

Excerpts read to the President's Committee on Mental Retardation in Philadelphia, June 20, 1974.

Service Integration for Deinstitutionalization.
Volume Cne: Summary.

SID Project, Richmond, Va.
Jun 75, 81p
Executive Summary available from PROJECT SHARE.
SHR-0000405 Available from NTIS, PC$ 6.00/MF$ 3.00.

Volume One of an eight-volume report on a three-year research and demonstration project on service integration for deinstitutionalization (Project SID) sets forth the major findings and conclusions of the project and outlines the contents of the accompanying volumes. Project SID was a collaborative effort among 12 State agencies in Virginia and their local community counterparts to develop a systematic, service-integrating procedure for the orderly deinstitutionalization of residents of State mental hospitals, training schools for the mentally retarded, and training schools for the juvenile offender. Toward this end, a procedural model was developed and demonstrated with approximately 500 clients from two geographic areas housed at 11 State institutions. The model embodies five basic components: assessment and prescription team, broker advocate, automated information system, quality control team, and committee of commissioners. The study also included a cost / benefit analysis designed to ascertain the fiscal wisdom of continued institutionalization versus community placement. In addition to providing a summary description of the project, the initial volume states a number of assertions drawn from the project and relates these to the appropriate accompanying volumes.

Volumes 2-8, and the Team Manual are available as SHR-0000722-730.

Service Integration for Deinstitutionalization.
Volume Two: Implementation Procedures.

SID Project, Richmond, Va.
May 75, 116p
Executive Summary available from PROJECT SHARE.
SHR-0000722 Available from NTIS, PC$ 6.50/MF$ 3.00.

Volume Two of the Project SID (Service Integration for Deinstitutionalization) report describes operational procedures for implementation of the SID model for the systematic deinstitutionalization of residents of State institutions. As documented in this and accompanying volumes, the SID model was constructed and is operative in two geographic areas in Virginia and with three classes of institutionalized clients: the mentally ill, the mentally retarded, and the juvenile offender. Volume Two provides a description of the model itself, and discusses coordination requirements for its implementation. Among the latter are the decision to implement; designation of the program director / coordinator, coordination at the State and local level, and maintenance and movement. Client processing procedures, in which broker advocates, assessment and prescription teams, and the clients themselves are the major communicators, are described and illustrated in flow charts. Procedures for program evaluation and resource planning, personnel requirements, and office management also are documented. An elaborated description of the model, details of coordination activities in Virginia, sample automated program evaluation reports, and job descriptions are appended. A methods and procedures manual, assessment and prescription team manual, and office procedures manual are bound separately.

Volumes 1, 3-8, and the Team Manual are available as SHR-0000405, SHR-0000723-730.

Service Integration for Deinstitutionalization.
Volume Three: Automated Information System.

SID Project, Richmond, Va.
May 75, 210p
Executive Summary available from PROJECT SHARE.
SHR-C000723 Available from NTIS, PC$ 9.25/MF$ 3.00.

Documentation of data processing activities involved in Project SID (Service Integration for Deinstitutionalization) is provided in Volume Three and in an accompanying volume of supplementary material. The SID automated information system electronically files assessment, prescription, resource availability, and service delivery information and generates a series of case management reports and program evaluation reports. The former are used in serving individual clients; the latter aggregate data across clients and enable monitoring of the overall program. Documentation is such that the SID information system can be adopted with little or no consultation. System documentation includes the following: (1) a system narrative describing every aspect of the system other than technical details of program mechanisms; (2) appended materials, including card and record formats and documentation reports referred to in the system narrative; (4) computer listings; (5) program narratives discussing the technical details of selected programs; (6) compiler listings of all COBOL programs with compiler-produced sorted cross-references and program flow cross-references produced by a SID program, together with a listing of an assembler language program (ISAM) used in the system but not written by SID personnel; and (7) the DYL-250 OS Users Manual, describing the use of a computer program which is an integral part of the system. Volume Three presents the system narrative in its entirety and is accompanied by a separate volume of sample printouts. Other components of the documentation are bound separately or are available on tape.

Volumes 1-2, 4-8, and the Team Manual are available as SHR-C000405, SHR-0000722, SHR-0000724-730.

Service Integration for Deinstitutionalization. Printouts for Automated Information System: Supplement to Volume 3.

