

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

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Executive Director

ADMINISTRATION OF THE MENTAL HEALTH
and
DEVELOPMENTAL DISABILITIES PROGRAMS

Second Supplementary Report

State of California
August 1979

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Honorable Edmund G. Brown Jr.
Governor of California

Honorable James R. Mills
President pro Tempore, and to Members of the Senate

Honorable Leo T. McCarthy
Speaker, and to Members of the Assembly

WILL THIS REPORT BE THE CATALYST TO IMPROVE
THE MENTAL HEALTH AND DEVELOPMENTALLY
DISABLED PROGRAMS?

The attached report is another in this Commission's series of supplemental reports concerning various facets of the State health program. This report deals with services to the mentally ill and developmentally disabled--services which were once delivered through the single Department of Health but which are now provided by two separate departments.

This supplemental report is based upon Commission review of staff analysis of the new Departments of Mental Health and Developmental Services, and on testimony from public hearings the Commission conducted March 29, 1979 in Sacramento and May 2, 1979 in Los Angeles.

The Commission made numerous recommendations in 1976--particularly concerning funding, staffing, policy development and administration. Since then, we have conducted annual reviews of State programs for mental health and developmental disabilities to assess what progress has been made. Our previous evaluations, you may recall, found a continuing and deplorable failure to effect major improvements in these two program areas. Unhappily, our latest report reflects deterioration in the administration of the Department of Mental Health.

HAS ANY PROGRESS BEEN MADE?

Yes, measurable progress is being made in the Department of Developmental Disabilities, which has managed to attain certification for its hospital programs and to take steps to improve the administration of regional centers. Legislative changes are required to strengthen control of regional center operations by the Department.

WHAT IS STILL URGENTLY NEEDED?

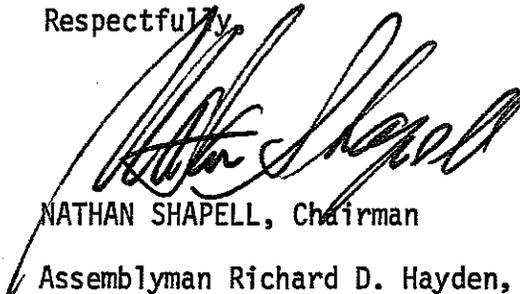
In the Department of Mental Health, we found inadequate funding, poor coordination with local authorities, inadequate authority for program planning, failure to correct State hospital deficiencies, and curtailment of acute mental health care in State hospitals.

The Commission has no doubt that an important fact contributing to the continuing problems has been the confusion, overlapping authority and lack of coordination brought about by the creation of the new departments. There has been some indication that department heads under the Health and Welfare Agency are inclined to consider themselves semi-autonomous and, therefore create a lack of communication and coordination and policy direction at the Agency level.

Because of the ongoing failure to implement the recommendations this Commission made three and one-half years ago, countless mentally ill and developmentally disabled Californians have been denied the quality care and compassion which this State should be providing.

The Commission urges you, our government's leaders, to take strong, swift steps to bring a turn-around in these two crucial program areas by putting into effect the attached recommendations, those the Commission made in 1976 and reiterated here, and those of other concerned groups and individuals whose goals are in concert with ours.

Respectfully,



NATHAN SHAPELL, Chairman

Assemblyman Richard D. Hayden, Vice Chairman
Senator Alfred E. Alquist
Maurice Rene Chez
Assemblyman Jack R. Fenton
Dixon R. Harwin*
Nancie Brooke Knapp
Senator Milton Marks
James F. Mulvaney
Manning J. Post
Philip J. Reilly
Jean Kindy Walker

*Mr. Harwin was appointed to this Commission on May 1, 1979 and, therefore, did not participate in the conduct or review of this study.

P.S. PART OF THE TAX SAVINGS AND FUNDS RECOVERED BY IMPLEMENTATION OF THE COMMISSION'S RECOMMENDATION IN OUR FORTHCOMING MEDICAL REFORM LETTER WILL AMPLY COVER THE COSTS MENTIONED IN THE ATTACHED RECOMMENDATIONS.

