DEVELOPMENTAL DISABILITIES

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Dedication:

This publication is dedicated to the members of the NACo Mental Health; Developmental Disabilities Task Force and the hundreds of other county officials who have given so generouslv of their time and ideas so that countv governments across the country can provide more effective services to their developmentally disabled citizens.

PREFACE

I am pleased to introduce *Developmental Disabilities: A Guide for County Officials.* This book documents the vital role of county governments in providing better opportunities for our developmentally disabled citizens. It stands as testimony to the benefits of public-private sector collaboration and cooperation among levels of government.

Publication of *Developmental Disabilities: A Guide for County Officials* is well-timed. County governments, the traditional providers of last resort, are constantly seeking cost-effective program strategies in health and human services. In this era of constraints on public expenditures, this book illustrates some of the many ways county officials meet their responsibilities to those in need. What has proven effective for a neighboring county may also work for you.

Approximately four million people in the United States are developmentally disabled. With our help and support they can participate as productive members of the community. It is my hope, and the hope of NACo, that *Developmental Disabilites: A Guide for County Officials* will be part of the successful effort to make that participation a reality.

Bernard F. Hillenbrand
Executive Director

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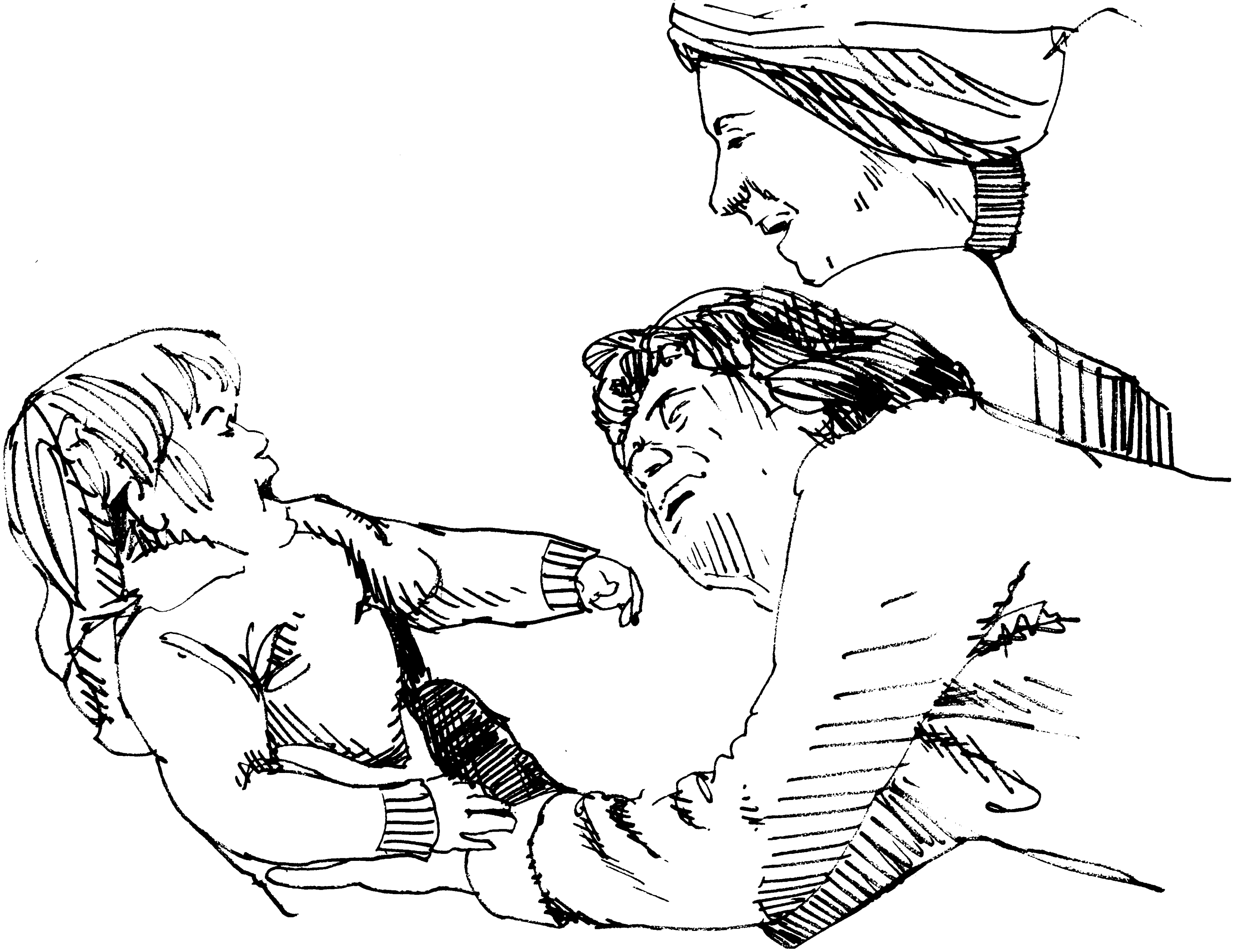


PART I

AN OVERVIEW

For the past several years, concerned county officials have asked the National Association of Counties (NACo) how they can respond more effectively to the needs of their developmentally disabled citizens. Their leading concern has been for those returning to the community from institutions.

In response, the National Association of Counties Research, Inc. (NACoR), the research affiliate of NACo, developed a technical assistance project. Funded as a Project of National Significance by the federal Administration on Developmental Disabilities beginning in October 1978, the NACoR project has identified hundreds of innovative and effective county developmental disability programs and strategies.

This publication highlights some of these programs. It is designed specifically for elected and appointed county officials; the focus is on what county governments can do to address the needs of their developmentally disabled citizens.

The developmental disabilities system involves officials at all levels of government, a variety of private and voluntary agencies, and most importantly, developmentally disabled people and their families. Therefore, the programs cited in this publication deal with the ways that counties interact and work with other elements of the system. This should be helpful to those outside county government, as well as county officials, who seek ways to work together more effectively.

This publication is not a compilation of federal funding resources for community-based developmental disability services. With the exception of a new Medicaid waiver authority for noninstitutional alternative services, the outlook for federal program funding is not encouraging. While some references to funding opportunities in the public sector are included, this publication's primary focus is on effective program strategies that minimize increases in public expenditures. Even counties that have been very successful in tapping federal resources are now searching for alternatives.

Fortunately, many services provided by county developmental disability programs have proven to be cost-effective. These services are noted for their involvement of family members and community volunteers; coordination strategies that reduce duplication and service gaps; resource sharing among agencies and programs; and collaboration with business and industry.

Part I presents an overview of developmental disabilities, the rationale for a coordinated community-based developmental disabilities service system, and the county role in developmental disabilities. Part II presents brief discussions of eighteen program areas and issues, and examples of how individual counties have taken action in these areas. Part III focuses on coordination and collaboration. It includes a detailed description of one county's coordination mechanisms, and discusses possible replication. Part IV is a comprehensive list of resources: county contacts; organizations involved with developmental disabilities; and a bibliography. Appendices list members of the NACo Mental Health/Developmental Disabilities Task Force, and include a section of the American County Platform highlighting NACo's policies affecting developmentally disabled people.

Who are the Developmentally Disabled?

When county officials talk about developmental disability services, they have specific people in mind.

Bill is a moderately mentally retarded man of fifty, who spent forty years in a state institution before returning to the community. Bill lives in a group home run by the county and works at the local Association for Retarded Citizens (ARC) sheltered workshop. He is gradually learning how to shop, cook, clean, and wash his own clothes. His temper outbursts must be brought under control if he is going to get along in a job outside the workshop. Without family ties, Bill is dependent on the service system for friendships and support.

Denise is five years old. A shunt has controlled her hydrocephalic condition ("water on the brain"). She is profoundly retarded; her measured intelligence (IQ) is below 20. Denise's divorced mother, who placed her in the county care facility, is now working full-time to provide for two other children. Her mother visits regularly, and 'tries to stay involved with her daughter's program. But she isn't sure she can ever cope with Denise's return home. She feels guilty about this.

David's parents placed him in an institution when he was quite young, on the firm advice of his pediatrician. Now, twenty years later, they are told he is leaving the institution to live in a group home near their town. They are frightened and confused about this plan; David is moderately retarded and still has occasional seizures. His parents had felt secure knowing that he would always be protected and cared for in the institution. They are now told that he will learn to live "independently," something they cannot imagine. They also feel-upset that strangers will make a home for him outside the institution. Are his parents failures for not having David at home with them?

Bob and Sue's first child has Down's syndrome. Fortunately, the hospital linked Bob and Sue promptly with the county infant stimulation and parent training program. Through this program, they met other parents of handicapped children and found support in shared feelings and experiences. They are very pleased with the baby's progress. However, the news of funding cutbacks concerns them. They wonder if needed services will be available as their baby gets older.

These profiles of developmentally

disabled people deliberately illustrate typical concerns expressed by consumers, family members, and service providers. There are many success stories, in which developmentally disabled people move successfully through a combination of specialized and generic programs and achieve their maximum level of skills and independence. But if that goal is to become a reality for all developmentally disabled people, a continuing concerted effort by concerned citizens is needed. At the county level, this means thoughtful and informed attention to the community-based developmental disabilities service system.

To highlight effective county programs working toward this goal, this publication focuses on developmental disabilities as defined in federal statute. All programs authorized and funded through the federal Developmental Disabilities Act must follow the federal definition. This means that the state Developmental Disabilities Plan, written jointly by the state Developmental Disabilities Council and the designated state agency, must describe needs and objectives in terms of the federal definition. However, the state law may provide a different definition that is used for all other purposes.

The federal definition of a "developmental disability" was enacted in 1975 and revised in the Developmental Disabilities Act Amendments of 1978 (P.L. 95-602). It remained unchanged when the act was reauthorized in 1981 (P.L. 97-35). The current definition is as follows:

> The term "developmental disability" means a severe, chronic disability of a person which—
> A. is attributable to a mental or physical impairment or combination of mental and physical impairments;
> B. is manifested before the person attains age twenty-two;
> C. is likely to continue indefinitely;
> D. results in substantial functional limitations in three or more of the following areas of major life activities:
>   i) self-care,
>   ii) receptive and expressive language,
>   iii) learning,
>   iv) mobility,
>   v) self-direction,
>   vi) capacity for independent living,
>   vii) economic sufficiency; and
> E. reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

The 1975 definition had described developmental disability in terms of a diagnosis of the individual's condition, such as "mental retardation" or "cerebral palsy." The current definition focuses instead on the functional capacity of the individual, that is, how (and how severely) the condition affects what the person can do. The following characteristics of the disability are emphasized:

Function: The definition is functional rather than categorical. Previous definitions used diagnostic names (mental retardation, epilepsy, autism, cerebral palsy, severe dyslexia).

Severity: The definition emphasizes that disabilities must be severe enough to result in "substantial functional limitations" and the need for "individually planned and coordinated services."

Age of onset: While the definition raised the "age of manifestation" from eighteen to twenty-two years, the emphasis remains on disabilities that interfere with normal preadult development.

Long-term disability: The disability must be "chronic" and the person expected to need services of "lifelong or extended duration."

There has been considerable debate about who does or does not meet the criteria in the federal definition. Questions have surfaced about exclusion of mildly retarded individuals and inclusion of chronically mentally ill individuals. These questions have not been completely resolved.

At the county level, decisions about eligibility for developmental disabilities services are more affected by state requirements and tradition than by the federal definition. While there has been some use of the federal standard, most state and local service systems have not formally adopted it. Therefore, some of the programs featured here serve some people who do not meet the federal definition; many, by design, serve only a subgroup of the people who meet the definition.

The trend at the local, state, and federal levels toward service priority for people with more severe handicaps produces some evidence of reduced program eligibility for mildly retarded people. There is also an expectation that what they lose in specialized developmental disability services can best be replaced by gaining access to "generic" services (those services available to citizens based on their income or other general criteria, rather than a categorical disability). At a time of general cutbacks in generic as well as categorical services, making this expectation a reality will be a special challenge.

The Rationale for Community-based Services

Most developmentally disabled people have never been institutionalized. Until about 1967, most public developmental disability services were provided through such large centralized institutions as hospitals, state schools, and training schools. Since then, the emphasis has shifted to providing services in the community for both developmentally disabled people discharged from institutions and those who never were admitted.

