

EXPLORATORY EVALUATION OF THE
HUD/HHS DEMONSTRATION PROGRAM FOR
**DEINSTITUTIONALIZATION OF THE
CHRONICALLY MENTALLY ILL**

Final Report
EXECUTIVE SUMMARY

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CHRONICALLY MENTALLY ILL

FINAL REPORT
, EXECUTIVE SUMMARY

Submitted to:

Office of the Assistant Secretary
for Planning and Evaluation
Department of Health and Human Services

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EXECUTIVE SUMMARY

This report documents the background, methodology, and results of an exploratory evaluation conducted by Macro Systems, Inc. , under contract with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the Department of Health and Human Services (HHS). The study was designed specifically to determine Federal intent and expectations for the HUD/HHS Demonstration Program for the Chronically Mentally Ill, to document and describe current Demonstration field operations, to identify relevant issues, and to develop appropriate options for future, more intensive evaluation of the Demonstration. The study was initiated in October 1981 and was completed in April 1982.

1. OVERVIEW OF THE HUD/HHS DEMONSTRATION PROGRAM

The HUD/HHS Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill was launched in 1978 and continued through 1980. The announcement of this initiative at the White House marked the culmination of an unprecedented process of joint planning and interagency collaboration among the Departments of Housing and Urban Development (HUD) and Health and Human Services (then the Department of Health, Education, and Welfare, HEW), largely in response to the recommendations of the General Accounting Office (GAO) Report of 1977^{1/} and the 1978 Report of the President's Commission on Mental Health (PCMH) .^{2/}

The design of the HUD/HHS Demonstration Program incorporated key themes and was consistent with the overall thrust of a number of earlier and concurrent Federal policies and initiatives directed at alleviating the problems encountered by deinstitutionalized mentally ill individuals in the community. In addition to the GAO and PCMH reports, these initiatives and policies included: (1) the Community Mental Health Centers (CMHC) Act, as amended in 1975; (2) the National Institute of Mental Health (NIMH) Community Support Program; (3) HUD's Ad Hoc Committee on the Handicapped and the Office of Independent Living for the Disabled; (4) the Housing and Community Development Amendments of 1978--Conference Report; (5) the Mental Health Systems Act of 1980;

^{1/} General Accounting Office. Returning the Mentally Disabled to the Community: Government Needs to Do More. (HRD-76-152), Washington, D.C., 1977.

^{2/} The President's Commission on Mental Health. Report to the President from the President's Commission on Mental Health. (Vol. 1), Washington, D.C., Government Printing Office, 1978.

(6) the National Plan for the Chronically Mentally Ill; and (7) the (White House) Independent Living Initiative. Thus, the Program sought to demonstrate that community-based housing linked with supportive services for the mentally ill could be provided and coordinated by States in a cost-effective and efficient manner.

The Demonstration design involved a commitment by each of the participating Departments of the following resources: HUD provided funds for housing development through the Section 202 Direct Loan Program and for rental subsidies for housing units through the Section 8 Program; HHS allowed for certain Medicaid regulations to be temporarily waived, at State option, through Section 1115 of the Social Security Act. These three financing mechanisms formed the basic framework of the Demonstration Program.

Specifically, Demonstration projects were expected to serve a 'broadly defined population of adult chronically mentally ill (CMI) individuals through the construction or rehabilitation of either group homes or independent living apartments, linked to a range of supportive services. Program guidelines were articulated so as to afford States and local sponsors much flexibility and discretion in (1) defining the population to be served, (2) determining the types of housing alternatives to provide, and (3) determining the extent and nature of services to be delivered to Demonstration clients.

Participation of States and sponsors in the Demonstration was competitive and contingent upon initial review and selection by HUD and HHS. Between 1978 and 1980, in three rounds of application, 201 sponsors were selected in 38 States across the nation, and 1,867 units were approved for construction or substantial rehabilitation. A total of \$65 million in Section 202 Direct Loan Program loan authorities was reserved and \$13 million in Section 8 rents subsidies was set aside for these Demonstration sponsors. In 1980, following the third and final round of project approval for the Demonstration, it was estimated that, if all approved housing units became operational, between \$20 million and \$30 million in Medicaid funds under the Section 1115 waiver may be expended for supportive services. Exhibit A, following this page, shows the funding levels and corresponding number of units approved in each year of the Demonstration for States and local sponsors.

Another key feature of the Demonstration Program design was an evaluation component intended to be completed over a five-year period. As such, initial evaluation efforts involved a HUD contract with Urban Systems, Research, and Engineering, Inc. (USR&E), to perform an intensive evaluation of the early experiences of Phase I of the Demonstration from the perspective of HUD Central and Area, State, and local levels. In addition, USR&E was requested to develop an evaluation design for future, intensive assessment of Demonstration experiences and results. Focusing on the early experiences of HUD Central and Area Offices, 10 of 13 Demonstration States, and 31 local sponsors approved in 1978, USR&E evaluated and documented housing production problems, administrative design limitations, and Demonstration accomplishments. In addition, USR&E submitted a longitudinal experimental cost-benefit evaluation design to measure the long-term impact of the Demonstration.

EXHIBIT A

HHS, Office of the Assistant Secretary
for Planning and Evaluation

OVERALL DEMONSTRATION PROGRAM CHARACTERISTICS

	<u>Section 202 Loan Reserves</u>	<u>Section 8 Rental Subsidies Set-Asides</u>	<u>Total States Approved</u>	<u>Total Sponsors Approved</u>	<u>Total Units Approved</u>
1978	\$15 million	\$ 3 million	13	58	479
1979	\$25 million	\$ 5 million	27*	77	730
1980	<u>\$25 million</u>	<u>\$ 5 million</u>	<u>31"</u>	<u>66</u>	<u>658</u>
	\$65 million	\$13 million	38**	201	1,867

* Duplicated Count

** Unduplicated Count

2. THE EXPLORATORY EVALUATION OF THE HUD/HHS DEMONSTRATION PROGRAM

By late 1981, it was estimated that 31 projects with a total of 273 units were operational in 15 States and that 26 projects were under construction. Five States were approved for Section 1115 waivers to reimburse for supportive services provided to Demonstration clients. Given this small number of operational projects with only a few operational in waiver-only States, and the great variability that appears to exist among project models developed, the cost-benefit study design developed by USR&E was deemed to be too ambitious in scope and content. As such, this evaluation was not undertaken as planned. Instead, a less intensive and more qualitative six-month exploratory evaluation of the HUD/HSS Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill was conceived and initiated in October 1981. The study was conducted in close collaboration with representatives from HUD and HHS.

The purpose of the exploratory evaluation was to determine:

- . The expectations and objectives of Federal program managers and policymakers at each level of management for the HUD/HHS Demonstration Program
- . An accurate description of what currently is occurring in selected Demonstration States and sites
- . A comparison of the actual activities being performed at State and local levels with the expectations of Federal program managers and policymakers
- . Relevant policy and management issues for consideration by program managers and policymakers
- . The appropriateness of more intensive evaluation of the Demonstration given current program conditions and to develop evaluation options accordingly

Specifically, the exploratory evaluation was divided into three broad tasks:

- . Task I--Documenting The Intended Program--The first exploratory evaluation task involved the delineation of the objectives and expectations of program managers and policymakers at each level of management for the HUD/HHS Demonstration Program. Specifically, this task involved the explication of program objectives, activities necessary to attain the objectives, and indicators of program success. Models describing the logic and activities of the intended HUD/HHS Demonstration were constructed.

Task Z--Documenting Actual Program Activities And Results--The purpose of this task was to describe the HUD/HHS Demonstration Program as it actually operates. In addition, this task involved the description of the types of project activities underway and

the objectives sought and accomplishments attained at State and local levels . As such, this task served as a check on the reality of the models developed in Task 1.

Task 3--Analysis And Synthesis Of Information And Findings And Identification Of Relevant Policy And Management Issues--This task involved the analysis and synthesis of information obtained in Tasks 1 and 2 to identify policy and management issues and/or problems. In addition, based on the analysis and issues, the appropriateness of a more in-depth evaluation of the Demonstration Program was determined and specific options for future evaluation of the Program were developed.

3. THE INTENDED OBJECTIVES OF THE HUD/HHS DEMONSTRATION PROGRAM

The HUD/HHS Demonstration Program was designed by Federal program managers and policymakers to attain certain intermediate and longer-range housing-, services-, and target population-specific objectives. These objectives, or intended results of the Demonstration, are sequential in nature and indicate that, although certain objectives are the ultimate aims of the Demonstration, more immediate results are also sought. As intended, both intermediate and longer-range objectives could be attained simultaneously. However, the intermediate objectives were viewed as precursors to longer-range ones. Ten such objectives were identified during the exploratory evaluation:

Intermediate Demonstration Program Objectives

- To construct or substantially rehabilitate permanent, community-based residential housing linked to supportive services appropriate to the needs of the CMI
- . To reinforce and expand the existing capability of States and localities in meeting the specialized housing and service needs of the CMI
- To integrate the CMI into the community, to normalize their lives, and to enhance their independence and functioning
- . To complement and enhance ongoing State and Federal deinstitutionalization efforts
- . To determine the viability of the 202 Program as a mechanism for providing housing for the CMI
- . To determine the viability of the Medicaid Program as a funding mechanism for supportive services through the application of Section 1115 waivers

Longer-Range Demonstration Program Objectives

To improve the quality of life of the CMI served by the Demonstration

- To determine the cost-effectiveness or benefit of **community-**based housing linked with supportive services, compared to institutionalization

To establish financing mechanisms for community-based housing and supportive services that are appropriate to the needs of the CMI

To improve the quality of life of the CMI as a whole

These objectives together form the basis for what the Demonstration was intended to accomplish.

4. ACCOMPLISHMENTS OF THE HUD/HHS DEMONSTRATION PROGRAM TO DATE

As of the time of this exploratory evaluation and four years after initiation of the Demonstration, 327 of the total of 1,867 approved units, or 18 percent, were operational. These units have a capacity to house 390 individuals, and they represent 32 projects, or 16 percent of the total number of projects for which Section 202 loan reservations were made. In the 16 States in which these 32 operational projects are located, 17 percent of the remaining approved projects were under construction, 37 percent are still in the Section 202 processing pipeline, and 17 percent were cancelled. Thus, if all those projects under construction or still in HUD processing are completed, 83 percent of the 201 projects for which Section 202 funds were reserved under the Demonstration will have become operational. Exhibit B, following this page, presents in detail Demonstration accomplishments in the 16 States studied during the exploratory evaluation. Based upon the sample of 9 projects visited during the conduct of this study, each facility took approximately 30 months to complete, from the time of loan reservation to actual occupancy by residents. Each project required, on the average, \$234,096 in Section 202 funds for construction or substantial rehabilitation, inclusive of all costs for acquisition, design, and so on.

Services rendered residents of the nine operational projects visited are generally restricted to those provided by project staff and include supervision, case management, and training in activities of daily living. In addition, limited mental health services, such as day treatment and medication, are made available to residents by sponsor organizations. As such, a full range of services necessary to meet the needs of residents of Demonstration projects is not available. By and large, Medicaid funds made available under the Section 1115 waiver in five waiver-only States are not being used to the extent anticipated to support service delivery. In all instances, Medicaid funds under the waiver are being used as financial support for staff working in operational projects and not for specific services per se. That is, projects are being reimbursed on a per-diem basis for Medicaid-eligible clients and not for individual services rendered such clients.

EXHIBIT B

HHS, Office of the Assistant Secretary for Planning and Evaluation

DEMONSTRATION ACCOMPLISHMENTS IN SIXTEEN STATES

STATE	No. of Approved Projects				ANNED		ACCOMPLISHED																Current Capacity	Current Occupancy
	Total No. of Units Approved				Total Fund Reservation	Project Status				Units Completed														
	78	79	80	Total		Cancelled N	Cancelled %	202 Processing N	202 Processing %	Under Const. N	Under Const. %	Operational N	Operational %	Total Units N	Total Units % 1/	Op. Home Units N	Op. Home Units % 2/	Apartment Units N	Apartment Units % 2/					
Colorado	7	--	3	10	84	2,702,800	3	30	--	--	1	10	6	60	65	77	22	33	43	66	65	65		
D. C.	--	4	1	5	52	1,798,300	1	20	1	20	2	40	1	20	9	17	5	55	4	44	18	10		
Georgia	4	2	1	7	87	2,768,200	--	--	2	29	1	14	4	57	44	50	24	54	20	4s	54	18		
Massachusetts	9	2	3	14	111	4,357,640	2	14	5	36	2	14	5	36	46	41	46	100	--	--	46	46		
Minnesota	3	--	--	3	24	852,274	--	--	--	--	1	33	2	67	20	83	--	--	20	100	33	33		
Oregon	5	--	--	5	43	1,289,100	3	60	--	--	--	--	2	40	16	37	16	100	--	--	20	20		
Pennsylvania	3	3	4	10	91	3,406,125	1	10	6	60	1	10	2	20	16	18	--	--	16	100	28	27		
Tennessee	--	3	1	4	49	1,824,600	--	--	--	--	3	75	1	25	8	16	8	100	--	--	8	7		
Vermont	6	4		10	60	2,082,019	2	20	5	50	3	30	0	0	(20) ^{3/}	33	12	60	8	40	(20) ^{3/}	--		
Subtotal	37	18	13	68	601	21,081,058	12	18	19	28	14	20	23	33	244	40	133	54	111	4s	292	226		
California	--	5	4	9	93	3,739,900	--	--	8	88	--	--	1	11	10	11	--	--	10	100	10	NA		
Florida	6	--	2	8	61	1,693,881	6	75	1	12	--	--	1	12	6	10	6	100	--	--	12	NA		
Illinois	--	5	4	9	91	3,566,442	--	--	5	55	3	33	1	11	11	12	11	100	--	--	11	NA		
North Carolina	--	3	--	3	23	759,300	--	--	2	66	--	--	1	33	4	17	4	100	--	--	8	NA		
Rhode Island	4	--	1	5	38	1,609,000	--	--	2	40	2	40	1	20	7	18	7	100	--	--	9	NA		
Utah	--	1	1	2	23	732,900	1	50	--	--	--	--	1	50	21	91	--	--	21	100	21	NA		
Wisconsin	--	4	3	7	60	2,320,200	--	--	4	57	--	--	3	42	24	40	8	33	16	66	27	NA		
Subtotal	10	18	15	43	389	14,421,623	7	16	22	51	5	11	9	21	83	21	36	43	47	57	98	NA		
GRAND TOTAL	47	36	28	111	990	35,502,681	19	17	41	37	19	17	32	29	327	33	169	52	158	48	390			

1/ Percent of total number of units approved.
 2/ Percent of units completed.
 3/ Units due to become operational in January 1982.

5. KEY FINDINGS EMERGING FROM THE EXPLORATORY EVALUATION

In comparison to other demonstrations, the HUD/HHS Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill has been unique in the following ways:

It is a demonstration within a demonstration in that the Section 1115 demonstration initiative is a component of a broader demonstration of community-based housing linked with supportive services.

It has sought to bring together three existing programs: HUD's Section 202 Program to defer construction or substantial rehabilitation costs of housing; HUD's Section 8 Program to subsidize resident rents and to assure sponsors' ability to meet mortgage commitments made under Section 202; and, at State option, HHS' Section 1115 waivers to Medicaid to defer the costs of delivery of needed services to residents.

The interagency nature of the Demonstration design is highlighted by the multiple funding source possibilities and the participation of HUD, HHS/ASPE, the Health Care Financing Administration (HCFA), and NIMH.

The guidance material forming the principal basis for the Demonstration was intentionally broad with respect to the target population to be served and the services to be provided, allowing States and local sponsors maximum flexibility in planning and implementing the concept of housing linked with services.

It predated the current shift in the locus of responsibility for administration of Federal mental health service funds (through block grants) from the local to the State level and, therefore, serves as an early illustration of State-level response and oversight.

Accordingly, several key issues emerged during the exploratory evaluation that are relevant to the program design and for continued State and local efforts in providing community-based housing and services for the chronically mentally ill. Ten separate issues were identified:

Impact Of The HUD/HHS Demonstration Program Across States And Projects--Although Demonstration accomplishments to date have fallen short of Federal expectations, they are significant nonetheless. In several States, the Demonstration embodied the only State-supported initiative to develop residential programs. In many of the communities in which Demonstration projects have become operational, quality housing and appropriate support services were previously unavailable. The Demonstration provided an excellent opportunity for States and local providers to respond, even if on a small scale, to the critical need for

community-based housing and services for the chronically mentally ill. In addition, the Demonstration Program has been successful in stimulating important relationships among housing and service providers in enhancing the awareness of key participants and, in some cases, serving as an impetus for related spin-off initiatives and key policy changes at the Federal, State, and local levels regarding housing for the chronically mentally ill.

Appropriateness Of The Section 202 Program As A Mechanism For Attaining Demonstration Housing-Related Objectives--Only a small proportion of the total number of projects and units approved by HUD in the three years of the Demonstration have actually become operational. Numerous reasons can be cited as to why production of Demonstration projects has been so slow. Most notable, however, have been the problems of adapting the Section 202 Program, which was designed for large-scale housing complexes to small, scattered-site housing projects. As presently constituted, the 202 mechanism has been extremely burdensome, complex, and costly. Field experiences indicated that the Section 202 Program, designed as it is for large-scale housing developments, does not appear to be well suited to attaining Demonstration housing objectives that are dependent on the construction or substantial rehabilitation of small group home or independent living apartment projects.

Community-Based Housing Linked With Services--The intent of the HUD/HHS Demonstration Program was for community-based housing to be linked with **services** and for strong service linkages and commitments to be forged so that a supportive system of care could be developed at the community level to meet the diverse needs of the CMI. Although a variety of service delivery models and service configurations exist across Demonstration projects, services are generally provided on-site by facility staff. The full range of services needed to maintain the CMI in the community was not observed. In general, sponsors have not established linkages to services beyond the mental health services they themselves provide. It appears that the notion of linking the residential facility with a comprehensive range of health, mental health, and social services essential for transitioning clients into less restrictive living arrangements has not been emphasized.

Target Population(s) Served--Although the formal definition of the target **population** for the HUD/HHS Demonstration was broad by **design**, *Federal-level expectations have been and continue to be that the severely disabled would be served by Demonstration projects. The population(s) actually being served by the Demonstration projects vary dramatically from site to site in terms of severity of disability, history of previous hospitalization, age, and so on. In general, however, severely disabled CMI (i.e., those individuals-most in need and representing the "revolving door" population between hospital and community) are not **necessarily** being served through the Demonstration projects.

The Role Of State Mental Health Agencies In The HUD/HHS Demonstration Program--The intent of Federal HUD/HHS Demonstration Program managers and policymakers was that State Mental Health Agencies would assume a leadership, coordinative, and facilitative role in initiating, implementing, and maintaining ongoing operations of the Demonstration. Moreover, they were to arrange for or establish ongoing funding mechanisms for a full complement of services needed by the CMI. However, it appears that States have generally not assumed an active, integrative role in the Demonstration. Rather, their role, with few exceptions, has evolved into a reactive one of providing consultation and technical assistance in response to local sponsor requests and coordinating with selected agencies on an as-needed basis.

• Factors Currently Affecting Overall Demonstration Program Performance And Outcome--Several salient influencing factors were observed during the course of the exploratory evaluation that currently have an impact on the Demonstration. These factors include : (1) overall cutbacks in mental health funding, (2) growing restrictiveness of Supplemental Security Income and Social Security Disability Insurance, (3) community resistance, and (4) Medicaid home and community-based waivers. These variables could, when taken together, overshadow the results of the Demonstration itself. At best, they could prove to be uncontrollable factors in investigating the results of the Demonstration on a longer-term basis.

• Future Factors Likely To Influence Demonstration Program Performance And Outcome--Several important factors related to sources of funds for meeting operating costs for housing and ongoing costs of services and likely to have an impact on the Demonstration in the future were identified. Housing may be affected by fiscal year 1983 Federal budget proposals to abolish Section 8 existing and new construction rental assistance and institute a voucher system, as well as other proposals to reduce budgetary amounts for federally assisted housing programs. Services, on the other hand, may be affected by continuing cutbacks in Federal and State mental health service funding.

Offsetting Institutional Costs--One of the Demonstration objectives calls for determination of the cost-effectiveness or benefit of community-based housing linked with supportive services compared to institutionalization. Over time, however, the Federal government has become concerned with and interested in the effects of Federal expenditures under the Demonstration in offsetting of costs to the Federal government for other or historical services provided to clients served through the Demonstration. The Federal government will share in the cost of institutional care provided to Medicaid-eligibles served in hospitals, skilled nursing facilities (SNF), and institutional care facilities (ICF).

There are limitations, however, in cost-sharing arrangements in the instance of institutional care for the treatment of a mental disease. Federal financial participation (FFP) in expenditures for care and services under Medicaid is not available on behalf of patients in institutions for mental diseases (IMD) except for patients 65 and over and individuals 21 and under, at State option. However, because the Demonstration projects are generally not serving: (1) clients 21 and under and 65 and over, (2) clients either previously in or referred by general hospitals, and (3) individuals either previously in or referred from long-term care facilities, the residents so described could not have been supported in institutional settings by Medicaid funds. Consequently, there exists, through this Demonstration, little potential for the offset of Medicaid-reimbursed institutional costs.

Availability Of HUD/HHS Demonstration Program Performance And Outcome Data--In general, the quantity and quality of available Demonstration-specific data across States and projects were insufficient and inadequate. Field observations indicated that there is a decided lack of uniform and consistent data on Demonstration experiences and outcomes. Individually and collectively, with few exceptions, States are not currently collecting Demonstration-specific information, nor do they appear to have formulated plans to establish reporting requirements for Demonstration projects at the present time.

Further Measurement And Evaluation Of The HUD/HHS Demonstration Program--It was determined at the conclusion of the exploratory evaluation that further evaluation of the Demonstration would not be realistic or feasible at this point in time for a number of reasons:

Only a small percentage of the projects approved are currently completed or will be completed shortly. For those projects still engaged in HUD processing, there was a possible slowdown in HUD processing activities because of an anticipated change in HUD 202 policy. How many additional projects will become operational remains to be seen.

Sufficient evaluation of the Section 202 mechanisms was undertaken through this evaluation and by **USR&E**. Only four States at the time of the exploratory evaluation were providing services under the Section 1115 waiver mechanism, with a correspondingly low level of Medicaid expenditures.

There is a complicated and impressive array of external influences impinging on the Demonstration and a decided lack of uniform and/or consistent data on the Demonstration across States and projects.

Even though, for the reasons cited above, further evaluation may not be particularly realistic or feasible at this time, HHS/HCFA may desire more intensive evaluation in keeping with its policy of evaluating the Section 1115 waiver projects. Four options for such evaluation are available, each requiring different levels of effort: (1) case studies, (2) State-specific self-evaluation, (3) evaluation of the Demonstration experience across waiver-only States, and (4) evaluation of Demonstration experiences across all States. Two key barriers would have to be overcome irrespective of the option selected: (1) the lack of uniform target population or services definitions and (2) the lack of structured, &form, or consistent record-keeping and reporting processes in the field.

6. CONCLUSIONS

To date, the housing component of the Demonstration has not lived up to expectations in terms of anticipated increases in quality housing stock for the CMI and the Section 202 Program has proved to be slow and expensive. If projects serving the CMI are going to continue to be eligible for Section 202, as is indicated in the April 20, 1982, Federal Register ("Section 202 Loans for Housing for the Elderly or Handicapped; Announcement of Fund Availability, Fiscal Year 1982"), some changes to the application of Section 202 specifically for the CMI should be made, as follows :

HUD currently will not make any loan reservations for housing that is to be "*transitional" in nature. All but one project visited during the evaluation considered the project to be a stepping-stone for residents to more independent living. For Section 202 to be in concert with preferred methods of treating the CMI, HUD's policy should be changed to include transitional facilities. It should be noted that HUD is presently considering such a change.

The Demonstration has shown that construction and substantial rehabilitation are expensive and, by sponsors' own observations, could have been undertaken more economically through purchase and minimal rehabilitation of existing property. The "Announcement of Fund Availability" cited earlier indicates: "subject to issuance of regulations that are presently being developed, applications may also be accepted for loans for the acquisition with or without moderate rehabilitation of housing and related facilities for use as group homes for the nonelderly handicapped." It appears that, during fiscal year 1982, this will apply only to the mentally retarded. H o w e v e r , issues observed during the exploratory evaluation, it is essential that such applications also be accepted with respect to facilities for the CMI. This is also important in coordinating with HUD's "modest design and cost containment" objectives.

During this evaluation, many issues were raised by sponsors and State Mental Health Agencies regarding the nonapplicability of certain aspects of Section 202 regarding the CMI and agencies serving the CMI. One way to address this would be to enact waiver authority to allow for project-specific waivers of troublesome, nonapplicable requirements. As such, sponsors could apply for and be granted, at HUD Area Office discretion, specific waivers of requirements impeding project development and adding to project costs, as long as such waivers could still ensure the quality of the housing stock and safety to residents. Such waiver authority would require an act of Congress.

During the evaluation, some early issues also began to surface with respect to the applicability of Section 8 to the CMI. One such issue was the requirement to consider all residents of a single unit as a family, e.g., one lease, pooling of income and resources, and so on. Although it appears that HUD policy has been changed in this regard, it has been observed throughout the field experience of this evaluation that this change is not yet uniformly operational. Consequently, it appears that it may be necessary for HUD to issue additional guidance to the Field and Area Offices to ensure that the new policy is implemented uniformly in the field.

During the evaluation, State Mental Health Agencies underscored their growing financial constraints in attempting to maintain, let alone expand, community-based services for the CMI. The evaluation highlighted the underutilization of Section 1115 waiver funding of services. Given that the waivers are applied on a project-by-project basis as projects become operational and that some projects have taken almost three years to become operational, it is not surprising that more funds have not been expended to date under the waiver authority. Yet the Section 1115 waivers represent the only source of services financing for some States and projects. In this regard, it is essential that HCFA maintain its current policy of allowing Demonstration States the option of applying waivers to all remaining Demonstration projects as they become operational.

In a broader sense, with respect to new projects that may be approved by HUD under Section 202 or existing or newly operational Demonstration projects, HCFA should consider the applicability of Section 1915 waivers for home and community-based services as a specific mechanism for services financing. This is in keeping with the intent of such waivers because a number of States deinstitutionalized many CMI into nursing homes and a number of CMI in the community may be at risk of going into nursing homes. Clearly, there is a need for flexibility at the State level in the financing of supportive services for the CMI that are linked to housing specifically designed for them.

Finally, with the formal mainstreaming of the CMI into the Section 202 program, HUD Area Offices will perform paper reviews of project "service packages." In the conduct of such reviews, it is reasonable to consider applying the requirements of the service component of the Demonstration. In this regard,

it may be necessary for HHS to provide assistance to HUD in adapting Demonstration Program service guidelines into operational Area Office review criteria and functions. However, the evolution of the service component of the Demonstration and the learning from its experiences would seem to augur for its use. This would also be in keeping with allowing for flexibility at the sponsor level in conceiving and implementing appropriate services strategies in meeting project- and target population-specific service needs. Moreover, this approach would acknowledge that the mental health field is not yet ready to accept a single approach to meeting the services needs of the CMI in the community.

Even though almost four years have passed since the start of the Demonstration, the lengthy processing times involved mean that the Demonstration is still in its operational infancy. As such, it is still too early to tell the effects of the Demonstration on the CMI or the viability of the Section 1115 services financing mechanism. However, the current evaluation has been useful in determining the overall effects of the Demonstration on increasing the housing stock for the CMI and how the housing financing mechanisms at the Federal level might be modified to expedite the process in both the near and long terms.

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

This report documents the background, methodology, and results of an exploratory evaluation conducted by Macro Systems, Inc., under contract with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the Department of Health and Human Services (HHS). The study was designed specifically to determine Federal intent and expectations for the HUD/HHS Demonstration Program for the Chronically Mentally Ill, to document and describe current Demonstration field operations, to identify relevant issues, and to develop appropriate options for future, more intensive evaluation of the Demonstration. The study was initiated in October 1981 and was completed in April 1982.

1. OVERVIEW OF THE HUD/HHS DEMONSTRATION PROGRAM

The HUD/HHS Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill was launched in 1978 and continued through 1980. The announcement of this initiative at the White House marked the culmination of an unprecedented process of joint planning and interagency collaboration, among the Departments of Housing and Urban Development (HUD) and Health and Human Services (then the Department of Health, Education, and Welfare, HEW), largely in response to the recommendations of the General Accounting Office (GAO) Report of 1977^{1/} and the 1978 Report of the President's Commission on Mental Health (PCMH).^{2/}

The design of the HUD/HHS Demonstration Program incorporated key themes and was consistent with the overall thrust of a number of earlier and concurrent Federal policies and initiatives directed at alleviating the problems encountered by deinstitutionalized mentally ill individuals in the community. In addition to the GAO and PCMH reports, these initiatives and policies included: (1) the Community Mental Health Centers (CMHC) Act, as amended in 1975; (2) the National Institute of Mental Health (NIMH) Community Support Program; (3) HUD's Ad Hoc Committee on the Handicapped and the Office of Independent Living for the Disabled; (4) the Housing and Community Development Amendments of 1978--Conference Report; (5) the Mental Health Systems Act of 1980;

^{1/} General Accounting Office. Returning the Mentally Disabled to the Community: Government Needs to Do More. (HRD-76-152), Washington, D.C., 1977.

^{2/} The President's Commission on Mental Health. Report to the President from the President's Commission on Mental Health. (Vol. 1), Washington, D.C., Government Printing Office, 1978.

(6) the National Plan for the Chronically Mentally Ill; and (7) the (White House) Independent. Living Initiative. Thus, the Program sought to demonstrate that community-based housing linked with supportive services for the mentally ill could be provided and coordinated by States in a cost-effective and efficient manner.

The Demonstration design involved a commitment by each of the participating Departments of the following resources: HUD provided funds for housing development through the Section 202 Direct Loan Program and for rental subsidies for housing units through the Section 8 Program; HHS allowed for certain Medicaid regulations to be temporarily waived, at State option, through Section 1115 of the Social Security Act. These three financing mechanisms formed the basic framework of the Demonstration Program.

Specifically, Demonstration projects were expected to serve a broadly defined population of adult chronically mentally ill (CMI) individuals through the construction or rehabilitation of either group homes or independent living apartments, linked to a range of supportive services. Program guidelines were articulated so as to afford States and local sponsors much flexibility and discretion in (1) defining the population to be served, (2) determining the types of housing alternatives to provide, and (3) determining the extent and nature of services to be delivered to Demonstration clients.

Participation of States and sponsors in the Demonstration was competitive and contingent upon initial review and selection by HUD and HHS. Between 1978 and 1980, in three rounds of application, 201 sponsors were selected in 38 States across the nation, and 1,867 units were approved for construction or substantial rehabilitation. A total of \$65 million in Section 202 Direct Loan Program loan authorities was reserved and \$13 million in Section 8 rents subsidies was set aside for these Demonstration sponsors. In 1980, following the third and final round of project approval for the Demonstration, it was estimated that, if all approved housing units became operational, between \$20 million and \$30 million in Medicaid funds under the Section 1115 waiver may be expended for supportive services. Exhibit A, following this page, shows the funding levels and corresponding number of units approved in each year of the Demonstration for States and local sponsors.

Another key feature of the Demonstration Program design was an evaluation component intended to be completed over a five-year period. As such, initial evaluation efforts involved a HUD contract with Urban Systems, Research, and Engineering, Inc. (USR&E), to perform an intensive evaluation of the early experiences of Phase I of the Demonstration from the perspective of HUD Central and Area, State, and local levels. In addition, USR&E was requested to develop an evaluation design for future, intensive assessment of Demonstration experiences and results. Focusing on the early experiences of HUD Central and Area Offices, 10 of 13 Demonstration States, and 31 local sponsors approved in 1978, USR&E evaluated and documented housing production problems, administrative design limitations, and Demonstration accomplishments. In addition, USR&E submitted a longitudinal experimental cost-benefit evaluation design to measure the long-term impact of the Demonstration.

EXHIBIT A

HHS, Office of the Assistant Secretary
for Planning and Evaluation

OVERALL DEMONSTRATION PROGRAM CHARACTERISTICS

	<u>Section 202 Loan Reserves</u>	<u>Section 8 Rental Subsidies Set-Asides</u>	<u>Total States Approved</u>	<u>Total Sponsors Approved</u>	<u>Total Units Approved</u>
1978	\$15 million	\$ 3 million	13	58	479
1979	\$25 million	\$ 5 million	27*	77	730
1980	<u>\$25 million</u>	<u>\$ 5 million</u>	<u>31"</u>	<u>66</u>	<u>658</u>
	\$65 million	\$13 million	38**	201	1,867

* Duplicated Count

** Unduplicated Count

2. THE EXPLORATORY EVALUATION OF THE HUD/HHS DEMONSTRATION PROGRAM

By late 1981, it was estimated that 31 projects with a total of 273 units were operational in 15 States and that 26 projects were under construction. Five States were approved for Section 1115 waivers to reimburse for supportive services provided to Demonstration clients. Given this small number of operational projects with only a few operational in waiver-only States, and the great variability that appears to exist among project models developed, the cost-benefit study design developed by USR&E was deemed to be too ambitious in scope and content. As such, this evaluation was not undertaken as planned. Instead, a less intensive and more qualitative six-month exploratory evaluation of the HUD/HSS Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill was conceived and initiated in October 1981. The study was conducted in close collaboration with representatives from HUD and HHS.

The purpose of the exploratory evaluation was to determine:

- . The expectations and objectives of Federal program managers and policymakers at each level of management for the HUD/HHS Demonstration Program
- . An accurate description of what currently is occurring in selected Demonstration States and sites
- . A comparison of the actual activities being performed at State and local levels with the expectations of Federal program managers and policymakers
- . Relevant policy and management issues for consideration by program managers and policymakers
- . The appropriateness of more intensive evaluation of the Demonstration given current program conditions and to develop evaluation options accordingly

Specifically, the exploratory evaluation was divided into three broad tasks:

Task 1--Documenting The Intended Program--The first exploratory evaluation task involved the delineation of the objectives and expectations of program managers and policymakers at each level of management for the HUD/HHS Demonstration Program. Specifically, this task involved the explication of program objectives, activities necessary to attain the objectives, and indicators of program success. Models describing the logic and activities of the intended HUD/HHS Demonstration were constructed.

Task 2--Documenting Actual Program Activities And Results--The purpose of this task was to describe the HUD/HHS Demonstration Program as it actually operates. In addition, this task involved the description of the types of project activities underway and

the objectives sought and accomplishments attained at State and local levels. As such, this task served as a check on the reality of the models developed in Task 1.

Task 3--Analysis And Synthesis Of Information And Findings And Identification Of Relevant Policy And Management Issues--This task involved the analysis and synthesis of information obtained in Tasks 1 and 2 to identify policy and management issues and/or problems. In addition, based on the analysis and issues, the appropriateness of a more in-depth evaluation of the Demonstration Program was determined and specific options for future evaluation of the Program were developed.

3. THE INTENDED OBJECTIVES OF THE HUD/HHS DEMONSTRATION PROGRAM

The HUD/HHS Demonstration Program was designed by Federal program managers and policymakers to attain certain intermediate and longer-range housing-, services-, and target population-specific objectives. These objectives, or intended results of the Demonstration, are sequential in nature and indicate that, although certain objectives are the ultimate aims of the Demonstration, more immediate results are also sought. As intended, both intermediate and longer-range objectives could be attained simultaneously. However, the intermediate objectives were viewed as precursors to longer-range ones. Ten such objectives were identified during the exploratory evaluation :

Intermediate Demonstration Program Objectives

- To construct or substantially rehabilitate permanent, community-based residential housing linked to supportive services appropriate to the needs of the CMI
- To reinforce and expand the existing capability of States and localities in meeting the specialized housing and service needs of the CMI
- To integrate the CMI into the community, to normalize their lives, and to enhance their independence and functioning
- To complement and enhance ongoing State and Federal deinstitutionalization efforts
- To determine the viability of the 202 Program as a mechanism for providing housing for the CMI
- To determine the viability of the Medicaid Program as a funding mechanism for supportive services through the application of Section 1115 waivers

Longer-Range Demonstration Program Objectives

To improve the quality of life of the CMI served by the Demonstration

To determine the cost-effectiveness or benefit of community-based housing linked with supportive services, compared to institutionalization

To establish financing mechanisms for community-based housing and supportive services that are appropriate to the needs of the CMI

To improve the quality of life of the CMI as a whole

These objectives together form the basis for what the Demonstration was intended to accomplish.

4. ACCOMPLISHMENTS OF THE HUD/HHS DEMONSTRATION PROGRAM TO DATE

As of the time of this exploratory evaluation and four years after initiation of the Demonstration, 327 of the total of 1,867 approved units, or 18 percent, were operational. These units have a capacity to house 390 individuals, and they represent 32 projects, or 16 percent of the total number of projects for which Section 202 loan reservations were made. In the 16 States in which these 32 operational projects are located, 17 percent of the remaining approved projects were under construction, 37 percent are still in the Section 202 processing pipeline, and 17 percent were cancelled. Thus, if all those projects under construction or still in HUD processing are completed, 83 percent of the 201 projects for which Section 202 funds were reserved under the Demonstration will have become operational. Exhibit B, following this page, presents in detail Demonstration accomplishments in the 16 States studied during the exploratory evaluation. Based upon the sample of 9 projects visited during the conduct of this study, each facility took approximately 30 months to complete, from the time of loan reservation to actual occupancy by residents. Each project required, on the average, \$234,096 in Section 202 funds for construction or substantial rehabilitation, inclusive of all costs for acquisition, design, and so on.

Services rendered residents of the nine operational projects visited are generally restricted to those provided by project staff and include supervision, case management, and training in activities of daily living. In addition, limited mental health services, such as day treatment and medication, are made available to residents by sponsor organizations. As such, a full range of services necessary to meet the needs of residents of Demonstration projects is not available. By and large, Medicaid funds made available under the Section 1115 waiver in five waiver-only States are not being used to the extent anticipated to support service delivery. In all instances, Medicaid funds under the waiver are being used as financial support for staff working in operational projects and not for specific services per se. That is, projects are being reimbursed on a per-diem basis for Medicaid-eligible clients and not for individual services rendered such clients.

EXHIBIT B

HHS, Office of the Assistant Secretary for Planning and Evaluation

DEMONSTRATION ACCOMPLISHMENTS IN SIXTEEN STATES

STATE	PLANNED					ACCOMPLISHW															Current Capacity	Current Occupancy
	No. of Approved Projects				Total No. of Units Approved	Total Fund Reservation	Cancelled		202 Processing		Project Status		Operational		Total Units	Units Completed						
	78	79	80	Total			N	%	N	%	N	%	N	%		N	% 1/	N	% 2/	N		
Colorado	7		3	10	84	2,702,800	3	30	--	--	1	10	6	60	65	77	22	33	43	66	65	65
D. C.	--	4	1	5	52	1,798,300	1	20	1	20	2	40	1	20	9	17	5	55	4	44	18	10
Georgia	4	2	1	7	87	2,768,200	--	--	2	29	1	14	4	57	44	so	24	54	20	45	54	18
Massachusetts	9	2	3	14	111	4,357,640	2	14	5	36	2	14	5	36	46	41	46	100	--	--	46	46
Minnesota	3	--	--	3	24	852,274	--	--	--	--	1	33	2	67	20	83	--	--	20	100	33	33
Oregon	5	--	--	5	43	1,289,100	3	60	--	--	--	--	2	40	16	37	16	100	--	--	20	20
Pennsylvania	3	3	4	10	91	3,406,125	1	10	6	60	1	10	2	20	16	18	--	--	16	100	28	27
Tennessee	--	3	1	4	49	1,824,600	--	--	--	--	3	75	1	25	8	16	8	100	--	--	8	7
Vermont	6	4		10	60	2,082,019	2	20	5	50	3	30	0	0	(20) ^{3/}	33	12	60	8	40	(20) ^{3/}	--
Subtotal	37	18	13	68	601	21,081,058	12	18	19	28	14	20	23	33	244	40	133	54	111	45	292	226
STATES NOT VISITED																						
California	--	5	4	9	93	3,739,900	--	--	8	88	--	--	1	11	10	11	--	--	10	100	10	NA
Florida	6	--	2	8	61	1,693,881	6	75	1	12	--	--	1	12	6	10	6	100	--	--	12	NA
Illinois	--	5	4	9	91	3,566,442	--	--	5	55	3	33	1	11	11	12	11	100	--	--	11	NA
North Carolina	--	3	--	3	23	759,300	--	--	2	66	--	--	1	33	4	17	4	100	--	--	8	NA
Rhode Island	4	--	1	5	38	1,609,000	--	--	2	40	2	40	1	20	7	18	7	100	--	--	9	NA
Utah	--	1	1	2	23	732,900	1	so	--	--	--	--	1	so	21	91	--	--	21	100	21	NA
Wisconsin	--	4	3	7	60	2,320,200	--	--	4	57	--	--	3	42	24	40	8	33	16	66	27	NA
Subtotal	10	18	15	43	389	14,421,623	7	16	22	51	5	11	9	21	83	21	36	43	47	57	98	NA
GRAND TOTAL	47	36	28	111	990	35,502,681	19	17	41	37	19	17	32	29	327	33	169	52	158	48	390	

1/ Percent of total number of units approved.
 2/ Percent of units completed.
 3/ Units due to become operational in January 1982.