August 1979

SECOND SUPPLEMENTARY REPORT ON
ADMINISTRATION OF THE
MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES PROGRAMS

This supplemental report is based on Commission review of staff analysis of the Department of Mental Health and the Department of Developmental Services, and on testimony provided at public hearings which the Commission conducted on March 29, 1979 in Sacramento and on May 2, 1979 in Los Angeles.

DEPARTMENT OF MENTAL HEALTH

The creation of this Department, expected to bring improvements, has instead resulted in a flurry of angry criticism emanating from many sources: committees of the Legislature; the Conference of Local Mental Health Directors; State and local mental health associations; the recently-established Organization of Mental Health Advisory Boards; the Citizens Advisory Council; and a variety of professional and citizen organizations and individuals with long-standing concern for the provision of adequate services to the mentally disabled in both community programs and State hospitals.

Extensive testimony at the Commission's public hearings brought remarkably similar criticisms before the Commission. Following are the major problem areas which have been identified:

Inadequate Funding

The \$34 million attached to the mental health "initiatives" proposed on April 16, 1979 by the Administration is grossly inadequate to meet needs. One Commissioner characterized the funding as "a drop in the bucket." The \$34 million is not enough, in fact, to cover inflation factors and loss of local matching funds resulting from Proposition 13. Unless funding is substantially increased, serious reductions in community mental health programs will occur in all California counties. The goal of reducing the bed capacity of State hospitals will also be completely compromised. Assurance of adequate intake assessment and placement of discharged State hospital patients by community mental health programs will require augmented community funding.

In the Spring of 1978, the Governor worked intensively with a Task Force of knowledgeable mental health professionals. He agreed that funding for community programs be increased at a level which would amount to \$200 million on an annual basis, if inflation is built in. In view of this previous commitment, the substantial reduction in the proposed budget for fiscal 1979-80 can only be attributed to the political pressures which accompanied passage of Proposition 13.

Loss of Local Control

The April "initiatives" are based on local application for funding of special programs in selected communities, rather than on the provisions of funding on an allocation formula to all local programs. This policy

The recent reorganization placed all but two State hospitals under the jurisdiction of the Department of Developmental Services. Metropolitan and Camarillo serve only the mentally disabled and are administered by the Department of Mental Health.

Five hospitals serve both types of clients. In these instances, dual administration poses many operational problems for each hospital director, who must respond to the directive of two departments which enjoy equal status.

Interagency agreements are being refined in an attempt to settle some of these problems. But the Department of Mental Health would like to have jurisdiction of those hospitals which serve a predominant population of mentally disabled clients.

Substandard Board-and-Care Homes

Conditions in most board-and-care homes serving the mentally disabled are persistently appalling. Problems include lack of adequate nutrition, sanitation and treatment supervision; overuse of medications; abuse of patients; denial of their rights; and intimidation of residents who air their grievances in public.

Testimony at the hearings from NOVA, a patient advocacy organization, indicated that no progress is being made in solving these problems and that, following reorganization of State health programs, licensing and certification inspections have deteriorated due to lack of inspection staff.

Licensing and certification of board-and-care homes, once the responsibility of a single State entity (the Department of Health), has reverted to the State Department of Social Services. Enforcement of standards is therefore not controlled by the new Department of Mental Health. This change is proving counterproductive, since conditions in these homes are no longer the direct responsibility of the single department designated to improve programs for the mentally disabled.

In spite of multiple and persistent complaints of patient abuse, law enforcement agencies have filed an insignificant number of actions against operators of poor quality board-and-care homes.

Inadequate Community Alternatives

In bridging local-state antagonisms, a consensus is emerging that local services should replace State hospital programs, to the extent feasible. But reduction in bed capacity at State hospitals can be achieved in an orderly fashion only if adequate funds are first made available to local communities for development of alternatives to State hospitalization.

Such alternatives are psychiatric health facilities providing ambulatory care to selected acute patients; residential treatment facilities for acute care and extended rehabilitation; crisis intervention teams available 24 hours a day, strengthened services to inmates of county jails to permit diversion of minor offenders and secure treatment facilities for serious offenders who are disturbed; and installation of active social and vocational rehabilitation into board-and-care homes to enhance the programs for independent living.

