

**A PROPOSAL TO REORGANIZE**

**CALIFORNIA'S  
FRAGMENTED SYSTEM  
OF SERVICES  
FOR THE  
MENTALLY RETARDED**



**ASSEMBLY OFFICE OF RESEARCH  
CALIFORNIA LEGISLATURE  
SACRAMENTO  
MARCH 1969**

California State Assembly

**A PROPOSAL TO REORGANIZE CALIFORNIA'S  
FRAGMENTED SYSTEM OF SERVICES FOR THE MENTALLY RETARDED**

**A staff report prepared for the  
ASSEMBLY WAYS AND MEANS COMMITTEE**

**Ways and Means Subcommittee on Mental Health Services**

**September 1968 – 1969**

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**MARCH 1969**



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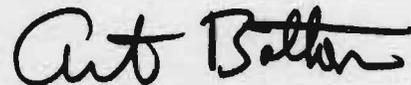
Honorable Frank Lanterman  
Member of the Assembly  
Room 3120, State Capitol  
Sacramento, California

Dear Assemblyman Lanterman:

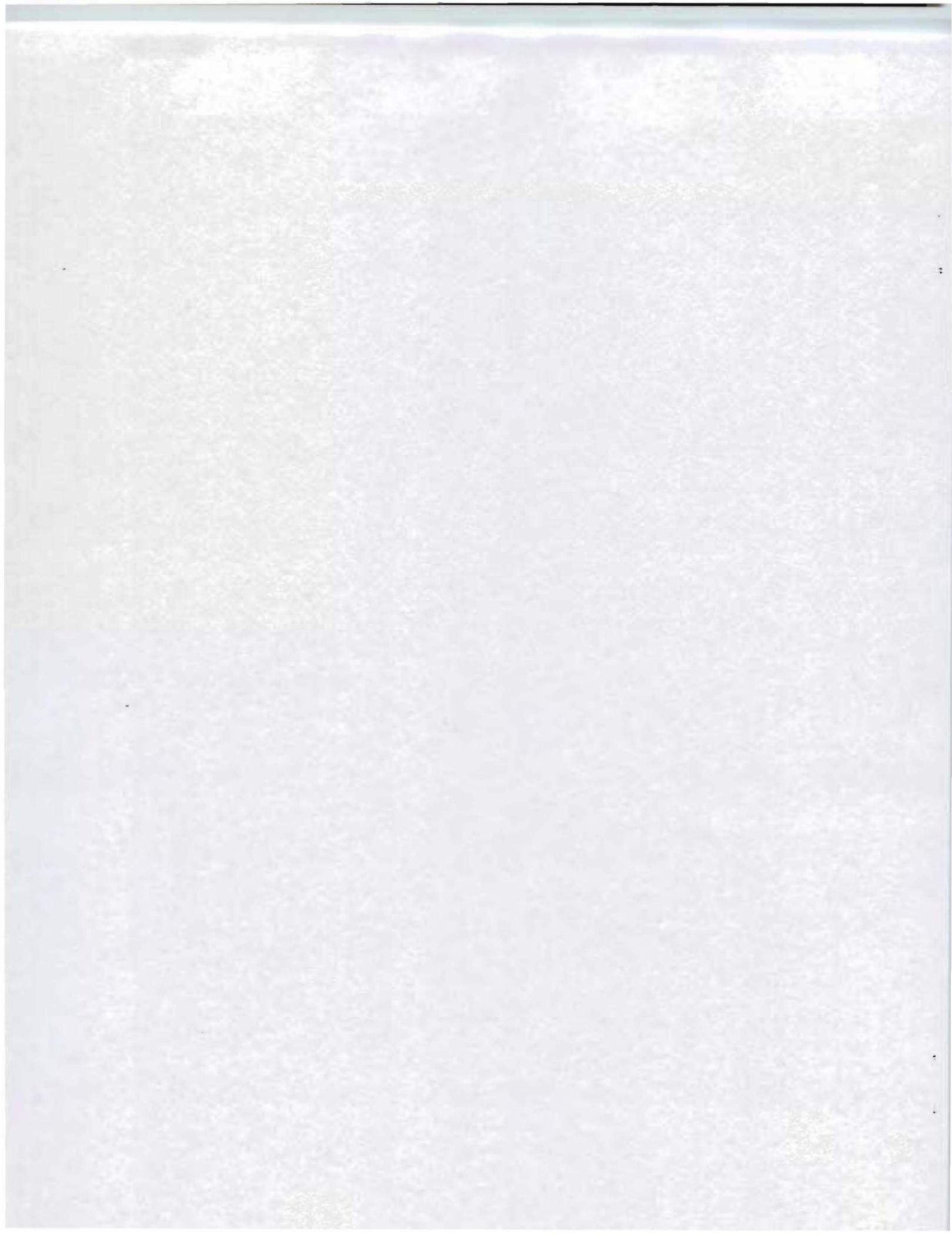
This report was prepared by the Assembly Office of Research and the staff of the Assembly Ways and Means Committee. The report is the result of a six month study conducted pursuant to your request and House Resolution 372 (1968).

