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ABSTRACT

This case study shares the perspectives of two individuals who worked from within Laconia Developmental Services (a state institution in New Hampshire for people with developmental disabilities) to close it. One individual was institutional superintendent and the other served as a liaison officer among the state government offices, Laconia Developmental Services, and the community service system represented by area agencies. The institutional superintendent identified four major areas as critical in the internal process of closing Laconia: (1) revisions in the personnel system; (2) caring for and about staff members; (3) restructuring and reorganizing the institution as it became smaller; and (4) maintaining institutional quality during the closure process. The liaison officer helped people from the community and institution to "get to know each other," in order to facilitate community placements by improving relationships between the community and institutional staff. Primary strategies for facilitating changes included: finding the window of opportunity, building trust and sharing expertise between the community and institutional system, reinvigorating the internal process by building on the knowledge and skills of institutional staff, shifting the attention of the area agencies to the people left in the institution, and focusing on individuals. Other critical issues included finances, the advantages of not having a formal closure plan, working with parents, developing individualized placements, and developing a capacity to make compromises and solve problems. (JDD)

THE CLOSING OF LACONIA: FROM THE INSIDE OUT

COMMUNITY AND POLICY STUDIES

THE CLOSING OF LACONIA: FROM THE INSIDE OUT

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COMMUNITY AND POLICY STUDIES
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This is one in a series of qualitative case studies on state and national practices in deinstitutionalization and community integration and the changes that will be necessary to promote the full participation of people with disabilities in all aspects of community life and daily policymaking. The research for this study was conducted in Fall 1991 through Summer 1992 in the state of New Hampshire. The author particularly extends thanks to Doug Watson and Richard Crocker for their contributions to this case study.

> When people understand these are the right things to do, even if it comes at a personal cost, they don't stand in the way.
> - Ray Bardley[1], Institutional Superintendent

On January 31, 1991, Laconia Developmental Services (LDS) closed its doors making the state of New Hampshire the first one in the United States without a public institution for people with developmental disabilities. This is part of the story of two people, Ray Bardley and John Simmons, who worked from within the institution to close it and the personal struggles and professional dilemmas they faced.

Ray, who was institutional superintendent at the time of the closure of Laconia, returned to New Hampshire from his supported employment agency director role out west. He had worked as a community services planner in New Hampshire in its development stages and decided to come back for this role based on the suggestion of his previous secretary.

John Simmons arrival at Laconia in August 1988 "was a wonderful stroke of luck." After a tumultuous period with one of his board members, John departed from his position as one of the state's 12 area agency executive directors. Because he was the "valued person in the system you hate to see leave or hurt," he was hired to work part-time at both the state division office and at Laconia in a flexible role.

This case study, which is based on semistructured interviews

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[1] Ray Bardley and John Simmons are pseudonyms, which are used due to diversity in the opinions regarding the use of actual names.

with these two talented and committed individuals and others within the state, shares their perspectives on what they learned, including how to pay attention to all of the people involved, whether they are the staff members or the residents who lived there during the closure process. As one of many diverse stories that form a composite picture of the inside view of the Laconia closure, it is particularly meant to be shared with those who are working within for change.

INTERNAL CONSIDERATIONS IN INSTITUTIONAL CLOSURE

There are probably as many different ways to examine the internal experience of the closure of Laconia as there are people who were involved in the process. Through the eyes of an administrator working within the institution, four major areas were particularly critical in the internal process of closing Laconia: revisions in the personnel system, caring for and about staff members, restructuring and reorganizing the institution as it became smaller, and maintaining institutional quality during closure process.

Revising the Personnel System

From an administrator's view, the closure of an institution is a tremendous personnel job with the lives of many people, both staff and residents, affected by the decisions that are made. Several critical strategies were used which affected how the personnel system operated during the closure process. These included: taking direct control of the personnel system, investing

in staff values based training, and revising the performance outcome system.

Taking control of the personnel system

When one of the first building closures at Laconia occurred, the institutional management team met to discuss the staffing decisions that had been made. At Laconia, as in many institutions, the staff members from that building had been reshuffled to other buildings and locations within the institution, so no actual staff reductions had taken place. As Ray shared,

> I said, well, I guess we can talk about reducing the staff because that building closed and there (were) so many people associated with it. My managers...weren't up to this... Everyone played dumb. What happened to the staff?..Of course, what happens in a lot of large organizations. People had been moved around and buried in different sorts of ways. Literally, twenty people had been buried (in obscure job roles).

