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COMMUNITY PLACEMENT OF THE
MENTALLY DISABLED IN MICHIGAN

Other

Region V, Chicago
Department of Health, Education, and
Welfare and other Federal agencies

**UNITED STATES
GENERAL ACCOUNTING OFFICE**

DETROIT REGIONAL OFFICE

JUL 19 1976

(Date)

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UNITED STATES GENERAL ACCOUNTING OFFICE
REGIONAL OFFICE
SUITE 500, WASHINGTON BOULEVARD BUILDING
234 STATE STREET
DETROIT, MICHIGAN 48226

JUL 19 1976

Mr. Richard E. Friedman
Regional Director
Department of Health,
Education, and Welfare
300 South Wacker Drive
Chicago, Illinois

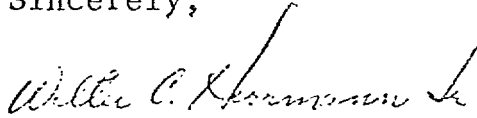
Dear Mr. Friedman:

This is our report on Community Placement of the Mentally Disabled in Michigan. Most of the issues discussed in this report are also included in a draft report to the Congress which has been forwarded to HEW for comment. We have also included as Appendix III, a copy of your memorandum to HEW Headquarters stressing the need for cooperation among Federal, State, and local agencies to adequately deal with the problem of community placement of the mentally disabled.

We are providing copies of this report to the Assistant Regional Director for Employment Standards, Department of Labor; the Regional Administrator, Department of Housing and Urban Development; the HEW Comptroller; and the Director, HEW audit agency.

We wish to express our appreciation for the cooperation given our staff during their visit to your agency.

Sincerely,


Walter C. Herrmann, Jr.
Regional Manager

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GENERAL ACCOUNTING OFFICE
REPORT TO THE REGIONAL DIRECTOR
DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE

COMMUNITY PLACEMENT
OF THE MENTALLY DISABLED
IN MICHIGAN

D I G E S T

Thousands of mentally disabled persons have been moved from Michigan institutions into the community in the past decade. (See p. 2.) Five State agencies and the community mental health boards share responsibility for community placement. (See p. 4.) GAO found that this divided agency responsibility has contributed to the problems faced by the mentally disabled when placed in the community. A review in the Detroit Metropolitan Area showed that:

- lack of money was a major factor in the limited community services made available to help maintain persons placed in the community; (See pp. 6 and 11.)
- there was insufficient housing for the mentally disabled waiting to be placed in the community; (See p. 8.)
- State agencies did not adequately monitor the care provided in foster care and nursing homes; (See p. 13.)
- most of the mentally disabled are placed in sections of the metropolitan area characterized by high crime rates, and abandoned housing; (See p. 15.)
- planning for the needs of people placed in the community was not always complete. (See p. 19.)

The State has primary responsibility for the care of the mentally disabled. The role of the Federal Government has been to help the States improve the delivery of services.

The Department of Health, Education, and Welfare has the principal Federal role but has not provided the necessary direction due in part to the fragmented responsibility throughout its many agencies. (See p. 27.) In addition, the lack of guidance from Washington headquarters has contributed to the low priority given community placement by the Federal agencies' regional offices in Chicago. (See p. 28.)

GAO believes that centralized management responsibility is a must for effective community placement of the mentally disabled. One State agency, the Macomb-Oakland Regional Center, came closest to having this overall responsibility. As a result, their community placement efforts showed some good success and avoided many of the problems experienced by other State agencies. (See p. 20)

To improve the community placement process, we recommend that the HEW Regional Director

- Develop and implement a more aggressive and systematic approach among HEW agencies in the region and among other Federal agencies in the region, perhaps through the Federal Regional Council, to address the problems associated with community placement.
- Work more closely with HUD and State mental health and developmental disabilities agencies to ensure that housing assistance plans prepared by local housing authorities adequately address the housing need of the mentally disabled residing in or expected to reside in their communities.

- Assist State and local agencies, possibly through State mental health plans required by the Special Health Revenue Sharing Act of 1975 and the State Developmental Disabilities program, to more closely delineate responsibilities and actions to be taken to more effectively implement community placement.
- Ensure that adequate discharge plans are prepared and follow-up performed for persons being released from mental hospitals and institutions for the retarded in accordance with Medicaid requirements.
- Evaluate (1) the adequacy of discharge plans and follow-up and (2) the appropriateness of placements for the mentally disabled released from mental institutions when HEW social services funds are used for these activities.
- Expand monitoring of nursing home compliance with Medicaid regulations to ensure that mentally disabled persons are appropriately placed and are receiving appropriate services for their mental disabilities.
- Evaluate the efforts made by State vocational rehabilitation agencies to assist in implementing community placement of the mentally disabled with the more severe handicaps and provide assistance to them in expanding their efforts, as appropriate.

In commenting on a draft of this report, the HEW Regional Director stated:

"I am in agreement with your recommendations for the Regional Director; however, I feel you should also make recommendations for Central Office staff of the programs you identify, especially regarding their relationship to State counterpart agencies. It would be difficult for any Regional Director to carry out your recommendations on this complex mission without support from Central Office staff and appropriate action by State and local agencies."

GAO recognizes the importance of the Regional Director's comments in implementing an effective, coordinated action plan. These and other matters of national significance are discussed in GAO's overall report to the Congress.

CHAPTER 1
INTRODUCTION

Community placement involves moving people out of institutions for the mentally disabled (mentally ill and mentally retarded) and placing them in community settings where they can live as normally as possible. It also entails providing the necessary services (recreation, social, medication, counseling, etc.) to help these people achieve and maintain a more normal life style.

In Michigan, community placement began in 1947 when a State program was funded to study the release of the mentally ill. The idea did not advance far until the early 1960's. An early indication of acceptance was a cooperative program entered into by the Department of Mental Health and Social Services in July 1962. The purpose of the program was to refer clients to a facility other than the State hospital.

Community placement of the mentally disabled became a national goal in 1963 when the President recommended that the Congress provide grants to the States for the planning and construction of comprehensive community mental health centers for the mentally disabled. He highlighted the need for community based services so the mentally disabled could be treated in community mental health centers rather than in State hospitals.

Federal efforts were supported by legislation in Michigan creating community mental health boards, responsible for development of community mental health services. The legislation was entitled Act 54, Public Acts of 1963 and the boards are commonly referred to as Act 54 boards.

President Nixon, in 1971, called for the return to the community of one-third of the more than 200,000 mentally retarded in public institutions. This goal was again affirmed in 1974 when President Ford stated that Federal housing agencies should help the mentally retarded obtain housing, and urged employers to use the U. S. Employment Service to assist in hiring them.

Thousands of mentally disabled persons have been moved from Michigan institutions into the community in the past decade. This is reflected in the sharp decrease of the mentally ill in State hospitals from over 20,000 in June 1964 to about 6,000 in June 1974. The number of mentally retarded in State institutions also declined from 12,300 in June 1969 to about 7,400 in June 1974 (See appendix I).