This shift has transformed thinking about developmentally disabled people, widened the range of services available, and increased access to specialized services by not conditioning services on institutionalization. At the same time, the establishment of community-based services has greatly increased the involvement of local governments in the developmental disabilities service system.

Statistics on deinstitutionalization of developmentally disabled people are limited generally to reductions in the population of public mental retardation institutions. This population has dropped every year since 1967, when it stood at a peak of 195,000. The current estimate is 130,000.

Data collected by the National Association of State Mental Retardation Program Directors projects a further decline to 95,000 by the mid-1980s. In addition to the thousands of discharges, there has also been a reduction in admissions. A 1978 study (Scheerenberger, 1979) found that annual admissions dropped from 16,000 to 10,000 between 1967 and 1978; only 36 percent were first-time admissions.

At the same time, there has been a growth in community developmental disabilities programs. A 1977 survey of community residences (Bruininks, Hauber & Kudla, 1980) found that of 4,920 community residential facilities of all sizes, 72 percent were developed since 1967. Interestingly, only 35 percent of the residents of these facilities came directly from state institutions; the majority came in about equal proportions from their natural homes or from another community residence. This probably indicates a need for experimenting to find the right program for each individual, as well as the proper expansion of developmental disability services to persons never institutionalized.

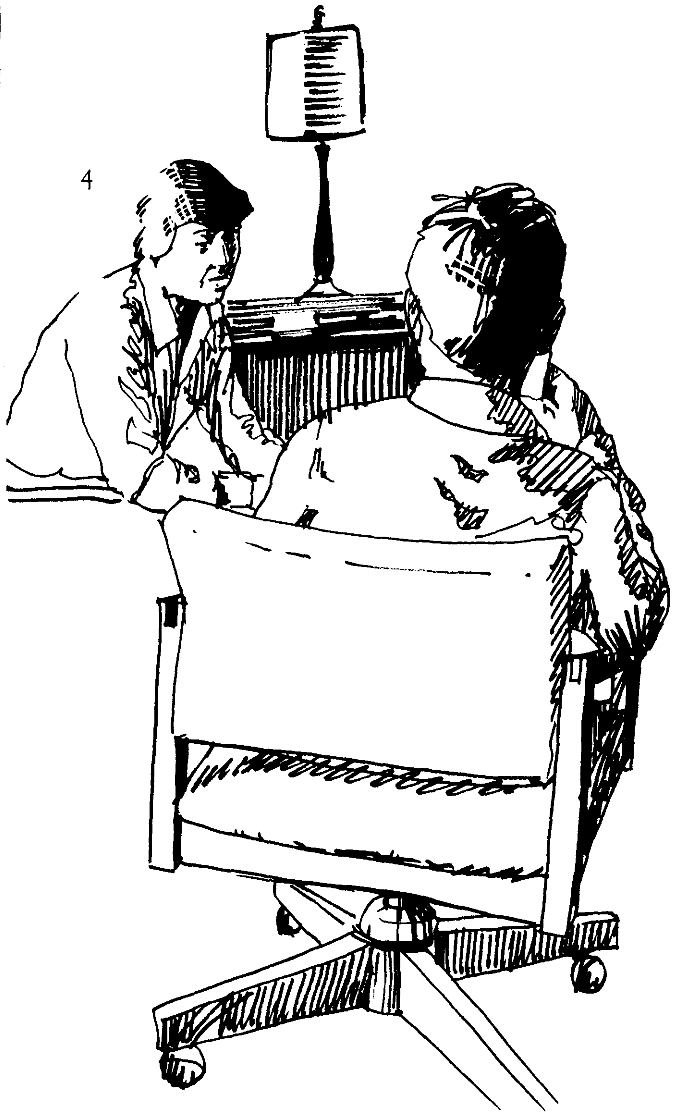
In addition to residential programs, there has been an explosion of such other developmental disability community services as education, vocational training and rehabilitation, early intervention, diagnostic and evaluative services, advocacy, and case management. Access to generic programs such as housing, supplemental security income (SSI), and disability income (SSDI) has also increased.

The evolution of the system over the past fifteen years demonstrates that virtually all developmentally disabled people can remain in the community, if provided with appropriate services. Institutionalization is becoming a rare exception. Much has been written about the shift toward community-based developmental disability services.

Discussion generally focuses on three areas. Habilitation and normalization is one area. This approach emphasizes development of the individual's skills and service delivery in the most "normal" setting, or one which promotes the most "normal" lifestyle. These settings include family or family-sized homes, and education and vocational programs provided separately from the place of residence.

Another major area of discussion is civil rights. Developmentally disabled people have the full range of rights guaranteed to all citizens, along with specialized applications of these rights and others granted by specific federal and state statutes. For example, the Education for All Handicapped Children Act (P.L. 94-142) creates the right to an individual education plan in order to ensure the general right to an appropriate education.

Funding is a third area of concern. While data is mixed, there is evidence that costs are lower in community programs than in institutions. There is a common-sense perception that programs aimed at full or at least partial self-sufficiency will be less costly in the long run than lifelong institutionalization and dependency. Increased availability of community service funding (especially from the federal government) for both individuals and community programs, along with the burgeoning cost of institutions, has made developmental dis-



ability community services fiscally attractive to state and local governments.

A consensus on the benefits of individualized habilitation is widespread, and those benefits are well-documented. Where the choice is between impersonal custodial care, with little or no opportunity for learning or self-sufficiency, and an individualized program of comprehensive education and training, it is clear that the latter is vastly preferable. There is less consensus on whether normalization is possible for some severely handicapped people or on how significant it is in contributing to optimal development.

The courts have consistently supported habilitation, normalization, and civil rights. Bradley (1981) lists thirty-nine "right to habilitation" lawsuits in twenty-seven states from 1971 to 1981, with the majority resulting in a mandate for deinstitutionalization. Only six suits were dismissed or rejected. Focusing on the rights and needs of developmentally disabled people, legal cases have frequently de-emphasized or ignored funding questions. In Pennhurst v. *Halderman*, 49 U.S.L.W. 4363 (U.S. April 20, 1981), however, the U.S. Supreme Court held that the federal Developmental Disabilities Act does not create an obligation on states which accept federal developmental disability program funding to provide services in accordance with the act's bill of rights. Given the limited federal developmental disability funds available and the enormous cost that might be entailed in the obligation to provide appropriate habilitation in the least restrictive setting, the Supreme Court held that Congress would have to be more explicit if it meant to require the states to implement the right to the least restrictive alternative in exchange for federal developmental disability funds.

It now appears that there is a consensus favoring a community-oriented developmental disability system emphasizing individual services provided in settings that do not unduly restrict the person's liberty. However, cost will exert a growing influence on the debate over implementing this policy.

Where counties can provide a full range of developmental disability service options, they may prefer to avoid detailed examination of the controversial normalization issue. They may leave this examination to the professional, academic, state and federal legislative and judicial arenas. County officials cannot, however, avoid debate on costs. Current public hearings on budgets are presenting county officials with some of the most difficult decisions they have ever faced, including funding priorities for community developmental disability programs.

Community services obviously require funding. But as developmentally disabled individuals have returned from institutions, the state dollars that paid for their institutional services generally have not followed them into the community. Federal Medicaid dollars have favored institutional settings, such as large nursing homes. Demand for services at the community level has outstripped the types of noninstitutional funding available.

Developmentally disabled people now in communities include those discharged from institutions, those who have always lived in the community and who have never been considered appropriate for institutionalization, and those who might once have been considered appropriate candidates for institutions, but who do not meet today's more stringent criteria for institutionalization. The development of community services to meet the needs of discharged individuals and to prevent unnecessary institutionalization for others has encouraged additional demand from developmentally disabled people who had not received services previously.

The result has been a large and growing demand for community services for developmentally disabled people without obvious sources of funds to pay for them. County officials are therefore particularly interested in cost-effective program models and ideas that stretch scarce public dollars through volunteer and private initiatives.

Cost comparisons between various forms of services are difficult. It is hard to assign monetary value to many program benefits and it is virtually impossible to "control" studies for such variables as client motivation, individual staff ability, family involvement, and community attitudes.

Comparisons frequently leave out important factors. For instance, community-based developmental disability services are often supplemented by services and other support paid for by families and by generic programs, which are not reflected in the developmental disabilities budget. At the same time, community residents receiving developmental disability services frequently perform productive work, which may be difficult to value if unpaid. Many are paid, and in turn pay taxes, which does not often show up in analyses of the cost of services. To the extent that community-based programs help an individual achieve greater self-sufficiency, current costs contribute to long-term savings, as compared with a lifetime of institutional dependency. Often, this does not show up in budget debates.

Despite these limitations, many studies demonstrate that community-based developmental disability services have lower per capita budgets than institutional services. A recent study by the National Association of Private Residential Facilities for the Mentally Retarded shows that for 67 private facilities, the average client cost per month was $1,187, compared with an average cost in large state institutions of $2,884. This translates to a savings of $20,364 per client per year. In San Diego, a group home for six mentally retarded persons costs $104,000 per year, while the average cost of serving six such clients in a state-operated institution is almost $333,000 per year. A Georgia study comparing institutions with community program costs found that the per capita costs were significantly lower for the community residential program, and that these programs increased client independence and productivity. For example, 84 percent of deinstitutionalized persons had no earnings while they resided in the institution; only 15 percent had no earnings after they moved to the community (Boggs, 1981).

Other studies are more equivocal, showing little cost difference between institutional and community service (Mayeda and Wai, 1976; Jones and Jones, 1976). Most are clear, however, that significant service system savings occur when developmentally disabled individuals return to the natural family setting or foster family care (Intagliata, Willer and Cooley, 1979). And most agree that community services provide significant developmental benefits that are difficult to measure quantitatively.

One study provides some data of interest to local governments concerned with total cost effects rather than simply developmental disabilities system costs. A Texas county program for severely mentally retarded children, many with additional physical handicaps, analyzed the impact on family income when developmental services were provided to the children. After one year of services, the income of fifty-seven of ninety-seven participating families had increased up to 150 percent. The median increase was 31 percent; where both parents were working, the median increase was 80 percent. Significantly, of the eleven families who entered the program on welfare, seven became self-sufficient. The average annual cost per family for services was $3,350, compared with Texas state institutional costs during the same time period ranging from $12,888 to $29,868 (Liberman, 1979).

The County Role

Current thinking about developmental disabilities calls for a continuum of services, with varying levels of supervision and intensity of service depending on individual needs. The key to this approach is coordination.

When all services are delivered in a centralized institution under the authority of one department, coordination is, more or less, built in. However, when developmental disability services are separated and clients must put together the array of services they need, specific attention must be given to coordination.

County governments play a variety of roles in community developmental disability services. In general, counties participate in two capacities: as administrative arms of state government and as locally elected general purpose governments. Some are mandated by state law to operate services, particularly for mentally retarded individuals. Others operate some services directly and provide significant funding through contracts with public and private service agencies. Still others are only minimally involved in developmental disabilities, but are concerned with increasing community demand.

Along with the county's administrative and fiscal roles, another role—an advocacy role—may become increasingly significant. In a time of budgetary pressure and program cutbacks, less vocal people such as the developmentally disabled are vulnerable. Tightened eligibility for generic programs and shrinking categorical programs may cause those who have difficulties in "negotiating the system" to fall between the cracks. Elected county officials may be called on to act as leaders and advocates for these often-forgotten citizens.

As the federal role diminishes, state and local roles are likely to expand. The programs described in this publication provide models for the kinds of programs counties can develop to meet their growing responsibilities in upcoming years.

PART II

PROGRAM AREAS AND ISSUES

Throughout the nation, counties have developed effective programs and strategies benefiting developmentally disabled citizens. The following pages illustrate successful approaches covering the program areas where the county role is significant. Additional information can be obtained from county resource people listed in Part IV.

Advocacy

Like other vulnerable people, developmentally disabled people sometimes need an advocate. County government may assume responsibility for their advocacy, as well as work with such external advocacy groups as the local Association for Retarded Citizens or the state developmental disabilities protection and advocacy unit. Counties may provide advocacy services to protect an individual's rights to service and nondiscrimination, or focus their advocacy efforts on systemwide problems, or do both.