In response to this situation, Ray decided to take direct control of the personnel system, so that no decisions for the rest of the closure process were made without his involvement. As he said:

> The next day, I took personal control of the whole personnel system and that was the smartest thing I ever did because no personnel decision, in terms of terminations, discipline, anything, could be done without my involvement...Eventually, I was able to loosen up on that, but we revamped the whole personnel structure.

He also established a Thursday morning personnel management meeting, which came to be known as the "cut and slash committee", where the hard decisions regarding staff reductions took place under his direction. The participants included himself, the personnel team, and two business office personnel. These meetings

were viewed with suspect by the program staff who did not feel represented, even though Ray said he was a program person. While an effective management strategy, Ray described the emotions that were involved in the decisionmaking that occurred:

> Those little cut and slash meetings. People used to think we sat up there and kind of in an aloof, unfeeling manner destroyed people's lives by laying them off or whatever... Those were awful meetings...There was crying in there.

Investing in staff values based training.

The original design of the personnel system at Laconia was viewed by one of the administrators as "a very punitive, capricious type of system." This resulted in a lot of time being invested in appeals meetings with the labor board down in Concord about the way employees were treated.

One strategy considered to be an essential part of the institutional closure process was to revamp the disciplinary structure, making it less punitive with training and counseling as the responses to disciplinary issues. As part of this new focus on training, huge amounts of money were invested in values based training in areas such as PASS or PASSING, which are founded on the principles of normalization. "This theme was woven into all aspects of training, including driver's ed(ucation), nursing, everything." At one time, over 70 staff, including all of the top management, the middle managers, and even some direct care staff had attended this training. As Ray describes the effect this had on one woman who was very "client-oriented,

> I sent her to Kentucky and she couldn't believe that I would send her for PASS or PASSING. She was always client oriented and had good values system. It was just who she was and she came back and she said "I understand now" and she quit; she retired.

As John echoed, "I just think that was very, very critical to help institutional staff understand" why they were working to get people out of the institution. This effort was so successful, that in 1991, the key leadership in New Hampshire's Alliance for Values Based Training, were former institutional employees. As Ray explained, the staff "were doing what was expected of them, and when we changed those expectations and gave them some training and some values, a lot of people changed. (Federal ICF-MR surveyors said they had) never seen such high quality institutional staff and that was because of the training."

Revising the staff performance outcome system.

Although the personnel system was revamped to become more focused on staff development and training, by 1988, performance standards were raised, deficiencies in staff performance were made known to other staff members, and a series of steps to respond to disciplinary issues were put into place. The performance standards were not about quality per se, but about doing your job, meeting objectives within a certain timeframe. If people were consistently appearing on the deficiency list, "a disciplinary process (would begin) which started with counseling, questioning, asking if they needed more training and support, and could get very serious. We ended up terminating a few people."

Caring For and About Staff

Probably more than anything else, the personnel changes and strategies were all based on principles of valuing and caring about and for the staff. Specific strategies included: creating a future for professionals, fairness in employment, appreciating the environmental context of the staff's work, and finding people jobs and staff support.

Creating a future for professionals

One of the creative ideas that Ray had early on proved to be critical in gaining the support of key professionals and managers. This was the development of a "cutting edge" adaptive equipment center on the grounds of the institution, which is now a state support center. Through creating a future for the professionals, they stayed:

> We had very little problem after the first year with professional staff because I created a future for ots, pts, speech pathologists... It is the adaptive equipment center, which is now a state support center. We had no problem.

Key managers who would be necessary throughout the process were told that every effort would be made to preserve their jobs. An effort was made to ask them what they wanted in the future and to make arrangements to see if that could happen for them. Ray is satisfied that "all of them really ended up doing exactly what they asked for, except for one, and she kept changing what she wanted so it was hard to orchestrate, but she's okay...They knew I meant that. I went and...orchestrated it for everyone..."

Appreciating the environmental context of staff's work

Unlike the negative images often portrayed of institutional staff, the administration believed in them, recognizing that staff members needed to adjust to their environment. When given the opportunity to do "wonderful things" like going down to Dunkin Donuts with one of the residents for coffee or going out to buy clothes, "they just loved it." As Ray explained, "And as it turns out, there are a lot of people here who are very good people, very committed, very dedicated to what they are doing, but have never been given the tools or the information to do anything other than what they are doing."