The report contains an analysis of certain problems in the structure of California's Mental Retardation system and recommendations for legislative reform.

Respectfully submitted,



Art Bolton



## TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION . . . . .	i
SUMMARY . . . . .	iii
CHAPTER I	
"You Can't Get There From Here" -- A Case History . . . . .	1
CHAPTER II	
Summary of the Problems . . . . .	4
1. No Single Responsible Agency . . . . .	4
a. The Need to "Shop Around" . . . . .	4
b. Lack of continuity. . . . .	4
2. Lack of Funds . . . . .	5
3. Lack of Services. . . . .	6
a. Lack of Services. . . . .	6
b. Rates Paid to Private Facilities. . . . .	7
4. Excessive Reliance on State Hospital System . . . . .	8
a. The State Hospital as a Place of First Resort . . . . .	8
b. Those Who Could Be Returned to the Community . . . . .	9
5. Lack of Effective Coordinating and Planning on both Regional and State Levels . . . . .	11
a. State Planning. . . . .	11
b. Regional Planning . . . . .	12
6. Disparity Among Fees Charged Parents. . . . .	12
7. Full Advantage Not Taken of Federal Funds . . . . .	13
8. Other Problems. . . . .	13
CHAPTER III	
You Can Get There From Here: Proposed Solutions. . . . .	14
1. Program . . . . .	14
A. Regional Center Responsibility. . . . .	14
B. Screening for State Hospitals . . . . .	14

	<u>Page</u>
C. Pre-hospital and After-Care Placement . . . . .	15
D. Regions . . . . .	15
E. Standards . . . . .	16
F. Regional Center Contracts . . . . .	16
2. Planning . . . . .	16
A. The Regional Plan . . . . .	17
B. State Program-Planning-Budgeting. . . . .	17
C. The Statewide Mental Retardation Program Board. . . . .	18
3. Financing . . . . .	18
A. State Funding . . . . .	19
B. Family Participation in Cost of Service . . . . .	19
C. County Participation in Cost of Service . . . . .	19

APPENDIX A

Department of Public Health, Bureau of Mental Retardation  
Services Statistics for Fiscal Years 1966-67 and 1967-68

APPENDIX B

Estimated Cost and Caseload of State-Supported Services for  
the Mentally Retarded

APPENDIX C

House Resolution No. 372

APPENDIX D

Partial List of Persons Interviewed

APPENDIX E

Rated Capacity and Population Comparison, Hospitals for  
the Mentally Retarded

APPENDIX F

Potential MR Placements 1-1-69

APPENDIX G

Patients on Leave, By Type of Leave, Hospitals for the  
Mentally Retarded

APPENDIX H

Comparison of Daily Costs, State Hospital Care and State  
Department of Social Welfare Post-Hospital Care

APPENDIX I

"Flap Over S.F. Foster Children"

APPENDIX J

Department of Mental Hygiene, Mentally Retarded Support  
Budget and Related Revenue



## INTRODUCTION

The California Legislature acted in 1965 to change the state government's responsibility for providing mental retardation services in California. The determination was made to develop a state-assisted, community-oriented system of services in lieu of constructing additional state hospital facilities. Assembly Bill 691 (Waldie) of the 1965 Regular Session created the Regional Diagnostic Centers for the Mentally Retarded and initiated this new approach for caring for the mentally retarded.

The legislation creating the centers was proposed in a study report prepared by the Assembly Ways and Means Subcommittee on Mental Health Services which found that community-located service alternatives to state hospital care were both necessary and desirable.<sup>1</sup>

Implementation of the legislation followed when two pilot regional centers were placed in operation in 1966—one in Los Angeles and one in San Francisco.

Funds for an additional four centers were included in the 1968-69 State Budget. The new centers are to be located in San Diego, Sacramento, San Jose, and Fresno. As of March 1, 1969, the new San Diego center was in operation.

The evidence clearly shows that the 1965 legislation and the resulting two pilot regional centers have solved many of the problems they were designed to solve. For example, *in the first year alone, 230 persons on the state hospital waiting list were served by the Los Angeles Regional Center, and all but 39 of these were cared for in community facilities rather than being sent to the state hospital;* other persons who were served were prevented from reaching the state hospital waiting list and are now receiving service in the community.<sup>2</sup>

Yet major problems remain: Those areas of the state not served by the regional centers still have all the problems which led to the creation of the regional centers, and even in areas served by the two centers many problems still exist despite the fact that California is spending almost \$160 million annually for mental retardation services.<sup>3</sup>

It was apparent to the Legislature that there are still serious problems requiring further action despite the significant progress which has been made since 1965. Consequently, HR 372<sup>4</sup> of the 1968 Regular Session was adopted to set in motion a study of California's mental retardation services. Subsequent to the passage of this Assembly Resolution, the Legislative Analyst also saw the need for a study and recommended that:

1. See Assembly Ways & Means Subcommittee on Mental Health Services, *A Redefinition of State Responsibility for California's Mentally Retarded* (Assembly of the State of California, 1965). Also, Study Commission on Mental Retardation, *The Undeveloped Resource: A Plan for the Mentally Retarded of California* (Sacramento, State of California, 1965).
2. See Appendix A for statistics regarding the Regional Centers.
3. See Appendix B.
4. See Appendix C.