In Sacramento County, California, the county board of supervisors created the Developmental Disabilities Planning and Advisory Council. When establishing the council in 1974, the board stated: "While the Sacramento County Board recognizes [the state's responsibility]. . .the board also realizes that the county has a role to ensure adequate services for the developmentally disabled. Maximum effort should be made for effective coordination within Sacramento County."

The council works closely with both public and private agencies. Planning council staff are on contract to the county's consolidated health department; the local Association for Retarded Citizens provides office space. With continuing support from the board of supervisors, the council successfully negotiated additional services for developmentally disabled people from the county parks and recreation agency, the regional transit system, and the county's foster grandparent and mental health programs.

Prince George's County, Maryland, established the Office for Coordination of Services to the Handicapped. County legislation gives the office a variety of responsibilities. These include collecting data on unmet needs and gaps in services and programs, and identifying, analyzing, and evaluating all programs and services for the handicapped population in the county. The office is also responsible for providing policy recommendations aimed at eliminating barriers to service delivery, and locating appropriate sources of financial assistance for expansion of services and programs.

The office does not provide direct services; this remains the responsibility of other agencies and departments. The office does provide an information and referral service, handling more than 1,000 calls annually, and acts as a catalyst for interagency coordination through its sponsorship of committees that address individual and community service needs.

In the northeast United States, approximately 100 county and city offices for the handicapped have been identified. A network of local offices, the Association of Local Government Agencies for the Disabled in the Northeast Region (ALGADNER) has been formed. The founder and current president is Don Dreyer, director, Nassau County (New York) Office for the Physically Handicapped. Through the ALGADNER network, county governments are working together as advocates.

Case Management

The basic element common to all case management systems is the designation of a single point of accountability. Because developmentally disabled people frequently have needs that cut across multiple programs and agencies, many counties have developed case management systems. These systems are characterized by a case manager who is responsible for ensuring that the consumer receives a comprehensive needs assessment, consistent case planning across agencies, and access to the full range of needed services. A case management system also provides monitoring and evaluation; revisions in the overall case plan as required; and documentation of service gaps and program deficiencies.

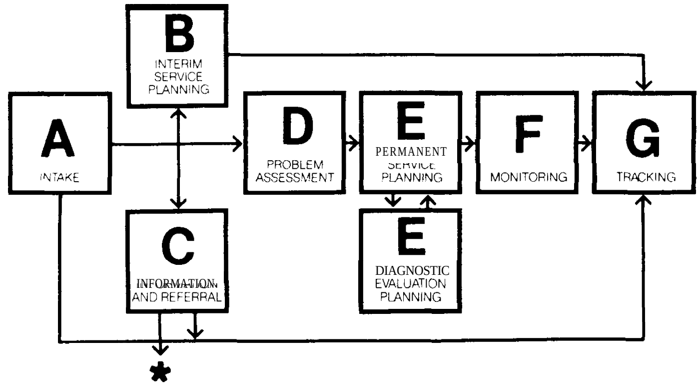
One benefit of case management, according to many proponents, is its separation from direct services. Potential conflicts between monitoring and service responsibilities are avoided, and the case manager's focus on access and coordination frees up direct service providers to perform their specialized functions. In contrast, some proponents feel that case management is best provided by the lead person among the client's service providers, e.g., their vocational program counselor or parents.

Most county developmental disability case management systems have taken a middle course: case managers are located within the county developmental disability agency, but are not involved in direct service delivery.

One exception is Alamance County, North Carolina, where the case managers are attached to the county manager's office. The county commissioners have found this arrangement responsive to constituent concerns; it also keeps the board informed of needs in the service system. The system is computerized, helping in client tracking, program monitoring, and planning. Regarding separation from service components, one case manager commented, "People respond to us because we're not connected to another agency. The clients see us as working for them, not 'doing a job' in an agency."

The Alamance County case management system was developed in collaboration with the North Carolina State Developmental Disabilities Council, using a system developed by the Center for Urban Affairs and County

Figure II-1. The Alamance County, N.C., Client Pathway



SOURCE: Snipes, Emerson, *Developmental Disabilities Case Management Systems Overview* (Raleigh: Center For Urban Affairs and Community Services, North Carolina State University, 1979).

Services at North Carolina State University. The client pathway design is illustrated in Figure II-1.

The system includes a formal established service planning team and an advisory board, composed of representatives of the county board of commissioners, key public and private agencies, and consumers. Another important component is the Service/Resource Directory and Index, listing developmental disability and generic services. The directory is indexed not only by service and agency, but also by service outcome, reflecting the case management system's emphasis on client outcome rather than agencies and programs.

Most other counties with developmental disability case management systems have assigned the function to a separate developmental disabilities division, or to a unit within a larger human service department. For example, in Hennepin County, Minnesota, case managers are part of the mental retardation division of the community services department, under the umbrella bureau of social services. This structure reflects Minnesota's implementation of the Community Services Act, which gives counties broad authority over federal and state funds. In *DeKalb* County, Georgia, case management is provided by the county developmental disability services office under the mental health/mental retardation division of the county health department. Case managers are selected from among members of the client's interdisciplinary service team.

Elsewhere, in Chester County, Penn*sylvania*, developmental disability case managers are located with their mental health counterparts. The county mental health/mental retardation administrator has found this particularly helpful when program needs cut across both disabilities. And Craven County, North Carolina, uses the same model as Alamance County. However, developmental disability case managers are attached to the county department of social services.

Regardless of location, the key to effective case management is the manager's ability to influence a complex system*on behalf of the client. The county is in a unique position to make this happen.

Community Education

County commissioners frequently request ideas on how to educate the community about their role as county officials. They want the community to understand how difficult decisions are made, and how special program needs, such as housing and other programs for developmentally disabled people, are fulfilled. One approach to community education is social marketing, which is the application of advertising and marketing techniques to social policy issues. Several counties have used this approach to help the community prepare for and accept developmentally disabled people as neighbors and co-workers.

Some advocates for developmentally disabled people have objected to community education when it appears to "seek permission" for group homes or other community programs. Other strategists have advocated a low-profile, "sneak them in during the middle of the night," approach. Most counties, however, have found that the ultimate goals of community acceptance and integration of developmentally disabled people are best served by a multifaceted approach that emphasizes the rights of disabled citizens, including their right to live in the community; their potential as productive members of the community; and the community's competence to make that productivity possible.

Experience with deinstitutionalization nationwide has established several key facts central to community education. One fact is that property values are not adversely affected when community residences come in; instead residences may actually contribute to neighborhood stability. Another fact is that the crime rate does not go up. Finally, it has been found that well-designed developmental disability community residences blend in with the neighborhood, are well maintained, and have a positive effect on neighborhood life style.

Nationwide statistics, however, do not necessarily allay local fears and concerns. Counties, therefore, have developed education tools that involve county officials and other community leaders and relate specifically to the local situation.

The Franklin County (Ohio) Commu-

nity Mental Health Board set up a group home task force, in response to concerns about community residence saturation in some neighborhoods. The interagency task force worked quickly to set up a clearinghouse on all human services group homes, and then began working on community education. In collaboration with the Metropolitan Human Services Commission, which has now assumed major responsibility, the task force has recruited and trained volunteer "community educators," who present information on community residences to organizations throughout the county. It has also analyzed property values, resulting in documentation that group homes have not adversely affected values in Franklin County; and developed a slide show on group homes which can be shown to the community.

In *Westchester County, New York,* County Executive Albert DelBello appointed a citizens committee on transitional services. Community leaders from all parts of the county laid the groundwork for acceptance of developmental disability and other community residences for people returning from institutions. This effort was succeeded by CRISP, the Community Residences Information Services Program. CRISP is operated by the county's private, nonprofit health and welfare planning group, the Westchester Community Service Council. The county department of community mental health services contracts with CRISP for community residence development and support activities. Under contract, CRISP locates appropriate sites for community residences, runs a clearinghouse to avoid saturation, and provides information on local building and zoning codes and relevant court decisions. It also assists with community acceptance strategies and the formation of neighborhood advisory boards and councils, presents educational programs through media and public speaking engagements, conducts research on community residence impact, and evaluates community acceptance strategies.

CRISP has published the nationally acclaimed reference on community education, *Gaining Community Acceptance: A Handbook for Community Residence Planners* (see bibliography). CRISP is a valuable source of information on all three levels of community education: acceptance of a specific community residence, support for community residences in general, and broad-based education to reduce stigma.

Coordination With State Facilities

Effective linkages between state developmental disability facilities and county developmental disability service systems are important to the success of moving deinstitutionalized people into the community. At a minimum, the county needs to be informed of and involved in discharge planning for institutionalized county residents, both as a group (e.g., how many present institution residents needing residential and day programming will be returning over the next two years) and for individual residents nearing discharge. In some areas, county programs and state facilities have actively collaborated beyond planning functions to share resources.

Unfortunately, many counties have been frustrated in their attempts to coordinate with state developmental disability facilities. Most institutions do not divide residents by county of origin, and many do not have county-based data on community needs that can be used for planning purposes. As a start, however, county developmental disabilities planners and case managers should contact the institution's community relations or social services director to request information on county residents.

Northern Virginia counties have participated actively in the deinstitutionalization project at the Northern Virginia Training Center, a state mental retardation/developmental disabilities facility. The project includes funds to county mental health/developmental disabilities service boards to stimulate the development of developmental disabilities community residences and adult prevocational and vocational training programs. Responsibilities are coordinated between facility staff and county boards and case managers.

In preadmission screening, the county board screens all applications for admission to the institution. Clients are diverted to community alternatives whenever possible.

For the purposes of individual program planning, the county developmental disabilities case manager is part of an interdisciplinary team for institution residents, which also includes a representative of the county school system (for school-age clients) and a representative from the vocational program (for adult clients).

In the area of discharge planning, the county case manager has primary responsibility for community program arrangements and consults with training center staff when clients are ready for discharge.

In the area of transitional services, the case manager and facility staff work with the client and family to ensure a smooth transition into the community. Following discharge, the case manager assumes responsibility. However, facility staff are available for consultation and may assist the client and case manager in arrangements for social visits to friends remaining at the facility.

Criminal Justice System Linkages

Some developmentally disabled people get caught up in the criminal justice system, especially in areas where deinstitutionalization preceded the development of comprehensive community service systems. Particularly when involvement with the criminal justice system is primarily the result of developmental disability (e.g., the homeless retarded young adult who is picked up for vagrancy or panhandling), county officials have sought links between systems so that developmental disability needs are recognized and met without sacrifice to community safety.

In Montgomery County, Pennsylvania, the county commissioners developed an emergency service for developmental disabilities, psychiatric, and substance abuse crises. The award-winning Montgomery County Emergency Services (MCES) provides consolidated emergency support services for the fifty-seven police agencies in the county. Because MCES supplements police services by providing an alternative to incarceration, it has increased the availability of police for their regular public safety activities. After the county provided the original seed money, the program became almost entirely self-supporting through third-party payments. MCES has established working relationships with the county mental health/retardation/substance abuse agency, social services, local hospitals, judges, police personnel, and probation officers. MCES has provided training programs for police officers, and has placed liaisons in the larger police departments. Because MCES uses trained social work interns from a local college as liaisons, consultation costs are kept low.

The sheriff of Galveston County, Texas, asked the county for help with developmental disability and mental health emergencies. In response, the Gulf Coast Regional Mental Health/Mental Retardation Center (serving Galveston and *Brazoria* counties) set up the mental health deputy program. The center worked with the sheriff's department to teach a corps of deputies about crisis intervention, the characteristics of mental illness and developmental disabilities, and appropriate referrals to the service system. Cross-fertilization between systems was promoted when one of the center staff took law enforcement training and joined the corps as a deputy. The mental health deputies are assigned around the clock so that developmental disabilities and mental health calls can be dispatched to them. The program has significantly reduced inappropriate hospitalization and incarceration, and has won the coveted American Psychiatric Association Gold Award.