5. KEY FINDINGS EMERGING FROM THE EXPLORATORY EVALUATION

In comparison to other demonstrations, the HUD/HHS Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill has been unique in the following ways:

It is a demonstration within a demonstration in that the Section 1115 demonstration initiative is a component of a broader demonstration of community-based housing linked with supportive services.

It has sought to bring together three existing programs: HUD's Section 202 Program to defer construction or substantial rehabilitation costs of housing; HUD's Section 8 Program to subsidize resident rents and to assure sponsors' ability to meet mortgage commitments made under Section 202; and, at State option, HHS' Section 1115 waivers to Medicaid to defer the costs of delivery of needed services to residents.

The interagency nature of the Demonstration design is highlighted by the multiple funding source possibilities and the participation of HUD, HHS/ASPE, the Health Care Financing Administration (HCFA), and NIMH.

The guidance material forming the principal basis for the Demonstration was intentionally broad with respect to the target population to be served and the services to be provided, allowing States and local sponsors maximum flexibility in planning and implementing the concept of housing linked with services.

It predated the current shift in the locus of responsibility for administration of Federal mental health service funds (through block grants) from the local to the State level and, therefore, serves as an early illustration of State-level response and oversight.

Accordingly, several key issues emerged during the exploratory evaluation that are relevant to the program design and for continued State and local efforts in providing community-based housing and services for the chronically mentally ill. Ten separate issues were identified:

Impact Of The HUD/HHS Demonstration Program Across States And Projects--Although Demonstration accomplishments to date have fallen short of Federal expectations, they are significant nonetheless. In several States, the Demonstration embodied the only State-supported initiative to develop residential programs. In many of the communities in which Demonstration projects have become operational, quality housing and appropriate support services were previously unavailable. The Demonstration provided an excellent opportunity for States and local providers to respond, even if on a small scale, to the critical need for

community-based housing and services for the chronically mentally ill. In addition, the Demonstration Program has been successful in stimulating important relationships among housing and service providers in enhancing the awareness of key participants and, in some cases, serving as an impetus for related spin-off initiatives and key policy changes at the Federal, State, and local levels regarding housing for the chronically mentally ill.

Appropriateness Of The Section 202 Program As A Mechanism For Attaining Demonstration Housing-Related Objectives--Only a small proportion of the total number of projects and units approved by HUD in the three years of the Demonstration have actually become operational. Numerous reasons can be cited as to why production of Demonstration projects has been so slow. Most notable, however, have been the problems of adapting the Section 202 Program, which was designed for large-scale housing complexes to small, scattered-site housing projects. As presently constituted, the 202 mechanism has been extremely burdensome, complex, and costly. Field experiences indicated that the Section 202 Program, designed as it is for large-scale housing developments, does not appear to be well suited to attaining Demonstration housing objectives that are dependent on the construction or substantial rehabilitation of small group home or independent living apartment projects.

Community-Based Housing Linked With Services--The intent of the HUD/HHS Demonstration Program was for community-based housing to be linked with services and for strong service linkages and commitments to be forged so that a supportive system of care could be developed at the community level to meet the diverse needs of the CMI. Although a variety of service delivery models and service configurations exist across Demonstration projects, services are generally provided on-site by facility staff. The full range of services needed to maintain the CMI in the community was not observed. In general, sponsors have not established linkages to services beyond the mental health services they themselves provide. It appears that the notion of linking the residential facility with a comprehensive range of health, mental health, and social services essential for transitioning clients into less restrictive living arrangements has not been emphasized.

Target Population(s) Served--Although the formal definition of the target population for the HUD/HHS Demonstration was broad by design, -Federal-level expectations have been and continue to be that the severely disabled would be served by Demonstration projects. The population(s) actually being served by the Demonstration projects vary dramatically from site to site in terms of severity of disability, history of previous hospitalization, age, and so on. In general, however, severely disabled CMI (i. e., those individuals most in need and representing the "revolving door" population between hospital and community) are not necessarily being served through the Demonstration projects.

The Role Of State Mental Health Agencies In The HUD/HHS Demonstration Program--The intent of Federal HUD/HHS Demonstration Program managers and policymakers was that State Mental Health Agencies would assume a leadership, coordinative, and facilitative role in initiating, implementing, and maintaining ongoing operations of the Demonstration. Moreover, they were to arrange for or establish ongoing funding mechanisms for a full complement of services needed by the CMI. However, it appears that States have generally not assumed an active, integrative role in the Demonstration. Rather, their role, with few exceptions, has evolved into a reactive one of providing consultation and technical assistance in response to local sponsor requests and coordinating with selected agencies on an as-needed basis.

Factors Currently Affecting Overall Demonstration Program Performance And Outcome--Several salient influencing factors were observed during the course of the exploratory evaluation that currently have an impact on the Demonstration. These factors include : (1) overall cutbacks in mental health funding, (2) growing restrictiveness of Supplemental Security Income and Social Security Disability Insurance, (3) community resistance, and (4) Medicaid home and community-based waivers. These variables could, when taken together, overshadow the results of the Demonstration itself. At best, they could prove to be uncontrollable factors in investigating the results of the Demonstration on a longer-term basis.

Future Factors Likely To Influence Demonstration Program Performance And Outcome--Several important factors related to sources of funds for meeting operating costs for housing and ongoing costs of services and likely to have an impact on the Demonstration in the future were identified. Housing may be affected by fiscal year 1983 Federal budget proposals to abolish Section 8 existing and new construction rental assistance and institute a voucher system, as well as other proposals to reduce budgetary amounts for federally assisted housing programs. Services, on the other hand, may be affected by continuing cutbacks in Federal and State mental health service funding.

Offsetting Institutional Costs--One of the Demonstration objectives calls for determination of the cost-effectiveness or benefit of community-based housing linked with supportive services compared to institutionalization. Over time, however, the Federal government has become concerned with and interested in the effects of Federal expenditures under the Demonstration in offsetting of costs to the Federal government for other or historical services provided to clients served through the Demonstration. The Federal government will share in the cost of institutional care provided to Medicaid-eligibles served in hospitals, skilled nursing facilities (SNF), and institutional care facilities (ICF).

There are limitations, however, in cost-sharing arrangements in the instance of institutional care for the treatment of a mental disease. Federal financial participation (FFP) in expenditures for care and services under Medicaid is not available on behalf of patients in institutions for mental diseases (IMD) except for patients 65 and over and individuals 21 and under, at State option. However, because the Demonstration projects are generally not serving: (1) clients 21 and under and 65 and over, (2) clients either previously in or referred by general hospitals, and (3) individuals either previously in or referred from long-term care facilities, the residents so described could not have been supported in institutional settings by Medicaid funds. Consequently, there exists, through this Demonstration, little potential for the offset of Medicaid-reimbursed institutional costs.

Availability Of HUD/HHS Demonstration Program Performance And Outcome Data--In general, the quantity and quality of available Demonstration-specific data across States and projects were insufficient and inadequate. Field observations indicated that there is a decided lack of uniform and consistent data on Demonstration experiences and outcomes. Individually and collectively, with few exceptions, States are not currently collecting Demonstration-specific information, nor do they appear to have formulated plans to establish reporting requirements for Demonstration projects at the present time.

Further Measurement And Evaluation Of The HUD/HHS Demonstration Program--It was determined at the conclusion of the exploratory evaluation that further evaluation of the Demonstration would not be realistic or feasible at this point in time for a number of reasons:

Only a small percentage of the projects approved are currently completed or will be completed shortly. For those projects still engaged in HUD processing, there was a possible slowdown in HUD processing activities because of an anticipated change in HUD 202 policy. How many additional projects will become operational remains to be seen.

Sufficient evaluation of the Section 202 mechanisms was undertaken through this evaluation and by USR&E. Only four States at the time of the exploratory evaluation were providing services under the Section 1115 waiver mechanism, with a correspondingly low level of Medicaid expenditures.

There is a complicated and impressive array of external influences impinging on the Demonstration and a decided lack of uniform and/or consistent data on the Demonstration across States and projects.

Even though, for the reasons cited above, further evaluation may not be particularly realistic or feasible at this time, HHS/HCFA may desire more intensive evaluation in keeping with its policy of evaluating the Section 1115 waiver projects. Four options for such evaluation are available, each requiring different levels of effort: (1) case studies, (2) State-specific self-evaluation, (3) evaluation of the Demonstration experience across waiver-only States, and (4) evaluation of Demonstration experiences across all States. Two key barriers would have to be overcome irrespective of the option selected: (1) the lack of uniform target population or services definitions and (2) the lack of structured, uniform, or consistent record-keeping and reporting processes in the field.

6. CONCLUSIONS

To date, the housing component of the Demonstration has not lived up to expectations in terms of anticipated increases in quality housing stock for the CMI and the Section 202 Program has proved to be slow and expensive. If projects serving the CMI are going to continue to be eligible for Section 202, as is indicated in the April 20, 1982, Federal Register ("Section 202 Loans for Housing for the Elderly or Handicapped; Announcement of Fund Availability, Fiscal Year 1982"), some changes to the application of Section 202 specifically for the CMI should be made, as follows :

HUD currently will not make any loan reservations for housing that is to be "transitional" in nature. All but one project visited during the evaluation considered the project to be a stepping-stone for residents to more independent living. For Section 202 to be in concert with preferred methods of treating the CMI, HUD's policy should be changed to include transitional facilities. It should be noted that HUD is presently considering such a change.

The Demonstration has shown that construction and substantial rehabilitation are expensive and, by sponsors' own observations, could have been undertaken more economically through purchase and minimal rehabilitation of existing property. The "Announcement of Fund Availability" cited earlier indicates: "subject to issuance of regulations that are presently being developed, applications may also be accepted for loans for the acquisition with or without moderate rehabilitation of housing and related facilities for use as group homes for the nonelderly handicapped. " It appears that, during fiscal year 1982, this will apply only to the mentally retarded. However, to overcome the time and cost issues observed during the exploratory evaluation, it is essential that such applications also be accepted with respect to facilities for the CMI. This is also important in coordinating with HUD's "modest design and cost containment" objectives.

During this evaluation, many issues were raised by sponsors and State Mental Health Agencies regarding the nonapplicability of certain aspects of Section 202 regarding the CMI and agencies serving the CMI. One way to address this would be to enact waiver authority to allow for project-specific waivers of troublesome, nonapplicable requirements. As such, sponsors could apply for and be granted, at HUD Area Office discretion, specific waivers of requirements impeding project development and adding to project costs, as long as such waivers could still ensure the quality of the housing stock and safety to residents. Such waiver authority would require an act of Congress.

During the evaluation, some early issues also began to surface with respect to the applicability of Section 8 to the CMI. One such issue was the requirement to consider all residents of a single unit as a family, e.g., one lease, pooling of income and resources, and so on. Although it appears that HUD policy has been changed in this regard, it has been observed throughout the field experience of this evaluation that this change is not yet uniformly operational. Consequently, it appears that it may be necessary for HUD to issue additional guidance to the Field and Area Offices to ensure that the new policy is implemented uniformly in the field.

During the evaluation, State Mental Health Agencies underscored their growing financial constraints in attempting to maintain, let alone expand, community-based services for the CMI. The evaluation highlighted the underutilization of Section 1115 waiver funding of services. Given that the waivers are applied on a project-by-project basis as projects become operational and that some projects have taken almost three years to become operational, it is not surprising that more funds have not been expended to date under the waiver authority. Yet the Section 1115 waivers represent the only source of services financing for some States and projects. In this regard, it is essential that HCFA maintain its current policy of allowing Demonstration States the option of applying waivers to all remaining Demonstration projects as they become operational.

In a broader sense, with respect to new projects that may be approved by HUD under Section 202 or existing or newly operational Demonstration projects, HCFA should consider the applicability of Section 1915 waivers for home and community-based services as a specific mechanism for services financing. This is in keeping with the intent of such waivers because a number of States deinstitutionalized many CMI into nursing homes and a number of CMI in the community may be at risk of going into nursing homes. Clearly, there is a need for flexibility at the State level in the financing of supportive services for the CMI that are linked to housing specifically designed for them.

Finally, with the formal mainstreaming of the CMI into the Section 202 program, HUD Area Offices will perform paper reviews of project "service packages." In the conduct of such reviews, it is reasonable to consider applying the requirements of the service component of the Demonstration. In this regard,

it may be necessary for HHS to provide assistance to HUD in adapting Demonstration Program service guidelines into operational Area Office review criteria and functions. However, the evolution of the service component of the Demonstration and the learning from its experiences would seem to augur for its use. This would also be in keeping with allowing for flexibility at the sponsor level in conceiving and implementing appropriate services strategies in meeting project- and target population-specific service needs. Moreover, this approach would acknowledge that the mental health field is not yet ready to accept a single approach to meeting the services needs of the CMI in the community.

Even though almost four years have passed since the start of the Demonstration, the lengthy processing times involved mean that the Demonstration is still in its operational infancy. As such, it is still too early to tell the effects of the Demonstration on the CMI or the viability of the Section 1115 services financing mechanism. However, the current evaluation has been useful in determining the overall effects of the Demonstration- on increasing the housing stock for the CMI and how the housing financing mechanisms at the Federal level might be modified to expedite the process in both the near and long terms.

I. BACKGROUND AND OVERVIEW OF THE HUD/HHS DEMONSTRATION PROGRAM AND THE EXPLORATORY EVALUATION APPROACH

I. BACKGROUND AND OVERVIEW OF THE HUD/HHS DEMONSTRATION PROGRAM AND THE EXPLORATORY EVALUATION APPROACH

To fully understand the results and conclusions of this exploratory evaluation, it is important to recognize and appreciate the background and nature of the HUD/HHS Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill as well as the purposes of the exploratory evaluation. Accordingly, this chapter is organized as follows:

Historical Antecedents of the HUD/HHS Demonstration Program

Overview of the HUD/HHS Demonstration Program

The Exploratory Evaluation of the HUD/HHS Demonstration Program

1. HISTORICAL ANTECEDENTS OF THE HUD/HHS DEMONSTRATION PROGRAM

Historically, the mentally disabled in the United States have been a highly vulnerable and poorly understood group. This population has generally been neglected by the existing mental health service delivery system and excluded from mainstream society. More recently, the mentally ill have been central to a variety of efforts to reform mental health treatment approaches and services. Whereas reform efforts in the 1950s and early 1960s emphasized conditions in large, crowded, and isolated mental hospitals, attention in the mid-1960s and 1970s shifted to the problems connected with deinstitutionalization and community placement of this population. Government studies, media and consumer exposes, and professional criticism have reflected growing public concern about the problems brought about by deinstitutionalization and the need for more comprehensive and responsive community-based care for the chronically mentally ill (CMI). A number of related problems that continue to impede the development and provision of effective community-based services have also been identified. Because considerable literature exists on the recent history and evolution of mental health

services in the U.S., this section will not recapitulate the many and varied issues involved. Rather, it highlights selected features, relevant topics, and pertinent trends that bear on deinstitutionalization, the availability of community-based services, and the general plight of the CMI in the community.

(1) Deinstitutionalization Of The Chronically Mentally Ill

Deinstitutionalization, the movement of patients from State mental hospitals to community settings, has been a formal national policy and a political goal since 1963.^{1/} Deinstitutionalization was and still is a highly controversial process that is enmeshed in complex philosophical, political, and economic issues. Its actualization is evidenced by the dramatic decrease in State mental hospital population across States since the mid-1950s. The census of State hospitals declined from a high of 559,000 in 1955 to 504,000 by 1963, 215,500 by 1974, and 146,000 by 1979. Yet, while the census was decreasing, admissions to State institutions were increasing sharply from 178,000 in 1955 to a high of 390,000 in 1972.^{2/} Readmissions accounted for a large proportion of such admissions-- in 1969, 47 percent of those entering public mental health hospitals had received treatment in such facilities before. By 1972, this proportion increased to 64 percent. Fifty percent of patients discharged in 1972 were readmitted within one year of their release.^{3/}

The recurrent readmission of the CMI has been commonly labeled the "revolving door phenomenon." Close examinations of this phenomenon have basically concluded that the lack of appropriate and effective community-based

^{1/} Rose, S. M. "Deciphering Deinstitutionalization: Complexities in Policy and Program Analysis," Milbank Memorial Fund/Quarterly/Health and Society, 57 (4), 1979.

^{2/} U.S. Government Accounting Office. Returning the Mentally Disabled to the Community: Government Needs to Do More, January 1977.

^{3/} Bassuk, E. L. and Gerson, S. "Deinstitutionalization and Mental Health Services," Scientific American, 238(2), February 1978.

services contributes significantly to the problem. Thus, despite dramatic hospital census reductions over the past two decades, deinstitutionalization remains extremely problematic for all involved--clients, service providers, communities, States, and the Federal government.

(2) The Chronically Mentally Ill In The Community

It is generally accepted by service providers and policymakers at all levels that many mentally disabled persons have been released from State institutions to unprepared communities ; most communities and States have inadequately planned for the development and provision of appropriate community-based residential arrangements and services for discharged CMI .

To stop the revolving door phenomenon requires that the CMI have access to a wide range of health, mental health, social, residential, and support services provided in the community by numerous agencies. In many communities across the country, however, these needed services and housing opportunities are entirely lacking. When available, services tend to be incompatible, insufficient, fragmented, and not specifically designed to meet the unique needs of the CMI. In sum, neither the quality nor the quantity of available services is sufficient, and the need for adequate residential alternatives with linkages to appropriate support services continues to be the most critical gap in the service delivery system. Accordingly, the CMI, rather than residing in normalized, least restrictive living arrangements, are more often than not housed in squalid conditions in segregated facilities or "mini-institutions," notably nursing homes, board and care facilities, and single room occupancy (SRO) hotels.

"Dumping" of patients into unsympathetic, often hostile communities persists despite more than 20 years of deinstitutionalization experience. Clearly, although long- term institutionalization has become less frequent, corresponding efforts to develop and expand community-based services, residential alternatives, and support systems have not kept pace with the need.

(3) Federal Initiatives And Policies Directed At The Chronically Mentally
III

Within the last decade, there has been a growing consensus at both the State and Federal levels that increased, directed attention be focused on the unique needs of the CMI and the problems they encounter in their efforts to assimilate into the community. The lack of consistent policies explicitly addressing the roles and responsibilities of Federal, State, and local governments in planning, funding, coordinating, implementing, and monitoring a coherent system of care for the CMI was documented and provided the impetus for the development of a number of key Federal initiatives and policies in the mid to late 1970s. Each of these is briefly described below.

The Community Mental Health Centers (CMHC) Act, As Amended In 1975--The CMHC legislation enacted in 1963 (Public Law 88-164), outlined a community-based mental health service delivery model that consisted of a comprehensive array of services. Its intent was to make services available and accessible to all citizens and to emphasize the following: (1) minimization of long and costly hospitalization, (2) early identification of mental disorders, and (3) initiation of preventive measures to reduce the incidence of mental disability. CMHCs were designed not only as alternatives to institutional care but also as facilities for the treatment of individuals who were at risk or not in need of institutionalization. The 1975 Amendments to the Act (Public Law 94-63) authorized, among numerous changes, the establishment of three new and essential services to be provided by CMHCs to address the needs of the chronically mentally ill--specifically, aftercare, screening, and community living programs. These amendments served to strengthen the requirements for a CMHC role in the deinstitutionalization process. In so doing, the legislation attempted to target needed services to a particular priority population. Additionally, the amendments called not only for increased coordination between State hospitals and CMHCs but also for a partnership among Federal, State, and local authorities in assuming leadership in dealing with the problems of deinstitutionalization and the development of an integrated system of mental health care.

The General Accounting Office (GAO) Report of 1977, "Returning The Mentally Disabled To The Community: Government Needs To Do More"--This major national policy study examined the effects of deinstitutionalization on mentally disabled individuals. It noted the lack of a planned, coordinated, and systematic approach to meeting the needs of the mentally ill in the

community and the deplorable living conditions in which they find themselves. In addition, the study documented some basic inadequacies in the delivery of community-based care, including: (1) fragmentation and confusion of responsibility among Federal, State, and local agencies whose programs have an impact on the delivery of services to the CMI; (2) fragmentation of responsibility across levels of government and among many health, mental health, and other human services for accessing, planning, implementing, and evaluating programs and services for the CMI; (3) lack of a systematic approach to financing community-based services and the absence of reimbursement mechanisms for nontraditional support services ; and (4) lack of advocacy efforts on behalf of the CMI for promoting necessary advances in services, resources, and opportunities. In short, the GAO called for better management of Federal programs, with clearly defined responsibilities and accountability. It highlighted the belief that Federal programs should have a greater impact on the deinstitutionalization process.

The National Institute Of Mental Health (NIMH) Community Support Program (CSP)--Largely in response to the GAO Report, the Community Support Program was established by NIMH in late 1977 as a pilot demonstration program to stimulate States to develop community support systems (CSSs) for CMI adults who are capable of living in the community. The initiation of CSP pointed to a Federal policy shift from a broad approach to the delivery of community mental health services to a more targeted focus of programmatic efforts on the deinstitutionalized CMI population. The CSP embraced the concepts of coordination and integration of service delivery organizations at all levels through the development of comprehensive systems of care--Community Support Systems for chronically mentally ill adults. Moreover, the CSP acknowledged the need for leadership and a focal point of responsibility for the CMI at Federal, State, and local levels in order to develop effective service delivery systems. Accordingly, CSP explicated essential roles as follows: (1) the NIMH in providing a national focus and fostering Federal interagency collaboration; (2) the State in providing leadership in promoting the development of CSS statewide; (3) designated local agencies in assuming responsibility for accessing, integrating, and coordinating the 10 components of a CSS (including housing); and (4) individual providers/case managers in accessing, arranging, and providing needed services at the client level. The CSP pilot sought to accomplish a number of significant and complex objectives. Specific objectives related to changes at a "systems" level and long-range objectives calling for broad changes in the nature and organization of the service delivery system to improve the life of the CMI in the community. Initially, CSP contracted with 20 States. By 1980, as it entered its fourth year of operation, the program was supporting 17 States through a grant mechanism. At this writing, CSP program managers are anticipating awarding CSP grants to an additional 22 States in fiscal year 1982.

HUD Ad Hoc Committee On The Handicapped And The Office Of Independent Living For The Disabled--The GAO Report stated emphatically that inadequate housing was "a critical obstacle to returning the mentally disabled to the community." It pointed out HUD's failure to develop a plan or strategy for informing local housing authorities, managers, and sponsors of HUD-supported programs that may be applicable to meeting the needs of the mentally disabled. Moreover, the Report documented the absence of substantive action on the part of HUD offices to assist in deinstitutionalization. It called for greater responsiveness in HUD programs to the needs of the mentally disabled. In 1977, in response to these concerns, HUD established an Ad Hoc Committee on the Handicapped. Later on that year, the Office of Independent Living for the Disabled (OILD) was created. The Office was congressionally mandated to address housing issues related to the handicapped and disabled specifically.

The Report Of The President's Commission On Mental Health (PCMH), 1978--Although its mission was broad, review of the mental health needs of the Nation, the PCMH highlighted the needs of the CMI and echoed the findings of the GAO Report regarding the plight of the deinstitutionalized in the community. The Commission reiterated the need for and appropriateness of developing support systems in the community. The importance of caring for the CMI in the community was stressed, as was the need for available, affordable living arrangements linked with supportive community services. The PCMH formulated recommendations for addressing identified needs and problems and urged reform through legislative action and substantive redirection of existing financing programs.

Housing And Community Development Amendments Of 1978, Conference Report--Until 1978, HUD policies and programs excluded the mentally ill despite the broadening of the definition of "handicapped" in 1974 with the inclusion of the developmentally disabled and mentally retarded. With the growing awareness of the housing needs of the mentally ill and mounting demands by advocates and various interest groups in the mid-1970s, the Federal government began exploring approaches to access HUD resources for the mentally ill. The 1978 Conference Report on the Housing and Community Development Amendments was important in two ways: (1) it lent formal support to these efforts in clarifying that Congress had never intended for the chronically mentally ill to be excluded from participation in the Section 202--Housing for the Elderly and Handicapped Program, and (2) it stipulated that criteria and standards for housing for the chronically mentally ill be developed. The Report included a description of the Congregate Housing Services Act. The Act mandated that "congregate housing and supportive services must be available as a coordinated package which receives secure and

continuous funding. " In addition, it reiterated the premise that congregate housing together with supportive services is a proven, cost-effective mechanism for averting institutionalization of the elderly and handicapped.

The Mental Health Systems Act (MHSA), 1980--The Act provided for the basic redefinition of Federal, State, and local government responsibilities for the delivery of mental health services generally. Specifically, Section 202 of the Act provided authority for a nationwide program of services development and improvement for the CMI. The intent of this Section was consistent with the concepts and efforts of CSP in developing coordinated systems of mental health and related support services in the community. MHSA continued support for State-level systems improvement and provided specific support for initiation and development of local community support services. Moreover, the Act recognized the lack of adequate and appropriate housing alternatives for the CMI as a nationwide problem and mandated that HUD and HHS submit to Congress a "Report on Shelter and Basic Living Needs of Chronically Mentally Ill Individuals, " which was to include: (1) an analysis of the extent of inappropriate housing in institutions and community, (2) an analysis of available noninstitutional housing alternatives, and (3) an evaluation of ongoing permanent and demonstration projects designed to provide residential and other services and funded with Federal support. With the enactment of the Omnibus Reconciliation Act of 1981, and the advent to block grants, many of the specific categorical programs authorized in the MHSA have been consolidated into the Alcohol and Drug Abuse and Mental Health block grant. Under the New Federalism, States have discretion over which services they will fund and to which special population group such services will be provided.

The National Plan For The Chronically Mentally Ill--The Plan was written in response to the recommendations of the PCMH that HHS in consultation with State and local governments develop a plan for: (1) continuing deinstitutionalization, (2) upgrading the quality of services provided in State institutions, and (3) allocating increased resources for developing comprehensive and continuous systems of community and institutional care. Accordingly, the primary emphasis of the recommendation in the Plan is on modifying and restructuring existing Federal financing programs such as Medicaid, Medicare, and Supplemental Security Income (SSI). The Plan documents the extent and nature of relevant issues and problems ; describes the chronically mentally ill population, estimated at 1.7 million nationally; and details a strategy for service system development to meet the needs of this severely disabled group. The Plan was published in 1980 and submitted to the Secretary. To date, no specific policy actions have mandated from the Plan and none of its recommendations have been implemented.

The (White House) Independent Living Initiative--This initiative was to be a pilot program to coordinate the funding resources of seven Federal agencies (HUD, HHS, Department of Labor, ACTION, Community Services Administration, Department of Transportation, and Department of Education) into a single funding mechanism for developing comprehensive service systems at the local level for the physically, developmentally, and mentally disabled. As of this writing, this initiative has not been implemented.

As evidenced by the selected studies, policies, and initiatives described above, certain common themes characterized Federal activities directed at addressing the problems encountered by deinstitutionalized mentally ill individuals in the community--a growing emphasis on the role of States in the delivery of mental health services, identification of community-based housing and supportive services as a major gap in the service delivery system, and the need for Federal interagency collaboration in developing new or modifying existing mechanisms for financing such services. The design of the HUD/HHS Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill incorporated these themes and was consistent with the overall thrust of these Federal policies and initiatives. A general overview of the HUD/HHS Demonstration Program is presented in the next section. A more detailed discussion of the Program's intent, implementation, and accomplishments is the focus of the next three chapters of this report.

2. OVERVIEW OF THE HUD/HHS DEMONSTRATION PROGRAM

The HUD/HHS Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill was initiated in 1978 and continued through 1980. The announcement of this initiative at the White House marked the culmination of an unprecedented process of joint planning and interagency collaboration among the Departments of Housing and Urban Development and Health and Human Services (then the Department of Health, Education, and Welfare, HEW) in response to the GAO and PCMH recommendations. The Program sought to demonstrate that community-based housing linked with supportive services for the mentally ill could be provided in a cost-effective and efficient manner. To this end, each of the Departments committed the following resources: HUD provided funds for

housing development through the Section 202 Direct Loan Program and for rental subsidies for housing units through the Section 8 Program; HHS allowed for certain Medicaid regulations to be temporarily waived through Section 1115 of the Social Security Act.

Specifically, the Section 202 Direct Loan Program provides a 40-year Federal mortgage loan to local nonprofit sponsors for new construction or substantial rehabilitation of community residences. Section 8 rental subsidies ensure that residents spend no more than 25 percent of their income on rent (the balance being paid by Section 8). Section 1115 of the Social Security Act permits HCFA to waive certain standard Medicaid requirements and definitions so that a broader range of services can become Medicaid reimbursable.

For the HUD/HHS Demonstration Program, the Section 1115 waivers have been and will continue to be granted at the States' option and with HCFA's approval for a maximum period of three years subsequent to each local project becoming operational. Waivers may be granted to permit: (1) reimbursement for services not covered by the State Medicaid Plan and/or (2) under Section 1115(a)(2), those persons who were potentially SSI/Medicaid eligible to become Medicaid eligible, i. e. , presumptive eligibility.^{4/} Application for the Section 1115 waivers was not a necessary condition for participation in the Demonstration. It was recognized that, within Federal regulations, each State establishes its own Medicaid Plan specifying eligibility, service coverage, and payment limits and rates. As such, some States already had provisions in their State Medicaid plans for coverage of a broad range of community-based mental health services. However, those States opting to fund services using the Section 1115 waivers are expected either to incorporate these services into the State Medicaid Plan or to find alternative funding sources following the three-year waiver period. After that time, the services must either be incorporated into a State's Medicaid Plan or alternative funding sources must be found. Thus, the waiver functions as a temporary funding mechanism until States can mobilize resources to finance

^{4/} This provision is made possible by certifying prospective residents as disabled using the definition of the target population specified in the Demonstration Program Description and all other Medicaid eligibility requirements.

services in the longer term, if desirable and feasible. In total, the three financing mechanisms formed the basic framework of the Demonstration Program.

The Demonstration design required that clients to be served be at least 18 years old and chronically mentally ill. Specifically, the target population definition outlined in each of three successive program descriptions was extremely broad and flexible. It included three generic categories of individuals to be served: (1) chronically mentally ill individuals currently residing in institutions but capable of more independent living; (2) chronically mentally ill individuals at risk of being reinstitutionalized; and (3) chronically mentally ill individuals who had no prior institutionalization but for whom housing linked to services would provide an alternative to institutionalization. As such, States and local sponsors were accorded the opportunity to exercise a great deal of discretion in defining the population to be served.

As evidenced in the 1978 Program Description, the Demonstration design initially did not provide clear-cut, structured guidelines to sponsors for developing the services component of the Demonstration application. The first year of the Demonstration, the program design loosely articulated Federal expectation for the extent and nature of services to be linked with housing. The Program Description merely listed a set of eleven services and opportunities as examples of the types of services sponsors should consider arranging for or providing. Over the three years of fund reservations for the Demonstration, these broad guidelines were refined and revised. By 1980, the Demonstration Program Description delineated more fully detailed requirements for the services to be delivered through the Demonstration. Accordingly, the program design stipulated that each client be assigned a case manager who would perform many diverse functions, such as providing linkage to needed services and monitoring of the client's functional status. An integral task for the case manager was formulation, assistance in implementation, and periodic revision of an Individual Service Plan tailored to each client's unique needs. In addition, in order to encourage the development of a variety of housing and supportive service models, a range of required and recommended services to be offered to residents of Demonstration housing was specified. Required services included case

management, house and milieu management, lifeskill development, medical and physical health care, and crisis stabilization. Recommended or optional services as required to fulfill the client's total needs included vocational development, sheltered workshops, education, psychotherapy, advocacy services, and recreational/vocational planning.

Within the program, two types of independent living residences could be developed: either group homes to serve a maximum of 12 individuals each or independent living complexes, i. e., apartments of 6 to 10 units, to house no more than 20 individuals.

Participation of States in the Demonstration was competitive and contingent upon initial selection by HUD. Selected States, in turn, were expected to: (1) invite local private nonprofit sponsors to submit applications for Section 202 fund reservations, (2) review and evaluate the applications, and (3) submit applications to HUD for final selection of sponsors.

Although administrative responsibility for the Demonstration rested with both HUD and HHS, the day-to-day management of the Demonstration Program was performed by HUD's Office of Independent Living for the Disabled in close collaboration with relevant HHS agencies. The Health Care Financing Administration (HCFA) was responsible for administering and monitoring the Section 1115 waivers, NIMH for reviewing and evaluating the service components of the Demonstration application, and the Office of the Assistant Secretary for Planning and Evaluation for departmental-level coordination and evaluation. An interagency committee was established to provide guidance and direction to the effort. Representatives from each agency also participated in each of three Demonstration rounds of review and selection of States and sponsors.

Between 1978 and 1980, a total of \$65 million in Section 202 Direct Loan Program loan authorities was reserved and \$13 million in Section 8 rent subsidies was set aside for Demonstration sponsors. Some 200 sponsors were selected in 38 participating States, with approximately 1,867 units approved. Exhibit I-1, following this page, presents a breakdown of funding for States and sponsors and indicates the total number of units approved for each

EXHIBIT I-1

HHS, Office of the Assistant Secretary
for Planning and Evaluation

OVERALL DEMONSTRATION PROGRAM CHARACTERISTICS

	<u>Section 202 Loan Reserves</u>	<u>Section 8 Rental Subsidies Set-Asides</u>	<u>Total States Approved</u>	<u>Total Sponsors Approved</u>	<u>Total Units Approved</u>
1978	\$15 million	\$ 3 million	13	58	479
1979	\$25 million	\$ 5 million	27*	77	730
1980	<u>\$25 million</u>	<u>\$ 5 million</u>	<u>31*</u>	<u>66</u>	<u>65%</u>
	\$65 million	\$13 million	38**	201	1,867

* Duplicated Count

** Unduplicated Count

Demonstration year. In 1980, following the third and final round of project approval for the Demonstration, it was estimated that, if all approved housing units became operational, between \$20 million and \$30 million in Medicaid funds under the Section 1115 waiver may be expended for supportive services.

3. THE EXPLORATORY EVALUATION OF THE HUD/HHS DEMONSTRATION PROGRAM

A key feature of the Demonstration Program design was an evaluation component intended to be completed over a five-year period. The evaluation was expected to focus on three areas: (1) an examination of the process of establishing Section 202-funded residential alternatives with support services, (2) an analysis of what services are delivered and the population served, and (3) an assessment of the effectiveness of the Demonstration in meeting the needs of the chronically mentally ill who do not require institutionalization.

Initial evaluation efforts conformed to this plan. HUD contracted with Urban Systems, Research, and Engineering, Inc. (USR&E) , to perform an intensive evaluation of the early experiences of Phase I of the Demonstration from the perspective of HUD-Central and Area, States, and local levels. In addition, USR&E was requested to develop an evaluation design for future assessment of Demonstration experiences and results.

(1) Early Efforts To Evaluate The HUD/HHS Demonstration Program

Focusing on the early experiences of HUD Central and Area Offices, of 10 of 13 Demonstration States, and of 31 local sponsors approved in 1978, USR&E evaluated and documented housing production problems, administrative design limitations, and Demonstration accomplishments. This study was comprehensive and intensive. It detailed and explained significant difficulties and delays encountered at all levels during the 202 processing phase--housing development. Moreover, the study analyzed the unique problems of applying the Section 202 Program, which was designed for the development of large-scale projects, to the development of small scattered site housing. The study presented selected key issues and

offered recommendations for modifying and improving the Demonstration Program design and for enhancing program achievements. USR&E also submitted a longitudinal, experimental cost-benefit study design to measure the long-term impact of the Demonstration.^{5/} The evaluation design was developed in accordance with the Social Security Act 1115 waiver provision that sponsors receiving Medicaid reimbursements under the waiver mechanism participate in program evaluation.

(2) Overview Of The Exploratory Evaluation

By late 1981, approximately 31 projects with a total of 273 units were operational in 15 States and 26 projects were under construction. Four of these States were approved for Section 1115 waivers to reimburse for supportive services provided to Demonstration clients. An additional State had been approved, but its projects had not become operational. Given

^{5/} Urban Systems Research and Engineering, Inc. Evaluation of the HUD/HHS Demonstration Program for the Chronically Mentally Ill: Design for the Cost-Benefit Study. Task 7: Cost-Benefit Design, Vols. I and II, April 1980.

Urban Systems Research and Engineering, Inc. Evaluation of the HUD/HHS Demonstration Program for the Chronically Mentally Ill: Early State Experiences With Phase I of the Demonstration Program. Task 4, June 1980.

Urban Systems Research and Engineering, Inc. Evaluation of the HUD/HHS Demonstration Program for the Chronically Mentally Ill: Examination of HUD's Experiences with Processing Phase I of the Demonstration Program. Task 6, June 1980.

Urban Systems Research and Engineering, Inc. Evaluation of the HUD/HHS Demonstration Program for the Chronically Mentally Ill: Evaluation of Sponsor Participation in Phase I of the HUD/HHS Demonstration. Task 5, July 1980.

Urban Systems Research and Engineering, Inc. Evaluation of the HUD/HHS Demonstration Program for the Chronically Mentally Ill: Evaluation of the Early Experiences of Phase I of the HUD/HHS Demonstration. Final Report, Task 8, October 1980.

Urban Systems Research and Engineering, Inc. Evaluation of the HUD/HHS Demonstration Program for the Chronically Mentally Ill: Evaluation of the Early Experiences of Phase I of the HUD/HHS Demonstration. Executive Summary, December 1980.

that only a small number of projects were operational, that only a few were operational in the waiver-only States, and that great variability appeared to exist among project models developed, the cost-benefit study design developed by USR&E was considered by the Interagency Committee of HUD and HHS representatives to be too ambitious in scope and content. As such, this evaluation was not undertaken as planned. Instead, the Committee agreed that a short-term, less intensive, and more qualitative analysis of Demonstration intent and accomplishments to date, would be more appropriate and realistic. Accordingly, the six-month exploratory evaluation of the HUD/HSS Demonstration Program for Deinstitutionalization of the Chronically Mentally Ill was conceived and initiated in October 1981 as a precursor to more intensive evaluation.

The exploratory evaluation was conducted by Macro Systems, Inc. , under contract with the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE). The tasks required to conduct the exploratory evaluation were performed in close collaboration with a Work Group that included Interagency Committee members from key Federal agencies/programs involved in the Demonstration--HUD-Direct Loan Program, Division of Housing Management and Special Users; HHS-ASPE, HCFA, ADAMHA, and NIMH; and one knowledgeable individual historically involved in the Demonstration. The Work Group provided substantive input and direction at key junctures in the exploratory evaluation.

The purpose of the exploratory evaluation was to determine:

The expectations and objectives of Federal program managers and policymakers at each level of management for the HUD/HHS Demonstration Program

An accurate description of what currently is occurring in selected Demonstration States and sites

A comparison of the actual activities being performed at State and local levels with the expectations of Federal program managers and policymakers

Relevant policy and management issues for consideration by program managers and policymakers

The appropriateness of more intensive evaluation of the Demonstration given current program conditions and to develop evaluation options accordingly

Specifically, the exploratory evaluation was divided into three broad tasks:

Task 1--Documenting The Intended Program--The first exploratory evaluation task involved the delineation of the objectives and expectations of program managers and policymakers at each level of management for the HUD/HHS Demonstration Program. Specifically, this task involved the explication of program objectives, activities necessary to attain the objectives, and indicators of program success. Models describing the logic and activities of the intended HUD/HHS Demonstration were constructed.

Task 2--Documenting Actual Program Activities And Results--The purpose of this task was to describe the HUD/HHS Demonstration Program as it actually operates. In addition, this task involved the description of the types of project activities underway and the objectives sought and accomplishments attained at State and local levels. As such, this task served as a check on the reality of the models developed in Task 1.

