ASSEMBLY HUMAN RESOURCES COMMITTEE
THE CITY AND BOROUGH OF JUNEAU, ALASKA

September 17, 2018 6:00 PM
Assembly Chambers

I. ROLL CALL

II. APPROVAL OF AGENDA

III. APPROVAL OF MINUTES

A. August 13, 2018 Human Resources Committee Minutes

B. August 27, 2018 Special Human Resources Committee Minutes

IV. PUBLIC PARTICIPATION

(Not to exceed a total of 10 minutes nor more than 2 minutes for any individual).

V. AGENDA TOPICS

A. Board Matters

1. ADA Committee - Appointment

Per Resolution 2429; the purpose of the ADA Committee shall be to advise and assist the Assembly and the Manager in implementing and carrying out the goals and provisions of the Americans with Disabilities Act. The committee may review the interim plan setting forth the City and Borough's efforts for compliance with the ADA; review of the policies, for compliance with ADA; and promote public awareness of the ADA requirements; and undertake other tasks and assignments relating to the ADA as requested by the Assembly or the Manager.

The committee consists of seven members appointed to serve for three-year staggered terms.

The committee has one member, Charlene Steinman, whose term expired August 31, 2018. Ms. Steinman has submitted her application for reappointment. The seat is for a term beginning September 1, 2018 and ending on August 31, 2021.

CBJ Board Rules of Procedure allows incumbents to continue to serve as voting members of a board past their term expiration date until one of the following takes place:

1. The member declares that they want to step down as of their term expiration date, or
2. They are reappointed to a new three-year term, or
3. A new applicant is appointed to fill the open seat.

Aside from Ms. Steinman's application, the Clerk's Office has not received any

other ADA Committee applications to date.

2. ADA Committee - Annual Report

3. Parks & Recreation Advisory Committee - Appointment

   The Parks and Recreation Advisory Committee (PRAC) consists of nine public seats and one Assembly liaison.

   In June, Christine Prussing, submitted her resignation which has left her PRAC seat vacant for a term beginning immediately an ending February 28, 2019.

   The Clerk's office has not received any new applications since it began advertising for this vacant seat but an application from Will Muldoon, which was previously considered by the HRC during its March 5, 2018 and May 14, 2018 meetings, is provided in your packet for consideration.

4. Sister Cities Committee Funding Request

5. Community Development Block Grant - CDD Staff Recommendation

B. Other Business

VI. STAFF REPORTS

VII. COMMITTEE MEMBER COMMENTS AND QUESTIONS

VIII. ADJOURNMENT

ADA accommodations available upon request: Please contact the Clerk's office 72 hours prior to any meeting so arrangements can be made to have a sign language interpreter present or an audiotape containing the Assembly's agenda made available. The Clerk's office telephone number is 586-5278, TDD 586-5351, e-mail: city.clerk@juneau.org

ASSEMBLY HUMAN RESOURCES COMMITTEE
THE CITY AND BOROUGH OF JUNEAU, ALASKA

August 13, 2018 6:00 PM
Assembly Chambers
AGENDA

I. ROLL CALL

Chair Maria Gladziszewski called the meeting to order at 6:00 p.m.

HRC members present: Mara Gladziszewski, Jesse Kiehl, and Rob Edwardson.

Members absent: none

Other Assemblymembers present: Loren Jones

Staff Present: Diane Cathcart, Deputy Clerk, Allison Eddins, CDD Planner II

Others Present: Zane Jones, Chair of Historic Resources Advisory Committee, Tom Rutecki, Parks & Recreation Advisory Committee Member to the Youth Activities Board

II. APPROVAL OF AGENDA

Hearing no objection, the Human Resources Committee agenda for August 13, 2018 was approved as presented.

III. APPROVAL OF MINUTES

A. July 23, 2018 Assembly Human Resources Committee Minutes

Hearing on objections, the minutes for the July 23, 2018 Human Resources Committee meeting were approved as presented.

IV. PUBLIC PARTICIPATION

(Not to exceed a total of 10 minutes nor more than 2 minutes for any individual).

V. AGENDA TOPICS

A. Board Matters

1. Historic Resources Advisory Committee - Board Roster

2. Historic Resources Advisory Committee - Appointment

Motion: by Mr. Kiehl to forward to the full Assembly, the recommendation to appoint Shannon Crossley to the Historic Resources Advisory Committee to a term beginning immediately and expiring June 30, 2021. *Hearing no objection, the motion passed.*

3. Historic Resources Advisory Committee - Annual Report

Zane Jones, Historic Resources Advisory Committee Chair and Allison Eddins, CDD Planner II and Staff Liaison to HRAC gave an overview of the individual HRAC board members and the expertise they each bring to the committee. Mr. Jones and Ms. Eddins also gave a summary of the annual report and described some of the agenda items HRAC typically has before them such as; reviewing design permits that come into CDD for businesses within the historic downtown district. HRAC is also working in conjunction with the City Museum on different historic events the museum puts on. HRAC other's main project is working on updating CBJ's current preservation plan.

4. Youth Activities Board - Roster

5. Youth Activities Board - Appointments

Motion: by Mr. Kiehl to forward to the full Assembly, the recommendation to appoint Caleb Peimann to the Youth Activities Board student seat for a term beginning September 1, 2018 and expiring August 31, 2021. Mr. Kiehl also recommended the appointment of Kiana Potter to the public seat for a term beginning September 1, 2018 and expiring August 31, 2021. *Hearing no objection, the motion passed.*

6. Youth Activities Board - Annual Report

Tom Rutecki, Youth Activities Board Chair highlighted one of the main accomplishments of YAB this past year was the board creating a subcommittee which worked on updating the YAB scoring system and self-evaluating that process. They came up with a better, more streamlined system and were able to put it in place for this years funding cycle.

Mr. Rutecki touched on were how great the students that hold the student seat on YAB throughout the years have been; always enthusiastic, thoughtful and sharing their ideas.

Mr. Rutecki also reported that all organizations who applied for a Youth Activities Grant this last year were able to receive some amount of funding. Sports accounted for half the grant applications with Academics and Arts evenly split for the other half.

B. Other Business

VI. STAFF REPORTS

VII. COMMITTEE MEMBER COMMENTS AND QUESTIONS

VIII. ADJOURNMENT

There being no further business to come before the committee, the meeting was adjourned at 6:28 p.m.

SPECIAL ASSEMBLY HUMAN RESOURCES COMMITTEE
THE CITY AND BOROUGH OF JUNEAU, ALASKA

August 27, 2018 6:15 PM
City Hall Conference Room 224
Immediately followed by Special Assembly Meeting for Board Appointment.

I. ROLL CALL

Human Resources Committee Chair Maria Gladziszewski called the meeting to order at 6:20p.m. in the Municipal Building conference room 224.

Assemblymembers Present: Chair Maria Gladziszewski, Mayor Ken Koelsch, Deputy Mayor Jerry Nankervis, Mary Becker, Jesse Kiehl, Loren Jones, and Rob Edwardson.

Assemblymembers Absent: None
Staff Present: Deputy Clerk Diane Cathcart

II. APPROVAL OF AGENDA

The agenda was approved as presented.

III. APPROVAL OF MINUTES

none

IV. AGENDA TOPICS

A. Board Matters

1. Docks and Harbors Board Applicant Interviews

Three applicants were interviewed for the one open seat on the Docks and Harbors Board; they were: Chris Peloso, Bob Wostmann (telephonically) and Kenneth Cassell.

The HRC recessed into Executive Session at 6:48 pm and reconvened at 6:53 p.m.

MOTION: by Mr. Kiehl for the Assembly Human Resources Committee to recommend the Assembly make the following appointment to the Docks and Harbors Board; Bernard (Bob) Wostmann to a term beginning immediately and expiring on June 30, 2019. *Hearing no objection, the motion carried.*

B. Other Business

V. EXECUTIVE SESSION

A. Executive Session - Committee Deliberation

VI. ADJOURNMENT

There being no further business to come before the committee, the meeting was adjourned at 6:54 p.m.

City and Borough of Juneau, AK

AMERICANS WITH DISABILITIES ACT COMMITTEE

BOARD ROSTER

CHARLENE STEINMAN

1st Term **Aug 31, 2015 - Aug 31, 2018**

Appointing Authority Assembly
Position Voting Member
Office/Role Secretary
Category Public
Dais Seat 7

PAMELA MUELLER-GUY

7th Term **Nov 01, 1998 - Aug 31, 2019**

Appointing Authority Assembly
Position Voting Member
Category Public
Dais Seat 5
Special Needs Needs Sign Language Interpreter

MATTHEW MCGUAN

2nd Term **Nov 04, 2013 - Aug 31, 2019**

Appointing Authority Assembly
Position Voting Member
Office/Role Chair
Category Public
Dais Seat 3

ELIZABETH (BECKY) HARRINGTON

1st Term **Dec 18, 2017 - Aug 31, 2020**

Appointing Authority Assembly
Position Voting Member
Category Public
Dais Seat 2
Special Needs Person with Disability

MARIANNE MILLS

3rd Term **Sep 19, 2011 - Aug 31, 2020**

Appointing Authority Assembly
Position Voting Member
Office/Role Vice-Chair
Category Public
Dais Seat 4

ROSS DOUGLAS

2nd Term **May 23, 2016 - Aug 31, 2020**

Appointing Authority Assembly
Position Voting Member
Category Public
Dais Seat 1

DANIEL HARRINGTON

Partial Term **Apr 02, 2018 - Aug 31, 2021**

Appointing Authority Assembly
Position Voting Member
Category Public
Dais Seat 6
Special Needs Person with Disability

CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

ADA Committee

(907) 586-0715
www.juneau.org/
community-development/ada-committee
155 S. Seward Street • Juneau, AK 99801

DATE: August 31, 2018

TO: Human Resources Committee of the Assembly

FROM: Matt McGuan, Chair
Americans with Disabilities Act (ADA) Advisory Committee

SUBJECT: ADA Committee 2018 Annual Report

On behalf of our committee of dedicated members, I am pleased to present the following accomplishments since the last Annual Report:

In September, we elected the following officers for the year: Matthew McGuan, Chair; Marianne Mills, Vice Chair; Charlene Steinman, Secretary.

Public Input: During the year, the Committee often receives input from the public regarding ADA concerns throughout the city. The Committee strives to make sure that public input is directed to the appropriate CBJ staff member for follow-up action. Staff Liaison, Charlie Ford, is extremely helpful in this regard. Input received this year included:

- Yellow curb paint faded or chipped away and truncated dome tactile plates worn down at various intersections.
- Taxi operators unable or unwilling to accommodate passengers with service animals.
- Difficulties having sign language interpreters available at Bartlett Regional Hospital.

Departures and Appointments: In September, long-time committee member Cheryl Putnam resigned due to health issues and time constraints. Members noted that her participation will be greatly missed as she has been of great service to the Committee and a tireless advocate for people with disabilities in Juneau. In December, Mr. Allen Hulett informed the Committee that he was unable to continue with his appointment due to an employment change. Becky Harrington and Dan Harrington volunteered and were appointed to fill the two vacancies.

Glacier Avenue Bus Stop: The Committee, in consultation with the Engineering Department, looked into the possibility of constructing a bus stop in front of the downtown fire station opposite Federal Building bus stop on Glacier Avenue. An existing electrical transformer at that location complicates the placement of a potential bus stop. The issue remains outstanding but is not considered a high priority.

Senior Housing: In October, the Committee toured the newly completed Trillium Landing senior housing facility. The senior facility (age 55 and up) provides accessible and non-accessible units with 1 and 2 bedroom units, a common area, and an exercise room. Solar power is utilized in the building energy system and plans for an adjacent assisted living facility are in the planning stages.

ADA Training: In April, several Committee members were able to attend a presentation on service animals given by Mr. David Barton, a training specialist at the Northwest ADA Center.

Dog-Free ADA-Accessible Hiking Trail: In June, the Parks and Recreation Advisory Committee (PRAC) reached out to the ADA Committee regarding the possibility of designating certain walking trails as no-dog trails. Preferably, such a trail would be ADA accessible. Members of the ADA Committee are generally receptive to the idea. However, it was pointed out that any prohibition on dogs should include an exception for service animals. The ADA Committee has yet to take action on the matter, pending follow-up discussions with the PRAC.

Juneau Coordinated Transportation Coalition and Lift-Equipped Taxis: In December, Mr. Tim Felstead, CBJ Community Development planner and liaison to the Juneau Coordinated Transportation Coalition (JCTC), and Aaron Brakel, REACH Facilities manager, presented on the development of the Transportation Plan. He explained how the plan was developed and what agencies were contacted in preparation. Service providers Catholic Community Services (Care-A-Van), SAIL, REACH, and JYS were contacted to determine what transportation services are currently provided and any challenges and/or opportunities they see for service in Juneau. Grant application for State and Federal funding consumed a large portion of the process. SAIL, for example, has applied for a new van. Mr. Felstead explained how SAIL provides taxi vouchers for when CARE-A-VAN's are unavailable. SAIL is currently working with local taxi companies to get three wheel chair accessible taxis, which is a goal of the JCTC. Key elements of the study included:

1. Need for Transit Training: Look at a vehicle sharing program. What are the possibilities for using existing vehicles that are underutilized?
2. SAIL is working with taxi companies to acquire wheel chair equipped taxis. There are currently 63 taxis in Juneau and only 3 are wheel chair equipped.
3. Is it possible for CBJ to mandate accessible taxis? What are other communities doing?
4. Possible incentives for compliance: Permits for locations such as harbors, airports, etc.
5. Other communities typically have 3% - 10% of the taxi fleets equipped for wheel chairs.

The issue of lift-equipped taxis also came up during the 2016-2017 Committee cycle as well. The Committee discussed possible avenues of involvement and follow-up items, including:

- Providing a letter of support that will go through the City Manager to the Assembly.
- Look at partnering with SEARHC for funding.
- What is the possibility of applying for Marine Passenger Fee funding? What other funding sources are available?

In January, the Committee followed up with Mr. Felstead and Mr. Brakel on the development of the Transportation Plan and how the ADA Committee can assist. Items discussed were:

1. There is a federal requirement, but difficult to meet without additional funding. Mr. Felstead spoke with the Municipal Attorney regarding the idea of tying it in with Docks and Harbors or the Airport permits. Another possibility may be to use the passenger fee as a funding source. There is no known record of the number of passengers visiting Juneau with disabilities, but it

could be an incentive to use a portion of the fee. Funding options also include CBJ funding this from the General Fund.
2. There are currently taxi vouchers available for individuals who meet requirements, but not necessarily for people with disabilities only.
3. Cruise ship passengers can call CARE-A-VAN the day before to schedule service.
4. A critical issue is that many times, taxis that are wheel chair equipped are not available and/or broken down.
5. The replacement requirement for taxis is high, as often as every two years.

The Committee has also discussed the issue of lift-equipped taxis with Deputy City Manager Mila Cosgrove but has yet to take action on the issue. The Committee considers this the most pressing issue for next year.

As requested by the Human Resources Committee, following is the **Committee Attendance Record for the past 12 months:**

Meetings	**Matthew McGuan**	**Allen Hullet**	**Marianne Mills**	**Pamela Mueller-Guy**	**Cheryl Putnam**	**Charlene Steinman**	**Ross Douglas**
September 2017	X	Absent	Absent	X	X Resigned	X	X
October 2017	X	Absent	X	X	Vacant	X	X
November 2017	X	Absent Resigned	X	X	Vacant	X	X
December 2017	X	Vacant	X	Absent	Vacant	X	X
January 2018	X	Vacant	X	X	Vacant	X	X
February 2018	X	Vacant	Absent	X	Vacant	X	X
March 2018	X	Vacant	X	X	**Becky Harrington**	X	X
April 2018	X	Vacant	X	X	X	X	X
May 2018	X	**Dan Harrington**	X	X	X	X	X
June 2018	X	X	X	X	X	Absent	Absent
July 2018	X	X	X	X	X	X	X
August 2018	X	X	Absent	X	X	X	X

City and Borough of Juneau, AK

PARKS & RECREATION ADVISORY COMMITTEE

BOARD ROSTER

MARIA GLADZISZEWSKI
1st Term **Oct 31, 2017 - Oct 31, 2018**

Appointing Authority Assembly
Position Ex-Officio
Office/Role Assemblymember
Category Assembly Liaison
Dais Seat 10

EDRIC CARRILLO
1st Term **Apr 03, 2017 - Feb 28, 2019**

Appointing Authority Assembly
Position Voting Member
Category Public
Dais Seat 2

TRACI GILMOUR
2nd Term **Apr 01, 2013 - Feb 28, 2019**

Appointing Authority Assembly
Position Voting Member
Category Public
Dais Seat 4

JON GELLINGS
1st Term **May 14, 2018 - Feb 28, 2020**

Appointing Authority Assembly
Position Voting Member
Category Public
Dais Seat 9

CHRISTOPHER MERTL
3rd Term **Aug 24, 2009 - Feb 28, 2020**

Appointing Authority Assembly
Position Voting Member
Office/Role Chair
Category Public
Dais Seat 5

JOSH ANDERSON
2nd Term **Feb 24, 2014 - Feb 28, 2020**

Appointing Authority Assembly
Position Voting Member
Office/Role 2nd Vice-Chair
Category Public
Dais Seat 1

TOM RUTECKI
3rd Term **Mar 01, 2018 - Feb 28, 2021**

Appointing Authority Assembly
Position Voting Member
Category Public
Dais Seat 8

KIRSTEN SHELTON
1st Term **Mar 01, 2018 - Feb 28, 2021**

Appointing Authority Assembly
Position Voting Member
Category Public
Dais Seat 6

EMILY PALMER
1st Term **Mar 01, 2018 - Feb 28, 2021**

Appointing Authority Assembly
Position Voting Member
Category Public
Dais Seat 3

MIKE EBERHARDT

5th Term **Jan 01, 2004 - Dec 31, 2028**

Appointing Authority Assembly
Position Ex-Officio
Office/Role State Parks Liaison
Category State Parks Liaison
Dais Seat 11

VACANCY

Appointing Authority Assembly
Position Voting Member
Category Public
Dais Seat 7

OFFICE OF THE MUNICIPAL CLERK/ ELECTION OFFICIAL

155 S. Seward St., Room 202
Phone: (907)586-0203 Fax: (907)586-4552
email: Beth.McEwen@juneau.org

Date: September 11, 2018

To: Assembly Human Resources Committee

From: Beth McEwen, Municipal Clerk

cc: Sister Cities Committee Members

Subject: Sister Cities Committee Funding Request

The Clerk's Office has received a funding request from the Sister Cities Committee (SCC) requesting partial reimbursement for participation in the Juneau Delegation traveling to Whitehorse, YK, Canada September 16-18, 2018. (See attached.)

The Assembly Advisory Board/Meeting Expenses budgetary line item has a total annual amount of $5,000 with guidelines that the Clerk can approve up to $500 on a first come/first served basis to be used by any CBJ board/commission/committee once during the course of a fiscal year without Assembly approval. At the May 14, 2018 HRC meeting, SCC requested funding approval for a Juneau representative to attend the Russian American Pacific Partnership (RAPP) meeting in Anchorage July 25-26. The HRC approved up to $1600 (of those funds) to be used to send a representative to the event. JEDC Executive Director Brian Holst attended as the representative; the $500 of FY18 funds paid for his registration and $918.04 of FY19 funds was used to reimburse him for airfare and hotel expenses.

Below is an accounting of all Assembly funds spent so far on Sister Cities related events/expenses in FY19.

$ 250.00 Royal Canadian Mounted Police Lunch on July 4, 2018
$ 918.04 Reimburse JEDC for Brian Holst RAPP trip
$1,168.04 Total Charged to Assembly Advisory Board account in FY19

$ 720.00 Travel for four JPD to Whitehorse for Canada Day Parade 7/1/18
$1,743.61 Room/board/expense totals for JPD Canada Day Trip
$2463.61 Total Charged to Assembly Travel account [per K. Koelsch's request]

In light of the above expenses already expended for Sister Cities related events, the Clerk's office would like the HRC to decide whether or not to approve the attached funding request in the amount of $308.00. The SCC member is paying for her own airfare in the amount of $480.00 and that amount is not included in the reimbursement request.

City and Borough of Juneau

ASSEMBLY ADVISORY COMMITTEES, BOARDS AND COMMISSIONS
APPLICATION FOR SPECIAL PROJECT FUNDING FY 19

Please note: This form is for use by those boards that are unable or choose not to do fundraising. This form is to request up to $500 for use by Advisory Boards to further their mission. Funds in this account are subject to the Assembly actually approving funds for this budget item in their final FY16 budge. If approved, funds are limited and granted on a first come, first served basis. Examples of previous uses of these funds by boards include: printing, advertising, mailings, and venue rentals that further the work of the board within the community.

Group Name: Sister City Committee
Contact Person: Chloie Watson
Mailing Address: 9333 Northland St
Phone (Day): 907-321-4106
Phone (Eve): 907-321-4106

Funding Amount Requested from CBJ: $308.00

Other Funding Sources and Amounts: $480.00 Paid by Member for Air Fare

Has your group received funding or other support services from the CBJ in FY14, FY15 or FY16?
No: _____ Yes: ✓ Years & Amounts: _____

Is this project a: ✓ one time funding request, or _____ an annual request?

Charges to the public for services provided by the project funds: Further Relations with Sister City

Project Description*:
Meet with city officials to further tourism & events in Juneau. Education Opertunities Meet with Hockey Officials about Old Timers Games

Project Budget*:
$308 Requested for 2 nights BOB & $90 international taxes. Member will pay own air-fare.

Benefit to the community and the audience served by the project*:
Now that we have direct air plane service want to promote more travel & commerce with sister city.

How will the project will be consistent with the mission, goals and objectives of the group*:
We are working on Cultural & Education opertanties to further our mutual goals with Whitehorse YK.

Assembly Policy: Funds to advisory groups must be used in a manner consistent with the mission statement as defined in the establishing ordinance or resolution. Please indicate in **quantifiable measurements how the budgeted item will be applied towards the mission of the board as defined in the establishing ordinance or resolution. All applications for funding are submitted to the City Clerk's office. No authorization of funds in excess of $500 in one fiscal year to a single group without approval by the Assembly. [attach additional pages as necessary]*

CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY
COMMUNITY DEVELOPMENT

(907) 586-0715
CDD_Admin@juneau.org
www.juneau.org/CDD
155 S. Seward Street • Juneau, AK 99801

DATE: September 11, 2018

TO: Assembly Human Resources Committee

FROM: Laurel Bruggeman, Planner
Community Development Department

SUBJECT: FFY 2018 Community Development Block Grant Project Proposal Recommendation

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INTRODUCTION

This memorandum contains the staff recommendation for a co-applicant for the FFY 2018 Community Development Block Grant (CDBG).

Project proposals were solicited from the community for funds through the Federal Community Development Block Grant program (CDBG). Through this program, a project may be eligible for a grant, up to $850,000, through the City and Borough of Juneau (CBJ) and the Division of Community and Regional Affairs, Department of Commerce, Community, and Economic Development (DCCED).

Grant applications must be sponsored by a local government and sent to DCCED by December 7, 2018. A local government may choose to generate its own project ideas or chose a community organization as a co-applicant for these funds. In the past, CBJ has chosen to partner with a community organization and has been successful in obtaining CDBG funds using this method.

PROCESS

The Community Development Department (CDD) uses a standardized process for soliciting project proposals, review, selection, and timelines. This process was developed by CDD staff and has been endorsed by the Human Resources Committee. The purpose of this standardized process is to create an equal opportunity for all co-applicant proposals and ensure that similar types and amounts of information are submitted in a proposal. This process also helps staff gather grant application materials early on, which makes the grant writing process more efficient.

An informational meeting was held on July 31, 2018 to discuss CDBG guidelines, as well as CDD's standardized process. This meeting was advertised in the "Your Municipality" section of the Juneau Empire four (4) days prior, and was also promoted by Information Officer Lisa Phu on social media and Newsroom. Additionally, letters of invitation were sent to social service agencies throughout the community. Approximately thirteen (13) people attended the informational meeting. The deadline to submit project proposals was August 24, 2018; three (3) were submitted for review.

A staff review committee was made up of three (3) CDD staff and two (2) staff from the CBJ Housing Program. Staff individually reviewed the three (3) project proposals and determined what additional information was required from each project proposal applicant. Additional information was requested from each applicant. The staff review committee met on September 5, 2018, reviewed the additional information provided, and discussed each proposal; then, decided which proposal to recommend be chosen as a co-applicant for CDBG funds.