Funding has also increased markedly with the Department of Mental Health budget rising to \$235 million in 1974 compared to \$79 million in 1964. Community programs absorbed 16 percent of the budget in 1974 compared to only 2 percent in 1964. (See appendix II)

PURPOSE AND SCOPE OF REVIEW

GAO wanted to identify the problems and progress of Federal, State, and local agencies in implementing community placement. The results of our review are discussed in the following chapters:

Chapter 2 - Problems in State Community Placement Efforts

Chapter 3 - Improvement in State Community Placement Efforts

Chapter 4 - Federal Assistance: A Divided Approach

Chapter 5 - Observations on the Impact of Federal Programs on Community Placement

Our recommendations are in Chapter 6.

We obtained information and interviewed various officials in the Department of Health, Education, and Welfare (HEW), Housing and Urban Development (HUD), and Department of Labor regional offices in Chicago and in various agencies of the State of Michigan in Lansing, Michigan and in Oakland, Macomb and Wayne Counties (the Detroit Metropolitan Area). We reviewed the files of 29 mentally retarded and 49 mentally ill patients and traced all the mentally retarded and 30 of the mentally ill patients to the residential facilities in the area in which they were placed.

CHAPTER 2

PROBLEMS IN STATE COMMUNITY PLACEMENT EFFORTS

Michigan has not given any one State agency the responsibility for managing community placement. As a result, responsibilities are divided among five State agencies. This divided responsibility also extends to the Community Mental Health Board at the local level. A February 1974 report prepared for the Governor's Office on community placement in Michigan, concluded that State and local agencies have not achieved a coordinated program with clear guidelines and assignment of responsibilities.

This divided agency responsibility has contributed to the problems faced by the mentally disabled when placed in the community. Problems noted in our review were:

- services were inadequate in the community and in many residential facilities, and there was a shortage of residential facilities for the mentally retarded,
- problems exist in funding community services,
- there was inadequate follow-up and monitoring of the care provided the mentally ill and mentally retarded in residential facilities,
- placement was made in undesirable neighborhood and residential settings, and
- aftercare plans were not always complete.

While a well organized community placement effort will not solve all of Michigan's problems, it should better insure the use of available resources. This point was demonstrated by the Macomb-Oakland Regional Center which was given complete management responsibility by the Department of Mental Health over mentally retarded community placement activities in two Michigan counties. Macomb-Oakland has been able to achieve some success while avoiding many of the problems experienced by other State agencies.

DIVIDED AGENCY RESPONSIBILITY
IN COMMUNITY PLACEMENT

Overall responsibility for the mentally disabled in State institutions is vested with the Department of Mental Health. However, when they are released to the community the responsibility and management of community placement becomes divided. For example,

- Within the Department of Mental Health no one group or agency is in charge of community placement. They have given the individual institution superintendent this responsibility and the institutions frequently enter into agreements which places this responsibility with the Department of Social Services or to the Community Mental Health Board.
- Department of Social Services has licensing responsibility for adult foster care homes in which the mentally disabled are placed. It is also responsible for placing the mentally disabled and providing necessary services.
- The Department of Public Health has licensing responsibility for nursing homes in which the mentally

disabled are placed and evaluates the level of care provided them under medicaid. It also administers the Developmental Disabilities Program which provides help to the mentally retarded.

- The Department of Education is responsible for providing special education to the mentally disabled through age 25.
- The Vocational Rehabilitation Service is responsible for providing job training for the mentally disabled.

The Department of Mental Health has given an agency of the Wayne County Community Mental Health Board responsibility for placing the mentally retarded in that county. The community mental health board also has the responsibility for providing mental health service within Wayne County. The Director of the Department of Mental Health told us that his Department and that of Social Services recently formalized a memorandum of agreement which identifies mutual roles and responsibilities for community placement. The two agencies, together with the community mental health boards, are developing operating procedures that will establish accountability for community placement.

SHORTAGE OF COMMUNITY SERVICES AND FACILITIES

There are not enough community aftercare services to reach the increasing number of persons released from institutions and there are also not enough residential facilities for the mentally retarded in Wayne County. We also found

that Department of Mental Health homes receive funds for its inhouse programs while Department of Social Services homes receive no funds and have no inhouse programs. Lack of inhouse programs in Department of Social Services homes is critical in Wayne County because the Department places more mentally ill clients in its homes than the Department of Mental Health does in its homes. For example, in fiscal year 1975 Northville State Hospital made 144 placements while the Department of Social Services made 430.

The February 1974 report prepared for the Governor concluded that community services were extremely limited in a number of areas of the State, and where they do exist they are sometimes poorly used, as evidenced by the relatively small volume of services by clients.

The Community Mental Health Board compiled data showing that about 22,000 mentally ill clients will need after-care services in Wayne County during fiscal year 1976. Further, they projected that about 2,800 new clients would enter the system each year. However, as of June 1975, only 9,466 clients were receiving services, and of these only about 2,100 were being served by community agencies. Hospitals, particularly Northville, accounted for the bulk of aftercare services because community agencies were unable

to deal with the number of clients. Since Northville plans to discontinue its aftercare services the problem will worsen.

The same situation seems to exist for the mentally retarded in Wayne County. Of the known 13,058 clients in Wayne County, most of whom still reside in their own homes, there was a waiting list as of May 1975 for all community services except education, as follows:

| <u>Community Services</u> | <u>In Program</u> | <u>Waiting</u> |
|-----------------------------------|-------------------|----------------|
| Adult Activity & Sheltered Work | 465 | 205 |
| Adult Activity Nonwork | 150 | 100 |
| Recreation - Socialization | 60 | 400 |
| Sheltered Workshops | 170 | 275 |
| Cerebral Palsy | 25 | 100 |
| Vocational Rehabilitation Service | 500 | 100 |
| Education (school under 25) | <u>10,508</u> | <u>-</u> |
| | <u>11,878</u> | <u>1,180</u> |

We also found that a shortage of community residential facilities in Wayne County resulted in a backlog of 596 mentally retarded clients awaiting to be placed. Further, when considering the estimated Wayne County mentally retarded population of 79,000, the shortages of services and facilities are even more serious since it indicates that only a small portion of them have been identified.

Results of tracing

We traced 30 of a sample of 49 mentally ill patients placed in the community. Eight of the 30 persons were placed in Department of Mental Health homes. These homes

had a full-time activities therapist to plan and organize inhouse activities, such as arts and crafts, sewing classes, recreation, musical entertainment, pottery, etc.

The homes licensed by Department of Social Services presented a different picture. We traced six persons to five adult foster care homes and 16 persons to five nursing homes. Only two of the five adult foster care homes had inhouse programming or activities beyond watching television. These homes also attempted to use community services when possible.