Task 3--Analysis And Synthesis Of Information And Findings And Identification Of Relevant Policy And Management Issues--This task involved the analysis and synthesis of information obtained in Tasks 1 and 2 to identify policy and management issues and/or problems. In addition, based on the analysis and issues, the appropriateness of a more in-depth evaluation of the Demonstration Program was determined and specific options for future evaluation of the Program were developed.

(3) The Exploratory Evaluation Approach And Methodology

The first task in the exploratory evaluation involved documenting and describing the intended program. The overall purpose of this task was twofold: (1) determining what activities and objectives are considered to constitute the HUD/HHS Demonstration Program in order to focus the exploratory evaluation and (2) determining the objectives and expectations of program managers and policymakers for the Demonstration in order to describe the logic of the causal assumptions that link program resource

inputs, activities, and intended outcomes and impacts. The program description developed during this task delineates what the HUD/HHS Demonstration Program was intended to accomplish and what activities were intended as necessary to attain objectives.

As a prelude to determining the objectives and expectations of program managers and policymakers at various levels of the Federal government, all available documentation pertinent to defining the objectives and activities of the Demonstration Program was reviewed and abstracted. Based on this review, an overview of the program was prepared. A complete list of all descriptive materials and documentation reviewed is included in Appendix A of this report; the Program Overview is presented as Appendix B.

With a preliminary understanding of the design of the Demonstration Program gained from the documentation review, a policymaker and program manager interview guide was developed. The guide was structured to elicit information from a wide range of perspectives on the major activities and resources, purposes and objectives, expectations, program performance or measurement information, and problems related to the HUD/HHS Demonstration Program. A sample of key Federal program managers and policymakers to be interviewed was selected by the Work Group and included individuals who are currently, or who have been historically, involved with the Demonstration and who represent diverse perspectives on the program. Exhibit I-2 lists the Federal program managers and policymakers interviewed. The interview guide used to obtain information on the intended HUD/HHS Demonstration Program from program managers and policymakers is included in Appendix C.

The data obtained from each interviewee were summarized individually and organized in a standard format to facilitate analysis. An across-interviews summary, aggregating and analyzing program manager and policymaker perceptions of key aspects of the intended HUD/HHS Demonstration Program, was then prepared. The summary is presented as

EXHIBIT I-2

HHS, Office of the Assistant Secretary
for Planning and Evaluation

FEDERAL PROGRAM MANAGERS
AND POLICYMAKERS INTERVIEWED

HUD

David Williamson--Special Assistant to the Assistant Secretary of
Housing

Gail Gebran Williamson--Housing Program Specialist, Office of Existing
and Moderate Rehabilitation, Existing Housing Division

. Deborah Greenstein--Program Analyst, Division of Housing Management
and Special Users

. Robert Wilden--Director, Elderly Cooperative, Congregate, and Health
Facilities Division

. Sharon **Mizzel--Chief**, Direct Loan Branch, Elderly Cooperative, Con-
gregate, and Health Facilities Division

HHS

. William Ten **Hoor--Policy** Coordinator, Executive Secretariat

. Jean Bainter--Nurse Consultant, Office of Demonstration and Evaluation,
HCFA

. Barbara Cooper--Acting Director, Office of Demonstration and Evaluation,
HCFA

Roberta Ward--Program Analyst, Policy and Procedures Branch, Division
of Operations, HCFA

Judy Turner--Chief, Community Support and Rehabilitation Branch,
Division of Mental Health Service Programs, NIMH

Dick Woy--Acting Chief, Program Analysis and Evaluation Branch, Office
of Planning, Development and Analysis, NIMH

OTHER

. Jack Noble--Senior Program Analyst, Department of Education

Paul **Carling--Deputy** Commissioner of Mental Health, Department of
Mental Health, Vermont

Appendix D. To reduce the volume of data obtained from the documentation review and interviews to a usable frame of reference for discussion, models were constructed. Modeling involved the development of concise descriptions of the Demonstration that capture the intended program as defined by Federal program managers and policymakers and by written materials. All information was synthesized into a form that attempted to clarify and graphically represent the logical structure of the intended program and the flow of its activities as well as its objectives.

Task 2 of the exploratory evaluation involved documenting actual HUD/HHS Demonstration Program activities and results. The purposes of this task were: (1) determining what actual program inputs, activities, and accomplishments are occurring in the field; (2) determining whether they are consistent with the description of the intended program; and (3) determining what data are available on program performance and outcome. Several important preliminary steps were undertaken in preparation for the field visits and data collection and analysis, including: (1) classifying and describing Demonstration States and projects, (2) selecting sites for more intensive study, and (3) reviewing selected State- and project-specific documentation.

The HUD Section 202 Program Status Report **as of** October 17, 1981, used by HUD Central to track housing production status of Demonstration projects, served as the primary information source for classifying Demonstration States and projects. General Demonstration characteristics of all States accepted into the Program between 1978 and 1980 were arrayed and grouped into two categories--housing and services, Exhibit I-3, following this page, displays in the aggregate these key Demonstration characteristics. The classification was used to develop an approach for site selection and review of State- and project-specific documentation.

As shown in Exhibit I-3, 15 of the 38 States approved for the Demonstration had operational projects (i.e. , fully constructed or rehabilitated, with **clients having moved in**) and **five States had applied and received**

EXHIBIT I-3

HHS, Office of the Assistant Secretary
for Planning and EvaluationDEMONSTRATION STATES HOUSING AND SERVICES
CLASSIFICATION MATRIX

state	Number of Sponsors Approved				Housing			Number of Units Constructed	Number of Sponsors Cancelled	Services Funding status
	1978	1979	1980	Total	Total Number of Units Approved	Number of Sponsors Starting/ Having Started Construction	Number of Sponsors with Construction Completed			
REGION I										
Massachusetts*	9	2	3	14	111	3	5	36	1	S
Vermont	6	4	-	10	60	3			2	W
Connecticut	-	-	4	4	24					
New Hampshire	-	4	2	6	54					P
Maine	-	3	1	4	37	2				
Rhode Island*	4	-	1	5	38	1		7		P
REGION II										
New York	3	5	3	11	116	3				
New Jersey	5	6	3	14	128				1	P
Puerto Rico			1	1	11					
REGION III										
Maryland	1	-	-	1	8					
West Virginia	-	2	1	3	29				3	
Pennsylvania*	3	3	4	10	91	0	2	16	1	S
Virginia	-	4	-	4	29	1			1	
D. C. *		4	1	5	52		1	12	1	W
REGION IV										
Georgia*	4	2	1	7	87	1	4	42		W
North Carolina*	-	3		3	23	0	1	6		S
Alabama	-	1	1	2	28	1				
Florida*	6		2	8	60	0	1	6	3	S
Kentucky	-	1	-	1	12	1				
Tennessee*	-	3	1	4	49	3	1	8		W
REGION V										
Illinois*		4	5	9	91	2	1	12		S
Ohio	-	3	4	7	67					
Michigan	2	-	2	4	48				1	
Indiana	-	-	3	3	32					
Wisconsin*	-	4	3	7	60	0	3	23		S
Minnesota*	3	-	-	3	24	0	2	20		1-W, 1-S
REGION VI										
Texas		2	2	4	39				1	
Arkansas	-	2	1	3	32					P
Louisiana		2	1	3	36					
REGION VII										
Kansas		1	2	3	31	1				
Colorado*	7	-	3	10	84	2		41		S
REGION VIII										
Utah*	-	1	1	2	23	0		18		S
South Dakota	-	-	1	1	12				1	
REGION IX										
Hawaii	-	1	1	2	22					
California*	-	5	4	9	87	0	1	10		S
Nevada	-	2	1	3	33				1	
REGION X										
Oregon*	5		-	5	43	0	2	16	2	P
Washington	-	3	3	6	56	1			3	
38 States	58	77	66	201	1,867	26	31	273	22	W=5 P=5 S=9
							in 15 States			

*States with operational projects

W=Waiver approved

P=Pending waiver approval

S=State funding only

Source: HUD Status Report, 10/17/81

approval for 1115 waivers.' Based on this information and given the study's emphasis on implementation experiences of both the housing and services components of the Demonstration, the efforts of Task 2 were limited to States with operational projects and/or States with approved 1115 waivers. Thus, the universe of States and projects to be examined during the exploratory evaluation was defined to include States with at least one operational project and States with approved waivers irrespective of project status. Only one of the waiver-only States (Vermont) did not have an operational project at the time of selection. In all, 16 States were selected for more intensive study; Exhibit I-4, following this page, presents a listing of these States.

From this universe, a sample of nine States was selected for on-site data collection that included all approved 1115 waiver-only States. The States selected were Colorado, the District of Columbia, Georgia, Massachusetts, Minnesota, Oregon, Pennsylvania, Tennessee, and Vermont.

Due to study resource and time limitations, in each of these nine States only one operational project was identified for purposes of field visits. In States with more than one operational project, sites were selected that were closest in proximity to the State capital. Exhibit I-5, following Exhibit I-4, displays all approved projects in the nine field visit States and their current HUD processing status and indicates the projects visited.

A two-pronged approach was developed to determine the current status of all approved Demonstration projects in the study's universe prior to the field visits. The approach involved: (1) review of available State-level documentation and written materials for all operational projects in the nine States selected for field visits^{6/} and (2) telephone interviews with

^{6/} It should be noted that the documentation review for the nine field visit States revealed that substantially less information was available on the **non-waivered** States and their projects. This is largely due to the fact that the HUD/HHS Program Description for 1978, the initial year of the Demonstration, did not specify structured guidelines for the service component of the application. Consequently, there was no uniformity in the information provided in the applications by the local sponsors in those four States. Some sponsors provided detailed discussion of their plans, whereas others only alluded to them in brief.

EXHIBIT I-4

HHS, Office of the Assistant Secretary
for Planning and Evaluation

LIST OF DEMONSTRATION STATES WITH AT
LEAST ONE OPERATIONAL PROJECT AND/
OR 1115 WAIVER APPROVAL

<u>State</u>	<u>At Least One Operational Project</u>	<u>Approved 1115 Waiver</u>
California	x	
Colorado	x	
District of Columbia	x	x
Florida	x	
Georgia	x	x
Illinois	x	
Massachusetts	x	
Minnesota	x	x
North Carolina	x	
Oregon	x	
Pennsylvania	x	
Rhode Island	x	
Tennessee	x	x
Utah	x	
Vermont		x
Wisconsin	x	

EXHIBIT I-5(1)

HHS, Office of the Assistant Secretary for Planning and Evaluation

FIELD VISIT STATES AND PROJECTS MATRIX

State	Regio	Project	Funding Year	Number of Units Approved	202 Processing Status	Status Determination Date	Percent Completed	Visit Planne
C'olorado (Non-Waiver)	VII	. Arapaho Mental Health Center	1978	6	. Construction completed	12/20/79	100	
		. Bethesda	1978	13	. Construction completed	2/11/81	100	
		. Community Corp	1978	12	. Construction completed	6/18/80	100	
		. Independent Living Project	1978	5	. Construction completed	4/1/80	100	
		. Redi Corp. Group Apartments	1978	5	. Construction completed	N/A	100	x
		. Spanish Peaks Mental Health Cons.	1978	9	. Construction started	6/23/81	52	
		. NE Colorado Mental Health Clinic	1978	10	. Construction started	9/30/81	0	
		. September House	1980	8	. Conditional received	5/29/81		
		. Aurora Community NH Center	1980	8	N/A			
		. Aurora Community MH Center	1980	8	N/A			
		10		84	2 started; 5 completed			
D.C. (Waiver)	III	Green Door	1979	12	Firm received	9/9/81		
		Catholic Charities Housing Corp.	1979	10	Cancelled	7/17/81		
		. Arlington County MH Residence	1979	7	Firm issued	9/30/81		
		Pathway Homes	1979	6	Initial endorsement	9/30/81		
		Anchor Housing Corp.	1979	12	Construction completed	9/17/81	100	x
		Woodley House	1979	12	SAMA*	9/15/80		
		Community Housing Hearing Impaired	1980	6	Construction started	9/30/81	0	
		7		65	1 started; 1 completed			
Georgia (Waiver)	IV	. Community Friendship Apartments	1978	11	Construction completed	6/17/81	100	x
		. Georgia Infirmary	1978	13	Construction completed	4/7/81	100	
		. Georgia Infirmary	1978	11	Construction completed	4/7/81	100	
		. Aesthetic Housing Project	1979	9	Conditional rejected	9/26/80		
		. Aesthetic Housing Project	1978	7	Construction completed	7/6/81	100	
		. Chatham Association for Retarded Citizens	1979	16	Construction started	9/30/81	0	
		. Christian Council Atl.	1980	20	SAMA	9/30/80		
		7		87	1 started; 4 completed			

* Statistical And Marketing Analysis

State	Category	Project	Funding Year	Number of Units Approved	202 Processing Status	Status Determination Date	Percent Completed	Visit Planner
Massachusetts (Non-Waiver)	I	. Springfield House	1978	11	Firm received	4/27/81		
		. Wellington House	1978	6	Construction completed	6/12/81	100	
		. Center House	1978	7	Construction completed	9/6/80	100	
		. Quincy House	1978	9	Construction completed	7/28/80	100	x
		. Prospect Street Group House	1978	6	Cancelled	7/17/81		
		. WHIP Community Apartments	1978	6	Construction started	3/25/81	40	
		. Alternative House	1978	8	Construction completed	8/1/81	100	
		. Cape Cod Group Home	1978	6	Construction completed	2/19/80	100	
		. Gardner House	1978	10	Construction started	9/30/81	0	
		. Coastal Community Counseling Center	1979	7	Conditional issued	10/9/80		
		. The Bridge of Westborough	1979	9	Construction started	9/30/81	0	
		. Bay Care Group Home	1980	6	Construction started	9/30/81	0	
		. Haverhill/Newburyport Human Service:	1980	8	Conditional received	1/23/81		
		. WHIP Independent Living	1980	12	Firm received	9/28/81		
		14		111	4 started; 5 completed			
Minnesota (Waiver/Non-Waiver)	V	. Northwest Apartment Living Training	1978	9	Construction completed	2/19/80	100	x
		. Kosciolk House	1978	11	Construction completed	3/31/81	100	
		. Lent Minnesota Mental Health Center	1978	4	Firm received	1/29/81		
				3		24	2 completed	
Oregon (Non-Waiver)	X	. Center for Community Mental Health	1978	10	Cancelled	7/17/81		
		. Tualatin Valley Workshop	1978	10	Cancelled	8/19/80		
		. Independent Living	1978	7	SAMA	8/22/78		
		. Alder Street Residence	1978	8	Construction completed	8/8/80	100	
		. Janus House	1978	8	Construction completed	4/15/81	100	x
				5		43	2 completed	
Pennsylvania (Non-Waiver)	[II]	. Webster Street Apartments	1978	8	Firm received	7/2/81		
		. Meson Apartments	1978	9	Construction completed	9/30/80	100	x
		. Meson Apartments II	1979	10	Conditional received	11/10/80		
		. Project Opportunity	1979	6	Conditional rejected	3/31/81		
		. Allied Monroe Apartments	1980	4	Conditional issued	8/20/81		
		. Lehigh Apartments	1980	11	SAMA	9/26/80		
		. Keystone Residence	1981	12	Conditional rejected	9/30/80		

EXHIBIT I-5(3)

state	Region	Project	Funding Year	Number of Units Approved	202 Processing Status	status Determination Date	Percent Completed	Visit Planned
Pennsylvania (continued)		. Stairways Apartments	1978	7	Construction completed	2/24/81	100	
		. Supportive Services . Transitional Services	1979 1980	6 18	Cancelled . SAMA	7/17/81 5/2/81		
		10		91 2	completed			
Tennessee (Waiver)	IV	. Beta Homes/Spring View	1979	11	. Construction started	7/29/81	0	
		. Walden Group Homes	1979	11	. Construction started	9/30/81	0	
		. Northeast Community MH Housing	1979	8	. Construction completed	4/13/81	100	x
		. Northeast Community MH Housing	1980	19	. Construction started	10/1/81	0	
		4		49 3	started; 1 completed			
Vermont (Waiver)	I	. Rutland Mental Health Services	1978	6	. Cancelled			
		. Northeast Kingdom MH Services	1978	6	. Cancelled (funds transferred)	8/79		
		. United Counseling Service of Bennington City	1978	7	. Construction started	9/17/81	0	
		. Franklin/Northern Grand Isle MB Services	1978	4	. SAMA	9/28/78		
		. Counseling Services of Addison county	1978	6	. Firm issued	9/22/81		
		. Howard MH Services	1978	7	. Construction started	9/30/81	0	x
		. Group Rome	1979	6	. SAMA	9/29/79		
		. United Counseling Service of Bennington County	1979	6	. Construction started	9/17/81	0	
		. Lamoyille Grand Isle	1979	6	. Conditional received	5/4/81		
		. Franklin Grand Isle MH Services	1979	6	. SAMA	9/29/79		
		10		60				

State Demonstration coordinators in the seven States with operational projects not selected for field visits,

Field visits to two HUD Area Offices, nine State Offices, and nine local projects within those States were conducted over a span of two months. Approximately 80 individuals at the HUD Area, State, and local levels were interviewed. The interview guides used during the field visits to target information collection and a complete list of individuals interviewed on site are included as Appendices E and F, respectively. In order to synthesize across-interviewee information on Demonstration operations collected on site, State and local level summaries aggregating all the data collected were prepared. These summaries served as the basic database for analysis.

Finally, the third task of the exploratory evaluation involved : (1) analysis and synthesis of information obtained regarding the intended and actual Demonstration Program; (2) documentation of key findings, Demonstration results to date, and their implications ; (3) determination of the appropriateness of more in-depth evaluation of the Demonstration; and (4) development of specific options for future evaluation of the program. Chapters II and III present a detailed discussion of the results of each of the study's three major tasks.

II. THE INTENDED AND ACTUAL HUD/HHS
DEMONSTRATION PROGRAM

II. THE INTENDED AND ACTUAL HUD/HHS DEMONSTRATION PROGRAM

As indicated in the preceding chapter, the first two tasks of the exploratory evaluation involved documenting the intended and actual HUD/HHS Demonstration program. The program description developed during the conduct of Task 1 delineates what the HUD/HHS Demonstration Program was intended to accomplish and what activities were intended by Federal program policymakers and managers as necessary to attain Demonstration objectives. The program description developed during the second major phase of the study is of program reality and is based on an examination of field operations. The focus of this portrayal is on the types of program activities and efforts actually underway, the goals and objectives sought at State and local levels, State and local-level program accomplishments, and the availability of program performance and outcome data. In addition, this latter task provides a comparison of the intended and actual program to highlight the extent to which the two descriptions are congruent. Accordingly, this chapter presents detailed discussion of the following :

- The Intended HUD/HHS Demonstration Program

- The Actual HUD/HHS Demonstration Program

- Comparison of the Intended versus the Actual HUD/HSS Demonstration Program

1. THE INTENDED HUD/HHS DEMONSTRATION PROGRAM

Based on the information obtained from Federal policymakers and program managers and from written materials, two models depicting the intended HUD/HHS Demonstration Program were constructed at varying levels of complexity. The Level I logic model provides a simplified representation of program intent, whereas the Level II logic model is more complex and captures in greater detail

and specificity the intended operations of the program. The models are used as a “descriptive language” to characterize essential aspects of the program’s intent--resources and conceptual inputs, activities, and outcomes--with a clear presentation of the logic of the causal assumptions linking these program elements . That is, each model is presented as a series of events occurring in a logical sequence to achieve stated program objectives.

The logic models of the intended HUD/HHS Demonstration Program are presented as Exhibits II-1 (Level I) and II-Z (Level II). The model format at both levels reflects a progression from inputs to activities to results or objectives . Activities are separated into those occurring at the Federal, area, State, and local levels. The objectives or results are grouped into intermediate objectives and longer-range housing, services, and client-specific outcomes. Accordingly, following the logic of the models, it can be stated that if the prescribed activities occur at the Federal, area, State, and local levels, then the HUD/HHS Demonstration Program objectives should be attained. The objectives or intended results of the program are displayed sequentially from intermediate to longer-range objectives to indicate that, although certain objectives are the ultimate aims of the program, more immediate results are also sought. Although both types of objectives can occur or be attained simultaneously, given the logic of the program, the intermediate objectives are viewed as precursors or required conditions for achieving ultimate goals. Each one of the objectives in both the Level I and II logic models is numbered and keyed to a set of suggested indicators of program performance identified through the review of documentation and cited by program managers and policymakers. The list of indicators follows the logic models as Exhibit II-3 and includes both quantitative and qualitative indicators of program performance. The specific content and derivation of the Level I model elements are explained and discussed below. The differences between the two models are also noted.

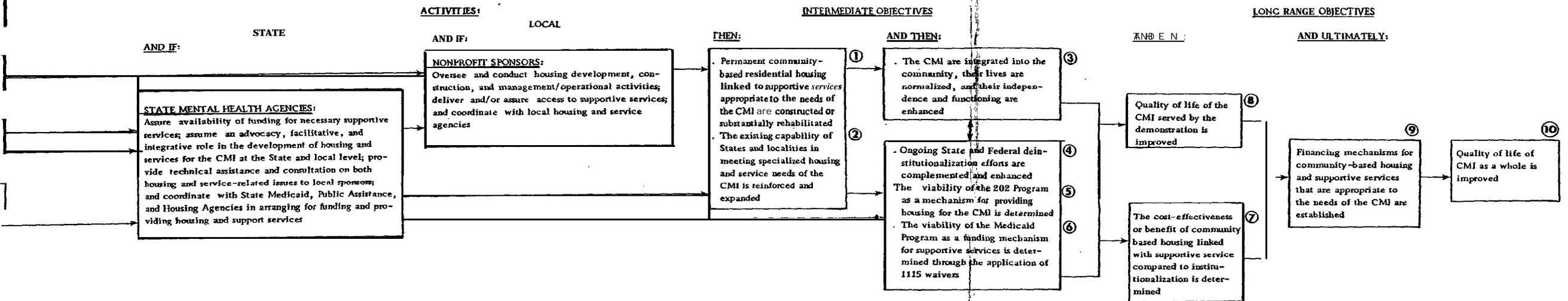
(1) Demonstration Inputs

The inputs listed in the first box of the model are organized into legislative, conceptual/policy , and funding categories. Clearly, a wide

EXHIBIT II-1

HHS, Office of the Assistant Secretary
for Planning and Evaluation

LOGIC OF THE INTENDED PROGRAM--LEVEL



INPUT

FEDERAL

AREA

Legislative

- Section 202--Housing and Development Act of 1974
- Section 8--Housing and Development Act of 1974
- Section 1115--Social Security Act
- Section 504--Rehabilitation Act of 1973
- Mental Health Systems Act of 1980

Conceptual/ Policy Bases

- GAO Report: "Returning the Mentally Disabled to the Community: Government Needs to do More," 1977
- HHS Deinstitutionalization Task Force
- NIMH Community Support Program
- President's Commission on Mental Health, 1978
- National Plan for the Chronically Mentally Ill, 1980
- White House Independent Living Initiative
- Other Bases, e. g., Allied Services Act Funding FY 1978-1980

- HUD: \$65 million--Section 202 Loan Authority reserves; \$13 million--Section 8 subsidy set asides

- HHS: \$20-\$30 million in Medicaid 1115 waivers

IF:

HUD:

- Section 202--Direct Loan Program--provides and oversees funds to selected States and local sponsors for construction and rehabilitation of housing
- Section 8--Housing Assistance Payment Program--provides and oversees rental subsidies to local sponsors with operational housing
- Office of Independent Living for the Disabled administers the Demonstration Program and provides technical assistance and consultation on housing issues to States and local sponsors
- Office of Independent Living for the Disabled coordinates and collaborates with key HHS agencies--ASPE, HCFA, NIMH

HHS:

- ASPE coordinates Department-wide Demonstration efforts, participates in application review process, and collaborates with HUD's Office of Independent Living for the Disabled on service issues
- HCFA funds, administers, and monitors 1115 waivers to States, provides technical assistance and consultation to States regarding 1115 waivers, and participates in application review process
- NIMH assists in planning service component and Program description guidelines, participates in application review process, and provides technical assistance and consultation to HUD, States, and local sponsors

AND IF:

HUD AREA OFFICES:

- Process Section 202 Program applications
- Designate Multifamily Housing Representative to provide technical assistance and consultation to States and local sponsors

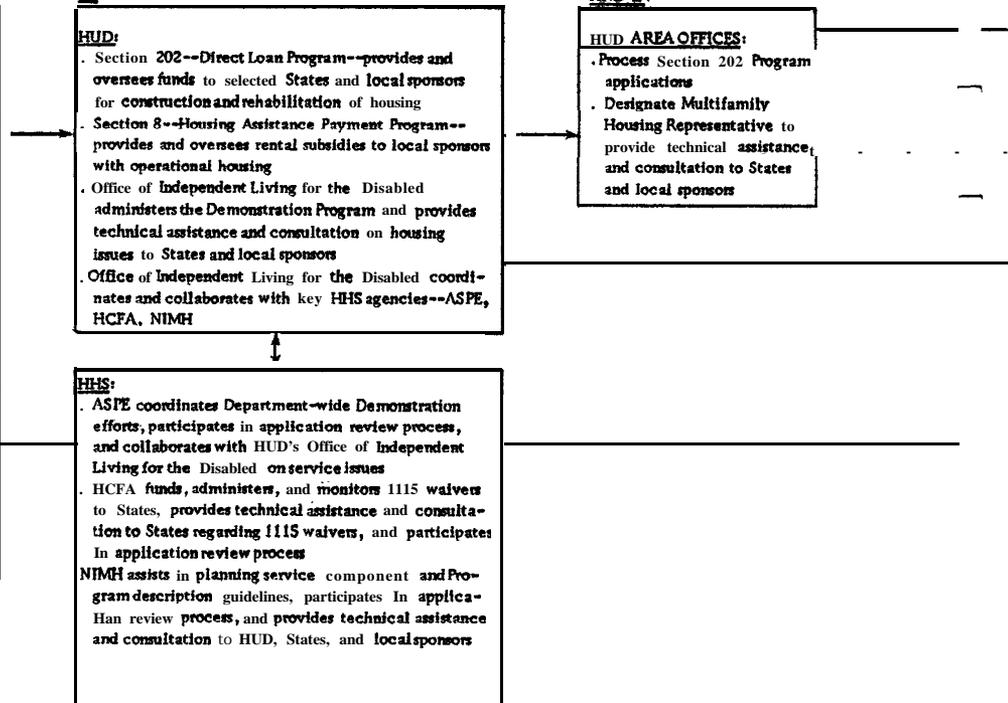


EXHIBIT II-2

HHS, Office of the Assistant Secretary
for Planning and Evaluation

LOGIC OF THE INTENDED PROGRAM--LEVEL II

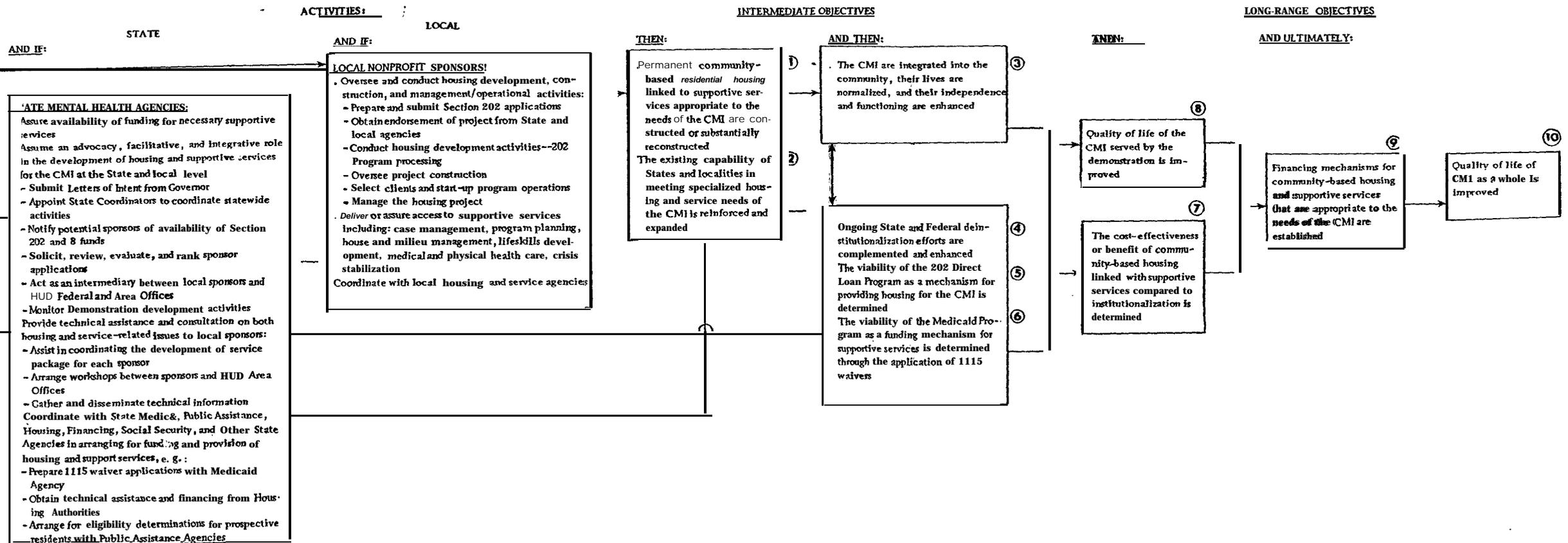


EXHIBIT II-3(1)

HHS, Office of the Assistant Secretary'
for Planning and Evaluation

SUGGESTED INDICATORS OF PROGRAM OBJECTIVES

① HOUSING

- . Number of projects and units approved
- . **Number** of operational projects and units
- . Number of projects and units under construction
- . **Number** of projects and units substantially rehabilitated
- . Types of living arrangements constructed, under construction, or substantially rehabilitated
- . Occupancy rates
- . Extent to which placement is appropriate
- . Quality of housing, i.e., **minimum** property standards, code violations over time

SERVICES

- . Nature and extent of services provided in-house or in the **community**
- . Appropriateness and configuration of facility staff
- . Nature and extent of services funding
- . Utilization of services
- . Service population characteristics
- . Number of **CMI** in housing facility with an Individualized Service Plan
- . Number of **CMI** in housing facility who have been assigned a case manager
- . Extent to which services are appropriate

②

- . Unit, component, staff, or individuals within the **SMHA** or locality responsible for the Demonstration Program and/or for provision of housing linked with services to the **CMI**
- . Extent and nature of local spinoffs from the Demonstration between local housing and service agencies
- . Extent to which States are developing their own housing linked with services
- . **Number** of State Mental Health Agencies organized as housing authorities
- . Extent and nature of formalized coordination, collaboration, and joint planning between housing and service agencies at State and local levels regarding the needs of the **CMI**
- . Extent of changes in responsibility and awareness vis-a-vis the needs of the **CMI**

③

- . Number of **CMI** residing in operational community-based housing
- . **Number** of **CMI** with a fully developed Individualized Service Plan
- . Number of **CMI** whose service needs are met as specified in the Individualized Service Plan
- . Number of **CMI** for whom the goals and objectives of the Individualized Service Plans have been accomplished
- . **Number** of **CMI** who move out of operational community-based housing into more independent living arrangements

④

- . Extent and nature of formalized coordination, collaboration, and joint planning between housing and service agencies at Federal and State levels
- . Evidence of commitments from housing and service agencies at Federal and State levels for shared responsibility for the **CMI**
- . Policies, procedures, or regulations altered or developed at the Federal and State levels to specifically address the needs of the **CMI**
- . Existing legislation, legislation introduced, **committee action**, etc., at the Federal and State levels to meet the needs of the **CMI**
- . Amount, types, and sources of Federal and State resources available for the development of housing linked with supportive services for the **CMI**
- . Shifts and increases in or new Federal and State resources available for the development of housing linked with supportive services for the **CMI** over time

⑤

- . **Number** of projects and units approved
- . Number of operational projects and units
- . Number of projects and units under construction
- . Number of projects and units substantially rehabilitated
- . Cost of construction per unit, site, State
- . Total costs of construction to the Federal Government
- . Average Fair Market Rents for each site
- . Average total rent per **occupant**
- . Extent and nature of problems encountered at Federal, State, and local levels with 202 Program procedures and requirements

EXHIBIT II-3(2)

- ⑥
 - . Number of States and projects utilizing the Medicaid 1115 waiver mechanism
 - . Number of States and projects utilizing Medicaid funds to finance supportive services for the CMI outside of the 1115 waiver process
 - Extent and nature of **problems** encountered at Federal, State, and local levels with the use of Medicaid funds to provide supportive services for the CMI
 - Cost and charges per unit of service per site and State
 - Total cost to the State of providing **community-based** supportive services to CMI served by the Demonstration
 - . Total cost to the Federal Government of providing community-based supportive services to CMI served by the Demonstration

- ⑦
 - . Total costs of **community-based** independent living arrangements linked with supportive services as compared with total institutional cost
 - Total service costs for CMI served by the Demonstration
 - Costs of *maintaining* a CMI individual served by a Demonstration project in the **community**
 - .. Income maintenance
 - .. Entitlements
 - Cost of maintaining CMI in an institutional setting and sources of payment for that cost

- ⑧
 - Improved functional levels
 - Measures of recidivism
 - Length of stay both in and out of institutions of residents
 - Service** utilization
 - Medication changes
 - Subjective assessments by residents
 - Employment status
 - Quality of housing, i.e., **minimum** property standards, code violations
 - Victimization

- ⑨
 - . Extent and nature of changes in Federal and State agencies' financing rules, regulations, and policies to focus on housing and service needs of the CMI, e.g.:
 - Changes in 202 Program or other HUD programs
 - Changes in Medicaid Program
 - . Legislation proposed and enacted at the Federal and State level enabling financing of housing and services appropriate to the needs of the CMI

- ⑩
 - Unproved functional levels
 - Measures of recidivism
 - Length of stay both in and out of institutions of residents
 - Service utilization
 - Medication changes
 - Subjective assessments by residents
 - Employment status
 - Quality of housing, i.e., **minimum** property standards, code violations, victimization

range of factors--political, social, and economic--too numerous to list and complex to identify contributed to the development of the HUD/HHS Demonstration Program. The inputs described below are not meant to be exhaustive but, rather, illustrative of the most relevant and concrete bases for the Demonstration.

Authorizing Legislation enabling the three funding mechanisms that constitute the basic administrative underpinnings of the Demonstration depicted on the Level I model includes: (1) Section 202 of the Housing and Community Development Act of 1974, which establishes the Direct Loan Program for Housing the Elderly and Handicapped and permits direct loan authority reserves to be made on behalf of eligible nonprofit sponsors interested in development of new or rehabilitated housing for special users ; (2) Section 8 of the Housing and Community Development Act of 1974, which establishes the Housing Assistance Payment Program, which provides rental subsidies for low-income individuals residing in existing, newly constructed, or substantially rehabilitated housing; and (3) Section 1115 of the Social Security Act, which establishes authority for waivers of certain Medicaid requirements for demonstration purposes. The Level II logic model lists two additional legislative inputs that contributed to the development and design of the Demonstration Program: Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of physical or mental handicap in every federally assisted program or activity in the country, and the Mental Health Systems Act of 1980, which provided for Federal support of a range of mental health services, including community-based housing, and which placed special emphasis on the chronically mentally ill.

Conceptual/Policy Inputs include several key reports, policy statements, and initiatives that contributed to the Demonstration design during its development and implementation and provided for its conceptual basis. The four major inputs indicated on the Level I model include: (1) the General Accounting Office (GAO) report, "Returning the Mentally Disabled to the Community: Government Needs to Do More," of 1977 that documented the lack of a planned, systematic approach to meeting the needs of the chronically mentally ill in the community and noted the deplorable living conditions in which most mentally ill reside; (2) the Deinstitutionalization Task Force established by the then Department of Health, Education, and Welfare (DHEW) in response to the GAO report to examine the role of DHEW in deinstitutionalization; (3) the National Institute of Mental Health's Community Support Program (CSP), a Federal initiative launched in 1977 to stimulate States to develop comprehensive community support systems for the chronically mentally ill who had been deinstitutionalized; and (4) other conceptual bases such as the Allied Services Act, which

formalized pertinent concepts including services integration. A number of other inputs depicted on the Level II model shaped and reinforced the Demonstration effort: the 1978 Report of the President's Commission on Mental Health, which reviewed the mental health needs of the nation and offered recommendations in eight important areas as to how best to meet these needs (e.g., the Report emphasized the needs of the chronically mentally ill and called for the development of a national plan for addressing the needs of this special population); "The National Plan for the Chronically Mentally Ill" of 1980, developed in response to the Commission's recommendations, which describes the **deinstitutionalization** process, the needs of the chronically mentally ill, and the range of available and desired treatment, residential, and service opportunities and offers recommendations for the development of an improved service delivery system; and the White House-endorsed Independent Living Initiative, which attempted to offer another approach to meeting the housing and services needs of the handicapped, including the **chronically** mentally ill, through the reorganization of resources from seven Federal agencies. It should be noted that this initiative was never implemented.

- Funding Inputs for the Demonstration included \$65 million in Section 202 direct loan authority reserves and \$13 million in Section 8 set-asides for fiscal years 1978-1980. In addition, an estimated \$20 to 30 million in Medicaid 1115 waivers was projected for projects approved during the same three years.

(2) Demonstration Activities

With the legislative, conceptual/policy, and financial inputs, it was expected that certain activities would be initiated and undertaken at the Federal, area, State, and local levels. Intended activities at each level are described below.

Federal Level--The role and responsibilities of each of the two key Federal agencies involved in the Demonstration are summarized in the next box of the models and were intended as follows: HUD activities were to involve the provision and oversight of funds made available to selected States and sponsors for new construction or substantial rehabilitation of housing and for rental subsidies. In addition, HUD was to administer the Demonstration Program, provide technical assistance and consultation on housing issues to States and local sponsors, and coordinate the effort with HHS. HHS, on the other hand, was to fund, administer, and monitor the 1115 waivers, disseminate

Demonstration-related information, provide technical assistance and consultation on service-related issues to States and local sponsors, and coordinate these activities with HUD.

Area Level--Activities at this level were intended to emanate only from HUD activities at the Federal level and to include routine processing and management of the Section 202 program applications and the provision of technical assistance and consultation to States and local sponsors.

State Level--State efforts were intended largely as the responsibility of State Mental Health Agencies (SMHAs) and, as shown on the models, were to follow from activities initiated at the Federal and area levels. SMHAs were expected to assume an advocacy, facilitative, and integrative role in the implementation of the HUD/HHS Demonstration Program at the State and local levels and to assure the availability of long-term funding for the supportive services developed in the Demonstration. Specifically, it was intended that SMHAs provide technical assistance and consultation on both housing and service-related issues to local sponsors and coordinate with other relevant State agencies such as those State-level agencies administering Medicaid, Public Assistance, and Housing in arranging for continued funding and provision of housing and support services for the chronically mentally ill.

Local Level--Following the progression of the models, local-level activities were to be undertaken by nonprofit sponsors and were intended to include oversight and conduct of housing development, construction and management activities, delivery and/or assurances of access to supportive services, and coordination with local housing and service agencies.

The descriptive statements of activities outlined above and depicted on the Level I logic model are intended to capture the primary focus or thrust of Federal, area, State, and local Demonstration efforts and are merely expanded upon in greater detail in the Level II model.

(3) Demonstration Objectives

The objectives of the HUD/HHS Demonstration Program shown on the models were identified following a thorough analysis of written documentation and interview data. As noted earlier, the objectives or intended results are sequenced from the intermediate to long range to indicate that, although the establishment of financing mechanisms for community-based

housing and supportive services to meet the needs of the chronically mentally ill and thereby improve their quality of life are the ultimate goals of the Demonstration, more immediate results are sought.

The 10 intermediate and long-range objectives of the Demonstration were distilled from a wide array of written and verbal objective statements and reflect in a simplified manner recurring themes and assumptions in both documentation and interviews. These themes and assumptions indicate that the availability of permanent community-based housing linked to supportive services must be assured and that the capacity of States and localities to meet the housing and service needs of the CMI must be reinforced and expanded in order for: (1) the CMI to be integrated into the community, (2) State and Federal ~~deinstitutionalization~~ efforts to be complemented and enhanced, and (3) the viability of the 202 Program and the Medicaid Program through the application of 1115 waivers as housing and services funding mechanisms to be determined. The attainment of these three intermediate objectives was intended as necessary to result in improvement in the quality of life of the CMI served through the Demonstration. The attainment of the intermediate objectives was intended also as necessary to determine the cost-effectiveness or benefit of community-based housing linked with supportive services developed under the Demonstration, as compared to institutionalization. One of the long-range objectives--establishment of more permanent financing mechanisms for housing and supportive services (Objective 9 on the Level I logic model)--is the direct, intended result of improved life quality and cost-effectiveness or benefit determination (Objectives 7 and 8). Finally, improvement of the quality of life of the CMI population as a whole--the ultimate objective of the Demonstration--is intended to result from the establishment of financing mechanisms for community-based housing and supportive services.