BACKGROUND

All eligible municipal governments in Alaska (except Anchorage) are allowed to apply for the Community Development Block Grant. In a typical year, application packets are distributed to municipalities in the fall and awards are made the following spring. Federal regulations require that at least fifty-one (51%) of the persons who benefit from a funded project be low to moderate income individuals as defined by the federal Department of Housing and Urban Development (HUD).

The goals of the CDBG Program are to:

- Ensure that the CDBG funds will be used to principally benefit low and moderate income persons;

- Provide financial resources to address public facility problems which encourage community self-sufficiency, increase health and safety of local residents, and reduce the costs of essential community services, and;

- Provide capital to assist in the creation or retention of jobs that primarily benefit low and moderate income persons.

The following objectives guide the distribution and use of CDBG Funds:

- To support activities which provide a substantial or direct benefit to low and moderate income persons;

- To support activities which eliminate clear and imminent threats to public health and safety;

- To support local efforts toward solving public facility problems by constructing, upgrading, or reducing operational/maintenance costs of essential community facilities;

- To support activities which demonstrate the potential for long-term positive impact;

- To support activities which encourage local community efforts to combine and coordinate CDBG funds with other available private and public resources whenever possible, and;

- To support activities which will result in business development and job creation or retention that principally benefits low and moderate income persons.

Past successful projects that CBJ has funded through the CDBG program include the Catholic Community Services Juneau Adult Daycare Center, St. Vincent de Paul's family oriented homeless shelter, and renovations and energy improvements for AWARE St. Vincent de Paul, Glory Hole, and Gastineau Human Services. The most recent funded project was the AWARE shelter, however; the grant funds were returned due to unexpected and prohibitive project costs.

We are requesting that the HRC make a recommendation to the Assembly on which project CBJ will sponsor from one of the proposals discussed below. Completed grant applications, printed with original signatures, must be received in Fairbanks by 5:00 p.m. on December 7, 2018.

PROJECT PROPOSALS

This year, the Community Development Department received three proposals; 1) Bartlett Regional Hospital, 2) Juneau Housing First Collaborative, and 3) St. Vincent de Paul. The maximum funding available for a single project from CDBG for FY 2018 is $850,000.

Bartlett Regional Hospital Crisis Stabilization Center

Bartlett Regional Hospital (BRH) proposes to use CDBG funds to design and secure cost estimates to construct a crisis stabilization center for adolescents (ages 10-17) and adults (ages 18+). The center would provide psychiatric services, medication administration, and crisis intervention and stabilization services. BRH is requesting the full $850,000 for the design of a 4,400 square foot building, which will offer new and expanded services, and allow patients to stay in Juneau to receive treatment. The current facility is roughly half this size and offers fewer services.

Juneau Housing First Collaborative Phase II of the Housing First Facility

The Juneau Housing First Collaborative proposes to use CDBG funds for the second phase of the construction of the Housing First facility. The project would consist of thirty-two (32) units of permanent supportive housing for chronically homeless adults. JHFC is requesting $550,000 in CDBG funds, to double the capacity of the services at the existing facility.

St. Vincent de Paul Dan Austin Transitional Support Services Center

St. Vincent de Paul (SVDP) proposes to use CDBG funds to renovate their existing facility and expand transitional support services for low income individuals, especially those experiencing homelessness and/or extreme disability. The services that will be offered at the facility include transitional planning and support; service agency exam, counselling, meeting and conference rooms; a thrift store exclusively for those in transition; a food pantry; laundry, locker room, and shower facilities; and meeting, training and event rooms. SVDP is requesting the full $850,000 to renovate an existing facility to accommodate these services.

EVALUATION OF PROJECT PROPOSALS

The Community Development Department has created an evaluation matrix for the review of project proposals. The evaluation matrix aims to answer these questions:

1. Will the proposal compete well at the state level?

2. Does the project meet local needs and concerns?

3. How much matching contribution will be provided by the project sponsors? Is the match reliable?

Bartlett Regional Hospital

- Has the potential to impact a broad range of individuals.
- BRH has experience administering federal grants.
- Has site control.
- The applicant has made the need clear in the proposal.
- Benefits to those of low/moderate income will have to be documented for the grant application.
- Has the administrative capability.
- Cash match – will need to be documented for a complete application.
- The total project is estimated to cost $1,137,880.00;
    - $850,000 is requested from CDBG
    - $287,880 will come from In-kind Contributions.
    - Cash match will be provided "as needed"

Juneau Housing First Collaborative

- The project is eligible under CDBG as a Community Development Project.
- Benefits an identified special population, so low/moderate income will not need to be documented.
- Has site control.
- Project is ready to go.
- Cash match – will need to be document for a complete application.
- The total project is estimated to cost $5,990,00.00
    - $550,000 is requested from CDBG
    - The rest of the funding will come from "a variety of local and state sources"

St. Vincent de Paul

- The project is eligible under CDBG as a Community Development project.
- Has site control.
- The project is ready to go.
- Benefits an identified special population.
- LMI may need to be documented if services are more than just for identified special populations.
- Provides a broad range of services.
- Has documented community support.
- Will use land as In-Kind Contribution.
- The total project is estimated to cost $1,530,528.00
    - $850,000 is requested from CDBG funds
    - $680,528 will come from in-kind contributions from SVDP in the form of land and building.

RECOMMENDATION

The staff review committee, based on the information provided, the above evaluation, and for reasons given below, recommended that the HRC recommended to the full Assembly that the City and Borough of Juneau co-apply with St. Vincent de Paul for a FFY 2018 Community Development Block Grant.

- The SVDP project is ready to go.
- The SVDP proposal has documented community support in the form of letters from community organizations.
- The SVDP proposal is consistent with CDBG goals and objectives.
- The SVDP proposal provides a broad range of services that will be beneficial to the community.
- The SVDP has the potential to serve a large number of clients.

While these decisions are not easy, the staff review committee believes that St. Vincent de Paul provided the most complete project proposal and will be the most likely project to receive CDBG funding from the DCCED.

ATTACHMENTS

Attachment A:	List of eligible activities from the DCCED Rating Criteria in Detail (from the 2018 CDBG Grant Application Handbook)
Attachment B:	Bartlett Regional Hospital Proposal
Attachment C:	Juneau Housing First Collaborative Proposal
Attachment D:	St. Vincent de Paul Proposal

F. ELIGIBLE PROJECT CATEGORIES & ACTIVITIES

The State of Alaska CDBG Program may be used to fund projects in three categories: **Community Development, Planning, and Special Economic Development.** The following summary, identifying the common types of eligible activities in each category, is for general reference only. A complete list of eligible and ineligible activities can be found in Title I of the Housing and Community Development Act of 1974, as amended.

Each applicant is expected to consult with CDBG Program staff about project eligibility prior to submission of an application. It is important that applications be submitted under the appropriate category.

Community Development

Under Section105(a)(2),(4),(5),(14)&(15), CDBG grant funds may be used for:

Public Facilities

- ✓ Health Clinics
- ✓ Daycare Centers
- ✓ Homeless Shelters
- ✓ Water & Sewer Systems
- ✓ Solid Waste Disposal Facilities
- ✓ Flood & Drainage Facilities
- ✓ Docks & Harbors
- ✓ Acquisition
- ✓ Construction
- ✓ Reconstruction
- ✓ Installation
- ✓ Improvements
- ✓ Electrical Distribution Lines
- ✓ Fuel & Gas Distribution Systems

Transportation Improvements

- ✓ Local Service Roads
- ✓ Boardwalks
- ✓ Barge Facilities
- ✓ Airports

Access to Public Facilities & Structures

- ✓ Removal of architectural barriers in conjunction with current renovations
- ✓ Improve access for handicapped & elderly persons

Real Property

- ✓ Acquisition
- ✓ Building Removal
- ✓ Improvements
- ✓ Clearance
- ✓ Demolition

Fire Protection Facilities & Equipment

- ✓ Acquisition
- ✓ Design
- ✓ Construction
- ✓ Rehabilitation
- ✓ Purchase

Note: *Community Development activities do not include the purchase of any personal property or any equipment unless it is attached to a facility or building and considered an "integral structural feature." Fire protection equipment is the only exception.*

Planning

Under Section 105(a)(12), CDBG grant funds may be used for:

- ✓ Data Collection
- ✓ Analysis
- ✓ Plan Preparation
- ✓ Marketing Studies
- ✓ Feasibility Studies
- ✓ Community Economic Development Plans
- ✓ Community Land Use Plans
- ✓ Capital Improvement Plans
- ✓ Plan Updates

Note: *Planning activities do not include engineering, architectural, and design costs related to a specific project activity. These activities may be eligible under the Community Development category.*

Special Economic Development

"Special Economic Development," as used in the CDBG Program, must meet the criteria below. See "Unique Requirements of Special Economic Development Projects" on page 9 for more information about the specific requirements for projects under this funding category.

Under Section 105(a)(14) CDBG grant funds may be used for:

- ✓ Commercial or Industrial Improvements
- ✓ Carried out by Grantee or Non-Profit Recipient
- ✓ Involving Commercial or Industrial Buildings, Structures, and Other Real Property Equipment & Improvements

Includes:

- ✓ Acquisition
- ✓ Construction
- ✓ Reconstruction
- ✓ Rehabilitation
- ✓ Installation

Under Section 105(a)(17), CDBG funds may be used for:

- ✓ Assistance (through eligible applicant) to an identified private, for-profit entity or entities

The project must:

- ✓ Create and maintain jobs for low or moderate income persons
- ✓ Assist businesses that provide goods or services needed by and affordable to low and moderate income residents

Special Economic Development Projects must fit under one of those two categories.

If your project is not for the purpose of acquisition, construction, reconstruction, rehabilitation, or installation of commercial or industrial buildings, structures, and other real property equipment and improvements, OR it is not for the purpose of providing assistance to an identified private for-profit entity **IT IS NOT** appropriate to submit it under the Special Economic Development category.

Note: *The examples provided under each of the three funding categories are for general information only and are not intended to be all-inclusive. Each community is encouraged to consult with CDBG Program staff about project eligibility and structure.*

V.

Rating Criteria

As described previously under the Grant Selection process, applications will be reviewed at two stages: threshold review and project rating and selection. During the threshold review process, staff will screen all applications for eligibility without awarding points. An application must meet all of the threshold review requirements in order to qualify for the second stage of the selection process. The project rating and selection process, stage two, will be conducted by the Application Selection Committee (ASC) using the criteria described below.

Applications will be evaluated and assigned points by the ASC based on the following criteria:

CRITERION #1 / Maximum Points Available 15

Project Description & Selection / Citizen Participation Plan

- ✓ Did the applicant describe the existing conditions, the nature of the proposed project, and what needs the project will address in the community? Although not required, did the applicant submit photos that show existing conditions?
- ✓ Did the applicant describe how the community decided on this project and why?
- ✓ Is there evidence of an active citizen participation plan which encourages citizen participation, provides reasonable access to public meetings, and provides technical assistance to low and moderate income citizens in developing proposals?
- ✓ Did the applicant describe the public participation process and explain how low and moderate income residents had the opportunity to comment?
- ✓ Does the applicant demonstrate there is a community consensus about this project?
- ✓ Did the applicant attach minutes of at least one public hearing, held within six months of the submission of this application, which verifies community consensus? Do the public meeting minutes demonstrate that citizens were asked to prioritize potential CDBG requests and that the majority selected this project?
- ✓ Did the applicant submit verification of public notification of the meeting? Were sign-in sheets attached?
- ✓ Does the applicant appear to have adopted a community development plan which identifies the proposed project as a community priority?

CRITERION #2 / Maximum Points Available 25

Project Plan / Readiness

- ✓ Did the applicant provide a clear and reasonable plan for implementing the proposed project?
- ✓ Did the applicant identify specific time lines, goals, objectives, and expected outcomes? Do these appear to be reasonable and achievable?
- ✓ Has the applicant identified and addressed permitting requirements, site control, State Fire Marshal approvals if appropriate, Energy Standards if appropriate, and Cooperative/Joint Agreements if appropriate?
- ✓ Has the applicant identified other agencies which will be or should be involved with this project?
- ✓ Is the applicant ready to proceed with the proposed project upon notification of award?
- ✓ Has the applicant obtained market assurances if appropriate? (Only for Special Economic Development Projects)
- ✓ In this section, does the applicant describe in detail that substantial efforts have been made to identify and seek other resources besides CDBG to support this project?
- ✓ Did the applicant receive CDBG funding within the past two years for project design, engineering, feasibility, and/or planning?

CRITERION #3 / Maximum Points Available 25

Project Impact

- ✓ Does the applicant provide evidence that the proposed activities will provide a substantial or direct benefit to low and moderate income persons?
- ✓ Does the applicant demonstrate that the proposed activities have the potential for long-term positive impact?
- ✓ Does the proposed project support activities that eliminate clear and imminent threats to public health and safety?
- ✓ Does the proposed project support local efforts toward solving public facility problems by constructing, upgrading, or reducing operational/maintenance costs of essential community facilities?
- ✓ Does the applicant document the specific health and safety needs that will be addressed by this proposed project? Does the applicant identify and document how long these health and safety needs have existed and the extent of the need?
- ✓ Does the applicant demonstrate that the proposed project is economically feasible and will have long-term viability?
- ✓ Does the proposed project provide development or encourage development in underdeveloped rural areas?
- ✓ Does the proposed project promote self-sufficiency and diversification in local economies?
- ✓ Does the proposed project make use of local resources and/or improve existing production/delivery capacity?

CRITERION #4 / Maximum Points Available 25

Budget / Match / In-Kind

- ✓ Is the overall Proposed Budget reasonable?
- ✓ Has the applicant clearly identified and submitted its proposed budget according to the four budget components (CDBG Request, Cash Match, In-Kind Contributions, and Total Project Cost)? Has the applicant included a Budget Narrative?
- ✓ Has the applicant secured other funds which are needed to complete this project? Is documentation included?
- ✓ Are matching funds at least 25% of the total project cost and has the applicant documented that this match is committed to the project? Has the applicant identified the source and type of this match?
- ✓ Has the applicant identified and documented all In-Kind Contributions, including their source and type? Does the amount of In-Kind Contribution indicate that the community is committed to making this project happen and willing to contribute significantly to its support? Are the computations for In-Kind Contributions reasonable and supported with documentation?
- ✓ Has the applicant identified whether the proposed project will be Force Accounted or Contracted Out, if appropriate?
- ✓ Has the applicant completed the Labor and Fringe Benefits computation chart contained in the Application Packet? Are the proposed wage rates appropriate and reasonable? Are the Fringe Benefits appropriate and reasonable?
- ✓ Has the applicant identified costs and attached price quotes or cost estimates for materials, freight, equipment rental, equipment purchase, contractual, insurance, administration, and other line items for which CDBG funds are requested? Are the costs reasonable and appropriate?
- ✓ Is no more than 5% in administrative costs requested from the CDBG funds?
- ✓ Does it appear that the applicant can complete this project and provide a benefit to the residents of the area with the funds currently available?

CRITERION #5 / Maximum Points Available 10

Administrative Capabilities

- ✓ Does the Application Packet and information provided therein support that the applicant has the administrative capability to properly manage CDBG funds and comply with all federal and state requirements?

- ✓ Has the applicant identified who will have the day-to-day management responsibility and oversight for this project?

- ✓ Does the applicant have the cash resources to administer a cost reimbursable grant or have they identified an alternative course of action which will allow this project to proceed?

- ✓ Has the applicant successfully administered other federal or state grants which have had similar requirements to the CDBG program? Has the applicant documented that it was successful with those grants?

- ✓ Did the applicant attach a copy of last year's audit or Certified Financial Statement with the Application Packet? Does the audit identify findings? Have those findings been satisfactorily resolved? Did the applicant include management letters and any other reports received with its audit?

- ✓ Has the applicant noted any tax liens or judgments and addressed them?

- ✓ Has the applicant clearly described what Administration costs will be charged to this grant?

- ✓ Did the applicant use the application form provided, adding pages if needed? Was the minimum font size used in the application (at least size 12) and was it easy to read? Was supplemental information (designs, comprehensive plans, etc.) inserted in appendices attached to the back of the application?

Total Maximum Score for all Five Criteria

Project Description & Selection/Citizen Participation Plan	**15**
Project Plan/Readiness	**25**
Project Impact	**25**
Budget/Match/In-Kind	**25**
Administrative Capabilities	**10**
Total Maximum Score	**100 Points**

Bartlett Regional Hospital
s
3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

FY2019 Community Development Block Grant Proposal: Bartlett Regional Hospital Crisis Stabilization Center for Adolescents (ages 10-17) and Adults (ages 18+)

I. Project Description and Selection/citizen Participation Plan

Project description

The state of Alaska is facing a decade long increase in hospital use by patients for mental health and substance abuse issues. This project would create a two story 4,000 square foot crisis stabilization center at Bartlett Regional Hospital serving adults and youth from Juneau and the surrounding communities. Youths needing stabilization are currently held at Bartlett Regional Hospital for a short time until they can be accepted into treatment programs outside of the Southeast Region. More often than not they are sent out of state. Adults are able to receive limited services at BRH, but more often than not, there is not enough capacity within the State to treat them either.

Crisis Stabilization services are direct mental health care to non-hospitalized individuals experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation.

For children already receiving residential services, there are no step-up/step-down community-based supports for sub-acute services designed to (a) provide services within the child's home or in the child's community and (b) prevent repeated placement in residential and inpatient services far from the child's community and home.

There are currently no residential facilities in Alaska for adults with acute mental health needs, leaving inpatient psychiatric emergency services, inpatient psychiatric hospitals, emergency departments, and inpatient general hospitals as the primary location for services. There is limited availability of crisis intervention/stabilization services within the Southeast Alaska region which are designed to identify and intervene before costlier acute services are necessary.

In order to align Behavioral Health Services with the impending direction of Division of Behavioral Health's service focus, Crisis Stabilization Services for SE Alaskans should be developed by Bartlett Regional Hospital**.** These services would be made available for children, adolescents, and adults in crisis. These are services for up to 72 hours of care in secure and protected environments, though we understand there will be instances where the length of stay

may be longer. These programs are clinically staffed, psychiatrically supervised, and include continuous nursing services. The primary objective is for prompt evaluation and/or stabilization of individuals presenting with acute symptoms or distress. Services include a comprehensive assessment, treatment plan development, and crisis intervention services necessary to stabilize and restore the individual to a level of functioning that does not require inpatient psychiatric hospitalization. These services would be designed to reduce inpatient mental health admissions while also addressing the patient capacity needs we have experienced for years at BRH.

This service would be non-acute/non-residential and developed on an outpatient crisis billing model and linked to other behavioral health services. Bartlett currently has a 12-bed adult inpatient psychiatric unit that is consistently at capacity, often resulting in other departments in the hospital having to board and care for patients experiencing acute psychiatric crisis. There are no acute behavioral health services in southeast Alaska for children & adolescents. These children and youth who present at Bartlett are often admitted to our medical unit until transport out of community can be arranged to a more appropriate setting. The development of a crisis stabilization program for both populations would help to:

1. Reduce the number of youth experiencing a behavioral health crisis being sent out of community, away from their family for treatment; thus serving them and their families in their home community.
2. Provide a step-down approach for adults discharging from the Mental Health Unit who are still in need of supports, allowing for patients with more acute behavioral health crises to utilize the Mental Health Unit beds.

These services are designed to reduce or shorten inpatient admissions, assist families during crisis, and provide stability and support. Services can range from a one-time intervention or an extended period encompassing several years based on individual needs. Crisis stabilization services could be added to the Bartlett Outpatient Psychiatric Services (BOPS) practice as the model viably expands.

This project would raze the existing double wide 2,000 sqft BOPS building and replace it with a two story 4,000 sqft building capable of serving both adults and youth. The building would have completely separate entrances with no access between the two per hospital standards.

The following services would be provided at this facility:

1. Psychiatric Services
2. Medication Administration
3. Crisis Intervention/Stabilization Services
    a. Therapeutic (Clinical and Rehab) Sessions
    b. Individual, Family, and Group (Can be provided (and billed) telephonically or via TeleMedicine if family is from out of community and cannot physically be in Juneau)

4. Case Management Aftercare
    a) Outpatient services through BOPS or another community provider
    b) TeleMedicine as needed

Description of existing conditions

As of July 2017, the number of youth presenting to Bartlett for psychiatric concerns have tripled over the past 3+ years, as had their length of stay pending transfer. Appropriate treatment is not available at Bartlett and transfer is required to a higher level of care not located within Southeast Alaska. Year to date, BRH has seen approximately 80 youth present in the Emergency Department who were experiencing a behavioral health crisis. It is estimated that 75% (60 youth) of those youth could have benefited from a Crisis Stabilization Program. These youth and their families present on their own or are referred by community providers (Juneau Youth Services, SEARHC, Primary Care Physician, School District, Office of Children's Services, etc). More often than not, it is determined that these youth and their families could benefit from short term crisis stabilization services. Unfortunately, due to the lack of this level of services, families are often required to look at out of community placement (NorthStar, Providence CRC) or longer term out of home placement (residential treatment).

Dialogue has centered around the development of a sub-acute voluntary behavioral health facility that focuses on helping individuals to effectively manage psychiatric symptoms in order to prevent unnecessary tragedy or frequent hospitalization. This proposal supports the development a short term crisis stabilization program at BRH, serving youth, adults and their families form Juneau and from around all of Southeast Alaska. Individuals ages 10-17 could be referred to the program by their psychiatric provider, through the emergency department, community behavioral health agencies, or self-referred by the family for assessment. Youth would be treated for both crisis emergencies and respite services. The success of such a program is to ensure families are engaged in care of youth placed to improve the chances of success when the youth returns home. This proposal provides both programmatic and fiscal data that evidences this service is both needed and can be sustainable for serving families in Juneau and Southeast Alaska.

Bartlett's Adult Mental Health Unit has 12 beds, accepts patients statewide, and is at capacity most days. This often results in patients being boarded in other hospital departments or shipped out of community if there is another bed available in Anchorage or Fairbanks. The impact of a crisis stabilization program for adults would provide a "sub-acute" setting for adults experiencing a behavioral health crisis that would offer:

1. Alternative to hospitalization through admission to the Crisis Stabilization Center
2. A step down option for patients from the Mental Health Unit who still require intensive support services to help them better prepare to return home successfully.

Citizen participation plan

This project requires space and an overall campus/community plan. This includes design, construction, operational expertise, and community and state buy in. Possible referrals for services could come from the following sources:

1. Family/Self-Referrals
2. Primary Care Physicians
3. Community Behavioral Health Providers (from Juneau & Southeast Alaska)
4. Office of Children's Services
5. Division of Juvenile Justice
6. Juneau Police Department
7. Alaska State Troopers
8. Juneau School District
9. Adult Protective Services

II. Project Plan and Readiness

Implementation schedule

This grant will able us to secure conceptual designs and cost estimations when the grant award is made. The project will occur in phases during 2019 through 2020. In 2019 we will complete Phase I - an architectural assessment, conceptual design services, a cost estimate, and will secure a competitive project design and construction bids. Phase II will be project construction beginning in the second half of 2019. A more specific timeline will be developed with CBJ should BRH be selected as the Co-Applicant project.

Documentation of outside support

The State of Alaska, Division of Behavioral Health continues to prioritize regional Crisis Stabilization for Children & Adults, as laid out in their proposal to CMS for the 1115 Medicaid Waiver. BRH is coordinating with community stakeholders and potential referral sources, including funders from the State and The Alaska Mental Health Trust to prioritize this service being made available in our community. BRH administration is communicating with other communities to look at the need for Crisis Stabilization from a statewide perspective while we continue to look closely at how a regional Crisis Program would operate in Juneau.

As part of Behavioral Healthcare Reform in Alaska, the State of Alaska Division of Behavioral (DBH) is has made it clear that a primary goal of this Reform effort is identify communities who would commit to providing intensive Community-Based Intervention Services to youth and their families with the ultimate goal of diverting these youth and adults from higher levels of out of home care, including short-term and long-term hospitalization. Specifically, DBH is seeking communities to provide short-term Crisis Stabilization Services both locally and regionally with

the goals of stabilizing the crisis and developing an aftercare plan to keep that family unit intact in their home community.