Ray explained that many of the long time staff members who came to the institution when they were younger could not at first believe the conditions in the institution or the way that people were living. He said, "They said...I couldn't believe what I was seeing. But this is...what everybody is doing and eventually, you adjusted to it." Ray said he understood that it was hard, if not impossible, for people to hold beliefs that are incompatible with their personal experiences in their environment. In line with human nature, the staff members adjusted to what many originally felt was an abnormal environment and over time came to see that as routine.

Instead of portraying the institution itself as a bad place, though, Ray described the problem more in terms of dormitory living as a permanent lifestyle for people. As he said:

> I simply said look you have thirty people living in a group. I used to live in college in a dorm and I couldn't hack it because of the number of people there. There is no way that 30 people can live comfortably in normal ways in groups of 30.

Fairness in employment

As the downsizing process took place, one critical element was to assure that management was fair to the employees on what was a fair day's work so that "employees were not pushed over the brink." This required a knowledge about the specific jobs that people did so that fair demands could be placed upon people. The underlying administrative belief was:

> ...if a person has accepted employment and they understand the conditions of it, we have a right to expect a reasonable day's work...You wanted to be fair.

When jobs were changed as reorganization took place, people were invited to restructure their jobs. A lot of this job restructuring was done around the issue of maintaining quality.

Finding people jobs and staff support

The management tried to create a situation where the staff felt that they were being paid attention to, treated fairly and related to on an individual basis. There was a concerted management effort to try to recognize people's strengths and skills. Other strategies used included: aggressively managing attrition, working with remaining staff to transfer to other state agency or community jobs, and attempting to respond to individual employee situations.

Each of the staff were viewed as having their own life story, and management tried to know, to some extent, what was going on in their lives. People noticed the effort to take care of people, and that contributed to improved morale. These efforts included trying to respond to individual employee situations by relocating the person within the system and supporting people who needed support.

There was also time spent in simply talking with staff, letting them know what was going on as far in advance of official notices as possible so that plans for jobs could be made. Ray describes this as one of the most "sensible things" that they did:

> We were nice. I think part of it was I talked with everybody ...I could walk in(to a room) and there wasn't a person who was afraid to say something. I was just a regular person and I talked to people; they talked to me.

Of the reduction of 650 positions to affect closure of the institution, 450 were managed through attrition and ultimately only twenty-two of the remaining people did not end up with jobs. Those people were direct care staff with less than two years of experience. Even when these staff members were laid off, the institutional management continued to work with them to find community jobs. Some people who had "bumping rights" had transferred to other state jobs, others retired and "there were some people who ended up making more money, and that didn't hurt either." A few of the institutional staff continued to work for state-operated residential programs. Very few institutional staff went to work in the community services system because the pay and benefits differential made it unaffordable to do so.

Restructuring and Reorganizing

There were three important strategies for change during the closure process, including: reorganization of infrastructure, creation of a culture for closure, and maintainence of cooperative relationships with the union.

Reorganization of the infrastructure

During the course of the downsizing and closure, at least eight major staff and program reorganizations occurred in a period of four and a half years. Ray tried to structure the place conceptually and structurally and head it on its new path a year and a half before closure. When key people left, and this did happen, the structure needed to be reorganized in order to manage with the people who remained.

The psychology unit, for example, was reorganized several times, always with attention to maintaining high quality, up-to-date professional services. Initially, the unit had been unitized and oriented toward "writing behavior plans versus assisting staff with client learning styles and troubleshooting (problems)." Ray departmentalized the unit, brought in new leadership and retrained the staff. When that supervisor left, leaving no management there, they contracted for psychological supervision from outside of state employment and brought it back to a mixed unitized-department structure.

The restructuring itself was very hard and demanding, partly because the same managers who had created and refined the institutional ICF-MR system basically needed to undo their own work. In fact, Ray said part of the reason his predecessor left was because he could not bear to undo what he had created.

> Restructuring is hard...one of the things I found here is that I (had) inherited a group of managers that spent their lives from 1975 to 1986 building up this ICF-MR system and getting the kinks out of it and restructuring this, and changing this, (and) polishing that and really working to get it as good as they could after 10 or 11 years only to have me come in and

say we are going to rip it apart.