SID Project, Richmond, Va.
May 75, 59p
Executive Summary available from PROJECT SHARE.
SHR-C000724 Available from PROJECT SHARE, PC$ 5.25.

Sample printouts for the SID (Service Integration for Deinstitutionalization) automated information system are provided as a supplement to the system narrative presented in Volume Three. Sample printouts are included for the following reports: edit, update, DYL-250 parameter card generation, intermediate DYL-250 parameter card generation, assessment summary, behavioral repertoire, prescription summary, behavioral repertoire statistics, fulfillment of institutional prescriptions digest, and client status. Sample printouts are also provided for reports on errors in client information, broker advocate caseload reports, resource search results report, resource directory table of contents and report, resource directory area index and resource directory service index, client processing summary report, and client status update report. Other printout samples illustrate the cumulative resource search results report, client file rebuild report, text file rebuild report, tables file update and print lists, control file rebuild report, agency file rebuild report, service file rebuild report, and branch file rebuild report.
Portions of this document are not fully legible.

Volumes 1-3, 4-8, and the Team Manual are available as SHR-C000405, SHR-0000722-723, SHR-0000725-730.

Service Integration for Deinstitutionalization.
Volume Four: Findings.

SID Project, Richmond, Va.
Jun 75, 218p
Executive Summary available from PROJECT SHARE.
SHR-0000725 Available from NTIS, PC$ 9.25/MF$ 3.00.

Data on client characteristics, client outcome, resource requirements, service availability, and service delivery are presented and discussed in Volume Four of the Project SID (Service Integration for Deinstitutionalization) report. Volume Four also contains a descriptive section on service integration findings and developments. The data represent clients from four State mental health or mental retardation institutions and seven juvenile corrections institutions who had homes in one of two districts. A total of 498 clients were assessed; 453 clients were assessed and prescribed for; and 163 reassessments / represcriptions were performed. SID assessment and prescription teams prescribed 63 percent of the clients for community placement. The principal service blockage preventing community placement of clients was the unavailability of suitable housing. Once placed in the community, clients overwhelmingly expressed a preference for community living over institutional living and exhibited a decrease in maladaptive behavior. With regard to service-integration functioning within the project, those functions related to direct service linkages are strong and well developed, while those related to administrative support services are weak and require strengthening. Service integration functions related to coordination development are strong at the community level, but weak at the State level. Possible causes for the various strengths and weaknesses observed are discussed. Supporting data are included.

Volumes 1-3 (and supplements), 5-8, and the Team Manual are available as SHR-0000405, SHR-0000722-724, SHR-0000726-730.

Service Integration for Deinstitutionalization. Volume Five: Cost / Benefit Analysis.

SID Project, Richmond, Va.
Apr 75, 240p
Executive Summary available from PROJECT SHARE.
SHR-C000726 Available from NTIS, PC$ 9.50/MF$ 3.00.

An analysis of economically measurable costs and benefits incurred in the operation of the Project SID (Service Integration for Deinstitutionalization) model is documented in Volume Five of the SID report. Costs and benefits of deinstitutionalizing and maintaining a sample of 52 mentally ill and metally retarded clients in the community are projected over a period of ten years, costs and benefits being determined from the perspective of society-at-large. To refine the analysis, clients are stratified by housing, employability, and source of income. Data are entered on an individual client basis for each of five cost and two benefit elements to which dollar values can be attached. Cost elements include community supportive services, client maintenance, service integration costs, deinstitutionalization costs, and lost economic productivity. Benefit elements include savings of institutional costs and increased economic productivity. In addition, intangible community-related costs and intangible psychosocial benefits to the client and to the community are considered. The only stratum (stratum 5) for which costs exceed benefits is that containing clients who are in ~~intensive~~ care housing, not employable, and receiving at least half their income from public sources. Ratios of benefits to costs for the other client strata range from 1.52 to 11.86. Average net benefits per client over ten years range from $13,000 to over $46,000 in those strata where the ratio exceed 1.00. In stratum 5, the average net cost per client for ten years is $395.93. Details of calculation methodology and sample selection are provided. Appended materials include a breakdown of cost and benefit elements, digests of client assessment and prescription data, and summary data for each stratum and across all strata. Portions of this document are not fully legible.

Volumes 1-4, 6-8, and the Team Manual are available as SHR-C000405, SHR-0000722-725, SHR-0000727-730.

