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

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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:

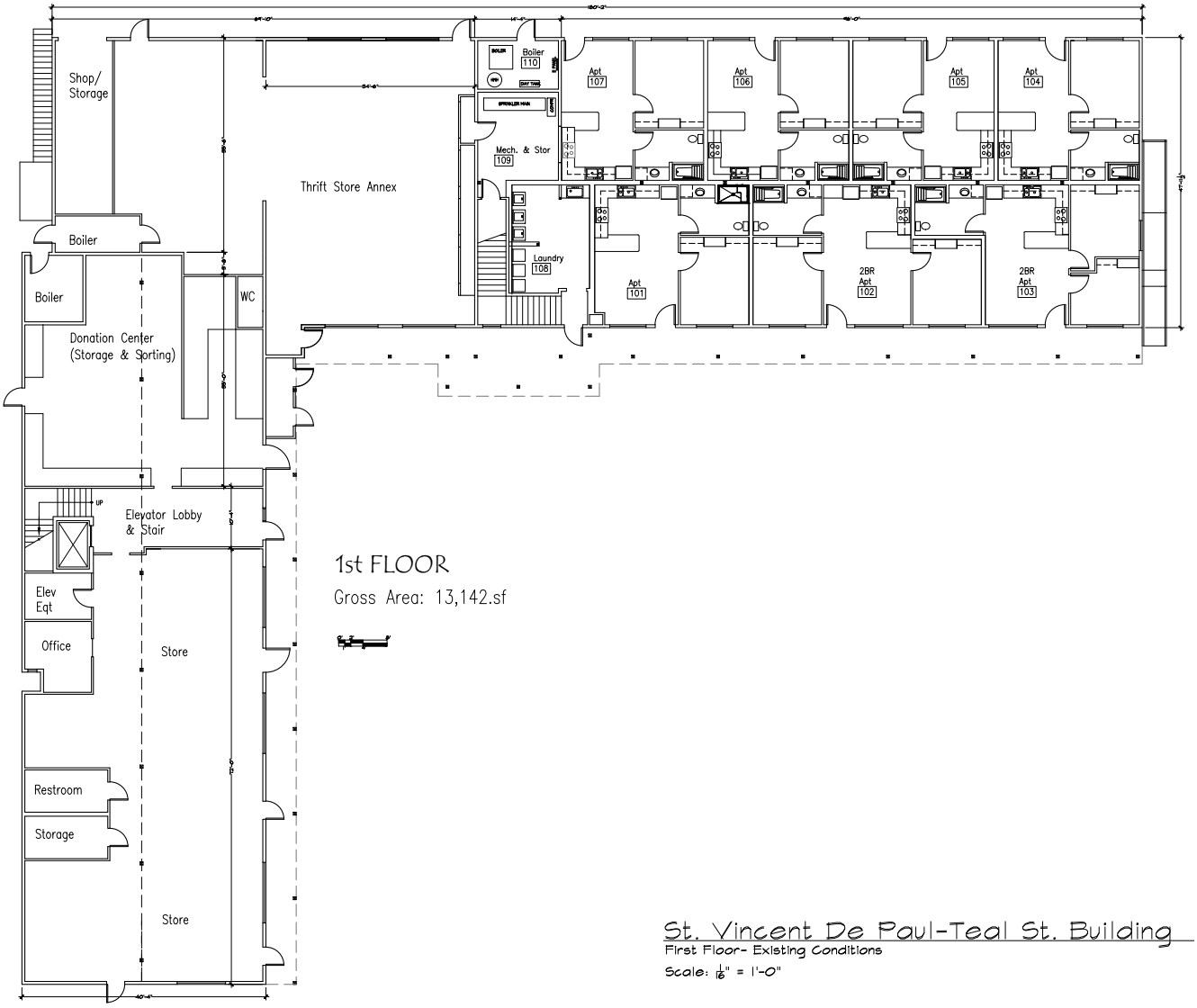
- Transitional Planning and Support by SVdP Navigators
- Third Party Service Agency Exam, Counselling, Meeting, and Conference Rooms
- Transitional Thrift Store
- Transitional Food Pantry
- Transitional Laundry, Locker Room and Shower Facility
- Peer Support Programs – SVdP Home Visits, Other One-to-One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