Creating a culture for closure

One of the important things that people did was to try to create an atmosphere within the institution of moving forward, of being part of the future, and of doing something worthwhile. Staff planned and organized celebrations to commemorate the closure of institutional buildings.

> We have some videotapes of some of the building closing parties...people came back who worked in the building years ago, plays, skits, songs; the last song that dealt with the (final building) closing...was called the "whole enchilada..."

Another part of this institutional culture involved creating a sense of openness so that the institutional service delivery system was open to everybody's purview. Ray described how he set up service delivery work group meetings where everyone could come and put anything on the agenda. This gave direct care people a voice in what was going on and helped to maintain quality. He said:

> And I chaired those meetings, and it was in those meetings that somebody who was a direct care staff person...who was working with a client who had occupational therapy needs, could say in front of the department head of occupational therapy, 'Your therapists aren't coming in on time; they haven't called; they haven't shown up for two weeks, and we don't know why'...I would then turn (to the department head) and say, how about that?

Maintaining the culture, also meant striving to pay attention to each of the residents. As the institution headed toward closure, particularly in the last year, this became more and more difficult to do as the attention of staff begin to focus on the community.

Working with the union

The union issues were not as difficult as in many states, and potential problems were averted by keeping the leadership informed of developments and by acting in ways that were fair which avoided grievances and the feeling that people were being treated unfairly. There was only one formal labor management consultation, which under the collective bargaining agreement occurred as needed, because issues were handled in preventive ways.

The institution began to send laundry to NH state hospital when the laundry operations were closed down. The President of the local employee's union coordinated the dirty and clean laundry and its shipment between the institutions. This meant that she was around the grounds, and at the various buildings talking to everybody on campus all the time. Ray shared how he kept in touch with her by informally responding to her questions and exchanging information as well as by formal channels.

Maintaining Institutional Quality During Closure

A critical focus of the closure strategy internally was to maintain the quality of institutional living for people who continued to reside there as the closure took place. In addition to the values based training, this was accomplished by improving the direct care staff ratios from 1:7 to 1:4, thus maintaining programmatic quality and meeting federal standards for continued funding.

Even though the ratios for both professional staff and direct care were better than three years earlier, staff members still felt

worse, possibly because the absolute decrease in numbers of people was noticeable and adversely affected staff morale. The reductions in support staff were the greatest. Though the ratios of staff increased, the demands in terms of programmatic quality increased.

The staff tried to maintain a "clean bill of health from the feds (federal service teams) without compromising values." This was done by interweaving into the individual service plans (ISP) community based objectives, functional skills, partial participation, "all kinds of things that are (generally) devoid in any (intermediate care facility) ICF." The quality was maintained within the institution to the extent that at the exit interview of the last federal look behind, "the HCFA (Health Care Financing Administration) people said they had never seen a place so well run. They never even sent us a piece of paper." The institutional team justifiably took pride in HCFA comments that "We have never seen it done so well."

KNITTING AND CONNECTING

John Simmons held a very different role within the institution, serving as a liaison, "knitter" or "switchboard operator" among three elements of the state's system: the state Division in Concord, Laconia Developmental Services (LDS), and the community service system represented by the area agencies. He was sometimes on the phone for the entire working day calling and talking with people, helping people from the community and institution to "get to know each other."

In bureaucratic terms, John's job was mainly a liaison or

"personnel" job and he influenced the placement process, though he did not have any specific responsibility, accountability, or authority for either the process or the supervision of staff activities. At the institution, he worked closely with the director for quality assurance who was responsible for the supervision of social workers and program coordinators. John was on the management team of the state division office, but not on the management team in the institution.

On another level, John's role was a very "intuitive" versus "structural" one which was hard to describe. This involved helping others to recognize and act on good opportunities and to negotiate agreements based on the uniqueness of the region, the person with a disability, their family and others involved.

The role he created for himself was described by Ray as "really quite a stroke of masterpiece." John interacted in a way that facilitated and supported the social workers and the program coordinators to communicate with community case managers and case manager supervisors about people rather than adhere to a defined placement process. He also had an ability to work among the area agencies, the state division and the institution, knowing that everyone had an important role to play.

The P .acement Process

The process of community placement in New Hampshire was formalized in regulation, and "made sense early on," though it became less functional over time. Both Ray and John agreed that the process basically worked, though there was a tension that

existed between the staff in the institution and those in the community. What John accomplished, together with others within and outside the institution, was to facilitate improved relationships between the community and institutional staff and to focus on the individual person and their family so that "even in the end, (when the pressure was on, we still) made some really good placements."