Service Integration for Deinstitutionalization.
Volume 6: Legal Issues.

SID Project, Richmond, Va.
14 Mar 75, 309p
Executive Summary available from PROJECT SHARE.
SHR-0000727 Available from NTIS, PC$11.75/MF$ 3.00.

Legal questions, issues, and problems encountered in the SID (Service Integration for Deinstitutionalization) project are reviewed in Volume Six of the SID report. Legal questions are examined on an issue by issue basis -- the legal issue or problem is set forth, the solutions attempted are explored, and solutions reached are briefly articulated. Statutory and legal - administrative barriers encountered in the development and operation of the SID model are enumerated and thoroughly explored. Among the issues disscussed are: clarification of statutory terms; right to treatment; release of information concerning juverile offenders; patient labor; and prospective regulations implementing patient rights. It is noted that the SID model is not designed to accommodated individual client advocacy or collective advocacy, since the organizational structure that provides the keystone for the operational success of the SID model is nct the proper medium for the growth, maturation, and flowering of legal analysis. Also included are exhibits providing additional details and nuances of legal issues presented in the text. Portions of this document are not fully legible.

Volumes 1-5, 7-8, and the Team Manual are available as SHR-0000405, 722-726, 728-730.

Service Integration for Deinstitutionalization.
Volume Seven: Plan for Extension.

SID Project, Richmond, Va.
Mar 75, 162p
Executive Summary available from PROJECT SHARE.
SHR-0000728 Available from NTIS, PC$ 8.00/MF$ 3.00.

The events leading to the development of a plan to extend the SID (Service Integration for Deinstitutionalization) model in the Commonwealth of Virginia are traced, the plan itself is presented, reaction to the plan is discussed, and the quest for supporting funds for the extension is reviewed. At the time of writing, the fate of the SID model in Virginia beyond June 30, 1975 was uncertain. The main recommendations of the plan for extension are: (1) that the five service-integrating components in the SID model be preserved; (2) that the SID program be organizationally situated within the Office of Human Affairs with direct authority from the Secretary to the program director; (3) that the SID committee of commissioners serve as an advisory board to the Secretary; (4) that coordination among State agency head members of the SID committee of commissioners be formalized in an interagency contract; (5) that, at the local level, the agency of which the assessment and prescription team chairperson is a member be the lead agency for that locale; and (6) that the assessment and prescription team chairperson assume the duties of community services coordination, assisted by the SID chief broker advocate. Other recommendations relate to supervision of client-related duties of the broker advocate staff; salaries for SID staff members, part-time assessment and prescription team, and committee of commissioners members; restriction of the SID model during Fiscal Year 1975-76 to two demonstration communities; continued development of procedures to enable processing of at-risk community clients, including formation of four local assessment and prescription teams in the large rural demonstration area and testing of a modified organizational arrangement; and the addition of four more geographic areas to the SID program in FY 76-78. Supporting documentation and a SID staff study of the relative merits of continuing or deleting Project SID are appended.

Volumes 1-6, 8, and the Team Manual are available as SHR-0000405, SHR-0000722-727, SHR-0000729-730.

Service Integration for Deinstitutionalization.
Volume Eight: Addendum.

SID Project, Richmond, Va.
Sep 75, 68p
Executive Summary available from PROJECT SHARE.
SHR-0000729 Available from NTIS, PC$ 5.25/MF$ 3.00.

The major purpose of the addendum to the SID (Service Integration for Deinstitutionalization) report is to provide updated information on the status of three previously unresolved issues: (1) funding of the SID model after September 30, 1975; (2) integration of the model into State and local governmental structures; and (3) development of community teams to serve multi-need, noninstitutionalized clients. The status of the model vis-a-vis the three issues has remained essentially unchanged since the writing of Volume Seven. Funding for 1976 has been established, but the committee of commissioners has made no decision regarding the future of the model after that date. The organizational structure outlined in the project's original grant has been maintained primarily by inaction. Although the committee of commissioners voiced opposition to retaining the existing organizational structure over the long-term, staff suggestions concerning alternative arrangements have not been acted upon. The development of community teams to serve multi-need local residents has shown progress. At the time of writing, teams were functioning in each SID demonstration area, and personnel from a variety of agencies were making referrals. It is suggested that the events reported in the addendum support an earlier hypothesis that the strength of the SID model rests at the local rather than the State level. The addendum also contains updated quantitative results related to the client outcome information presented in Volume Four, as well as a summary of recent developments in the automated information system.