Site Control

Bartlett Regional Hospital is an open, but controlled, campus with 24-hour security. BRH owns the land and surrounding property. This project would be developed on City and Borough owned property.

Permits, approvals, agreements, etc.

This project is in the planning stage for construction. The need has been established and the project has been discussed by the BRH board of directors who have expressed support for having crisis stabilization services offered in Juneau. We are currently seeking Community Development Block Grant funding to anchor our project budget. A more accurate cost estimate will be determined upon securing project bids and subsequent project contract.

III. Project Impact

Description of how the project benefits low to moderate income individuals AND/OR identified special populations

Most patients served would be insured under Medicaid. Medicaid is a program created by the federal government, but administered by the state, to provide payment for medical services for low-income citizens. People qualify for Medicaid by meeting federal income and asset standards and by fitting into a specified eligibility.

Medicaid began as a program to pay for health care for people in need who were unable to work. It covered the aged, the blind, the disabled, and single-parent families. Over the years, Medicaid has expanded to cover more people. For instance, children and pregnant women may qualify under higher income limits and without asset limits. Families with unemployed parents may qualify, and families who lose regular Family Medicaid because a parent returns to work may continue to be covered for up to one year.

There have also been changes in the eligibility rules for people who need the level of care provided in an institution, such as a nursing home. Now, most Alaskans who need — but cannot afford — this expensive care may qualify for Medicaid. In addition, recent changes within the Alaska Medicaid program give some people who need an institutional level of care the opportunity to stay at home to receive that care.

This facility is designed to accommodate/treat from 80-150 patients a year with an average stay of between 3-7 days, depending on the individual needs of each patient and their family.

Description of long term impacts

Involving families and community support in treatment leads to more successful outcomes; if youth are treated closer to home, there is a greater potential to involve families and caregivers. Follow up with services outside of southeast Alaska is difficult and expensive. It would be easier for local providers to develop supportive care systems for youth and adults in crisis to avoid admissions and reduce readmissions with a Crisis Stabilization Center.

In order to align Behavioral Health Services with the impending direction of DBH's service focus, Crisis Stabilization Services for SE Alaskans should be developed by BRH. These services would be designed to reduce inpatient mental health admissions. This service would be non-acute/non-residential and developed on an outpatient crisis billing model linked to other youth focused behavioral health services.

These services should be designed to reduce inpatient admissions, assist families during crisis, and provide stability and support. Due to the longer term nature and follow up required with youth and adults in these types of programs, multiple families may be involved over longer period of times to reach a stabilized family dynamic. Services can range from a one-time intervention or an extended period encompassing several years based on individual needs.

This project efficiently treats community members, and helps free up valuable Emergency Room services creating a more efficient community hospital. Additionally, the program creates a healthy community by addressing the causes of mental and substance abuse crises. This prevents future crises.

Description of how the project will solve community health and safety issues

More intensive evidenced- based crisis treatment could meet the needs of the majority of people within the region. This type of treatment is currently unavailable with in Southeast Alaska and it allows Alaskans to get treatment closer to home.

<u>Benefits of a Southeast Based Crisis Stabilization Center:</u>

1. Alternative to hospitalization through admission to the Crisis Stabilization Center
2. A step down option for patients from the Mental Health Unit who still require intensive support services to help them better prepare to return home successfully.
3. Law enforcement, physicians, and schools would have an alternative for individuals and families experiencing a behavioral health crisis. Transport for services to Anchorage and Seattle could be significantly reduced.
4. Crisis resolution would work in conjunction with Juneau Youth Services, JAMHI Health & Wellness Juneau School District, primary medical providers, faith communities, etc., to connect complimentary community based services as patients return home with a plan for ongoing supports.

Description of how the project solves public facility problems

A crisis stabilization program frees up precious Emergency Room space, and personnel while providing more affordable and effective treatment for people needing medical treatment to prevent themselves from harming themselves and others. Crisis Stabilization addresses mental health, and substance abuse issues holistically and is effective. Additionally, it is the most cost effective way of providing treatment for patients, and the hospital. The current BOPS building is a tired old double wide trailer ill equipped and designed to deliver the care required. This project would raze the existing double wide trailer 2,000 sqft BOPS building and replace it with a two story 4,000 sqft building capable of serving both adults and youths in though in the same building. The building would have completely separate entrances with no access between the two per hospital standards.

IV. Budget/Match and In-Kind Funds

Detailed budget including 4 budget components:
CDBD Request, Cash Match, In-Kind Contributions, Total Project Costs

Bartlett Regional Hospital estimates this project could cost upwards of $3 million dollars for a new building. This project budget would raze the existing structure. A fully funded award towards a Crisis Stabilization Center from the CDBD grant would be added to with other BRH funds.

1. CDBD Request: $850,000.00
2. Cash Match: as needed
3. In-kind Contributions: $287,880.00
4. Total Project Costs: $1,137,880.00

Documentation of matching funds – at least 25% of the total project cost should be match committed to the project.

BRH will use Medicaid reimbursements, and in-kind match exceeding $287,880.00 for this project. Bartlett Regional Hospital has projected revenue based off of Alaska Community Behavioral Health Center Medicaid Reimbursement Rates. This would operate and bill as a “Crisis Stabilization Outpatient Program”. Average daily revenue (Based off of Medicaid) would be $1,200.00 per day per patient. This project is sustainable from Medicaid revenue to support staff. Most patients served would be insured under Medicaid; however, Medicare, Premera, TriCare, and Aetna do reimburse for this service.

Documentation of Administrative Costs – the administrative costs should be no more than 5% of the CDBG request

Bartlett Regional Hospital does not charge an indirect cost rate on grants for administrative costs. As a CBJ entity, BRH does have to follow normal procurement guidelines which has a 4% CBJ administration and Management fee for construction projects.

V. Administrative Capabilities

Description of cash resources available to administer a cost reimbursable grant or an alterative

Bartlett Regional Hospital receives cash each weekday on a daily basis for services rendered for healthcare. At any given time, the hospital has the cash resources to be able to pay for goods or services and then be reimbursed. The hospital is a non-profit entity and operates under accrual accounting. Therefore, items such as “depreciation” are recorded on the income statement, however it is considered a “non-cash” expenditure. This allows for processing expenditures that will be reimbursed and also allows for capital expenditures for equipment and building improvement.

Description of how the applicant has administered similar grants

Bartlett Regional Hospital has an average grant load of between six to twelve state and federal grants open at any given time. The grants range from $10,000 to those exceeding $1,000,000 in grant revenue. The Grants office is part of the hospital administration and works closely with the Comptroller, CFO, and accounting. BRH is subject annual audits from the city and borough of Juneau, and the Federal Government. Our accounting and business is in good audit standing.

Attachment B

Project Budget for BOPS Crisis Intervention Facility

ITEM	UNIT	AMOUNT	QUANTITY	SUBTOTAL
Land	LS	$ -	1	$ -
Sitework	LS	$ 35,000.00	1	$ 35,000.00
Site Utilities (water, sewer, electrical service)	LS	$ 135,000.00	1	$ 135,000.00
Renovate Existing BOPS Building	SF	$ 175.00	2400	$ 420,000.00
New sprinkler system installation	EA	$ 90,000.00	1	$ 90,000.00
Estimating Unknowns	%		15%	$ 102,000.00
SUBTOTAL CONSTRUCTION				**$ 782,000.00**
Consultant Design Services	%	$ 782,000.00	10%	$ 78,200.00
Cosultant CA and Inspection Services	%	$ 782,000.00	4%	$ 31,280.00
CBJ Administration and Management	%	$ 782,000.00	4%	$ 31,280.00
Furnitire Fixtures & Equipment	LS	$ 80,000.00	1	$ 80,000.00
Permits and Fees	LS	$ 5,000.00	1	$ 5,000.00
Printing, Advertising, Postage	LS	$ 5,000.00	1	$ 5,000.00
1% for Art	%	$ 782,000.00	1%	$ 7,820.00
Project Contingency	%	$ 782,000.00	15%	$ 117,300.00
SUBTOTAL INDIRECT COSTS				**$ 355,880.00**
TOTAL PROJECT COST				**$ 1,137,880.00**

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

First, can you explain a bit more the difference between the existing services Bartlett has to offer and what is proposed?

Bartlett Regional Hospital's (BRH) current Behavioral Outpatient Psychiatric Services (BOPS) program serves children, adolescents, and adults offering mental health, substance use disorder, and Medication Assisted Treatment for adults with opioid addictions. The BOPS building is a mid-1990s modular construction, 2000 sqft building initially designed to utilize an existing concrete foundation. The foundation was originally BRH's sewage treatment facility, when BRH went on city Sewer the building was initially constructed as an activity center for the Rainforest Recovery Center. It has been modified many times over the years. Due to the modular construction technique you are limited in how you can modify the space. Today's needs patient needs can no longer be met by this building.

Currently BOPS serves children (as young as four), adolescents, and adults. The facility currently consists of three physician offices, two licensed therapist stations, and one nursing station. There are no beds available at BRH, in Juneau, or in the Southeast Alaska region for these crisis focused services. As a result, patients are sometimes held at BRH until a bed is located out of community, and for youth, some are sent out of state, in either scenario, separated from their family.

The proposed two story 4,400 sqft BOPS building would offer new and expanded services to serve adolescents (age 10-17) and adults (age 18+) in two separate programs each with five treatment bedrooms. Treating patients in Juneau, or at least in their home region, has many benefits and improves patient outcomes for successful treatments. The new building would house on the top floor a new BOPS service space, and the bottom floor would have a nursing station, a psychiatric station, and a therapist/assessment office spaces for both the youth and adult crisis stabilization programs. The two programs would have separate entrances and access points to keep the patient populations separate.

Second, in your proposal you say that most patients served would be covered under Medicaid. Can you tell us how many of the patients last year that would have qualified for this services were eligible for Medicaid? Alternatively, how can you show that the project will serve primarily low to moderate income individuals? The state requires that at least 51% of the people benefiting from the project be of low to moderate income, we would be required to show them how we meet this threshold.

A new Crisis Stabilization Center would serve two populations currently receiving care from BRH using BOPS and the MHU. Using data from FY2018 the MHU had 3,493 patient days, and BOPS had 4,817 patient days of use. 65% of adults using BOPS were Medicaid/Medicare recipients, 75% of adults using the MHU were Medicaid/Medicare recipients. Nearly 100% of

the kids at BOPS plus those we sent out of town were on Denali Kid Care (Medicaid). Of the 90 youth assessed at BOPS, 50% were sent out of Juneau due to a lack of services available here. These children were sent to either Northstar Hospital in Anchorage, API in Anchorage, or to long-term care centers, both in state and out of state. Crisis stabilization allows children stay within their communities with the goal of returning home as soon as possible. It ensures all services provided are family focused and family engaged. This program would also help house adults leaving the MHU by coordinating housing since many of our adult patients are either 1) homeless, or 2) have recently lost their housing, being kicked out, or evicted.

August 24, 2018

Good Afternoon,

Thank you for considering Juneau Housing First Collaborative's (JHFC) proposal for the Community Development Block Grant application, in the amount of $550,000. We believe that the Juneau Housing First Collaborative project fits the CDBG application criteria. The project will provide support and housing services to extremely low-income individuals and especially to individuals experiencing extreme disability. The project a community priority and is shovel ready. The project has passed all necessary environmental reviews and inspections.

The project has site control of the land. The project will have substantial and positive economic impact on the community and the region through substantially reducing the amount of money and resources spent on emergency services and department of correction time.

The project will consist of 32 units of permanent supportive housing for chronically homeless adults. These units are an addition to the existing 32 units of the project which have been full and operating since October 2017. We have attached a study conducted by University of Alaska Fairbanks outlining the positive benefits of our project on emergency service utilization. Development of additional units will create additional benefits. We have attached a fuller description of the project as a memo from MRV Architects.

Thank you again for your consideration and please do not hesitate to contact me with any questions or comments at (907) 957-2885 or info@feedjuneau.org.

Best Regards

Mariya Lovishchuk

Mariya Lovishchuk

Executive Director, TGH Project Coordinator, JHFC

MRV ARCHITECTS

1420 GLACIER AVENUE, JUNEAU, AK 99801 (907) 586-1371

Project: Housing First, Phase II
Re: General Scope, Configuration, and Pricing
To: Mariya Lovishchuk, Bruce Denton
By: Paul Voelckers
Date: August 7, 2018 MRV 1815

MRV Architects has completed Schematic design documents for a proposed Phase II expansion of the Juneau Housing First project. As background, the initial project design was developed in 2015 with consideration of a second phase to approximately double the number of residential units. A parking reduction variance, for instance, was approved after analysis of the full project, including the Phase I scope with 32 units of housing, and a potential future Phase II to add an additional 32 units.

The attached graphics illustrate the proposed solution. The plan of the building is roughly mirrored to the south, partially enclosing an interior garden space, and extending the building along the developed parking and street frontage. The full size is 14,700 sq.ft. over three levels.

The proposed design will include 32 apartments in the base bid. The building configuration differs slightly from Phase I, with the provision of seven apartments on the first level, and only limited expansion of administrative and support space. Phase I, in contrast, utilized the entire first floor for general purpose support spaces, management offices, and a separate health clinic. Consequently, the Phase II size is somewhat smaller than Phase I to net the same unit count.

As identified in a separate memo from Housing First, a total budget of $5,990,000 for Phase II has been identified, using a variety of local and State sources. Both a construction cost estimate, and an overall total project cost, have been developed as follows:

Construction cost estimates for the Phase II design are extrapolated from Phase I actual costs. The 2016 costs for Phase I averaged out to $365/sq.ft., a competitive price developed by Triplette Construction utilizing modular off-site fabrication at their nearby plant. Phase I costs also included several overall costs that partially reduce some costs of Phase II, including parking lot development and paving, elevator, and fresh water/waste water utilities.

Given this, a relatively conservative cost of $375/sq.ft. is proposed for Phase II construction. This number reflects two years of cost escalation, and a slightly higher base cost than Phase I. Using a cost of $375/sq.ft., and the size of 14,700 sq.ft., a base construction cost of $5,510,000 is derived. Other costs, such as design, administration, and contingency, are also estimated to give the full Project Costs.

Project Costs:

1.	Construction Cost: Base bid,	$5,510,000
2.	Design costs, reflecting simplified scope:	$100,000
3.	Administrative expenses: permits, legal, mgmt.:	$70,000
4.	Construction Administration, Special Inspections:	$80,000
	Subtotal:	$5,760,000
	Overall project contingency: 4% allowance:	$230,000
	Total Project Costs:	**$5,990,000**

Attachment C

Juneau Housing First
6 Month Pre/Post Service Usage and Indicators of Wellbeing Comparison
June 2018

Heidi Brocious, PhD, MSW, &
Morgan Erisman, MSW & MPH

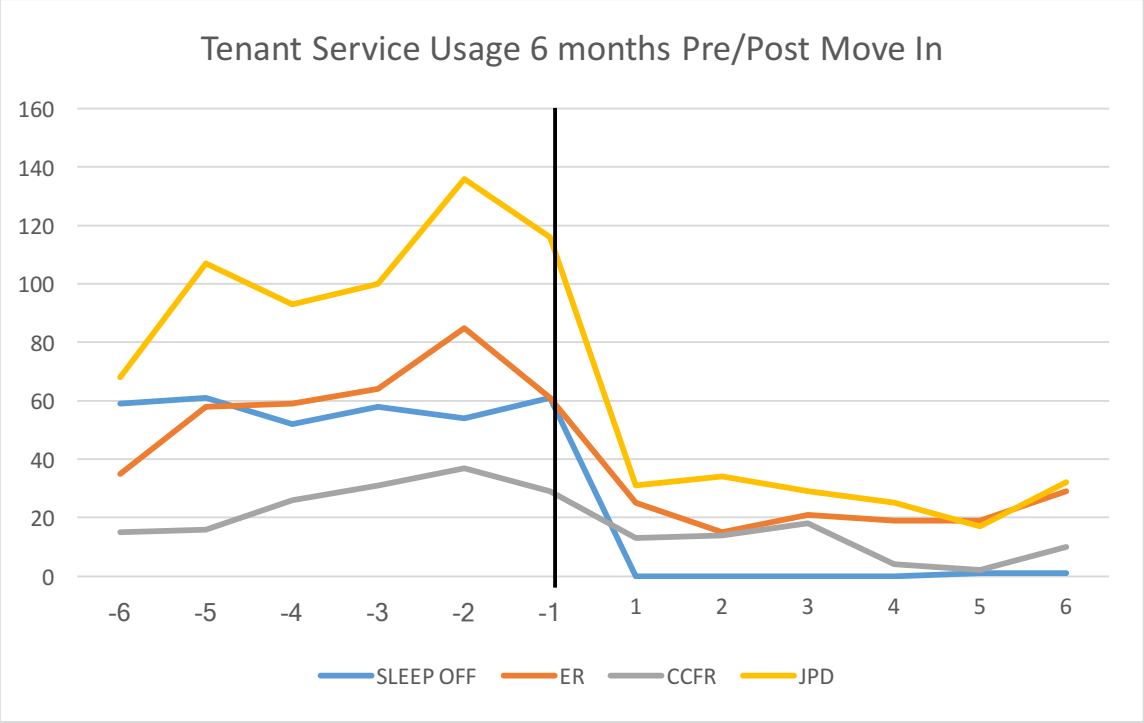
Service Utilization

Comparison of resident pre/post move-in usage of Bartlett ER, Rainforest Recovery Center Sleep Off, Contact with Juneau Police Department (JPD), and contact with Capital City Fire and Rescue (CCFR).

	6 months prior to move in	6 months post move in	Percent of decrease in usage between 2 six month periods
Bartlett ER Visits	360	126	65%
RRC sleep off visits	344	2	99.4%*
Contacts with JPD officers (any reason)	604	168	72%*
Transport by CCFR	137	63	54%

*indicates statistically significant difference

Usage Trends Visualized



Attachment C

Resident Demographics

Average age of residents	50 years old (range of 31-62)
Gender	80% Male 20% Female
Race/Ethnicity	85% Alaska Native/American Indian 10% Caucasian 5% Mixed-race
Education	5% Graduate School 10% Undergraduate College 5% Vocational Education 75% High School Diploma or GED 5% Less than High School
Median number of Months Homeless	180 (approximately 15 years)

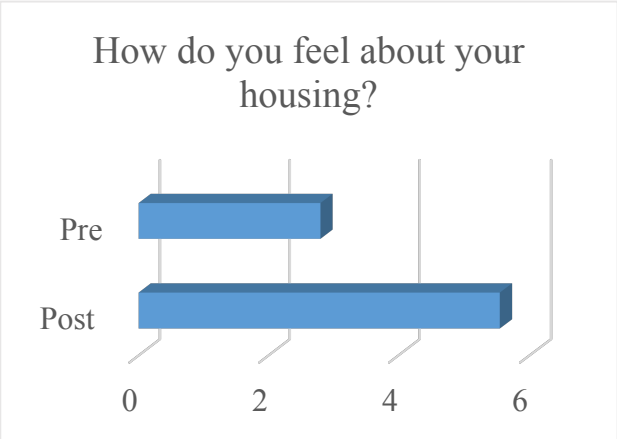
Residents' Experiences with Trauma

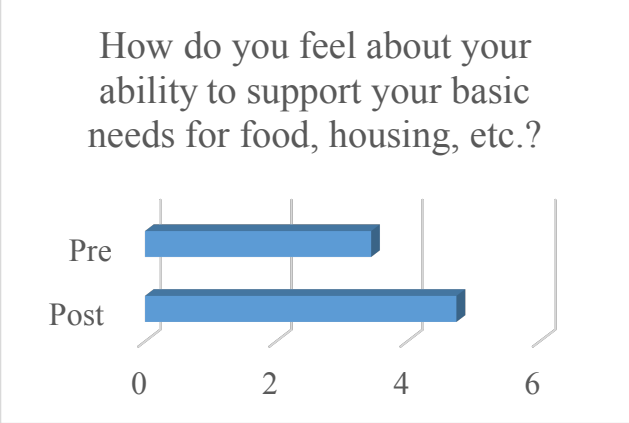
Lived with someone who abused substances	90%
Lived where there was not enough to eat, had to wear dirty clothes, or was not safe	80%
Lived with someone who was sent to prison	70%
Has been physically mistreated	60%
Lived with someone who was physically mistreated	50%
Lived with someone who attempted or committed suicide	45%
Personally in foster care, or a close relative in foster care	45%

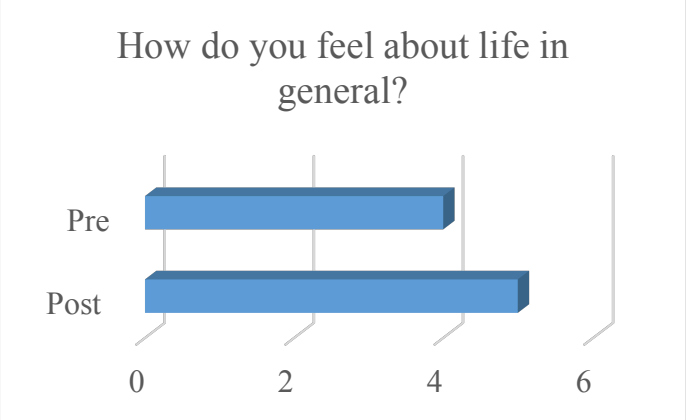
Attachment C

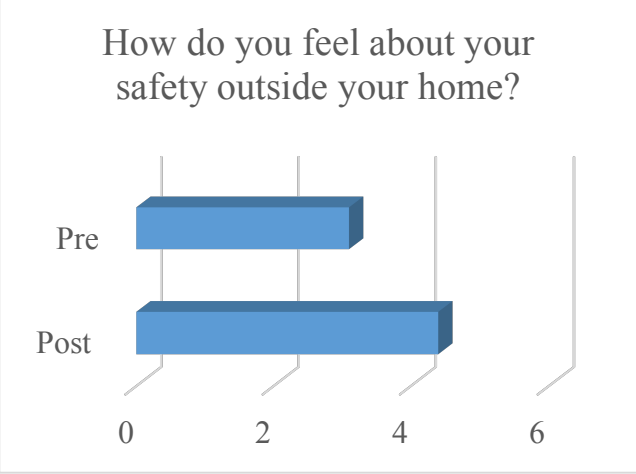
Indicators of Well-being Average Group Scores (statistically significant findings at 6 months)

1=terrible, 2=unhappy, 3=dissatisfied, 4=mixed, 5=satisfied, 6=pleased, 7=delighted



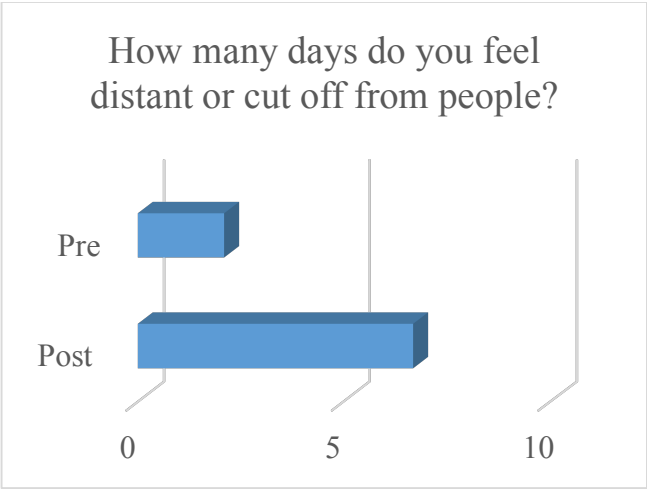


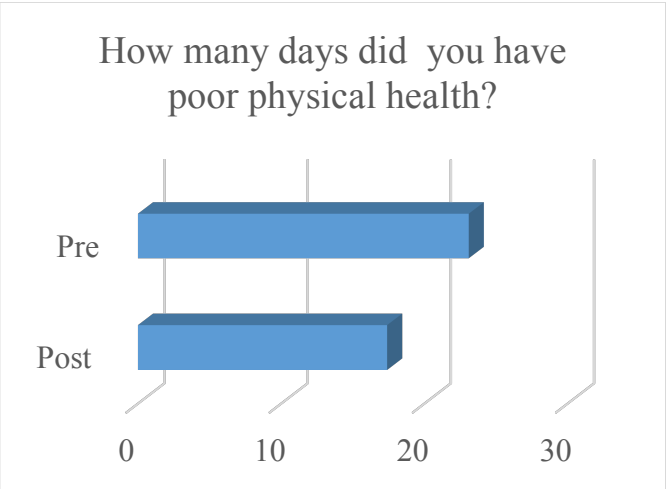




Attachment C

Indicators of Well-being
(Statistically Significant)
Self-Reported Average Number of Days