John used and built upon many of the standard structures already put in place at Laconia through Ray's management efforts. The standard team process at Laconia "was more highly evolved than the team process" in many regions, already incorporating futures planning, attention to relationships, functional skills and community participation. There were high expectations for staff, and the management support and values base that made the realization of these values possible.

The primary strategies for creating these changes included: finding the window of opportunity, building trust and sharing expertise between the community and institutional systems, reinvigorating the internal process by building on the knowledge and skills of institutional staff, shifting the attention of the area agencies to the people left in the institution, and more intently focusing on individual people.

Shifting Attention Back to the Institution

At the beginning, after the court order, there had been a very strong effort to bring people out of Laconia, but placements reached a plateau by the mid-80s. As the community system had built up, people in the area agencies focused less on the people

in the institution as attention was needed "in their own backyards." The community staff were working hard on the stability of their system and also on keeping people out of the institution. There was a lot of problem solving going on at the local level on behalf of the people who were already there. As ordinary turnover took place among casemanagers and community staff, "people at the institution got lost. They just weren't a priority."

It was natural to be concerned about someone "at your front door" and easy to forget about someone 100 miles away. Yet, it was frustrating especially to institutional administrators when money was being pulled out of the institution to build up the community and then the placements were not occurring on schedule. When the placements were not done on time, this placed the institutional superintendent in the position of losing credibility and at risk of having reduced quality within the institution. He explained that although people in the community and institution basically wanted the same thing, a lot of conflict occurred around these kinds of placement issues.

The state division also had increasing pressures in the community and their attention had necessarily shifted. Because of the slower placement rate in recent years, there was a lack of belief at all levels that the institution would really close. Thus, part of what needed to occur was to "raise people's consciousness again" that there were still a lot of people in the institution, that "the job isn't done." According to state regulations, people in the institution were still the number one

priority, so efforts had to be made to get people back in touch, to get the area agencies to "lead," and to help people with disabilities to all live again in the community.

Bridging the Institution-Community Gap

One fundamental problem revolved around the gap between the institutional and community staff, including their images of each other and the lack of knowledge about each other's areas of expertise. As John shared, it was not clear that the community was good and the instituion was bad. Instead, he believes that different staff, each with their different experiences of the person, needed to work together across community and instituional lines to design the right supports.

Overcoming the evil-good dichotomy

One of the most important steps that happened was overcoming the community's image of the staff at the institution, including recognizing the strengths of the people who worked there. The Laconia staff "were tremendous" because they knew the people who were to move into the community, could bridge the gap with the families and could offer some very practical training to providers. John explained why this exchange between community and institutional staff seldom happened before:

> (A belief seemed to evolve) that the institution was evil and the community was good and the role of developmental services system around the court order was to save people from the institution. Therefore, it was a bad place and all the people who were there were probably bad too, or even if they were not bad, they were probably so institutionalized they aren't going to change. None of that was true. It was not true largely because Ray had done a lot of work in getting people (to develop good) skills (and values).

John describes this process as "happening naturally" and he says, "if you tried, it just wouldn't have (happened)." However, as can be seen below, John placed a lot of effort into "getting the relationships between the institution and community side to the point where they saw each other's skills and strengths."

Connecting community and institutional staff.

John described his role as helping the institutional and community staff to recognize each others' expertise, "and especially, their lack of expertise." This meant that everyone needed to recognize that they don't know some things, whether they are staff in the community or in the institution. "The reality was neither had any real basis for understanding the others' experiences." John did a lot to get people to "go off and see things" or "come and see things" so they could learn from each other firsthand.

One of the ways John attempted to connect people together was by writing and calling the community casemanagers to let them know which folks were still in the institution. After telling them about the people ("the folks you still have who live here") he then invited community staff to visit and asked the institutional staff to serve as hosts. John said he purposefully avoided being viewed as the person who could answer questions about residents at Laconia so other people would correctly be seen as the experts. He came to know people well demographically and anecdotally, but left the expertise to the staff in the institution, thus validating their roles to community staff and providers.

The rule or framework they used was to try to identify the person in the institution who knew or cared for the person the most. Whenever possible, this person acted as the host, so the institutional staff started assuming a different role; "they were matchmakers. They introduced and they talked." John said that the investment in the values based training really helped at this time because "the community staff got to see that the institutional staff really cared, that they used the right language, really talked the right way...Ray's training paid off and relationships started improving."