Some of these alternatives are presented in a very sketchy fashion in the April initiatives. But funding is not sufficient even to maintain ongoing community programs, let alone to develop an expanded capacity to serve those now being seriously neglected.

Certain State hospital programs continue to provide indispensable services to adolescents, young adults, autistic individuals and those suffering organic brain damage from injury, disease or aging.

The acute wards at State hospitals have increased and upgraded their staffs, but admissions are being curtailed. This has placed a burden on those communities which lack sufficient capacity for acute care, such as Los Angeles and the San Francisco Bay Area counties. In compacted urban communities, lack of access to State hospitals is resulting in jailing of patients; admission to facilities not staffed or equipped to handle acute care problems; escape into the street; injury; and even death.

The Conference of Local Mental Health Directors is on record in favor of eventual local control of programs conducted in State hospital facilities on a regional basis to improve continuity of patient care and to end the destructive rivalry for funding between State hospital programs and community mental health programs.

Dr. Louis Simpson, a prominent psychiatrist from Los Angeles, called for expanded financing of community programs with emphasis on the care of chronic patients through treatment combined with job training and acquisition of new behavior skills. He emphasized the need to stop conflict between State and local programs. He also called for a new spirit of cooperation and dedication to excellence. The content of the hearing, he remarked, gave him a feeling of déjà vu.

Where counties require complex treatment programs beyond their capacity to organize and maintain, joint powers agreements could be made for operation of central programs within the State hospitals, operating as specialized regional treatment centers.

Local services to inmates of county jails remain deficient. Most law enforcement authorities are convinced that the problem of unnecessary jailing of mentally ill patients can only be resolved by the development of alternative local treatment facilities able to respond night and day to divert patients from jail to a secure treatment facility. In large jail institutions, discharge of inmates expected to require continual psychiatric care can be achieved by setting up departure centers. In these centers, jail staff would be assisted by mental health professionals in assuring appropriate placement of inmates for continual care.

Services for children and adolescents and the elderly continue to be inadequate in most local programs. This results in the need to refer patients to crowded State hospitals or to facilities at a distance from home -- this denies relatives the opportunity to participate in therapy when indicated or to visit relatives placed in distant communities.

Review of patients' financial status upon intake to community mental health services should be conducted in such a way so as not to deter patients from continuing treatment.

Reimbursement Formula Problems

Alternatives in reimbursements formulas have been suggested by the Department: 80/20 State/local for State hospitalization, 90/10 for local hospitalization, and 100/0 for programs which do not involve hospitalization. Such formulas may be logical in some counties, but not in others -- especially those which lack the capacity to handle acute treatment needs of certain types of patients.

Reimbursement policy must be tailored to meet divergent needs and not be imposed statewide. In the absence of adequate funding by the State, revisions of reimbursement policy are counterproductive.

Recommendations -- Mental Health

1. The budget for State programs for mental disability should be augmented by \$200 million for Fiscal Year 1979-80. This money should not be an addition to the total budget for all State health programs, but by shifting savings from Medi-Cal gained by implementing the Commission's prior recommendations on Medi-Cal. A further communication to the Governor and Legislature relating to Medi-Cal restructuring will be released in the immediate future.
2. Long-term planning for the Department should be based upon the assumption that all direct services will eventually return to local control through use of joint powers agreements among counties for the operation of specialized treatment programs on a regional basis within the renovated buildings now housing State hospital programs.
3. Funds provided for Short-Doyle should continue to be allocated on the basis of locally determined priorities, and not on the basis of demonstrations selected by the Department from among competing counties.
4. Administrative responsibility for State hospital programs should be strengthened by making the Department of Mental Health fully responsible for State hospitals which house a majority of patients with mental disabilities.
5. The Department of Mental Health should take the lead in assuring that adequate treatment programs are conducted in both small and large board-and-care facilities. Standards should assure adequate supervision of medications, activity programs, vocational and social rehabilitation, and treatment plans to assure early return to independent living. Licensing and certification of these homes should revert to the Licensing and Certification Division of the Department of Health Services, with assurance of adequate staff to fulfill this function.
6. State hospital programs should be financed at a level to assure their certification.