Findings that were not statistically significant, but will be interesting to track and see with more time and more data:

	Average # of Days Pre	Average # of Days Post
Alcohol use	21.4	21.05
Drank more than four drinks	18.55	15.35
Used Tobacco	14.1	16.35
Felt barely able to control their anger	1.3	3.3
Felt Suicidal	1.5	3.6

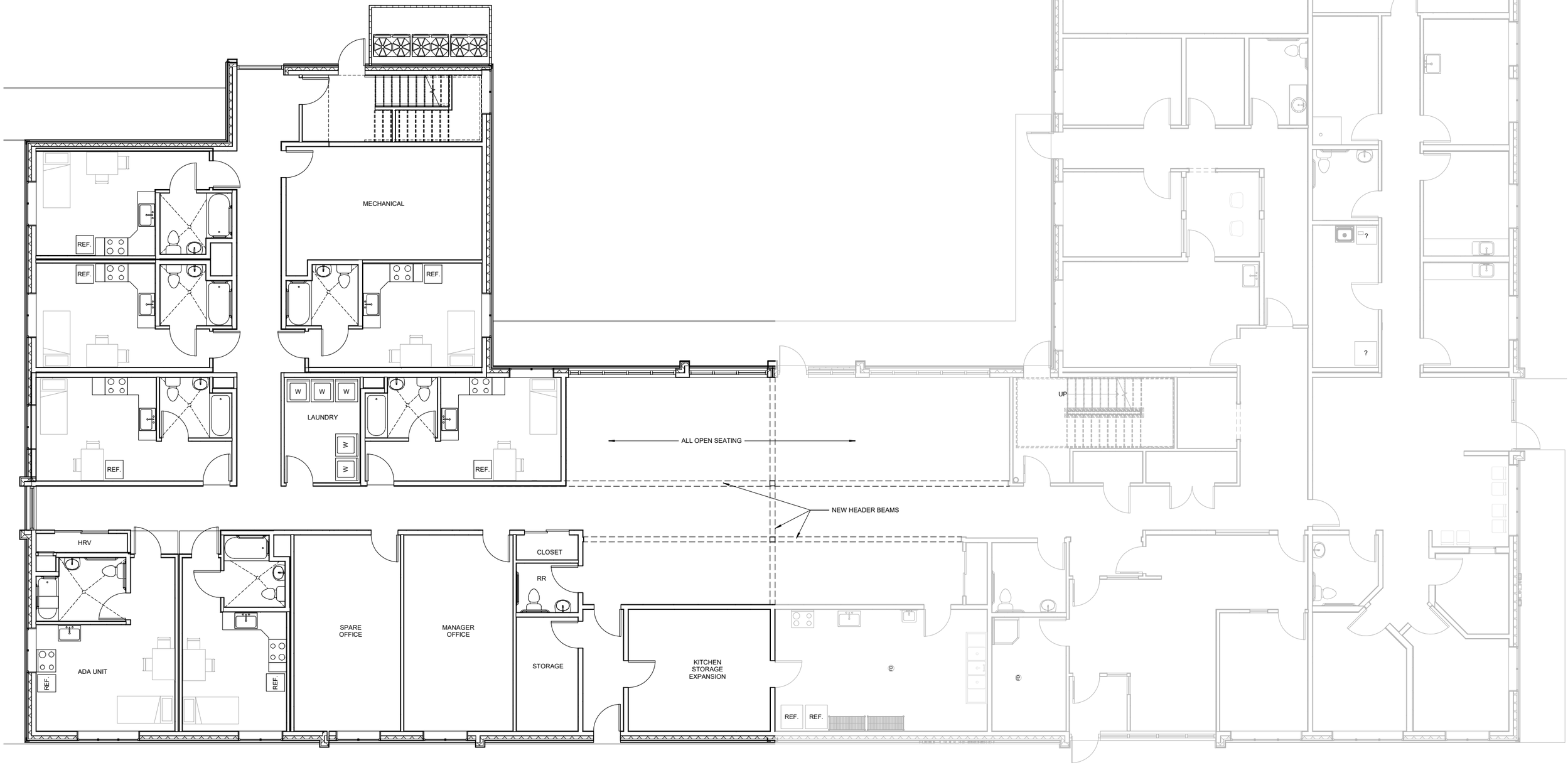
This study is funded in part with a grant from the Alaska Mental Health Trust Authority

Trust
Alaska Mental Health Trust Authority


HOUSING FIRST

Attachment C

Attachment C

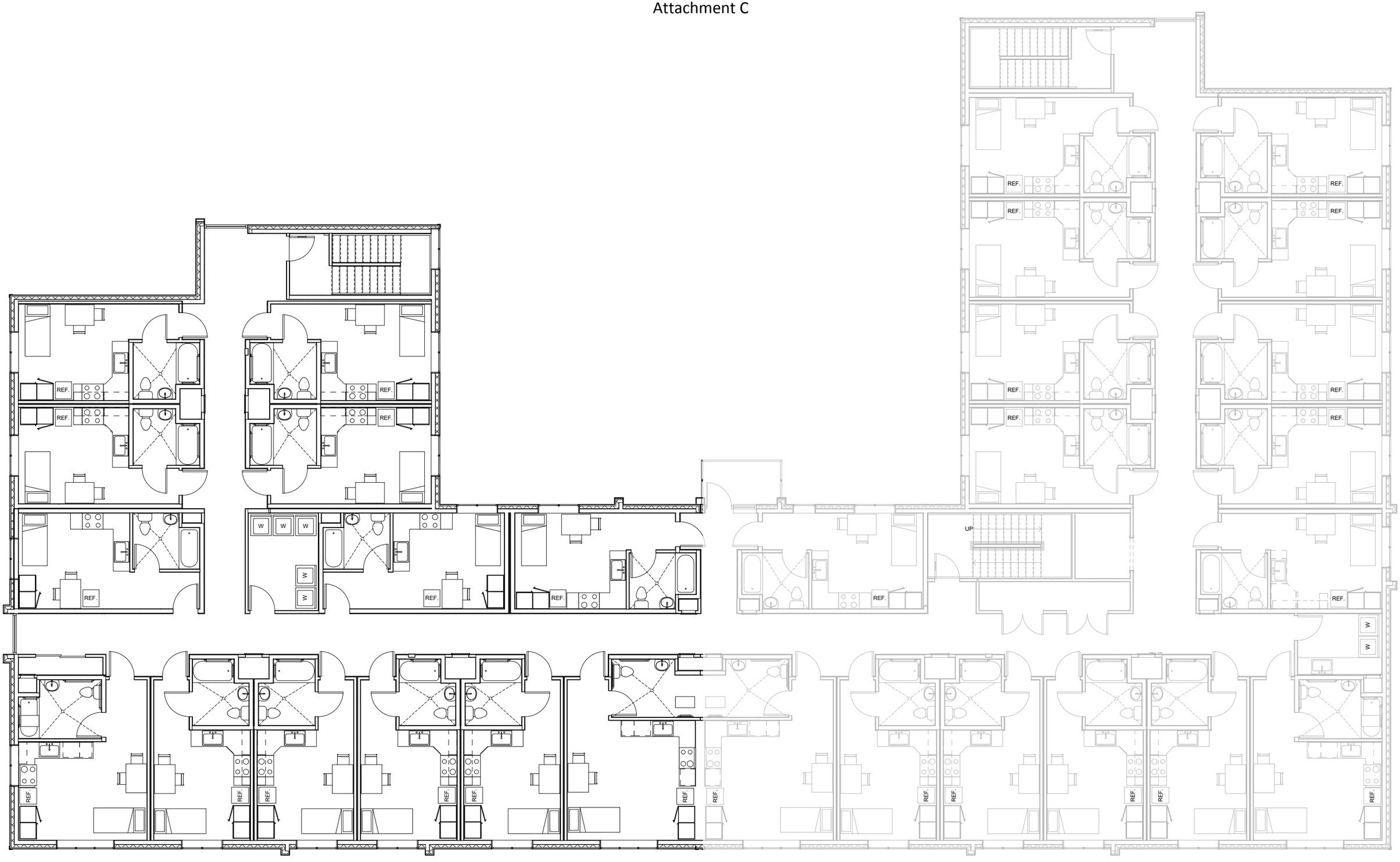


MRV Architects

Juneau Housing First - **Phase II Expansion**

August 8 2018

Attachment C



St. Vincent de Paul Society
Diocesan Council of Southeast Alaska

8617 Teal Street
Juneau, Alaska 99801
office (907) 789 5535
fax (907) 789 2557
email st.vincentdepaul@gci.net
website www.svdpjuneau.org

We provide material and spiritual charity and work for social justice for all people.

August 24, 2018

Submitted by mail and email to laurel.bruggeman@juneau.org.

Laurel Bruggeman, Planner
Community Development Department
City & Borough of Juneau, Alaska
155 South Seward Street, Juneau, Alaska 99801
Juneau, AK 99801

Regarding: Proposal for Grant Funds Through the Federal Community Development Block Grant (CDBG) Program

Dear Ms. Bruggeman,

Thank you for considering our proposal for the Community Development Block Grant application, in the amount of $850,000. We believe that the St. Vincent de Paul (SVdP) project fits the CDBG application criteria by funding construction of the Dan Austin Transitional Support Services Center (TSSC). The TSSC would provide much needed services to the CBJ area, including transitional plan development with SVdP's in-house team of three Community Navigators (case managers), selected thrift store items, food pantry, locker-storage, showers, laundry, food service, training and meeting facilities, and professional service facilities for medical, legal, financial and counselling to low-income individuals and especially to individuals experiencing homelessness and/or extreme disability. The project a community priority, is already open (in a very limited form) in SVdP's former Thrift Store complex on Teal Street.

The project is matched by SVdP's commitment of $680,528 of the $1,530,528 of the total project costs by providing 3,761 sq. ft. of its 25,566 sq. ft. of its 8619 Teal Street facility. The project will have substantial and positive economic impact on the community and the region by substantially reducing the amount of money and resources spent on social services for individuals and families assisted by the TSSC who are successfully transitioned from homelessness and/or publicly-supported transitional housing into fully self-sustaining housing and employment situations.

Thank you again for your consideration and please do not hesitate to contact me with any questions or comments at (808) 782-5795 or bradleysvdp@gmail.com.

Sincerely,

Bradley Perkins, Interim General Manager
St. Vincent de Paul Juneau

Enclosures St. Vincent de Paul CDBG Proposal

St. Vincent de Paul Society
Diocesan Council of Southeast Alaska

8617 Teal Street
Juneau, Alaska 99801
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We provide material and spiritual charity and work for social justice for all people.

Proposal for Grant Funds Through
The Federal Community Development Block Grant (CDBG) Program

Dan Austin Transitional Support Services Center Project

St. Vincent de Paul Society, Diocesan Council of Southeast Alaska

No child should have to sleep in a car, no elder should have to live out in the cold, and no one should ever live without hope. Whether it is the working poor, disabled individuals, or seniors living on social security, every person deserves a roof over their head, a place to call home, and adequate clothing for themselves and their families. A desire to help the poor is the reason St. Vincent de Paul Juneau (SVdP) operates a transitional housing facility with 26 rooms, provides 108 units of additional low-income housing, and offers food and other assistance throughout the year. Additionally, SVdP has been a leader in Southeastern Alaska providing affordable housing to those transitioning from homelessness, and poverty into permanent housing.

Background of Project

SVdP operates one of two thrift stores in the City and Borough of Juneau (CBJ). The store provides important services to the community in terms of low-cost items for purchase, a place for donations, and is a major source of SVdP's operation revenue. This year, SVdP was able to move the thrift store from its historic location on the first floor of 8619 Teal Street, beneath its transitional housing facility to a new, more visible and accessible location on Glacier Hwy near Nugget Mall.

Prior SVdP Thrift Store Location

New SVdP Thrift Store Location

Since the thrift store paid its portion of the utilities, maintenance, and mortgage of the 8619 Teal Street building, SVdP first considered remodeling the vacant space into long-term, affordable, rent-producing housing. This had been done with the remainder of the first floor a number of years ago when the administrative offices of SVdP moved next-door to its Smith Hall senior housing facility. These proposed rental apartments would have paid their share of the building overhead, once paid by the thrift store.

However, long-time General Manager Dan Austin, withdrew that plan from consideration by the board – despite his tireless pursuit of permanent, affordable housing in Juneau. With the recently awarded grants to SVdP for three community navigators (case managers) and a part-time administrative staff person, Dan saw the potential of SVdP focusing on transitional support services to help homeless and low-income individuals and families transition into healthy, self-sufficient, productive situations with long-term housing. And he had a vision that the former thrift store complex (about 6,500 sq. ft.) could be repurposed into a transitional support services center. The CDBG funds would allow SVdP to realize this dream and get such a transitional support services center up and running in 2019.

Project Description & Selection/Citizen Participation Plan

Project Description

The funds from the CDBG would be used for remodeling and construction of the Dan Austin Transitional Support Services Center, using the first floor of SVdP's facility located at 8619 Teal Street, Juneau, Alaska. The new facility would provide much-needed support services to homeless and low-income individuals and families to help them transition into healthy, self-sufficient, productive situations with long-term housing, in one, easily navigated location.

Transitional support services that will be offered in the Dan Austin Transitional Support Services Center include:

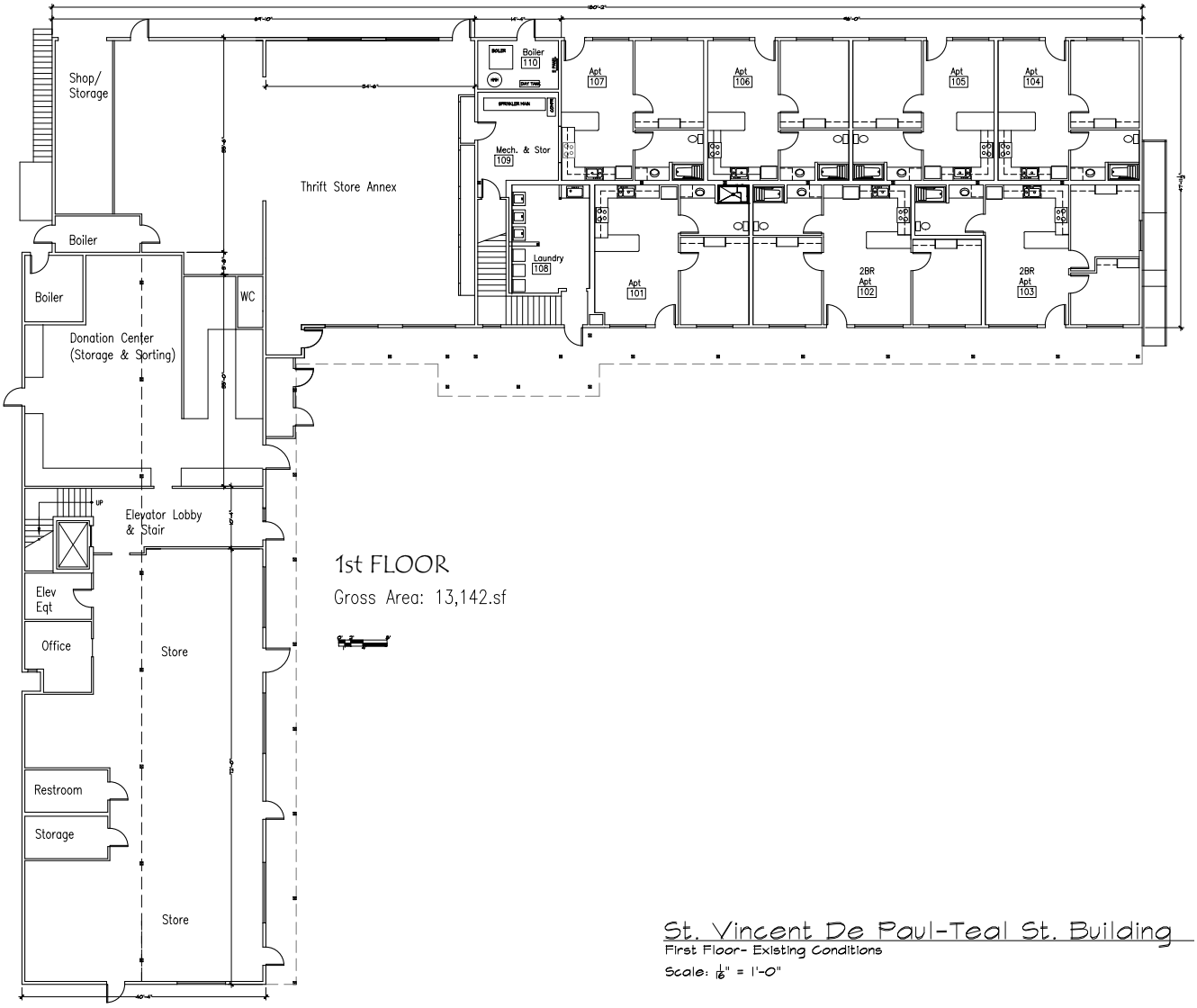
- Transitional Planning and Support by SVdP Navigators
- Third Party Service Agency Exam, Counselling, Meeting, and Conference Rooms
- Transitional Thrift Store
- Transitional Food Pantry
- Transitional Laundry, Locker Room and Shower Facility
- Peer Support Programs – SVdP Home Visits, Other One-to-One Programs
- Large Meeting, Training and Event Room and Commercial Kitchen

Description of Existing Conditions

Currently, transitional support services are offered by a number of different federal, Alaska State, and City and Borough of Juneau (CBJ) agencies. Additionally, a number of other agencies in the CBJ offer these services along with SVdP, including Aiding Women in Abuse and Rape Emergencies (AWARE), Alaska AIDS Assistance Association (4As), Alaska Coalition on Housing and Homelessness (ACH2), Alaska Housing Development Corporation, Alaska Legal Services Corporation, Alaska Mental Health Trust Authority, Bartlett Regional Hospital, Catholic Community Service, Central Council Tlingit Haida Indian Tribes of Alaska, Family Promise, Front Street Community Health Center, Gastineau Human Services Corporation, The Glory Hall (formerly The Glory Hole), Haven House, Juneau Alliance for Mental Health, Inc (JAMHI), Juneau Coalition on Housing and Homelessness, Juneau Community Foundation, Juneau Economic Development Council, Juneau Reentry Coalition, Juneau Youth Services, Inc., NAMI Juneau, Love Inc., Polaris House, Prama Home Inc., Rainforest Recovery Center, Reach, SERHC - Alaska's Educational Resource Center, Southeast Alaska Independent Living (SAIL), Tlingit and Haida Regional Housing Authority, United Way of Southeast Alaska, Zach Gordon Youth Center. While many of these agencies strive to direct clients to other agencies when they are not able provide services needed by clients, not all agencies have case managers (sometimes called community navigators), are equipped to developed transitional plans and/or provide on-site services for clients.

While the breadth of available services in the CBJ is vast, navigating these services can be daunting, especially for someone who is trying to transition out of homelessness or poverty. There is need to provide case management for developing a plan for transition that helps clients meet basic needs, such as clothing, food, attention to personal needs, job seeking skills, medical, legal, financial, counselling, and peer support. The goal of the Dan Austin Transitional Support Services Center (TSSC) is to bring these services into one, easily navigated facility. SVdP plans to use the space vacated by its relocated thrift store for the TSSC on the first floor of SVdP's facility located at 8617 Teal Street.

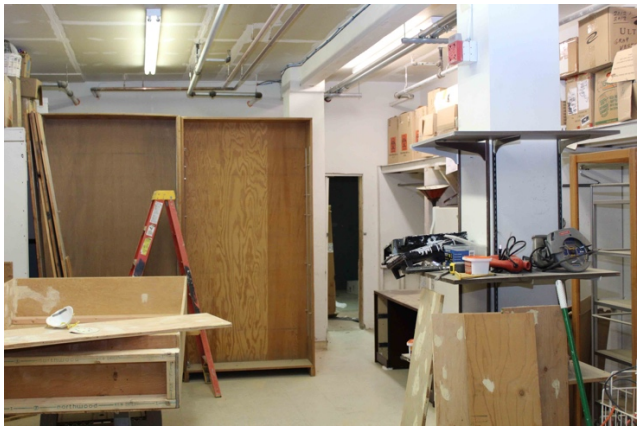
SVdP is unique in the CBJ area in that it is able to offer low-barrier case management, as it does not rely on Medicaid or other reimburse programs. The SVdP navigators assist anyone who asked for assistance. This will allow the TSSC to be an open access point for anyone needing transition assistance, regardless of there current resources.



Current Configuration of First Floor SVdP 8617 Teal Street Facility

The prior thrift store is configured as a large sales area with fitting rooms, a bathroom and a manager's office. There is a large sorting, storage and maintenance area for donations, and building maintenance. The former community room was subdivided into an auxiliary store space with free-standing dividers, walls, counters and display areas. Adjoining the auxiliary store space, there is a commercial kitchen that was decommissioned a number of years ago.

Current Main Store

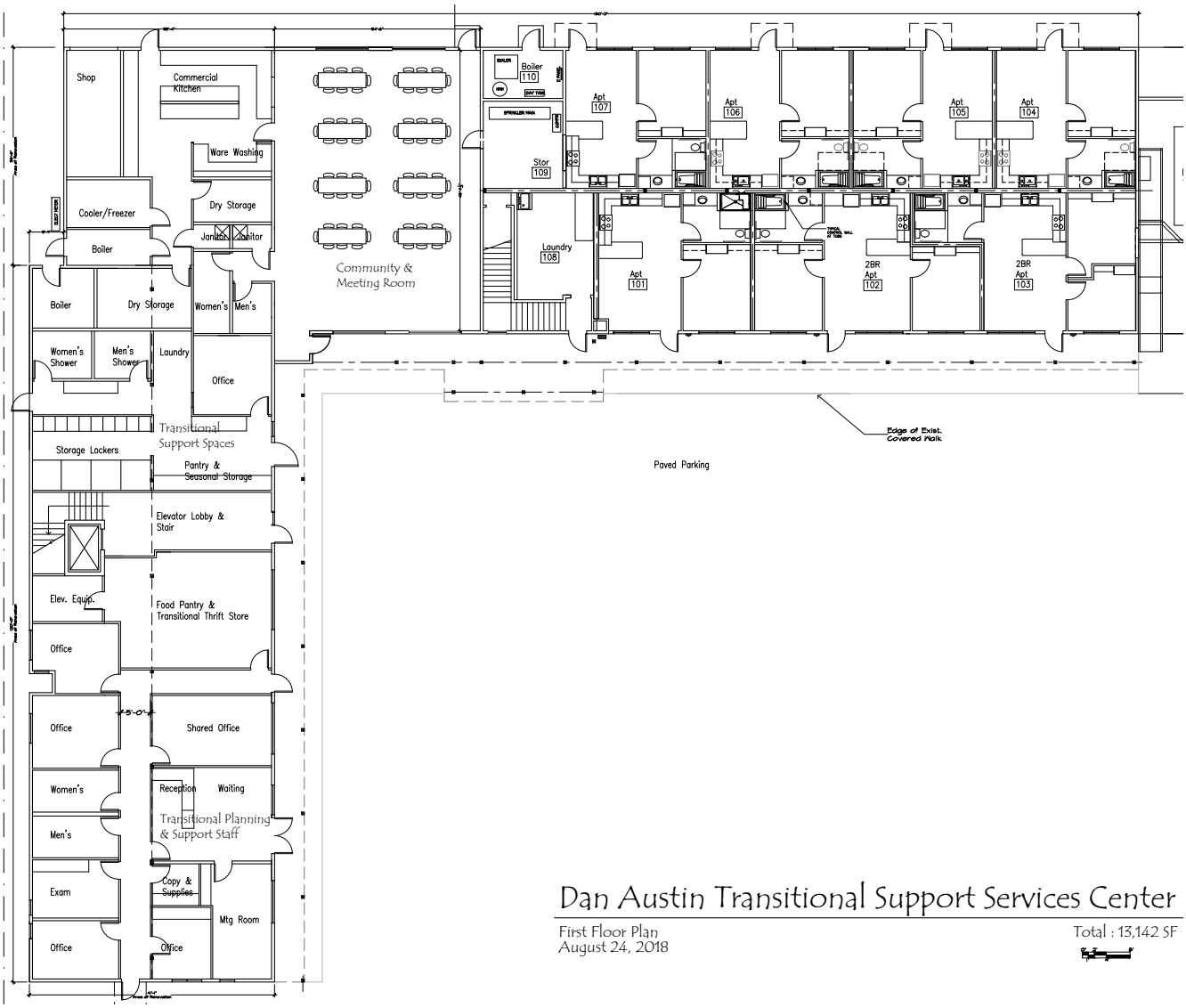


Current Donation, Sorting and Maintenance Space

Current Auxiliary Store Space

Current Decommisioned Kitchen

Out of this space, SVdP believes the Dan Austin Transitional Support Services Center (TSSC) can be remodeled. Even without the funds from the CDBG, SVdP has opened the TSSC in the main area without any remodeling – albeit with very limited services (case management, thrift store items and food pantry), because SVdP believes in the mission of the TSSC.