Early Intervention

While prevention of developmental disabilities remains the ideal priority, early intervention or secondary level prevention is essential to minimize the severity of developmental disabilities. In some cases, early intervention with developmentally delayed children has enabled the child to catch up completely.

Many county developmental disability programs have focused on services to infants and toddlers. One of the most cost-effective programs in the system, early intervention programs generally include identification and outreach (e.g., coordination with local hospitals and pediatricians) and infant stimulation and developmental training for toddlers. The training programs may be offered at a central location, at home, or at both.

The Hamilton County, Ohio, Board of Mental Retardation provides early intervention classes for children, from birth to three years of age. Classes meet three days per week for two hours. Parents provide transportation and are required to participate in classroom activities one day weekly. A monthly fathers' night helps both parents to participate in the child's program. Board staff work actively with local parent groups for handicapped children; the parent groups have aggressive outreach programs with hospitals, doctors, and day care centers. They also use radio and television public service announcements to inform parents that help is available.

In Westchester County, New York, the county department of community mental health developed the Early Years Prevention Service. The program serves developmentally delayed and emotionally disturbed children (from birth to five years old) and their parents through area day care centers. In addition to the direct services offered at the day care centers and a therapeutic nursery at a neighborhood health center, program staff provide consultation and in-service training to child care workers. As a result, many children are accepted for day care who had previously been excluded because of their developmental and emotional problems.

Education

Education programs appropriate for developmentally disabled children are an essential component of the local developmental disability service system. As mandated by P.L. 94-142, "a free, appropriate, public school education" must be available for handicapped children. Commonly known as the Education for All Handicapped Act, the legislation requires such education to be available for children from age three to the state-established upper age limit for education services, usually age 21. In combination with requirements under Section 504 of the vocational rehabilitation statute, procedures are spelled out for individual rights to assessment, planning, placement, and appeal.

County developmental disability programs commonly work with local school districts to support public school programs for developmentally disabled children and to prepare children who require interim specialized programs outside the public school setting for "mainstream" education. In addition, many county developmental disability programs have worked with adult education providers to set up basic education and skills development classes for developmentally disabled adults.

Parents, educators, developmental disability specialists and developmentally disabled children are still grappling with the implications of "mainstreaming" and appropriate public education. During this period of transition, there are major unresolved questions on funding, the definition of education-related services, training and support for teachers, and the criteria for placement within or outside the "regular" school and classroom. Many county developmental disability programs have performed a valuable role as the bridge between specialization and "mainstreaming."

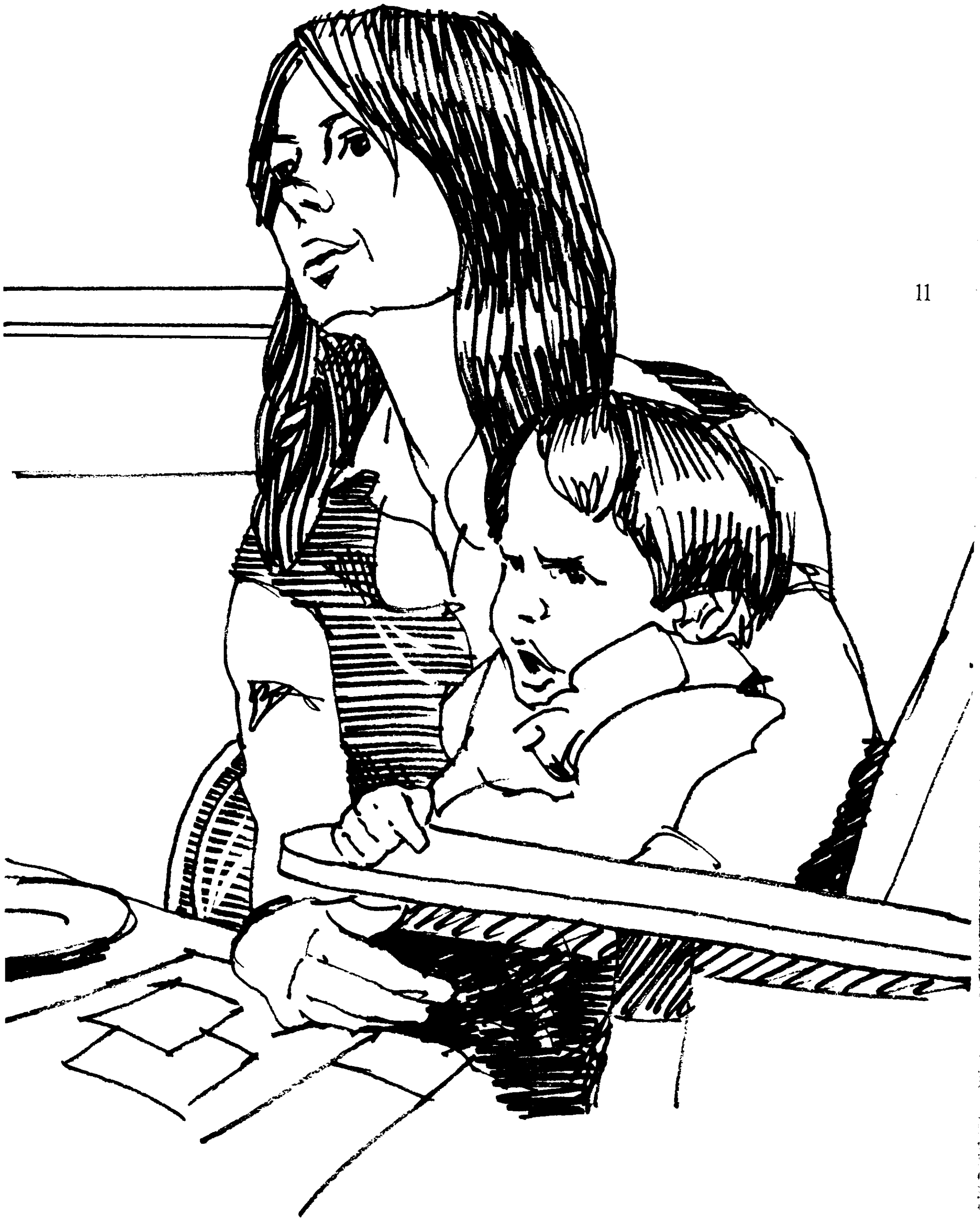
In Contra Costa County, California, the mental health division of the county health department collaborated with the county superintendent of schools for special education to develop a joint education, therapy, and support program for school-age developmentally disabled children and their families. Health department staff provide diagnostic services, special therapies, counseling for family members, and consultation to the education staff. The county special education department staffs six classrooms with trained teachers and aides, provides transportation, and works with parents to help them reinforce the classroom experience. Both school and health department staff work together on the development and implementation of each child's Individual Education Plan (IEP). Children progress to classrooms in their neighborhood school whenever possible; center staff work with the new school to make the transition go smoothly.

In DeKalb County, Georgia, voters passed a $1.7 million bond issue to build the DeKalb County Mental Retardation Services Center. The center is staffed primarily by county health department developmental disability personnel; the county board of education provides speech therapists and special education consultants and works closely with the center staff. The center uses community volunteers for classroom and supplementary education activities and for community relations. The center has been very successful in preparing children to move into public school programs, and is now expanding its adult program.

In Johnson County, Kansas, the county mental retardation center and the Johnson County Community College jointly developed Project CLEAR (College Learning Experiences for Adults with Retardation). The project provides noncredit, educational opportunities for mentally retarded adults. Classes focus on strengthening independent living skills and offering life-enhancing experiences. Programming is designed to complement training offered by other agencies within the local service system. There is a four-level continuum of services, designed to integrate students into regular noncredit college programming whenever possible. Only Level 1 utilizes specialized instructors and separate student populations. Levels II-IV use regular continuing education staff and include nonretarded students. Coordination is provided at Level IV to integrate students into regular college programming. In addition to the continuing education classes, Project CLEAR sponsors mental retardation programs in parent training, professional training, and community awareness. Consultation is available on how to set up similar programs.

In Marion County, West Virginia, the multicounty Valley Comprehensive Community Mental Health Center developed RISE (Reinforcing Independence through Systematic Education). This adult day treatment program is a cooperative effort involving the local adult basic education program, the developmental disability sheltered workshop, the Marion County public school system, and a local church where classes are held. Clients include both developmentally disabled and chronically mentally ill people. Transportation can be arranged.

RISE teaches functional remedial skills such as reading and money management, trains persons in such com-



munity living skills as shopping and housecleaning, and monitors and evaluates the adjustment of persons living in the community.

In addition, RISE works with West Virginia University and Fairmont State College; selected students earn academic credit by working in the program.

Foster Homes

For adults unable to live independently and children unable to remain in their natural home, foster home placement is a welcome alternative to larger group living arrangements. Foster homes are generally operated and licensed under fewer restrictions than larger community residences, and payments to foster parents are generally lower than per diem program costs in larger programs. Foster homes, then, are an attractive alternative for budget-conscious administrators.

Foster care has been used to describe everything from individual foster home placement to larger group homes. For our purposes, a foster home is a residence where foster parents provide a home for one to four developmentally disabled people.

In the District of Columbia, the bureau of community services of the mental retardation/developmental disabilities administration has mounted an aggressive and very successful campaign to develop developmental disability foster homes. In a little over three years, it has developed thirty-six foster homes for seventy-four developmentally disabled people. Program publicity includes radio and television public service announcements; distribution of the program brochure through service organizations, churches, and libraries; speeches at churches and neighborhood advisory committee meetings; and word-of-mouth by the foster parents themselves.

The program has strict standards for the selection of foster parents, and homes must meet local foster home licensure standards. All foster parents go through an orientation program, which includes resource information on developmental disabilities and deinstitutionalization. Additional training is required at a minimum of twelve hours per year. Extensive support and consultation is available from the developmental disability case manager, a registered nurse, and special consultants in psychology, vocational rehabilitation, education, and recreation. A new home-based training program is being developed. The current rate for foster home placements is $417 per month; this figure includes a $25 clothing and $36 personal needs allowance for the client.

In *Hennepin* County, Minnesota, the adult foster care division of the county community services department works with the mental retardation division to locate and monitor foster homes for developmentally disabled adults. Foster parents are expected to provide room and board and the guidance and support of a caring family. They are screened carefully, and the home itself must meet county and state licensure standards. To promote the foster home client's independence, she or he is responsible for paying the foster parent at the rate set by the county, regardless of the client's source of income.

Both the adult foster care and mental retardation divisions provide consultation to foster parents and residents to keep the program running smoothly. The foster care staff have prepared a comprehensive handbook for foster parents, so that important information is in one handy reference. In addition to long-term arrangements, special crisis homes are available for developmentally disabled and other people going through a psychiatric emergency. The current rate for foster home placement is $375 per month; crisis home parents receive $28 per client per day.

Guardianship

Over the past few years many states have enacted legislation on the rights of developmentally disabled people. These statutes frequently include a section requiring that developmentally disabled adults are presumed to be competent unless there has been a specific, substantiated finding that they are incompetent to manage their affairs and court action to declare them incompetent and appoint a legal guardian. Many parents have routinely functioned in a guardianship capacity for their adult developmentally disabled children, with or without legal action. Many developmentally disabled adults have no need for guardianship. Unfortunately, some who do have no concerned relative or friend available and willing to assume guardianship. This can present major problems for county developmental disability programs and clients: the client is in "legal limbo" regarding management of assets, program placement decisions, and even questions on consent to needed elective surgery.

In some states, such as Minnesota, the county developmental disability agency assumes custody in these situations. In other states, such as Ohio, the state developmental disability agency has developed a statewide system of guardianship and protective services. Some counties with guardianship responsibilities have chosen to delegate them to a noncounty agency. This has the advantage of minimizing conflict of interest, while simultaneously improving collaboration with the private, voluntary sector.

In *Rock County, Wisconsin*, the county developmental disabilities board and county department of social services cooperatively planned and established high quality, cost-effective guardianship and protective services. Working with the Wisconsin Association for Retarded Citizens, the county agencies set up Guardian/Friend Associates. The program is operated by the association under contract with the county developmental disabilities board. Under terms of the contract, the association acts as legal guardian for up to 100 Rock County citizens who have been legally determined by the county courts to need guardianship services when there is no appropriate family member to assume the responsibility. It also recruits, trains, and supervises a pool of volunteers to assist Wisconsin Association for Retarded Citizens staff in providing personalized guardianship services, informs the general public of the guardianship statute, and assists citizens in obtaining these services when needed.