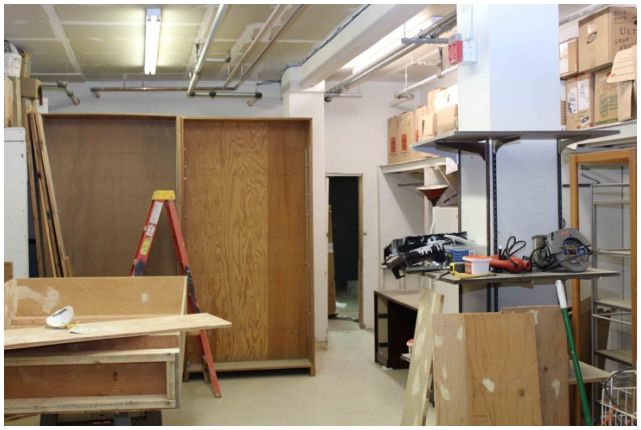
SVdP is unique in the CBJ area in that it is able to offer low-barrier case management, as it does not rely on Medicaid or other reimburse programs. The SVdP navigators assist anyone who asked for assistance. This will allow the TSSC to be an open access point for anyone needing transition assistance,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

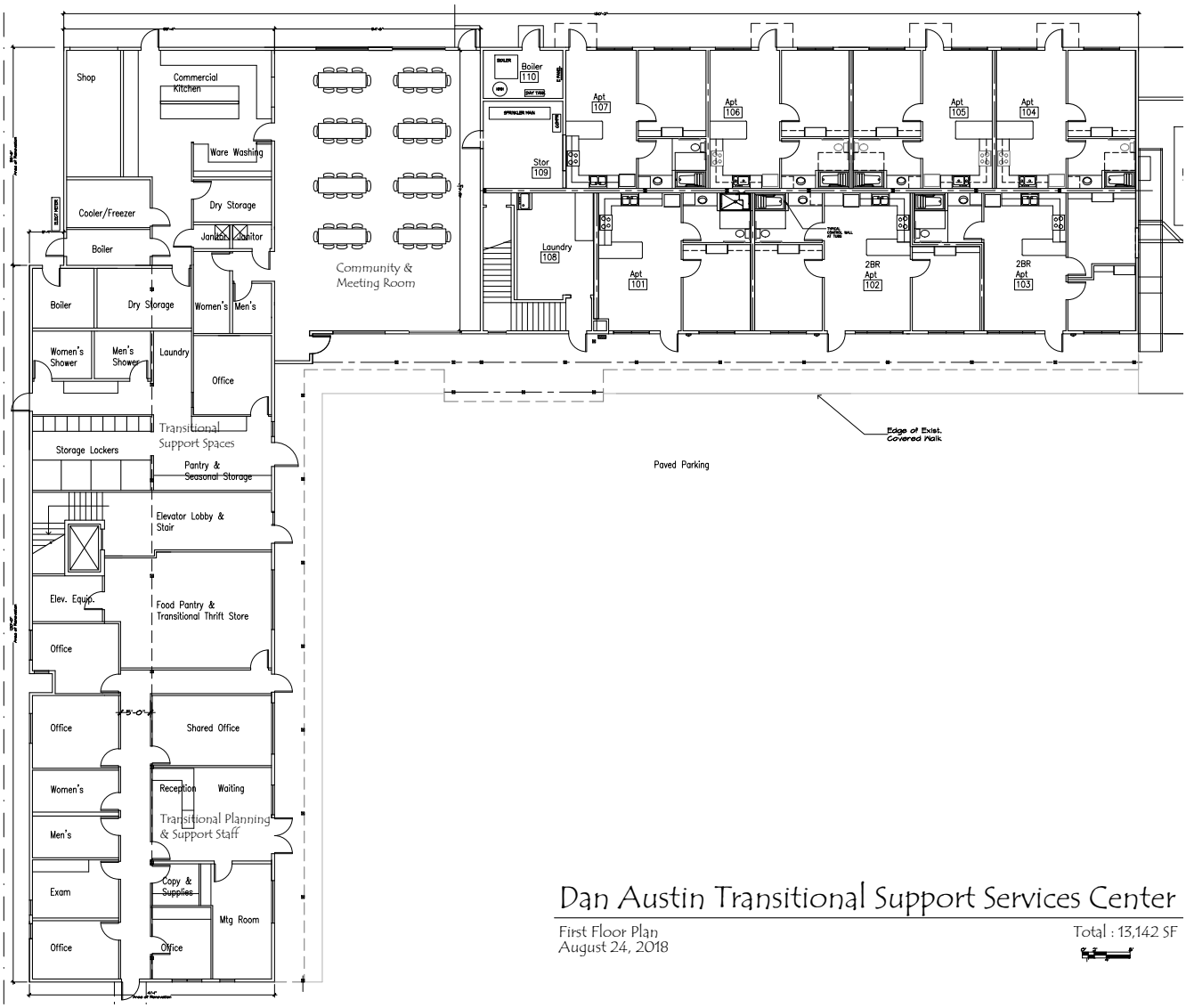


Current Donation, Sorting and Maintenance Space

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:

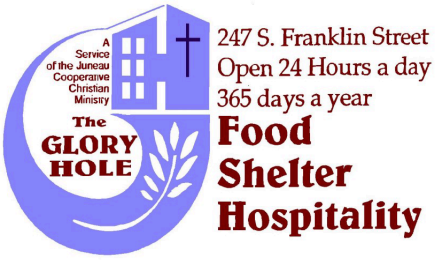
Please accept this letter on behalf of AWARE Inc.'s support of St. Vincent de Paul's (SVdP) proposal for funds under the CDBG program. We believe the Dan Austin Transitional Support Services Center (TSSC), as described in SVdP's proposal, has the potential to create a cohesive, manageable and supported 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.**

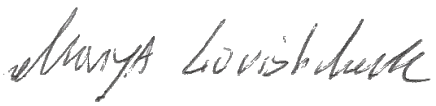
The TSSC's ability to provide transitional plan development with SVdP's in-house team of three Community Navigators (case managers), selected thrift store items, food pantry, locker-storage, showers, laundry, food service, training and meeting facilities, and professional service facilities for medical, 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:

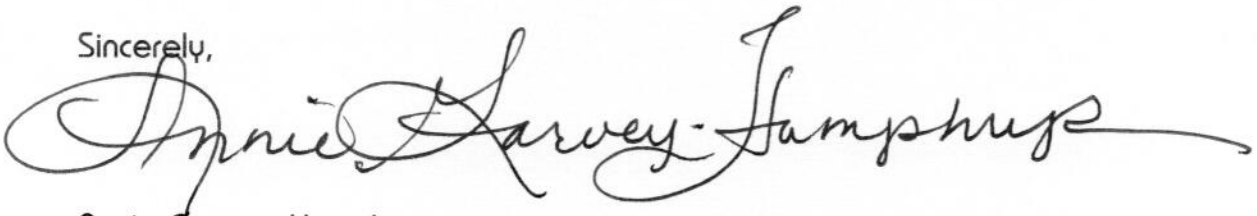
Please accept this letter on behalf of Chez Alaska Cooking School's support of St. Vincent de Paul's (SVdP) proposal for funds under the CDBG program. We believe the Dan Austin Transitional Support Services Center (TSSC), as described in SVdP's proposal, has the potential to create a cohesive, manageable 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.

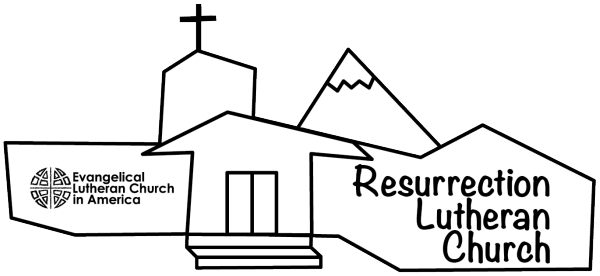
The TSSC's ability to provide transitional plan development with SVdP's in-house team of three Community Navigators (case managers), selected thrift store items, food pantry, locker-storage, showers, laundry, food service, training and meeting facilities, and professional service facilities for medical, 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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[1] This article is a shortened version of a 43-page paper developed under contract to the NIMH Community Support Program and presented at the Community Support and Reha-

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.

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