While the operators at the five nursing homes stated that they had an organized activities program, we found that in four of these homes, this program was minimal. Most of the patients in these homes were found either sitting in their rooms, watching television, or lying on their beds. Space allocated to recreational activities was limited. For the most part, it appeared that the homes relied on volunteer help to make their program function.

In direct contrast, the home with a full-time program had patients that appeared happy and who were busy most of the day and evening. Inhouse programming is the only option open to clients in Department of Social Service houses, because, as many of the proprietors explained, there are very few community services available.

We traced 12 mentally retarded clients who were the responsibility of the Center For Community Living For Retarded Citizens of Wayne County (Wayne Center). Six clients were in six Department of Mental Health homes and were receiving habilitative training, basic self care, and social skills. Five of these clients were also enrolled in a public school program, while the other was on a waiting list for a community workshop program.

Three other clients were traced to Department of Social Service homes and two others were found in nursing homes, where they received reasonable room and board but limited or no programming. The last one reviewed was found back at the State hospital after being placed in a nursing home. In addition, we traced two mentally retarded persons placed directly by a State hospital into a nursing home for the mentally retarded. Both clients were receiving limited programming.

Our review of the Macomb-Oakland Regional Center showed it was able to provide inhouse activities and community services for all 15 mentally retarded clients placed in the community. We found that, in many instances, it had programmed a service for an individual different from that recommended by the releasing institution. For example,

the releasing institution recommended that one client be placed in competitive employment. However, Macomb-Oakland believed the client was capable of higher achievement than the menial jobs then available. His aftercare plan was changed and he was enrolled in a local high school where he is working toward a diploma and learning a trade as an automobile mechanic.

PROBLEMS IN FUNDING COMMUNITY SERVICES

Although the Department of Mental Health has increased the percent of its total budget (See appendix II) for community care of the mentally disabled, there are still not enough funds to take care of their comprehensive needs in Wayne County. A Michigan Senate Appropriations Subcommittee on Mental Health report also cited the need for additional funding for community services.

Under the current Department of Mental Health management plan to reduce the number of mentally disabled in institutions, the funding situation will probably worsen. For example, about 2,500 more people will be placed in the county in the year ending June 1976 as shown below.

| | <u>6/30/75</u> <u>Residents</u> | <u>6/30/76</u> <u>Residents</u> | <u>Difference</u> |
|---|------------------------------------|------------------------------------|-------------------|
| Institutions for the Mentally Retarded | 6,523 | 5,363 | 1,160 |
| Institutions for the Mentally Ill | <u>4,922</u> | <u>3,530</u> | <u>1,392</u> |
| Total | <u>11,445</u> | <u>8,893</u> | <u>2,552</u> |

These planned reductions are placing the Department of Social Service Community Mental Health Board in a difficult position. A State institution official told us the Department of Mental Health pressures them to release patients through budget cuts with the result that some patients are released too early. Similarly, Department of Social Service officials said they are pressured by State institution officials to place patients not ready for placement and when needed, services established by the Community Mental Health Board are inadequate.

In commenting on this situation the Director of the Department of Mental Health said they have made it quite clear to institution officials that placements should not be made unless proper housing and programs are available in the community.

The Community Mental Health Board on May 19, 1975, in an internal memo, referred to a serious crisis among the area agencies. The crisis was attributed to reduced staff

and the increase in mentally ill patients discharged from Northville State Hospital. The memo said inappropriate discharges from State hospitals are being made and many of the community services are unable to accept additional patient loads because of inadequate funds and waiting lists were being created at more and more service centers. The memo concluded with the statement, "Our entire system (of aftercare) appears to be breaking down."

The shortage of funds appeared to be a general complaint except in the operation of Macomb-Oakland. Officials told us that the Department of Mental Health generally had been providing them with adequate funds for its operations.

PROBLEMS IN FOLLOW-UP
OF THE MENTALLY DISABLED

The report to the Governor's Office suggests that a reasonable caseload for follow-up by case workers is between 40 and 60 clients and in special circumstances, as low as 25. Follow-up is particularly important in the first year after placement.

Agencies such as Northville State Hospital, Wayne Center, and Macomb-Oakland were able to adhere generally to these guidelines. However, the Department of Social Service is unable to provide adequate follow-up for the

mentally disabled placed in homes it licenses and monitors. In the report prepared for the Governor's Office, it was noted that of clients placed by them, statewide, over 55 percent were followed up less than monthly or not at all.

Department of Mental Health homes

The follow-up in Department of Mental Health homes is provided by Northville State Hospital social workers. The caseload for each social worker averages between 25 and 35 clients, with weekly visits to the home and periodic visits to the clinics servicing the clients. Our tracing of the mentally ill indicated that social workers made these visits.

Social workers employed by Wayne Center are responsible for between 24 and 46 mentally retarded, depending on the home. One problem that Wayne Center has encountered is its inability to determine the number of mentally retarded placed in Department of Social Service homes. Many mentally retarded clients were placed by Department of Social Service prior to Wayne Center's inception and their records are either non-existent or incomplete. Wayne Center officials are concerned that these persons are receiving little or no care and are trying to identify these individuals.

On the other hand, Macomb-Oakland has developed a follow-up system to assure continued development of their

clients. Social workers are responsible for supervision of between 25 and 50 clients, depending on the type of home. We were informed that social workers were required to visit clients about twice a month and most of the service providers once a month.

Follow-up by Department of
Social Services

The follow-up procedure for the mentally disabled followed by the Department of Social Services in adult foster care and nursing homes are a sharp contrast to those of the Department of Mental Health. The average caseload in the adult foster care homes is about 200 and for nursing homes about 1,400.

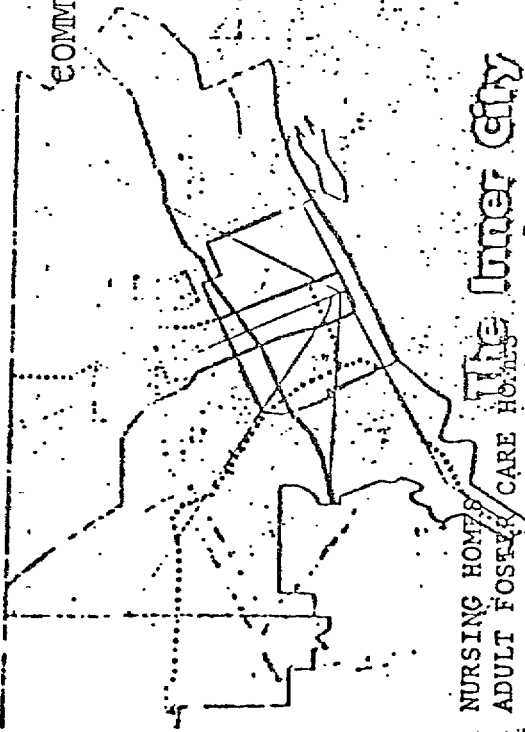
Our review demonstrated the problems with this extremely high caseload. Of 22 case files reviewed only one contained a record of the required 7-day visit to each client after placement. Five contained no recorded visits, and first visits for 13 clients were made at least 3 months after placement. We were told that 39 additional employees have recently been hired to reduce the average caseload and provide better follow-up.