Guardian/Friend Associates has provided extensive training sessions for professionals and volunteers. They have implemented a broad-based public information campaign, including speaking engagements and media placement. More than fifty volunteers have been recruited and trained; volunteers assist staff by visiting the wards, attending their program staffings, and by being interested community friends. Through the volunteer program, costs are one-half guardianship costs in a nearby county that uses paid staff almost exclusively.

In *Lauderdale County, Mississippi*, the chancery court county administrator has responsibility for developmental disability guardianships. The administrator and his small staff work very closely with public and private developmental disabilities and generic agencies to ensure that the wards' program goals are met. While guardianship services are not delegated to volunteers, the guardians routinely identify concerned neighbors who can assist the wards with community adjustment and can help in emergency situations. The neighbors have proven extremely valuable as extensions of the guardians' efforts on behalf of their clients.

Home Training

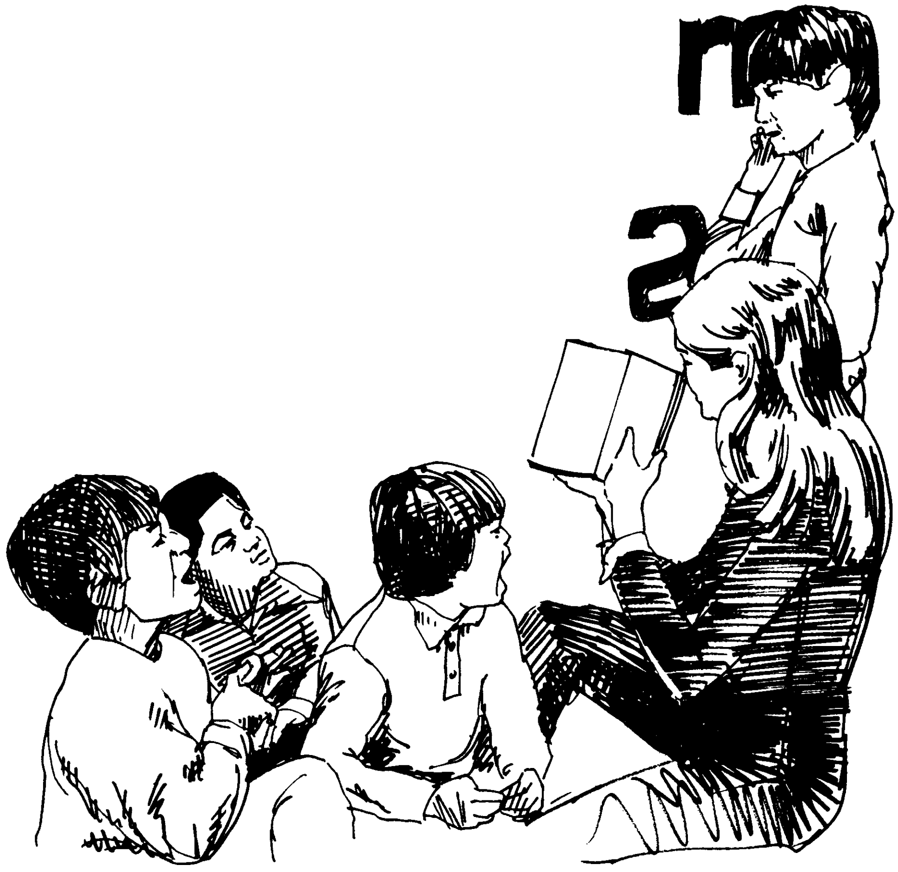
As noted in the discussion of early intervention and education, many county developmental disability programs help parents reinforce skills development. Parent training at the school or developmental center allows parents to participate as active partners in the program and parents frequently are able to help and support each other. To supplement centralized parent training, or to serve the homebound, many counties have a home training component.

In seven rural counties in northwestern Montana, the Comprehensive Developmental Center (CDC) family services unit trains families in the home to help their developmentally disabled children. Home trainers establish programs, train parents to implement them, and make periodic visits to check progress and provide support. In addition, parents are trained to be effective case managers and advocates for their children. The seven counties served by CDC are each represented by a county commissioner; the seven commissioners comprise the CDC Board of Directors.

CDC emphasizes parent involvement. Visits to families are scheduled at the convenience of the family rather than the home trainer, even if it means getting up at 4:30 a.m. on a winter morning to drive a hundred miles on icy roads. Parents are reimbursed for training their children if they keep detailed records of the programs they administer and the child's progress. Parents can receive a $100 per year allowance to purchase toys and other materials used in training their children.

The program has been extremely successful in preventing institutionalization; the greatest benefit has been to the children whose developmental gains are increased while they remain with their natural family.

In Eau Claire County, Wisconsin, the county department of human services contracts with the Development and Training Center (DTC) to provide a developmental disabilities infant home training program for children up to three years of age. DTC staff visit the child in the home when requested by a family suspecting developmental delay. DTC and the county have widely distributed a brochure illustrating developmental delay to assist families in knowing when to seek help. If developmental delay is confirmed in the assessment process, an individual program is designed that the parents can carry out. Following the parents' initial training, the home trainer visits weekly to reinforce training and to help the parents meet program needs without massive disruption to the family schedule.



Intermediate Care Facilities for the Mentally Retarded

The intermediate care facilities for the mentally retarded (ICF/MR) program is part of the Medicaid program under Title XIX of the Social Security Act. Each state has the option to include ICF/MR as part of its state Medicaid plan; forty-four states have elected to do so. Because Medicaid is considered a federal program, the federal Health Care Financing Administration of the Department of Health and Human Services sets standards that states must follow in certifying an individual facility as an intermediate care facility for the mentally retarded. While these standards are currently being revised, requirements may be retained in such areas as staffing, including the ratio of staff to residents and the qualifications of professional staff, individual program planning and monitoring of all residents, and delineation of program services that must be available. Detailed record-keeping and reporting, and health and safety requirements can also be expected. In addition to standards specific to facilities for the mentally retarded, certified facilities must also meet all the general intermediate care facility standards, which are also being revised.

Most states have used the ICF/MR program to certify state mental retardation/developmental disabilities institutions and other large facilities. Minnesota and a few other states, however, have taken advantage of the program to develop small (i.e., fifteen or fewer residents) intermediate care facilities for the mentally retarded in the community. If residents in these small centers are "ambulatory and capable of self-preservation," the facility can be certified under the less stringent boarding home health and safety standards, rather than institutional requirements.

Proponents of ICF/MR have seen the program as a relatively quick way to create a community-based residential services network. Federal participation in the Medicaid program has been reduced up to 3 percent under the 1981 Omnibus Budget Reconciliation Act (P.L. 97-35). In comparison to resident programs without federal participation, the ICF/MR program can still result in savings to counties and states.

Critics of the ICF/MR program question its appropriateness for clients who do not need medically oriented services. They perceive strong medical and institutional biases in the program, which may interfere with attempts to provide residential programs that have home-like atmospheres and are easily integrated into neighborhoods. In states where counties pay a portion of the nonfederal share of Medicaid, shifts to ICF/MR may increase the county's financial burden. It should be noted that the entire Medicaid program is being scrutinized to check its rapid escalation, which has averaged 15 percent a year during the last five years. Particular attention is being directed to long-term care, including intermediate care facilities for the mentally retarded; federal Medicaid long-term care expenditures in federal fiscal year 1980 accounted for one-half of the program's $17.1 billion total.

There is a new opportunity to use

the ICF/MR program for noninstitutional services under Medicaid waiver provisions included in the 1981 Omnibus Budget Reconciliation Act (P.L. 97-35). States may request waivers that will permit Medicaid reimbursement for home and community-based care services to persons who would otherwise require an ICF/MR level of care. Reimbursable services under the waiver authority include case management, homemaker services, habilitation, personal care, respite care, adult day health services, and home health aide services. Other services may be approved for reimbursement, if the state provides adequate rationale and shows how they will be cost effective. Room and board, however, is specifically excluded under the law.

A November 1981 survey by the National Association of State Mental Retardation Program Directors indicated that twenty-one states intended to request waivers and an additional twenty were seriously considering a request. While these requests included waivers in addition to the ICF/MR program, thirty-one states reported they planned to include community-based mental retardation/developmental disability services. Twenty-six states listed the services they planned to include in their waiver requests. In descending order of frequency, they were case management, habilitation, adult day health care, respite care, personal care, homemaker services, and home health aide service.

County developmental disability administrators can work actively with their state developmental disability and Medicaid agencies to promote the use of these waivers and to ensure that local needs are reflected in the waiver request. Since the waiver request must include the state's assurance that service needs will be evaluated, counties have a significant role in identifying needs in their area. Counties can get specific information on their state's waiver plans under the ICF/MR program by contracting the state mental retardation/developmental disabilities administrator; information is also available from the National Association of State Mental Retardation Program Directors, 2001 Jefferson Davis Highway, Arlington, VA 22202.

In *Hennepin* County, Minnesota, the present ICF/MR program is widely used by developmental disability community residences. Minnesota has certified numerous intermediate care facilities for the mentally retarded, including many smaller community residences; until recently, there were more small (fifteen persons or less) facilities in Minnesota than in all the other states combined. Intermediate care facilities for the mentally retarded are owned and operated by private organizations, both nonprofit and proprietary. In response to concerns about a home-like atmosphere, many operators have developed building designs that blend well with residential neighborhoods and provide family size units within the facility.

In Lebanon County, Pennsylvania, the county mental health/mental retardation administration uses the ICF/MR program for its Life Support Program, a twenty-five bed facility for nonambulatory severely and profoundly retarded people. Based on the developmental maximization concept, the program provides intensive health care and habilitation services to the residents, who range in age from three to fifty-one years. About one-half of the residents have active family involvement; placement in the facility enables developmentally disabled people to stay close to home when their level of care or the family situation does not permit them to remain in their natural home. Preschoolers and school-age children who are able to, leave the facility daily for community classes. The county intermediate school district provides classes at the facility; three community students also attend. The county has kept construction and operating costs down by a unique link between Life Support and Cedar Haven, the county nursing home. The two buildings are physically connected; food services, a pharmacy, and numerous support services are shared. Joint purchasing permits additional cost savings. The use of shared resources reduces costs to the Medicaid program. Since county funds are used to pay for costs in excess of Medicaid reimbursement, the savings also benefit county taxpayers.

Mental Health Services

Developmentally disabled people sometimes need mental health services. They may need short-term help to get through a difficult adjustment; a small percentage may require hospitalization or long-term mental health intervention to treat more serious difficulties. Studies cited in Toward a National Plan for the Chronically Mentally *Ill* (U.S. Department of Health and Human Services, 1980) indicate that up to 35 percent of the developmentally disabled population will require mental health services at some point in their lives.

All too often, developmentally disabled people with mental health problems have had difficulty getting services. Technologies blending developmental disabilities and mental health expertise have developed slowly, and are just now beginning to be identified and disseminated. The problem is compounded by rivalries between the two systems for resources, separation of state administrative agencies and program funding sources, and a concern on the part of some developmental disability advocates that the stigma of mental illness not be added to the existing stigma of developmental disability or that the two handicaps are not further confused in the minds of the public.

Counties frequently can reduce barriers to mental health services for developmentally disabled people when mental health and developmental disability programs are jointly administered at the county level. Counties which purchase mental health services can stipulate that providers do not discriminate on the basis of developmental disability. Counties can also bring the two systems together to discuss better mechanisms for direct service collaboration, consultation, and education.

In Cascade County, Montana, the multicounty Northcentral Montana Community Mental Health Center has an outpatient clinic that provides group therapy for retarded adults. The therapists are the clinic director and a developmental disabilities professional. The focus of therapy is interpersonal skills, which help retarded adults to adjust successfully to the community and the job. The clinic is located in a shopping center, where clients can come and go without fear of being identified as mental patients.