In general, the Level II model adds more detail and specificity throughout the input and activity components, defining more explicitly Federal, area, State, and local Demonstration activities. In contrast, the intermediate and long-range objectives depicted on both models are presented at the same level of specificity.

2. THE ACTUAL HUD/HHS DEMONSTRATION PROGRAM

Overall, a substantial amount of State- and project-specific information was collected through field visits, written documents, and telephone interviews. However, significant variability exists among States and projects in the quality and quantity of the data obtained. These differences were largely due to several important factors : (1) early stage of Demonstration implementation in some States, especially of the service component; (2) lack of available Demonstration-specific information; (3) roles, responsibilities, and number of individuals interviewed at each site; and (4) the extent to which interviewees were comprehensive in their responses.

This section is organized into two substantive areas, one describing certain features of the Demonstration Program across States, the other discussing across-project experiences. Where appropriate, State- and project-specific examples are provided to supplement aggregated information. It should be noted that the information collected from the seven States contacted by telephone was not particularly comprehensive or complete. The State Coordinators interviewed often were not familiar with the details of Demonstration implementation in their State and with specific project experiences and accomplishments. They were, however, able to provide broad overviews of the Demonstration Program and to discuss problems and factors that might influence the success of Demonstration sponsors within their individual State context. Consequently, the information collected in this fashion served to support field visit observations and findings and to expand the database for analysis. Accordingly, the observations and findings presented below focus on the experiences of the nine field visit States and are only supplemented with relevant telephone interview information, where appropriate.

(1) Program Activities And Results Across States

The information presented below describes actual State level Demonstration operations. The data are aggregated across States and are divided

into seven basic categories that characterize relevant State-level experiences, efforts, and accomplishments.

Organizational Characteristics

In all States but one, the State Mental Health Agency (SMHA) assumed responsibility for the Demonstration and assigned a State Coordinator. In several waiver-only States, two individuals have been assigned the coordination role, one for housing, the other for services. Most often, the Coordinator is located in the organizational entity charged with administering, funding, and/or developing community mental health services. In the District of Columbia, however, responsibility for the Demonstration rests with a special assistant for mental health located in the Office of the Director of the Department of Human Services--an umbrella agency that includes the Mental Health Services Administration. Generally, the State Coordinators collaborate with a range of key individuals within the SMHA whose roles are pertinent to Demonstration implementation. The roles and responsibilities of State Coordinators tend to be similar across States. They are generally reactive and facilitative and are limited to: (1) overseeing of Demonstration activities and (2) providing or arranging for technical assistance and consultation. Oversight of the Demonstration does not appear to be a formalized function with built-in mechanisms for accountability; rather, it involves tracking the status of approved projects and keeping abreast of problems and difficulties as they arise. Technical assistance and consultation are usually provided or arranged for on an as-needed basis, on site and off, in response to specific problems and difficulties encountered by local sponsors. These problems have been both housing and/or services related. For example, in Georgia, the HUD Coordinator, who now is a special private housing consultant, continues to provide consultation on a range of housing development and management issues to sponsors. In the District of Columbia, an informal monthly meeting of sponsors, the State, and the Medicaid Coordinator has been established. This meeting serves as the forum for discussing specific problems common across sponsors with knowledgeable individuals who are invited to attend and provide consultation.

In the five waiver-only States visited, State Coordinators also performed those duties associated with the implementation of the Section 1115 waivers-- development and submission of initial application and progress reports ; collection of project-specific cost and services data; coordination with the State Medicaid Agency, where applicable; and interaction with HCFA . In Tennessee, a committee of relevant actors was established specifically to develop policies and procedures for implementing the waiver. In all other cases, the State Coordinator interacted with representatives of agencies external to the SMHA such as the social services agency and the Medicaid agency to discuss matters relatively narrow in scope and issue specific. In fact, as Exhibit 11-4, following this page, indicates, the involvement of other State-level agencies in the Demonstration effort has been minimal. Where Housing Authorities did participate in the Program per se, their involvement tended to occur at the inception of the Demonstration and to consist of providing general consultation on housing development issues. It should be noted that, in Colorado where the SMHA has also been designated the Housing Authority, the two roles are closely integrated and mutually supporting.

The involvement of State Medicaid Agencies (SMAs) also varies dramatically from State to State and does not appear to be related to the organizational location of the SMA. That is, SMAs located within the same umbrella agency as the SMHA were not necessarily more involved in the Demonstration than SMAs located in organizationally separate departments. In some States, as in Massachusetts, Vermont, and Colorado, the SMA has not been directly involved in the Demonstration. In other States, especially those employing the 1115 waiver mechanisms, the role of the SMA is more apparent and defined.

Statewide Housing And Services Development Efforts Undertaken
Prior To And/Or Concurrent With The Demonstration Program

All of the States visited had been actively involved in deinstitutionalization, some for more than a decade, others since the mid to late 1910s. Each State has been and continues to be engaged in one or more housing

EXHIBIT II-4

HHS, Office of the Assistant Secretary for Planning and Evaluation

ORGANIZATIONAL AUSPICES AND RELEVANT
STATE DEMONSTRATION CHARACTERISTICS

State	Auspices	Demonstration-Related Responsibilities	Other Agencies Invoked in Demonstration
Colorado	. Division of Mental Health, Department of Institutions	. Monitor development of specific Demonstration projects . Provide consultation and technical assistance	. None specified
District of Columbia	. Office of the Director, Department of Human Services	. Coordinate initial Demonstration activities . Provide ongoing consultation, technical assistance, and coordination	. Department of Human Services - Mental Health Services Administration - Medical Assistance--Office of Health Care Financing . Department of Housing and Community Development
Georgia	. Division of Mental Health and Mental Retardation, Department of Human Resources	. Oversee Demonstration activities, especially as they relate to the 1115 waivers . Provide technical assistance and consultation to Demonstration projects	. Department of Medical Assistance
Massachusetts	. Division of Mental Health Services, Department of Mental Health	. Monitor overall Demonstration implementation activities	. None specified
Minnesota	. Bureau of Mental Health, Department of Public Welfare	. Resolve problems with Medical Assistance Division ova-applicable waiver rules . Provide consultation to Demonstration projects . Prepare quarterly 1115 waiver reports for HCFA	. Department of Public Welfare - Medical Assistance Division
Oregon	. Mental Health Services Division, Department of Human Resources	. Provide technical assistance to Demonstration projects . Contract for service components	. Department of Human Resources - Senior Services Division
Pennsylvania	. Bureau of Community Programs, Office of Mental Health, Department of Public Welfare	. Fund, monitor, and contract with counties for mental health services generally, including Community Residential and Rehabilitation Services . License and approve all mental health facilities	. Community Affairs--State Housing Authority
Tennessee	. Community Service Section, Department of Mental Health and Mental Retardation	. Establish 1115 Waiver Committee to develop policies and procedures for implementing waivers . Provide technical assistance in implementing waivers	. Department of Public Health - Medicaid . Office of the Comptroller
Vermont	. Division of Community Mental Health Programs, Department of Mental Health, Agency of Human Services	. Oversee implementation of Demonstration . Contract with nonprofit mental health agencies (sponsors) . Perform evaluation and monitoring of residential programs	. Vermont Housing Finance Agency . Vermont Council of Community Mental Health Services

and/or services development efforts to meet the needs of the chronically mentally ill in the community. The nature and extent of these efforts span a broad spectrum of activities and include a range of initiatives, legislative actions, policies, and programs.

On the whole, some community-based housing alternatives and mental health services existed in each State prior to the Demonstration. However, the quality, quantity, and appropriateness of these arrangements and the length of time they were operational at the inception of the Demonstration varied from State to State. With respect to housing opportunities, at least three States--Georgia, Massachusetts, and Minnesota--funded their own State residential programs. Specifically, Georgia has been funding a small scale Supportive Living Program since 1969. In Massachusetts, the SMHA has been funding a range of residential models since the settlement in 1978 of the Northampton Consent Decree--a court order that specifies that clients are entitled to live in the least restrictive, most normal residential alternatives and to receive appropriate treatment. In Minnesota, the State legislature, in enacting Rule 22 in 1976, established that community-based residential care programs have to be coordinated with services. Rule 22 was passed in tandem with the legislatively mandated Sharing Life in the Community program--a nonresidential community-based service program providing psychosocial rehabilitation services to the CMI. In two States, residential slots subsidized by Section 8 were available for housing the mentally disabled prior to the Demonstration. In Colorado, the SMHA in its dual role as the State Housing Authority has been administering Section 8 slots (currently 212 slots) since 1977. In Georgia, the Community Residential Finance Agency allocated 250 Section 8 slots for clients served by CMHCs. Boarding home, domiciliary care, group home, halfway house, and apartment slots were available in at least six of the field visit States. However, it should be noted that the availability of such residential arrangements was generally limited to a handful of slots scattered statewide or concentrated in one locality. In addition to specific housing and related services efforts, licensure standards for residential programs were either in effect or being developed in the majority of States. The specific

requirements stipulated by each appear to differ across States and to be applicable to different residential alternatives.

Generally, most of the housing efforts initiated prior to the Demonstration were still ongoing at the time of the field visits. A number of States, however, have undertaken new housing-related initiatives since the Demonstration, although the effect of the Demonstration on these efforts (and vice versa) could not be discerned. Most notable are the following: (1) Massachusetts' Chapter 689 Program (the State's counterpart to the Federal Section 202 Program) initiated in 1969 in response to legislative mandate and administered by the State Housing Finance Agency--since 1980, 3 percent of the total slots allotted by the 689 Program (approximately \$2.3 million in fiscal year 1982) are designated for the SMHA; (2) Rule 12, passed in 1980 in Minnesota, which establishes licensing requirements for residential facilities for adult mentally ill persons; and (3) the Community Residential and Rehabilitation Program established in 1978 in Pennsylvania to develop residential programs for the CMI.

Six of the nine States visited participate in the Community Support Program (CSP). Two CSP States were involved in implementing a statewide strategy approach to the development of community support systems, and the rest were developing community support system demonstration projects at the local level. Other significant efforts have been undertaken by individual States; for example, (1) in the District of Columbia, efforts have been underway to implement the Dixon versus Schweiker court order to deinstitutionalize St. Elizabeths Hospital; (2) in Minnesota, the State is funding services for persons residing in board and care facilities in Minneapolis, using Medicaid, and the State legislature in 1981 authorized grants to counties for the development of community support services (Rule 14) as well as grants for services to adult mentally ill persons in residential programs (Rule 36); and (3) in Oregon, payments are available for residential services in five county mental health centers and the State has been involved in long-term planning for community residential services for the CMI. Exhibit II-5 highlights activities undertaken both prior to and concurrent with the Demonstration.

EXHIBIT II-8(1)

HHS, Office of the Assistant Secretary for Planning and Evaluation

STAT3 HOUSING-, SERVICES-, AND FINANCING-RELATED
ACTIVITIES AND EFFORTS UNDERTAKEN PRIOR TO AND/OR
CONCURRENT WITH THE DEMONSTRATION PROGRAM
IN NINE STATES

state	Activities Prior to Demonstration	Ongoing/ Concurrent Activities
Colorado	<ul style="list-style-type: none"> Division of Mental Health has been administering 212 Section 8 slots since 1977 community support Program 	<ul style="list-style-type: none"> Division of Mental Health Section 8 slots Community Support Program For FY 1982, the State legislature authorized \$288,000 for housing for the "serious, critical, and chronically mentally ill"
District of Columbia	<ul style="list-style-type: none"> Dixon vs. Schweiker--Court order to deinstitutionalize St. Elizabeths 2,000 domiciliary care placements (beds) Home Safety Act--Licensing Law of 1977--stipulates physical facility and programmatic requirements 200 Community Residence Facility slots SSI supplementation for residents of Community Residence Facilities since 1978 Community Support Program 	<ul style="list-style-type: none"> Domiciliary care placements Community Residence Facility slots SSI supplementation for residents of Community Residence Facilities Community Support Program Currently, \$2.3 million is available for Dixon Plan implementation that includes developing residential alternatives Development of a standardized level of care instrument
Georgia	<ul style="list-style-type: none"> State-funded residential program--Supportive Living Program--initiated in 1969 Community Residential Finance Agency allocated 250 Section 8 slots for clients served by CMHCs Community Support Program Contractual agreements with families to provide Adult Foster Care Four group homes statewide Liberal Medicaid reimbursement policy for mental health services 	<ul style="list-style-type: none"> Supportive Living Program--currently serving 1,300 clients (60 percent are CMI); FY 1982 budget \$1.8 million; 40-45 workers around the State are designated as supportive living workers Currently, 180 of the Community Residential Finance Agency's Section 8 slots are used Community support Program Contractual agreements with families to provide Adult Foster Care Four group homes statewide in addition to Demonstration facilities Liberal Medicaid reimbursement policy for mental health services
Massachusetts	<ul style="list-style-type: none"> Northampton Consent Decree--passed in 1978--specifies that clients are entitled to live in the least restrictive, most normal residential alternatives and to receive appropriate treatment Department of Mental Health funds a range of residential models in accordance with the Northampton Consent Decree Community support Program 	<ul style="list-style-type: none"> Northampton Consent Decree Department of Mental Health residential alternative Community Support Program Chapter 689 Program--initiated in 1980--State-funded housing program for the handicapped administered by Massachusetts Housing Finance Agency. Three percent of allotted units are allocated to the Department of Mental Health--approximately \$2.3 million (IO projects) in FY 1982 Developing standards for licensing and monitoring residential facilities
Minnesota	<ul style="list-style-type: none"> Sharing Life in the Community (SLIC)--established in 1976--a nonresidential community-based program for the CMI; program focuses on activities of daily living Rule 22--State legislation establishing a community-based residential care program that is coordinated with services--passed in 1976 in tandem with SLIC Conducted a housing study in 1977 State-funded services for persons residing in board and care facilities, using Medicaid, in Minneapolis (HHS has made an audit exception with respect to this practice) Community Support Program 	<ul style="list-style-type: none"> SLIC Rule 22 Community Support Program Rule 12--State legislation setting licensing requirements for residential facilities for adult mentally ill persons--passed in 1980 Rule 14--State legislation authorizing grants to counties for community support services--effective 1981 Rule 36--State legislation authorizing grants for services to adult mentally ill persons in residential facilities--established in 1981

<u>State</u>	<u>Activities Prior to Demonstration</u>	<u>Ongoing/ Concurrent Activities</u>
Oregon	<ul style="list-style-type: none"> . Alternatives to State Hospitalization Programs--began in 1973--large-scale effort at deinstitutionalization, focused on upgrading of residential programs, development of standards, licensing, and funding of services . Licensing of Adult Residential Care, Homes serving the Mentally or Emotionally Disturbed (RCF/MED) . Long-term planning for community residential services for the CMI, including transitional living programs, board and care facilities, short-term emergency shelter, RCF/MED group homes, homes for the aged, and adult foster homes, ICFs, and nonhospital crisis/respite services . Payment for residential services in five county mental health centers . Community Support Program 	<ul style="list-style-type: none"> . Alternatives to State Hospitalization Programs . Licensing of RCF/MED . Payment for residential services in five county mental health centers
Pennsylvania	<ul style="list-style-type: none"> . Mental Health and Mental Retardation Act--passed in 1966--services to be provided at the community level: inpatient, outpatient, partial services, emergency services, aftercare and interim care, rehabilitation and training, consult and on and training, and unified intake . Medicaid program reimburses for partial hospitalization/day treatment, outpatient mental health care, and inpatient care in private psychiatric hospitals and psychiatric units in general hospitals 	<ul style="list-style-type: none"> . Community Support Program . Mental Health and Mental Retardation Act, 1966 . Medicaid reimbursable mental health services . Community Residential and Rehabilitation Services (CRRS) Program--initiated in 1978 with \$1.2 million to develop residential slots for CMI; 400 slots in 20 projects were added to 330 existing slots . FY 1979 categorical State allocation of \$1.8 million specifically for residential programs . Currently, there are 2,200 residential slots statewide: these include 40 group homes with 3 to 13 slots each
Tennessee	<ul style="list-style-type: none"> . In 1977, the State offered a one-time opportunity for CMHCs to fund liaison workers to be located in State institutions--\$1.0 million was allocated for this purpose. In addition, a funding formula was developed whereby \$3.50 per day per deinstitutionalized client was given to a CMHC as an incentive for centers to serve the deinstitutionalized. This effort was not continued once State funds were no longer available . In 1978, there were six halfway houses in the State; four of these were in Memphis . Boarding homes available for deinstitutionalized CMI 	<ul style="list-style-type: none"> . Four halfway houses currently remain in the State . Currently, there are approximately 600 boarding homes housing from 8 to 12 residents each . State is currently developing standards for State-funded services provided by CMHCs, including transitional services. Transitional services standards will attempt to link CMHCs with boarding homes and to require that services be provided to boarding home residents . In 1980, CMHCs receiving State funds were required to have affiliate agreements with a boarding home to provide residential placements for CMI served by the CMHC
Vermont	<ul style="list-style-type: none"> . Structured Treatment Programs--initiated in 1975--comprised three residential programs that were started to coincide with the closing of a ward in Vermont State Hospital; these programs were large congregate housing arrangements serving between 15 and 20 residents . Impact Program (HIP Grant): (1) developed adult foster care placements--a boarding home concept whereby 3, 4, 5, or 6 beds were available in a home for deinstitutionalized clients--and (2) hospital staff was assimilated into community mental health agencies 	<ul style="list-style-type: none"> . Currently, one Structured Treatment Program exists . Currently, three residential programs are State funded and supplemented by resident SSI; all three are professionally staffed, two are owned and operated by CMHCs, one is operated under a subcontract with a CMHC . State funds an apartment program with one CMHC to assist people in transition from group homes . Continuing deinstitutionalization efforts

Problems States Sought To Address Through Participation In The Demonstration Program

Not surprisingly, it was evident from the high degree of consistency among interview responses that States' involvement in the Demonstration was spurred by three key problems identified in the community-based service delivery system: (1) the lack of safe, affordable housing alternatives for the CMI; (2) the inappropriateness of housing opportunities, where available, to meet the needs of the CMI; and (3) the absence of appropriate support services. Individual States identified additional, related problems such as the need to slow down the "revolving door" of the CMI between the hospital and the community, stacking up of clients in State institutions, and the inappropriate placement of many CMI in long-term care facilities.

Statewide Demonstration Program Objectives

In accordance with the problems delineated above, States were in general agreement on their primary program objectives. That is, all nine States indicated that they expected to: (1) increase the availability of quality community residential alternatives for the CMI, (2) expand existing State-supported residential programs, (3) provide supportive services, and (4) transition residents into less restrictive, more independent residential alternatives. In only one State was improving the quality of life of the CMI in the community a specific stated Program objective. On a broader level, it was apparent that the HUD/HHS Demonstration Program was perceived across States simply as a mechanism for obtaining additional Federal support.

Statewide Demonstration Program Accomplishments To Date

Statewide Demonstration accomplishments have been realized across States in a number of significant areas, namely, housing development, service provision, and others, impinging on States' ability to maintain the CMI in the community. As such, these accomplishments are consistent with

stated Demonstration objectives. Housing slots are now available in localities previously lacking residential alternatives for the CMI; in several States, Demonstration projects have been integrated into ongoing State-funded residential programs, thereby expanding such efforts; and supportive services are being provided to a greater or lesser extent either on site or off site in most operational projects.

Information on statewide Demonstration Program housing development accomplishments was available for all 16 States in the study's universe, as defined in Chapter I. As shown in Exhibit 11-6, following this page, 29 percent of all projects approved in these States in the three-year Demonstration Program period are operational, with construction fully completed and clients occupying the residences. In all, 327 single or double occupancy units have been built.; 52 percent of these units are in group homes and 48 percent are apartment units. The total estimated capacity for these operational units is 390. Current occupancy figures were only available in eight States with at least one operational project. In these States, 226 clients are currently being served in Demonstration projects--an 83 percent occupancy level. Seventeen percent of the projects in the 16 States are currently under construction and 37 percent are still in the Section 202 processing pipeline. To date, 17 percent of the approved projects have been formally cancelled.

Cancellations were due to a wide range of reasons, including: (1) unresolved problems with site selection, (2) inadequate financial resources of the sponsor, (3) community resistance to location of specific housing units, (4) lack of follow through by the sponsor, and (5) sponsor discontent with Section 202 paperwork requirements and time delays.

In the nine field visit States, 68 projects and 601 units were approved in 1978, 1979, and 1980. Fund reservations for these projects over the three-year period totalled \$21,081,058. Of these approved projects, 33 percent are operational with a total of 244 units and a capacity for 292 residents. **Fourteen projects (20 percent) are still under construction, whereas**

EXHIBIT II-6

HHS, Office of the Assistant Secretary for Planning and Evaluation

DEMONSTRATION ACCOMPLISHMENTS IN SIXTEEN STATES

STATE	No. of Approved Projects				PLANNED		ACCOMPLISHED														Current Capacity	Current Occupancy
	Total No. of Units Approved				Total Fund Reservation	Project Status				Operational				Units Completed				Apartment Units				
	78	79	80	Total		Cancelled	202 Processing		Under Const.		Operational		Total Units		Cop. Home Units		Apartment Units					
N	%	N	%	N	%	N	%	N	%	N	%	N	% ^{1/}	N	% ^{2/}	N	% ^{2/}					
Colorado	7		3	10	84	2,702,800	3	30	--	--	1	10	6	60	65	77	22	33	43	66	65	65
D. C.	--	4	1	5	52	1,798,300	1	20	1	20	2	40	1	20	9	17	5	55	4	44	18	10
Georgia	4	2	1	7	87	2,768,200	--	--	2	29	1	14	4	57	44	so	24	54	20	4s	54	18
Massachusetts	9	2	3	14	111	4,357,640	2	14	5	36	2	14	5	36	46	41	46	100	--	--	46	46
Minnesota	3	--	--	3	24	852,274	--	--	--	--	1	33	2	67	20	83	--	--	20	100	33	33
Oregon	5	--	--	5	43	1,289,100	3	60	--	--	--	--	2	40	16	37	16	100	--	--	20	20
Pennsylvania	3	3	4	10	91	3,406,125	1	10	6	60	1	10	2	20	16	18	--	--	16	100	28	27
Tennessee	--	3	1	4	49	1,824,600	--	--	--	--	3	75	1	25	8	16	8	100	--	--	8	7
Vermont	6	4		10	60	2,082,019	2	20	5	50	3	30	0	0	(20) ^{3/}	33	12	60	8	40	(20) ^{3/}	--
Subtotal	37	13	13	68	601	21,081,058	12	18	19	28	14	20	23	33	244	40	133	54	111	45	292	226
California	--	5	4	9	93	3,739,900	--	--	8	88	--	--	1	11	10	11	--	--	10	100	10	NA
Florida	6	--	2	8	61	1,693,881	6	75	1	12	--	--	1	12	6	10	6	100	--	--	12	NA
Illinois	--	5	4	9	91	3,566,442	--	--	5	55	3	33	1	11	11	12	11	100	--	--	11	NA
North Carolina	--	3	--	3	23	759,300	--	--	2	66	--	--	1	33	4	17	4	100	--	--	8	NA
Rhode Island	4	--	1	5	38	1,609,000	--	--	2	40	2	40	1	20	7	18	7	100	--	--	9	NA
Utah	--	1	1	2	23	732,900	1	so	--	--	--	--	1	so	21	91	--	--	21	100	21	NA
Wisconsin	--	4	3	7	60	2,320,200	--	--	4	57	--	--	3	42	24	40	8	33	16	66	27	NA
Subtotal	10	18	15	43	389	14,421,623	7	16	22	51	5	11	9	21	83	21	36	43	47	57	98	NA
GRAND TOTAL	47	36	28	111	990	35,502,681	19	17	41	37	19	17	32	29	327	33	169	52	158	48	390	

1/ Percent of total number of units approved.
 2/ Percent of units completed.
 3/ Units due to become operational in January 1982.

19 projects (28 percent) are in one of the 202 processing stages. Eighteen percent of the projects approved in the nine States have been cancelled to date. Specific information on services actually provided on site and off site in all operational projects was not available at the State level either across the 16 States or in the sample of nine.

In the four non-waiver States visited--Colorado, Massachusetts, Oregon, and Pennsylvania--the Demonstration projects were fairly well integrated into existing State-funded residential programs and no special services arrangements had been made. These four States fund services provided in Demonstration projects with State revenue and/or Medicaid. They opted not to apply for Section 1115 waivers for various reasons that tended to be State specific. For example, interviewees in Colorado reported receiving conflicting messages from HCFA Central and Regional Offices. Respondents interviewed in Massachusetts indicated that the State Medicaid Agency was reluctant to get involved, that the State legislature did not allow State departments to accept "new" Federal funds, and that clear guidance from the Federal level on how to obtain the waivers was not forthcoming. However, in the five waiver-only States, information was collected on the types of services these States were planning on providing, the services they expected to fund through Medicaid reimbursements and their total projected budgets for services in each of the three waiver years.

In general, the five waiver-only States planned to provide the range of required and optional services specified in the 1980 HUD/HHS Demonstration Program Description : case management, house and milieu management, life skills development, medical and physical health care, crisis stabilization, vocational development, family relations planning, recreational and avocational activity planning, psychotherapy, and advocacy and legal assistance . Services to be provided on site and reimbursed by Medicaid tended to be similar across States, with only a few exceptions. On the whole, States planned to fund case management, life skills training, supervision, and transportation. In the District of Columbia, supervision was not specified as a waived service, whereas individual and group counseling services as well as crisis stabilization were added to the basic list

above. In Minnesota, medical management and individual and group counseling were added. Total projected 1115 waiver budgets for the first year of the waivers ranged from \$80,737 in Tennessee to \$342,469 in Vermont, with an average projected budget across the five States for the first year of \$218,233. These projected budgets were determined with the assumption that 19 of a total of 29 approved projects in these five States would be operational and in a position to bill Medicaid for services rendered. Exhibit II-? provides in more detail the definitions of the services the five waiver-only States planned to provide, the services they planned to cover under the 1115 waivers, and the total projected 1115 waiver budgets for three demonstration years. The information contained in this exhibit was abstracted from the initial 1115 waiver application submitted to HCFA. Additional services-related information was collected for the nine local projects visited. This information is presented in the next major section of this chapter .

Other important achievements emanating from the Demonstration that impinge on the State's ability to maintain the CMI in the community were described across field visit States. They include: (1) increased awareness and sensitivity on the part of mental health agencies and providers at the State and local levels of the unique community-based housing needs of the CMI and the issues involved in housing development and production generally ; (2) increased familiarity of mental health agencies and providers with HUD's Section 202 and Section 8 programs specifically; and (3) growing coordination, interaction, and interchange among housing and mental health agencies at both the State and local levels.

Moreover, there was a sense across States that the Demonstration served as a means to publicize and promote the needs of the CMI, helped in reconceptualizing a continuum of care for this population, and provided an opportunity for comprehensive planning, creative thinking, and the development , in some States, of policy options for obtaining additional support for services for the CMI.

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SERVICES PLANNED AND BUDGETS PROJECTED
BY FIVE 1115 WAIVER-ONLY STATES

STATE	SERVICES PLANNED	SERVICE DEFINITION	1115 WAIVER SERVICES	TOTAL PROJECTED 11 WAIVER BUDGETS*
DISTRICT OF COLUMBIA	<ul style="list-style-type: none"> . Case Management . Clinical Consultation Services . Temporary Crisis Beds . Life skills Development Services: Skills Training, Individual Training, and Group Training . Counseling Services--Individual, Emergency, Family, and Adaptive Counseling 	<ul style="list-style-type: none"> Activities of an accountable individual aimed at linking needed services to a patient and coordination of various service components in order to assure that the elements of treatment--residential and supportive services planned--are delivered Periodic assistance provided by a psychiatrist, psychologist, social worker, and/or other mental health professional to staff and residents under contract agreement with the providers Temporary residence in a supportive living environment aimed at providing crisis stabilization to help clients adjust to emergency situations and Performed by a skilled professional Training in self-maintenance and adaptive skills in order to increase capacity for independent living--grooming and hygiene, budgeting and fiscal management, food preparation, exercise, recreation, use of public transit, etc. 	<ul style="list-style-type: none"> . Case Management . Counseling (Individual and group) . Crisis Stabilization . Life Skills Development (individual and group) . Consultation 	<ul style="list-style-type: none"> . Year 1: \$203,363 . Year 2: \$228,784 . Year 3: \$257,382
GEORGIA*	<ul style="list-style-type: none"> . Case Management . House and Milieu Management Services . Life Skills Development Services . Medical and Physical Health Care Service . Crisis stabilization Services . vocational Development Services . Education Development Services . Family Relations Planning . Recreational/Avocational Activity Planning Services . Psychotherapy Services . Advocacy Services 	<ul style="list-style-type: none"> Continuous availability of appropriate forms of assistance for residents and goal-oriented individual program plans Clarification of basic expectations relative to housekeeping, group behavioral norms, mechanisms for conflict resolution, roommate selection, collection of rents, resident government, as well as other factors related to immediate environment and its management Includes personal grooming and hygiene, budgeting and fiscal management, food preparation and diet, exercise, use of public transit, etc. Medication maintenance and monitoring, general medical and dental care 24-hour telephone assistance, in-person on-site assistance, and inpatient services Prevocational testing, assessment through transitional sheltered and competitive employment Appropriate involvement at elementary, high school, or college levels Assistance in planning for crucial relationships with parents, children, spouses, siblings, and other close family members Familiarize residents with and develop their capacity to enjoy social, athletic, outdoor, and cultural activities Individual, group, and family counseling Includes assistance in applying for benefits and entitlements and ensuring rights 	<ul style="list-style-type: none"> . Supervision . Life Skills Training . Case Management . Transportation to Other Needed Services 	<ul style="list-style-type: none"> . Year 1: \$228,168 . Year 2: \$250,985 . Year 3: \$276,083
MINNESOTA	<ul style="list-style-type: none"> . crisis Assistance . Psychosocial Rehabilitation Services . Supportive Services of Indefinite Duration . Medical and Mental Health Care 	<ul style="list-style-type: none"> 24-hour assistance to the disabled in their homes/jobs Programs that help clients evaluate strengths and weaknesses and participate in setting goals and planning for appropriate services; train clients in community living skills; obtain or provide appropriate living arrangements; develop social skills; improve employability Include supportive work opportunities, supportive living arrangements, daytime and evening activities 	<p><u>Northwest Mental Health Center</u></p> <ul style="list-style-type: none"> . Case Management . Counseling/Individual/ Group Supportive Therapy . Individualized Program Planning/Monitoring . Independent Living Skills Training . Medical Management . Transportation 	<ul style="list-style-type: none"> . Year 1: \$236,429 . Year 2: \$271,893 . Year 3: N/A

*Services specified are those included in the 1980 Demonstration Program Description as required and optional services. The definitions provided in the 1115 waiver application are recoded verbatim from the Program Description.

**Projected budgets include State and Federal shares.

STATE	SERVICES PLANNED	SERVICE DEFINITION	11 15 WANER SERVICES	TOTAL PROJECTED 11:15 WAIVER BUDGETS**
MINNESOTA (continued)	<ul style="list-style-type: none"> . Backup Support, Assistance, and Consultation to All in contact with the Mentally Ill . Case Management and Program Planning Service5 . Vocational and Educational Services . Psychotherapy and Counseling Services . Advocacy Services . Legal Assistance Services 			
ENNESSEE*	<ul style="list-style-type: none"> . Case Management and Program Planning Services . House and Milieu Management Services . Life Skills Development Services . Medical and Physical Health Care Services . Crisis Stabilization Services . Education Development Services . Family Relations Planning . Recreational/Avocational Activity Planning Service . Psychotherapy Services . Advocacy Services . Legal Assistance Services 	<ul style="list-style-type: none"> . Same as Georgia definitions 	<ul style="list-style-type: none"> . Supervision . Life Skills Training Case Management Transportation to Other Needed Services Other Than Medical 	<ul style="list-style-type: none"> Year 1: \$ 80,737 Year 2: \$ 92,923 Year 3: \$106,961
VERMONT	<ul style="list-style-type: none"> . Supervision . Independent Living Skills Training . Case Management . Vocational Development Services . Educational Development services . Family Relations Planning . Recreational/Avocational Planning Services . Psychotherapy Services . Advocacy/Legal Assistance Services . Medical and Physical Health Care Services 	<ul style="list-style-type: none"> . 24-hour supervision of all residents . Includes (1) self-care skills training--to help clients learn to perform routine daily living activities, (2) social skills training--to help clients learn age-appropriate and situation-appropriate social behavior . Includes: treatment planning, coordination, brokerage, linkage, referral, and counseling, which assure continuous availability of appropriate forms of assistance for residents. Also monitoring, documenting, and reporting of resident's progress . Provided primarily through State Division of Vocational Rehabilitation . Provided by Community Mental Health Agency (CMHA), or where available . To be provided by Planned Parenthood . Provided by residential and CMHA's day treatment programs in conjunction with the Department of Forests and Parks . Provided by CMHAs . Provided through a contract between DMH and Vermont Legal Aid . Provided off-site by generic providers 	<ul style="list-style-type: none"> 24-Hour Supervision Independent Living Skills Training Case Management Transportation to Other Needed Services 	<ul style="list-style-type: none"> Year 1: \$342,469 Year 2: \$462,639 Year 3: \$508,902

Problems And Barriers Impeding Demonstration Program Accomplishments

The HUD/HHS Demonstration Program seeks to achieve complex and difficult objectives at the State, local, and client levels. The State-level accomplishments described in the previous section must, therefore, be viewed within a context that takes into account not only the significance and difficulty of Demonstration objectives but also the substantial barriers, obstacles, and problems that States have encountered in their efforts to implement the Program.

Information on problems and barriers that impede Program performance and achievement of objectives was collected during the field visits and telephone interviews. Highlights of housing, services, 1115 waivers, and other problems encountered by the nine field visit States are presented in Exhibit 11-8. Barriers and problems identified tended to focus almost exclusively on the housing development component of the Demonstration and difficulties encountered with Section 202 processing. Projects across States spent anywhere from 16 to 36 months working through the processing stages, construction, and, finally, admission of clients to the facility. In general, States had had very little experience with the services aspect of the Demonstration. Few projects had been operational for more than several months at the time of the field visits. The housing development and management problems cited in Exhibit II-8 echo the findings of the USR&E study. Consequently, they will not be discussed here in detail. The reader is referred to the excellent discussion and analysis of the early housing development experiences of the Demonstration presented in the USR&E reports referenced in Chapter I.

No service delivery-related problems per se were discussed during the State-level visits. However, a number of difficulties were identified by interviewees in the five waiver-only States. These problems involve either the 1115 waiver application, process itself or initial experiences in waiver implementation. For example, the District of Columbia had problems in developing unified services definitions and formulating fair reimbursement

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PROBLEMS AND BARRIERS ENCOUNTERED IN
DEMONSTRATION IMPLEMENTATION IN NINE STATES

STATE	HOUSING	SERVICES	1115 WAIVERS	OTHER
COLORADO (Non-waiver)	<ul style="list-style-type: none"> . A myriad of 202 processing problems were experienced (see USR and E Report) . Section 8: (a) time delays in verifying incomes can cause delays in admission so that placement breaks down; (b) occupancy regulations preclude the use of Section 8 funds for transitional living; and (c) unrelated individuals cannot occupy a one-bedroom unit 		<ul style="list-style-type: none"> . Did not apply for waivers because of conflicting messages from HCFA Regional and Central Offices 	<ul style="list-style-type: none"> . SSI/SSDI eligibility cutbacks are beginning to take a toll on Medicaid and basic financial assistance; the State is now seeing "zero income" clients in its Section 8 slots for the first time
D. C. (Waiver)	<ul style="list-style-type: none"> . HUD processing, site selection, delays, constant revisions in HUD requirements, and bureaucratic red tape have all been problematic . Lack of housing experience at all levels (especially provider/sponsors) . Housing is very expensive in D. C. 	<ul style="list-style-type: none"> . Anchor Mental Health Association has not, to date, started billing Medicaid for services rendered 	<ul style="list-style-type: none"> . Developing unified service definitions . Formulating fair reimbursement rates (each provider had different rates) . Lack of experience in developing waivers . Unresponsive bill-paying system 	
GEORGIA (Waiver)	<ul style="list-style-type: none"> . Site selection and zoning difficulties . HUD requirements for housing development . Architects not limited by budget escalates the cost of the projects . Problems of scale: the 202 program is inappropriate and not cost-effective for development of small scattered site facilities . HUD Area Office Management Section has requirements incompatible with data available from Demonstration projects . Section 8: (a) no two unrelated individuals can share a unit--the lease is for the unit not the individual; (b) sponsors want to underwrite the resident supervisor unit, i.e., to get the unit covered by Section 8 . Lack of experience at sponsor level 			<ul style="list-style-type: none"> . Community resistance . Increasing restrictiveness of SSI eligibility determinations and redeterminations . Overall, the Demonstration Program was disproportionately time consuming and cumbersome for small projects
MASSACHUSETTS (Non-waiver)	<ul style="list-style-type: none"> . Section 202 has been laborious, time and paper consuming, and difficult to predict from an operational perspective . Community resistance has been encountered with every project 		<ul style="list-style-type: none"> . MA did not apply for the 1115 waivers because (a) clear guidance from Washington on how to obtain the waiver was not forthcoming; (b) the State match would have to come from the Department of Public Welfare's (DPW) budget which DPW was reluctant to do; and (c) the legislature would not allow any State department to accept "new" Federal grants 	<ul style="list-style-type: none"> . Budget cuts

STATE	HOUSING	SERVICES	1115 WAIVERS	OTHER
<p>MINNESOTA (Waiver/ Non-waiver)</p>	<ul style="list-style-type: none"> . HUD construction regulations . HUD Area Office did not understand the concept of the Demonstration Program . 504 compliance issues 		<ul style="list-style-type: none"> . Medical Assistance (MA) under the 1115 waivers has been problematic in several respects: <ul style="list-style-type: none"> - County Department of Social Services believed it could waive disability requirements, but, in reality, it could not because it is a central State function performed by the Disability Review Team - Disability definition under the waiver may be too stringent - Residents were reluctant and sometimes refused to apply for SSI, even though required; the result is that they are ineligible for MA until they do so - MA prefers that eligibility be established prior to a client's entry into the residence; this results in a three-week delay in intake, with no alternative housing available - MA was not initially using the 90-day retroactive payment period so that Northwestern Apartments was losing substantial MA reimbursements - MA has opted not to use presumptive eligibility; the result is that no reimbursements are possible until eligibility is established - Although monthly earned income limitations have been raised under the waivers, it still may be too low for some residents to qualify for MA 	
<p>OREGON (Non-waiver)</p>	<ul style="list-style-type: none"> . HUD processing was slow and involved much paperwork . Differences in opinion regarding housing development requirements 			<ul style="list-style-type: none"> . HUD case managers currently have responsibility for screening and placing mentally or emotionally disturbed (MED) clients. During Janus House's first year of operation, 375 clients screened declined placement at Janus House and Alder street Residence . Increasing numbers of SSI denials and terminations

STATE	HOUSING	SERVICES	1115 WAIVERS	OTHER
PENNSYLVANIA (Non-waiver)	<ul style="list-style-type: none"> . 202 program is an inappropriate mechanism for building small projects . HUD has exceedingly strict regulations on how the 202 fund reservation can be used . The projects are too expensive and "too nice"; the result is the development of facilities clients do not want to move out of, thereby contradicting the transitional philosophy of the Demonstration . State does not want to create permanent housing for the CMI or mini-institutions within the community; HUD, however, views the Demonstration as potential long-term housing . State would prefer developing projects for mixed populations (i. e. , the handicapped and CMI) instead of segregated sites as currently exist under the Demonstration . Community resistance . The concept of the Demonstration was good; the implementation was/is horrendous 		<p>Did not initially apply for waivers because the long-term State commitment for service funding required was not politically viable. In addition, a State funding base for residential services was developed concurrent with the implementation of the demonstration.</p>	<p>SSI eligibility determinations have been problematic; to date, most of the Demonstration residents are not SSI eligible and are being maintained through the State welfare system</p>
TENNESSEE (Waiver)	<ul style="list-style-type: none"> . HUD Area Office not cognizant of rules and regulations of the Demonstration Program . Community resistance 	<ul style="list-style-type: none"> . Northeast Mental Health Housing has not started billing Medicaid for services rendered 	<ul style="list-style-type: none"> . Northeast Community Mental Health Housing (NECMHH) had difficulties developing costs for residential care; i.e. , the sponsor is having some difficulties separating out waived services for costing purposes . Sponsor needs technical assistance on record-keeping so as to keep services covered by the waiver disrate; there has been a four-month delay in NECMHH's submission of the cost report . State does not have the data needed for the waiver-continuation application 	<p>SSI eligibility determinations have been very difficult</p>
VERMONT (Waiver)	<ul style="list-style-type: none"> . The Demonstration Program was low priority at the HUD Area Office; consequently, the State's congressional delegation became involved to pressure the field offices into action . Lack of housing experience and confidence on the sponsor level . HUD did not offer technical assistance . Actual costs of the Demonstration facilities are excessive . time frame for beginning construction is 12-18 months, which results in additional increased costs (i. e. , the 	<ul style="list-style-type: none"> . None of the Vermont projects are operational to date 		

STATE	HOUSING	SERVICES	1115 WAIVERS	OTHER
<p>VERMONT (Waiver) (continued)</p>	<p>sponsor has to offer an unreasonable purchase to the seller in compensation for a lengthy option)</p> <p>HUD Area Office has stopped processing all projects that did not close before 9/30/ 81; this affects at least four sponsors</p> <p>The 202 program is time consuming and cost excessive</p>			

rates across three of its sponsors in preparing the waiver application. In Minnesota, problems involving disability determination and payment methods were encountered with the Medical Assistance unit. In Tennessee, State interviewees indicated that the one operational project appeared to be having difficulties developing service definitions for costing purposes. As a result, the sponsor had not started billing Medicaid for services provided to Demonstration clients. The four non-waivered States simply indicated why they decided not to apply for the 1115 waivers. There was some agreement among these States that clear guidance from HHS regarding the application process was not available or was conflictual.