PROBLEMS IN UNDESIRABLE NEIGHBORHOOD
AND RESIDENTIAL SETTINGS

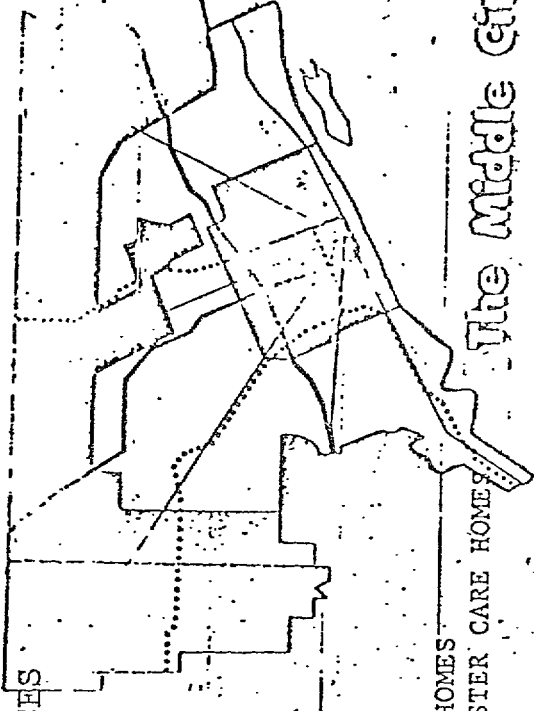
Undesirable neighborhoods

A primary goal of the community placement concept is to move people out of the institution into a setting that will resemble as normal a lifestyle as possible to help

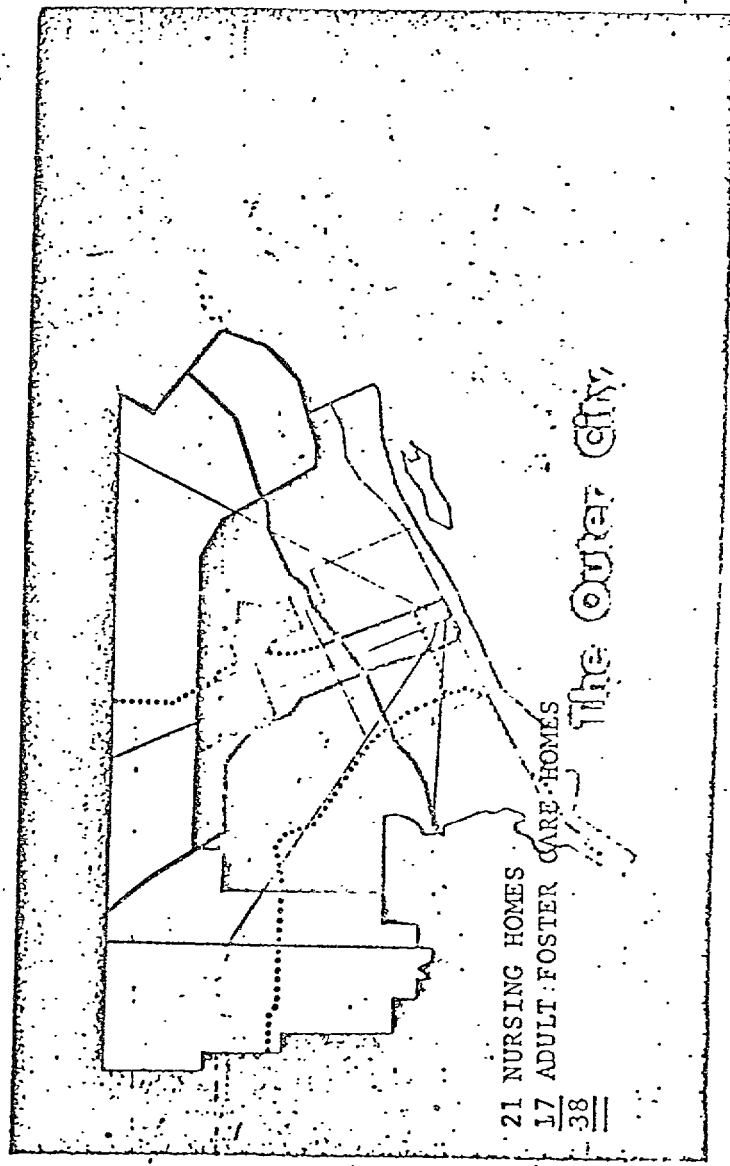
MAP SHOWING NUMBER OF
COMMUNITY PLACEMENT RESIDENCES
IN DETROIT



41 NURSING HOMES
124 ADULT FOSTER CARE HOMES
165



23 NURSING HOMES
152 ADULT FOSTER CARE HOMES
175



21 NURSING HOMES
17 ADULT FOSTER CARE HOMES
38

COMMUNITY PLACEMENT
RESIDENCES IN:

| | |
|--------------------|------------|
| INNER CITY | 165 |
| MIDDLE CITY | <u>175</u> |
| SUBTL | <u>340</u> |
| OUTER CITY | <u>38</u> |
| TOTAL DETROIT | <u>378</u> |
| TOTAL WAYNE COUNTY | <u>464</u> |

rehabilitate the individual and prevent future occurrences of the individual's problems.

Our review showed that most clients included in our tracing were not placed in a normal environment--they were placed in sections of Detroit characterized by high crime rates, abandoned housing, poor economic conditions and other social and economic problems. Of 378 homes in Detroit housing the mentally disabled, 340 are located either in the inner or middle part of Detroit. (See map p. 16.).

When asked the reason for the development of residential facilities in this part of Detroit, agency officials said that very large homes can be bought in these areas for a low price and can easily be converted to adult foster care or nursing home use. They also said a contributing factor to this concentration is the Detroit zoning ordinance which, in effect, limits the placement of after-care homes to the older and run-down sections of the city.

Undesirable residential facilities

We also noted some residential facilities licensed and monitored by the Department of Social Services that appeared undesirable as housing for the mentally disabled. Beds in two homes were located in what would ordinarily be considered the living and dining rooms of the home. This leaves very little space for leisure activity and makes it

crowded for the residents. In four homes we observed that (1) floors, walls and ceilings were extremely dirty, (2) bed linens were ragged and soiled, and (3) shower and toilet facilities were dirty and in disrepair.

The Department of Social Services issued new licensing regulations that were implemented in February 1975. All homes operating at that time were to be inspected within the next 12 months to determine whether they would receive a new license. Prior to these regulations, formal eligibility standards did not exist for adult foster care homes.

Questionable mixture of clients in homes

Our tracing showed that mentally ill, mentally retarded, and geriatric clients are mixed together in many of the Department of Social Service adult foster care and nursing homes visited. Employees of the homes stated the needs of each group vary considerably and these needs frequently are served better in separate facilities.