Proposed Configuration of First Floor SVdP's 8617 Teal Street Facility

SVdP proposes to use the funds from the CDBG to remodel this area of SVdP's facility located at 8617 Teal Street. In addition to the funds used for the remodeling of the current facility, funds from the grant would be used for relocation of the SVdP maintenance operations currently operating out of the current donation, sorting and maintenance space into a new adjoining maintenance shed.

Here are the support services that are expected to be offered by the TSSC:

Transitional Planning and Support

SVdP's current two Community Navigators have been relocated to the new TSSC (in the currently unimproved old thrift store space) and will be hiring a third navigator and part-time administrator. These navigators already provide transitional support services to help homeless

and low-income individuals and families in transition. They have been working out of the community room upstairs on the second floor of the building, in SVdP's transitional housing facility. SVdP has been a leader in the CBJ navigator community by hosting weekly meetings on best practices and social services updates. The new TSSC will allow the SVdP navigators to expand the number of clients they serve and the breadth of services they can offer, both within the TSSC and outside the TSSC. Currently, the navigators use SVdP vehicles (all donated) to shuttle clients to and from housings to social services, training, interviews, etc.

Service Agency Exam, Counselling, Meeting, and Conference Rooms

Small rooms and one conference room for part-time use, scheduled by the TSSC administrator to be used by service agencies and clients for medical, legal, financial, housing, employment, and other appointments and meetings. One room will be outfitted as a medical exam room. Services provided will be at a cost based on the client's ability to pay the service provider. SVdP will negotiate facility-use fees with service provides or donate facilities, depending on the status (profit or non-profit, etc.) of service provider.

Transitional Thrift Store

Items from SVdP Thrift Store and other Juneau second-hand stores that are not sold at their existing stores will be available according to the client's ability to pay in this store, including interview clothing, targeted at needs of those in transition. The navigators and administrator will open the store only when TSSC clients are already at the TSSC or are scheduled to visit the store. It will not be opened to the public.

Transitional Food Pantry

SVDP currently operates two food pantries – one upstairs in the transitional house housing facility and the other out of a closet in its offices, next door in its senior affordable housing facility, Smith Hall – for both clients in transition and others in need. This combined Transitional Food Pantry would be at low- or no-cost targeted to those who approach SVdP in need, and would be opened by the TSSC staff, and the SVdP staff, when needed.

Transitional Laundry, Locker Room and Shower Facility

The day-use laundry, locker room and shower facility would assist those needing a place to prepare for interviews, vocational training, classes, appointments and other situations, when they need to store their belongs (for a short period), and clean themselves and their clothes. Use of this facility would be part of transitional plan developed with the center's navigators and would be at low- or no-cost.

TSSC Peer Support Programs – SVdP Home Visits, Other One-to-One Programs

Through the SVdP Home Visit program and other one-to-one and peer support programs, the TSSC will provide support to low-income individuals and families. The TSSC will assist with scheduling, adverting, food service, etc. These programs have been effective in providing peer assistance to individuals and families in transition and will be part of the transitional support services plan developed by the TSSC's navigators for the clients of the TSSC.

Meeting, Training and Event Room and Commercial Kitchen

The commercial kitchen and community room in the facility were once a vital part of the community when they were added to the facility in 1991. They were used by SVdP and many community groups for events, meetings and parties, and were a community resource and a source of rental income to the SVdP, which defrayed the costs of the building. SVdP is not asking for CDBG funds for renovation the meeting, training and event room and commercial kitchen, as it believes it can do the renovation work itself from donations, staff and volunteer time (which is regularly contributed, i.e. the remodeling of the new SVdP Thrift Store). However, the renovated meeting, training and event room is expected to regularly host classes, meetings and other events for TSSC clients, peer-to peer groups, sponsors, third-party service providers, etc., associated with the TSSC. The renovated commercial kitchen will support:

- food for events, training and meetings held by the TSSC;
- food for events, training and meetings held by the SVdP;
- food for events, training and meetings held in meeting, training and event room (rental and SVdP-donated use); and
- possible TSSC client meal needs (according to ability to pay) as part of potential TSSC vocational training provided by third parties in the commercial kitchen.

<u>Citizen Participation Plan</u>

SVdP has always had broad community support for its works and projects and expects the Dan Austin Transitional Support Services Center to be the same. That community and citizen support is represented by these attached letters of support:

- Mandy O'Neal Cole, Deputy Director, AWARE, Inc.
- Mariya Lovishchuk, Executive Director, The Glory Hall
- Annie Garvey-Humphrys, Executive Chef and Owner, Chez Alaska Cooking School
- Donald Habeger, Juneau Reentry Coalition
- Mary Alice McKeen, President, Board of Directors, Haven House Juneau
- Rev. Karen Perkins. Resurrection Lutheran Church

Project Impact

Description of How the Project Benefits Low to Moderate Income Individuals and/or Identified Special Populations

While the breadth of social services available in the CBJ is vast, navigating these services can be daunting, especially for someone who is trying to transition out of homelessness or poverty. The Dan Austin Transitional Support Services Center would provide support services to homeless and low-income individuals and families to help them transition into healthy, self-sufficient, productive situations. This is achieved by developing a plan for transition that helps them meet basic needs, such as clothing, food, job seeking skills, medical, legal, financial, counselling, and peer support.

Description of Long-Term Impacts

Each of the transitional support services provided by the TSSC has already been proven to be effective in the CBJ and elsewhere in the US. The implementation of these services within one facility, merely simplifies and makes the process more efficient for SVdP, other service providers and the clients.

In the research paper (attached) "Research on Community Support Services, What Have We Learned" William Anthony and Andrea Blanch report the results of a comprehensive review of published literature related to the essential components of a community support services such as medical, mental health, housing, economic, peer support and case management. Each component was analyzed with respect to its documented need, effective intervention strategies, and cost. The need for the types of services and support which is part of a client combined plan is validated, as conceptualized in the Dan Austin Transitional Support Services Center.

Project Plan / Readiness

SVdP is "shovel-ready," or in this case "hammer-ready," to proceed with the project. In fact, the thrift store staff, the current two navigators and the maintenance staff have been busy working in the old thrift store space. The navigators have setup make-shift offices and have been seeing clients in the open space, and the thrift store staff have setup a temporary transitional thrift store for the navigators' clients.

Implementation Schedule

August 2018	SVdP moves existing navigators into unimproved, existing space
Fall 2018	SVdP starts renovation of meeting room and commercial kitchen
Date of Funding	Architectural plans developed for remodeling
Date of Funding + 1 mo.	Apply for permits, approvals, etc.
Date of Funding + 3 mo.	Remodeling begins / negotiations with TSSC service providers
Date of Funding + 8 mo.	Remodeling completed / soft opening
Date of Funding + 9 mo.	TSSC grand opening

Documentation of Outside Support

SVdP has always had broad community support for its works and projects and expects the Dan Austin Transitional Support Services Center to be the same. That community and citizen support is represented by these attached letters of support:

- Mandy O'Neal Cole, Deputy Director, AWARE, Inc.
- Mariya Lovishchuk, Executive Director, The Glory Hall
- Annie Garvey-Humphrys, Executive Chef and Owner, Chez Alaska Cooking School
- Donald Habeger, Juneau Reentry Coalition
- Mary Alice McKeen, President, Board of Directors, Haven House Juneau
- Rev. Karen Perkins. Resurrection Lutheran Church

Site Control

SVdP is remodeling its own facility and has sufficient site control for the project.

Permits, Approvals, Agreements, Etc.

SVdP believes it will be able to secure the necessary permits, approvals and agreements to complete the project.

Budget/Match/In-Kind

Detailed Budget Including Four Budget Components

Project Budget

Project Costs

SVdP site and facility (14.7% apportionment of $4,626,000 CBJ assessment)	$680,528
Remodel thrift store space into offices, transitional store and food pantry	575,000
Remodel donation, storage, maintenance space into showers, lockers and laundry	250,000
Pre-built maintenance shed and pad (to replace lost maintenance space)	25,000
Total Project Costs	$1,530,528
Project Funding	
CDBG Funding Request	$850,000
SVdP Cash Match	0
SVdP In-Kind Contributions	
SVdP site and facility (14.7% apportionment of $4,626,000 CBJ assessment)	680,528
Total Project Funding	$1,530,528

Documentation of matching funds – at least 25% of the total project cost should be match committed to the project

SVdP is committing $680,528 of the $1,530,528 (44%) of the total project costs by providing 3,761 sq. ft. of its 25,566 sq. ft. (14.7%) in its 8619 Teal Street facility, which has a current CBJ assessment of $4,626,000.

SVdP has its own internal accountants, and outside accounts, which manage in many affordable-housing projects, as well as the property which will host the TSSC.

Documentation of Administrative Costs – The Administrative Costs Should Be No More Than 5% of the CDBG Request

The administrative costs of the TSSC will be paid by SVdP under one of two community navigator grants. Overall project management will be done by the general manager of SVdP and will not be charged to the project, as is customary to SVdP projects.

Administrative Capabilities

Description of Cash Resources Available to Administer a Cost Reimbursable Grant or an Alterative

SVdP has cash resources, and more importantly, significant income streams from rental properties, its Thrift Store, and donations to administer the grant.

Description of How the Applicant has Administered Similar Grants

SVdP has extensive experience in managing significantly larger construction and operating projects. Its administrative abilities in the area of community social services and transitional services is well known within, and outside the CBJ. SVdP has been, and is currently, the recipient of many federal, state and local grants, and is experienced with complying with requirements and reporting. In fact, SVdP was a co-recipient of the CBJ selected and funded CDBG in 2007 and the sole recipient the CBJ selected and funded CDBG in 2005.

The TSSC Lead Navigator, Trevor Keller, would be the supervisor of services in the TSSC. The new administrator would be responsible for facility operations. The general manager of SVdP would be responsible for the administration and completion of the project.

Attachment D

Aiding Women in Abuse and Rape Emergencies

"Serving Juneau and Nine Southeastern Communities"

Sha'a Ka Atyátx'i Noowú
DOVE COTTAGE
A Place of Peace

P.O. Box 20809 • Juneau, Alaska 99802-0809
(907) 586-6623 (business)
(907) 586-2479 (fax)
(907) 586-1090 (crisis)
1-800-478-1090 (toll free in state)
E-mail: info@awareak.org
Website: www.awareak.org

August 24, 2018

Regarding: Support for St. Vincent de Paul's Proposal for Grant Funds Through the Federal Community Development Block Grant (CDBG) Program

To Whom It May Concern:

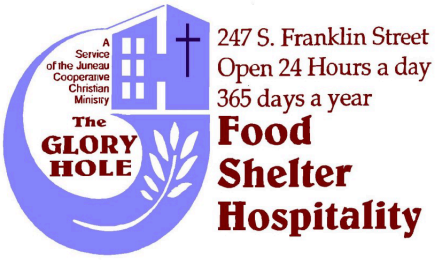
Please accept this letter on behalf of AWARE Inc.'s support of St. Vincent de Paul's (SVdP) proposal for funds under the CDBG program. We believe the Dan Austin Transitional Support Services Center (TSSC), as described in SVdP's proposal, has the potential to create a cohesive, manageable and supported program for homeless or low-income individuals and especially individuals experiencing homelessness, extreme disability and/or re-entry from incarceration.

The TSSC's ability to provide transitional plan development with SVdP's in-house team of three Community Navigators (case managers), selected thrift store items, food pantry, locker-storage, showers, laundry, food service, training and meeting facilities, and professional service facilities for medical, legal, financial and counselling, is needed in this community. It is also a fitting memorial to SVdP's long-time General Manager Dan Austin's life work of transitioning people into permanent housing.

Sincerely,

Mandy O'Neal Cole
Deputy Director, AWARE

cc: Bradley Perkins, Interim General Manager, St. Vincent de Paul



The Glory Hall

247 South Franklin Street, Juneau, Alaska 99801

907 586.4159, fax: 907-586-4304

email: info@feedjuneau.org

website: www.feedjuneau.org

August 24, 2018

Regarding: Support for St. Vincent de Paul's Proposal for Grant Funds Through the Federal Community Development Block Grant (CDBG) Program

To Whom It May Concern:

Please accept this letter on behalf of The Glory Hall's support of **St. Vincent de Paul's (SVdP)** proposal for funds under the CDBG program. We believe the Dan Austin Transitional Support Services Center (TSSC), as described in SVdP's proposal, has the potential to create a cohesive, manageable and supported program for **low-income individuals and especially individuals experiencing homelessness and/or extreme disability.**

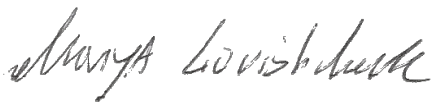
The TSSC's ability to provide transitional plan development with SVdP's in-house team of three Community Navigators (case managers), selected thrift store items, food pantry, locker-storage, showers, laundry, food service, training and meeting facilities, and professional service facilities for medical, legal, financial and counselling, appears to be can't lose combination.

Specifically, The Glory Hall intends to support SVdP's TSSC by supporting the food services program for clients of the TSSC in need of immediate meals, by sharing our extensive knowledge of operating our dining

facility in our emergency shelter in downtown Juneau. Additionally, we expect the support the TSSC's operation of its locker-storage, shower and laundry facility from our vast experience in operating our emergency shelter in downtown Juneau. Of course, The Glory Hall expects to refer clients to the TSSC.

The Dan Austin Transitional Support Services Center (TSSC) is also a fitting memorial to SVdP's long-time General Manager Dan Austin's life work of transitioning people into permanent housing.

Best Regards



Mariya Lovishchuk
Executive Director, TGH

Cc: Bradley Perkins, Interim General Manager, St. Vincent de Paul

Chez Alaska Cooking School
2092 Jordan Ave. Ste. 585
Juneau, AK 99801

Phone: 907 723 8801
E-mail: annie@chezalaska.com
Website: www.chezalaska.com

Regarding: Support for St. Vincent de Paul's Proposal for Grant Funds Through the Federal Community Development Block Grant (CDBG) Program

To Whom It May Concern:

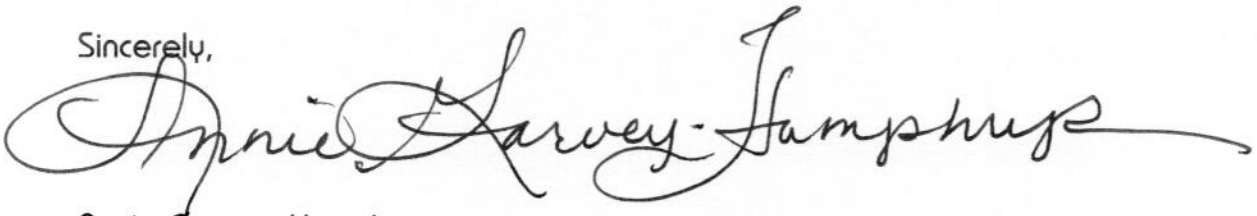
Please accept this letter on behalf of Chez Alaska Cooking School's support of St. Vincent de Paul's (SVdP) proposal for funds under the CDBG program. We believe the Dan Austin Transitional Support Services Center (TSSC), as described in SVdP's proposal, has the potential to create a cohesive, manageable and supported program for low-income individuals and especially individuals experiencing homelessness and/or extreme disability.

The TSSC's ability to provide transitional plan development with SVdP's in-house team of three Community Navigators (case managers), selected thrift store items, food pantry, locker-storage, showers, laundry, food service, training and meeting facilities, and professional service facilities for medical, legal, financial and counselling, appears to be can't lose combination.

Specifically, Chez Alaska Cooking School intends to support SVdP TSSC by looking to start a vocational training program for clients of the TSSC (with the meals provided to clients (according to their ability to pay) of the TSSC, possibly in the commercial kitchen to be re-fitted under the CDBG at the TSSC, classes in the training and meeting facility at the TSSC, or classes in our facility located less than ½ mile down the street from the TSSC.

The Dan Austin Transitional Support Services Center (TSSC) is also a fitting memorial to SVdP's long-time General Manager Dan Austin's life work of transitioning people into permanent housing.

Sincerely,



Annie Garvey-Humphrys

Executive Chef and Owner

cc: Bradley Perkins, Interim General Manager, St. Vincent de Paul

Attachment D

JUNEAU REENTRY COALITION

Promoting Public Safety &
Strengthening Our Community

August 23, 2018

Re: Support for St. Vincent de Paul's Proposal for Grant Funds Through the Federal Community Development Block Grant (CDBG) Program

To Whom It May Concern:

Please accept this letter on behalf of Juneau Reentry Coalition's support of St. Vincent de Paul's (SVdP) proposal for funds under the CDBG program. We believe the Dan Austin Transitional Support Services Center (TSSC), as described in SVdP's proposal, has the potential to create a cohesive, manageable and supported program for homeless or low-income individuals and especially individuals experiencing homelessness, extreme disability and/or re-entry from incarceration.

The TSSC's ability to provide transitional plan development with SVdP's in-house team of three Community Navigators, selected thrift store items, food pantry, locker-storage, showers, laundry, food service, training and meeting facilities, and professional service facilities for medical, legal, financial and counselling can provide for many needed services for the reentry population. It is also a fitting memorial to SVdP's long-time General Manager Dan Austin's life work of transitioning people into permanent housing.

Specifically, Juneau Reentry expects to support SVdP TSSC by connecting the reentry population to the TSSC for transitional support services.

Sincerely,

Donald Habeger
Community Coordinator
Juneau Reentry Coalition

Haven House Juneau

P.O. Box 20875
Juneau, Alaska 99802

August 23, 2018

Regarding: Support for St. Vincent de Paul's Proposal for Grant Funds Through the Federal Community Development Block Grant (CDBG) Program

To Whom It May Concern:

Please accept this letter in support of St. Vincent de Paul's (SVdP) proposal for funds under the CDBG program. We believe the Dan Austin Transitional Support Services Center (TSSC), as described in SVdP's proposal, has the potential to create a cohesive, manageable and supported program for homeless or low-income individuals and especially individuals experiencing homelessness, extreme disability and/or re-entry from incarceration.

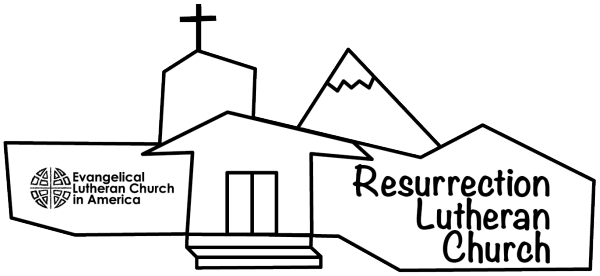
The TSSC's ability to provide transitional plan development with SVdP's in-house team of three Community Navigators (case managers), selected thrift store items, food pantry, locker-storage, showers, laundry, food service, training and meeting facilities, and professional service facilities for medical, legal, financial and counselling, appears to be can't lose combination. It is also a fitting memorial to SVdP's long-time General Manager Dan Austin's life work of transitioning people into permanent housing.

Haven House is a home providing supportive transitional housing to women who have been incarcerated. We have current residents and former residents and we have contact with many women who have been formerly incarcerated but do not live at Haven House. Specifically, Haven House expects to support SVdP TSSC by referring our clients to the TSSC for transitional support services.

Sincerely,

Mary Alice McKeen
President, Board of Directors

cc: Bradley Perkins, Interim General Manager, St. Vincent de Paul



Pastor Karen Perkins
voice only (907) 885 6824
voice and text (808) 782 6653
pastor email rlcpastor@ak.net
skype rev.karen.perkins

740 West Tenth Street
Juneau, Alaska 99801
office (907) 586 2380
fax (907) 586 6225
office email rlcoffice@ak.net
website www.rlcjuneau.org

August 24, 2018

Regarding: Support for St. Vincent de Paul's Proposal for Grant Funds Through the Federal Community Development Block Grant (CDBG) Program

To Whom It May Concern:

Please accept this letter on behalf of Resurrection Lutheran Church's support of St. Vincent de Paul's (SVdP) proposal for funds under the CDBG program. We believe the Dan Austin Transitional Support Services Center (TSSC), as described in SVdP's proposal, has the potential to create a cohesive, manageable and supported program for low-income individuals and especially individuals experiencing homelessness and/or extreme disability.

The TSSC's ability to provide transitional plan development with SVdP's in-house team of three Community Navigators (case managers), selected thrift store items, food pantry, locker-storage, showers, laundry, food service, training and meeting facilities, and professional service facilities for medical, legal, financial and counselling, appears to be can't lose combination.

Specifically, Resurrection Lutheran Church intends to support SVdP TSSC by support their existing food bank program with our experience in running the most utilized food pantry in downtown Juneau, serving about 100 clients (feeding over 200 family members) each Monday afternoon. The Church's Food Pantry Committee heard a presentation from SVdP on the TSSC and unanimously voted to support it. Additionally, I have had personal experience with programs at churches which adopt families in transition, and support them with non-financial assistance, such as household and childcare duties, errands, etc. for a period of six-months to a year and will consider such a program in conjunction with the TSSC, utilizing its training and meeting facilities and food services.

Finally, I expect to refer people I encounter with transitional service needs the SVdP TSSC. The Dan Austin Transitional Support Services Center is also a fitting memorial to SVdP's long-time General Manager Dan Austin's life work of transitioning people into permanent housing.

Blessings+

Rev. Karen Perkins

Research on Community Support Services What Have We Learned

William A. Anthony
Andrea Blanch

William A. Anthony is Director of the Center for Psychiatric Rehabilitation and a Professor in the Department of Rehabilitation Counseling, Boston University.
Andrea Blanch is Director of Community Support Programs, New York State Office of Mental Health, Albany, NY.

Abstract: This article reports the results of a comprehensive review of published literature related to the essential components of a CSS. Each component is analyzed with respect to its documented need, effective intervention strategies, and cost. The need for the types of services and supports initially conceptualized as a CSS in the mid-1970s has been well documented. Also, prior research has now set the stage for large-scale, long-term, experimental studies of measurable, replicable CSS-type interventions.

There is a developing base of research relevant to community support systems (CSS). Reviews of a variety of research studies have reported that persons with severe and long-term mental illness can be helped in the community without undergoing long-term hospitalization (Braun et al., 1981; Dellario & Anthony, 1981; Kiesler, 1982; Test & Stein, 1978). As momentum continues to build toward the development of more and better community-based services for persons with psychiatric disabilities (Larsen, 1987; NIMH, 1987), it is critical to summarize what we know about the need for CSS services, their outcomes, and their costs.

Organization of this Review

This article examines what we currently know about each of the essential components of a CSS with respect to the following dimensions: 1) what is the documented need; 2) what works; 3) what is the cost. Essentially, a matrix guides the research review with the CSS components running down the left hand margin and the three dimensions of analysis running across the top (see Table 1).