Volumes 1-7, and the Team Manual are available as SHR-0000405, SHR-0000722-728, SHR-0000730.

Service Integration for Deinstitutionalization Project: Methods and Procedures Manual.

Virginia Department of Mental Health and Mental Retardation, Richmond. Service Integration for Deinstitutionalization Project.
Feb 1975, 169p
PB-254 850 Available from NTIS, PC$8.00/MF$3.00.

Procedures and forms resulting from the service integration for deinstitutionalization (SID) project in Virginia are contained in this manual. Procedures focus upon requirements associated with obtaining, recording, and distributing information on a given client. The method employed to gather information from service agencies to construct an automated resource directory is detailed. Steps followed in processing a given client under the SID model are detailed, and consideration is given to forms control, man-hours, and training aspects of data collection. Eight sections of the manual deal with authorization to furnish information on mentally ill and mentally retarded clients and on juvenile offender clients, an assessment format for clients, prescription format for clients with regard to institutionalization versus community placement, determination of resource availability and utilization, client movement and status, client followup, reporting of blockages to community placement, and caseload accounting. Extensive procedural information and related forms pertaining to these eight sections are contained in appendices.

Service Integration for Deinstitutionalization Project: Office Procedures Manual.

Virginia Department of Mental Health and Mental Retardation, Richmond. Service Integration for Deinstitutionalization Project.
Feb 1975, 32p
PB-270 441 Available from NTIS, PC$4.50/MF$3.00.

This document is part of a multivolume report on a 3-year research and demonstration project involving service integration for the deinstitutionalization of client care in Virginia. Fringe benefits and office procedures designed for the staff of the project are detailed, and an organizational chart of the project and a staff directory are provided. Detailed instructions for filling out client processing forms and procedural guidelines relating to the duties and responsibilities of staff members are also included. The goal of the service integration deinstitutionalization project is to develop a systematic procedure for placing residents of State institutions in the community setting.

Services to Troubled Youth. A Review and Recommendations.

Pennsylvania Joint State Government Commission, Harrisburg, Pa. Task Force on the Study of Services to Delinquent, Dependent, and Neglected Children.
Mar 75, 114p
Executive Summary available from PROJECT SHARE.
SHR-0000195 Available from NTIS, PC$ 6.50/MF$ 3.00.

A review is presented of the history and development of existing systems of services for troubled youth in the Commonwealth of Pennsylvania, and findings and recommendations are presented relative to coordination and responsibility, funding, and deliquency prevention and community - based services. Statutory authorization is cited for six basic types of services: juvenile courts, probation subsidies, Pennsylvania Institutions for Children, child welfare, mental health and mental retardation, and rehabilitative and educational programs. An imperative need for coordination of existing services to the delinquent and deprived child at the community level is identified, as is a need for fixing the responsibility for overseeing, coordinating, and directing these services. It is recommended that State - level coordination be implemented through establishment of a Department of Youth Services, and local - level coordination through youth services bureaus. A revision of the State - local funding responsibility for treatment of delinquent children and supervision of deprived children is recommended, as are development of effective methods of preventing and reducing juvenile delinquency, greater utilization of the existing school system to identify antisocial behavior and needs of deprived children, development of alternative education opportunities for children who do not benefit from existing programs offered in the schools, and encouragement of community - based treatment programs and facilities for rehabilitation of delinquent children to divert juveniles from the traditional juvenile justice systems and to provide alternatives to institutionalization. In support of its recommendations, the Task Force on Services to Delinquent, Dependent, and Neglected Children presents a draft of proposed legislation establishing a Department of Youth Services. Supporting tabular data and documents are included.

SID Project. Plan for Continuation of SID Program Beyond June 30, 1975.

Virginia Service Integration for Deinstitutionalization Project, Richmond.
18 Oct 74, 76p
Executive Summary available from PROJECT SHARE.
SHR-0000244 Available from PROJECT SHARE, PC$ 6.00.