The main problem seems to exist in nursing homes where the geriatric clients are afraid of the younger mentally ill clients because of their aggressive behavior. The problems in adult foster homes revolve around the mixture of mentally ill and mentally retarded and their mutual resentment at being identified with the deficiencies of the opposite group.

AFTERCARE PLANS ARE NOT COMPLETE

Prior to placing a client in the community, an after-care or discharge plan must be prepared for each client by the releasing institution. The plan sets forth a person's strengths, weaknesses and the care needed to be successfully placed in the community. Although each client had an aftercare plan prepared, certain information was missing from those prepared by Northville State Hospital.

These plans did not describe the type of activity or community service for all the 49 mentally ill clients reviewed. We also found that some homes did not receive any plan while others believed the plan was inadequate. Further, the Department of Social Services was not involved in the preparation of aftercare plans for the mentally ill placed for Northville. Officials told us in commenting on our draft that as a result of a closer working relationship with Northville, they are now involved in these preparations.

Our experience at Northville was not unusual. A recent Statewide report of aftercare plans showed that, in over 60 percent of the cases reviewed, less than half the needed information was recorded.

Wayne Center was not involved in any aftercare plans prepared by releasing institutions for the mentally retarded we reviewed. Although Macomb-Oakland was not

involved in the preparation of aftercare plans by the releasing institution, it modified plans when necessary.

CONCLUSIONS

The problems involved in community placement are significant and represent a serious lack of organization and coordination. No one agency is really in charge of the placement process, but many have responsibilities. We believe that centralized management responsibility is a must for effective community placement of the mentally disabled.

Organizing a successful community placement program in Wayne County would be difficult under any circumstances, and with the problems already established by past practices --placements in inappropriate community and residential settings--it is going to be even more difficult. We believe, however, that the success achieved by the Macomb-Oakland Regional Center, with complete control over community placement, is an example that should be considered by other jurisdictions.

CHAPTER 3

IMPROVEMENT IN STATE COMMUNITY PLACEMENT EFFORTS

Although serious problems still exist, State and private groups have helped the community placement of the mentally disabled. For example, the Department of Mental Health is attempting to demonstrate that a State institution, given proper resources and authority, can successfully manage the placement of the mentally retarded in its community.

Agreements with other State agencies have also helped in obtaining educational services and housing. Action by advocate groups has helped in obtaining community services for, and in drawing attention to the problems of, community-placed mentally disabled persons.

MACOMB-OAKLAND REGIONAL CENTER

The Macomb-Oakland Regional Center will have a capacity to house 96 mentally retarded persons when construction of its building is completed. Pending completion it is serving as a placement agency for the mentally retarded. It began operations in August 1971 and through February 1975 had placed 528 persons from State institutions into the community. Macomb-Oakland is a unique State effort

because it has the authority and responsibility for the entire placement process.

Macomb-Oakland locates, recruits, and develops the residential facilities into which its clients are placed. These facilities include nursing homes, family care training homes housing 1 to 3 persons, group homes housing 5 to 12 persons, and apartment units housing the highest functioning mentally retarded persons. It does not operate any of the residential facilities, but contracts with second parties to operate them. It does, however, provide clients training, programming, coordination with other service agencies, and follow-up services for the facilities.

AGREEMENTS AMONG STATE AGENCIES

The Department of Mental Health is responsible for providing services to the mentally disabled in the institution. However, since services needed for these persons are provided by many different agencies, they entered into written agreements with other State agencies to provide some services, as follows:

- a. The State Vocational Rehabilitation Service agreed to expand current program activities to respond to the rehabilitation needs of the mentally disabled at the community level.
- b. A memorandum of understanding was reached between Department of Social Services and the

Michigan State Housing Development Authority to supply housing for the adult mentally retarded.

- c. The Department of Education agreed to provide special education programs under the Mandatory Special Education Act.

HOUSING FOR THE MENTALLY RETARDED

The Michigan State Housing Development Authority in a cooperative effort between State and Federal agencies, has developed a program to provide housing to meet the special needs of the mentally retarded living in the community. The program, developed in 1971, provides for the needs of the mentally retarded living in the community. Housing, food, inhouse supervision, training, personnel and group counseling, work, job follow-up and program coordination are provided through cooperative agreements with the Departments of Mental Health and Social Services.

In a 1974 report the Authority stated that total production for 1974 was set at 350 living units for mentally retarded adults. It is also attempting to develop alternative sources of financing to continue their housing rents at reasonable levels. The need for this type of housing is critical since there are an estimated 76,000 mentally retarded persons in the State of Michigan requiring decent housing.

MANDATORY EDUCATION OF HANDICAPPED PERSONS

The State Legislature passed the Mandatory Special Education Act of 1971 which established the right of handicapped persons, through the age of 25, to equal educational opportunity within Michigan public schools. The Act also required that it be implemented through the intermediate school districts. Under this Act, the Department of Education is the responsible State agency, and if services are not provided, legal action can be taken against the State. Although the Act also covers the mentally ill, the beneficiaries have been primarily the mentally retarded.

CHANGES IN THE LAW

Acting under the impetus of a Federal Court opinion that stated the Michigan mental health code was unconstitutional, a new mental health code was passed by the Legislature and signed into law by the Governor on August 6, 1974. The new code emphasizes community services for community placed mentally disabled persons by:

- more clearly defining and expanding the role of community mental health services and increasing state support for local programs;
- making it easier for a person to obtain services in his community on a voluntary basis; and
- increasing the authority and responsibility of the county community mental health boards.

ACTION BY ADVOCATE GROUPS

Advocacy groups have been active supporters for the rights of the mentally retarded and mentally ill. They have also contributed to the progress made in obtaining services for the mentally disabled placed in the community and in calling attention to their problems.

The Michigan Association for Retarded Citizens, an organization of 65 State chapters and 8,500 members, has been active in the development of residences for the mentally retarded and in obtaining educational aid for them under the Mandatory Special Education Act. Another organization, the Michigan Association for Emotionally Disturbed Children, is primarily a lobby group concerned with the care of children and young adults. They perform fact-finding surveys on quality of health care, including community placement facilities.

The Michigan Society for Mental Health, Inc. is a non-profit group dealing essentially with legislative aspects of mental health. This group was instrumental in obtaining approval of legislation, passed in 1963, authorizing the community mental health boards. A fourth organization, Citizens for Better Care, is a consumer organization concerned with the health of the general public. It has a membership of about 1,300 persons and

organizations. They are active in reviewing residential facilities for the placement of released mental patients and have been very successful in obtaining media support for their findings.

CHAPTER 4

FEDERAL ASSISTANCE: A DIVIDED APPROACH

Despite Presidential and congressional emphasis on community placement, Federal agencies in the Chicago Region were not taking positive action to implement this concept.