This same approach was used in identifying who in the institution would go to visit the region. "It didn't matter if it was the janitor, (kitchen staff) or the program director, or whoever. Who seems to care the most about this person?" That person was then empowered to "go explore that community setting or go to the meeting or whatever and come back and tell us what they think about it." That person's role was to try to figure out if that would be a good place for someone to live and they were able to be very vocal about "whether or not it was a good idea...always with the question, what would it take, what was needed to support this person (in this place)?"

Finding the Window of Opportunity

John said he saw a kind of window of opportunity to ask the question, "what would it take, individual by individual, for this person to succeed in the community?" He felt people didn't understand that question so he explained that if these issues were

not paid attention to, the person would be perceived as failing. He then devised a questionnaire of 23 "supports/needs" questions about the kind of supports they would need, not what skills. This questionnaire included areas that must be paid attention to:

> Do they take medications? Do they have seizures? Do they take seizure medications or psychotropics? Is there an active nursing care (plan) or some attention to detail like communication, sign language? Do they use a wheelchair?...

Most of the questions were about what was likely to go wrong if people did not pay attention to these concerns and about what assistance the individual would need to keep him or her from being at risk. None of the questions had to do with "Do they have any skills or are they toilet trained?" The only exception was about perceived behavior problems. "The attempt was to shift the philosophy away from the incapacities and deficits of people to building capacities of community systems, the capacity of staff or whatever." The question was not whether they were "ready", but what would it take for the person to do well?

John shared this information with many of the institutional staff to validate what was known so that the information could be used for planning. He would keep visitor and telephone logs and note updates in a computerized status report that would go to the superintendent, institutional building directors, program directors, division staff, and the regions. John attributed part of their success to the fact that someone, "it just happened to be me", was paying attention to these things. He said it also "began to make it real" for people because they could see that action was

taking place.

From the beginning of his work, John tried to personalize the process. They asked people in the community to visit in groups of no more than two or three people, "no entourages." People were not there to sit around and observe. As John said,

> You cannot come to a meal unless you are going to have a meal. There is not going to be anyone sitting around observing. We encouraged people to go off into the community...(with institutional staff along to introduce the person).

There was a concerted effort for people to meet individuals and before anyone moved, they always visited a couple of times and spent overnights.

Reinvigorating the Placement Process

Internally, the placement process itself was reinvigorated because people began to see each other and themselves differently. "It really did happen." Over the next two years John helped develop "a reasonable collaborative process. It wasn't without its arguments. It was just a nicer process between peers working to solve this problem."

John's priorities for placement were the youngest than the oldest, then people with the most severe disabilities. It didn't work out that way ultimately; yet, it was a safeguard to avoid picking people who were seen as easy. The people who were the most difficult to match or to figure out ultimately had some of the most "individualized placements." Advantageous to all concerned, "they ended up going to places (the regions) ordinarily wouldn't consider or didn't used to consider." This meant placements like regular

homes with in-home staff support for people with "real behavioral challenges" or "lots of physical needs."

The focus was always on the individual person. There was not a regional contract or divisional money appropriated and available for x number of people to go to the community. Money was moved as necessary from one region to another. The idea of region of origin was abandoned for people who had been in the institution for 35 years, 50 years, 70 years...and had no ties to the region of origin. As John explained:

> What made more sense was finding a place and a program that was very compatible. It wasn't whether they belonged to Manchester or belonged someplace else. So people became less obsessed with that and started looking more closely at individual people (and to places where they might have genuine connections to people).

The placement process itself just "snowballed." In "the first year, placements were 115% of contract. In the second year, 137% of contract. And for the previous several years they were less than 40% or 50% of contract. We exceeded our best expectations." It turned out that everything was so far ahead of schedule that no one actually believed it or even fully realized it until one day somebody said, "this (closure) is really going to happen."

At some point, it became competitive, too, a sense of personal "disgrace" if the regional director didn't make some contribution to this effort. Each region was aware of how many placements were done in other regions through the use of the computerized information and placement tracking tools.

John said the pressure and the calls never let up as they

moved toward closure. Placement toward the end was most difficult, not because of the needs of the people, but because the community system itself was becoming saturated. The effort had been high and people were tired.