A model for a systematic, service - integrating procedure to facilitate the orderly deinstitutionalization of residents of State institutions is described in this report of the Service Integration for Deinstitutionalization (SID) project implemented under a 3 - year grant to the State of Virginia. A system which is being developed contains the following five components, each with service integrating properties: the assessment and prescription team, which assesses each client's individual suitability for deinstitutionalization; the broker advocate, who arranges and coordinates service deliveries to the client; the automated information system; the quality control team consisting of staff members representing different disciplines (sociology, psychology, law, social work and government management); and the Committee of Commissioners, composed of agency heads of the participating State agencies. The model is being demonstrated in two areas, one rural and one urban. It includes the following institutions: two large State mental hospitals for the mentally ill; two large State training schools for the mentally retarded; and seven small State training schools for the juvenile offender. Constraints and pitfalls in the project are described with steps outlined to meet these problems. Results of the program to date indicate a success ratio of 66. The organizational placement of SID is described, and the operational mode for 1975-1976 is outlined according to geographic areas, manpower, funding, and clientele, with a similar mode presented for 1976-1978. Priorities, needs, and products also are analyzed. Portions of this document are not fully legible.

SID Team Manual.

SID Project, Richmond, Va.
Feb 76, 114p
Executive Summary available from PROJECT SHARE.
SHR-C000730 Available from NTIS, PC$ 6.50/MF$ 3.00.

The structure, functions, and procedures of the Project SID (Service Integration for Deinstitutionalization) assessment and prescription teams are described and placed within the context of the SID model in a manual directed primarily to team members. The interdisciplinary assessment and prescription, or community resource, teams are composed of a coalition of service delivery professionals and comprise a central component of the SID model. Team membership includes representatives of the 12 State agencies sponsoring the model's development in Virginia. The team assesses each client, makes a decision with respect to the client's individual suitability for community residence, and writes a prescription detailing services required to meet the client's needs in the community, or, if the client requires institutional services, to maximize the client's functioning within the institution. Team assumes quasi-legitimate authority in the form of making recommendations for client movement, overseeing service delivery activities and serving as a focus for interchange on service integration matters. Another component of the SID model, the broker advocate, compiles the assessment information, receives the prescription, signals the team when service plans are complete, and monitors the client's receipt of services in the community or institution. The team manual fully documents each of the client processing procedures. Also included in the manual are examples of assessment summaries; sample prescription documents; definitions of community placement prescription elements; sample recommendation process documents; examples of prescription summary and fulfillment of institutional prescription reports; a sample client status report; and sample resource search results and client status update. Portions of this document are not fully legible.

Volumes 1-8 (and supplements) are available as SHR-C000405, SHR-0000722-729.

Social Services in the United States: Policies and Programs.

Sheila B. Kamerman, and Alfred J. Kahn.
Columbia Univ., New York. Cross-National Studies of Social Service Systems.
1976, 561p
SHR-C001123 Available from Temple University Press, Philadelphia, PA 19122.

Program and policy descriptions are provided for a sampling of personal social services areas, with an emphasis on the dynamics of the system in which these services are offered. The topics are selected from among the priority concerns of DHEW and Congress and include child care, child abuse and neglect, children's institutions and alternative programs, community services for the aged, and family planning. The activities, problems, and possibilities of discrete programs in these areas are clarified, and it is suggested that some of these activities become components of a social program field tentatively called personal or general social services. Additional services which might be included in personal or general social services are: social services for families, homemaker or home health aid programs, veterans programs, and correctional and penal services. Service provision is also viewed from the perspective of the structure and organization of services and the arrangements under which services are delivered to consumers. An overview is provided of national initiatives toward service delivery as reflected in legislation, program models, and relevant research. A description of service delivery in one city illustrates one structure for the provision of services. Data concerning social welfare in U.S. communities are contained in the appendix. References follow each chapter.

Summaries and Characteristics of States' Title XX Social Services Plans for Fiscal Year 1976.

Eileen Wolff, and Candace Mueller.
Office of the Assistant Secretary for Planning and Evaluation (HEW), Washington, D.C.
4 Jun 76, 211p
SHR-0000808 Available from House Document Room, U.S. Capitol, Washington, D.C. 20515.