The CSS components listed down the left hand side of the matrix are drawn from the latest conceptual analysis of the CSS framework (Stroul, 1988). These eleven components represent the latest thinking with respect to what constitutes a CSS. In addition to the eleven CSS components, the literature will be analyzed with respect to what we know about systems level interventions (Cells 12A, 12B, 12C). Integral to the CSS literature has

Table 1
Analyzing What We Know

CSS Components	A) Is the Need Documented?	B) What Works and What Doesn't Work?	C) What's the Cost?
1) Client Identification and Outreach	1A	1B	1C
2) Mental Health Treatment	2A	2B	2C
3) Health and Dental Services	3A	3B	3C
4) Crisis Response Services	4A	4B	4C
5) Housing	5A	5B	5C
6) Income Support & Entitlements	6A	6B	6C
7) Peer Support	7A	7B	7C
8) Family & Community Support	8A	8B	8C
9) Rehabilitation Services	9A	9B	9C
10) Protection & Advisory	10A	10B	10C
11) Case Management	11A	11B	11C
12) Systems Integration	12A	12B	12C

been the notion that a CSS is more than a listing of necessary service components. The range of service components must be organized into an integrated system. System integration efforts are characterized by formal arrangements between two or more components to better serve the population. These system integration efforts typically involve such activities as coordinated or joint planning, financing, training, and monitoring and/or evaluation.

The literature reviewed is not just "CSS literature," that is, literature authored by persons familiar with CSS concept who directly relate their data to the CSS concept. Rather, the literature reviewed includes research and program evaluation studies that have collected data relevant to CSS components, whether or not the author has ever even heard of a CSS! Even literature published prior to the development of the CSS concept, if relevant to the matrix, is analyzed.

Included in this review are published articles or articles about to be published. Wherever possible, recent literature reviews are used to review

the field. (Readers may then examine these literature reviews for complete citations.) Book review chapters are occasionally referenced for this purpose.

With respect to outcome studies (Table 1, Column B), data from experimental and quasi-experimental studies are used. Descriptive studies are used for need documentation and cost-benefit data. Unless otherwise noted, only research relevant to "persons with severe and long-term mental illness" (Stroul, 1988) is referenced.

Client Identification and Outreach

Some persons with psychiatric disabilities do not know about available services and must first be *located* in order to be *informed* about them. Others know about services but have not been *informed and engaged* in a manner that entices them to remain in services. Those persons who are homeless and mentally ill (30%-40% of all homeless) are a good example of the first group (Morrissey & Levine, 1987). The one-fourth to two-thirds of people who do not follow through on referrals are a good example of the second group (Solomon, Gordon, & Davis, 1986), as are the 30-40% who quickly drop out of treatment (Sue, McKinney, & Allen, 1976) or miss scheduled appointments (Miyake, Chemtob, & Torigoe, 1985). Even the drop out rate for state-of-the-art psychotherapy and medication management has been found to be as high as 42% by 6 months, 56% by 1 year, and 69% for 2 years (Stanton et al., 1984).

Identification, outreach, and engagement techniques currently exist to increase engagement in services. Various successful strategies have been reported by a number of researchers (Perlman, Melnick, & Kentera, 1985; Stickney, Hall, & Gardner, 1980; Wasylenki, Goering, Lancee, Ballantyne, & Farkas, 1985; Witheridge, Omega, & Appleby, 1982.)

Another method to achieve the goal of engagement in services is to inform and refer clients to *services they want and from which they can benefit*. A review of current research on mentally ill persons who are homeless concluded that most are willing to accept help if they perceive that the services will meet their needs (Morrissey & Levine, 1987). For example, Lipton, Nutt, and Sabatini (1988) randomly assigned 52 "chronically mentally ill" homeless inpatients to an experimental group who received a supportive housing placement at discharge or to a control group who received "routine discharge planning." At hospital discharge 26% of the control group refused discharge placement assistance while all experimental subjects accepted placement. At 12 months 69% of the experimental group were still permanently housed, versus 30% of the control group.

Cost of non-engagement in services is a two-edged sword. Failure to keep appointments wastes professional time (Miyake et al., 1985); yet

successful engagement in services for those who were not previously engaged can increase cost of service (Franklin, Solovitz, Mason, Clemons, & Miller, 1987). Unknown is the difference between the cost of services in which the client is actually engaged compared to the costs to society and to the client if the client is not engaged in services at all.

Mental Health Treatment

When we think of treatment in a CSS, the image that comes to mind is medication and psychotherapy. In fact, the overwhelming majority (90%-100%) of long-term mentally ill at some point receive chemotherapy (Ayd, 1974; Dion, Dellario, & Farkas, 1982; Matthews, Roper, Mosher, & Menn, 1979).

It is an accepted fact that chemotherapy works; it reduces symptomatic behavior and clinical relapse (Cole, Goldberg, & Davis, 1966; Davis, 1976). For example, about 70% of schizophrenia patients show substantial improvement with an antipsychotic drug; however, 20%-40% of patients show measurable improvement on a placebo (Davis & Gierl, 1984). With maintenance therapy, the 6-month relapse rate for chemotherapy is 20% and for placebo 53% (Davis, 1975). Unfortunately, it is impossible to predict who needs medication maintenance (Davis & Gierl, 1984; Fenton & McGlashen, 1987). Surprisingly, in light of the overwhelming use of medication, some studies have demonstrated the value of non-neuroleptic treatment (Carpenter, Heinrichs, & Hanlon, 1987; Matthews, Roper, Mosher, & Menn, 1979; Paul, Tobias, & Holly, 1972).

In contrast to the almost universal use of chemotherapy, the idea of providing intensive psychotherapy to persons with severe mental illness has fallen on hard times. Although resource issues have prevented most of the severely mentally ill persons from routinely receiving intensive psychotherapy, consumers and policy makers currently doubt the need for intensive psychotherapy (Mosher & Keith, 1980; Spaniol & Zipple, 1988). The current treatment recommendation, supported by some research, is long-term supportive psychotherapy combined with the minimum amount of medication needed (Conte & Plutchik, 1986; Hogarty, Goldberg, & Schooler, 1974; Hogarty, et al., 1979). Supportive psychotherapy, as contrasted to intensive psychotherapy, is designed to help the person learn basic problem solving skills and work on day-to-day, practical issues in the context of a caring, accepting relationship (Neligh & Kinzie, 1983).

At present, there are no benefit-cost studies of supportive psychotherapy relative to other interventions. Of interest to this issue of cost are the periodic reviews of the data assessing the comparative effectiveness of paraprofessionals and credentialed professionals (Anthony & Carkhuff, 1978; Durlak, 1979; Hattie, Sharpley, & Rogers, 1984; Moffic, Patterson, Laval,

& Adams, 1984). It appears that many of the tasks and objectives of supportive psychotherapy can be addressed equally well by paraprofessionals.

Health and Dental Services

There is no question that people with psychiatric disabilities have a need for basic health and dental services that often goes unmet. A decade of research shows consistently high rates of physical illness in all groups of psychiatric patients. In a review of 12 studies, Koranyi (1980) found major medical illness in up to 50% of all psychiatric patients. The same rate was found in a meta-analysis of four studies of psychiatric inpatients (Hoffman & Koran, 1984). In a more recent review of this research, weighted prevalence rates of physical illness were found to be 37% for psychiatric inpatients and 38% for psychiatric outpatients (Maricle, Hoffman, Bloom, Faulkner, & Keepers, 1987). Using aggregate data, Taube and associates found that one-third of all heavy users of mental health outpatient services had multiple medical problems (Taube, Goldman, Burns, & Kessler, 1988).

Clearly, clients in community support programs are not automatically receiving routine health care. Seventy-seven percent of the medical problems in one study would have been detected with a regular check-up (Roca, Breakey, & Fischer, 1987). In another study, 68% of the clients had their last physical examination during their last psychiatric hospitalization, and 88% could not name a primary care physician in the community (Farmer, 1987). Other authors also have noted that basic health care services (e.g., reproductive counseling and options) often are unavailable to people with psychiatric disabilities or are difficult to access (Test & Berlin, 1981).

Despite the clear indication of need, little research has been done on ways to improve the basic health and dental care available to people with psychiatric disabilities. Estimates of costs for a basic battery of tests range from about $750 (Koran, Sox, Marton, & Moltzen, 1984) to about $400 (Hall, Gardner, Popkin, Lecann, & Stickney, 1981). Costs for follow-up medical care would depend on how and where it was delivered. Burns and Schulberg (1986) suggest three different models for general hospital inpatient medical care for psychiatric patients, and Pincus (1980) describes different models for linking health and mental health care. No research is available, however, on the relative costs or outcomes of these different approaches to health care delivery.

Crisis Response Services

Research is just beginning to identify and measure the major sources of life stress facing people with psychiatric disabilities (Stein, 1984). How-

ever, the need for crisis services is clearly documented by increasing hospital admission rates, emergency room visits, and numbers of mentally ill persons incarcerated in jails or short-term lock-ups (Schoonover & Bassuk, 1983). Furthermore, the known suicide rate among this population is quite high, especially during the first year after discharge from inpatient care.

Early research demonstrated that emergency screening services could reduce state hospital admissions (Billings, 1978; Delaney, Seidman, & Willis, 1978); that crisis intervention programs such as family crisis therapy produced as good or better outcomes than inpatient treatment, often at lower cost (Auerbach & Kilmann, 1977); and that a wide range of non-hospital settings could be used effectively for crisis resolution (Brook, 1982; Maguire, Lorack, & Hardy, 1979; Mosher & Menn, 1978). The consistency of these research results has led several authors to comment on the surprising lack of implementation of crisis programs (Mosher, 1983; Rissmeyer, 1985).

Stroul (1987) identifies four major types of crisis service: crisis telephone services, walk-in crisis intervention, mobile outreach, and crisis residential programs. We found no recent studies evaluating telephone hotlines and only one study focusing on a walk-in crisis program, i.e., a psychiatric emergency room in a general hospital (Solomon & Gordon, 1988).

In contrast to telephone and walk-in services, several recent studies have reported on the effectiveness of mobile outreach services. Benglesdorf and Alden (1987) demonstrated that 70% of all patients seen in crisis could be maintained in the community with a mobile outreach team, with two-thirds of the rest being admitted to community hospitals rather than state or county institutions. Similarly, Bond and associates (Bond et al., 1988) found that clients randomly assigned to an assertive outreach team had significantly fewer hospital episodes and total days of hospitalization than during the previous year, and significantly fewer than clients randomly assigned to a low-expectation drop-in center. Moreover, only one client dropped out of the assertive outreach program, in contrast to 74% of drop-in center clients who never returned after an initial visit. Hoult and Reynolds (1984) obtained similar results in another study with random assignment—only 10% of the outreach group was hospitalized for more than 2 weeks, versus 68% of the control group, which received traditional hospitalization and aftercare. Moreover, both clients and families were significantly more satisfied with the outreach services (Reynolds & Hoult, 1984). There were no significant differences, however, on jobs maintained, money earned, medications, or symptoms.

Several crisis residential programs also have been shown to be effective. Bond, Witheridge, Wasmer et al. (1988) found that two-thirds of all clients served in a staffed crisis house and in a program that purchased emergency housing (coupled with intensive crisis outreach) avoided hospitalization for at least 4 months after admission. Both programs were also effective in

helping to stabilize permanent housing and income supports. Similarly, Sheridan and associates (1988) found that two-thirds of all clients referred for hospitalization could be served successfully in a special 17-bed unit at the YMCA.

General hospital inpatient units currently provide crisis stabilization services for a growing number of clients. Problems faced by these units include staff reluctance to handle potentially violent or suicidal patients, the need to introduce a more rehabilitative treatment philosophy, and the need to develop closer relationships with other community programs (Schoonover & Bassuk, 1983).

Costs of various residential crisis programs and factors influencing cost are summarized by Stroul (1987). Per diems of programs surveyed vary from $35 to $285 with the average length of stay between 10 days to 2 weeks for most programs. Inpatient programs are clearly the most expensive, ranging up to $500 per day (Lipton et al., 1988). However, it is important to examine costs over time, since there is some evidence that the intensity of services needed during the first few days of a crisis diminishes over time (Bond, Witheridge, Wasmer et al, 1988).

Housing

This country is currently in the midst of a low-cost housing crisis (Boyer, 1987). As a result of increasing rents and decreasing housing stock, increasing numbers of adults with psychiatric disabilities are being housed by their families. Others are forced to move frequently or end up homeless (Appleby & Desai, 1987).

Most mental health systems have responded to this situation by developing residential treatment programs (Blanch, Carling, & Ridgway, 1988). Research has shown that virtually all forms of community-based residential programs can substitute for inpatient treatment, including foster care settings (Linn, Klett, & Caffey, 1980); short term residential facilities (Fields, 1980; Jordan, 1985); and transitional group homes (Wherley & Bisgard, 1987). On the other hand, research on the effectiveness of residential treatment facilities on reducing long-term recidivism, increasing economic self-sufficiency, reducing symptoms, or improving community functioning has been ambiguous at best (Cometa, Morrison, & Ziskoven, 1979).

One consistent finding in the research on residential settings is that characteristics of the environment are more predictive of outcome than characteristics of the residents (Cournos, 1987; Hull & Thompson, 1981, Segal & Aviram, 1978). A number of studies have shown that highly structured institutional environments can lead to social disability, that demanding or stimulating environments can lead to relapse, and that poor housing environments have a negative impact on client adjustment (Cournos, 1987).

Similarly, clients who are satisfied with their living arrangements and who perceive them to be well matched to their needs and not "treatment oriented" are most likely to have good outcomes (Cournos, 1987). Research on client preferences in housing is scarce, but at least one published study shows that clients prefer to live on their own or with their families, although staff regard group facilities as the best answer to client living needs (Solomon, Beck, & Gordon, 1988). Despite this lack of data, increasing attention has been paid to helping people with psychiatric disabilities to achieve permanent housing arrangements in non-mental health settings. One such program is the Assisted Independent Living Program in San Francisco, where staff serve as hired consultants to groups of clients who form their own households, find their own living situations, determine their own household routines, and hire and fire staff (Meddars & Colman, 1985). Initial program results indicate a substantial reduction in days of hospitalization. However, no research has been done on other client outcomes or on the specific aspects of this innovative program which are most important to its success.

Similarly, research on homelessness has only recently begun to address the factors involved in helping people to achieve permanent housing. Lipton, Nutt, and Sabatini (1988) found that when they offered homeless people with psychiatric disabilities permanent housing arrangements in a renovated single-occupancy hotel in New York City, 100% accepted the offer and 69% were still living there a year later. Moreover, although there was no effect on symptomatology, they had spent fewer days in the hospital, had a better quality of life, and were more satisfied with their living arrangements than a control group. Although somewhat self-evident, these findings contradict common assumptions about the willingness of homeless people to accept help with housing.

The costs of various residential and housing assistance programs vary according to the setting, services and staffing provided. Structured residential facilities described in the literature range from about $40 per day to $100 per day (Meddars & Colman, 1985); and nursing home care from $40 per day to $70 per day (Linn et al., 1985). Housing assistance programs, where clients pay their own rent, are generally the least expensive, as low as $8.00 per day (Meddars & Colman, 1985).

Income Support and Entitlements

Persons who are psychiatrically disabled receive a substantial number of benefits from welfare and income maintenance programs (Baker & Intagliata, 1984; Estroff & Patrick, 1988; Goldstrom & Manderscheid, 1982; Jansen, 1985) at a considerable cost to the taxpayer. The attempt to remove persons with long-term mental illness from benefit programs by means of the invalid, injudicious use of the disability determination process (Anthony & Jansen, 1984) was viewed as a way to reduce the overall budget deficit.

Estroff and Patrick (1988) have analyzed the participation of persons with psychiatric disabilities in the Social Security Administration's Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs. Estroff and Patrick's (1988) national estimates suggest that 482,400 persons received SSI and/or SSDI due to psychiatric disability in 1986; approximately 28% of those with severe long term mental illness are disability income recipients, but their numbers continue to grow (Estroff & Patrick, 1988).

With respect to helping persons with long-term mental illness obtain the benefits they deserve, Estroff & Patrick (1988) review data which suggest that a higher percentage of persons who are participants in the mental health system receive benefits than those who are not connected to the system (Baker & Intagliata, 1984; Estroff & Patrick, 1988; Tessler & Manderscheid, 1982; Solomon, Gordon & Davis, 1983). Case management interventions, with their goal of linking persons to services, also can increase the percentage of persons who are linked to various financial benefits (Wasylenki et al., 1985).

Perhaps the most significant intervention question about which there is little useful data is how to help people get off the benefit rolls and on to the payrolls. Disability benefits can be a disincentive to work if rational people decide that the level of available benefits in comparison to the wages of available jobs influences negatively a person's desire to work (Berkowitz, 1985). Studies of persons with disabilities (not just persons with psychiatric disabilities) have reported the expected relationship between number of benefits and vocational rehabilitation outcome (Rehabilitation Research Institute, 1980; Walls, 1982).

The direct financial cost of payments to beneficiaries has been estimated to be $2.24 billion (Estroff & Patrick, 1988). Could the cost of administering the system be reduced without reducing the benefits to the recipient? Will the law passed by Congress in 1987 (PL 99-643), making permanent the work incentive program (known as the Section 1619 program), reduce disincentives to competitive employment? What are the psychological costs to the recipient of applying, failing to be eligible, or receiving services? In the absence of research data, Estroff and Patrick (1988) have clearly articulated the positive and negative consequences of participation in the disability benefits program. The process of the disability determination system, its rules and regulations, its psychological impact, and the policy which guides it currently are not well informed by empirical data.

Peer Supports

The social networks of schizophrenics have been shown to be smaller than average and to differ structurally from the networks of nonschizophrenic populations (Leavy, 1983). For example, they seem to include fewer multiple-role relationships and fewer people to whom the individual gives support as well as receiving it (Hammer, 1981). The need for peer

supports also can be deduced from the fact that many deinstitutionalized clients spend their time alone (Solomon, Baird, Everstine, & Escobar, 1980). Several authors also have suggested that hospitals function as substitute networks, and that rehospitalizations sometimes are due to patients' needs for companionship (Solomon et al., in Harris & Bergman, 1985).

A number of different interventions have been devised to replace or augment natural support networks for people with psychiatric disabilities. Fairweather Lodge programs, clubhouse programs (Fraser, Fraser, & Delewski, 1985) and consumer-controlled networks and housing arrangements (Borck & Aber, 1981) all have been shown to reduce hospitalization. However, it is difficult to isolate the effects of peer support in these programs.

A number of professional interventions also are being developed based on principles of networking and social support. Harris and associates have suggested that professionals may help augment existing social networks by adding members, functions, or linkages to the network or by assisting with crisis intervention (Harris & Bergman, 1985; Harris, Bergman, & Bachrach, 1987). Using a retrospective control group design, Schoenfeld and associates (Schoenfeld, Halevy, Hemley van der Velden, & Ruhf, 1986) demonstrated that network therapy can be effective in reducing the number of hospital admissions and the total days of hospitalization and that the effect endures for at least a year. Again, the extent to which peer supports contribute to these effects is unclear.

The need for and importance of peer support has been asserted by consumers and is increasingly recognized (Chamberlin, 1979, Leete, 1988), with peer support taking the form of self-help groups and consumer-run service programs of various types ranging from drop-in centers to consumer-run businesses (Stroul, 1988). Although it often has been suggested that self-help groups can replace lost support networks (e.g., Gartner & Reissman, 1982), research on the efficacy of self-help, mutual support groups, and consumer-run services has been scarce. Recently, Rappaport and associates (1985) embarked on a longitudinal evaluation of GROW groups. This study is, to our knowledge, the first outcome evaluation of a mental health self-help organization. The full results of this study are not yet available. However, initial results indicate that people who have been actively participating in GROW groups for more than 9 months differ significantly in size of social networks, rate of employment, and measures of psychopathology (Stein, 1984) from those who have been participating for fewer that 3 months. Attendance at GROW meetings has been shown to be significantly related to decreases in negative coping responses such as isolation and brooding, and help-seeking responses at GROW meetings are significantly related to decreases in coping responses that rely on distraction (Reischl & Rappaport, 1988).

There have been few studies of the costs of peer support interventions.

The costs associated with consumer-run services are lower than for the professional mental health system, primarily as a result of the extensive use of volunteers and staff members paid modest salaries. GROW, for example, is a very inexpensive program. One paid "field worker" is hired for every seven or eight local groups; all other roles are filled by volunteers. Moreover, GROW maintains a posture of deliberate understaffing to encourage members to take on leadership roles (Salem, 1984).

Family & Community Support

Data have clearly shown the psychological, social, physical, and economic impact on the family of living with a long-term mentally ill family member (Fadden, Bebbington, & Kuipers, 1987; Lefley, 1987; Spaniol & Zipple, 1988; Tessler, Killian & Gubman, 1987). Over one-third of long-term mentally ill adults live with their families (Lefley, 1987), and 50%-90% remain in contact with their families (Fadden et al., 1987; Lefley, 1987). The question becomes, "What will help family members cope with this situation and promote the integration of the ill family member into the natural community support system?"

Approaches to families, loosely categorized as "psychoeducational," have demonstrated their effectiveness in reducing the relapse rate of ill family members, and/or in providing support and information to the family itself (Anderson, Hogarty, & Reiss, 1980; Falloon, et al., 1982; Goldman & Quinn, 1988; Goldstein & Ropeikin, 1981; Hogarty et al., 1986; Jacob, Frank, Kupfer, Cornes, & Carpenter, 1987; Leff, Kuipers, Berkowitz, Eberbein-Vries, & Sturgeon, 1982; Smith & Birchwood, 1987; Spiegel & Wissler, 1987). A review by Zipple and Spaniol (1987) suggested that these types of approaches, no matter what their conceptual base, meet all or some of the most critical needs of families, such as a nonblaming partnership with the families combining various elements of skill development, information, and support. Each approach seems to significantly reduce relapse and/or provides family support.

The other major innovation directed at the issue of family support has been the development of a national family self-help and advocacy group, the National Alliance for the Mentally Ill (NAMI), with numerous local chapters. Family members report that membership in self-help groups provides them a great deal of education and support (Hatfield, 1981). Of the NAMI members surveyed by the Center for Psychiatric Rehabilitation, 75% rated their self-help group as "very helpful" (Spaniol & Zipple, 1988). However, there have been no longitudinal or comparative studies of the effect on families of joining a support group. There are data which indicate that family members' satisfaction with the support group is correlated with their perception of the group's activities as empathic, cathartic, non-judgmental, and non-threatening (Biegel & Yamatani, 1987). Related to the support dimension, a preliminary study of respite care has shown its

effectiveness in reducing the number of days the ill family member is in the hospital (Geiser, Hoche, & King, 1988).

One of the most straightforward ways to reduce family burden and provide respite is to provide the family's ill loved ones with the community programs they want and need. In order to do this effectively, providers need community members' acceptance of persons with psychiatric disabilities. It is an empirical fact that the attitudes of the general public toward persons who are mentally ill are very poor (Melton & Garrison, 1987; Page, 1977, 1983; Phillips, 1966; Rabkin, 1974; Sarbin & Mancuso, 1970). Of all groups of persons who are considered disabled, persons with psychiatric disabilities are the most stigmatized (Anthony, 1972; Scheider & Anderson, 1980). To the extent that such negative attitudes interfere with the person's ability to access vocational and social opportunities, they may affect the person's community and personal adjustment (Grusky, Tierney, Manderscheid, & Grusky, 1985).

The importance of changing the public's attitudes toward persons who are psychiatrically disabled is obvious. Less obvious is an empirically based, agreed upon method to change these attitudes. Research from the field of disability research in general has suggested three fundamental methods of promoting attitude changes: 1) providing information about the disabled person, 2) providing contact with the disabled person, and 3) providing both (Anthony, 1972). While there are some inconsistencies in the literature when information and contact are studied separately, studies that have combined the information and contact dimensions have consistently reported positive results (Anthony, 1972; Schneider, & Anderson, 1980).

One implication of these research data is that perhaps persons who are psychiatrically disabled are the best change agents, as they can provide a natural combination of contact and experience for the general public. For example, research on employer attitude change suggests that these negative attitudes can be overcome if the person himself or herself makes an effective in-person presentation to the employer (Brand & Claiborn, 1976; Farina & Felner, 1973). Stigmatized persons themselves have the capacity, if given the opportunity, to be the agent of attitude change. Peterson (1986) describes how a psychosocial rehabilitation program, by successfully teaching former patients to function in nonpatient roles, has generated positive community acceptance for those persons in the community who come in contact with persons who are psychiatrically disabled.

In terms of the cost of attitude change programs and their resultant cost-benefits, there are no data. The common sense assumption is that if attitudes change, and more employers hire, and more neighbors become accepting, and more schools become inviting, and media descriptions become more fair, then the overall costs of disability will be reduced. This line of reasoning remains reasonable and empirically untested.