Similarities across States in other problems encountered also emerged. Interviewees in at least five States emphasized the potentially devastating effects on the CMI of the increasing restrictiveness of SSI eligibility determinations and the growing numbers of individuals who had been denied SSI benefits or whose eligibility has been redetermined and benefits subsequently terminated.

Future Factors Likely To Influence Statewide Demonstration Efforts

A range of broadly defined economic and political factors were cited across States as likely to influence statewide Demonstration efforts in the near future. Most notable were the current state of the economy, the resulting fiscal cutbacks at all levels of government affecting both services and housing support, and the growing restrictiveness of Supplemental Security Income (SSI) eligibility determinations, discussed earlier. These three issues and the concerns they generate seemed to overshadow other factors mentioned in individual States. State-level persons interviewed are deeply concerned about their ability to maintain current levels of support for mental health services in general and, in the five waiver-only States, for services presently reimbursed under the 1115 waiver mechanism specifically. Cutbacks in the SSI and Social Security Disability Insurance (SSDI) rolls have meant that, in some States like Colorado and Tennessee, clients who have no sources of income are currently being served in Demonstration

facilities. State officials fear that this trend seems likely to continue, thereby jeopardizing community tenure of the CMI.

On a more positive note, a majority of the States visited indicated their intent to apply for Home and Community Care waivers authorized under the Omnibus Budget Reconciliation Act of 1981. Respondents stated that, if approved, these waivers may be used to enhance and broaden efforts initiated under the Demonstration.

2. DEMONSTRATION PROGRAM ACTIVITIES AND RESULTS ACROSS NINE PROJECTS

The information presented below describes the operating realities of eight operational Demonstration projects and one nearing completion in five waiver-only and four non-waiver States. Across-project information in eight descriptive categories is presented below.

Organizational Characteristics

Sponsors of the nine projects visited were all private nonprofit local mental health service delivery organizations. Five of the agencies were community mental health centers, although one had not been federally funded. The other four projects were sponsored by a range of service providers including a psycho-social service agency, a county mental health association, a mental health association under the auspices of the Catholic Church, and a community-based mental health service agency. Generally, these sponsors have been serving the mentally ill for years, some having been established in the early 1960s. Their involvement with chronically mentally ill adults, however, tends to be more recent. For example, the Child Guidance and Mental Health Clinic of Delaware County in Media, Pennsylvania, was initially founded to serve children exclusively. The Center broadened its scope in the 1970s and now serves mentally disabled, emotionally disturbed, and mentally retarded children and adults. Seven of the sponsors visited were already providing residential services to the CMI in the community prior to the Demonstration--Northeast Community Mental Health Center in Memphis, Tennessee, operated a halfway house and worked

closely with specific boarding homes; Howard Mental Health Services in Burlington, Vermont, operated a residential treatment program targeted at moderately functioning mentally ill clients; and South Shore Mental Health Center in Quincy, Massachusetts, established a Residential Service Program for the CMI, organized to provide a continuum of residential services from supervised to semi-independent living. For the remaining two sponsors, participation in the Demonstration signified their initial involvement in residential programming. For all sponsors, the Demonstration Program was their first experience in developing housing opportunities using the Section 202 mechanism. At least five sponsors employed the services of a housing consultant to assist in 202 processing.

Four sponsors established separate corporate entities to administer, and manage the fiscal aspects of the housing component of the Demonstration and to limit the liability of the parent agency. The responsibilities of these housing corporations across projects emphasized the physical aspect of the project and involved oversight of 202 processing and construction, management (i.e., landlord duties) and maintenance of the facility once operational, and provision of administrative services. The overall responsibilities of sponsors themselves were similar across projects and included: (1) providing or assuring the delivery of services on and off site, (2) arranging for project staffing, and (3) overseeing the Demonstration project--developing policies and procedures, overseeing budgets and staff, and so on. Additional project-specific organizational characteristics are presented in detail in Volume II of this final report.

Housing Development Experience

Seven of the local projects visited received fund reservations in 1978 and two in 1979. As Exhibit II-9 indicates, their housing development experience was lengthy, ranging from 16 to 36 months from initiation of processing to the time clients moved into the facility. This, however, was not unexpected; 202 processing generally takes from 18 to 24 months. The development experiences between sponsors undertaking substantial rehabilitation of existing structures (seven of the field visit projects) and those undertaking new construction did not differ. Although in one State, Colorado, where all but one project underwent moderate rather than substantial rehabilitation, the length of processing

EXHIBIT II-9

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for Planning and Evaluation

HOUSING DEVELOPMENT MILESTONES IN NINE PROJECTS

STATE/PROJECT	DATE PROCESSING BEGAN	DATE CONSTRUCTION BEGAN	TIME ELAPSED IN MONTHS		DATE CONSTRUCTION COMPLETED	TIME ELAPSED IN MONTHS		DATE CLIENTS MOVED IN	TIME ELAPSED IN MONTHS		DATE SECTION 8 FUNDS BEGAN
			Since Last Event	Cumulative		Since Last Event	Cumulative		Since Last Event	Cumulative	
Colorado (Redi Corporation)	8/78	3/80	20	20	7/80	4	24	7/80	0	24	9/80 (retroactive to 7/80)
District of Columbia (Anchor House)	6/79	6/81	24	24	9/81	3	27	10/81	1	28	11/81 (retroactive to 10/81)
Georgia (Community Friendship Apartments)	7/78 (Summer)	10/80	≈ 26	≈ 26	5/81	7	≈ 33	5/81	0	≈ 33	8/81 (retroactive to 5/81)
Massachusetts (Revere Road House)	7/78 (Summer)	7/80 (Summer)	≈ 24	≈ 24	2/81	7	≈ 31	2/81	0	≈ 31	2/81
Minnesota (Northwestern Apartment Living)	10/78 (Fall)	10/79 (Fall)	≈ 12	≈ 12	1/80	3	≈ 15	2/80	1	≈ 16	2/80
Oregon (Janus House)	1978	10/80	≈ 26	≈ 26	4/81	6	≈ 32	5/81	1	≈ 33	9/81
Pennsylvania (Mason I Apartments)	9/78	8/80	23	23	4/81	8	31	6/81	2	33	6/81
Tennessee (Northeast Community Mental Health)	4/79	11/80	19	19	5/81	6	25	10/81	5	30	10/81
Vermont (Howard Mental Health Services)	10/78 (Fall)	10/81	≈ 36	≈ 36		Construction not complete		--- anticipated completion		3/82	

was significantly reduced. On the average, across States, 23 months elapsed from the time processing was initiated to the time construction actually began. Construction itself, either new or substantial rehabilitation, was completed within three to eight months. In seven projects, clients were admitted to the residences either immediately upon completion of construction or within a month or two. At Northeast Mental Health Housing in Memphis, Tennessee, five months elapsed between the time construction was completed and residents were accepted. Howard Mental Health Services., in Burlington, Vermont, was still under construction at the time of the field visit.

Section 8 funds began to flow to most projects. as soon as clients moved into the facility, although three projects--Colorado-Redi Corporation, the District of Columbia-Anchor House, and Georgia-Community Friendship Apartments--experienced delays in payments of one to three months. However, once Section 8 funds were available, payments were made retroactive to the date clients entered the project. Only in Georgia did respondents indicate that this delay caused serious cash flow problems for the project and sponsoring agency.

On the whole, interviewees across the nine projects emphasized the difficulties and problems they encountered during the housing development phase of Demonstration implementation. Although most of the difficulties with Section 202 processing have already been well documented by USR&E, sponsors had to overcome additional, though less burdensome, problems in the initial operational stages of the Demonstration. These problems are discussed later in this section.

Residential Facility Characteristics

Eleven facilities have been constructed across the nine field visit projects. Anchor Mental Health Association in the District of Columbia and Child Guidance and Mental Health Clinics of Delaware County in Media, Pennsylvania, each developed residences on two separate sites. In total, 74 units are currently available (66 are operational) with a potential capacity for 111 residents. At the time of the field visit, 79 percent of the available slots across projects were occupied. There are anywhere from 4 to 18 units per facility across projects,

with an average number of 6.7 units per project. On the average, 10 clients could reside in each facility with 1.54^{1/2} residents per unit,

Across projects, five group homes and six independent living apartment complexes were constructed.^{2/} All of the group homes were rehabilitated; one group home was built with two adjoining apartments. Four of the apartment projects were rehabilitated and two were newly constructed. Thirty-four group home units with a capacity for 46 residents are currently or will be available at the five sites, and 49 apartment units with a capacity for 65 residents are available across projects. As noted earlier, Howard Mental Health Services was not yet fully constructed at the time of the field visits. On the average, there are 6.8 and 6.7 units per group home and apartment complex, respectively, with a range of five to eight units per group home and four to nine per apartment complex. Group homes across the nine projects could accommodate 9.2 residents on the average, whereas apartment complexes could accommodate 10.8 residents per project. Mean resident capacity per unit for each of the two housing types was 1.35 for group homes and 1.7 for apartments.

All of the facilities visited are located in residential or semiresidential neighborhoods, and most are accessible to and/or within walking distance of a range of services, shopping, transportation and other amenities. Only one project--Northwestern Apartment Living in Crookston, Minnesota--is not within walking distance of necessary services. On the whole, respondents at the local level reported encountering very little community resistance once a site was actually obtained, although some indicated that construction was undertaken without formally or publicly informing the neighborhood of the nature of the facility being constructed or rehabilitated or the types of individuals expected to assume residence. It should be noted, however, that several sponsors had

^{1/} Only units available for residents were used in calculating this mean. Of a total of 74 units, two were specifically built for staff.

^{2/} Howard Mental Health Services in Burlington, Vermont, built a group home with two adjoining apartments. For the purposes of this study, this facility is considered a group home.

initial difficulties in obtaining sites for the Demonstration due to neighborhood resistance.

Nine of the 11 facilities studied are or will be staffed with a range of professionals and support personnel responsible for performing a broad spectrum of duties. Two apartment projects are unsupervised. Staff sizes across the nine facilities ranged from one to approximately eight^{3/} and are formed into somewhat different staffing patterns. All have either a live-in or daytime director/housing manager, although he/she is not necessarily located on site, as in the instance of Colorado's Redi- Corp. Three facilities have made provisions for relief workers to assume the housing manager's responsibilities for weekends and/or evenings. Four facilities are staffed more extensively. Professional staff in these facilities include a diverse group of providers such as resident counselors, life skills trainers, case managers, program aides, and so on.

On-site staff appear to be performing similar duties and providing similar services across projects. In general, across the nine staffed facilities, services available include : (1) supervision--periodic, daytime, or 24 hour; (2) case management; (3) counseling; and (4) skills of daily living training--individual and group. Other services provided on site in individual facilities are as follows: crisis stabilization, medication, assessment, and transportation. Facility staff responsibilities also include assuring or arranging for the delivery of certain key services off site. The most common off-site service available across projects is day treatment. This service is available to residents in nine of the 11 facilities studied, whether staffed or unsupervised. Prevocational, vocational rehabilitation, and sheltered employment is available to residents of five facilities, although the nature and extent of these services were not specified. Moreover, the nature, quantity, and quality of services provided on site and off site across projects were not assessed.

^{3/} Total full-time equivalents were not calculated across projects because, in several of the projects, the time availability of certain staff members, i.e., relief workers, support staff, and residents' time contributions, was not specified.

In eight of the nine projects visited, the stated guiding service philosophy is one of enhancing residents' independence and functioning and of transitioning them into less restrictive residential alternatives. Although most of the projects' service components were still at an early stage of development and residents had not actually been transitioned, the majority of sponsors plan to move clients through the facilities within one to two years of admission. Northeast Community Mental Health Center in Memphis, Tennessee, was the only sponsor not holding to the transitioning philosophy. In this case, the Demonstration project is viewed as a permanent housing project rather than as a transitional residential treatment program.

Exhibit 11-10, following this page, details further the facility characteristics described above on a project-by-project basis.

Selection And Exclusion Criteria For Screening Residents

Comparisons of selection and exclusion criteria for screening potential residents in nine projects visited highlighted certain similarities across projects and indicated that no two projects employ criteria that are completely alike. In addition, it was clear from interviewee responses, that no specific criteria for inclusion or operational definitions of clients to be served have been delineated. That is, few projects had specified a range of criteria in two key areas: (1) severity of disability with specifications for duration of treatment, number of episodes and time frames for occurrence of such episodes, e.g. , history of hospitalization, history of continued community-based treatment, and maintenance on medication, and (2) functional impairment, including impaired role performance, e.g. , unemployment, need for public financial assistance, or inappropriate social behavior, and/or impairment in the ability to perform basic activities of daily living.

Most of the selection and exclusion criteria outlined are either behavioral or functional in nature, tend to be rather broad, and are generally undefined in terms of duration, frequency, and severity of behavioral and functional impairment. It appears that determination of the degree of impairment is usually

EXHIBIT II-10(1)

HHS, Office of the Assistant Secretary for Planning and Evaluation

FACILITY CHARACTERISTICS IN NINE PROJECTS

State/Project	Facility Type/ Nature of Construction	Number of Units	Capacity	Current Occupancy	Neighborhood Characteristics/Reaction	Community Access	Licensure Standards	Staffing	Services Available
Colorado (Redi-Corp)	Rehabilitated apartments	5	5	5	Residential apartments, rooming houses, and single-family homes No community resistance	Close to shopping, a city park, on a bus line	No licensure standards	A Redi-Corp nurse and voca- tional counselor available to serve residents on an as-need basis--no project staffing	On-site - None Off-site - Day treatment - Case management - Sheltered workshop
District of Columbia (Anchor House)	Rehabilitated group home	5	10	8	Residential, mixed racially and in terms of age No community resistance	Within walking distance of shopping and services; on bus route; Anchor Mental Health Services (Anchor Social Center and Anchor Workshop) within walking distance	Licensed as a community residential facility (CRF)	Director Assistant Director Resident Counselor 2 c-l-a	On-site - 24-hour supervision - Case management - Counseling - Individual living skills traini - Group living skills training Off-site - Consultation - Assessment/reassessment - Social club - Sheltered workshop
	Rehabilitated apartments	4	8	2	Same as above (the two facilities are within four blocks of each other)		Does not meet CRF require- ments	None--unsupervised	On-site - None Off-site - Same as above
Georgia (Community Friendship apartments)	Newly constructed apartments	11 (one for staff)	20	18	Developing midtown section of town- semi-residential with some businesses. Mixed racially and economically Initial resistance prior to construction this dissipated over two-year process and construction period	Access to all services--shoppi and health and social services; on bus route	No licensure standards	Program Specialist Live-In Resident Manager Part-time relief Resident Manager 2 Life Skills Trainers Part-time Secretary	On-site - Supervision - Life skills training - Case management - Adult education, testing, evaluation; vocational preparation; transitional employment placement; etc Off-site - Crisis stabilization - Day treatment - Vocational rehabilitation - Mental health care - Social club

EXHIBIT II-10(2)

State/Project	Facility Type/ Nature of Construction	Number of Units	Capacity	Current Occupancy	Neighborhood Characteristics/Reaction	Community Access	Licensure Standards	Staffing	Services Available
Massachusetts (Revere Road House)	Rehabilitated group home	8	8	6	<ul style="list-style-type: none"> On edge of downtown, residential neighborhood populated by elderly Italian and Irish people No community resistance 	<ul style="list-style-type: none"> Within walking distance of shopping, near public transportation, two blocks from the Center 	<ul style="list-style-type: none"> No licensure standards 	<ul style="list-style-type: none"> House Manager 5 Behavior Training Specialists 2 Case Managers Dietitian 	<ul style="list-style-type: none"> On-site <ul style="list-style-type: none"> Activities of daily living training Medications Supervision Case management Off-site <ul style="list-style-type: none"> Day treatment CMHC services Medical/dental services Psychiatric evaluations Day programming
Minnesota (Northwestern Apartment Living)	Newly constructed apartments	9	18	18	<ul style="list-style-type: none"> On very edge of northeastern part of town, between a new apartment complex and a church--a new residential neighborhood No community resistance 	<ul style="list-style-type: none"> Not within walking distance of shopping or services. No transportation is available 	<ul style="list-style-type: none"> No licensure standards 	<ul style="list-style-type: none"> Program Director 2 Counselors 3 Program Aides Secretary Janitor 2 residents for after-hour security and emergencies 	<ul style="list-style-type: none"> On-site <ul style="list-style-type: none"> Supervision Case management Counseling Crisis intervention Skills of daily living training Transportation Off-site <ul style="list-style-type: none"> Day treatment CMHC services for a fee
Oregon (Janus House)	Rehabilitated group home	7	12	11	<ul style="list-style-type: none"> Residential, changing neighborhood in downtown that is becoming increasingly commercial No community resistance 	<ul style="list-style-type: none"> On bus line, within blocks of shopping, recreational raw- &lea, and services 	<ul style="list-style-type: none"> State group home licensure standards--Currently, project does not meet these standards 	<ul style="list-style-type: none"> Director 3 House Managers (full-time) 2 House Managers (part-time) 	<ul style="list-style-type: none"> On-site <ul style="list-style-type: none"> Skills of daily living training Case management Medications Off-site <ul style="list-style-type: none"> Day treatment
Pennsylvania (Meson I Apartments)	Rehabilitated apartments	4 (1 resident manager unit)	6	6	<ul style="list-style-type: none"> A housing development of multi-family dwellings--population highly transitory in nature, includes small businesses No community resistance 	<ul style="list-style-type: none"> Shopping across the street, mass transit not accessible 	<ul style="list-style-type: none"> Licensed by State as a Community Residential and Rehabilitation Services Program 	<ul style="list-style-type: none"> Live-In Resident Supervisor 2 weekend relief workers 	<ul style="list-style-type: none"> On-site <ul style="list-style-type: none"> Skills of daily living training Supervision Assessment Crisis intervention Liaison with base services Off-site <ul style="list-style-type: none"> Day program Vocational rehabilitation training Mental health services Case management Transitional employment Crisis stabilization

EXHIBIT II-10(3)

State/Project	Facility Type/ Nature of Construction	Number of Units	Capacity	Current Occupancy	Neighborhood Characteristics/Reaction	Community Access	Licensure Standards	Staffing	Services Available
Pennsylvania (continued)	Rehabilitated apartments	5 (1 resident manager unit)	8	7	Multifamily dwellings and small businesses No community resistance	Accessible to bus and trolley services. Medical and emergency are nearby	Same	Same	On-site - Same as above Off-site - Same as above
Tennessee (Northeast Community Mental Health Housing)	Rehabilitated group home (2 duplexes)	8	8	7	Owner occupied, rental, blue collar, mixed racially; generally in good repair No community resistance	On major bus routes, within walking distance of shopping, accessible to mental health and health services	State licensure standards for residential facilities serving four or more mentally ill persons (boarding homes)	Housing Manager	On-site - Life skills training - Supervision - Case management - Transportation Off-site - Day treatment - Crisis stabilization
Vermont (Howard Mental Health Services)	Rehabilitated group home	6	6	*	A commercial/residential neighborhood No community resistance	Near bus route, convenient to all major services and shopping	Will be licensed by the State as a transitional care residence	Live-in couple	On-site - 24-hour supervision - Case management - Skills of daily living training - Transportation Off-site - Day treatment - Prevocational services
	Rehabilitated apartments	2	2	*	Same as above--the apartments are adjoining the group home	Same as above	Same as above	None--unsupervised	On-site - None Off-site - Same as above
TOTALS	11 (1 with adjoining apartments)	74	111	88					
Group Home	5	34	46						
Apartments	6	40	65						

*Not yet occupied at time of visit.

left up to the clinical judgment of intake staff. In other words, it was evident that the selection and/or exclusion criteria are used loosely as guides for screening and in support of clinical judgments of client suitability. The specifications are not used as “hard and fast” criteria for either selecting clients or refusing admission to particular clients. Thus, projects have not targeted specific individuals with particular impairment or disability characteristics for inclusion in the HUD/HI-IS Demonstration Program. Rather, the projects visited have outlined general selection and exclusion criteria for consideration that permit much flexibility and discretion in client selection.

As outlined in Exhibit II-11, certain commonalities did exist in the selection and exclusion criteria used among projects. A majority of projects have chosen to exclude individuals with histories of substance abuse and of inappropriate, antisocial, and violent behavior.

Given the approach taken across projects in screening potential residents and the variability among projects in specific criteria delineated for either selection or exclusion, it is clear that, although all projects refer to the population served as the chronically mentally ill, they may in fact be serving widely differing populations. This finding has far-reaching implications for evaluating the Demonstration effort more intensively and is discussed further in Chapter IV. In terms of the exploratory evaluation, this finding has profound implications not only for comparing of activities undertaken on behalf of the chronically mentally ill across the nine projects but also for aggregating and generalizing from study findings. Because each project may be serving a unique population, drawing conclusions about the national Demonstration experience may not be appropriate or meaningful. In addition, this finding must be taken into account in examining the Demonstration overall.

Current Resident Characteristics

Eighty-eight clients are currently being served in eight of the nine projects visited. An examination of specific resident characteristics indicated that Demonstration projects, with few exceptions, are serving a relatively young

EXHIBIT II-11 (1)

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SELECTION AND EXCLUSION CRITERIA USED TO
SCREEN DEMONSTRATION CLIENTS IN NINE PROJECTS

<u>State/Project</u>	<u>Operational Definition/Exclusion Criteria</u>
Colorado (Redi-Corp)	<ul style="list-style-type: none"> • Residents must be low functioning, severely disabled persons who do not have a history of violence or property destruction. Termination criteria include these limitations as well as mutual consent that the resident needs either a more structured or a more independent living arrangement Issues considered in client selection: <ul style="list-style-type: none"> - Length of time client was known to staff - Diagnosis - Strengths - Type of disruptive behavior exhibited while under staff care - Others involved with client's treatment - Agreement of treatment team on client's chance to succeed in an independent living setting - Frequency of staff visits to client in the apartment - Existence of a support system for the client outside mental health center staff - Adequacy of client's independent living skills required to maintain an apartment - Client's vocational level - Designation of an individual responsible for client's case management - Frequency of client treatment plan reviews - Level of supervision required by client - History of client's danger to him/herself or others - History of drug or alcohol abuse - Coals Rent Subsidy program will help to achieve
District of Columbia (Anchor House)	<p>Exclusion criteria--will have reservations about client with the following characteristics:</p> <ul style="list-style-type: none"> • Frequent and lengthy hospitalizations • Alcohol and drug abuse • Violent behavior--physical or verbal--to self or others • Sexually inappropriate behavior • Suicidal tendencies • Problems in taking prescribed medications • Poor employment history in terms of attendance and motivation <p>Residents have to be 18 years of age or older and usually under 65 years of age</p>
Georgia (Community Friendship Apartments)	<p>Criteria for selection of residents</p> <ul style="list-style-type: none"> - Adults (18 and over) - Section 8 income eligibility • Medicaid eligibility • Psychiatric disability • Linkage with a community mental health program <p>The following are also considered in the screening process:</p> <ul style="list-style-type: none"> • Current location of residence (priority is given to serving Central Fulton catchment area residents) • Willingness to participate in structured daytime activities or work • Relationship of apartment living/residential services to current community mental health service plan • Presence of skills and/or attitudes that make independent living seem important and feasible • Past experience in independent living • Potential for independent living outside this program • Client involvement in the application process
Massachusetts (Revere Road House)	<ul style="list-style-type: none"> • Referrals may be made by Medfield State Hospital or DMH Area Office • Successful candidates will: <ul style="list-style-type: none"> - Have a Monday-Friday day program, job, sheltered workshop placement, or volunteer work for a minimum of 30 hours per week - Have a stable source of financial income providing a minimum of \$275 per month plus Medicaid or additional funds to cover costs of medications • Demonstrate an ability to interact and cooperate with other clients, program staff, and the Residential Services program as a whole - Toilet independently

<u>State/Project</u>	<u>Operational Definition/Exclusion Criteria</u>
Massachusetts (Revere Road House) (cont.)	<ul style="list-style-type: none"> - Be compliant in taking medications - Be able to pass the self-preservation test . Applicants will not be accepted who: <ul style="list-style-type: none"> - Are actively suicidal, homicidal, or fire setting - Are actively engaged in drug or alcohol abuse or physical self-abuse - Have serious medical problems - Habitually run away - Exhibit deviant sexual behavior
Minnesota (Northwestern Apartment Living)	<ul style="list-style-type: none"> . Selection criteria: <ul style="list-style-type: none"> - Diagnosis of mental illness (mental retardation or chemical dependency may be secondary) - Indication that the individual will become independent within two years - Personal hygiene is not problematic - Exclude persons with suicidal tendencies and those requiring "holding services"
Oregon (Janus House)	<ul style="list-style-type: none"> . Between ages of 18-50 . Disability definition that is demonstrable . Exclusion criteria: <ul style="list-style-type: none"> - Alcohol or drug abuse history - Sociopathy - Criminal or violent tendencies
Pennsylvania (Meson I Apartments)	<ul style="list-style-type: none"> . Screening criteria: <ul style="list-style-type: none"> - Residents of the county - Need for supportive services, i.e., from the aftercare population - 18 years of age or older - Client's desire for residential placement . Exclusion criteria: <ul style="list-style-type: none"> - Mental retardation - Substance abuse history
Tennessee (Northeast Community Mental Health Housing)	<ul style="list-style-type: none"> . HUD/HHS Demonstration definition: <ul style="list-style-type: none"> - Chronically mentally ill individuals currently residing in institutions but capable of independent living - Chronically mentally ill individuals at risk of being reinstitutionalized - Chronically mentally ill individuals with no prior institutionalization but for whom housing linked to services would provide an alternative to institutionalization . Preliminary screening by the Selection Committee will be based on the following criteria: <ul style="list-style-type: none"> - History of psychiatric disorder - Capability of self-preservation - Capability of basic self-care skills - History of drug or alcohol dependence - History of antisocial behavior - History of aggression against persons or property
Vermont (Howard Mental Health Services)	<ul style="list-style-type: none"> . Howard Mental Health Services (HMHS) has not yet specified inclusion/exclusion criteria-- the project is still under construction. Definition is expected to take into consideration the following: <ul style="list-style-type: none"> - Length of hospital stays over time - Individuals not currently served by HMHS residential program

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population, in its 20s and 30s. Males tend to outnumber females almost two to one. The population is mostly white; only 18 percent of the residents are nonwhite. Fifty-three percent of the residents across projects receive monthly SSI benefits ranging from \$176 to \$391. In three projects--Northwest Apartment Living in Minnesota, Janus House in Oregon, and Meson I Apartments in Pennsylvania-- some residents receive public assistance. Only in Northwestern Apartment Living do five of the 18 residents live on personal earnings of \$561 per month on the average.

In general, the majority of the residents are diagnosed as schizophrenics and have histories of prior long-term hospitalizations, and 86 percent are currently medicated. However, in three projects a significant proportion of the residents do not have histories of long-term institutionalization. For example, at Northwest Apartment Living in Minnesota, 10 residents (55 percent) have a history of prior acute hospitalizations, family care, or no previous mental health treatment history. At Janus House in Oregon, seven of 11 residents only have histories of previous community mental health treatment. None of the residents at Northeast Mental Health Housing in Tennessee has a history of long-term hospitalization. Viewed in the context of the discussion above on selection and exclusion criteria, this finding is not surprising. Nonetheless, it is significant in that at least one-third of the projects studied do not appear to be serving a severely disabled population. The implications of this finding in eight of the intended Demonstration Program sites are significant and will be examined in more detail in the next chapter.

Across projects, referrals to Demonstration facilities were made from a wide range of agencies and organizations. However, two-thirds of the current residents were referred by either a State institution (33 percent) or a community- or county-based mental health or social service agency (34 percent). Other agencies referring with less frequency include programs external to the sponsoring agency such as board homes, other residential programs, and residents' families. In a number of projects, referrals were made from within, either from the sponsor's day treatment program or some other residential program. Exhibit II-12 describes more fully the characteristics of current residents in each of the eight operational projects visited.

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CURRENT RESIDENT CHARACTERISTICS IN
EIGHT OPERATIONAL PROJECTS*

CHARACTERISTICS	STATE/PROJECT								TOTALS		
	Colorado (Redi-Corp.)	District of Columbia (Anchor Howe)	Georgia (Community Friendship)	Massachusetts (Severe Road House)	Minnesota (Northwestern Apartment Living)	Oregon (Janus House)	Pennsylvania (Meson I Apartments)	Tennessee (Northeast Mental Health)	NO.	%	
AGE:											
18-24		9 in 20s and early 30s	5		Mostly between 20s and 30s	On average, between 25 and 35	5	2			
25-29			2	1							
30-34	2		3					6	2		
35-39			1						1		
40-44	2	1 in 40s	1	2							
45-49	1		3	1		1	2				
50-64			3	2							
65+											
SEX:											
Male	3	7	9	3	12	8	9	3	54	61	
Female	2	3	9	3	6	3	4	4	34	39	
RACE:											
White	4	3	11	6	18	11	11	6	70	79	
Black		6	7				2	1	16	18	
Hispanic		1							1	.1	
Other	1 (Eskimo)								1	.1	
INCOME SOURCE/AMOUNT:											
SSI	5	10 (\$391)	18 (\$176-\$264)	6 (\$276-\$290)	3 (\$285)		3 (\$240)	5 (\$264)	47	53	
Social Security									3	3	
Food Stamps								2	2	2	
Public Assistance					10 (\$130)	11	10 (\$172)		31	35	
Personal earnings					5 (\$561)				5	5	
PREVIOUS MENTAL HEALTH HISTORY:											
Prior long-term hospitalization	4	10	18	6	8	4	Most residents	7			
Prior acute hospitalization	1				4						
Community mental health						7					
Family					3						
None					3						
REFERRAL SOURCES:											
State institution		10		6		9	4		29	33	
Community/county agency			7 (CMHCs)		17 (county)	1	5		30	34	
Boarding home	3								3	3	
Other sponsor program			4					2	6	7	
Other sponsor residential prog			5					5	5	6	
Other residential program			2						5	6	
Family	1								3	3	
Other	1				1	1	4		7	8	
TOTAL RESIDENTS	5	10	18	6	18	11	13	7	88		

*Project visited in Vermont is not operational.

Program Construction Costs

Exhibit II-13, following this page, shows the housing construction costs, costs per unit, and fair market rents for the nine local Demonstration projects visited. The construction costs shown, for either new construction or rehabilitation, ranged from \$134,600 for one of the District of Columbia Anchor House facilities to \$341,694 for the Pennsylvania Meson I apartments. The average cost for construction was \$234,096. The cost per unit ranged from \$26,920 to \$37,966, with a per-unit average of \$31,635. Respondents at the local level commented on the high cost of meeting Section 202 requirements, particularly those pertaining to "substantial" rehabilitation, barrier-free access, and bonding. The excessive costs are reflected in the high aggregate and per-unit construction costs. All those interviewed felt that construction could have been undertaken more economically had some of the Section 202 requirements been waived.

The monthly fair market rents shown, which must be approved by HUD in order to receive Section 8 funds, are based upon estimated operating costs including debt service. These rents ranged from \$341 per month to \$545, with an average monthly fair market rent of \$436. With Section 8 funds being used to defer the payment of these rental costs on the behalf of the CMI, at least an average of \$327. per month (75 percent of \$436) of the monthly fair market rent is paid by HUD.

Although information on the operational costs associated with the residences was obtained from some operational projects, such information was usually only available in budgetary form and was not comparable across projects. Consequently, operational costs are not reported herein.

Problems And Barriers Encountered

As with the discussion of problems encountered at the State level, difficulties experienced in Demonstration implementation at the local level tended to be related almost exclusively to housing development. Problems with the initial stages of the Demonstration and Section 202 processing restated by the USR&E

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HOUSING CONSTRUCTION COSTS, COSTS PER UNIT,
AND FAIR MARKET RENTS FOR NINE DEMONSTRATION PROJECTS

State/ Project	Total Construction Costs	Number of Units Constructed	Cost Per Unit	Monthly Fair Market Rent
Colorado (Redi-Corporation Group Apartments)	\$169,900	5	\$33,980	\$403
District of Columbia (Anchor House)	\$134,600--Monroe Street \$141,500--Lawrence Street	5 4	\$26,920 \$35,375	\$341 --Monroe Street \$411--Lawrence Street
Georgia (Community Friendship Apartments)	\$319,700	11	\$29,064	\$389
Massachusetts (Revere Road House)	\$225,000	8	\$28,125	\$525
Minnesota (Northwest Apartment Living)	\$288,163	9	\$32,018	\$545
Oregon (Janus House)	\$220,900	7	\$31,557	\$352
Pennsylvania (Meson I Apartments)	\$341,694	9	\$37,966	\$447.50
Tennessee (Northeast Community Mental Health Housing)	\$243,000	8	\$30,375	\$390
Vermont (Howard Mental Health Services)	\$256,500	8	\$32,063	\$462 --Group Home \$529--Apartments

study, will not be presented here. Rather, this section details some of the problems encountered by individual projects with the Section 8 Program, implementation of the 1115 waivers, where applicable; and services. In addition, several other problems not directly related to the Demonstration but likely to impede Demonstration efforts are outlined, Housing, services, and other problems and barriers encountered to date by each project are highlighted in Exhibit II- 14.

An across-project examination of interviewee responses regarding problems with Section 8, the 1115 waiver mechanism, and service delivery indicated how relatively few specific, procedural problems actually arose (or were reported) with these aspects of the Demonstration. In addition, it emphasized the project-specific nature of Demonstration experiences. That is, problems discussed by respondents tended to be somewhat idiosyncratic and almost no two projects recounted the same specific difficulties. Only three projects specified problems with Section 8. Most notable were Community Friendship Apartments in Atlanta, Georgia, and Anchor House in the District of Columbia. At Community Friendship Apartments, for example, delays in the signing of the Housing Assistance Payment (HAP) contract resulted in serious cash flow problems for the sponsor--the project was operational and clients were being served for several months before Section 8 funds were received. Once the contract was signed, however, payments were retroactive to the date clients entered the residence. Staff interviewed at Anchor House in the District of Columbia felt that certain HUD Section 8 requirements were inappropriate given the population served: (1) that two unrelated individuals sharing a unit be considered a "family," (2) that their incomes be pooled for income eligibility determination purposes, and (3) that a single lease be signed by both residents. Given the transient nature of the chronically mentally ill, the sponsor anticipated that these requirements would be administratively burdensome. That is, a new "family" member would have to be found and a new lease drawn up every time one or the other member of the current "family" left the program or was rehospitalized for a long period of time. At the time of the field visit, Anchor House staff were developing individualized leases and hoping for HUD approval of them. The same problem was encountered by Community Friendship Apartments. In this particular case, however, HUD waived the requirements so that residents are now able to sign individual

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PROBLEMS AND BARRIERS ENCOUNTERED IN DEMONSTRATION
IMPLEMENTATION IN NINE PROJECTS

STATE	HOUSING	SERVICES	OTHER
COLORADO (Redi-Corp)	<ul style="list-style-type: none"> . Site rejection due to multiple use zoning . Low property appraisals . Delays in release of HUD funding necessitating the purchase contract to be extended four times . HUD regulation permitting only one resident/unit . Resentment on the part of HUD Regional and Area Offices regarding the Demonstration 	<ul style="list-style-type: none"> . Pending constraints at the Federal, State, and local levels make it difficult to provide services 	<ul style="list-style-type: none"> . Clients admitted who have no income as a result of SSI/SSDI eligibility determination cutbacks
DISTRICT OF COLUMBIA (Anchor House)	<ul style="list-style-type: none"> . 202 processing was problematic and too complex-using the 202 mechanism for single family, small group home is inappropriate--process increased costs substantially . Site selection--lost control of one site as well as \$4,000--building contained 13 units, HUD approved project for only 12 . The changing nature of HUD requirements related to accessibility to the physically handicapped . HUD central was not cooperative; HUD Area Office marginally cooperative . Section 8 requirement that two individuals sharing a unit be considered a "family" end sign one lease 	<ul style="list-style-type: none"> . Medicaid agency is requiring that special forms be filled out by resident and his/her therapist in order to verify Medicaid eligibility--the forms are lengthy and detailed, requiring staff intervention for completion--this negates "independence-building" objectives of the program . Have not started billing for services 	<ul style="list-style-type: none"> . Facility currently underutilized . A new project/experience for all involved--this trial and error process creates some distrust among clients
GEORGIA (Community Friendship Apartments)	<ul style="list-style-type: none"> . Construction and opening delays . HAP requirements that were in conflict with 1115 waivers--no two unrelated people can live in the same unit; lease is for the unit rather than individual . Section 8 funds did not flow until HAP contract was signed--project operated for several months without funds--this led to a cash flow problem . Problems with income and eligibility determination--HUD requirement that 40 percent of all residents be "low income" and that 30 percent be "very low income"--to meet these requirements, residents had to be admitted who had sufficient income and would therefore not be SSI eligible and therefore not Medicaid eligible . Emphasis of HUD on "units" built rather than people served . Lack of support from HUD Area Office in initial phases of Demonstration--Area Office did not understand the program--project became overburdened with unnecessary paperwork . Lack of provisions in standard 202 and Section 8 programs to accommodate special needs of the Demonstration--all modifications and changes in regulations are done on a case-by-case basis rather than across the board; HUD was generally unwilling to make changes . Project is still in the process of final closing 	<ul style="list-style-type: none"> . Lack of start-up funds for staff for purposes of program/services planning and development . Outstanding Medicaid bill dating back to mid-November of approximately \$16,000-\$18,000, mostly for staff salaries. Community Friendship, Inc., has covered this, but the time lag for reimbursements (approximately 50 days at present) creates a cash flow problem for the sponsor and project . Medicaid reimbursements are not sufficient to cover staff salaries; even though the housing project is a significant financial aspect of the sponsor's overall program (14 percent of sponsor income), Medicaid reimbursements cover only 1.6 percent of the project's operating costs--essentially, sponsor is subsidizing the project 	<ul style="list-style-type: none"> . Lack of communication between HUD and HHS resulting in contradicting requirements among 202 program, Section 8, and 1115 waivers . Need for obtaining special waivers to overcome contradictions . Redetermination of SSI eligibility

STATE	HOUSING	SERVICES	OTHER
<p>MASSACHUSETTS (Revere Road House)</p>	<ul style="list-style-type: none"> . Difficulty with site selection due to community resistance . HUD access/barrier-free requirements . Local ordinance/codes enforced by the town's building inspector delayed completion . Final closing has not been reached due to consultant delay in processing appropriate papers and delays in cost certification--mortgage rates have not been set as yet 		<p>Replacing clients has been problematic--facility only 75 percent occupied at time of visit; State hospital may be "running out of appropriate clients"</p>
<p>MINNESOTA (Northwestern Apartment Living)</p>	<ul style="list-style-type: none"> . HUD processing was extremely time consuming . Continued disagreement about "dally" debt service . Facility has a waiting list--there continues to be a need for housing in the outlying areas of the catchment area . Site selection due to issues raised regarding the sale of "nontaxable" land 	<p>Continuing problems in obtaining Medicaid eligibility for residents--a minimum of 30 days for a disability determination--resulted in loss of Medicaid revenues and client discontent in applying for SSI benefits</p>	<p>Problems with SSI disability determinations Concerns among County Boards regarding which county should be financially responsible for a client who leaves "against medical advice" and does not return to his/her "county of residence" Facility maintains a very low profile in the community provides virtually no publicity or public information in order not to "stir up community emotions"</p>
<p>OREGON (Jams House)</p>	<ul style="list-style-type: none"> . Delays in beginning construction--contractor could not be bonded; this raised costs . Delays in final closing due to slow paperwork 	<p>Duplication in case management functions among facility county, and State personnel--each defines case management differently, particularly in terms of treatment plans and length of stay</p>	<p>State funds are insufficient to have adequate staffing and reasonable compensation; as a result, the facility has not been licensed--cannot meet staffing standards</p>
<p>PENNSYLVANIA (Meson I Apartments)</p>	<ul style="list-style-type: none"> . HUD processing is extremely burdensome and counter-productive from a planning standpoint . Coordinating and keeping track of numerous actors key to the process: contractor, architect, lawyer, property owner, housing consultant, and project staff . Sponsor's lack of housing expertise . Discrepancies and inconsistencies in requirements stipulated by HUD inspector . Communication difficulties with HUD and local housing authority regarding programmatic issues in serving CMI . HUD standards are too high--result in increased costs 	<p>Lack of available funding for vocational rehabilitation</p>	<p>Difficulties in obtaining SSI eligibility determinations and loss of benefits SSI--"a Catch-22 of the system"--individuals must be labeled disabled to receive benefits--this serves as a disincentive to becoming independent because, if one does, one is likely to lose one's benefits</p>
<p>TENNESSEE (Northeast Community Mental Health Housing)</p>	<ul style="list-style-type: none"> . HUD and State housing regulations were inconsistent-- State codes are more stringent than HUD's regarding accessibility to the physically handicapped . Conflict of interest inherent in the role of housing consultant and his/her relationship with the contractor . 202 program is an excessively expensive mechanism for providing small scattered site housing 	<ul style="list-style-type: none"> . Have not started billing Medicaid for services rendered-- have had difficulty in defining the four support services covered under the 1115 waiver for costing purposes . Difficulty in reaching agreement with the State Medicaid Agency regarding budgeting costing procedures and terminology/definition of services 	<p>Difficulty in obtaining SSI eligibility determinations and in loss of benefits following redeterminations</p>

STATE	HOUSING	SERVICES	OTHER
<p>VERMONT (Howard Mental Health Services)</p>	<ul style="list-style-type: none"> . 202 processing and associated paperwork were burdensome; it is not a cost-effective mechanism . Local building codes . HUD at all levels was not interested in programmatic aspects of project; there was a lack of incentives for HUD Area Office to get involved in the Demonstration . Requirements of 202 program are not conducive to building small housing projects for the CMI . Lack of reimbursement from HUD for internal agency costs incurred during development phase . Sponsor lack of housing expertise 	<ul style="list-style-type: none"> . It took two years to receive waiver approval . As yet, project is not operational--service component is still in the preliminary planning stages 	<ul style="list-style-type: none"> . Difficulty with clients meeting Medicaid/SSI eligibility criteria, with some losing SSI benefits

leases. An additional housing-related issue raised by at least four projects involved the delays in final closing, although this did not appear to be a major barrier to project operation.