Summary data are presented from Tital XX Comprehensive Annual Service Program (CASP) Plans prepared by 51 States for fiscal year 1976. The plans represent the first attempt by States to publicly describe their social service programs. For each State, a tabular summary is presented of expenditures, clients served, and average cost per client for each social service program in the State. At the bottom of each State's services listing is a breakout by eligibility category for number of individuals served and expenditures (expressed as percentages of totals). The State lists are accompanied by a series of technical notes which offer nationwide summaries for a number of the major services and for various provisions of the Act. Included here are estimates of social services expenditures for all States, data related to the planning process, data on eligibility standards and fees for services, and nationwide summaries of plan content relative to the following service areas: day care services for children, adult day care, services to the aged, family planning services, universal services designated by Title XX (information and referral, protective services for children and adults), home based services, services to alcohol and drug abusers, services to the developmentally disabled and blind, services to child and youth, legal services, health and mental health services, transportation services, and housing services.

Supplementary Services Guidelines for Services Supplementary to Home Health and Homemaker-Home Health Aide Services.

National Council for Homemaker-Home Health Aide Services, Inc., New York.
1977, 32p
SHR-0002389 Available from National Council for Homemaker-Home Health Aide Services, Inc., 67 Irving Place, New York, NY 10003.

Standards and guidelines for safe and effective homemaker-home health aide services have been developed by the National Council for Homemaker-Home Health Aide Services and other national organizations. The National Council has adopted a policy statement on supplementary services, because it actively supports the development of various in-home services to meet a broad range of human needs and enable people to remain in their homes. Elements in planning and delivering supplementary services are as follows: initial planning for a service; providing professional and administrative staff support; recruiting, assigning, and supporting personnel; orientation and ongoing training; planning for emergencies; developing procedures and instruments for effective administration, planning, and accountability; and job descriptions for all categories of workers in each service (paid or volunteer). Procedures for handling insurance matters and related legal problems are detailed. Materials which provide general background information on the aging, atypical children and their families, birth defects, mental health, cancer patients, patients with chronic obstructive pulmonary disease, the retarded, and volunteers are listed. Operational considerations in the establishment of a visitors program, telephone reassurance, chore services, meals on wheels, and transportation and escort services are noted. Basic national standards for homemaker-home health aide services are outlined in an appendix.

Survey of Mental Health Services to the Non-Institutionalized Elderly in New Jersey.

New Jersey State Dept. of Community Affairs, Trenton. Div. of Aging.
Mar 76, 28p
SHR-0001573 Available from NTIS, PC$ 4.50/MF$ 3.00.

A survey was conducted by the New Jersey Division on Aging in the spring of 1975 to determine the level and extent of mental health services for noninstitutionalized elderly residents of the State. Mental health services were defined in the survey to include psychiatric, case work, and counseling services provided by family service agencies, county welfare boards, State grant-in-aid psychiatric clinics, community mental health centers, and other related agencies. The survey was conducted in three phases: (1) preliminary investigation and interviews to obtain data and provide information relevant to the survey; (2) mailed questionnaires to all statewide agencies; and (3) followup interviews at a selected number of agencies. The return rate of the questionnaires mailed was 114 or 68 percent. Information was obtained on the proportion of elderly people in the total agency caseload, the number and type of programs designed specifically for older people, and services offered to all clients and those offered to elderly clients by the various agencies. It was found that over half of the agencies in New Jersey had some type of program designed for older people. Outreach and transportation were the most frequently cited problems in the delivery of service. County welfare boards saw more elderly people, although they were the least prepared in terms of dealing with mental health problems. Most agencies reported that an older person's resistance to coming for help was the most serious barrier to the provision of service. Funds were noted as the most needed resource to increase services to the elderly. The interview schedule and supporting tabular data are included.

Systems of Service. Report No. 2: Studies of P.L. 92-603.

B. Jeanne Mueller.
Cornell Univ., Ithaca, N. Y.
1 Jun 74, 137p
Executive Summary available from PROJECT SHARE.
SHR-0000341 Available from Dept. of Community Services, College of Human Ecology, Cornell University, Ithaca, N. Y. 14853.

The varieties of services needed by aged, blind, and disabled people to enable them to function optimally in the community are presented in this state of the art report based on experiences of the author and practitioners from service agencies across the nation. Alternatives to institutional care require a network of human services, some of the services provided to help children and adults who are physically, emotionally, or intellectually handicapped are described. Provision of these human services for various levels of social dependency is one aspect of the new technology for social care; the second is provision for continuity in care. Normalization of the lives of the handicapped is an important new concept involving the nurturance of other capacities in order to diminish the severity of the handicap. Opportunities to be educated in regular, not segregated classrooms, and to look after their own personal needs are examples of normal. The more life can be normalized for the chronically ill or disabled, the more social competency will be achieved. The services pharmacopoeia includes living systems and homebound services for handicapped adults; it includes the cultivation of services for the mentally retarded from infancy and early childhood through old age. Programs for disabled children, including a model program, are presented, and the restoration of the adventitiously blind and the physically disabled is discussed. Conservation programs for the mentally ill, both as inpatients in after-care programs, and conservation programs for the aged are described. An epilogue is devoted to the question of institutional versus community care.