Rehabilitation Services

Many more persons need rehabilitation services than are currently receiving them. Data are overwhelming that suggest the functional and role incapacity of persons with long-term mental illness (Anthony, Buell, Sharratt, & Althoff, 1972; Dion & Anthony, 1987; Tessler & Manderscheid, 1982). Surveys have documented that both consumers and family members appreciate the importance of rehabilitation services (Lecklitner & Greenberg, 1983; Spaniol & Zipple, 1988). Yet rehabilitation services are not currently provided at a level commensurate with their need (Solomon, Gordon, & Davis, 1983; Wasylenki, Goering, Lancee, Fischer, & Freeman, 1981).

Dion and Anthony (1987) reviewed 35 experimental and quasi-experimental studies that attempted to change the skills and/or environmental supports of persons with psychiatric disabilities. Studies were included in the review regardless of whether or not the researcher specifically called the intervention psychiatric rehabilitation. Dion and Anthony (1987) provided a tabular overview of all 35 studies described in terms of treatment setting, environmental focus, types of outcome measured, type of intervention, research design, and findings. Within the limitations of measurement and research design, their review suggests that psychiatric rehabilitation interventions positively affect rehabilitation outcome on measures such as recidivism, time spent in the community, employment and productivity, skill development, and client satisfaction (Dion & Anthony, 1987).

Bond and Boyer (1988) have reviewed research on vocational programming for persons who are psychiatrically disabled. Of the controlled studies that they reviewed, four studies reported positive results, two studies found marginally significant results, and thirteen studies found no difference between the experimental and control groups. In contrast, when investigators examined whether experimental subjects were more successful in sheltered or transitional placements, seven of eight studies favored the experimental group. In a earlier review of vocational programming by Anthony, Howell, and Danley (1984), they identified several other positive studies of vocational programming (e.g., Kline & Hoisington, 1981).

In terms of cost studies, Bond and Boyer (1988) report no rigorous cost studies of vocational programming. Bond (1984) has analyzed data on the benefits and costs of Thresholds, a psychosocial rehabilitation center, and reported considerable cost savings of several of Threshold's programs, especially in terms of their ability to reduce hospitalization costs. In contrast to employment studies of persons with psychiatric disabilities, the methodology for benefit and cost studies is being developed in the area of supported employment for persons who are mentally retarded (Hill, Wehman, Kregel, Banks, & Metzler, 1987; Hill & Wehman, 1983; Noble & Conley, 1987; Rhodes, Ramsing, & Hill, 1987). A review by Noble

and Conley (1987) indicates that despite weaknesses in the data, "Sufficient information exists to argue that all forms of employment—supported, transitional and sheltered—are more productive in terms of savings and less costly to provide than adult day care" (p.163). Much of this cost methodology should be able to be used in CSS initiated employment research.

Protection and Advocacy

Major civil rights issues facing psychiatrically disabled people in the community include the expansion of outpatient commitment (Applebaum, 1986; Scheid-Cook, 1987), the increasing number of people inappropriately or involuntarily maintained on medication (Waxman, Klein, & Carner, 1985), increasing acceptance of highly intrusive procedures such as ECT (Blaine, 1986), the practice of seclusion and restraint in community hospital settings (Soloff, Gutheil, & Wexler, 1985; Telintelo, Kuhlman, & Winget, 1983), and common discriminatory practices such as denying child custody to women who have been labeled mentally ill (Stefan, 1987). In addition, most states still fail to protect mentally disabled people from discrimination in housing, employment, or public accommodations (Melton & Garrison, 1987).

Advocacy also includes working for more and better services. The need for more services is demonstrated by data on the number of mentally ill people living in the community who are denied disability benefits (Mental Health Law Project Update, 1987), the number who do not receive basic services such as health care (e,g., Handel, 1985), and the general lack of funds to support adequate community services.

Advocacy for rights and advocacy for services are sometimes seen as opposing forces, with one seeking to expand and the other to reform or abolish the existing service system (e.g., Chamberlin, 1980). Increasingly, however, different forms of advocacy are being seen as parts of a larger whole, working together to improve social conditions facing people with mental disabilities (Lecklitner & Greenberg, 1983; Rappaport, 1981).

There are no generally agreed upon criteria for successful or effective advocacy (Schwartz, Goldman, & Churgin, 1982), and few studies actually have attempted to measure the impact of advocacy on client's lives. However, there is evidence that lawsuits can effectively fight zoning discrimination (Kanter, 1986) and that consumer lobbying can lead to legislative reform (Lecklitner & Greenberg, 1983). In addition, advocacy increases awareness about patients' rights, and clients usually express satisfaction with advocate efforts on their behalf (Scallet, 1986).

A recent study of an external review procedure for involuntary medication decisions implemented on a pilot basis in a California state hospital found that the program was very expensive, with a projected cost of $1.5 million to implement statewide. However, the new procedure had virtually no impact on clients' knowledge about their rights, on medication prac-

tices, or on a number of indicators of clinical outcome (Hargreaves, Shumway, Knutsen, Weinstein, & Senter, 1987).

In a study of the implementation of an outpatient commitment (OPC) statute, Scheid-Cook (1987) found that the law was, in general, being applied to an "appropriate population" (i.e., those with a history of noncompliance who would otherwise be institutionalized). However, 39.3% of individuals placed on OPC had no previous hospitalizations, 53% had no prior evidence of dangerousness, and 55.6% had no indication of medication refusal. Moreover, a significantly higher percentage of blacks than whites were placed on OPC. No data were gathered on the outcomes or on the services provided for these individuals, although it would seem that a procedure, which expands the number of individuals under state control, needs to be carefully evaluated.

There have been few studies of the costs of various forms of advocacy, although the expense of class action lawsuits has often been noted (Scallet, 1986). Planners are also beginning to consider the potential costs of various legally mandated procedures as a legitimate factor in balancing patients' rights and needs (Mills, Yesavage, & Gutheil, 1983). We found no research at all on the long-term effects of legal procedures or advocacy interventions on clients' self concepts, attitudes towards treatment, or ability to obtain desirable jobs, housing, health care, or other benefits of society.

Case Management

The need for case management is evidenced by a number of factors. These include the numbers of persons who are homeless and mentally ill, and/or not connected to services and benefits (Billig & Levinson, 1987; Ridgway, 1986); data indicating that typical discharge planning greatly underestimates the needs for services other than medical/therapeutic aftercare services (Wasylenki et al., 1985); the generally recognized system fragmentation and lack of coordination of existing services (Rapp & Chamberlain, 1985); and the fact that many clients do not follow through on referrals or drop out of services (see references to Identification and Outreach component in this paper).

Case management outcome studies are difficult to analyze because case managers often perform other community support functions, in addition to the essential elements of identification and outreach, assessment, planning, linking, monitoring, and advocacy (Levine & Fleming, 1984). Services often added are crisis intervention and one-to-one "in vivo" rehabilitation. Studies in which the case manager also provides crisis intervention services with a staff-to-client ratio of about 1:10 are reviewed under the heading Systems Integration. Outcome studies reviewed in this section are on case managers who are not as intensively involved in service provision and crisis intervention.

Most studies of case management describe the characteristics of the case

manager rather than the outcomes of the clients. According to Anthony, Cohen, Farkas, and Cohen (1988), outcome studies of case management began to appear in the 1980s. The data are sparse and contradictory, with some studies suggesting a positive impact on at least some measures of client outcome (Curry, 1981; Goering, Wasylenki, Farkas, Lancee, & Ballantyne, 1988; Modrcin, Rapp, & Poertner, in press; Muller, 1981; Rapp & Chamberlain, 1985; Rapp & Wintersteen, 1988) and others suggesting little or no impact on client outcomes (Cutler, Tatum, & Shore, 1987; Franklin et al., 1987). For example, two of the most recent, best controlled studies reported different case management outcomes (Franklin et al., 1987; Goering et al., 1988). In contrast to the lack of positive results reported by Franklin et al. (1987), Goering et al. (1988) found that case management had an impact on measures of instrumental role functioning, independent housing status, occupational status, and social isolation. Differences favoring the case managed clients over a matched historical group increased over the two-year follow-up period.

Studies relevant to the cost of case management are also beginning to emerge. Cost studies are difficult because there are a number of variables that affect cost, such as the amount of direct services provided by the case manager (Billig & Levinson, 1987; Schwartz et al., 1982; Wright, Sklebar, & Heiman, 1987). Direct services range from one-third to two-thirds of a case manager's time. Other variables that affect the actual cost of case management are caseload size (Goldstrom & Manderscheid, 1983), the amount and kind of system resources, and the case managers' control over these resources (Schwartz et al., 1982).

Case management could be a more costly service, especially if it increases outpatient and inpatient services use without any concomitant increase in client outcome (Franklin et al., 1987). When case management is provided within a capitation financed system that is fiscally responsible for providing almost all services, it is possible to identify case management costs as a part of total costs. Harris and Bergman (1988) provide clinical case management within such a total system and estimate average case management costs at $5,200 per year out of a total program cost of $15,000, which they contrast to a CMHC yearly cost of $47,000 and an inpatient yearly cost of $82,000 for these same types of clients.

Systems Integration

The fact that multiple, fragmented service systems can interfere with effective service delivery has long been noted. There is some evidence that lack of coordination directly affects clients. Tessler (1987) found that when clients don't connect with resources after discharge from inpatient care, their overall community adjustment is poorer and there are more complaints about them. On the other hand, "poor coordination" is sometimes blamed for failures that are actually due to insufficient resources or inap-

propriate services (Solomon, Gordon, & Davis, 1986). Research has not yet clarified the relationship between increasing coordination of services (thereby eliminating service gaps and overlap) and increasing client choice and competition among providers.

For the purposes of this article, attempts at ensuring services integration will be grouped according to whether they have emphasized legislated relationships and program models, financing mechanisms, strategies for improving interagency linkages, or assignment of responsibility. Many initiatives have, of course, incorporated several of these elements.

Legislated relationships and program models. Georgia's "balanced service system" model, New York's "unified services" legislation, and California's "model program standards" were early attempts to legislate relationships among state, county, and local providers and to describe and fund a specific set of services. Several attempts also have been made to evaluate the introduction of community support programming through state legislation and funding. A historical analysis of hospitalization rates in Oregon (Hammaker, 1983) shows a period of backsliding and lack of coordination of services in the late 1970s, no real changes during a period of statewide community support planning (1977-1979), and a dramatic decrease in hospital bed-day use when funding and monitoring of community support services actually began (1980-1982). Similarly, Lannon and associates (Lannon, Banks, & Morrissey, 1988) demonstrated improvement or maintenance of high levels of community tenure for older CSS clients in New York state, although there was no improvement for younger clients.

Financing Mechanisms. Recently, attempts have been made to improve service integration through new financing mechanisms. Many of these initiatives build on the notion of centralizing clinical and fiscal responsibility in the same administrative structure, a concept which has worked well in Dane County, Wisconsin (Dickey & Goldman, 1986). For example, the Robert Wood Johnson Foundation has funded several pilot projects, which are pooling existing funds through a single mental health authority (Rubin, 1987). Similar experiments are being tried with Medicaid and Medicare demonstration sites, health maintenance organizations, and regional authorities for comprehensive care (Dickey & Goldman, 1986). No data are yet available on the impact of these programs on service utilization or client outcome.

Interagency Linkages. Empirical research in this area is scant. Dellario (1985) found a trend towards improved vocational outcomes for clients served by mental health and vocational rehabilitation agencies with good interagency relationships, but the trend failed to reach significance. Similarly, Rogers, Anthony, & Danley (1988) found improved vocational outcomes in two pilot areas participating in interagency training and joint policy-making activities; other areas in the state didn't show the same increase until 2 years later. Several case studies also describe different ways

of organizing community support systems to facilitate interagency cooperation, but no outcome data are available (Grusky et al., 1985; Morrissey, Tausig, & Lindsey, 1985).

Assignment of Responsibility. A fourth strategy for improving service integration (often used along with other initiatives) is to identify a specific group of clients and assign responsibility for their care and treatment to an individual, team, or organization. Recent examples of this approach include the "core service agency" or "lead agency" concept, as well as various case management models that designate specific pools of "high risk" or "high demand" clients. Several studies have demonstrated the effectiveness of case management teams that assume responsibility for providing or coordinating all needed services for a specific group of clients (Bond, Miller, Krumwied, & Ward, 1988; Bond, Witheridge, Dincin, Wasmer, Webb, & De Graaf-Kaser, 1988; Brekke & Test, 1987; Field & Yegge, 1982; Test, Knoedler, & Allness, 1985). These studies suggest that assignment of responsibility for specific clients can reduce dropout rates, lead to allocation of more time to more disabled clients, reduce hospitalization, and increase employment and social activity. The specific factors which lead to success are still uncertain. Some authors emphasize the establishment of continuity over time; others focus on the credibility and experience of case managers and the visibility of the program (Grusky et al., 1987; Test et al., 1985).

Summary

Over a decade after the CSS concept was developed and implemented (Turner & TenHoor, 1978) some empirical facts with respect to CSSs are emerging. Research in the 1980s has documented the need for the array of services and supports originally posited by the 1975-1977 Community Support Working Conferences. The need for CSS component services now has a base in empiricism as well as logic.

The CSS research agenda is poised for an explosion of meaningful research capable of informing policy and changing the configuration and delivery of services to persons who are psychiatrically disabled. Data exist suggesting the future research direction of each CSS component. Most importantly, interventions relevant to most CSS components now can be described at a level of detail that will permit their implementation to be observed, measured, and monitored reliably. A significant number of quasi-experimental and small scale experimental studies have been carried out. These studies show that future research is not only needed but increasingly feasible. The stage is now set for larger, long-term research studies of measurable, replicable CSS-type services.

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bilitation Services Research Meeting, held May 3-5, 1988 in Bethesda, Maryland. This paper is available from the Center for Psychiatric Rehabilitation at a cost of $4.00 to cover postage, copying, and handling. A 41-page reference list, grouped by topic headings, is also available under separate cover at a cost of $4.00.

REFERENCES

Anderson, C. M., Hogarty, G., & Reiss, D. J. (1980). Family treatment of adult schizophrenia patients: A psychoeducational approach. *Schizophrenia Bulletin, 6*(3), 490-505.

Anthony, W. A. (1972). Societal rehabilitation: Changing society's attitudes toward the physically and mentally disabled. *Rehabilitation Psychology, 19,* 117-126.

Anthony, W. A., Buell, G., Sharratt, S., & Althoff, M. (1972). The efficacy of psychiatric rehabilitation. *Psychology Bulletin, 78,* 447-456.

Anthony, W. A., & Carkhuff, R. R. (1978). The functional professional therapeutic agent. In A. Gurman & A. Razin (Eds.), *Effective psychotherapy,* (pp. 84-119). London: Pergamon Press.

Anthony, W. A., Cohen, M., Farkas, M., & Cohen, B. F. (1988). Case management—More than a response to a dysfunctional system. *Community Mental Health Journal. 24,* 219-228.

Anthony, W. A., Howell, J., & Danley, K. (1984). The vocational rehabilitation of the psychiatrically disabled. In M. Mirabi (Ed.), *The chronically mentally ill: Research and services,* (pp. 215-237) Jamaica, NY: SP Medical and Scientific Books (Division of Spectrum Publications).

Anthony, W. A., & Jansen, M. (1984). Predicting the vocational capacity of the chronically mentally ill. *American Psychologist, 39,* 537-544.

Applebaum, P. S. (1986). Outpatient commitment: The problems and the promise. *American Journal of Psychiatry, 143*(10), 1270-1272.

Appleby, L., & Desai, P. (1987). Residential instability: A perspective on system imbalance. *American Journal of Orthopsychiatry, 57*(4), 515-524.

Auerbach, S. M., & Kilmann, P. R. (1977). Crisis intervention: A review of outcome research. *Psychological Bulletin, 84*(6), 1189-1217.

Ayd, F. (1974). Treatment resistant patients: Amoral, legal and therapeutic challenge. In F. Ayd (Ed.), *Rational psychopharmacotherapy and the right to treatment.* Baltimore: Ayd Medical Communications.

Baker, F., & Intagliata, J. (1984). The New York State Community Support System: A profile of clients. *Hospital and Community Psychiatry, 35,* 39-44.

Bengelsdorf, H, & Alden, D. C. (1987). A mobile crisis unit in the psychiatric emergency room. *Hospital and Community Psychiatry, 38*(6), 662-665.

Berkowitz, M. (1985). Forestalling disincentives to return to work. *Business and Health,* March, 30-32.

Biegel, D. E., & Yamatani, H. (1987). Help-giving in self-help groups. *Hospital and Community Psychiatry, 38*(11), 1195-1197.

Billig, N. W., & Levinson, C. (1987). Homelessness and case management in Montgomery County, Maryland: A focus on chronic mental illness. *Psychosocial Rehabilitation Journal. 6*(1), 59-66.

Billings, A. (1978). The impact of a community screening program on psychiatric hospital admissions. *American Journal of Community Psychology, 6*(6), 599-605.

Blaine, J. D. (1986). Electroconvulsive therapy and cognitive function. *Hospital and Community Psychiatry, 37,* 15-16.

Blanch, A., Carling, P., & Ridgway, P. (1988). Normal housing with specialized supports: A psychiatric rehabilitation approach to living in the community. *Rehabilitation Psychology. 33,* 47-55.

Bond, G. R. (1984). An economic analysis of psychosocial rehabilitation. *Hospital and Community Psychiatry, 35,* 356-362.

Bond, G. R., & Boyer, S. L. (1988). The evaluation of vocational programs for the mentally ill: A review. In J. A. Ciardiello & M. D. Bell (Eds.), *Vocational Rehabilitation of Persons with Prolonged Mental Illness.*

Bond, G. R., Miller, L. D., Krumwied, R. D., & Ward, R. S. (1988) Assertive case management in three CMHCs: A controlled study. *Hospital and Community Psychiatry, 39,* 411-418.

Bond, G. R., Witheridge, T. F., Wasmer, D., Dincin, J., McRae, S. A., Mayes, J., & Ward, R. S. (1988). Short-term assertive outreach and service coordination: A comparison of two crises housing alternatives to psychiatric hospitalization. (Manuscript submitted for publication.)

Bond, G. R., Witheridge, T. F., Dincin, J., Wasmer, D., Webb, J., & DeGraaf-Kaser, R. (1988). *A controlled evaluation of the Thresholds Bridge Assertive Outreach Program.* Manuscript submitted for publication.

Borck, L. E., & Aber, R. A. (1981). The enhancing of social support for mental health patients through the development of self-help groups. *Community Support Service Journal, 2,* 11-15.

Boyer, C. A. (1987). Obstacles in urban housing policy for the chronically mentally ill. In D. Mechanic (Ed.), *Improving mental health services: What the social sciences tell us: New directions for mental health services,* (No. 36). San Francisco: Jossey-Bass.

Brand, R. C., & Claiborn, W. L. (1976). Two studies of comparative stigma: Employer attitudes and practices toward rehabilitated convicts, mental and tuberculosis patients. *Community Mental Health Journal, 12,*168-175.

Braun, P., Kochansky, G., Shapiro, R., Greenberg, S., Gudeman, J., Johnson, S., and Shore, M. (1981). Overview: Deinstitutionalization of psychiatric patients, a critical review of outcome studies. *American Journal of Psychiatry, 138*(6), 736-649.

Brekke, J. S., & Test, M. A. (1987). An empirical analysis of services delivered in a model community support program. *Psychosocial Rehabilitation Journal, 10,*(4), 51-62.

Brook, B. D. (1982). Community families: A seven-year program perspective. *Journal of Community Psychology, 8,* 147-151.

Burns, B. J., & Schulberg, H. C. (1986). Organizing psychiatric care in general hospitals to meet medical and psychiatric needs. *Administration in Mental Health, 13*(3), 180-188.

Carpenter, W. T., Heinrichs, D. W., & Hanlon, T. E. (1987). A comparative trial of pharmacologic strategies in schizophrenia. *American Journal of Psychiatry, 144,* 1466-1470.

Chamberlin, J. (1979). *On our own: Patient-controlled alternatives to the mental health system.* New York: McGraw-Hill.

Chamberlin, J. (1980). The future of mental health advocacy. *Advocacy Now, 2,* 52-53.

Cole, J. O., Goldberg, S. C., & Davis, J. M. (1966). Drugs in the treatment of psychosis: Controlled studies. In P. Solomon(Ed.), *Psychiatric drugs.* New York: Grune & Stratton.

Cometa, M. S., Morrison, J. K., & Ziskoven, M. (1979)., Halfway to where: A critique of research on psychiatric halfway houses. *Journal of Community Psychology, 7,* 23-27.

Conte, H. R., & Plutchik, R. (1986). Controlled research in supportive psychotherapy. *Psychiatric Annals, 16,* 530-533.

Cournos, F. (1987). The impact of environmental factors on outcome in residential programs. *Hospital and Community Psychiatry, 38*(8), 848-852.

Curry, J. (1981). A study in case management. *Community Support Service Journal, 2,* 15-17.

Cutler, D., Tatum, E., & Shore, J. (1987). A comparison of schizophrenic patients in different community support treatment approaches. *Community Mental Health Journal, 23,* 103-113.

Davis, J. M. (1975). Overview: Maintenance therapy in psychiatry: Schizophrenia. *American Journal of Psychiatry, 133,* 1237-1245.

Davis, J. M. (1976). Recent developments in the drug treatment of schizophrenia. *American Journal of Psychiatry, 133,* 208-214.

Davis, J. M., & Gierl, B. (1984). Pharmacological treatment in the care of schizophrenic patients. In Alan S. Bellack (Ed.), *Schizophrenia: Treatment, management, and rehabilitation* (pp. 133-173). New York: Grune & Stratton.

Delaney, J. A., Seidman, E., & Willis G. (1978). Crisis intervention and the prevention of institutionalization: An interrupted time series analysis. *American Journal of Community Psychology, 6*(1), 33-45.

Dellario, D. J. (1985). The relationship between mental health, vocational rehabilitation, interagency functioning, and outcome of psychiatrically disabled persons. *Rehabilitation Counseling Bulletin, 28,* 167-171.

Dellario, D., & Anthony, W. A. (1981). On the relative effectiveness of institutional and alternative placement for the psychiatrically disabled. *Journal of Social Issues, 51,* 21-33.

Dickey, B., & Goldman, H. H. (1986). Public health care for the chronically mentally ill: Financing operation costs: Issues and options for local leadership. *Administration in Mental Health, 14*(2), 63-77.

Dion, G., & Anthony, W. A. (1987). Research in psychiatric rehabilitation: A review of experimental and quasi-experimental studies. *Rehabilitation Counseling Bulletin,* March, 177-203.

Dion, G., Dellario, D., & Farkas, M. (1982). The relationship of maintenance neuroleptic dosage levels to vocational functioning in severely psychiatrically disabled clients: Implications for rehabilitation practitioners. *Psychosocial Rehabilitation Journal, 6*(2), 29-35.

Durlak, J. A. (1979). Comparative effectiveness of paraprofessional and professional helpers. *Psychological Bulletin, 86,* 80-92.

Estroff, S. E., & Patrick, D. L. (1988). *Disability income maintenance and severe, persistent mental illness.* Manuscript submitted for publication.

Fadden, G., Bebbington, P., & Kuipers, L. (1987). The burden of care: The impact of functional psychiatric illness on the patient's family. *British Journal of Psychiatry, 150,* 285-292.

Falloon, I. R. H., Boyde, J. L., McGill, C. W., Razani, J., Moss, H. B., & Gilderman, A. M. (1982). *New England Journal of Medicine, 306,* 1437-1440.

Farina, A., & Felner, R. D. (1973). Employment interviewer reactions to former mental patients. *Journal of Abnormal Psychology, 82,* 268-272.

Farmer, S. (1987). Medical problems of chronic patients in a community support program. *Hospital and Community Psychiatry, 38*(7), 745-749.

Fenton, W. S., & McGlashan, T. H. (1987). Sustained remission in drug-free schizophrenic patients. *American Journal of Psychiatry, 144,* 1306-1309.

Field, G., & Yegge, L. (1982). A client outcome study of a community support demonstration project. *Psychosocial Rehabilitation Journal, 6*(2), 15-22.

Fields, S. (1980). Progress Foundation, La Posada, Acute treatment programs. *A.A.R.T.,* Winter, 6-8.

Franklin, J. L., Solovitz, B., Mason, M., Clemons, J. R., Miller, G. E. (1987). An evaluation of case management. *American Journal of Public Health, 77,* 674-678.