We found:

- the Federal Regional Council had not selected community placement as an area needing inter-agency coordination;
- HEW had not emphasized, coordinated, or monitored its programs which impacted on the mentally disabled returning to the community;
- HUD had not responded to Presidential mandates, which pledged their assistance in the development of special housing arrangements for the mentally retarded to facilitate independent living in the community; and
- Labor had not aggressively implemented legislation that required Federal contractors to take affirmative action to hire the handicapped.

FEDERAL REGIONAL COUNCIL

The Chicago Regional Council--established to coordinate, implement, and evaluate Federal efforts--had not considered the problems involved in community placement. The Director of HEW's Chicago Regional Office said community placement activities were so disorganized and scattered throughout HEW, that it was difficult to deal with the fragmentation of these activities in his own agency, let alone

organize and coordinate other Federal departments. However, he did recognize the importance of coordinating with the other Federal agencies in the region. For example, in a memorandum (See appendix III) to HEW Headquarters discussing the problem of fragmentation as it related to community placement, he made the following comment:

"The Housing and Community Development Act of 1974 is possibly one place to focus on the needs of the handicapped, especially the mentally handicapped, and their inclusion in state and local housing plans."

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The HEW Chicago Region was generally not emphasizing community placement activities. Most regional officials believed that the programs they administered had little or no impact on community placement. Therefore, they had not coordinated, monitored, or evaluated their progress to focus on the solution of problems being encountered by the States in the implementation of their community placement programs.

This inaction was attributed to a lack of:

- a clear mandate or priority to devote effort to community placement,
- specific instructions from headquarters, and
- resources and staff.

Representatives responsible for administering programs which impact on community placement made the following comments about their programs:

Developmental Disabilities

- Community placement was not a high priority in the regional office.
- Developmental Disabilities activities were generally limited to reviewing required State plans, offering technical assistance to the States and administering special project grants, many of which were aimed at community placement.
- The staff was limited to one person who was responsible for overseeing the Developmental Disabilities program in the six states in the region.
- Cooperative efforts did not exist with other Chicago Region HEW officials, HUD, or Department of Labor in matters relating to community placement.

Community Mental Health Centers

- Formal responsibility for community placement had not been delegated to the region.
- Responsibilities consisted of administering and monitoring the Community Mental Health Centers program, reviewing State mental health plans and providing technical assistance to the States.
- Other Federal agencies had not been contacted on matters relating specifically to community placement and the Community Mental Health Centers program.

Vocational Rehabilitation

- Community placement is not a goal, priority or objective in the Vocational Rehabilitation program, even though Vocational Rehabilitation has a role to play in the process.
- The Region had not received any regulations or guidelines from Washington concerning community placement.
- Department of Labor Regional officials were contacted in regard to implementation of the affirmative action program for employing the handicapped, but not specifically relating to community placement.

- State Vocational Rehabilitation plans and programs are monitored but the States' efforts in regard to community placement are not evaluated.

Supplemental Security Income

- Regional responsibilities were limited to making eligibility determinations and Supplemental Security Income payments.
- Responsibilities did not include evaluating the quality of services purchased with Supplemental Security Income funds.

Community Services Administration 1/

- Community Services Administration had not established program objectives, issued instructions or worked with other Federal agencies concerning community placement, even though officials realize the program has a role to play.
- The Community Service Administration staff has provided technical assistance and supervisory and consultant services to the states, but does not have sufficient staff to monitor or evaluate the program effectiveness as it related to community placement.

Medicaid

- Medicaid does not have a mandate to become involved in community placement activities.
- Since community placement is not a Medicaid priority, program officials have not worked with other HEW or Federal agencies nor have they monitored, evaluated or assisted the States in this respect.
- The Regional Medical Services Administration has not enforced the HEW Medicaid regulations, (45 CFR 208) which requires the States to prepare a community placement plan and submit annual progress reports on the development of alternatives to institutionalization.

In summary, the Director of the HEW Chicago Regional Office stated that many problems have been associated with

1/ HEW's Community Services Administration was changed to the Public Services Administration in February 1976.

the placement of the mentally disabled into communities in Michigan, as well as most other places throughout the country. He acknowledged that the Chicago Regional Office has not placed a high priority on solving these problems.

He outlined the following problems involved in administering the concept:

- Congress has placed the responsibility for the community care concept under many different programs in HEW, as well as other Federal agencies and has not made it a high priority effort.
- Responsibility for providing services to the mentally disabled is diffused among many HEW, HUD, Labor, and other Federal agencies. Even within HEW, responsibility for helping persons to return to or remain in communities is fragmented and no one group has been given overall responsibility.
- Effective linkage among these agencies and their programs are needed at all levels of government. Neither objectives nor responsibilities for community placement have been clearly defined.

During our review, the Chicago Region HEW Director in a memorandum (See p. 28) to HEW Headquarters urged that HEW take more aggressive action on a national basis to help resolve some of the problems that are associated with the community placement of the mentally disabled. He commented, in part, that:

"In many respects, the problems in the placement of these 'hard-to-place' groups is similar to, but much more difficult than, in the long term care and nursing home problems of the elderly--with which we are not dealing on a Regional basis.

It is my suggestion that we begin to give this some serious thought on a national basis, such as we have given to the long term care problems of the elderly. The Regional Director's Office, with some support from Washington, could assume a leadership role in tackling this problem."

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

HUD's Chicago Regional Office had not taken an active role to provide for the special housing needs of the mentally disabled. HUD Regional officials said they:

- were not aware of the 1971 or 1974 Presidential statements promising HUD's assistance in the development of housing for the retarded;
- had not established goals, objectives, or priorities, or taken any specific actions to provide housing for the retarded; and
- did not know the extent to which existing HUD housing programs had served the needs of the mentally disabled.

The Assistant Regional Administrator for Community Development said cities and communities are required to plan for the housing needs of low income persons. However, they are not required to specifically address or break out the needs of special groups of low income persons, such as the mentally disabled. Therefore, when HUD reviews the local housing plans, it does not know whether the needs of the mentally disabled have been considered. Unless the mentally disabled have a strong voice or advocacy group at the local level, their needs probably will not be met under HUD programs.

DEPARTMENT OF LABOR

Regional officials were aware of the community placement concept, its goals and objectives, but, had not established it as a priority or operational objective. However, they are responsible for administering a law that could have a major impact on community placement. The Law--Section 503 of Public Law 93-112--provides additional employment opportunities and attempts to eliminate job discrimination, by requiring Federal contractors with contracts valued over \$2,500 to take affirmative action to employ the handicapped.

The regional activities as of April 1975 to implement Section 503 included:

- meeting with major Federal contractors to encourage them to hire the handicapped,
- implementing an educational and informational program to inform the handicapped of their rights. Television commercials have been prepared on this subject but it has been difficult to convince television stations to use them, and
- investigating individual complaints resulting from their educational and informational program. One case has been referred to the Department of Labor Solicitor's Office for litigation.