In Ramsey County, Minnesota, Aurora House is used as a residential program contract agency by Ramsey and Hennepin counties for mentally ill, retarded adults. Residents must be diagnosed as both mentally retarded and mentally ill; admissions are expected to last from six months to two years. The program uses token economy and behaviorial contracts as part of its highly structured treatment approach. Aurora House staff work closely with the various programs and jobs residents go to during the day. Individual treatment plans are based on goal attainment scaling and problem-oriented record methods; these methods promote program integration and ensure accountability.

In Montgomery County, Maryland, the county health department contracts with Rock Creek Foundation for outpatient psychiatric evaluation and treatment services for developmentally disabled people and their families. The Rock Creek program uses a community support system model; services provided include day treatment, psychosocial rehabilitation, psychotherapy, vocational training, and training in independent living and socialization. Clients are mentally retarded adults with emotional disturbances; many have other handicapping conditions present. Services are designed to respond to all disabilities and are staffed accordingly.

Rock Creek has consistently found ways to blend mental health and developmental disabilities expertise. The "Fountain House" model for psychosocial rehabilitation involves mental health clients as club members, rather than patients. Clients work with staff to manage their clubhouse. The "Fountain House" model was adapted to serve the needs of retarded clients, giving them guided experience in socialization, work activities, and independent living.

The traditional mental retardation workshop program was transformed inta a "workshop without walls." Prevocational and vocational training activities are set up in community settings to promote integration into competitive employment. Rock Creek staff work with the client's residential setting (institution, group home, family or transitional apartment); consultation is also provided to both mental health and developmental disability agencies.

Recreation Programs

Although they seldom top the list of needed developmental disability services, recreation and leisure programs are an important part of the services system. Follow-up studies on deinstitutionalized people have shown that a lack of alternatives to sitting at home and watching television creates a void in many lives. Physical barriers in recreation activities can be a problem for people whose mobility or senses are impaired. County park and recreation departments have significantly enriched community living for developmentally disabled people.

In Prince George's County, Maryland, the Special Populations Division of the Maryland-National Capital Park

and Planning Commission, Department of Parks and Recreation, developed a comprehensive recreation and accessibility project for developmentally disabled people and others with special needs. Using both volunteers and paid staff, the program serves hundreds of children and adults annually. Programs are integrated with programs for nonhandicapped people whenever possible. Special services staff provide technical assistance to park and recreation center directors on program design and implementation. Linkages are established with all major organizations serving the handicapped.

In Sacramento County, California, the county department of parks and recreation worked with the county developmental disabilities planning and advisory council to develop a comprehensive recreation program for developmentally disabled adults. Regular evening activities include bowling, softball, cultural trips, art projects, movies, and "rap sessions." Once or twice a month, the recreation program offers such special events as theme dances and trips. The recreation department works with the county regional transit system to ensure that programs are accessible. Transit information is included on recreation department announcements, which are widely distributed through the developmental disabilities network.

Residential Programs

The developmentally disabled person's home is the cornerstone of his or her life in the community. In the broad context, residential programs include all the places where developmentally disabled people live, not just those that are part of the formal service system. Residential programs include natural family homes, independent living, group homes, and other specialized community residences. There is a general consensus that emphasis should be placed on residential programs that are as "normal" as possible, provided that habilitation needs are met.

With the expansion of community programs and supports, many developmentally disabled children can live with their parents and many adults can live independently, even when disabilities are severe. When this is not possible, a variety of residential options is necessary to respond to individual needs, including opportunities for progression to greater independence over time.

County responsibility for community residences varies greatly from state to state. In most states, the county is not directly responsible for their development. Regardless of their mandated responsibility, county governments have actively participated in the expansion of residential programs. Counties have provided residential needs assessment; technical assistance (e.g., through the county planning department) to private groups seeking to develop community residences; financial support; community education; and case management and other support services to promote linkages between residential and other programs.

In eastern Nebraska, five counties work together to provide a full range of residential services. One commissioner from each county (*Cass*, Dodge, Douglas, *Sarpy* and Washington) is on the governing board of the Eastern Nebraska Community Office of Retardation (ENCOR), which provides case management, advocacy, vocational programs, residential programs, and other direct services. Every possible effort is made to enable developmentally disabled people to stay in their natural homes and live independently. When alternatives are necessary, the emphasis is to adapt programs to meet the client's needs, rather than to place people into predetermined program structures. For example, children with complex maladaptive behaviors participate in individually designed behavioral programs within their community residences. ENCOR disbanded its discrete behavior shaping unit when administrators concluded that it was not sufficiently responsive to individual clients.

In addition to natural family homes, the major ENCOR residential program components are respite care placements; the developmental maximization unit for multiple-handicapped and medically involved children, located at the Douglas County Hospital; alternative living units serving three or four people in houses or apartments, generally with live-in staff; and supervised apartments where adults live alone or with a roommate, with staff dropping by a few times weekly to reinforce independent living skills.

ENCOR has developed a management system based on the core and cluster concepts, which it has found beneficial in maintaining program quality and meeting accountability requirements.

In Franklin County, Ohio, the county mental retardation board contracts with the Association for the Developmentally Disabled (ADD) for residential services. The agency operates two types of programs: one to prepare developmentally disabled people for independent living and one for people who will probably need a protective environment for an indefinite period. Both programs emphasize training in personal and community living, and assist clients in reaching their maximum level of self-sufficiency. There are multiple levels within each program area. Clients progress at their own pace, moving from a protective environment to training in independent living. ADD also provides respite care for both children and adults. Volunteers are used extensively to enhance residential programs and respite care; a volunteer coordinator is employed on a full-time basis.

In Black Hawk County, lowa, the county board of supervisors works closely with Exceptional Persons, Inc. (EPI), to provide a range of residential alternatives for developmentally disabled people. The county board is represented on the agency's board of directors, along with program agency representatives in the public and private sector, consumers, and members at large. EPI provides supervision of residential program staff, program planning, and monitoring. Group homes are owned by Permanent Planning, Inc., a subsidiary of EPI that was organized by parents of developmentally disabled people concerned about their children's long-range needs. Group homes are designed to meet the needs of severely handicapped adults. Hostels are homes that provide training and supervision on a temporary basis until residents can become self-sufficient. Area churches provided the houses that are used as hostels, and have continued their involvement as part of the broad-based community support network.

Subsidized Housing

In some counties, developmentally disabled people have been able to take advantage of subsidized housing programs, especially the Section 8 program. Under Section 8, developmentally disabled people may be eligible for subsidized rental housing; the client pays only 25 percent of his income (soon to be increased to 30 percent), and the U.S. Department of Housing and Urban Development (HUD) pays the rest through the state or local housing development agency. Only a limited number of Section 8 certificates are available in each area, which includes eligibility for low-income, elderly and disabled people, and there is great competition for them. Unless there is a well-established "set-aside" for developmentally disabled people, they are frequently discouraged by long waiting lists. In addition, many landlords do not accept Section 8 tenants, unless obligated to do so because they received Section 8 financing for renovation or construction.

The complexities of HUD 202, Section 8, Community Development Block Grants (CDBG) and Farmers Home Administration loans and grants for the development of residential programs are beyond the scope of this publication. Readers are referred to *Housing for Developmentally Disabled Citizens: an Analysis of Policy Issues* and other references in the bibliography. Suffice it to say that there are difficulties inherent in the programs, including the amount of available funds, complicated and time-consuming requirements, competition among groups in need of housing, and specific problems around fair market rent (FMR) limitations. Despite the obstacles, some counties have been successful in using these federal programs for residential services for developmentally disabled people.

The *Alexandria, Virginia,* mental health and mental retardation board contracts with Sheltered Homes of Alexandria, Inc., to provide various program services, including residences for developmentally disabled people. To meet housing needs, Sheltered Homes applied to the Virginia Housing and Development Authority for a HUD 202/Section 8 loan. When plans to renovate an existing apartment building fell through, the agency received permission to build. A unit of twelve one-bedroom apartments was constructed, including two with full accessibility for handicapped people. The state housing authority set aside twelve Section 8 certificates for apartment residents.

When Sheltered Homes purchased the land from the city of Alexandria, it also acquired a house on the property, which had been deeded to the city in lieu of property taxes. The house has now been renovated for the apartment program counselor, who visits the apartment residents as needed to help with independent living skills. The residents have formed a self-government council to resolve tenant issues and plan group activities.

In *New Castle County, Delaware,* the county department of community development and housing worked with Independent Living, Inc., to develop alternative community living arrangements for handicapped adults. The Section 8 existing regulations were analyzed until ways were found to use the program without getting caught up in the fair market rent limitations and rigidity of Section 8 certificiate eligibility.

In *Bergen County, New Jersey,* the county community development agency used Community Development Block Grant (CDBG) funds to help provide community residences for developmentally disabled people. The New Jersey Association for Retarded Citizens received CDBG funds to renovate an existing group residence, and a local Association for Retarded Citizens received CDBG funds to acquire and renovate an apartment building.

Vocational Programs

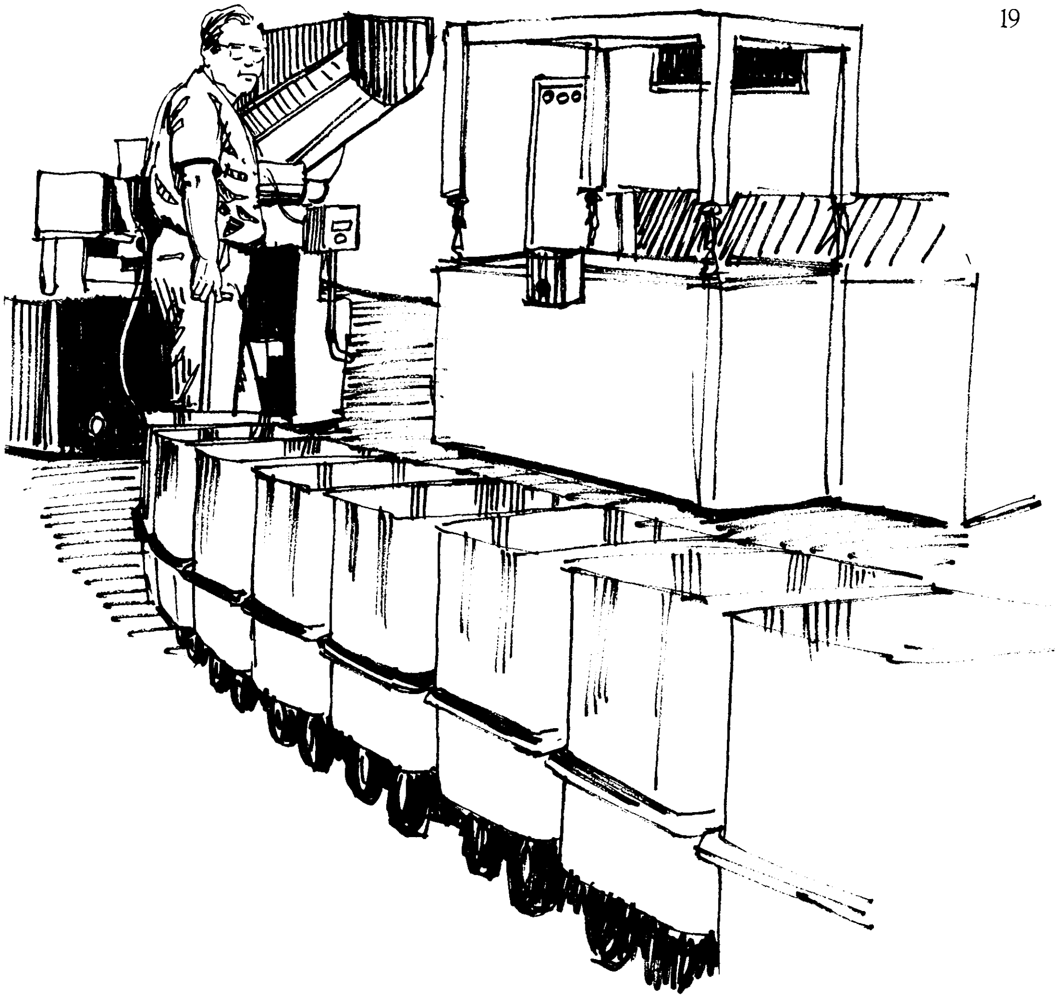
For developmentally disabled adults, having a job is almost as important as having a home. Most developmentally disabled people, including those with severe handicaps, can acquire skills useful in the production of goods and services. The opportunity for employment, including necessary training, can also mean the difference between being supported by society and productively contributing to it. Recent breakthroughs in vocational training and rehabilitation have shown that developmentally disabled people's vocational limitations are more the result of limited program design rather than their own handicapping conditions.