Fraser, M. W., Fraser, M. E., & Delewski, C. H. (1985). The community treatment of the chronically mentally ill: An exploratory social network analysis. *Psychosocial Rehabilitation Journal, 9*(2), 35-41.

Gartner, A. J., & Riessman, F. (1982). Self-help and mental health. *Hospital and Community Psychiatry, 33,* 631-635.

Geiser, R., Hoche, L., & King, J. (1988). Respite care for mentally ill patients and their families. *Hospital and Community Psychiatry, 39,* 291-295.

Goering, P. N., Wasylenki, D. A., Farkas, M., Lancee, W. J., & Ballantyne, R. (1988). What difference does case management make? *Hospital and Community Psychiatry, 39,* 272-276.

Goldman, C. R., & Quinn, F. L. (1988, March). Effects of a patient education program in the treatment of schizophrenia. *Hospital and Community Psychiatry, 39,* 282-286.

Goldstein, M. J., & Ropeikin, H. S. (1981). Short and long-term effects of combining drug and family therapy. In M. J. Goldstein (Ed.), New directions for mental health services: *New developments in interventions with families of schizophrenics* (No. 12). San Francisco: Jossey-Bass.

Goldstrom, I. D., & Manderscheid, R. W. (1982). The chronic mentally ill: A descriptive analysis from the Uniform Client Data Instrument. *Community Support Service Journal, 2,* 4-9.

Goldstrom, I. D., & Manderscheid, R. W. (1983). A descriptive analysis of community support program case managers serving the chronically mentally ill. *Community Mental Health Journal, 19,* 17-22.

Grusky, O., Tiernay, K., Anspach, R., Dans, D., Holstein, J., Unruh, D., & Vandewater, S. (1987). Descriptive evaluation of community support programs. *International Journal of Mental Health,* 15(4), 26-43.

Grusky, O., Tiernay, K., Holstein, J., Anspach, R., Dans, D., Unruh, D., Webster, S., Vandewater, S., & Allen, H. (1985). Models of local mental health delivery systems. *American Behavioral Scientist, 28*(5), 685-703.

Grusky, O., Tiernay, K., Manderscheid, R. W., & Grusky, D. B. (1985). Social bonding and community adjustment of chronically mentally ill adults. *Journal of Health and Social Behavior, 26,* 49-63.

Hall, R. C. W., Gardner, E. R., Popkin, M. K., Lecann, A. F., & Stickney, S. K. (1981). Unrecognized physical illness prompting psychiatric admission: A prospective study. *American Journal of Psychiatry, 138,* 629-635.

Hammaker, R. (1983). A client outcome evaluation of the statewide implementation of community support services. *Psychosocial Rehabilitation Journal, 7*(1), 2-10.

Hammer, M. (1981). Social supports, social networks, and schizophrenia. *Schizophrenia Bulletin, 7*(1), 45-57.

Handel, M. (1985). Deferred pelvic examinations: A purposeful omission in the care of mentally ill women. *Hospital and Community Psychiatry, 36,* 1070-1074.

Hargreaves, W. A., Shumway, M., Knutsen, E. J., Weinstein, A., & Senter, N. (1987). Effects of the Jamison-Farabee Consent decree: Due process protection for involuntary psychiatric patients treated with psychoactive medication. *American Journal of Psychiatry, 144*(2), 188-192.

Harris, M., Bergman, H. C. (1985). Networking with young adult chronic patients. *Psychosocial Rehabilitation Journal, 8*(3), 28-35.

Harris, M., & Bergman, H. C. (1988). Capitation financing for the chronic mentally ill: A case management approach. *Hospital and Community Psychology, 39,* 68-72.

Harris, M., Bergman, H. C., & Bachrach, L. L. (1987). Individualized network planning for chronic psychiatric patients. *Psychiatry Quarterly, 58*(1), 51-56.

Hatfield, A. B. (1981). Self-help groups for families of the mentally ill. *Social Work,* September, 408-413.

Hattie, J. A., Sharpley, C. F., & Rogers, H. J. (1984). *Psychological Bulletin, 95,* 534-541.

Hill, M., & Wehman, P. (1983). Cost benefit analysis of placing moderately and severely handicapped individuals into competitive employment. *TASH Journal, 8,* 30-38.

Hill, M. L., Wehman, P. H., Kregel, J., Banks, P. D., & Metzler, H. M. D. (1987). *Journal of the Association for the Severely Handicapped, 12,* 182-189.

Hoffman, R. S., & Koran, L. M. (1984). Detecting physical illness in patients with mental illness. *Psychosomatics, 25*(9), 654-659.

Hogarty, G. E., Anderson, C. M., Reiss, D. J., Kornblith, S. J., Greenwald, D. P., Javna, C. D., & Madonia, M. J. (1986). Family psychoeducation, social skills training, and maintenance chemotherapy in the aftercare treatment of schizophrenia: I. One-year effects of a controlled study on relapse and expressed emotion. *Archives of General Psychiatry, 43,* 633-642.

Hogarty, G. E., Goldberg, S. C., Schooler, N. R. (1974). Drug and sociotherapy in the aftercare of schizophrenic patients: Adjustment of nonrelapsed patients. *Archives of General Psychiatry, 31,* 609-618.

Hogarty, G. E., Schooler, N. R., Ulrich, R., Mussare, F., Ferro, P., & Herron, E. (1979). Fluphenazine and social therapy in the aftercare of schizophrenic patients. *Archives of General Psychiatry, 36,* 1283-1294.

Hoult, J., & Reynolds, I. (1984). Schizophrenia: A comprehensive trial of community orientated and hospital orientated psychiatric care. *Acta Psychiatric Scandinavia, 69,* 359-372.

Hull, J. T., & Thompson, J. C. (1981). Factors which contribute to normalization in residential facilities for the mentally ill. *Community Mental Health Journal, 17*(2), 107-113.

Jacob, M., Frank, E., Kupfer, D. J., Cornes, C., & Carpenter, L. L. (1987). *Hospital and Community Psychiatry, 38,* 968-972.

Jansen, M. (Ed.) (1985). Special section. A chronicle of major health policy reform of the 1980s: Social security disability reform—reasons for optimism. *Psychosocial Rehabilitation Journal, 9*(1), 3-54.

Jordan, D. D. (1985). The impact of an alternatives program on client utilization of services in a county mental health system. *Hospital and Community Psychiatry, 36*(12), 1291-1296.

Kanter, A. S. (1986). Recent zoning cases uphold establishment of group homes for the mentally disabled. *Clearninghouse Review, 18,* 515-518.

Kiesler, C. A. (1982). Mental hospitals and alternative care. *American Psychologist, 37,* 349-360.

Kline, M. N., & Hoisington, V. (1981). Placing the psychiatrically disabled: A look at work values. *Rehabilitation Counseling Bulletin, 24,* 365-369.

Koran, L. M., Sox, H. C., Marton, K. I., & Moltzen, S. (1984). Mobile medical screening teams for public programs. *Hospital and Community Psychiatry, 35,* 1151-1152.

Koranyi, E. K. (1980). Somatic illness in psychiatric patients. *Psychosomatics, 21,* 887-891.

Lannon, P. B., Banks, S. M., & Morrissey, J. P. (1988). Community tenure patterns of the New York State CSS population: A longitudinal impact assessment. *Psychosocial Rehabilitation Journal, 11*(4), 47-60.

Larsen, J. K. (1987). Community mental health services in transition. *Community Mental Health Journal, 23,* 16-25.

Leavy, R. L. (1983). Social support and psychological disorder: A review. *Journal of Community Psychology, 11,* 3-21.

Lecklitner, G. L., & Greenberg, P. D. (1983). Promoting the rights of the chronically mentally ill in the community: A report on the Patient Rights Policy Research Project. *Mental Disability Law Review, 7,* 422-429.

Leete, E. (1988). The role of the consumer movement and persons with mental illness. Presented at Rehabilitation Support Services for Persons with Long-Term Mental Illness: Preparing for the Next Decade. Mary Switzer Memorial Seminar, Washington, D.C.

Leff, J., Kuipers, L., Berkowitz, R., Eberbein-Vries, R., & Sturgeon, D. A. (1982). Controlled trial of social intervention in the families of schizophrenic patients. *British Journal of Psychiatry, 141,* 121-134.

Lefley, H. P. (1987). Aging parents as caregivers of mentally ill adult children: An emerging social problem. *Hospital and Community Psychiatry, 38,* 1063-1069.

Levine, I. S., & Fleming, M. (1984). Human resource development issues in case management. Center for Rehabilitation and Manpower Services. College Park, MD: University of Maryland.

Linn, M. W., Gurel, L., Williford, W. O., Overall, J., Garland, B., Laughlin, P., & Barchiesi, A. (1985). Nursing home care as an alternative to psychiatric hospitalization. *Archives of General Psychiatry, 42,* 544-551.

Linn, M. W., Klett, J., & Caffey, E. M., Jr. (1980). Foster home characteristics and psychiatric patient outcome. *Archives of General Psychiatry, 37,* 129-132.

Lipton, F. R., Nutt, S., & Sabatini, A. (1988). Housing the homeless mentally ill: A longitudinal study of a treatment approach. *Hospital and Community Psychiatry, 39*(1), 40-45.

Maguire, G. E., Lorack, W. H., & Hardy, I. (1979). Nonhospital acute psychiatric inpatient care. *New Directions for Mental Health Services* (No. 1). San Francisco: Jossey-Bass.

Maricle, R. A., Hoffman, W. F., Bloom, J. D., Faulkner, L. R., & Keepers, G. A. (1987). The prevalence and significance of medical illness among chronically mentally ill outpatients. *Community Mental Health Journal, 23*(2), 81-90.

Matthews, S. M., Roper, M. T., Mosher, L. R., & Menn, A. Z. (1979). A non-neuroleptic treatment for schizophrenia: analysis of the two-year postdischarge risk of relapse. *Schizophrenia Bulletin, 5,* 322-332.

Medders, N. M., & Colman, A. D. (1985). The assisted independent living program: A new model for community care. *Psychiatric Annals, 15,* 667-672.

Melton, G. B., & Garrison, E. G. (1987). Fear, prejudice, and neglect: discrimination against mentally disabled persons. *American Psychologist, 42,* 1007-1016.

Mental Health Law Project Update, 6, September 13, 1987.

Mills, M. J., Yesavage, J. A., & Gutheil, T. G. (1983). Continuing case law development in the right to refuse treatment. *American Journal of Psychiatry, 140,* 715-719.

Miyake, S. M., Chemtob, C. M., & Torigoe, R. Y. (1985). The effect decreasing delays in appointment on patients' failure to keep appointments. *International Journal of Partial Hospitalization, 3,* 131-135.

Modrcin, M., Rapp, C. A., Poertner, J. (in press). The evaluation of case management services with the chronically mentally ill. *Journal of Evaluation and Program Planning.*

Moffic, H. S., Patterson, G. K., Laval, R., & Adams, G. L. (1984). Paraprofessionals and psychiatric teams: An updated review. *Hospital and Community Psychiatry, 35,* 61-67.

Morrissey, J. P., & Levine, I. S. (1987). Researchers discuss latest findings, examine needs of homeless mentally ill persons. *Hospital and Community Psychiatry, 38,* 811-812.

Morrissey, J. P., Tausig, M., & Lindsey, M. L. (1985). Community mental health delivery systems. *American Behavioral Scientist, 28*(5), 704-720.

Mosher, L. R. (1983). Alternatives to psychiatric hospitalization: Why has research failed to be translated into practice? *New England Journal of Medicine, 309*(25), 1579-1580.

Mosher, L. R., & Keith, S. J. (1980). Psychosocial treatment: Individual, group, family and community support approaches. *Schizophrenia Bulletin, 6,* 10-41.

Mosher, L. R., & Menn, A. Z. (1978). Community residential treatment for schizophrenia: Two-year follow-up. *Hospital and Community Psychiatry, 29*(1), 715-723.

Muller, J. B. (1981). Alabama community support project evaluation of the implementation and initial outcome of a model case manager system. *Community Support Service Journal, 6,* 1-4.

National Institute of Mental Health. (1987). Toward a model plan for a comprehensive, community based mental health system. Rockville, MD: Division of Education and Service Systems Liaison.

Neligh, G., & Kinzie, J. O. (1983). Therapeutic relationships with the chronic patient. In D. L. Cutler (Ed.), *Effective aftercare for the 1980s* (pp. 73-83). (New Directions for Mental Health Services, No. 19). San Francisco: Jossey-Bass.

Noble, J. H., & Conley, R. W. (1987). Accumulating evidence on the benefits and costs of supported and transitional employment for persons with severe disabilities. *Journal of the Association for the Severely Handicapped, 12*(3), 163-174.

Page, S. (1977). Effects of the mental illness label in attempts to obtain accommodation. *Canadian Journal of Behavioral Science, 9,* 85-90.

Page, S. (1983). Psychiatric stigma: Two studies of behavior when the chips are down. *Canadian Journal of Community Mental Health, 2,* 13-19.

Paul, G. L., Tobias, L. L., & Holly, B. L. (1972). Maintenance psychotropic drugs in the presence of active treatment programs. *Archives of General Psychiatry, 27,* 106-114.

Perlman, B. B., Melnick, G., Kentera, A. (1985). Assessing the effectiveness of a case management program. *Hospital and Community Psychiatry, 36,* 405-407.

Peterson, C. L. (1986, February). Changing community attitudes toward the chronic mentally ill through a psychosocial program. *Hospital and Community Psychiatry, 37,* 180-182.

Phillips, D. L. (1966). Public identification and acceptance of the mentally ill. *American Journal of Public Health, 56,* 755-763.

Pincus, H. A. (1980). Linking general health and mental health systems of care: Conceptual models of implementation. *American Journal of Psychiatry, 137,* 315-320.

Rabkin, J. (1974). Public attitudes toward mental illness: A review of the literature. *Schizophrenia Bulletin, 10,* 9-33.

Rapp, C. A., & Chamberlain, R. (1985). Case management services for the chronically mentally ill. *Social Work,* September-October, 417-422.

Rapp, C. A., & Wintersteen, R. (1988). Case management with the chronically mentally ill: The results of seven replications. Manuscript submitted for publication.

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. *American Journal of Community Psychology, 9,* 1-25.

Rappaport, J., Seidman, E., Toro, P. A., McFadden, L. S., Reischl, T. M., Roberts, L. J., Salem, D. A., Stein, C. H., & Zimmerman, M. A. (1985). Collaborative research with a mutual help organization. *Social Policy,* 12-24.

Rehabilitation Research Institute. (1980). *Bringing research into effective focus (Rehab Brief* No. 3). Florida: University of Florida, Gainsville, College of Health Related Professions.

Reischl, T. M., & Rappaport, J. (1988, August). Participation in mutual help groups and coping with acute stressors. Paper to be presented at the Annual Meeting of the American Psychological Association.

Reynolds, I., & Hoult, J. E. (1984). The relatives of the mentally ill: A comparative trial of community-oriented and hospital-oriented psychiatric care. *Journal of Nervous and Mental Disease, 172*(8), 480-489.

Rhodes, L., Ramsing, K., & Hill, M. (1987). Economic evaluation of employment services: a review of applications. *Journal of the Association for the Severely Handicapped, 12,* 175-181.

Ridgway, P. (1986). *Case management services for persons who are homeless and mentally ill: Report from an NIMH workshop.* Boston: Boston University, The Center for Psychiatric Rehabilitation.

Rissmeyer, D. (1985). Crisis intervention alternatives to hospitalization: Why so few? *Psychosocial Rehabilitation Journal, 9*(2), 54-63.

Roca, R. P., Breakey, W. R., & Fischer, P. J. (1987). Medical care of chronic psychiatric outpatients. *Hospital and Community Psychiatry, 38*(7), 741-745.

Rogers, E. S., Anthony, W. A., & Danley, K. (1988). The impact of interagency collaboration on system and client outcome. *Rehabilitation Counseling Bulletin.* Paper submitted for publication.

Rubin, J. (1987). Financing care for the seriously mentally ill. In D. Mechanic (Ed.), *Improving mental health services: What the social sciences can tell us: New directions for mental health services,* (No. 36) (pp. ???). San Francisco: Jossey-Bass.

Salem, D. A. (1984, August). Learning from the failure of deinstitutionalization: The mutual help alternative. Paper presented at the Annual Meeting of the American Psychological Association, Toronto, Ontario.

Sarbin, T. R., & Mancuso, J. C. (1970). Paradigms and moral judgments: Improper conduct is not disease. *Journal of Consulting and Clinical Psychology, 39,* 6-8.

Scallet, L. J. (1986). Protection and advocacy systems for people receiving mental health services. Issue Brief prepared under NIMH Purchase Order 85M046981501D.

Scheid-Cook, T. L. (1987). Commitment of the mentally ill to outpatient treatment. *Community Mental Health Journal, 23*(3), 173-182.

Schneider, C. R., & Anderson, W. (1980). Attitudes toward the stigmatized: Some insights from recent research. *Rehabilitation Counseling Bulletin,* June, 299-313.

Schoenfeld, P., Halevy, J., Hemley van der Velden, E., & Ruhf, L. (1986). Long-term outcome of network therapy. *Hospital and Community Psychiatry, 37*(4), 373-376.

Schoonover, S. C., & Bassuk, E. L. (1983). Deinstitutionalization and the private general hospital inpatient unit: Implications for clinical care. *Hospital and Community Psychiatry, 34*(2), 135-139.

Schwartz, S., Goldman, H., & Churgin, S. (1982). Case management for the chronically mentally ill: Models and dimensions. *Hospital and Community Psychiatry, 33,* 1006-1009.

Segal, S. P., & Aviram, U. (1978). *The mentally ill in community-based sheltered care: A study of community care and social integration.* New York: John Wiley and Sons.

Sheridan, E. P., Zuskar, D. M., Walsh, S. F., & O'Brien, S. (1988). identifying variables predictive of success: The next step in alternatives to psychiatric hospitalization research. (Manuscript submitted for publication.)

Smith, J. V., & Birchwood, M. J. (1987). Specific and non-specific effects of educational intervention with families living with a schizophrenic relative. *British Journal of Psychology, 150,* 645-652.

Soloff, P. H., Gutheil, T. G., & Wexler, D. B. (1985). Seclusion and restraint in 1985: A review and update. *Hospital and Community Psychiatry, 36,* 421-426.

Solomon, E. B., Baird, R., Everstine, L., & Escobar, A. J. (1980). Assessing the community care of chronic psychotic patients. *Hospital and Community Psychiatry, 31,* 113-116.

Solomon, P., Beck, S., & Gordon, B. (1988). A comparison of perspectives on discharge of extended-care facility clients: Views of families, hospital staff, community mental health workers, and clients. *Administration in Mental Health, 15,* 166-174.

Solomon, P., & Gordon, B. (1988). Outpatient compliance of psychiatric emergency room patients by presenting problems. *Psychiatric Quarterly.*

Solomon, P., Gordon, B., & Davis, J. M. (1983). An assessment of aftercare services within a community mental health system. *Psychosocial Rehabilitation Journal, 8*(2), 33-39.

Solomon, P., Gordon, B., & Davis, J. M. (1986). Reconceptualizing assumptions about community mental health. *Hospital and Community Psychiatry, 37,* 708-712.

Spaniol, L., & Zipple, A. (1988). Family and professional perceptions of family needs and coping strengths. *Rehabilitation Psychology, 33,* 37-45.

Spiegel, D., & Wissler, T. (1987). Using family consultation as psychiatric aftercare for Schizophrenic Patients. *Hospital and Community Psychiatry, 38,* 1096-1099.

Stanton, A. H., Gunderson, J. G., Knapp, P. H., Frank, A. F., Vannicelli, M. O., Schnitzer, R., & Rosenthal, R. (1984). Effects of psychotherapy on schizophrenia: I. Design and implementation of a controlled study. *Schizophrenia Bulletin, 10,* 520-563.

Stefan, S. (1987). Advocating for mothers in the mental health system. In *Protection and Advocacy for People who are Labelled Mentally Ill,* (Vol. II), Washington, D.C.: Mental Health Law Project.

Stein, C. H. (1984). Assessing individual change among members in a mutual help organization. Paper presented at the Annual Meeting of the American Psychological Association, Toronto, Ontario.

Stickney, S. K., Hall, R. L., & Gardner, E. R. (1980). The effect of referral procedures on aftercare compliance. *Hospital and Community Psychiatry, 31,* 567-569.

Stroul, B. (1987). *Crisis residential services in a community support system.* Rockville, MD: National Institute of Mental Health, Community Support Program.

Stroul, B. (1988). Community support systems for persons with long-term mental illness: Questions and answers. National Institute of Mental Health Community Support Program. Rockville, MD: National Institute of Mental Health.

Sue, S., McKinney, H., & Allen, D. B. (1976). Predictors of the direction of therapy for clients on the community mental health center system. *Community Mental Health Journal, 12,* 365-375.

Taube, C. A., Goldman, H. H., Burns, B. J., & Kessler, L. G. (1988). High users of outpatient mental health services: Vol. 1. Definition and characteristics. *American Journal of Psychiatry, 145*(1), 19-24.

Telintelo, Huhlman, T. L., & Winget, C. (1983). A study of the use of restraint in a psychiatric emergency room. *Health and Community Psychiatry, 34,* 164-165.

Tessler, R. C. (1987). Continuity of case and client outcome. *Psychosocial Rehabilitation Journal, 11*(1), 39-53.

Tessler, R. C., & Kilhan, L. M., & Gubman, G. D. (1987). Stages in family response to mental illness: An ideal type. *Psychosocial Rehabilitation Journal, 10*(4), 3-16.

Tessler, R. C., & Manderscheid, R. W. (1982). Factors affecting adjustment to community living. *Hospital and Community Psychiatry, 33*(3), 203-207.

Test, M. A., & Berlin, S. B. (1981). Issues of special concern to chronically mentally ill women. *Professional Psychology, 12*(1), 825-831.

Test, M. A., Knoedler, W. H.,& Allness, D. J. (1985). The long-term treatment of young schizophrenics in a community support program. In L. I. Stein & M. A. Test (Eds.), *The training in community living model: A decade of experience* (New Directions for Mental Health Services No. 26). San Francisco: Jossey-Bass.

Test, M., & Stein, L. (1978). Community treatment of the chronic patient: Research overview. *Schizophrenia Bulletin, 4,* 350-369.

Turner, J. E., & TenHoor, W. J. (1978). The NIMH community support program: Pilot approach to a needed social reform. *Schizophrenia Bulletin, 4,* 319-348.

Walls, R. T. (1982). Disincentives in vocational rehabilitation: Cash and in-kind benefits from other programs. *Rehabilitation Counseling Bulletin,* September, 37-46.

Wasylenki, D. A., Goering, P. N., Lancee, W. J., Ballantyne, R., & Farkas, M. (1985). Impact of a case manager program on psychiatric aftercare. *Journal of Nervous & Mental Disease, 173,* 303-308.

Wasylenki, D. A., Goering, P., Lancee, W., Fischer, L., & Freeman, S. J. J. (1981). Psychiatric aftercare: Identified needs versus referral patterns. *American Journal of Psychiatry, 138,* 1228-1231.

Waxman, H. M., Klein, M., & Carner, E. A. (1985). Drug misuse in nursing homes: An institutional addiction. *Hospital and Community Psychiatry, 36,* 741-742.

Wherley, M., & Bisgaard, S. (1987). Beyond model programs: Evaluation of a countywide system of residential treatment programs. *Hospital and Community Psychiatry, 38*(8), 852-857.

Witheridge, T. F., Omega, J., & Appleby, L. (1982). Working with the most frequent recidivists: A total team approach to assertive resource coordination. *Psychosocial Rehabilitation Journal, 5,* 9-11.

Woy, J. R., & Dellario, D. J. (1985). Issues in the linkage and integration of treatment and rehabilitation services for chronically mentally ill persons. *Administration in Mental Health, 12*(3), 155-165.

Wright, R. G., Sklebar, H. T., & Heiman, J. R. (1987, Spring). Patterns of case management activity in an intensive community support program: The first year. *Community Mental Health Journal, 23*(1), 53-59.

Zipple, A. M., & Spaniol, L. S. (1987). Current educational and supportive models of family intervention. In A. B. Hatfield & H. P. Lefley (Eds.), *Families of the mentally ill: Coping and adaptation* (pp. 261-277). New York: The Guilford Press.