Regional officials said little or no activity is assigned to the staff regarding community placement except when there is a refusal to hire employable handicapped persons. Officials told us they had only recently been able

to hire persons to perform this function, and as of November 1975, 4 of the 7 positions allocated to the region for this function had been filled.

CONCLUSION

The care and treatment of the mentally disabled is primarily a State responsibility. The role of the Federal government has been to provide support to the States to improve the delivery of service to the mentally disabled. However, it is a divided support. No one group or agency is in charge or is directing the many programs designed to help community placement. Responsibility has been placed under varied programs in HEW and other Federal agencies. There has been no clear instruction from Washington on the Regional Office role, thus community placement has had low priority with the HEW, HUD, and Department of Labor Regional Offices. As a result, the Federal Regional Council had also considered it as a low priority effort.

The Regional Offices have provided little or no support or guidance to Michigan to improve community placement. With Michigan also divided in its community placement efforts, vigorous Federal support could be the catalyst that Michigan needs to organize its own efforts.

CHAPTER 5

OBSERVATIONS ON THE IMPACT OF FEDERAL PROGRAMS ON COMMUNITY PLACEMENT

Federal Programs, although applied in a piecemeal fashion, have had some impact on Michigan's community placement efforts. The Medicaid and Supplemental Security Income Programs probably have had the most significant impact because both programs were a means to finance the daily care of the mentally disabled.

Other Federal programs having less impact include those that (1) provide social services for the mentally disabled, (2) promote planning for the care of the mentally retarded, (3) promote development of community mental health centers, and (4) help find employment for the handicapped, and provide job training and education.

MEDICAID

Michigan's Medicaid program is administered by the Department of Social Services. Michigan's Medicaid program includes care of the eligible mentally ill in community-based clinics, and the care of mentally disabled persons in skilled and intermediate nursing homes.

Our tracing efforts show that many mentally disabled persons have been placed into nursing homes that were not prepared to provide the special services needed. An agency

official stated that nursing homes have been in past years a "dumping ground" for the State institutions. Thousands of mentally disabled have been placed in nursing homes, and as a result, the State has only substituted one institutional setting for another one - in a nursing home. In two nursing homes used by the State for this purpose - one has 440 beds while the other has 350.

Department of Social Service officials told us nursing homes are not helping individuals to become self-sufficient but are, rather, mini-institutions. As a result the Department is trying to place more persons in adult foster care homes which are smaller.

As part of its Medicaid requirements, Michigan evaluates nursing home patients' (including the mentally disabled) needs annually and determine whether their admission and continued stay is necessary. In our opinion, these evaluations have had little impact on community placement.

SUPPLEMENTAL SECURITY INCOME

The majority of persons in private institutions--nursing homes, group homes, adult foster homes, etc.--are receiving Supplemental Security Income. However, the Department of Social Services cannot determine the number of mentally disabled persons that are receiving these benefits. Social Security uses a disability requirement that

is strictly medical and, as a result, mental disability is not adequately taken into account in determining eligibility. Agency officials said there are some mentally disabled persons not receiving benefits who may be eligible, but they did not know how many because of this limitation on eligibility.

The Department of Social Services and Mental Health have also had trouble in dealing with delayed payments to mentally disabled persons--some Supplemental Security Income recipients have waited 6 to 8 months for checks because of these delays. Social Security officials said they are holding meetings with officials from both agencies to develop working agreements so that persons scheduled for discharge and eligible for Supplemental Security Income benefits can receive them on release. They said there were no instructions in the beginning on how Supplemental Security Income was to be administered and the Social Security Administration was slow in processing applications. Therefore, Supplemental Security Income benefits to eligible persons were delayed.

SOCIAL SERVICES

Social services provided under the Social Security Act generally include services needed to prepare a mentally disabled adult for placement in the community and also to maintain them in the community.

State and local agencies have had problems in qualifying for Federal funds for this purpose. According to State officials over \$31 million in fiscal year 1974 was not spent because HEW procedures were much too complicated. Additional staff could have been hired to help in the followup of persons placed in residential facilities if these funds had been available.

Federal funds were available but there have been problems in providing structured work activity for adults because no one State agency is accountable for sponsoring this service. There are also no activities to help prepare the mentally ill for independent living. Department of Social Services makes agreements with other State agencies to provide specialized help. For example, a January 1975 agreement with the Michigan State Housing Development Authority provides for preplacement and post-placement services for mentally retarded adults who are placed in special housing.

State officials told us they have encountered many problems in using Federal funds for social services, such as, inadequate community services due to a lack of accountability among State and local agencies, and a lack of community acceptance of the community placed mentally disabled.

DEVELOPMENTAL DISABILITIES

Michigan participated in a federal project of "national significance" by developing "A Plan For Improved Services For The Developmentally Disabled In Michigan," issued in June 1974. The purpose of the plan was to meet the needs of developmental disabled persons of all ages who are currently in inappropriate placement.

The Developmental Disabilities program is guided by a 20 member State Advisory Council and is administered by the Department of Public Health. An agency official told us that State agencies work together in placing mentally retarded persons in the community. Department of Social Services has provided funds for transportation costs to workshops for persons on welfare and many agencies have made special efforts for persons placed in the community. Some local mental health agencies also employ specialists to deal with the special problems of the mentally retarded.

He said there are also problems because gaps in various laws, rules, and regulations do not spell out each State agency's responsibilities for these persons. Further the advisory council cannot require agencies to cooperate and it has also been unable to influence agencies to the extent needed.

COMMUNITY MENTAL HEALTH CENTERS

Community mental health centers are designed to provide mental health programs for the mentally disabled placed in the community. As of July 1975 Michigan had received a total of \$29.5 million for the construction and staffing of 10 mental health centers. The Community Mental Health Centers program has not yet achieved its goal of being the focal point for the community care of the mentally disabled, and because of funding and organizational problems it does little more than dispense medication.

MICHIGAN EMPLOYMENT SECURITY COMMISSION

Agency officials told us they were not formally made aware of community placement, nor did they have enough information on whether section 503 of PL 93-112 has had any impact on providing jobs for the handicapped. There has been very little enforcement of this section because there are no Federal guidelines. The Michigan Employment Security Commission, however, is encouraging employers to take affirmative action in hiring the handicapped, especially the mentally disabled.

Officials told us that despite the Federal requirements employer attitudes and resistance are major problems to finding employment for the mentally disabled placed in the community. There is strong resistance to the employment of the mentally ill because employers tend to associate

these persons with the violent crimes featured in the news media and therefore believe they would be difficult to supervise. There is resistance but it is considerably less when hiring the mentally retarded.

VOCATIONAL REHABILITATION SERVICE

The Vocational Rehabilitation Service provides counseling, physical restoration, training, job placement, and other services designed to improve employability of the handicapped. The Vocational Rehabilitation Service fiscal year 1975 expenditures were estimated to be about \$32 million, with the Federal contribution at about \$27 million. They have identified about 711,000 persons including about 152,800 mentally disabled who might need their services. VRS planned to serve only about 13,600 mentally disabled during fiscal year 1975.