As with residential programs, a full range of vocational services should be available to meet individual needs and to permit movement between program components. Services should include competitive employment, with assistance available in locating and securing jobs and back-up support in job adjustment; work stations in industry, which emphasize on-the-job training and transition to competitive employment; and sheltered workshops, including those with an employment orientation as well as those with a training orientation. In addition, work activity centers, which focus on training in meaningful work skills, and day activity centers, providing a mix of developmental activities for clients who appear to have minimal employment or vocational training potential, should be available.

These components offer varying degrees of employment, vocational training, and rehabilitation services. The relative weight local vocational programs give to each of these activities tends to reflect individual program philosophy as much as or more than client characteristics.

Counties play many different roles in relation to vocational programs for developmentally disabled people. Most counties use private vocational service agencies, and some counties provide programs directly. All counties, regardless of their degree of responsibility for vocational programs, can assist developmentally disabled people by enforcing nondiscrimination in employment of qualified handicapped individuals; purchasing goods and services produced by developmentally disabled people; and collaborating with local businesses, industry, and vocational agencies for developmentally disabled people to promote employment, training, and marketing opportunities in the private sector.

Those responsible for providing vocational services for developmentally disabled people have struggled for adequate funding resources. Federal and state funding, primarily vocational rehabilitation and Title XX, have been major resources. The Comprehensive Employment and Training Act (CETA) has been used successfully in several counties, especially through the recently discontinued public service employment (PSE) pro-



gram. Despite termination of PSE, there are still many ways CETA can benefit developmentally disabled people. Counties have integrated services for developmentally disabled people with categorical CETA programs (Title IIBC, III, IV and VII), which provide job training and youth services geared to the industry-specific training needs of private sector employers.

Finally, it should be noted that it is possible for a vocational program to be self-supporting, at least in its employment component.

In Pierce County, Washington, the developmental disabilities division of the county social services department contracts with Qualitex, a vocational training and long-term employment program for severely retarded adults. Qualitex bases their program on the Specialized Training Program at the University of Oregon, which emphasizes a normalized work setting (e.g., use of a time clock and separation of work and nonwork areas), and specialized training in small parts assembly, communication, and community skills. Tasks are broken down into small components to facilitate learning. Typical products include cable harnesses, printed circuit boards of kidney dialysis machines, electronic components, and chain saw sprockets. Items are produced under subcontracts with manufacturers; workers' pay is based on the prevailing wage for comparable work in industry. Each worker's ability and interest are analyzed so that both task design and payment for work performed will optimize the worker's performance. Skills training and production data are computerized in the university system; monthly printouts permit tracking and evaluation of progress. The program emphasizes high productivity and specialized support. It provides excellent earnings for workers, and product sales are helping the program become self-supporting.

In Newaygo County, Michigan, the county mental health center contracts with the Newaygo County Association of Retarded Citizens (ARC) to run Newday Industries, a vocational program for developmentally disabled adults. Most clients are former institution residents. Since taking over administration of the program from the intermediate school district, the association has expanded services and emphasized training for community employment. Twenty-one of the forty clients are now working at more than 50 percent of nonhandicapped worker productivity. Training includes operation of power equipment, including the power saw used to make a bench-picnic table product for sale to the community. A new janitorial service employs six trainees to clean a local apartment complex.

Recently, Newday Industries launched a new venture, with exciting potential for steady employment and revenues to offset training costs. Using a recipe developed by the director's wife, Newday has begun production of "The Spice!," a food seasoning product. After successful trials in the Gerber Foods test kitchen and local restaurants, "The Spice!" is now on some local store and restaurant shelves. A large seafood distributor in the area will be marketing "The Spice!" throughout Michigan.

The health division of the Metro-Dade County, Florida, Department of Human Resources contracts with the Association for the Development of the Exceptional (ADE) for vocational services to developmentally disabled adults. Clients combine adult education classes with their work schedules. ADE is expanding its successful silkscreening program to take advantage of the market for message tee shirts. With its new photo silkscreen equipment, ADE will be able to process all steps in the production. Tee shirts are produced for businesses, private clubs, and organizations.

In Gwinnett County, Georgia, the county employment and training program worked with state and local developmental disability and vocational rehabilitation agencies to develop a training program for mentally retarded adults. Using the private sector initiatives component (Title VII) of the CETA program, they developed a project at the Lovable Company, an international manufacturer of women's undergarments. The company participated enthusiastically, and collaborated with the county agency to set up an effective program. The program includes orientation for trainers, supervisors, and employee relations personnel; eight weeks of classroom instruction at the plant; four weeks of on-the-job training; and regular employment as sewing machine operators for successful trainees.

The Lovable Company donated classroom space and training equipment (sewing machines); some equipment was modified to enable physically handicapped trainees to use it. Consultation was available from vocational rehabilitation staff.

At the end of the training period, eight of the ten trainees were hired as full-time employees. Fifteen months later, all were still employed. The company president has taken a personal interest in the program and has flown in plant managers from as far away as Venezuela to observe its success. Co-workers have reached out to the trainees, sharing rides and offering support and friendship. Representatives of the Lovable Company have told other businesses about the program and why it makes good sense to work with CETA training programs for developmentally disabled people.

Volunteers

For many years, volunteers—usually parents of developmentally disabled children—were the heart of the community developmental disabilities service system. They organized and taught classes, provided family support and counseling, transportation, and respite care. As public-sector resources in-

creased, volunteers became a minority among service providers for developmentally disabled people.

Even before the current return to volunteerism, many county programs have included volunteers as a significant resource. In addition to the potential for cost savings, county officials feel involved family members and community volunteers foster effective community integration of developmentally disabled people. Programs are enriched by the new ideas, approaches, and resources that volunteers bring, and volunteer involvement contributes to community education. Counties have also found that thoughtful planning, coordination, and clarity of roles is necessary if full benefits from volunteers are to be realized. Formally or informally, some form of contract needs to be developed, spelling out responsibilities, roles, and requirements for both the program and the volunteer.

Volunteers include all those who participate in the community developmental disabilities system, but are not employees. Volunteers range from the concerned citizen who sits on the county developmental disabilities board to the Chamber of Commerce advisor who helps a workshop establish better marketing and accounting techniques to the social work student in field placement at the county case management office.

In DeKalb County, Georgia, churches have taken the lead role in working with the county to establish community residences for developmentally disabled people. A coalition of churches, covering a broad ecumenical spectrum, organized to counteract neighborhood opposition. The coalition located and opened two community residences; people with church affiliations were identified and contacted by a member of their own church to gain support for the residence. One church developed a developmental disabilities ministry. Under contract with the county, the Rainbow Park Baptist Church has opened two additional homes, staffed entirely by church members. There is a waiting list of church members to volunteer to have a group home resident for the weekend. The church's activism has also had an impact on community attitudes; Rainbow Park has received several calls telling of houses for sale and neighborhood interest in setting up another community residence.

In Orange County, California, the developmental disabilities regional center developed a program to train parents as case managers. The center developed a ten-week training curriculum which is offered at the county community college and is available in programmed instruction for those unable to attend classes. During the formal part of the training, parents learn the mechanics of the service system: program components, admission requirements and procedures, individual program planning, and the rights of developmentally disabled people under state and federal laws. After the ten-week program, parents "intern" under professional supervision, gradually assuming more responsibility. After one year, they are certified as case managers for their developmentally disabled son or daughter.

In Westchester County, New York, the Community Residence Information Services Program (CRISP) works with neighborhood advisory committees as part of its contract with the county Department of Community Mental Health. Under state law, all community residences for developmentally disabled people must have a neighborhood advisory committee. When new residences are developed, CRISP provides technical assistance to the sponsoring agency on committee recruitment and organization. Consultation is available in such areas as the advisability of appointing a hostile neighbor, developing meaningful and satisfying activities for committee members, and how to keep the committee's advisory role distinct from staff responsibility for program management. CRISP also provides staff assistance to the Westchester Council of Neighborhood Advisory Committees, a coalition that works actively to make the council's committees effective.

Zoning

Zoning for community residences has been a subject of much debate. Many developmental disability advocates have sought preemptive zoning through state legislation that establishes the right of small community residences to zoning under single family, or "R-1," designation. Court rulings on the constitutionality of preemptive zoning legislation and the definition of "family" in relation to groups of unrelated developmentally disabled people, especially adults, have varied in consistency. Neighbors opposed to community residences have frequently invoked zoning code requirements in attempts to keep homes from opening; where group residences require approval of a zoning variance, public hearings have sometimes degenerated into ugly attacks and recriminations.

County government is frequently caught in the middle of these situations. On the one hand, counties support local authority and responsibility for land-use planning and decisions. At the same time, counties with responsibility for community services for developmentally disabled people are frustrated when municipal zoning authorities block the development of needed community residences. While counties can help city, village, and township officials develop community education strategies, they do not have the authority to supersede municipal zoning decisions.

In *New York*, the state legislature enacted a statute that defines required procedures for siting a developmental disabilities community residence. Now Section 41.34 of the New York State Mental Hygiene Law, the law covers community residences housing from four to fourteen mentally ill and/or mentally retarded persons. It requires the sponsoring agency to notify the chief executive officer of a municipality of its intention to locate a community residence. The municipality then has forty days to approve the site, or suggest other suitable sites in the area, or object due to an overconcentration of residences in the area.

If no agreement is arrived at between the municipality and the sponsoring agency, the state commissioner of mental hygiene makes the final decision.

In *Westchester County, New York,* the state developmental disabilities service office and the community residence information services program (CRISP), the county contract agency, have developed effective techniques that go beyond the law's formal procedures. When a residence is contemplated, they approach the municipal chief executive long before formal notification and ask him or her to appoint a citizens committee to designate acceptable sites. Whenever possible, the recommendation comes to the zoning board or municipal council as a product of local decision making. In addition, as part of its technical assistance activities, CRISP provides consultation on compliance with local zoning codes to sponsoring agencies.

In *Florida*, the state legislature addressed the issue in relation to planning, rather than overriding local zoning authority. A law was passed requiring that the housing element of the local government comprehensive plan contain "standards, plans and principles" which include provisions for group homes and foster care. The provisions are now part of Section 163.3177 of the Florida local government comprehensive plan statute.

In *Broward County,* Florida, the board of county commissioners passed a model ordinance defining foster care homes (up to eight unrelated individuals) and public and private facilities (up to sixteen unrelated individuals). The ordinance, which applies to all unincorporated areas of the county, designates zoning districts where such residences are permitted uses, and sets dispersal requirements (with existing residences exempted). It also delineates minimum standards for foster homes and facilities not licensed by the state Department of Human Resources, and provides exception standards and procedures for facilities in certain districts (R-4B). The county ordinance supports the rights of developmentally disabled people to live in the community while simultaneously supporting the rights of the neighborhood to be protected from oversaturation and unsupervised programs.

PART III

COORDINATION AND COLLABORATION

Even in the institution, where housing, education and training, counseling, recreation, health care, individual benefits, and record keeping are all provided and administered in one location, it isn't easy to coordinate developmental disability services. In the community, maintaining coordination is a constant challenge at the systems level, as well as at the program level. Just keeping all components of the service system informed of each other's activities and the client's needs and progress can be a monumental task. Excessive meetings and paperwork can take away too much time from direct services. The complexities of multiple funding streams, each with separate timetables, restrictions, and reporting requirements, taxes the patience and ingenuity of even the most sophisticated administrators.

The new era of block grants and federal deregulation holds some promise for counties to coordinate programs more effectively. However, without comparable deregulation and block granting at the state level, counties will have to continue to exercise all their creativity to overcome barriers to coordination and collaboration in the community-based developmental disabilities system.