Several sponsors voiced a concern with the quality of HUD-funded residences in comparison to existing housing stock in the same neighborhoods. That is, the quality of the facilities built under the Demonstration is substantially higher than that of generally available community housing slots. As such, interviewees indicated that transitioning residents into less restrictive alternative residential arrangements that are of inferior quality may be problematic--there would be no incentive for residents to move out.

On a more global level, a consensus emerged among the nine projects visited that perhaps the major stumbling block in the Demonstration was the lack of provisions made by HUD in the standard Section 202 and 8 programs to accommodate the Demonstration. Moreover, there was agreement that this situation was exacerbated by the fact that exceptions to the regulations applied to the Demonstration were made on a case-by-case basis, in response to individual project needs rather than across the board. Each sponsor had to learn from its own experiences and fight its own battles. New projects could not rely on or learn and benefit from the experiences of older operational projects.

As with the housing problems, difficulties with services and 1115 waiver implementation were project specific. Four of the five waiver-only projects visited are operational. Two encountered procedural or administrative difficulties in implementing the waivers. For example, Northeast Community Mental Health Housing in Memphis, Tennessee, has not started billing Medicaid for services rendered to date because of difficulties in: (1) defining the four services covered by the waiver, for costing purposes, and (2) reaching agreement with the State Medicaid Agency regarding budgeting and costing procedures. In the District of Columbia, Anchor House has not started billing for services either. In this case, however, the delay is due to special requirements for information collection established by the District's Medicaid Agency that are considered to be burdensome and to counter project philosophy.

In Georgia and Minnesota, the two waiver-only projects visited are experiencing some operational difficulties. Community Friendship Apartments in Georgia currently has an outstanding Medicaid bill dating back to mid-November 1981. Although this may not be an uncommon situation in the processing of Medicaid claims in Georgia, it has resulted in cash flow problems for both the sponsor and the project. Northwestern Apartment Living in Minnesota has had continuing problems in establishing Medicaid eligibility for residents, particularly regarding the meeting of disability definitions, resulting in the loss of Medicaid revenues.

Service-related problems reported in the four non-waivered projects included: (1) lack of available funding for specific services (Meson I Apartments, Pennsylvania); (2) duplication of case management functions across project, county, and State levels (Janus House, Oregon); and (3) general funding constraints (Redi-Corp, Colorado). Revere Road House in Massachusetts did not specify any problems encountered with the operations of the services component of the Demonstration. It was clear from the discussion of problems and barriers to service delivery that the broad overarching issue across both waiver-only and non-waivered projects is the current state of the economy and general cutbacks in Federal, State, and local services funding. Respondents expressed grave concern about being able to maintain their current level of effort in view of these growing fiscal constraints.

Finally, two key problems that are not directly related to either housing or service delivery, but that may impede Demonstration achievements nonetheless, were mentioned across projects. One recurrent problem identified by at least six of the nine projects visited was the growing restrictiveness of SSI and SSDI eligibility determinations and the increased frequency of redeterminations and loss of benefits by certain clients. Consequently, some of the projects are beginning to serve individuals with no income. The implications of this particular development are discussed further in Chapter III of this report. Another problem mentioned in two projects-- Anchor House in the District of Columbia and Revere Road House in Massachusetts--is the underutilization of or reduced occupancy level in each facility. The reasons for this situation in either project were not clearly articulated. In Massachusetts, there is a sense that the State

hospital may be "running out of appropriate clients." In the District, the sponsor speculated that the St. Elizabeths Hospital deinstitutionalization effort may not be proceeding at an adequate pace. It should be noted that, in the District, community agencies receiving District funds are required under the Schweiker versus Dixon court order to give placement priority to referrals from St. Elizabeths Hospital.

Future Factors Likely To Influence The Demonstration

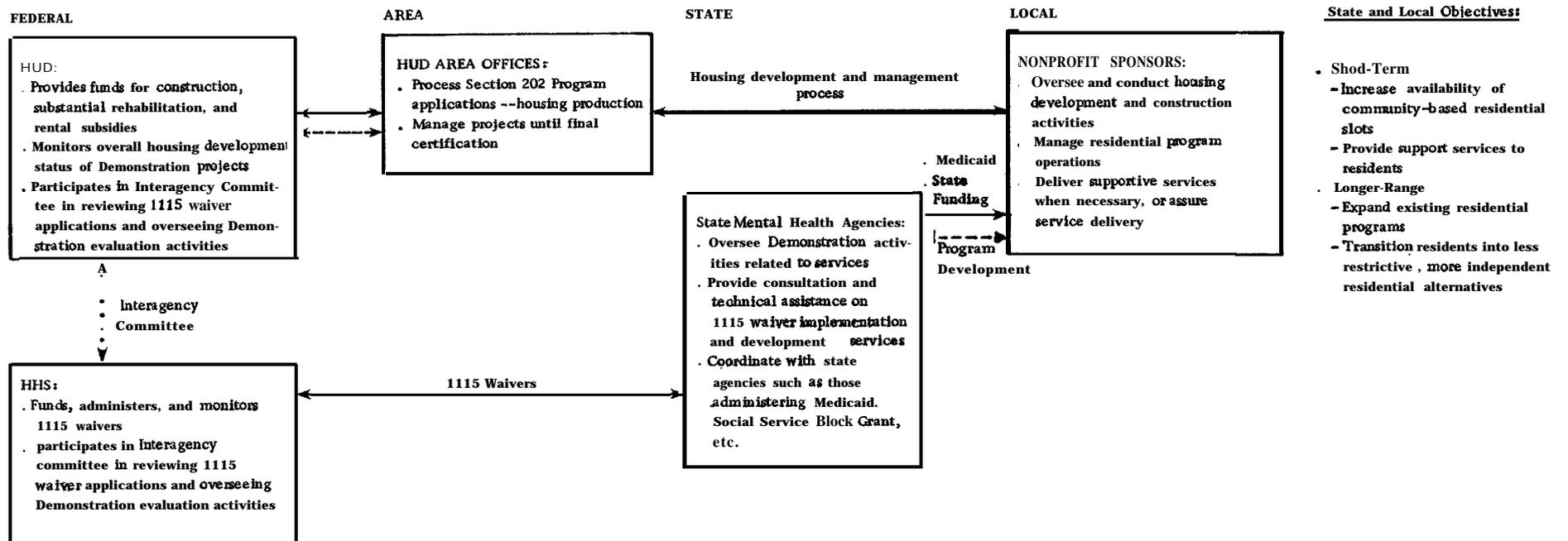
Numerous factors likely to affect the Demonstration at the local level were identified across projects. There was an overriding concern with the economy; growing fiscal constraints at the Federal, State, and local levels; and shrinking sources of available funding for mental health services generally and those initiated under the Demonstration specifically. The increasing costs of services, growing restrictiveness of SSI and SSDI, termination of Federal grants for community mental health centers, and possible cutbacks in the Section 8 program are being seen as significant contributing factors. Several of these factors and the policy implications for the HUD/HHS Demonstration Program are discussed in the next chapter.

3. COMPARISON OF THE INTENDED VERSUS THE ACTUAL HUD/HHS DEMONSTRATION PROGRAM

Following the analysis of actual Demonstration field operations, two models were developed to represent graphically and describe actual Demonstration-related roles and structural relationships among Federal, State, and local levels--one for the five waiver-only States and the other for four non-waiver States. The models, presented as Exhibits II-15 and II-16, are based upon information collected in the field and observations regarding the program's "reality." They were developed to reduce the volume of data collected in the field into a form that could be easily reviewed and assimilated. Because the models provide a generalized characterization of program reality, it should be clear that some of the roles and structural relationships observed in the field differ in certain aspects from those depicted. In addition, it should be noted that exceptions to the conclusions drawn about the actual Demonstration Program exist given the

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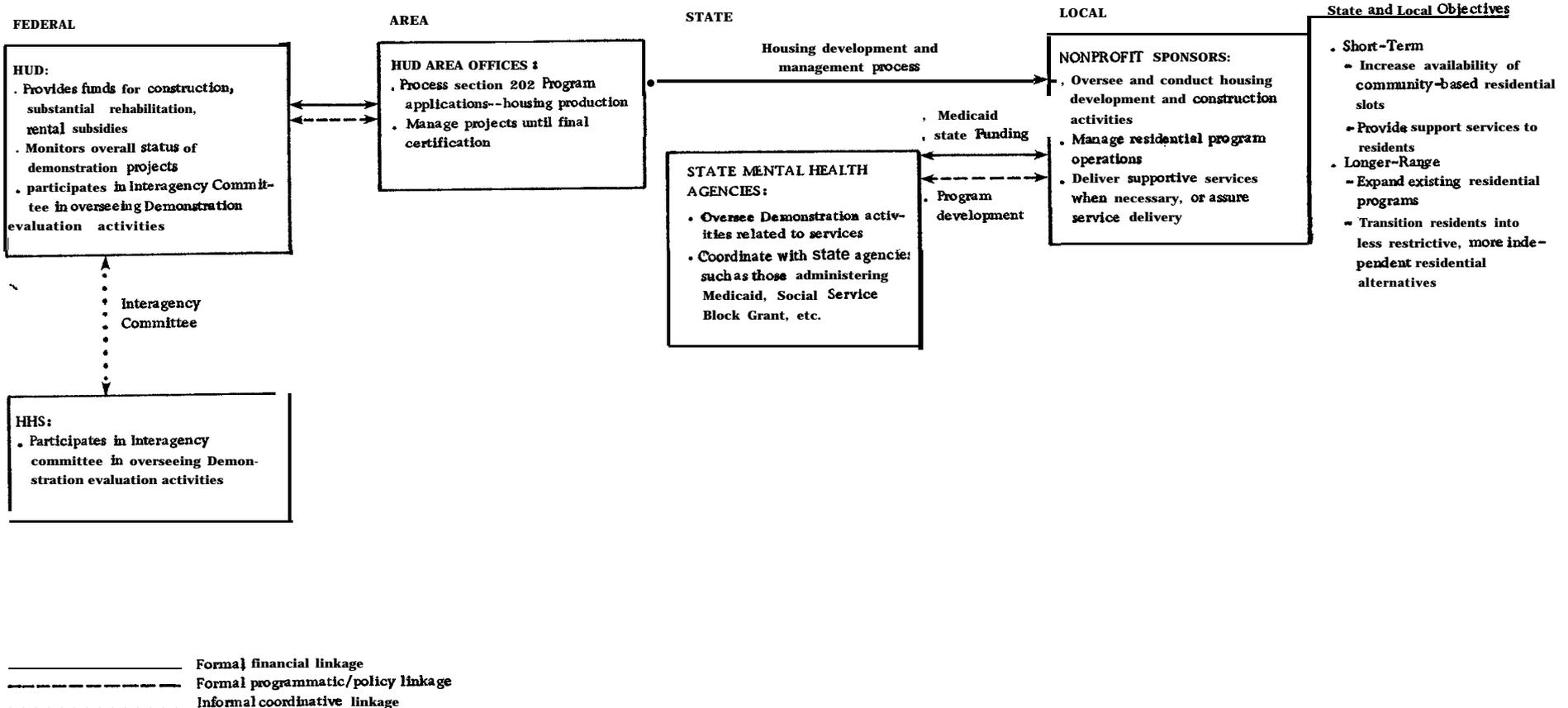
CURRENT DEMONSTRATION-RELATED ROLES AND
STRUCTURAL RELATIONSHIPS AMONG FEDERAL, STATE, AND
LOCAL LEVELS IN FIVE WAIVER-ONLY STATES



- Formal financial linkage
- Formal programmatic/policy linkage
- Informal coordinative linkage

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CURRENT DEMONSTRATION-RELATED ROLES AND
STRUCTURAL RELATIONSHIPS AMONG FEDERAL, STATE, AND
LOCAL LEVELS IN FOUR NON-WAIVER STATES



variability and difference in stages of development across States and projects. The model depicting the five waiver-only States (Exhibit 11-15) is described briefly below in terms of the roles and structural relationships among Demonstration participants as they were observed in the field. An abbreviated discussion of the model depicting the roles and relationships in non-waiver States follows and emphasizes features that differentiate the two models.

(1) Roles And Structural Relationships Among Federal, State, And Local Levels In Five Waiver-Only States

The model shown as Exhibit II-15 depicts the roles and structural relationships among HUD and HHS, the HUD Area Office, State Mental Health Agencies, and local nonprofit sponsors, as well as State and local Demonstration objectives. The model elements at each governmental level can be characterized as follows:

Federal Level--HUD, in interacting with HHS on the one hand and the HUD Area Offices on the other, performs three basic roles: providing funds for construction, substantial rehabilitation, and rental subsidies; monitoring overall housing development status of Demonstration projects; and participating in the Interagency Committee in reviewing 1115 waiver applications and overseeing Demonstration evaluation activities. HUD's current relationship with HHS vis-a-vis the Demonstration is informal and is embodied in the Interagency Committee, which is composed of members from key agencies in both Departments. HUD's relationship with the HUD Area Offices is formalized through the regular Section 202 and 8 programs, which involve both fiscal and programmatic/policy inputs. This latter relationship currently remains unmodified in terms of the Demonstration Program. HHS interacts with HUD and State Mental Health Agencies. In doing so, HHS participates in the Interagency Committee in reviewing 1115 waiver applications and overseeing Demonstration evaluation activities and funds, administers, and monitors the 1115 waiver-only States. As described above, the linkage between HHS and HUD is informal and coordinative through the Interagency Committee. HHS relationships with the SMHAs, however, are formal, involving the payment of Federal Medicaid funds for support services under the 1115 waiver mechanism.

Area Level--HUD Area Offices basically perform two functions in accordance with the Sections 202 and 8 programs: (1) process Section 202 Program applications and (2) manage the projects until final certification. The Area Offices relate directly to HUD

Central through formal financial and programmatic/policy channels. They also have a financial relationship with local nonprofit sponsors through the regular Section 202 Program, housing development, and management process.

State Level--State Mental Health Agencies essentially interact with HHS in regard to the 1115 waivers and with local nonprofit sponsors via Medicaid reimbursement and State funding of mental health services provided to Demonstration clients. In doing so, SMHAs oversee Demonstration activities related to services, provide technical assistance and consultation on 1115 waiver implementation and development of services, and coordinate with other State agencies. SMHAs' relationship with HHS is formal, being basically financial in nature. Their relationship with sponsors, on the other hand, consists of both financial and programmatic/policy linkages.

Local Level--Sponsors perform three key roles: (1) overseeing and conducting housing development and construction activities, (2) managing residential program operations, and (3) delivering supportive services and assuring service delivery. In performing these roles, local nonprofit sponsors established relationships with two governmental levels--HUD Area Offices and SMHAs. As mentioned above, their relationship with the HUD Area Office is financial and formalized through the Section 202 Program housing development and management process. Their interaction with the SMHAs is both financial and programmatic.

The objectives specified by the nine States and local projects visited can be simply summarized into two short-term objectives and two longer-range objectives, as follows:

Short-Term Objectives

Increase availability of community-based residential slots
Provide support services to residents

Longer-Range Objectives

Expand existing residential programs
Transition residents into less restrictive, more independent residential alternatives

(2) Roles And Structural Relationships Among Federal, State, And Local Levels In Four Non-Waiver States

Exhibit II-36 depicts a model that is similar in many respects to the one described above. However, several fundamental differences exist in the roles and structural relationships observed in the field between waiver-only and non-waiver States and projects. These key differences at the Federal and State levels provided the rationale for developing two distinct models and are outlined below.

Federal Level--HUD's roles and structural relationships with HHS and the HUD Area Offices remain essentially the same. The HHS role, however, is reduced to the performance of one function only, namely, participating in the Interagency Committee in overseeing Demonstration evaluation activities. The relationship is informal and coordinative in nature. As can be seen from the model, no relationship specific to the Demonstration program exists between HHS and the other levels.

State Level--SMHAs in non-waiver States perform two rather than three basic Demonstration-related functions. They oversee Demonstration activities related to services and coordinate with other State agencies. Their formal relationship with local non-profit sponsors is both financial and programmatic/policy in nature in that they provide funding for the services component of the Demonstration and programmatic input to the extent the Demonstration project is integrated into an existing State-supported residential program. SMHAs in non-waiver States, as indicated above, do not relate to HHS regarding the Demonstration, per se.

The roles and structural relationships among HUD-Federal, HUD Area Offices, and local nonprofit sponsors are similar to those in waiver-only States. They are all formal and are delineated by the Section 202 and 8 program regulations. State and local short-term and longer-range objectives identified by respondents in non-waiver States were essentially identical to those sought by waiver-only States.

(3) General Observations About Program Reality In Nine Waiver-Only And Non-Waiver States And Projects

Based on the synthesis and analysis of data collected in nine States and nine local HUD/HHS Demonstration Program projects, general

observations about the Program's field operations can be made. However, these observations must be considered within the context of the stage of development of the HUD/HHS Demonstration in the field and the constraints inherent in the mechanisms used to implement it. The overall Demonstration effort in the States visited is still relatively new in that most States and projects have only recently become involved in both the housing and services components of the Demonstration and have had little operational experience with the total program. Two projects visited became operational in early to mid-1980 ; the other six projects, however, became operational in 1981 and all had less than one year experience at the time of the visit. On the average, these six projects were in operation approximately 5.8 months at the time of the field visits. Furthermore, most of the State and projects visited had had no prior experience in housing development and the Section 202 Program with its myriad administrative and financial requirements. At this stage of program development, it would not be reasonable to expect to observe highly developed residential programs that are formally linked to services in the community.

By and large, the HUD/HHS Demonstration Program was neither perceived nor implemented at the State and local levels as a demonstration--an experiment, per se. Most States and projects visited indicated that the Demonstration Program was viewed simply as a means to access Federal funds, develop additional community-based residential slots, provide additional support services, and/or expand existing residential programs. As such, States and projects have generally not instituted special Demonstration-related operational and client data collection and evaluation procedures, nor have they been required to do so.

At this time, it also appears that at least four of the-five waiver-only States have no plans to continue support or establish more permanent funding mechanisms for Demonstration services initiated under the 1115 waivers. In some cases, plans have not been formulated because of the uncertainty and flux in the current services financing structure; in others, it is deemed premature to develop plans two or three years in advance, given

State funding cycles; and, in still others, a combination of the two factors was cited. In at least one State, there was a sense among State-level interviewees, that planning for continued service support should more appropriately be the concern of the local sponsors who participated in the Demonstration. The services funding issue was addressed somewhat differently in the four non-waiver States. In these States, it was observed that the HUD/HHS Demonstration Program projects were incorporated into existing residential programs and services funding mechanisms and, as such, States were planning to continue efforts initiated within the Demonstration context, to the extent possible. Several of these States expect cutbacks in services but anticipate continuing their community-based residential programs, even if on a somewhat reduced level. It is important to note that, even with a reduction in the scope of services provided to the chronically mentally ill, the housing element of the Demonstration and the knowledge gained on the part of State and local mental health service agencies would likely sustain budget cutbacks. However, whether housing without any or with reduced supportive services could sustain the CMI in the community was considered by respondents at all levels to be a major issue.

(4) Comparison Of The Actual Program In The Field And The Intended Program Described By Program Managers And Policymakers

In order to determine whether the actual program in the field is consonant with the description of the intended HUD/HHS Demonstration Program presented earlier in this chapter, the generalized models of Demonstration-related roles and structural relationships were compared and contrasted with the logic model of the intended program. The comparisons focus on both discrepancies and similarities in the actual and intended programs, although emphasis is placed on identifying major differences. Based upon this comparison, a number of observations about Demonstration activities and objectives were made.

At the Federal level, there appears to be some consonance in the functions program managers and policymakers expected would be undertaken

at the Federal level and those that are currently being performed from the perspective of the field. However, the similarities are more evident with respect to the waiver-only States where HHS/HCFA has responsibility for overseeing the Section 1115 waivers. Discrepancies between the intended and actual program were observed in terms of the relationships and linkages between the various key actors in the Demonstration. It was anticipated that both HUD and HHS would play active roles in Demonstration implementation, provide technical assistance and consultation on housing and service issues, and formally coordinate with each other. State and local sponsors indicated that HUD Central has played a relatively minor role in their efforts, and, with the dismantling of the Office of Independent Living for the Disabled at HUD in mid-1981, they did not foresee receiving technical assistance on housing-related issues. HHS's relationship with SMHAs, as discussed above, is only evident in those States funding Demonstration services under the Section 1115 waiver mechanism. This relationship, however, appears to be mostly administrative and the interaction limited to HCFA. With the decision not to fund additional projects, the collaborative relationship between the two Departments has been reduced to the activities of the Interagency Committee. As depicted on the generic models, the Interagency Committee's responsibilities are confined to the review of the Section 1115 waiver applications and to oversight of Federal Demonstration evaluation activities, e.g., the exploratory evaluation.

At the area level, the logic model depicts a relationship between the HUD Area Offices and SMHAs. This relationship was not observed in the field, with some exceptions. On the whole, the HUD Area Offices work directly with local Demonstration sponsors.

Federal program managers and policymakers intended that SMHAs assume a leadership and integrative role in the Demonstration. They expected SMHAs to convene a wide range of pertinent agencies and to mobilize resources for developing housing and services statewide. In the field at this time, there does not appear to be the kind of active stance

associated with a "leadership" role. SMHAs' Demonstration-specific activities, with few exceptions, appear to be reactive and supportive in nature. SMHAs across States tend to provide technical assistance and support to local sponsors on an as-needed basis and to monitor Demonstration accomplishments informally. They generally have not become involved with other agencies that may impinge on the Demonstration and Demonstration clients, although in some cases the SMHAs have interacted with the State Medicaid Agency and the State Housing Authority on specific issues or problems.

Demonstration efforts at the local level appear to match the Program intent. Not surprisingly, local nonprofit sponsors are the most active participants in the Demonstration and, in many cases, have implemented the housing component, in isolation from other key actors. It did not appear across projects that they coordinated with local housing and service agencies to the extent expected.

The logic model of the intended program specifies a set of 10 short-term, intermediate, and long-range objectives conceived within a demonstration, i.e., research design, framework. Field visit observations indicate that States and local sponsors in both waiver-only and non-waiver States are generally not seeking to attain the broad range of objectives intended by program managers and policymakers. Although the short-term goals identified in the field--increase the availability of community-based residential slots and provide support services to residents--are consistent with the short-term objectives of the intended program, States and local sponsors do not perceive the program as a demonstration. As such, they do not appear to be as concerned with the more intermediate and longer-range objectives of the Demonstration. Field observations would indicate that States and local sponsors are interested in alleviating and responding to immediate needs and are not, with few exceptions, viewing their efforts in the larger context of systems and/or fiscal change.

In addition, it should be noted that States and local sponsors, with only one exception at the local project level, espouse the service philosophy

of enhancing the independence and functioning of the chronically mentally ill and of transitioning clients into less restrictive residential arrangements appropriate to their needs. That is, residential facilities constructed or rehabilitated under the Demonstration are perceived as transitional rather than permanent housing opportunities. Transitioning of clients, therefore, is seen in the field as an end in itself, not as a means to attain longer-range objectives.

III. HUD/HHS DEMONSTRATION PROGRAM FINDINGS AND
OUTCOMES TO DATE

III. HUD/HHS DEMONSTRATION PROGRAM FINDINGS AND OUTCOMES TO DATE

Several key findings and outcomes emerged from the analysis of field operations and the comparison of the intended versus actual HUD/HHS Demonstration Program. Inherent in these broad areas of consideration are important conclusions regarding Demonstration experiences to date and relevant implications for continued State and local efforts in providing community-based housing and services for the chronically mentally ill. Ten separate issues are discussed. Each is presented in terms of its substantive features and implications.

1. IMPACT OF THE HUD/HHS DEMONSTRATION PROGRAM ACROSS STATES AND PROJECTS

The HUD/HHS Demonstration Program set out to attain certain short-term, intermediate, and long-range objectives. At the time of the field visits, approximately three years following the launching of the Program, some but certainly not all of these objectives have been achieved. Successes related to specific short-term and intermediate objectives have been realized across the 16 States and nine local projects studied during the exploratory evaluation. Specifically, these accomplishments include the construction and/or rehabilitation of 327 residential units in 32 projects across the nation, with a capacity to serve approximately 390 chronically mentally ill individuals. In terms of the availability of services, data were only available for the nine States visited. In these States, 226 chronically mentally ill residents are currently receiving support and other needed mental health services in the community. Although these accomplishments fall short of Federal program manager and policymaker expectations, they are significant nonetheless. In several States, the Demonstration embodied the only State-supported initiative to develop residential programs. In many of the communities in which Demonstration projects have become operational, quality housing and appropriate support services were previously unavailable. The Demonstration provided an excellent opportunity for States and local providers

to respond, even if on a small scale, to the critical need for community-based housing and services for the chronically mentally ill. 'Further, with the availability of housing and support services in some communities, the "revolving door" phenomenon may have been checked for some of the clients served by the Demonstration.

In addition to these concrete accomplishments, the Demonstration Program has been successful in stimulating important relationships among housing and service providers, enhancing the awareness of key participants and, in some cases, serving as an impetus for related spin-off initiatives and key policy changes at the Federal, State, and local levels. Participation in the Demonstration has encouraged States and local mental health organizations to become involved, in many cases on a sustaining basis, in providing residential programming and in expanding the complement of mental health services already offered. Similarly, the Demonstration has served to increase the awareness of and sensitivity to the housing and services needs of the chronically mentally ill among individuals and agencies involved in housing at all levels. In several States, SMHAs have been designated as public housing authorities to facilitate the development of residential services; in others, State Medicaid agencies have become involved, although in many of the States visited, these linkages tend to focus on Demonstration efforts rather than on expanding Medicaid coverage for community support services on a statewide basis. The Demonstration, with its high national visibility and Presidential support, spurred and enhanced the initiation of some State-funded, statewide residential treatment programs and the design of additional Federal activities. Furthermore, it provided an appropriate context for publicizing the need for community-based housing and support services for the CMI. Finally and perhaps most importantly, HUD's recent policy decision to include and mainstream the chronically mentally ill into the Section 202 Program was due by and large to Demonstration experiences.^{1/} In summary, the

^{1/} HUD new policy stance is formally articulated in the Federal Register, Volume 47, No. 76, Tuesday, April 20, 1982-- "Projects designed exclusively for the chronically mentally ill are eligible under the same conditions and criteria as other projects designed solely for the nonelderly handicapped."

Demonstration successfully served as a focal point for growing advocacy efforts on behalf of the chronically mentally ill and fostered new and unprecedented relationships and policy shifts at Federal, State, and local levels.

2. APPROPRIATENESS OF THE SECTION 202 PROGRAM AS A MECHANISM FOR ATTAINING DEMONSTRATION HOUSING-RELATED OBJECTIVES

It is clear from the discussion above that the availability of housing slots appropriate to the needs of the chronically **mentally ill** has improved in certain communities due to the Demonstration effort. Housing is now available where none would have existed, if it were not for the Demonstration. However, it is also evident that only a small proportion of the total number of projects and units approved by HUD in the three years of the Demonstration, have actually become operational. Accordingly, the number of clients expected to be served in Demonstration projects has not been reached and the housing needs of many CMI remain unmet.

Numerous reasons can be cited as to why production of Demonstration projects has been so **slow**. For example, local respondents emphasized the difficulties encountered with : (1) site selection, e.g. , community **resistance** zoning, and site control, **e . g .** , difficulties with long term options, and (2) the myriad of Section 202 Program processing requirements and regulations that were complex, time consuming, and burdensome. Moreover, States and local sponsors recounted the general lack of sponsor and State Mental Health Agency housing development experience, cooperation and assistance from the HUD Area Offices, adequate technical assistance, and established mechanisms to ameliorate administrative and technical Demonstration-specific barriers encountered. Most notable, however, have been the problems of adapting the Section 202 Program which was designed for large scale housing complexes. This study's findings regarding problems experienced during the housing development phase of the Demonstration **corroberate** the results and conclusions of the earlier Demonstration evaluation conducted by URS&E. Clearly, the issues raised by that study and the **recom-** mendations offered are still relevant to small, scattered site housing. Sponsors continue to experience **great difficulty with 202 processing and much time,** effort, and financial resources have been expended for a relatively small

return. As presently constituted, the 202 mechanism has been extremely burdensome and many States and sponsors expressed reluctance to become involved with other small, scattered site 202 projects if the opportunity were to present itself. Some, however, did indicate that with appropriate modifications the use of the Section 202 Program for small scale projects would be improved. Thus, the Section 202 Program, designed as it is for large-scale housing developments, does not appear to be suited to **attainining** Demonstration housing objectives that are dependnet on the construction or rehabilitation of small group home or independent living apartment projects. However, it should be emphasized that the processing and housing development difficulties experienced by Demonstration States and local sponsors are not necessarily related to specific or unique characteristics of the population to be served, i. e. , the chronically mentally ill. Rather, the problems are inherent in the process of applying a program desiged to achieve one set of objectives to attain a different set of objectives. These problems are generic to the 202 program processing procedures and would be encountered during the development of small, scattered site housing for any handicapped or disabled group. As such, the appropriateness of the current 202 Program for the construction or rehabilitation of small residential projects has far reaching implications not only for expanding community-based housing opportunities for the CMI but for the handicapped and disabled generally.

3. COMMUNITY-BASED HOUSING LINKED WITH SERVICES

The intent of the HUD/HHS Demonstration Program was for community-based housing to be linked with services to ensure continuity of care and to provide for the diverse needs of the chronically mentally ill. Accordingly, program managers and policymakers at the Federal level expected that strong service linkages and commitments be forged and that a supportive system of care be developed at the community level: A wide range of required and recommended services to be provided in the residence or the community was delineated. In addition, **it** was intended that services be provided in the community "whenever possible in order to retain the concept of normalized housing," that "services provided within the facility should not be inpatient in character, " and that no more services "be provided than are absolutely essential to accommodate the degree of disability" of residents.

A variety of service delivery models exist across Demonstration projects. Different configurations of support and other essential mental health services and delivery locations were observed. However, despite this variability, certain common features emerged from the analysis of services delivered across projects. As specified in the HUD/HHS Program Description, support services to be provided to Demonstration clients across projects, included case management, supervision, and life skills training. In general, these services were provided on-site by live-in staff. Other mental health services such as crisis stabilization and day treatment were available off-site. On the whole, the full range of services needed to maintain the chronically mentally ill in the community was not observed, at any one site. Residents received on-site services and whatever mental health services are offered by the sponsoring agency, but in general, sponsors have not established linkages to services beyond the mental health services they themselves provide. It appears that the notion of linking the residential facility with a comprehensive range of health, mental health, and social services essential for transitioning clients into less restrictive living arrangements, has not been emphasized. Many sponsors have concentrated almost exclusively on ensuring that housing and on-site support services are available and, to date, have not formally arranged for other essential services. In addition, it should be stated that a general lack of emphasis on specifically linking housing with a full complement of services was noted throughout the data collection effort of the exploratory evaluation. Moreover, the application of the Section 1115 waivers to reimburse for support services provided on-site by inhouse staff to the exclusion of other services has reinforced this development.

It is evident from this finding that the need for services and housing linkages persists as do the gaps in the service delivery system. Despite efforts to ensure the community tenure of the chronically mentally ill through the development of coordinated systems of care and the rhetoric of transitioning, their needs often continue to go unmet.

4. TARGET POPULATION(S) SERVED

Although the formal definition of the target population for the HUD/HHS Demonstration was broad by design, Federal level expectations have been and

continue to be that the severely disabled would be served by Demonstration projects. As noted in Chapter II, the population(s) actually being served by Demonstration projects vary dramatically from site to site in terms of severity of disability, history of previous hospitalization, age, and so on. In general, however, severely disabled CMI , i. e. , those individuals most in need and representing the "revolving door" population between hospital and community is not necessarily being served through the Demonstration projects. For example, only 33 percent of the clients being served at the time of the field visits were referred by State institutions, although a number of other individuals may have had a prior history of long-term hospitalization. Most striking is that many individuals served are in their early 20's and have had no previous hospitalization or a single acute care episode.

Without clearly specifying that the most severely disabled were to be served through the Demonstration, it would be unreasonable for Federal level program managers and policymakers to expect that they would be. Yet, States and projects have, by and large, served populations through the Demonstration whose characteristics fall within the target population definition delineated in Demonstration guidelines. On the other hand, it behooves the States, particularly those waiver-only States and those others depending upon Medicaid to finance services components, to serve a more disabled population. Should the clientele served through the Demonstration not be sufficiently disabled, services funding could be jeopardized because clients may not meet third-party disability definitions as noted later in this chapter.

5. THE ROLE OF STATE MENTAL HEALTH AGENCIES IN THE HUD/HHS DEMONSTRATION PROGRAM

The intent of HUD/HHS Demonstration Program managers and policymakers was that State Mental Health Agencies would assume a leadership, coordinative, and facilitative role in initiating, implementing, and monitoring ongoing operations of the Demonstration. States were expected to convene and mobilize a wide range of agencies and individuals whose programs impinge on the Demonstration and the chronically mentally ill in an effort to link housing to comprehensive community-based services. Moreover, they were to arrange for or establish

on-going funding mechanisms for a full complement of services needed by the CMI. Inherent in these expectations was the basic assumption that States, traditionally the major providers of mental health services to the chronically mentally ill, would be the appropriate locus of responsibility for coordinating the Demonstration and that they would assume an active role in its implementation. As discussed in Chapter II, however, States have generally not assumed an active, integrative role in the Demonstration. Rather, their role, with few exceptions, has evolved into a reactive one of providing consultation and technical assistance in response to local sponsor requests and coordinating with selected agencies on an as-needed basis. This has been especially true to States participating in the Section 1115 waivers. Non-waivered States, to the extent that they are involved in funding and program development of State-supported residential programs, have assumed a more direct role in the Demonstration. However, this role has consisted of customary functions performed by the SMHA in relation to statewide residential programs and do not necessarily involve special consideration of the Demonstration projects.

This finding takes on special significance when viewed in the context of current shifts in the roles and responsibilities of Federal, State, and local governments. With the advent of block grants and the New Federalism, the responsibility for services funding decisions and planning have been formally organized at the State and local levels. In light of Demonstration experiences to date, the likelihood that State Mental Health Agencies would in fact initiate innovative and creative approaches that would essentially modify their traditional roles, must be questioned.

6. FACTORS CURRENTLY AFFECTING OVERALL DEMONSTRATION PROGRAM PERFORMANCE AND OUTCOME

No demonstration is without external influences (exogenous variables) affecting its implementation and results. Highlighted below are the most salient influencing factors observed during the course of the exploratory evaluation that currently impact on the HUD/HHS Demonstration Program, as reported by State and local respondents. The factors highlighted include : (1) overall cutbacks

in mental health funding, (2) growing restrictiveness of SSI/SSDI, (3) community resistance, and (4) Medicaid home and community-based waivers. These variables could, when taken together, overshadow the parameters of the Demonstration itself. At best, they could prove to be uncontrollable factors in investigating the results of the Demonstration on a longer-term basis. This impinges on any further evaluation of the Demonstration and is discussed further in this chapter.

(1) Overall Cutbacks In Mental Health Funding

Since the enactment of the Omnibus Budget Reconciliation Act of 1981, less aggregate Federal mental health funds have entered the States--an overall reduction of more than 25 percent. Although for the first time State Mental Health Agencies now have direct administrative responsibility over such funds, as a consequence of the Act, the States still must make do with fewer resources. These Federal funding reductions, in concert with a stagnant economy that results in less than the anticipated or hoped for revenue generation at the State level and **increasing** demands for State and local level services, have exacerbated the financial constraints on the States. Accordingly, there is an overall cutback in funding for community-based mental health services and other supportive services essential to maintaining the CMI in the community, nationwide. Whether the funding cutbacks have resulted in services reductions and a lessening of other opportunities for the CMI is unknown at this time. Confounding this is that the full impact of the Act, at least with respect to mental health services financing, will not begin to be felt until July 1, 1982--a point in time at which community mental health centers will no longer receive any direct, Federal **categorical** mental health funds.

The criticality of continued and sufficient financing on the ability of States and localities to maintain the community tenure of the CMI cannot be overstated, and will potentially affect any positive outcomes for the Demonstration. For example, in Colorado during the latter part of the 1981 Fiscal Year, the State faced a severe fiscal crisis resulting in services funding curtailment. As a result, Redi-Corp had to close its partial hospitalization program for three and one-half months for lack of funds.

During that time, there was a threefold increase in hospitalization of Redi-Corp clients, as compared to usual patterns of hospitalization when the program was operational.