The Vocational Rehabilitation Service recognizes some mentally retarded needing help have not received adequate service. A lack of staff, funds, and facilities have prevented them from providing adequate evaluation and/or rehabilitation services to those persons being released from State mental institutions.

EDUCATION

To help develop special education programs and services to handicapped persons (including the mentally

retarded) in State institutions and in the community the State used funds from the Elementary and Secondary Education Act to hire teachers, teacher aides and various support personnel. For fiscal years 1973-74 they used \$3.2 million of these funds.

CHAPTER 6

RECOMMENDATIONS

Our review has demonstrated that the community placement process of the mentally disabled has not been effective. The low priority assigned by Federal agencies and the fragmented responsibility in both Federal and State agencies has contributed to problems faced by the mentally disabled when placed in a community.

To improve the community placement process, we recommend that the HEW Regional Director:

- Develop and implement a more aggressive and systematic approach among HEW agencies in the region and among other Federal agencies in the region, perhaps through the Federal Regional Council, to address the problems associated with community placement.
- Work more closely with HUD and State mental health and developmental disabilities agencies to ensure that housing assistance plans prepared by local housing authorities adequately address the housing needs of the mentally disabled residing in or expected to reside in their communities.
- Assist State and local agencies, possibly through State mental health plans required by the Special Health Revenue Sharing Act of 1975 and the State Developmental Disabilities program, to more clearly delineate responsibilities and actions to be taken to more effectively implement community placement.
- Ensure that adequate discharge plans are prepared and follow-up performed for persons being released from mental hospitals and institutions for the retarded in accordance with Medicaid requirements.

- Evaluate (1) the adequacy of discharge plans and follow-up and (2) the appropriateness of placements for the mentally disabled released from mental institutions when HEW social services funds are used for these activities.
- Expand monitoring of nursing home compliance with Medicaid regulations to ensure that mentally disabled persons are appropriately placed and are receiving appropriate services for their mental disabilities.
- Evaluate the efforts made by State vocational rehabilitation agencies to assist in implementing community placement of the mentally disabled with the more severe handicaps and provide assistance to them in expanding their efforts, as appropriate.

In commenting (See appendix IV) on a draft of this report, the HEW Regional Director stated:

"I am in agreement with your recommendations for the Regional Director; however, I feel you should also make recommendations for Central Office staff of the program you identify, especially regarding their relationship to State counterpart agencies. It would be very difficult for any Regional Director to carry out your recommendations on this complex mission without support from Central Office staff and appropriate action by State and local agencies."

GAO recognizes the importance of the Regional Director's comments in implementing an effective and coordinated action-plan. These and other matters of national significance are discussed in GAO's overall report to the Congress.

APPENDIX I

Department of Mental Health
Resident Population of
All Institutions For Fiscal
Years Ending in June

| <u>Fiscal Year</u> | <u>Mentally Ill Resident Pop. at Year End</u> | <u>Mentally Retarded Resident Pop. at Year End</u> |
|------------------------|---|--|
| 1964 | 20,083 | 12,741 |
| 1965 | 19,016 | 13,011 |
| 1966 | 17,377 | 13,016 |
| 1967 | 16,284 | 13,139 |
| 1968 | 15,029 | 12,601 |
| 1969 | 12,283 | 12,300 |
| 1970 | 11,134 | 11,844 |
| 1971 | 9,661 | 10,970 |
| 1972 | 8,430 | 9,500 |
| 1973 | 6,865 | 8,317 |
| 1974 | 5,999 | 7,339 |

APPENDIX II

Department of Mental Health
 Total Budgets and Percent
 Expended on Community
 For Fiscal Years Ending in June

| <u>Fiscal Year</u> | <u>Total Budget</u> (in millions) | <u>Percent of Budget to</u> | |
|------------------------|--|-----------------------------|---------------------|
| | | <u>Community</u> | <u>Institutions</u> |
| 1964 | \$ 79 | 2 | 87 |
| 1965 | 88 | 3 | 86 |
| 1966 | 91 | 8 | 81 |
| 1967 | 106 | 10 | 86 |
| 1968 | 124 | 11 | 83 |
| 1969 | 144 | 12 | 85 |
| 1970 | 158 | 12 | 85 |
| 1971 | 188 | 12 | 86 |
| 1972 | 201 | 12 | 85 |
| 1973 | 215 | 12 | 84 |
| 1974 | 235 | 16 | 81 |

- 2 -

Effective linkages are obviously required between the above agencies, both at the Washington level, regional, state and local community.

There is a need for models for community-based services that would address the following issues:

1. Approaches to aftercare, outreach, and monitoring of medication.
2. Approaches to re-socialization, recreation, and the development of social networks of caring relationships.
3. Approaches to the provision of supporting living arrangements, such as halfway houses, cooperative apartment programs, and foster care.
4. Approaches to increasing employment opportunities for the former or potential mental patient through sheltered workshops, lodge programs, transitional employment programs, and cooperative relationships with Vocational Rehabilitation.
5. Approaches to overcoming "systems" problems and finding ways to put the pieces together for a continuum of appropriate and effective support services.

The Housing and Community Development Act of 1974 is possibly one place to focus on the needs of the handicapped, especially the mentally handicapped, and their inclusion in state and local housing plans.

In many respects, the problems in the placement of these "hard-to-place" groups is similar to, but much more difficult than, the long term care and nursing home problems of the elderly - with which we are now dealing on a Regional basis.

It is my suggestion that we begin to give this some serious thought on a national basis, as we have given to the long term care problems of the elderly. The Regional Director's Office, with some support from Washington, could assume a leadership role in tackling this problem.

Attachments

RH/pi



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REGION V

300 SOUTH WACKER DRIVE
CHICAGO, ILLINOIS 60606OFFICE OF
THE REGIONAL DIRECTOR

June 25, 1976

Mr. John P. Competello
Assistant Regional Manager
U. S. General Accounting Office
Suite 500, Washington Boulevard
Building
234 State Street
Detroit, Michigan 48226

Dear Mr. Competello:

This is in response to your letter of June 16, 1976 requesting comments on the recommendations in Chapter 6 of your report on "Community Placement of the Mentally Disabled in Michigan".

I am in agreement with your recommendations for the Regional Director; however, I feel you should also make recommendations for Central Office staff of the programs you identify, especially regarding their relationship to State counterpart agencies. It would be very difficult for any Regional Director to carry out your recommendations on this complex mission without support from Central Office staff and appropriate action by State and local agencies.

Sincerely,

Richard E. Friedman
Regional Director

C o n t e n t s

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ABBREVIATIONS

| | |
|-----|---|
| HEW | Department of Health, Education and Welfare |
| HUD | Department of Housing and Urban Development |
| GAO | General Accounting Office |