> We worked very hard on the first 105 and when we got to the last 33, it took more and more work as you got less and less, not necessarily because the people were difficult, just that the pressure on the system all around require you to explore more avenues.

John said he was not particularly significant in the process, in that the staff at the institution did it. He said, "I just asked the stupid questions. You know, like why don't you come up? Is there anything we can help with? ... Would you like us to give his mom a call?" John also said that he always ended by asking if there was anything he could do to help. While the answer was virtually always no, it did mean that people then felt obligated to do it. He found it was important to keep a very high profile, maintaining high activity levels so that people knew that someone was concerned about this and would follow up on communication to find out whether things had been done.

STRATEGIES FOR CHANGE

Other critical areas that contributed to the internal efforts in the closure of Laconia included how the money worked, the advantages of not having a formal closure plan, working with parents, developing individualized placements, and a capacity to make compromises and solve problems.

How the Money Worked

In 1988, near Christmas, there was a meeting ("the big bang committee") of a group of people around the state, including the area agency directors, the Division people and John. The issue was about how to move money from the institution to follow people into the community and whether placements could then be accomplished. They figured out an initial number of placements, about 25, that needed to be made "that would be the big bang, a sufficient number of placements that would infuse enough money into the community system from the institution to enable people to do this." As John reported:

> We had a tremendous bang, not just a big bang; it was more significant than that...by the following June, there were 105 people placed which wasn't extraordinary, but given the state of the system, the way it had plateaued, it was significant.

Because of the way financing is set up in New Hampshire, it was particularly advantageous to move money from the institution to the community. Combined with the community care Medicaid waiver, the available resources increased greatly. For example, the highest budget in the institution was $18 million which when combined with federal funds translated to $35 or $36 million in the community, which is about half of the total community budget.

In New Hampshire, the institution was funded with state dollars upfront. When Medicaid money was received, it would get paid to the order of the General Fund and sent down to Concord, the state capitol. Because of the combination with community care, $1 million from the institution would buy $2 million in community care

services.

> They used to refer to Laconia as the bank. It'll be too bad when the bank closes...We bankrolled the development of the community system...It was the bank.

Another point to consider is that in the closure process, the management needed to move from an institutional per diem, which was no longer meaningful, to separating out a building maintenance cost, for example the amount necessary to keep the boilers going whether or not any people lived there.

The Advantages of No Plan

One of the important strategies was that there never was an external master plan for closure. Although both Ray and John, together with others around the state, wanted to see the institution closed, no one was sure this would occur. The lack of a formal plan had a number of advantages, including that people could concentrate on immediate issues and handle those well instead of debating about the ultimate future of the institution. As Ray explained,

> All I had to say is the plan now is to close the unit or...the plan is to get to the center of campus because they want the north end...And so we never had an external plan about the closure and so we continued to focus on let's do this right.

Lack of a formal plan also meant there was more flexibility for "reality to unfold." Strategies could be rethought, timeframes changed and resources re-evaluated. It also kept potential pressures from the union, legislature, and parents "off the table" allowing people instead to look at the issues as they unfolded.

their most difficult roles was working with the parents who were very involved with the Laconia parents' group, the institutional branch of the ARC. Two of these parents were very reluctant to consider community placements. John would make sure that the parents had an opportunity to meet whomever would be able to answer their questions and show them whatever they wanted to see.

The Division director was very supportive and was considered to be a staunch advocate of the parents. As John describes it, "he never let us off the hook once. If a parent said they wanted to see everything in the entire state, he said you better get out and figure out how to make this happen. And he backed the parents all the way and at the same time backed us in trying to present those options." Several people in the institution also were considered to be real good at working with families who had reservations.

Developing Individualized Placements

As John explained, "the key element in a good situation is that somebody cares and is committed to the person." Community, access and integration can happen subsequent to that. In some cases, the person who cares may be the parent, and this meant that community casemanagers needed to learn a lot about what it to took to help parents whose sons and daughters had been in the institution for 40 years to understand the possibilities.

The whole notion of finding individualized service option providers for people who were challenged with behavioral issues was a "lesson to the system." The risk was that people would see these as being "cost effective" (i.e., "cheap placements") or that the

John explained that a written plan can even be detrimental because people will try to implement it even though it is out-of-date before it is even written. He said, a plan creates "an illusion of order that does not exist...that's not the experience of people with disabilities in the community...you can make it look like a factory and have a factory mentality about solving this problem...And I think if you look at the pockets of excellence around the world, wherever (good) things are happening for people (with disabilities), there aren't plans like that."