The Unified Services System

In Rensselaer County, New York, the Unified Services System has won several NACo County Achievement Awards and a special award from the American Psychiatric Association. Services unified include those provided by the state, the county, and the private sector. Despite roadblocks to establishment of a community service system in a state where deinstitutionalization has proceeded so rapidly that critics have referred to it as "dumping," the system is working. To date, more than 98 percent of the county's citizens residing in state schools and hospitals for the retarded have returned to the community. Appropriate services exist for all ages and levels of disability, and movement through the service system is planned and coordinated. Clients with more than one disability can have their needs met through a well-defined structure. Former state institutional employees work in community programs, side by side with county and other agency employees. And county expenditures average between 10 percent and 20 percent of total costs, as a variety of state and federal funding sources have been tapped effectively.

As deinstitutionalization in New York accelerated in the early 1970s, the state government experimented with ways to resettle institutional residents in the community. One response was the enactment of the state's Unified Service System law in 1973.

The law offered an explicit tradeoff to counties. The state would pay 80 percent (rather than 50 percent) of the net costs of county mental hygiene programs and increase the per capita state aid allowance. In exchange, counties would pay a portion of the cost of care for institutionalized county citizens.

If they chose to apply for unified services designation, counties also were faced with stringent planning requirements. A single plan was required for the delivery and financing of mental health, mental retardation, and alcoholism services. Coordinated local-state planning was also required.

Under the direction of Mental Hygiene Commissioner Ara Baligian, Rensselaer County submitted its application and prepared its first comprehensive plan in 1974. It was the first county to apply for unified services status.

Making the system work was a delicate task. It involved the careful building of coalitions, overcoming limitations of established organizational structures, and gathering political and community support. County Executive William Murphy actively supported Baligian, aiding reorganization within the county government and allowing restructuring of county relationships with state and local agencies. The process was difficult, and at times nearly failed. But Rensselaer County persevered, and in 1975, it became a unified services county.

Rensselaer County has taken full advantage of the incentives offered by the state. Baligian says, "Unified services has been a rewarding experience for Rensselaer County. We have the benefit of local control of planning and delivery of services, which has enabled our county to reallocate resources, develop new and model services, and establish new service delivery structures."

While other New York counties have an uneasy relationship with state agencies, Rensselaer enjoys the rewards of a cooperative partnership. The state's principal involvement is through Eleanor Roosevelt Developmental Services (ERDS), a state program involved in virtually all community services to mentally retarded citizens. Program officials from the state and county meet regularly to plan and improve services, and the continuing high level of state financial assistance reinforces support for the county's efforts,

The Rensselaer County program demonstrates that it is possible to create a community service system responsive to the needs of even the most severely disabled citizens. The availability of adequate resources and strong county leadership and coordination are essential.

Unified services counties, and the funding mechanisms they are provided, are not common; they require states to agree that counties deserve a leadership role in service planning and coordination. Even in New York, it is no longer possible for a county to receive unified services designation—the state cut off eligibility after five counties were designated.

But even without unified services, a county may seek and accept the responsibility of assuring high quality services to its residents. "Our unified services system is founded upon commitment to program excellence, and dedication to a coordinated attack on problems," says Rensselaer County Executive Murphy. "Upon this foundation, even without formal unified services legislation, a county can build a superior service system."

A common reaction to the Rensselaer County system is that other counties do not have the particular set of circumstances and actors that made unified services possible. James Flanigan, executive director of the Rensselaer chapter of the New York State Association for the Retarded, addressed the replication issue in a companion piece to a NACoR case study on Rensselaer County in the October 10, 1982, County News:

> In any comprehensive service system, the two factors that can contribute most significantly to inflated costs are duplicate services and gaps in services. While most of us are ready to accept duplicate services as being costly, we rarely see the true cost of gaps which can, and usually eventually do, lead to placing a person into a more expensive service than they need.
>
> For want of some relatively inexpensive services in the community, such as recreation, case services, or respite, many people have been placed into expensive institutional settings, which were not really needed. Unfortunately, when the community services are offered through the county and the institution is run by the state, people sometimes become shortsighted and don't look at what is best for the client and the taxpayer in general.
>
> Meetings can serve two important purposes in the unified services process. In addition to the formal agenda of each meeting, there is an important byproduct. Through the process of attending meetings with the same people, discussing issues and working together toward solutions, you begin to develop an understanding and respect for other agencies.
>
> In each service area, a continuum of services should be identified based on the needs of prospective clients, rather than the needs of the agency. For example, in the area of day programing for retarded adults, a full range of services would run all the way from pre-vocational programs to work activity centers to sheltered workshops to placement and follow-up services. A coordination and planning group can then identify which agency or agencies would have primary responsibility in each service area and which services can best operate on a shared basis.
>
> One of the biggest obstacles to a fully coordinated service system is our tendency to identify people as "ARC clients" or "state clients" or "county clients," etc. Usually this is based on the individual's residential services. We then generalize this label and say that the person must receive all their services from that particular component of the system. For example, three people, one residing in a state institution, one living in a group home operated by a private agency and one living at home with his natural family, may have very similar day programing needs. Because we have labeled these clients, we could very easily wind up with three separate' day programs, each performing a very similar function. In addition to the added expense of such duplicate services, the chances are good that none of the three programs will be as good as one unified program and some gaps in services will be left elsewhere.
>
> In looking for ways that cooperative services can be funded, we sometimes tend to give up too easily. For example, if a person is a resident of a Medicaid-funded state facility, they cannot be funded through Medicaid for day programing, as this would constitute double billing. However, the state agency might be able to provide the day program with leased space, shared staff or some other service that would compensate the program for the Medicaid funds lost.
>
> In looking at cooperative services, a major consideration should be which component of the system can best provide the needed resources. For example, in the transportation system run in Rensselaer County it was found that there are equipment grants available to not-for-profit agencies that are not available to the state or county, so a private agency provided the vehicles, while the state and county provided other elements, such as drivers and routine maintenance work.
>
> In the age of Proposition 13 and close scrutiny of public expenditures, service providers will almost be required to look at the factors mentioned above and some of the assumptions upon which their service systems have been based if they wish to continue to operate adequately funded programs.

Collaboration with the State Developmental Disabilities Council

In North Carolina, the state developmental disabilities council has focused on collaboration with county governments. The model case management system now in place in Alamance, Craven, and other North Carolina counties was developed by the council and North Carolina State University. The system was one outgrowth of the council's two-year technical assistance to counties program.

Under the technical assistance program, the council worked with individual county governments to identify their needs. If the county commissioners requested assistance, a formal contract was executed. The contract specified what developmental disability planning or service needs the council would help provide. This process ensured that the council was responding to county needs and that all parties were clear on objectives.

In some counties, the immediate priority was to assess the needs of local developmentally disabled people; in other counties, technical assistance focused on development of a particular service component. A few counties progressed through a series of contracts, as accomplishment of one set of objectives led to delineation of new priorities.

In collaboration with the North Carolina Association of County Commissioners, the council put on a one-day workshop on developmental disabilities at a state association conference. While much of the workshop focused on the technical assistance program, it also provided an excellent forum for elected county officials and state developmental disabilities council staff to discuss ways they could

work together on behalf of developmentally disabled citizens.

Building Interagency Linkages

Counties that control funding to community developmental disability agencies have a particular advantage when it comes to interagency coordination. Yet there are many ways counties can stimulate and promote links even when they lack legal authority over all the relevant components.

As described in the section on advocacy, Sacramento County, California, created the county developmental disabilities planning and advisory council, by action of the board of supervisors. The council works actively to promote coordination and resource sharing between both public and private agencies.

In Prince George's County, Maryland, the county office for the handicapped set up three interagency committees to address local service needs. Both the adult interagency committee and the children's interagency committee have representatives from public and private agencies whose services are needed by handicapped people. The committees review individual problem cases that have come to the attention of the county office for the handicapped or are referred by one of the agencies. Committee members work together to develop a service plan that combines agency resources. Success of the strategy can be measured by the decrease in the number of cases on the agenda; now that the agencies have worked together for three years many problems are solved outside of committee meetings through established interagency contacts.

The county also created the program directors committee to address problems requiring major changes in the service system and support agreements negotiated by the interagency committees. This committee, composed of county and state program officials, meets twice a year to focus on policy and practices at the systems level.

A board appointed by the county to oversee the developmental disabilities system is one of the best mechanisms to promote interagency linkages. In *Newaygo County, Michigan*, the board of directors of the county mental health center is responsible for both developmental disabilities and mental health policies. The board is appointed by the county commissioners; Commissioner Tom Cooper is also a member of the board. Other board members include representatives of Newaygo County Community Services and the Fremont Area Foundation, local education systems, the Association for Retarded Citizens, and area clergy. An attorney and a farmer also serve on the board.

Don Eib, director of the Newaygo County Mental Health Center, feels strongly that the board's diversity contributes to the strength of the programs. "By the time the board thrashes out a policy decision, we've pretty much covered the bases as far as community input is concerned," he said. "Board involvement has been very helpful in promoting collaboration between public and private agencies."

Summing up the county's approach, Newaygo County commissioner Tom Cooper stated, "In this era no one can do it alone. The county is the cornerstone, but all the programs—both public and private—have to work together if we're going to have a system that works. We aim to serve people close to home, and the only way we can have something that makes sense is through strong county leadership and promotion of the partnership we need."

PART IV
RESOURCES

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Appendix B

NACo Policies Affecting Developmentally Disabled People

5.5 Mental Health and Mental Retardation/Developmental Disabilities

Counties will continue to act in partnership with municipalities, other counties, state government, and local private citizens to develop and operate community-based services for the mentally ill and mentally retarded/developmentally disabled as part of a comprehensive human services planning approach.

The rapidly increasing return of the mentally and developmentally handicapped from traditional facilities to the community requires that counties have sufficient resources for program planning, implementation, and continuity. NACo supports federal action that reduces current disincentives for deinstitutionalization and promotes the expansion of community-based services, provided that such action guarantees sufficient financial support, both program and individual, to permit mentally and developmentally handicapped citizens to live with decency and dignity in the least restrictive environment. NACo urges the federal government to reduce categorical restrictions in such programs as social services, health, rehabilitation, criminal justice, etc., as these restrictions severely impede counties' ability to provide comprehensive and coordinated services to the mentally and developmentally disabled.

The entire concept of deinstitutionalization should be periodically monitored for its effectiveness in delivery of service.

In cases where the "county line" does not define a functional service area, regional cooperation may be necessary to plan, develop, finance, and control mental health and retardation/developmental disability service programs serving groups of counties. NACo endorses the concept of the integration of mental health and retardation/developmental disability, alcohol and drug abuse, public health, and related human services programs, where feasible, at the local level.

While counties must have local program control, state governments should establish standards for such programs, and federal and state governments should provide a substantial proportion of the financing of construction and staffing of these programs. NACo endorses increased emphasis on mental health and mental retardation/developmental disability services at all levels of government and urges states to adopt enabling legislation to implement this cooperative federal/state/county effort.

5.19 Education of the Handicapped

The National Association of Counties supports the goal of available free public education to all handicapped children. In endorsing the implementation of P.L. 94-142 (Education for All Handicapped Children Act) and compliance with Section 504 regulations pertaining to education, NACo reaffirms its request that the federal government ensure adequate funding to supplement state and local efforts for timely compliance. Timetables and other regulations should be coordinated with state and federal fiscal policy in order that handicapped children receive optimal benefits from expanded education opportunity.

6.13 Services to the Disabled

Counties recognize that the objectives of encouraging self-support, self-reliance, strengthening of family life, and protective services apply equally to the physically, mentally, and developmentally disabled. NACo supports federal action that will promote these objectives by removing categorical restrictions that inhibit comprehensive planning and delivery of services to the disabled.

When deinstitutionalization of the mentally and developmentally handicapped results in increased demand for human services, mechanisms should be improved for funding to follow the person from the institution into the community.

NACo supports federal action that reduces current disincentives for deinstitutionalization and promotes the expansion of community-based services, provided that such action guarantees sufficient financial support, both program and individual, to permit mentally and developmentally handicapped citizens to live with decency and dignity.

Source: American County Platform (Washington, D.C.: National Association of Counties, 1981)