DEPARTMENT OF DEVELOPMENTAL SERVICES

Regional Center Improvements

This new department, under David Loberg, Ph.D., is making measurable progress in strengthening the administration of regional centers. Deficiencies previously recorded (some of which were referred to the Attorney General by this Commission in 1976) are coming under control.

However, an opinion of the Attorney General dated May 11, 1979, raises a serious question concerning the relationship between the department and the operations of regional centers. The opinion states that the department has no authority to control the operations of regional centers except where specific statutory provisions authorize control in limited areas.

The Commission strongly recommends that regional centers be subject to unequivocal supervision of their operations by the department. Authority should be conferred to the department relative to priorities in the programs, fiscal accountability, evaluation of case management, client status, and progress, statistics on utilization of services, personnel practices etc.

Improvements have been attained by elimination of conflicts of interest by vendors by removing them from council membership. Misappropriation of funds is no longer apparent following imposition of tighter fiscal controls by the department.

Priorities for serving clients have been spelled out in departmental guidelines for purchase of services. An operations manual has been distributed to each center. Waiting lists for intake and evaluation are not as long, although that for certain types of services remains a significant problem.

Uniform standards for staffing and salaries have been issued. Activities and positions appropriate for direct service have been distinguished from those which are best accomplished by purchase of service. Budget allocations reflect this policy.

A method for annual evaluation of patient progress is in use, as is a document outlining standards and methods for program evaluation.

A field staff from the department is attempting to perform site evaluations of the performance of each center. Optimum and thorough evaluation are impeded by staff shortages.

A committee, seating regional center administrators and departmental staff is at work on planning, policy refinement and uniform fiscal accounting procedures.

Concern amongst parents and advocacy groups relating to regional centers revolves around these issues:

- ° Lack of availability of certain services and programs. For example, adults over 18 years of age, either in community programs or coming

out of State hospitals on their own initiative are not being accommodated in activity or work programs. They are facing discrimination in employment, use of generic community services, rentals, and other aspects of community life.

- ° Since the average age of the developmentally disabled is advancing, as is that of the general population, planning should place greater emphasis on the needs of the adult population.
- ° Access to primary care, routine hospitalization and specialty care remains a problem for the developmentally disabled person residing in the community.
- ° Low income, minority citizens continue to experience difficulty in meeting the needs of disabled family members. Greater efforts at outreach and communication are needed to improve access to regional center intake and referral.

Funding Problems

Interagency agreements are being developed at staff level for provision of various services to clients who are developmentally disabled, such as special education, services to children, vocational rehabilitation and psychiatric services. These activities and changes have not occurred without tense dispute, most of it originating from severe budgetary constraints.

Regional centers point to the increased administrative cost attached to client evaluation demanded at a time when serious service cutbacks are occurring.

The Director of the Department does not intend to seek a \$4.7 million supplemental appropriation for Fiscal Year 1978-79 to meet anticipated deficits for the operations of the regional centers. He justifies this decision on the basis of the annual reversion of regional center funds to the general account. Instead, he intends to transfer allocations among centers which are overfunded to those which face operating deficits, thereby avoiding reversions. The centers complain that the budget cycle provides funds in such a fashion that money is received too late in the fiscal year to encumber for much needed services to clients.

In an apparent effort to stay within this year's budgets, the Department has recently adopted a Federal standard for basic habilitation plan (BHP) for each client, in order to assure that basic needs are given a priority in treatment plans.

The regional centers view this as contrary to State law, in that standards for reimbursement for services included in the Individual Program Plan (IPP) are more generous in scope and required by State statute.

The Director, in seeking a more efficient use of existing resources, does not deny that a reduction in services to clients of regional centers is taking place. Basic habilitation services are, however, being given a

priority and the reduction is effecting desirable but not essential services. He believes that this is inevitable in face of the climate reflected in passage of Proposition 13, and points to a pattern of significant fiscal increases over the past five years in staff support to the regional centers.

The centers counter that the law contains a mandate which does not permit a retraction of commitment to funding essential local services adequately in order to assure the rights of clients to live in the least restrictive environment and to receive those basic services necessary to maximize their potential toward normalization close to home.