Compared to some other states, the New Hampshire legislature was never sold on the community system as a way to save money. Instead, moving to the community was considered to be the right thing to do. As Ray describes the advantages of this:

> We never formally presented any numbers to (the legislature), except maybe at the end because the campus was being greatly under utilized. But it was never sold on you were going to save money; it was the right thing to do to have people living in the community and having real jobs.

The lack of a statement on closure was also the result of a genuine attempt by the division to take "everyone's concerns as legitimate and valid." The director of the division always stood by parents, and in fact, they almost ended up with one place on the grounds of the institution to satisfy a very small group of parents. Lack of a closure statement meant that the staff could work together with the parents to figure out what to do.

Working with the Parents

From the perspective of staff within the institution, one of

person would become isolated. However, "where it worked well, it has been because people really cared..."

Ten former institutional staff who had been very close to people in the institution, took them home with them, and those placements worked out extremely well. There also were lots of enhanced family care and individualized service options (ISOs), as well as apartments and smaller settings. Enhanced family care is a person living with a family funded through a particular rate in the waiver. An ISO reflects a higher level of funding to provide additional supports to a person or additional respite, a difficulty of care kind of payment. It is more flexible and can take other forms; for example, it could be used for somebody to live in his/her apartment with a roommate who might be getting a subsidy to give support.

One of the most difficult areas to move from was thinking in terms of funding streams, regulations, existing services - "those are the obstacles that people have the hardest time getting over." In some ways, the administration took the position that if it was in a grey area to "take a leap of faith" as long as it was in the best interest of the person.

The Compromises and Problem Solving

While a number of excellent placements were developed, there were compromises made, with different people feeling various levels of comfort with these compromises. John, a strong supporter of attention to each person, explained that for a variety of reasons some people did end up in group home settings. As he perceived some

of the reasons why this occurred:

> I recognize it as a compromise that..was made sometimes. Sometimes it was made in the interests of the parents. Sometimes parents feel better about something that looked...more institutional. Sometimes it was because those regions...hadn't developed the capacities (to support people in individualized settings). Sometimes it was because there were vacancies there.

However, when staff came back and said they could not support a placement, even if there was a vacancy, John tried to reframe the question by asking if or how it might be made different or what would be necessary for this particular person. This kept the "problem solving mode" high and placed the problem in a whole different light. Whomever was necessary to solve the problem, whether family, program people, direct care, people who knew the person for years, whatever their role or title, would be brought together.

As he worked through issues, John would follow the chain of command very closely, drawing on his previous experiences to know who to go to. Doing some of the non-traditional things often involved mundane issues such as overtime and use of the car for which administrative support was necessary. John was able to elicit this support from unit staff and supervisors.

Overcoming the Search for Perfection

John shared, as did another division staff, that at times people's positive values sometimes stood in the way of their ability to act. "(In one region), they couldn't get anybody out...The reason for that was they wanted everything to be

perfect." He was concerned that good values could inadvertently become an excuse for good people not doing something.

John's initial approach was to gently challenge people to think about personal capacity for growth and to make sure that decisions about what people would do and who they would spend time with were not all made before the person moved into the region. This was not entirely successful, however, and finally some financial, contractual pressure was placed on the region to make placements happen.

John said he learned a lesson from this, that there is a need to introduce more diversity so that people do not hear only one angle or draw one line about a situation. The basic message is that people with disabilities need to be in the community and that there must be an acceptance of the fact that there is a lot to learn and we are likely to make mistakes.

CONCLUSION

Since the time the research for this case study was collected, Ray and John have both moved to new roles within New Hampshire's state Division of Mental Health and Developmental Services. John shares, "I was very glad to be a part of something...like that. And in some ways, it was a culmination of my career of 25 years." As Ray reflects back on his personal experience:

> There was a...(lot of) tears here and a lot of pain. There was a lot of consternation at the individual level, we were changing their jobs...They had their individual troubles, but they could relate to the bigger part...It wasn't easy.

While it is likely that not everybody is totally satisfied, there have been very few complaints about the way the closure and placements were handled. And today, though it was not easy, New Hampshire has become one of the nation's leaders in moving people to good places within local communities, in part because of the work of people from within the institution.

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