(2) Growing Restrictiveness Of SSI/SSDI

Medicaid eligibility is established as a consequence of inadequacy of income and resources and, in general, categorical relatedness. That is, for persons to be eligible for Medicaid, they must not only have income and resources at or below State-established levels, but be either dependent, aged, blind, or disabled, as well. Most CMI qualify for Medicaid by virtue of their mental "disability." The criteria for disability have been established for the Supplemental Security Income (SSI) Program and adopted by Medicaid, as follows :

An individual shall be considered disabled if he or she is unable to engage in any "substantial gainful activity" by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months and only if his or her physical or mental impairment or **impairments** are of such severity that he or she is not only unable to do his or her previous work but cannot, considering his or her age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he or she lives, or whether a specific job vacancy exists for him or her, or whether he or she would be hired if he or she applied for **work**.

In general, these criteria are applied to both the "categorically needy" (SSI recipients) and the "categorically-related medically needy" (those individuals whose income and/or resources are too great to qualify for SSI).

During the course of the exploratory evaluation, every State reported growing numbers of CMI who could not meet initially or continue to meet these disability criteria. As a result, growing numbers of clients served by Demonstration projects are either not receiving or not continuing to receive Medicaid benefits, placing strain on the financial viability of the

projects in both waiver-only and non-waiver States. More important, however, growing numbers of CMI are reported to be losing, or not being able to obtain initially, financial entitlement& because of the growing inability of meeting established disability criteria. Although 53 percent of the residents of Demonstration projects at the time of the field visits were reported to have SSI, this does not reflect either the magnitude of the problem and concern, or its growth. The gravity of the problem is poignantly illustrated by the fact that several projects reported they are now accepting, for the first time, clients without any financial resources. This means that not only does Section 8 pay for the full fair market rent for such individuals but these individuals do not have any other resources with which to meet other basic, let alone, personal needs. Of paramount concern, however, is that the ability to maintain the community tenure of individuals who are mentally disabled (even if they do not meet Federal criteria for such definition) without financial resources, is being and will continue to be, in a larger way, sorely tested. Whether such individuals can be maintained in the community without financial resources remains to be seen.

It should be noted that the observations with respect to SSI/SSDI are not unique to the Demonstration States visited. There are reports of like occurrences nationwide. Such a phenomenon is neither serendipitous nor is it the result of a legal change pertaining to SSI/SSDI disability definitions. It could only occur as a result of an administrative initiative by the Social Security Administration. For example, for SSI the disability definition, codified in law, has not changed at all since the federalization of SSI in 1974. Consequently, it can be expected that all States and localities will continue to be affected until such a time that the administrative initiative is curtailed.

^{2/} It should be noted that States reported identical trends with regard to Social Security Disability Insurance (SSDI).

(3) Community Resistance

The stigma of mental illness persists. It is manifested through the Demonstration by community resistance to supportive housing for the CMI at specific sites. Illustrative of such resistance is organized citizen group action (or even individual, usually homeowner, action) in blocking appeals for facility-specific zoning variances, blocking changes in zoning, blocking the issuance of land use or building permits, raising issues regarding easements, and blocking the issuance of occupancy permits. Tactics range from the filing of law suits, to using the media to present arguments, to exercising political influence. Most projects visited during the exploratory evaluation experienced some type of community resistance to a particular site sought by the sponsor, usually resulting in the necessity to secure an alternate site(s) and delays in time in embarking upon construction or rehabilitation. Consequently, community resistance has been, and continues to be, an important factor in the less than anticipated increase in housing stock for the CMI through the HUD/HHS Demonstration Program.

It should be noted that community resistance is not new nor is it exclusive to the CMI. From the earliest days of deinstitutionalization, communities have fought the placement of CMI in "their own backyard," with many legendary zoning battles on record. The mentally retarded have experienced similar resistance as have substance abusers and victims of spousal assault. Resistance has also been evidenced with respect to status offenders and either community correctional facilities or halfway houses. The length of time of resistant efforts and the diversity of population segments covered attest to pervasive misconceptions about and fear of the CMI living in the community (as well as other groups). To counteract this, educational efforts must intensify and advocates must persevere. This may even mean establishing facilities without alerting the community as has been done successfully by advocates of the mentally retarded.

(4) Medicaid Home And Community-Based Services Waivers

Section 2176 of the Omnibus Budget Reconciliation Act of 1981 presents specific statutory authority for Medicaid waivers to provide "home and community-based services to certain individuals. " Specifically, the Secretary of HHS may waive current Medicaid requirements to allow for the inclusion of home and community-based services under a Medicaid State plan, where such services "are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan .^{3/}" Such individuals could either currently be in a SNF or ICF or at risk of entering one without such a waiver. The services, themselves, to be covered under the waiver are left to the discretion of each State but cannot include room and board.

As of the time of this evaluation, only Oregon had received a Section 1915^{4/} waiver for home and community-based services. During the course of the field visit to Oregon, State plans for the implementation of the waiver were examined. Although the intent of Oregon's request for the waiver was not to focus on the CMI specifically, the Oregon Senior Services Division (which will administer the implementation of the waiver) believes that some CMI will receive services funded under the Section 1915 waiver. Consequently, a Medicaid waiver other than Section 1115 will be used to support, to some extent, the provision of services to clients served through the Demonstration in the State of Oregon. Vermont is also seeking Section 1915 waivers, targeted more toward persons with mental disabilities to prevent the inappropriate placement of such persons in long-term care facilities. This is in addition to the Section 1115 waiver granted the State

^{3/} Public Law 97-35, Section 2176.

^{4/} Section 2176 of Public Law 97-35 modified Section 1915 of the Social Security Act so that Section 1915 is the appropriate section to be cited.

of Vermont under the Demonstration. Thus, one or more Medicaid waivers may be used to pay for supportive services to clients served through the HUD/HHS Demonstration.

Although the authorization of Section 1915 waivers for home and community-based services has emerged as an exogenous variable potentially impacting the HUD/HHS Demonstration, it also offers the States another mechanism by which to fund supportive services for the CMI. This is particularly true for those States which **deinstitutionalized** the CMI into SNFs and ICFs or for which there is a **sizeable CMI** population at risk of being placed in SNFs and ICFs, for lack of home and community-based services. Such service funding opportunities may include but not be limited to: case management services, homemaker/home health aide services, personal care services, adult day health services, habilitation services, and respite care. Finally, unlike Section 1115 waivers, Section 1915 waivers are renewable for additional three-year periods at the discretion of the Secretary of HHS.

7. FUTURE FACTORS LIKELY TO INFLUENCE DEMONSTRATION PROGRAM PERFORMANCE AND OUTCOME

Just as there are factors currently impinging on the Demonstration, so will there be specific influences affecting it in the future. Highlighted below are several salient influences reported by State and local respondents during the field visits and those gleaned from the analysis:

(1) Sources Of Funds For Meeting Operating Costs For Housing

As noted in Chapter 11; projects are dependent on Section 8 to meet the operational costs of housing constructed or rehabilitated under the Demonstration. The Administration's Fiscal Year 1983 Budget provides for the abolishment of Section 8 existing and new construction rental assistance-- to be replaced by a voucher system with an average yearly subsidy of

approximately \$2,000 (\$167 per month) .^{5/} In addition, other aspects of the budget proposal would result in higher rent contributions for assisted housing tenants : (1) including as income the value of food stamps in calculating Federal rental subsidies; (2) eliminating any ceiling (fair market rent) on the rental amount charged on units occupied by tenants receiving vouchers ; and (3) raising the out-of-pocket portion of the rents paid by tenants to 30 percent^{6/} of income for all new occupants of HUD subsidized housing.

Should any or all of these budget proposals be enacted, or any others having a like impact of reducing budgetary amounts for federally assisted housing, there is some question as to whether the projects begun under the HUD/HHS Demonstration Program could continue to meet operating costs. This possibility is exacerbated by study findings with respect to growing SSI/SSDI restrictiveness. Except for those States that provide for housing assistance for the mentally ill wholly out of State funds, the burden of supporting the operating costs of the Demonstration projects would fall on general purpose local government through general assistance (GA), or, in some States , a shared State-local GA program. Given the financial constraints at both the State and local levels however, this is unlikely. Thus, as more than one State-level representative interviewed during the field visits noted, curtailment of Section 8 would likely result in foreclosure on mortgages for some or all of the projects constructed or rehabilitated under the Demonstration Program.

(2) Sources Of Funds For Meeting Ongoing Costs Of Services

As noted in Chapter II, waiver-only States generally do not have any specific plans for assuming support for services once the three-year waiver

^{5/} It should be noted that as the Administration's voucher plan is currently proposed, it would exempt the Demonstration projects from its application.

^{6/} It should be noted that the 1981 Fiscal Year Budget law authorized the rent contribution ceiling to be raised to this level, to be phased in over a three-year period.

period terminates. ^{7/} The overall cutbacks in mental health funding emanating currently from the Federal and State levels were also noted in this chapter. Additional cutbacks in Federal funding, as has been proposed in the Administration's 1983 Fiscal Year Budget with respect to block grants and optional services under Medicaid, would jeopardize further the ability to continue to provide services to clients served through the Demonstration. Even if Federal funding for services is stabilized, States and localities will continue to be hard-pressed to support services at current levels into the foreseeable future.

The net effect of the two factors above may be reinstitutionalization of persons served through the Demonstration, for the lack of necessary support to maintain them in the community. Should this occur and should it be for a prolonged period of time, disability may be established under Social Security Disability Insurance, which may ultimately lead to an increase in costs to the Federal government--through Medicare.

8. OFFSETTING INSTITUTIONAL COSTS

The program logic of the HUD/HHS Demonstration described in Chapter II calls for a determination of the cost-effectiveness or benefit of community-based housing linked with supportive services compared to institutionalization. From a measurement perspective, this means comparing the cost of maintaining clients in community-based independent living arrangements linked with supportive services to the cost of maintaining clients in institutional settings. Over time, however, the Federal government has become concerned and interested in the

^{7/} It should be noted that this is not a new finding. Rather, it is a persistent one in that States and projects have exhibited a dearth of planning for the loss of Federal funds, even when it is known well in advance that it is coming. On the one hand, this is understandable given that States do not budget beyond a two-year period. On the other hand, there has been an absence of longer-range fiscal planning even in instances where appropriations cannot be guaranteed. See for example: Morrison, L. J. "Barriers to Self-Sufficiency for Mental Health Centers," Hospital and Community Psychiatry, 28(3), 1977, 185-191.

effects of Federal expenditures under the Demonstration in offsetting of costs to the Federal government for other or historical services provided to clients served through the Demonstration. More specifically, HCFA has become interested in whether expenditures incurred under the Demonstration for Medicaid-waivered services offset other or historical costs to Medicaid for the population served. Of particular interest is whether there is an offset of Medicaid-reimbursed institutional costs.

The Federal government will share in the cost of institutional care provided to Medicaid-eligibles served in hospitals, skilled nursing facilities (SNF), and institutional care facilities (ICF). There are limitations, however, in cost-sharing arrangements in the instance of institutional care for the treatment of a mental disease. Federal financial participation (FFP) in expenditures for care and services under Medicaid is not available on behalf of patients in institutions for mental diseases (IMD) except for patients 65 and over and individuals 21 and under, at State option. An IMD means "an institution that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such."^{8/} Operationally, HCFA has determined the "overall character" to be, in addition to psychiatric hospitals, facilities with 51 percent or more of the residents diagnosed as having a mental disease.^{9/}

The analysis of the current resident characteristics of the operational projects visited (Exhibit 11-12, following page 11-25) showed that projects are generally not serving: (1) clients 21 and under and 65 and over; (2) clients either previously in or referred by general hospitals; and (3) individuals either previously in or referred from long-term care facilities. Accordingly, the

^{8/} 42 CFR 435.1009(e) (2)

^{9/} It should be noted that Medicaid will participate in the cost of inpatient psychiatric treatment in a general hospital, irrespective of age.

residents so described could not have been supported in institutional settings by Medicaid funds. Although a case might be made that projects supported under the Demonstration may interrupt the flow of clients into Medicaid-reimbursed facilities, the lack of a historical relationship between Demonstration clients and such facilities and the recent and increased attention to IMDs by Federal auditors would seem to augur against such a possibility. Consequently, there exists , through this Demonstration, little potential for the offset of Medicaid-reimbursed institutional costs nor was the Demonstration so designed as to expect or affect such off sets . Should there be any offsets observable through the Demonstration, they would accrue only with respect to State-incurred costs for institutional care. That is, the increased funding for services made possible by the granting of Medicaid waivers could possibly result in compensatory savings only in State appropriations-financed institutional care programs due to lessened numbers of or duration of institutional care stays for the clientele served through the Demonstration. As such, offsets of Federal Medicaid expenditures are not likely through the Demonstration.

9. AVAILABILITY OF HUD/HHS DEMONSTRATION PROGRAM PERFORMANCE AND OUTCOME DATA

In general, the quantity and quality of available Demonstration-specific data across States and projects was insufficient and inadequate. Field observations indicated that there is a decided lack of uniform and consistent data on Demonstration experiences and outcomes. Individually and collectively, States with few exceptions , are not currently collecting Demonstration-specific information nor do they appear to have formulated plans to establish special reporting requirements for Demonstration projects, at the present time.

Waiver-only States are collecting project-specific data for service reporting and cost accounting purposes in accordance with Federal Section 1115 waiver requirements and procedures. However, this information, although critical in documenting the type and costs of services rendered to Demonstration clients, is inherently limited in its usefulness. Services reimbursed under the **1115 waiver mechanisms are confined to those delivered on-site, therefore, the information collected does not reflect the total** service experience of clients. In

addition, these requirements do not include data on Demonstration housing experiences, facility and client characteristics, and client outcome. Waiver-only States, on the whole, were not planning to initiate specific efforts to evaluate Demonstration performance and outcome for purposes of future program planning and improvement. In only one State, Vermont, had an evaluation design been developed and specific activities undertaken to obtain comprehensive Demonstration-related information. Vermont has developed an assessment instrument--the Vermont Scale for Independent Living Assessment, that is currently being pilot tested and will be used every four months to assess clients' level of independent skills, and clinical, and maladaptive behavior. Vermont's evaluation approach also includes collection of consumer feedback data during the first year of the Demonstration and the use of quality assurance and utilization review procedures. In the District of Columbia, evaluation plans have been articulated, however, to date, these plans are still in the development stage and no data has actually been collected.

In the four non-waiver States visited, whatever data collection and/or evaluation efforts are underway are not specific to the Demonstration projects themselves. In other words, in keeping with their general approach of integrating the HUD/HHS Demonstration projects into existing residential programs, these States, to the extent that they collect information from the program or facility level, obtain information that is generic to State-supported residential programs. For example, in Pennsylvania, the SMHA collects periodic aggregated county data on the Community Residential and Rehabilitation Services Program of which the Demonstration projects are a part. However, the aggregated nature of this data obviates the possibility of extracting information on Demonstration experiences and clients.

Field observations regarding data collection efforts at the local project level are consistent with these State-level findings. Local sponsors tend to perceive Demonstration clients as part of their overall agency caseloads. Accordingly, they have implemented certain clinical intake, individualized service plans and client monitoring, and evaluation forms and procedures. Although these forms, when completed, constitute a client database of sorts,

there is no uniformity and consistency across projects within and among States that would ensure comparability in the data collected. This problem is clearly evidenced by the observations made earlier in this report regarding the variability in the criteria applied by projects in selecting and excluding clients from Demonstration facilities.

In conclusion, it should be noted and emphasized that the current absence of usable and available Demonstration performance and outcome data cannot be attributed to a lack of compliance or negligence on the part of Demonstration participants. Neither HUD nor HHS developed standard data collection or reporting guidelines to be imposed on States and local sponsors at the inception of the Demonstration or at any time during its three years of implementation.

10. FURTHER MEASUREMENT AND EVALUATION OF THE HUD/HHS DEMONSTRATION PROGRAM

As was noted in Chapter I, it was originally planned that there would be a full-scale cost-benefit evaluation of the Demonstration, including assessment of improvements in the quality of life of the clients served. To this end, USR&E developed an expansive evaluation design and instrumentation to support its implementation. After review of the evaluation design and instrumentation, the Interagency Committee determined, that the design was too ambitious, that its implementation would be too expensive, and that the instrumentation would be too overwhelming and intrusive and place too great a "response burden" on projects and clients. Consequently, the design and instrumentation were rejected, to be replaced at some future point by a more feasible and realistic evaluation design. Accordingly, one of the purposes of exploratory evaluation was to formulate evaluation options and to further develop an appropriate option into an evaluation design. However, given some key findings that emerged from the exploratory evaluation, the consensus among Work Group members was that more intensive evaluation of the Demonstration was not likely at this time. Consequently, the Work Group requested the contractor to develop detailed case studies of State and local project Demonstration experiences, rather than expand limited resources on formulating an evaluation design that would likely not be implemented. The case studies are included in Volume II of this report.

As mentioned above, although an objective of the exploratory evaluation was the design of a more intensive evaluation of the Demonstration, it was determined that further evaluation would not be realistic or feasible at this point in time for a variety of reasons. First, only a small percentage of the projects approved (for which Section 202 funds were reserved) are currently, or will be, shortly, completed. Overall, approximately 32 of the 201 projects approved, or 16 percent, were completed and operational at the time of the exploratory evaluation. Second, for those projects still engaged in HUD processing, there was a possible slowdown in HUD processing activities because of an anticipated change in HUD 202 policy. How many additional projects will become operational remains to be seen. Third, sufficient evaluation of the Section 202 mechanisms was undertaken through this evaluation and by USR&E. Fourth, only four States at the time of the exploratory evaluation were providing services under the Section 1115 waiver mechanism, with a correspondingly small level of expenditures under Medicaid. For example, for the 1980 Fiscal Year, the only year for which there is actual, complete expenditure data, approximately only \$30,000 in combined Federal-State Medicaid funds were expended under the waiver. Fifth, there is a complicated and impressive array of exogenous variables impinging on the Demonstration. Finally, as noted in the immediately preceding findings, there is a decided lack of uniform and/or consistent data on the Demonstration across States and projects.

Even though, for the reasons cited above, further evaluation may not be particularly realistic or feasible at this time, HHS may desire more intensive evaluation in keeping with its policy of evaluating the Section 1115 projects. Four options for such evaluation are available, each requiring different levels of effort. However, two key barriers would have to be overcome irrespective of the option selected : (1) the lack of uniform target population or services definitions, and (2) the lack of structured, uniform, or consistent record keeping and reporting processes in the field. In addition, it should be noted that HCFA will be the only remaining agency with an active role in **the** Demonstration , specifically as it relates to the Section 1115 waiver-only

States,^{10/} Accordingly, the evaluation options delineated below are guided by the assumption that HCFA will be the evaluating agent in any future efforts to further assess the HUD/HHS Demonstration Program. The options are also guided by the recognition that States and projects have, from the beginning, been told to expect an evaluation and, as a condition of the Demonstration, have agreed to participate in one.

EVALUATION OPTION 1: CASE STUDIES

Volume II of this report contains case studies of the nine States and nine projects site-visited during the course of this evaluation. At the State level, each case study highlights the following:

. The State Mental Health service delivery system

State Mental Health Agency organizational structure and responsibilities

Mental health service delivery system components (for institutional services, community-based services, and residential alternatives)

State involvement in the HUD/HHS Demonstration Program

Reasons for participating in the Demonstration
State Demonstration objectives
Statewide Demonstration accomplishments to date
Evaluation activities

Problems and barriers encountered

Housing
Services
Other

. Current or future factors likely to affect the Demonstration

^{10/} This is not to deny the role of HUD in continued Section 202 processing and in Section 8. Rather, it is to acknowledge that with two evaluations of the Section 202 component of the Demonstration already performed, there is no further need for evaluation of this mechanism, and no need to evaluate the Section 8 mechanism.

Future plans to continue activities initiated under the Demonstration

Housing support
Services support

Other pertinent information

At the project level, each case study highlights the following :

. Sponsor/borrower characteristics

Background
Organizational characteristics
Reasons for participating in the Demonstration
Relationship to the Demonstration project

Housing development experience

Critical dates
Construction costs

. Facility characteristics

Type of facility
Number of units
Resident capacity
Current occupancy
Neighborhood characteristics and community access/reaction
Staffing
Services provided or available
Licensure requirements
Operating costs

The client population

Operational definition/exclusion criteria

Referral sources and intake/termination procedures

Characteristics of current residents (in terms of age, sex, race, income, previous mental health treatment history, diagnosis, referral sources, and medication status)

Problems and barriers encountered

Housing
Services
Other

Current and future factors likely to affect the project

Other pertinent information

The first evaluation option is to expand the concept of developing case studies to the universe of States and operational projects under the Demonstration. There are two basic approaches to implementing this option. First, HCFA staff could request, by letter, that each State and project prepare a case study of itself by including an appropriate sample case study from those contained in Volume II of this report. Second, HCFA could contract for independent, objective development case studies through on-site review by an outside contractor. Ultimately and irrespective of the approach taken, case studies could be analyzed across States and projects to determine certain effects of the Demonstration, i.e., essentially an operational description of the implementation and results of the Demonstration.

A variation of this option, particularly at the project level, would be a "delta" approach. That is, there would be updating of the case studies at particular points in time, focusing on changes in such salient elements as resident characteristics, operating costs, and problems and barriers. This variation would afford examination of the effects of the Demonstration over time, as opposed to a single point in time. This variation, in combination with outside contractor development of the case studies, would be preferred by eliminating self-report bias, by enhancing comparability of information across States and projects, and by assessing the longer term effects of the Demonstration.

Although not addressed as an aspect of the current evaluation *vis-à-vis* the case studies, future case studies, even if the delta approach is not adopted, should include information on client outcome. Given the availability of information at the project level, such information would need to be limited to :

- . Days hospitalized for psychiatric reasons for residents of Demonstration facilities, preferably prior to and after their entry into the Demonstration facilities

Reasons for leaving the Demonstration facilities, **e.g.** , in need of hospitalization, **in** need of long-term care facility, behavior disruptive to other residents, disappeared, able to live more independently, etc.

- Referral sources upon leaving the Demonstration facilities

EVALUATION OPTION 2 : STATE-SPECIFIC SELF-EVALUATIONS

HCFA can, as a condition of granting Section 1115 waivers, require waiver-only States to undertake their own evaluations. Because the requirement for self-evaluation is already contained in the approved HUD/HHS Demonstration Section 1115 waiver applications as are State-specific plans and intentions for such evaluation, HCFA can exercise its right and stipulate that States indeed undertake evaluation. Historically, when this has been done, HCFA has not issued guidelines as to the parameters of any self-evaluation, particularly as regards the types of data to be collected, analyses to be performed, and methods for reporting. However, because of the problems noted earlier regarding the paucity of data pertaining to this Demonstration, the issuance of some guidance to waiver-only States in undertaking self-evaluation would seem both necessary and appropriate.

The cornerstone of self-evaluation by the waiver-only States would be the collection and analysis of data on the Demonstration, including the following elements :

- Who is served through the Demonstration, i.e. , demographic and psychosocial/behavioral characteristics of clients served?
- How are they served through the Demonstration, i.e. , services received?

What mechanisms are used to finance services rendered the clients through the Demonstration, i. e. , Section 1115 and other sources of funding?

What effects does service provision have on the client population served through the Demonstration, i. e. , in terms of specific outcome measures?

To implement this option for self-evaluation of waiver-only States, the following steps would need to be undertaken :

HCFA would need to enforce the evaluation requirements of the waivers by determining the status of those States supposedly undertaking self-evaluation and requiring those States currently without evaluation plans to develop, submit to HCFA for approval, and implement such plans.

HCFA would need to issue guidance to the States on data collection and reporting and provide technical assistance to the States to improve, strengthen, and enhance their evaluation plans--in general, to facilitate implementation of the guidance.

At a minimum, HCFA would need to require that States submit year-end evaluation reports in order to continue to receive the waivers and a three-year final evaluation report of Demonstration experiences.

Minimal comparability would be expected among States if such an option were exercised, to the extent that HCFA guidance and technical assistance could enhance comparability of information so collected and reported by the States.

EVALUATION OPTION 3: EVALUATION OF DEMONSTRATION EXPERIENCES ACROSS WAIVER-ONLY STATES

This option would involve a more intensive evaluation of the Demonstration's waiver-only States and would require that HCFA establish minimum information collection and reporting requirements to include: client characteristics ; service utilization ; costs for specific services rendered (not per diem); client outcome data such as community tenure, rehospitalization rates, level of functioning over time, where clients go on leaving 202 facility, and sources of funding used to maintain clients once they leave the Demonstration site. Ideally, it would be desirable to collect service utilization and cost data for both waived and nonwaived services provided to Demonstration clients. In addition, it would be desirable to the extent possible, to collect or reconstruct similar **pre-Demonstration data to enable meaningful pre- and post-Demonstration analyses.**

The ****Long-Term Health Care Minimum Data Set^{11/}**, for example, could serve as the basis for the collection and reporting of information on Demonstration clients. It contains the following items germane to the above minimum information collection requirements.

Personal Identification

Sex

Birth Date

Race/Ethnicity

Race
Ethnicity

Marital Status

Usual Living Arrangements

Type
Location

Court-Ordered Constraints

Court-Ordered Care
Court-Ordered Guardian

Vision

Hearing

Communication

Expressive Communication
Receptive Communication

Basic Activities of Daily Living

Bathing or Showering
Dressing
Using Toilet
Transferring In and Out of Bed or Chair
Continence
Eating
walking

^{11/} U.S. Government Printing Office: 1979-o - 629-526/2328 Region 3-1. It is commonly referred to as LTC/MDS.

- . Mobility
- . Adaptive Tasks
 - Behavior Problems
- . Orientation/Memory Impairment
 - Disturbance of Mood
 - Primary and Other Significant Diagnoses
- . Provider Identification
 - Unique Number
 - Location
 - Type
 - Last Principal Provider
 - Date of Admission/Commencement of Service
 - Direct Services
 - Principal Source of Payment
- . Charges
 - Discharge/Termination of Service
 - Date
 - Status/Destination

Should the LTC/MDS be used, or if any other requirements are issued to the waiver-only States for that matter, HCFA will need to develop guidance for the reporting of data so collected and specify time frames for reporting. Such guidance must allow for the aggregation of data across clients to facilitate reporting and may best include simple frequency distributions and cross-tabulations.

Although the application of the LTC/MDS would further the evaluation of the Demonstration, it would be subject to specific limitations regarding internal and external validity. To enhance the usefulness and validity of the data, particularly measures of outcomes, two alternatives are possible: (1) using

Demonstration clients as their own controls, or (2) using the service area of the sponsor as a control. For example, data on the average days Demonstration clients are hospitalized for psychiatric reasons prior to and subsequent to the Demonstration could be used to control for potential bias arising from not knowing important historical information on Demonstration clients, to which Demonstration results would be compared. In addition, the identical measure could be used to control for Demonstration effects on a service/catchment area basis. This would be particularly important if indeed Demonstration clients represent the "revolving door" population.

Once data collection and reporting requirements have been established, HCFA would, either in-house or under contract, require the periodic collection and analyses of the data and the reporting of findings and results.

EVALUATION OPTION 4: EVALUATION OF DEMONSTRATION EXPERIENCES ACROSS ALL STATES

The first two options considered waiver-only States. This option would build upon the previous one and consider non-waiver States as well, for a global examination of the HUD/HHS Demonstration experience. This would be necessary to isolate the effects of the Section 1115 waivers on the types of clients served, services, costs, and outcomes. The LTC/MDS could be used as the basis for data collection and reporting, which would be entirely voluntary on the part of non-waiver States ; HCFA would have no leverage with these States unless they were to be reimbursed for their data collection and reporting activities. As with the previous options, pre- and post-Demonstration analyses would be particularly important in controlling for threats to internal and external validity.

The design would be enhanced further by the selection of matched control groups not influenced at all by the parameters of the Demonstration. Such groups might be comprised of the following:

CMI screened by the sponsor but not accepted for assisted housing

CMI served by the sponsor but not provided with assisted housing

CMI in an adjacent **service/catchment** area provided with assisted housing

- . CMI in an adjacent service/catchment area not provided with assisted housing

Inclusion of all four groups as comparison groups would offer the evaluation design the most comprehensive approach to examining the effects of the Demonstration, although use of only one or more groups would be better than no comparison groups.

Implementation of this option would require contractor support in designing the evaluation plan including the use of comparison groups, conceiving data collection reporting requirements, collecting data, and reporting findings and results.

IV. CONCLUSIONS

IV. CONCLUSIONS

This chapter presents overall summary conclusions of the exploratory evaluation of the HUD/HHS Demonstration Program. The conclusions are presented in two parts:

Summary Overview of Exploratory Evaluation Findings

Housing- and Services-Related Issues, Implications, and Conclusions

1. SUMMARY OVERVIEW OF EXPLORATORY EVALUATION FINDINGS

In comparison to other demonstrations, the HUD/HHS Demonstration Program for **Deinstitutionalization** of the Chronically Mentally Ill has been unique. First, it is a demonstration within a demonstration in that the Section 1115 demonstration initiative is a component of a broader demonstration of **community-based housing linked with supportive services**. Second, the Demonstration has sought to bring together three existing programs--HUD's Section '202 Program to defer construction or substantial rehabilitation costs of housing; HUD's Section 8 Program to subsidize resident rents and to assure sponsors' ability to meet mortgage commitments made under Section 202; and, at State option, HHS' Section 1115 waivers to Medicaid to defer the costs of delivery of needed services to residents--without actually changing the requirements of any one program. Third, the multiple funding source possibilities highlight the interagency nature of the design and implementation of the Demonstration, including HUD, HHS/ASPE, HCFA, and NIMH. Fourth, the guidance material constituting the principal basis for the Demonstration was intentionally broad with respect to the target population to be served and the services to be provided. This flexibility resulted partly from the rapidity with which the Demonstration was mounted, considering particularly that third-year program guidance was more sharply

defined regarding the types of services to be provided. Finally, the Demonstration predated the current shift in the locus of responsibility for administration of Federal mental health service funds (through block grants) from the local to the State level and, therefore, serves as an early illustration of State-level response and oversight.

The Demonstration Program was intended to accomplish a number of intermediate and long-range objectives. The most immediate objective it sought to attain was the construction or substantial rehabilitation of permanent community-based housing linked to supportive services appropriate to the needs of the CMI. In this regard, Section 202 loan reservations in the amount of \$65 million were made during fiscal years 1978, 1979, and 1980 in 38 States, for 1,867 housing units on behalf of 201 sponsors. In addition, \$13 million in Section 8 rental subsidies was set aside for approved projects when they became operational, and HCFA estimated that between \$20 and \$30 million in Medicaid funds under the Section 1115 waiver could be expended for supportive services to residents in operational projects.

As of the time of this evaluation and four years after initiation of the Demonstration, 327 of the total of 1,867 approved units, or 18 percent, were operational. These units have a capacity to house 390 individuals and represent 32 projects, or 16 percent of the total number of projects for which Section 202 loan reservations were made. In the 16 States in which these 32 operational projects are located, 17 percent of the remaining approved projects were under construction, 37 percent are still in the Section 202 processing pipeline, and 17 percent were cancelled. Based upon the sample of nine projects site-visited during the conduct of this study, each facility took approximately 30 months to complete from the time of loan reservation to actual occupancy by residents. Each project required, on the average, \$234,096 in Section 202 funds for construction or substantial rehabilitation, inclusive of all costs for acquisition, design, and so on.

Services rendered residents of the nine operational projects visited, are **generally restricted to those provided by project staff and include supervision, case management, and training in activities of daily living.** In addition, mental

health services such as day treatment and medication are made available to residents by sponsor organizations. By and large, Medicaid funds made available under the Section 1115 waiver in five waiver-only States are not being used to the extent anticipated to support service delivery. For example, for the only year for which there are complete data, fiscal year 1980, approximately \$30,000 in combined Federal-State Medicaid funds were used to pay for services provided to residents in operational projects. In all instances, Medicaid funds under the waiver are being used as financial support for staff working in operational projects and not for specific services per se. That is, projects are being reimbursed on a per-diem basis for Medicaid-eligible clients and not for individual services rendered such clients. Also, in general, a full range of services necessary to meet the needs of residents of Demonstration projects is not available,

Although the definition of the target population to be served through the Demonstration was intentionally broad, the title of the Demonstration--HUD/HHS Demonstration Program for **Deinstitutionalization** of the Chronically Mentally Ill--and the expectations of Federal policymakers and program managers interviewed during the course of this evaluation indicate that the severely mentally disabled were to be the primary focus of the Demonstration. On-site review of individual projects indicates, however, that projects are idiosyncratic in terms of the clientele served. Although one project actually has used the Demonstration to **deinstitutionalize CMI** and to close State hospital beds, the majority of the projects have chosen to serve clients in their early 20s and 30s who have either no history of psychiatric hospitalization or only a single acute episode. As noted in Chapter III, despite serving clients within the broad target population definition of the Demonstration, projects dependent on Medicaid financing of services are jeopardizing their services funding base by not focusing on the severely disabled--those able to meet Medicaid (as defined by SSI) disability definitions.

Longer-range objectives for the Demonstration emphasize the determination of the viability of the Sections 202 and 1115 waiver, i.e., Medicaid, as funding mechanisms ; the determination of the cost-effectiveness of housing linked with services as compared to institutionalization ; and the improvement of the quality of life of the CMI. With respect to the viability of Section 202, Chapter III

considered the problematic nature of adapting this program designed for large-scale projects to a small, scattered site application. With respect to the viability of Section 1115 waivers, Chapter III noted in detail the underutilization of Medicaid funds under the waivers by Demonstration projects. Because projects have been operational for two years or less, it is too early to determine the impact of the Demonstration on the quality of life of the CMI and on cost-effectiveness. However, as noted in detail in Chapter III, any compensatory savings or cost offsets to be possibly observed through the Demonstration will be only in regard to State institutional care expenditures because of the nature of the target population actually being served.

2. HOUSING- AND SERVICES-RELATED ISSUES, IMPLICATIONS, AND CONCLUSIONS

To date, the housing component of the Demonstration has not lived up to expectations in terms of anticipated increases in quality housing stock for the CMI and the Section 202 Program has proved slow and expensive. If projects serving the CMI are going to continue to be eligible for Section 202, as is indicated in the "Section 202 Loans for Housing for the Elderly or Handicapped; Announcement of Fund Availability, Fiscal Year 1982,"^{1/} some changes to the application of Section 202 specifically for the CMI should be made, as follows:

- HUD currently will not make any loan reservations for housing that is to be "transitional" in nature. Specifically, HUD's policy is to fund only those projects that are to be permanent housing for the elderly or handicapped. Although this policy is reasonable with respect to the elderly and the mentally retarded, the operational reality of the Demonstration indicates its **nonapplicability** to the CMI. All but one project visited during the evaluation considered the project to be a stepping-stone for residents to more independent living. For Section 202 to be in concert with preferred methods of treating the CMI, HUD's policy should be changed to include transitional facilities. It should be noted that HUD is presently considering such a change.

^{1/} Federal Register, April 20, 1982, 16892-16894.

The Demonstration has shown that construction and substantial rehabilitation are expensive and, by sponsors' own observations, could have been undertaken more economically through purchase and minimal rehabilitation of existing property. The "Announcement of Fund Availability" cited above indicates: "subject to issuance of regulations that are presently being developed, applications may also be accepted for loans for the acquisition with or without moderate rehabilitation of housing and related facilities for use as group homes for the nonelderly handicapped." It appears that, during fiscal year 1982, this will apply only to the mentally retarded. However, to overcome the time and cost issues observed during the exploratory evaluation, it is essential that such applications also be accepted with respect to facilities for the CMI. This is also important in coordinating with HUD's "modest design and cost containment" objectives.

During this evaluation, many issues were raised by sponsors and State Mental Health Agencies regarding the nonapplicability of certain aspects of Section 202 regarding the CMI and agencies serving the CMI. Specifically highlighted were such requirements as "barrier free access," parking slots, and minimum capital investment. Because most of the projects are not serving individuals who are both physically and mentally disabled and because of the nature of the CMI population, application of these requirements not only appears to be inappropriate but also adds to development time and project costs. Because it was a finding of the evaluation that a number of projects were cancelled due to the sponsors' inability to meet minimum capital investment requirements, it would appear that future increases in the housing stock for the CMI may be further jeopardized due to this requirement as well as related facility costs issues. One way to address these issues would be to enact waiver authority to allow for project-specific waivers of troublesome, nonapplicable requirements. As such, sponsors could apply for and be granted, at HUD Area Office discretion, specific waivers of requirements impeding project development and adding to project costs, as long as such waivers could still ensure the quality of the housing stock and safety to residents. Such waiver authority would require an act of Congress.

During the evaluation, some early issues also began to surface with respect to the applicability of Section 8 to the CMI. One such issue was the requirement to consider all residents of a single unit in a group home as a family, e. g., one lease, pooling of income and resources, and so on. Given the findings of the evaluation regarding the transitional nature of Demonstration projects and the fact that residents do turn over (although they are not necessarily transitioned to more independent living), such a requirement is not appropriate to the CMI. Although it

appears that HUD policy has been changed in this regard ^{2/} it has been observed throughout the field experience of this evaluation that this change is not yet uniformly **operational**. Consequently, it appears that it may be necessary for HUD to issue additional guidance to the Field and Area Offices to ensure that the new policy is implemented uniformly in the field.

During the evaluation, State Mental Health Agencies underscored their growing financial constraints in attempting to maintain, let alone expand, community-based services for the CMI. The evaluation highlighted the underutilization of Section 1115 waiver funding of services. Given that the waivers are applied on a project-by-project basis as projects become operational and that projects have, in some cases, taken almost three years to become operational, it is not surprising that more funds have not been expended to date under the waiver authority. Yet the Section 1115 waivers represent an important source of services financing for some States and projects. In this regard, it is essential that HCFA maintain its current policy of **allowing** Demonstration States the option of applying waivers to all Demonstration projects as they become operational.

In a broader sense, with respect to new projects that may be approved by HUD under Section 202 or existing or newly operational Demonstration projects, HCFA should consider the applicability of Section 1915 waivers for home- and community-based services as a specific mechanism for services financing. This is in keeping with the intent of such waivers because a number of States ~~deinstitutionalized~~ many CMI into nursing homes and a number of CMI in the community may be at risk of going into nursing homes. This conclusion, and the preceding, indicate the need for flexibility of the States in the financing of supportive services for the CMI in housing **specifically** designed for them.

^{2/} A HUD Fact Sheet prepared for training purposes for HUD Field Offices in August of 1981 indicates that "The current lease for Section 202 projects with Section 8 is Appendix 21 of Handbook 4371.1, as amended by Notice 80-121. In a group home when two or more unrelated persons, each person must have a lease based on each individual's admission eligibility. Each individual must pay the appropriate percentage of income for the monthly rental, these amounts should be **totalled** and then subtracted from the unit's contract rent; Section 8 *covers* the balance."

In summary, with the formal mainstreaming of the CMI into the Section 202 program, HUD Area Offices will perform paper reviews of sponsors' "service packages." In the conduct of such reviews, it is reasonable to consider applying the requirements of the service component of the Demonstration. In this regard, it may be necessary for HHS to provide assistance to HUD in adapting Demonstration Program service guidelines into operational Area Office review criteria and functions. However, the evolution of the service component of the Demonstration and the learning from its experiences would seem to augur for its use. This would also be in keeping with allowing for flexibility at the sponsor level in conceiving and implementing appropriate services strategies in meeting project- and target population-specific services needs. Moreover, this approach would acknowledge that the mental health field is not yet ready to accept a single approach to meeting the services needs of the CMI in the community.

Even though almost four years have passed since the start of the Demonstration, the lengthy processing times involved mean that the Demonstration is still in its operational infancy. As such, it is still too early to tell the effects of the Demonstration on the CMI or the viability of the Section 1115 services financing mechanism. However, the current evaluation has been useful in determining the overall effects of the Demonstration on increasing the housing stock for the CMI and how the housing financing mechanisms at the Federal level might be modified to expedite the process in both the near and long terms.

APPENDICES

APPENDIX A

DOCUMENTS PERTINENT TO DEFINING
THE INTENDED PROGRAM

HUD /HHS DEMONSTRATION PROGRAM EXPLORATORY EVALUATIONDOCUMENTS PERTINENT TO DEFINING
THE INTENDED PROGRAMBACKGROUND DOCUMENTS

Carling, P.J. "Choreography with an Unclear Score: Federal Collaboration in Housing and Mental Health." Undated.

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Urban Systems Research and Engineering, Inc. Evaluation of the HUD/HHS Demonstration Program for the Chronically Mentally III: Early State Experiences With Phase I of the Demonstration Program. Task 4, June 1980.