Two Approaches to Human Services Integration.
Working Paper.

Steve Redburn.
Youngstown State Univ., Ohio. Dept. of Political Science.
Mar 75, 27p
SHR-0000654 Available from NTIS, PC$ 4.50/MF$ 3.00.

Two modes of human services integration, services integration and program integration, are discussed and compared. The objective of program integration is the structural rationalization of the delivery of human services in a community or region to improve its efficiency. Services integration is intended to achieve a related, but distinct, objective: provision of the appropriate mix of services to an individual or family in a community or region. DHEW has failed to distinguish between the types of integration, particularly in implementation of the Allied Services Act. Program integration involves the destruction of functional and professional autonomy, while services integration may be achieved without altering territorial imperatives. A set of hypotheses is suggested concerning the relationship of program and services integration to other tendencies in the organization of human services. These tendencies include: decentralization, deinstitutionalization, democratization, individualization, and advocacy. It is asserted that services integration can be achieved without program integration. Portions of this document are not fully legible.

Volunteer Model of Vocational Habilitation as a Component of the Deinstitutionalization Process.

Timothy A. Andriano
Wisconsin Univ. - Madison, Rehabilitation Research and Training Center on Mental Retardation.
1977, 4p
SHR-0002549 Pub. in Mental Retardation v15 p58-61 Aug 77.

The volunteer model for vocational training outlined in this article demonstrates the need for linkage mechanisms between large residential facilities and community settings in programs involving deinstitutionalization. Traditionally, volunteer programs cast the retarded person in the role of recipient of community volunteerism. An intriguing question is whether former recipients can assume active volunteer roles. A four week demonstration project, in which five mentally retarded adolescents and adults served as community volunteers within a nonprofit organization, vowed that they can. Nonprofit organizations which utilized volunteers appeared best designed to incorporate a vocational training program as the organizational structure of this setting accommodates flexibility. Often an employee is already present who has acted in the role of volunteer director and can manage a changing staff. Volunteer work exists on all skill and ability levels in this setting and employees are accustomed to seeing new faces and helping volunteers become part of the workflow operation. Nonprofit organizations offer high visibility due to regular employees and the continual influx of volunteers. Benefits to the retarded included: (1) exposure to normal work models; (2) opportunity to be in a noninstitutional setting; (3) opportunity to learn varied work skills and work flexibility; and (4) a demonstration of the ability to become a contributing member of the community. A community questionnaire survey, summarized in tabular form, shows that the involvement of the retarded in volunteer activity significantly improves the social image of the retarded. This facilitates the community acceptance necessary for continual deinstitutionalization. A bibliography follows the article.

Widening Horizons: The Teaching Aspect of Homemaker Service. A Guide.

National Council for Homemaker-Home Health Aide Services, Inc., New York.
1974, 113p
SHR-0002348 Available from National Council for Homemaker-Home Health Aide Services, Inc., 67 Irving Place, New York, NY 10003.

This guide to the teaching role in homemaker services was published by the National Council for Homemaker-Home Health Aide Services to help individuals and families achieve a more satisfying quality of life. This aspect of homemaker services is designed to improve the quality of life for both young families and older persons. The teaching homemaker service team demonstrates and teaches home management, health and hygiene practices, cooking and nutrition, sewing and care for clothing, shopping, and the utilization of community resources. The team also teaches parents how to care for and train children, and shows the elderly, ill, and disabled how to live as independently as possible. Ten chapters in the guide are specifically concerned with the enhancement of daily life, criteria for using the teaching aspect of homemaker services, the involvement of individuals and families, the role of professionals in service delivery, the homemaker in a teaching role, administration, program planning and evaluation, the use of community resources, the use of groups, and adaptation to special needs. Appendices contain teaching guidelines, a sample training session, information on behavior modification, a listing of national information sources, and recommended readings for homemakers in a teaching role.

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