Testimony presented by several regional centers pointed to increasing stress and hardship being experienced by clients and their families as a result of inability by the regional centers to purchase services essential to the welfare of their clients. The centers strongly disagree with Director Loberg regarding the need for the supplemental appropriation of \$4.7 million.

All State hospitals which offer services to the developmentally disabled are currently conditionally certified on the basis of an acceptable plan of correction of deficiencies.

A report on staffing standards has been issued in response to a resolution of the Legislature. The Administration to date has not yet endorsed this plan.

At present, the rate of discharge of patients to care in community facilities exceeds the rate of admission. Special funds have been targeted for use of regional centers to accomplish community placement for clients deemed to be ready following a recently completed assessment of all developmentally disabled clients now residing in State hospitals.

In terms of long-term planning activity, the Department has recently issued a draft report which delineates, in detail, the complexities to be dealt with in the development of community living arrangements which meet the great variety of needs of developmentally disabled clients. This report points up the fragmented character of existing living arrangements and acknowledges the need for development of a range of alternative living arrangements and supportive services required to assume community placement and normalization.

It is clear that even after the following recommendations are implemented much expanded funding will be necessary to build the capacity of regional centers to assure beneficial placement in the community and to expedite placement of State hospital clients in the community programs. Equitable and uniform rates of reimbursement will require negotiation and continuation of cooperative planning between the departments and the regional centers.

Other Developments

The continuing care services "opt-out" program has been reinstated, thus enabling regional centers to take over case management services for discharged State hospital clients.

The lack of control of licensing and certification of community care facilities is also a problem for the Department. Return of this function to the Licensing and Certification Division of the Department of Health Services would restore the effective inspection of such facilities, provided that adequate staffing is provided.

The administration of programs for the developmentally disabled has improved both in State hospitals and in the regional centers. This improvement, however, is being obscured by legitimate protests that insufficient funding is being provided to assure that all essential services to the developmentally disabled are provided.

In order to meet statutory requirements relating to the developmentally disabled citizen, adequate financing by the State is an urgent reality, exacerbated by passage of Proposition 13 and subsequent reduction in services financed by local tax dollars.

Recommendations -- Developmental Services

1. The Legislature should revise statutes relating to regional centers to provide to the Department of Developmental Services adequate authority to supervise the operations of regional centers in regard to their budgets, fiscal accountability, program service statistics, reports of client status and progress, service priorities, staffing, standards, etc.
2. The Department should be required to produce an annual State plan for services to the developmentally disabled oriented toward the State budget for services to the developmentally disabled and not toward assessments or statewide need made by the State Council on Developmental Disabilities and area boards.
3. Estimates of funding requirements for regional centers should be based upon an evaluation of the needs of clients reported by the centers to the department and upon an assessment of the professional performance of each center made by the staff of the department.
4. The needs of adult clients and those with low income and ethnic minority identification should receive greater priority by augmenting outreach programs and developing services to meet unmet needs, such as appropriate residential placement programs for adult activity, employment, recreation, education, etc.
5. Citizens suffering from both developmental disability and mental disability should be considered as clients with a primary diagnosis of developmental disability in both community programs and in State hospitals. No discrimination should be tolerated in terms of access to psychiatric treatment for citizens suffering developmental disability. A mechanism should be created to permit the families of a client with a dual diagnosis to appeal to the Director of the Department in case of discrimination or neglect.

6. The licensing and certification of board-and-care facilities should revert from the Department of Social Services to the Department of Health Services. Adequate staff must be provided to permit regular inspection of such facilities in order to assure compliance with sanitary, safety and structural standards. The Department of Developmental Services should assume responsibility for program standards relating to activity programs, client supervision, and the development and referral of clients to active treatment programs in the community.
7. The needs of the developmentally disabled for community-based services for primary, secondary and specialty medical care should be met without discrimination by appealing to local medical and hospital associations to provide a local plan to accommodate citizens with such needs.
8. The budget for hospital-based programs for the developmentally disabled should be adequate to assure compliance with licensing, certification, accreditation, life safety and environmental standards.
9. Discharge of hospital patients to the community should not be made until a plan for placement is developed which assures that supportive services are available to maximize potential for normalization.