Urban Systems Research and Engineering, Inc. Evaluation of the HUD /HHS Demonstration Program for the Chronically Mentally III: Examination of HUD's Experiences with Processing Phase I of the Demonstration Program. Task 6, June 1980.

Urban Systems Research and Engineering, Inc. Evaluation of the HUD /HHS Demonstration Program for the Chronically Mentally III: Examination of Sponsor Participation in Phase I of the HUD /HHS Demonstration. Task 5, July 1980.

Urban Systems Research and Engineering, Inc. Evaluation of the HUD /HHS Demonstration Program for the Chronically Mentally III: Evaluation of the Early Experiences of Phase I of the HUD /HHS Demonstration. Executive Summary, December 1980.

DEMONSTRATION PROGRAM DOCUMENTS

- . Section 1115 waiver applications
- . 1115 Waivers Quarterly Reports
- . Service component of initial applications
- . Other pertinent data, correspondence and memorandum
- . HUD 202 Processing Status Report

APPENDIX B

SUMMARY OF DOCUMENTED PROGRAM INPUTS,
PROBLEMS, OBJECTIVES, ASSUMPTIONS,
ACTIVITIES, AND DEFINITIONS

HUD/HHS DEMONSTRATION PROGRAM--EXPLORATORY EVALUATIONSUMMARY OF DOCUMENTED PROGRAM INPUTS, PROBLEMS,
OBJECTIVES, ASSUMPTIONS, ACTIVITIES AND DEFINITIONSI. PROGRAM INPUTSLegislative/Statutory

- . Section 504 of the Rehabilitation Act of 1973
- . Section 202 of the Housing and Community Development Act of 1974 (Direct Loan Program for Housing the Elderly and Handicapped)
- . Section 8 of the Housing and Community Development Act of 1974 (Housing Assistance Payment Program)
- . Social Security Act, Section 1115 (waiver authority)
- . Mental Health Systems Act of 1980

Conceptual/Policy

- . GAO Report to Congress, "Returning the Mentally Disabled to the Community: Government Needs To Do **More**" (1977)
- . President Carter's Urban Policy
- . President's Commission on Mental Health (1978)
- . National Plan for the Chronically Mentally Ill (1980)
- . National Institute of Mental Health's Community Support Program
- . White House Independent Living Initiative

Funding

- . HUD
 - FY 1978: Section 202--\$15 million--loan authority reserves
Section 8--\$3 million--set aside
 - FY 1979: Section 202--\$25 million--loan authority reserves
Section 8--\$5 million--set aside
 - FY 1980: Section 202--\$25 million--loan authority reserves
Section 8--\$5 million--set aside

- HHS
 - HCFA: \$20- 30 million in Medicaid 1115 waivers for supportive services
- Total funds for the Demonstration Program: 1978- 1980
 - HUD: \$65 million in Section 202 loan authority reserves
\$13 million in Section 8 set aside
 - HHS: \$20-30 million in Medicaid 1115 waivers

II. PROBLEMS TO BE ADDRESSED

- Many deinstitutionalized CMI persons are inappropriately housed (e.g., in nursing homes, board and care facilities) and have been unable to gain access to supportive and rehabilitative services available in the community
- Deplorable living conditions of a large portion of CMI persons residing in the community
- Sporadic and uneven development of residential programs became a critical issue and national problem as increasing numbers of mentally ill people were released from State hospitals
- Thousands of mentally disabled persons have been released from institutions before sufficient community facilities and services were available, and without adequate planning and follow-up
- Thousands of CMI remain in, continue to enter or re-enter institutions primarily because appropriate community services do not exist, or are not readily accessible
- Thousands of CMI have been placed in "community" settings which are not appropriate to their needs
- Institutional census reductions were achieved far more easily than the complementary development of community-based service networks and residential opportunities appropriate to the needs of the CMI
- Resources potentially available to this special population are inefficiently utilized due to fragmentation of programs and poor coordination between administering agencies
- Not enough model programs in place to convince legislators or others to put dollars into housing linked with services for the CMI
- No federal incentives for State involvement
- The numbers of people in need, lack of stable funding, inadequate range of types of facilities, and lack of good consistent program models all converge on a compelling immediate need for a long-term housing program

III. OBJECTIVES

Short-Term

- To address the problem of providing housing and support services needed by persons with chronic mental illness who are making the transition from institutional to community life
- To provide for the acquisition and rehabilitation of existing structures or, where need is substantiated for the new construction of group homes or congregate facilities for 20 or less persons which will provide permanent community-based housing for severely mentally ill or **handi-**capped citizens
- To provide a source of Federal housing funds complemented by appropriate supportive **service** funding which will facilitate the implementation of Federal court decisions requiring that persons with mental disabilities receive care in the least restrictive setting
- To reinforce and expand the existing capability of States and localities in meeting the specialized housing and supportive services needs of their chronically mentally ill citizens
- To immediately provide a residential alternative to hospitalization for hundreds of mentally ill persons capable of living independently, but now unable to find decent, accessible, and affordable housing in the private market
- To provide States with Federal funds to augment the resources in their existing efforts to reduce the populations of large State institutions
- To make available new funding sources to assist States in developing linked housing and service programs for the **CMI**
- To ensure the funding of services, and that the range of supportive services and opportunities required by **CMI** individuals is linked to their housing
- Coordination of housing and service resources will occur at the State level through cooperative working agreements between the appropriate agencies responsible for housing and services
- To serve as a test case of how HUD's contributions and the contributions of other- Federal and State agencies can be most effectively coordinated in supporting a community-based residential treatment network

- To highlight the eligibility of the CMI for programs designed to serve the handicapped
- The housing shall be architecturally and programmatically integrated into the community
- To coordinate Federal interdepartmental efforts to further deinstitutionalization
- To afford the Federal, State, and local governments an opportunity to form partnerships, consistent with President Carter's Urban Policy, to use existing Federal funds to address the housing and service needs of persons with chronic mental illness
- To serve as a "test case" of several of the recommendations reiterated in the CSP program, the Mental Health Systems Act, the National Plan, and the Independent Living Initiative
- To identify the successes and problems in interagency coordination of a joint program (i.e., HUD and HHS)
- To specifically test how residential program development can be coordinated with the development of requisite supportive services
- To assist HUD in its development of future activities and policies pertaining to the CMI which it may undertake on its own and in coordination with other Federal agencies

Long-Term

- To integrate the chronically mentally ill into the community
- To improve the quality of the lives of the CMI by providing housing arrangements linked to supportive and rehabilitative services
- To help normalize the lives of the CMI by providing for an environment that protects privacy and personal dignity, and which offers incentives and encouragement for them to assume increasing responsibility and control over their own lives which will hopefully lead to complete independent living in the community
- To provide the supportive services needed to maintain clients in the community and to provide encouragement for clients to eventually lead independent lives
- To develop alternative methods of care and treatment in the community so that the mentally disabled are prevented from being admitted to institutions in the first place
- To establish and maintain a responsive residential environment in order to release mentally disabled persons from institutions or prevent them from being institutionalized

- To normalize housing opportunities for the CMI through development of small scattered-site housing facilities integrated into communities
- The Departments of HUD and HHS are seeking innovative methods of meeting the needs of chronically mentally ill persons by providing a variety of housing and supportive service options under the general heading of "Independent Living Residence," (e.g., group home and independent living complex")

To legitimize the housing needs of the mentally ill within the housing bureaucracy and industry

To lead to a clearer understanding of the full range of efficient and workable ways in which permanent financing can be obtained for future housing and service delivery packages for the chronically mentally ill

To require interagency involvement at Federal, State, and local levels to achieve the common purpose of developing linked housing and service programs

To assure long-term viability of each project by linking it with agencies which are capable of providing additional capital and/or service dollars as necessary

To complement ongoing Federal and State deinstitutionalization efforts

To promote client social interaction and involvement in the community

To play a key role in further policy developments

IV. ASSUMPTIONS

To integrate the chronically mentally ill into the community and improve the quality of their lives by providing housing arrangements linked to supportive and rehabilitative services

To help normalize the lives of the CMI by providing for an environment that protects privacy and personal dignity, and which offers incentives and encouragement for them to assume increasing responsibility and control over their lives which will hopefully lead to complete independent living in the community

To provide a source of Federal housing funds complemented by appropriate supportive service funding which will facilitate the implementation of Federal court decisions requiring that persons with mental disabilities receive care in the least restrictive setting

Successful deinstitutionalization requires not only having available the range of services needed to help the chronically mentally ill in the community, but assuring that these services are accessible and are provided when needed over a long period of time; sometimes even a lifetime

- Integrated community-based housing and services may be viewed as a community support system, and this demonstration effort should contribute to the development of community support systems for this vulnerable population
- Since appropriate supportive services will enable the CMI to leave the medical environment of institutions and live more independently in the community, services provided within the facility should not be inpatient in character
- Long-term State and local commitment to an involvement in the process of deinstitutionalization is critical to the success of this program
- Projects of such size or less are preferable. The underlying principle is to keep the facility as small as possible and still retain the quality of the program

V. ACTIVITIES

Federal

- HUD
 - Office of Independent Living for the Disabled: Coordinate HUD's role with formal operational units and HHS, including provision of funds in construction, renovation, and rental subsidy funds
 - Evaluate Letters of Intent to select States for participation
 - Select States submitting Letters of Intent for participation in Phase I, II, III
 - Make the final selection for participation in the Program
 - Evaluate process of granting loan reservations
- HHS
 - Assure that the residents of the demonstration will receive an appropriate service package and reimbursement for selected services
 - Waive Medicaid regulations to allow Federal Title XIX matches for mental health and supportive services for Demonstration clients. Section 1115 of the Social Security Act as amended permits this HHS commitment
 - NIMH: Linkage with Community Support Program-funded States
 - NIMH: Review applications to assure appropriateness of services
 - NIMH: Provide technical assistance to the States in the area of mental health services and to identify service linkage potentials within States

- NIMH: Provide input into the HHS evaluation design
- HCFA: Approve Section 1115 waiver applications
- HCFA: Reimbursement for services States are unable to fund under current funding programs
- HCFA: Monitor activities subsequent to Section 1115 funding
- HCFA: Provide input into the design of the project evaluation
- ASPE: Serve as HHS liaison to HUD
- ASPE: Coordinate HHS project activities
- ASPE: Responsible for HHS evaluation of the overall program (service and cost benefit)
- ASPE: Secure funding for the HHS evaluation

- . Combined Activities

- Three Federal reviews of applications
- HUD: Review and approve the applications with adequate housing plans
- HCFA: Review applications for feasibility and appropriateness of intended usage of the Section 1115 waiver of the Social Security Act requirements
- NIMH: Review and prioritize the applications for adequacy and appropriateness of services

Regional/Area (HUD)

- Designate Multifamily Housing Representative to provide technical assistance to States and local sponsors
- . Provide prospective borrower/sponsors with regular Section 202 application package immediately upon request
- . Forward copy of application to Mortgage Credit Branch for complete review of financial statements of each application
- Forward completed evaluation forms to HUD Headquarters
- . Process selected applications in order to make 202 Fund Reservations

State

- . Notify potential sponsors from local private non-profit agencies or organizations of the availability of Section 202 Direct Loan funds

Convene a meeting for all interested applicants to orient them to the policies and procedures of the Demonstration Program

- Review and evaluate all applications from local sponsors
- Provide input into the final selection of sponsors by ranking applications in order of preference

Forward Letters of Intent to HUD Headquarters

Assist in coordinating the development of services package for each sponsor

Work with State Medicaid agency in developing Section 1115 waiver applications. State Medicaid agency must submit formal Section 1115 waiver applications to HCFA six months prior to the expected date of operation of the first demonstration project

- Appoint "State Coordinators" within each State to be the key contact for the program, to focus State involvement in the Demonstration, and to coordinate Demonstration activities at a statewide level
- State Coordinator: Identify and obtain service funds
- State Coordinator: With the State Medicaid agency's help, prepare Section 1115 waiver applications
- State Coordinator: Assist in the development process by arranging workshops between sponsors and HUD Area Office staff, gathering technical information and acting as intermediaries between sponsors and HUD - both at the Area Office and Central Office level

Monitor development activities and serve as an advocate for sponsors in expediting HUD processing whenever possible

- Provide technical assistance, support, and financial commitment to the local sponsors in developing the housing/service program
- Ensure the provision of the necessary supportive services to Demonstration clients once projects are operational
- State Housing Agencies provide technical assistance to State Coordinators, and in a few States, front-end financing to sponsors
- State Mental Health Agencies serve as interagency advocates, conduits for substantial HUD approval, technical assistance providers, and service funders
- Broker the Federal housing resources and integrate existing services with the housing, and where necessary, fill service gaps by providing Section 1115 waiver resources

- Services provided in connection with the housing under this program must be licensed, certified, regulated, operated, or approved and monitored by the State or operated by a service provider under contract with the State
- The appropriate State social services agency will be responsible for determining the eligibility of individuals for the program

Local

- Prepare applications and submit them to their HUD Area Office. Applications include a written endorsement from the State Mental Health Agency to HUD indicating the agency's approval and support of the service program, and the extent of the agency's funding commitment to the program
- Provide letters from appropriate State and local agencies endorsing the objectives of this Program, and describing the present and continuing support that the agency plans to provide
- Conduct housing development functions prior to the actual construction
- Upon loan approval, oversee project construction, client selection, and start-up of program operations
- Once the residential programs are in operation, manage the housing project and oversee the delivery of supportive services
- Provide the following services to Demonstration residents: case management, program planning, house and milieu management, life skill development, medical and physical health care, and crisis stabilization
- Offer or assure access to vocational development, sheltered workshops, education development, psychotherapy, advocacy /legal assistance services, recreational/vocational activity planning, and family relations planning
- Selected sponsors participate in and provide data. for the overall evaluation

VI. TARGET POPULATION DEFINITION

- The chronically mentally ill are defined as "any adult, age 18 or older, with a severe and persistent mental or emotional disorder that seriously limits his or her functional capacities relative to primary aspects of daily living such as personal relations, living arrangements, work, recreation, etc. , and whose disability could be improved by more suitable housing conditions" (alcoholism and drug abuse are not included in this definition)

The following categories of individuals may be served under the Demonstration:

Chronically mentally ill individuals currently residing in institutions but capable of more independent living

Chronically mentally ill individuals at risk of being re-institutionalized

Chronically mentally ill individuals with no prior institutionalization, but for whom housing linked to services would provide an alternative to institutionalization

VII. DEFINITIONS OF SERVICES

- Required Services either within the facility or in close proximity:

Case management and program planning services, which assure continuous availability of appropriate forms of assistance for residents, and goal-oriented individual program plans, developed with maximum resident participation within one week of entering the program and reviewed at least bimonthly during the first year of residence.

House and milieu management services, which include clarification of basic expectations relative to housekeeping, group behavioral norms, mechanisms for conflict resolution, roommate selection, collection of rents, resident government, as well as other factors related to the immediate environment and its management.

Lifeskill development services, which include personal grooming and hygiene, budgeting and fiscal management, food preparation and diet, exercise, use of public transit, telephone, birth control, shopping skills, social interaction development skills, and other aspects of community survival.

Medical and physical health care services, involving medication maintenance and monitoring, general medical and dental care.

Crisis stabilization services, including provisions for 24 hour telephone assistance, in person, on-site assistance, and inpatient services when other less restrictive alternatives have been exhausted.

- Additional services recommended but not required:

Vocational development services, including a range of vocational services from prevocational testing and assessment through transitional sheltered and competitive employment.

Education development services, for appropriate involvement at elementary, high school or college levels.

Family relations planning, to assist in planning for crucial relationships with parents, children, spouses, siblings and other close family members.

Recreational/avocational activity planning services, which familiarize residents with and develop their capacity to enjoy social, athletic, outdoor and cultural activities and events from table tennis to museums to camping.

Psychotherapy services, including individual, group and family counseling.

Advocacy /legal assistance services, including assistance in applying for benefits and entitlements and ensuring rights and, if necessary, representation by legal counsel in securing all applicable rights and entitlements.

Other services, as may be appropriate.

VIII. DEFINITIONS OF HOUSING TYPES

- Group Home- -A small living arrangement set up specifically to create a home-like environment for chronically mentally ill individuals who require a planned program of continual supportive services and/or supervision, but do not require continual nursing, medical or psychiatric care. Supervision may be provided by resident assistants, supervisors, attendants or personal aides, who may live in, or may come in daily or as needed by the residents. As the residents become more independent, supervision may gradually be reduced to the point where the residents may ultimately manage the facility with minimal supervision or entirely by themselves, or be able to move out into the community at large. The home may serve a maximum of 12 people with no more than two persons per bedroom.
- Independent Living Complex--A living arrangement of 6 to 10 individual apartment units which are supervised by professional or paraprofessional staff living in a separate or adjacent apartment or living off the grounds of the facility. The complex may house no more than 20 chronically mentally ill individuals. The individual apartment may contain from zero to two bedrooms with a maximum of two persons per bedroom. Thus, if a Borrower /Sponsor is proposing 10 two-bedroom units, there may be only one person per bedroom to keep within the 20-person limit for the complex. Apartment living may include a rehabilitation and training component aimed at developing independent living skills. The degree of direct supervision varies with the level of disability of the client.

APPENDIX C

SUMMARY OF MANAGER/POLICYMAKER PERCEPTIONS
OF THE INTENDED PROGRAM

**SUMMARY OF MANAGER /POLICYMAKER PERCEPTIONS OF THE INTENDED
HUD/HHS DEMONSTRATION PROGRAM FOR DEINSTITUTIONALIZATION
OF THE CHRONICALLY MENTALLY ILL**

This document was prepared as part of the exploratory evaluation of the HUD /HHS Demonstration Program. It contains a summary analysis of Federal-level manager and policymaker perceptions of the program as it was intended.

Documenting the intended program is one of the initial tasks to be undertaken in an exploratory evaluation. Interviews with key Federal program managers and policymakers knowledgeable about the program are conducted to supplement and enhance the program description derived from the review of program documents. The information gathered during the interviewing process includes information regarding the problems the program seeks to address; the program's purposes or objectives, underlying assumptions, activities, expectations, performance, and measurement information available and/or needed; and, the intended uses of evaluation information. In short, interview information is used to document the program according to what it is intended to accomplish, what it is expected to accomplish, what activities are intended for the accomplishment of its goals, why it is believed that the activities will lead to achievement of objectives, what evidence is acceptable for assessing accomplishments, whether the evidence is available, and how that evidence may be used for improving program performance. In addition, interview information is used to determine if there are discrepancies in perceptions of the intended program at different management and policy levels.

Interviews were conducted with a wide variety of key individuals who were and continue to be involved with the Demonstration Program at various management and policy levels. Each interview was analyzed and summarized, and interview information was aggregated. The following is a summary of interviewee responses. It should be noted that the information presented is based solely on manager/policymaker interview responses reflecting their perceptions of the intended Demonstration Program. The aggregated responses are outlined according to the frequency with which they occurred across interviews. The final page of this summary presents a brief overview of observations and conclusions drawn from the analysis.

**SUMMARY OF MANAGER/POLICYMAKER PERCEPTIONS OF THE INTENDED
HUD /HHS DEMONSTRATION PROGRAM FOR DEINSTITUTIONALIZATION
OF THE CHRONICALLY MENTALLY ILL**

I. PROBLEMS THE PROGRAM SEEKS TO ADDRESS

The CMI were not being served by HUD programs including Section 202.

- The viability of the Section 202 Direct Loan Program as a mechanism for providing support for housing for the CMI needed to be tested.
- Lack of adequate housing arrangements for a large proportion of the deinstitutionalized population.
- Mechanisms for funding as well as financing for services and housing were incompatible, did not work well together, or were lacking entirely.
- Housing field did not consider itself responsible for making available special shelter arrangements for the mentally ill, while the mental health field did not see itself as responsible for the provision of housing--the gap between housing and services.

The need for a coordinated approach (at the Federal, State, and local levels) to provide housing and support services to a special population.

II. PROGRAM OBJECTIVES

- To improve the quality of life of the CMI; reduce recidivism; improve client functioning.
 - To determine the viability of the 202 Program as a mechanism for providing housing for the CMI.
- To assist States in their deinstitutionalization efforts.
- To provide financing and establish funding mechanisms for independent living arrangements and support services that are appropriate to the needs of the CMI.
- To develop more appropriate housing that is linked with services and available on a broad base.
- To provide an opportunity to determine the cost effectiveness/benefit of community based independent housing arrangements linked with services as compared with institutionalization.
- To provide a structure and mechanisms for continuous planning and coordination between housing and services at the Federal, State, and local levels to address the needs of the CMI.
- To identify the problems and barriers in Federal financing of housing and services in order to restructure such mechanisms.
- To integrate the CMI into the community by building housing arrangements in residential communities.
- To open Federal financing programs--Medicaid, HUD Section 202 and Section 8, to the CMI.

III. MAJOR PROGRAM ACTIVITIES

(1) Federal

HUD

Office of Independent Living for the Disabled--Responsible for all administrative functions of the Program between 1978-1980: development of Program description; preparation of letters of invitation; evaluation of Letters of Intent and applications; provision of technical assistance.

Section 202--Direct Loan Office--Responsibilities are largely mechanical: oversight of 202 Program, processing of applications and Area Office activities.

HHS

Health Care Financing Administration--(1) Office of Demonstration and Evaluation : general oversight of 1115 waiver projects; review of waiver only applications; provision of technical assistance, project monitoring; (2) Policy and Procedures Branch: review of waiver applications; provision of technical assistance on eligibility questions.

National Institute of Mental Health--Encourage HUD to assume greater responsibility for CMI; plan jointly with HUD for services financing at the Federal level (interagency collaboration); participation in and coordination of service component reviews; dissemination of information on the Demonstration through CSP Learning Community Conferences.

Assistant Secretary for Planning and Evaluation--Coordination of all HHS efforts related to the Demonstration.

(2) Regional/Area (HUD)

Processing of applications

Performance of implementation activities

Designation of Multi-Family Housing Representative

Several interviewees indicated that the roles and responsibilities of the HUD Area Office as they related specifically to the Demonstration were ill defined. No special provisions for special Area Office activities were made. Area Offices were expected to respond to the Demonstration as they would to any other 202 project.

(3) State

- . Submission of Letters of Intent
- Inform potential sponsors of the Demonstration
- Participation in sponsor selection
- Designation of State Coordinators
- Provision of technical assistance to sponsors
- Submission of 1115 waiver applications

(4) Local /Sponsor

- . Development of applications; follow-through on 202 processing
- . Outreach, locate, and house CMI
- Deliver services

(5) Across-Levels

One interviewee broadly summarized the activities to be performed on all levels: (1) interagency agreements, (2) development of close working relationships, (3) joint housing/mental health planning, (4) joint financing of projects (at local level), (5) legislation

Several interviewees stressed that Demonstration-related activities and responsibilities at all levels were not clearly delineated at the inception of the program and that the roles of various actors were defined through time on an ad hoc basis

IV. INDICATORS /MEASURES OF OBJECTIVES**Indicators of improved quality of life of residents**

- Improved functional levels
- Measures of recidivism--"revolving door" phenomenon
- Length of stay both in and out of institutions
- Service utilization
- Medication changes
- Subjective assessments by residents
- Employment status

Indicators of housing availability and housing component status

- Number of operational projects
- Number of projects under construction
- Number of projects approved
- Number of projects in 202 processing pipeline
- Types of living arrangements built
- Occupancy rates
- Extent to which placement is appropriate

Service component status

- Nature and extent of services provided in-house or in the community
- Appropriateness and configuration of facility staff
- Nature and extent of services funding
- Service population characteristics

Indicators of Federal, State, and local level inter- and intraorganizational changes and characteristics

- Extent and nature of local spinoffs from the Demonstration between local housing and service agencies
- Extent to which States are developing their own housing linked with services programs

Number of State Mental Health Agencies organized as housing authorities

Formalized, continuous dialogue between housing and service agencies at all levels regarding the needs of the CMI

- Extent and nature of changes in agencies' rules, regulations, and policies to focus on housing and service needs of the population--changes to the 202 Program ; restructuring of resources ; new legislation

Indicators of changed responsibility and awareness

Extent and nature of involvement of the State level agencies and State Coordinator

Extent to which the Demonstration Program is integrated into ongoing State operations

Cost-related measures /indicators

Total costs of community based independent living arrangements linked with services as compared with total institutional costs
Cost of small scattered site housing versus institutionalization versus other living arrangements

Several interviewees stated that Program "output" or measures of Program success were not well defined either at the inception or during Program implementation

V. PROGRAM PERFORMANCE INFORMATION

There appears to be a consensus across interviewees on the lack of available information at the Federal level and a general lack of awareness among interviewees of the availability of Demonstration-specific data at the State and local levels. Several interviewees did identify the following potential sources:

Federal

- .. HUD data on number of applications, number of starts, number of drop-outs
- .. USRE reports on HUD 202 processing experience
- .. HUD Multi-Family Housing Representative (HUD Area Offices)

State

- .. State Coordinators
- .. Service utilization and cost data for 1115 waiver States

Local

- .. Individual service plans ; Medicaid billing

VI. PROBLEMS AND INFLUENCING FACTORS

(1) Operational /Implementation

Continued difficulties with 202 processing, HUD regulations, and bureaucracy--prolonged timetables and delays in processing; resentment on the part of Area Offices for not having been included in selection process; Section 8 subsidies cannot be used for short-term transitional housing arrangements; possible cancellation of projects not meeting deadlines and withdrawal of Section 8 set asides; Davis-Bacon wage requirements

- . Lack of familiarity with the Demonstration Program in the production and loan management offices of HUD Area Offices
- . Lack of knowledge and sophistication in the mental health field about housing development and the Medicaid Program
- . Lack of local sponsor financial capability to handle a long-term, direct loan
- . Community resistance and difficulties in site selection

Continued lack of technical assistance from the Federal level with the dissolution of the Office of Independent Living at HUD

Difficulties with 1115 waiver application process and Medicaid Program--delays in submission of applications, lack of understanding of waivers as demonstration, exclusion of CMI from Medicaid's functional definition of "disabled" ; delays in obtaining Medicaid eligibility due to SSI disability determinations; eligibility issues

Continued difficulties in the "marriage" between a short-term service component commitment and a long-term housing commitment--e.g., as more projects approach construction and completion, greater difficulty may be experienced in following through on service commitments, configuration of service commitment initially proposed may change due to funding changes over time

Dependency on Federal funds for services will likely make transition to State funding (within three years) problematic--States may view Demonstration projects as a "new service" and will be reluctant to fund them

(2) Economic/Political

General economic factors--inflation; skyrocketing housing costs; Fair Market Rents have not kept up with inflation; cuts in services funding; institutional cost inflation ; interrelationship between housing costs and Fair Market Rents not favorable in break even analysis

General political factors--Administration's philosophy of turning away from special populations and earmarked Federal initiatives for special groups; lack of HUD responsiveness to lessons learned from the Demonstration regarding 202 processing difficulties; continued questioning of whether HUD should serve the CMI

Demonstration housing projects are service intensive, if services are cut the Program as intended will no longer exist

Program is vulnerable--implies a great fiscal overhang into the future; budget authorizations obligated by a previous administration can be legally deobligated

Continued need for viable financing methods for both housing and services--as financing alternatives dry up the need will intensify

Medicaid cap may affect delivery of services begun under the Demonstration

Expanded waiver authority under the Omnibus Reconciliation Act will likely affect the Demonstration

VII. OTHER IMPORTANT INFORMATION

Demonstration-specific changes in the 202 and Medicaid 1115 waiver Programs

262 Program--usually decentralized, demonstration applications reviewed centrally; site control was not required; coordination with services was required

1115 Waiver--no changes were made in the waiver process, the applicable Federal-State matching ratio was used

Several interviewees at HUD emphasized that in making the long-term commitment in loan reservations HUD took a "leap of faith" and assumed that HHS and the States would assure that services were in place once projects became operational. There is no HUD mechanism to ensure that HHS and States follow through on their commitments. HUD interviewees were not familiar with the services component

Some HUD interviewees suggested that the problems encountered by sponsors with the 202 Program were not unique to the CMI but were related to difficulties associated with the provision of small scattered site housing for any special populations

A number of sponsors are interested in using Demonstration housing as short-term transitional living arrangements. This is prohibited under current HUD guidelines and regulations. HUD views 202 housing as permanent residences. In addition, transitional housing poses a special problem with Section 8 rental subsidies

The HUD/HHS Demonstration is a demonstration within a demonstration in instances where 1115 waivers are applied which affect statewideness, covered services, eligibility requirements or other statutory or regulatory aspects of the Medicaid Program

A number of interviewees felt that the burden of how Demonstration experiences are used is on the States, i.e., it is up to the States not the Federal government to take advantage of what has been learned from the Demonstration

Some interviewees at HHS indicated that in initially delineating the services to be provided, the Program set out a "menu" of services from which sponsors could choose. There was no formally organized approach to defining and stipulating the services to be provided

OVERVIEW OF ACROSS-INTERVIEW OBSERVATIONS

On a broad and global level, consensus on the intended program appears to exist among interviewees. Interviewees described problems to be addressed, program objectives, activities, and measures of success that were consistent and generally similar in focus.

Despite the overarching agreement among interviewees on the broad parameters of the intended Program, interviewees in each of the major agencies included in the interviewing process, i.e. , HUD, HCFA, NIMH, tended to emphasize different aspects of the Program and to discuss in somewhat greater detail those problems, objectives, and activities with which they have (or had) direct experience or which fell within the purview of their agency. For example, HUD interviewees focused almost exclusively on the housing component of the Program and had little knowledge of the services component. Interviewees at HCFA on the other hand tended to be concerned with cost/benefit issues and problems associated with Medicaid and administration of 1115 waivers.

Interviewee responses lacked specificity, especially in terms of the definition and discussion of key Program concepts. Interviewees described the overall Program design in very general, somewhat ill-defined terms and expressed a lack of knowledge or clarity on specific Program features and their interrelationships. It appears from several interviews, however, that this lack of specificity and clarity was characteristic of the Demonstration from its inception. The Program apparently was not conceived through a planned approach to program design and development; rather, it was an ad hoc response to various external and internal pressures--a response that attempted to build upon existing Federal mechanisms.

APPENDIX D

INTERVIEW GUIDE FOR PROGRAM MANAGERS/POLICYMAKERS

EXPLORATORY EVALUATION

HUD /HHS DEMONSTRATION PROGRAM FOR THE
CHRONICALLY MENTALLY ILL

INTERVIEW GUIDE FOR PROGRAM MANAGERS /
POLICYMAKERS

1. What is your (or your office's, division's, organization's, etc.) relationship to the HUD/HHS Demonstration Program?
2.
 - a. How is the HUD/HHS Demonstration Program staffed and organized at the HUD Federal level/Office of Independent Living for the Disabled?
 - b. What other components of HUD are involved with the program other than the Office of Independent Living?
 - c. What agencies external to HUD are involved with the HUD /HHS Demonstration Program and how?
3. From your perspective, what are the problems the HUD /HHS Demonstration Program seeks to address?
4. From your perspective, what are the main purposes or objectives of the Program ? What is the HUD/HHS Demonstration Program trying to accomplish?
5. Please describe the Program's funding award process.
6. How were States and local sponsors selected?
7.
 - a. What are the major activities of the HUD/HHS Demonstration Program at the Federal level? Regional level? In the States,? What specifically are States and local sponsors expected to be doing?
 - b. What resources are applied to these activities?
8. Why do you think that these activities or the approach taken by the HUD/HHS Demonstration Program will lead to the achievement of the objectives?
9. What accomplishments is the HUD /HHS Demonstration Program likely to achieve in the next two to three years? What are your expectations?
10. What measures or evidence would indicate to you that the Demonstration Program is achieving its objectives? How would you assess the Program's success?

11. a. What information (data and data sources) is currently available to assess progress toward HUD /HHS Demonstration Program objectives and accomplishments? (How are projects monitored?)
 - b. How is this information used?
12. a. What additional information do you think is needed to evaluate the progress and success of the HUD/HHS Demonstration Program?
 - b. How would this information be used?
13. a. What are the most serious problems or constraints (conceptual and operational) that face the HUD/HHS Demonstration Program in meeting its objectives?
 - b. How might these problems /difficulties be overcome?
14. What factors are likely to influence the program **over** the next two to five years ?

APPENDIX E
INTERVIEW GUIDES FOR STATE AND
LOCAL LEVEL FIELD VISITS

EXPLORATORY EVALUATION
HUD/HHS DEMONSTRATION PROGRAM

STATE-LEVEL INTERVIEW GUIDE FOR STATE COORDINATORS

1. What is your role in the HUD/HHS Demonstration Program?
2. What activities related to housing and/or housing linked with services for the CMI existed in your State prior to the HUD/HHS Demonstration Program?
3. What problems is the program in your State seeking to address?
4. What are the major purposes or objectives of the program? What is it trying to accomplish?
5. What other State-level agencies and/or programs are involved in this effort?
6. What are the major activities of the program? (Probe for clear, detailed descriptions of major activities at State and local levels.)
7. What Federal, State, and local resources (sources and amounts) are available to the program (staff; annual budget; in-kind support; Federal, State, and local share, appropriations, etc.)?
8. What evidence is necessary to see whether program objectives are met, whether identified problems are being resolved? What would you look for to assess program accomplishments?
9. What information on the program generally, and on program performance or results specifically, is currently collected or is potentially available? What information do you collect? What are the data sources? (Probe specifically for availability of service cost and utilization data.)
10. How is this information used? Does anything change based on such data?
11. What do you see as your program's major accomplishments or results to date?
12. What problems or barriers do you encounter in achieving your objectives?
13. How would you characterize or describe your relationship with the HUD Area Office? What role does HUD, HHS--HCFA or NIMH at the Federal level--play in your program?
14. What will happen to your program in the next two to five years? What are your future expectations for the program? What are your State's plans for meeting the housing and **service** needs of the CMI in the future?
15. What forces or factors will impact your ability to continue operating effectively? And how?

EXPLORATORY EVALUATION
HUD/HHS DEMONSTRATION PROGRAM

STATE-LEVEL INTERVIEW GUIDE (WAIVER-ONLY STATES) FOR
REPRESENTATIVE OF STATE MEDICAID AGENCY

1. What is your role in the HUD/HHS Demonstration Program? How does your agency relate with the SMHA on this effort?
2. What services appropriate to the needs of the CMI were included in your State Medicaid Plan prior to the HUD/HHS Demonstration Program?
3. What problems, from your perspective, is the program seeking to address?
4. What are the major purposes or objectives of the program? What is it trying to accomplish?
5. What are the major activities of the program? (Probe for clear, detailed descriptions of major activities at State and local levels .)
6. What evidence is necessary to see whether program objectives are met, whether identified problems are being resolved? What would you look for to assess program accomplishments?
7. What do you see as the program's major accomplishments or results to date?
8. What has been your experience with the 1115 waiver application process? What problems have you or do you continue to encounter with the waiver mechanism?
9. What waivers were initially requested? What waivers were approved by HCFA? How were the approved waivers implemented in your State from a policy and procedural standpoint?
10. What is the source(s) of State matching funds for your State's financing share for waived services?
11. What are your plans for evaluating the 1115 waiver process in your State? (Probe for clear and detailed description of evaluation methodology and data to be collected.)
12. What information on the program generally, and from the Medicaid perspective specifically, is currently collected or is potentially available? What information do you collect? What are the data sources? (Probes to include the following : (1) dollars spent by the State Medicaid Agency for the CMI, by service and geographic location; (2) service utilization by CMI; and (3) the denial rate in instances of presumptive eligibility in the following categories--AFDC , SSI , other optional group.)

13. How is this information used? Does anything change based on this information?
14. What problems or barriers do you encounter through your involvement with the demonstration program?
15. What are your State's plans for funding services appropriate to the needs of the CMI following the three-year 1115 waiver demonstration period?
16. What forces or factors (including the Omnibus Reconciliation Act of 1981) will likely affect the program in the next two to five years?

EXPLORATORY EVALUATION
HUD/HHS DEMONSTRATION PROGRAM

STATE-LEVEL INTERVIEW GUIDE FOR
REPRESENTATIVE OF STATE HOUSING -AUTHORITY

1. What is your role in the HUD/HHS Demonstration Program? How does your agency relate with the SMHA on this effort?
2. What activities related to the provision of housing appropriate to the needs of the CMI is your agency engaged in prior to the HUD/HHS Demonstration Program ?
3. What problems, from your perspective, is the program seeking to address?
4. What are the major purposes or objectives of the program? What is it trying to accomplish?
5. What are the major activities of the program? (Probe for clear, detailed descriptions of major activities at State and local levels.)
6. What evidence is necessary to see whether program objectives are met, whether identified problems are being resolved? What would you look for to assess program accomplishments?
7. What information on the program generally, and housing specifically, is currently collected or is potentially available? What information do you collect ? What are the data sources?
8. How is the information used? Does anything change based on this information?
9. What do you see as the program's major accomplishments or results to date?
10. What problems or barriers do you encounter through your involvement with the demonstration program?
11. What are your State's plans for meeting the housing needs of the CMI in the future? (Probes to include--funding for housing, procedural or policy changes to focus on the needs of the CMI, collaboration with SMHA, etc.)
12. What forces or factors will likely affect the program in the next two to five years ?

EXPLORATORY EVALUATION
HUD/HHS DEMONSTRATION PROGRAM
HUD AREA OFFICE INTERVIEW GUIDE

1. What is your role with respect to the HUD/HHS Demonstration Program? How many and which States within your purview have approved projects?
2. From your perspective, what are the main purposes or objectives of the program ? What is the program trying to accomplish?
3. What are the major activities of the programs in your Area?
4. What evidence is necessary to see whether program objectives are met? What would you look for to assess program accomplishments?
5. To your knowledge, what information on the program generally, and the housing component specifically, is currently being collected or is potentially available? What information do you collect? What are the data sources?
6. How is this information used? Does anything change based on the information?
7. What do you see as the major accomplishments or results of the programs in your Area to date?
8. What problems or barriers do the programs in your Area face in meeting their objectives?
9. How would you characterize or describe your relationship with the demonstration program in the States in your Area ? With HUD Central Office?
10. What problems do you encounter in your involvement with the program?
11. What do you see as the future of the program? Where will the programs in your Area be in two to five years?
12. What forces or factors will likely affect the programs in your Area in the next two to five years?

EXPLORATORY EVALUATION
HUD/HHS DEMONSTRATION PROGRAM

LOCAL LEVEL INTERVIEW GUIDE

QUESTIONS 1 - 3 ARE FOR SPONSOR AND/OR PROJECT DIRECTOR

1. Why did your organization decide to enter the Demonstration Program?
2. What were the responsibilities of the Sponsor and/or facility vis-à-vis the CMI prior to the Demonstration?
3. What are the roles and responsibilities of the Sponsor vis-à-vis the project?

REMAINING QUESTIONS ARE FOR
PROJECT DIRECTOR AND PERSONNEL

4. When :
 - . Did the processing begin?
 - . Did construction begin?
 - . Was construction completed?
 - . Did residents begin to move in?
 - . Did Section 8 funds begin to flow?
5. What problems, if any, did you experience regarding each of the above events?
6. Please describe your facility in terms of:
 - . Type and special design features
 - . Number of units
 - . Neighborhood characteristics
 - . Community access
 - . Community reaction
 - . Licensure and /or certification-obtain standards
 - . Occupancy level by client type
7. What is the staffing pattern of the project and what are the qualifications, roles, and responsibilities of project staff?
8. What is the service philosophy of the project?
9. Do you have an operational definition for the residents you will serve? Is any type of resident excluded?
- P0. Please describe the flow of residents into the project, including such items as outreach, intake, service plan development, **service** provision, monitoring of service plans., and termination.

11. What are the characteristics of your past and current residents in terms of:
 - . Age
 - . Sex
 - . Race
 - . Income (sources and amounts)
 - . Previous mental health treatment (where and how long)
 - . Referral source (most recent)
 - . Diagnosis
 - . Medication status
12. Please describe your current residents in terms of:
 - . Service plans
 - . Service provision--what services, who provides them, in what amounts or at what frequency, costs and /or charges
13. What were your costs for construction of the residence?
14. What are your ongoing, operational costs per month? (Obtain budget)
15. What is the average fair market rent? What is the average rent paid by current residents? From what source of funds? Where does the difference come from?
16. What ongoing housing and/or services-related problems is the project experiencing?
17. What factors do you expect may affect the project in the next one to three years? How ?

APPENDIX F

FIELD VISIT STATES AND AGENCY REPRESENTATIVES INTERVIEWED