..... the Legislature reassess and reevaluate all existing programs for the mentally retarded with the specific goal of creating a genuine program approach for the more efficient and coordinated rendering of these services.<sup>5</sup>

The staff of the Assembly Ways and Means Committee and the Assembly Office of Research worked on the study and, in addition to other fact-finding activities, interviewed many persons involved in the provision of services to the mentally retarded.<sup>6</sup>

This report presents, in summary form, the major findings. The proposed legislation is largely the result of these interviews and the Committee wishes to extend its deep appreciation to all those who participated in developing the proposals offered in this report.

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5. California Legislature, *Analysis of the Budget Bill of the State of California for the fiscal year July 1, 1969 to June 30, 1970* Report of the Legislative Analyst, p. 936.

6. See Appendix D for list of persons interviewed.

A PROPOSAL TO REORGANIZE CALIFORNIA'S FRAGMENTED  
SYSTEM OF SERVICES FOR THE MENTALLY RETARDED

SUMMARY

A. PROBLEMS EXISTING IN THE SYSTEM OF SERVICES FOR THE MENTALLY  
RETARDED

1. In most areas of the state, there is no single agency vested with the responsibility, and with appropriate funds and authority to assure the provision of needed services to retarded persons.
2. There is a lack of funds for the purchase of service for retarded persons.
3. There is a lack of essential services in many parts of the state.
4. There is excessive reliance on the state hospital system.
5. There is a lack of effective coordinating and planning on both regional and state levels.
6. There is a wide disparity among fees imposed upon parents of retarded children, depending upon where the child is receiving service, thus resulting in inequities.
7. Full advantage is not being taken of all sources of federal funds available for services to the retarded.

B. PROPOSED SOLUTIONS

1- Program: It is proposed that the state fully implement the policy adopted in 1965 which proposed the establishment

of a statewide network of regional centers for the mentally retarded.

- a. Regional centers will be responsible for the provision of diagnosis, counseling, referral, purchase of service, and guardianship.
- b. The regional centers will be required to do all screening for admission of the State Hospitals for the Mentally Retarded, and will also secure care for persons leaving the state hospitals.
- c. The regional centers will assume responsibility for purchasing out-of-home pre-hospital care and post-hospital services for the retarded.
- d. Regions will be designated by the State Department of Public Health.
- e. Statewide standards shall be set by the State Department of Public Health.
- f. Regional centers may be operated under contract by private or public agencies, including county agencies.

2- Planning: It is proposed that planning for Mental Retardation Services be required on the Regional and State Levels.

- a. Regional Mental Retardation Program Boards (established through a joint powers agreement in multi-county regions) will be formed in each region to function in three capacities:
  1. It will be the MR Program Board and will be responsible for operating the regional center

either directly or by contract.

2. It will be the planning body for the regional and will develop a regional plan for mental retardation services.
  3. It will act as a sub-unit of the Comprehensive Health Planning body for its region.
- b. The regional plan will indicate the services required by retarded persons in the region, the number of persons needing such services, the available service resources, priorities for the development of needed services, anticipated costs and revenues.
  - c. On the state level, the Human Relations Agency will be required to develop a statewide plan and a total program budget for services to the mentally retarded which crosses over departmental lines.
  - d. The Statewide Mental Retardation Program Board will include as voting members only private persons and will be broadly based with representatives of the various disciplines serving the retarded, parents of the retarded, and the general public. This board will act as a sub-unit of the State Comprehensive Health Planning Council and will be advisory to the Human Relations Agency, the Governor, and the Legislature.

3- Financing: It is proposed that the Regional Center Program be funded with state funds, parental contributions and county contributions.

- a. State funding shall be on a regional basis with

funds flowing through the State Department of Public Health to each Regional Mental Retardation Program Board.

- b. Families of children under the age of 18 who are receiving out-of-home services purchased by the regional center will be required to contribute to the cost of services depending upon their ability to pay, but not to exceed the cost of caring for a normal child at home. Fees shall be the same regardless of where the child receives care and shall take into consideration extraordinary family expense in the care of the child. All funds thus collected shall be used for additional service.
- c. Counties will be required to pay no more than \$20.00 per month for each person receiving purchased out-of-home care through the regional center regardless of whether a state hospital or non-state facility is providing the service, unless this amount has been paid by the parent.

## CHAPTER I

### "YOU CAN'T GET THERE FROM HERE" – A CASE HISTORY

The following is the actual case history of a retarded child prepared by the Santa Cruz County Office of Education.<sup>7</sup> This case is quoted in its entirety since it illustrates so well the problems faced by large numbers of families and clearly reveals many deficiencies of the system.

#### STEVEN A

"Steven A and his father moved to this area in 1966. Steven is a severely mentally retarded boy, 16 years old, who has been living with his father since 1966 when Mr. and Mrs. A got a divorce. Mrs. A presently lives in another part of the State with Steven's brother and sister.

Mr. A found employment in the Santa Cruz area and he and Steven lived in a small farm house provided by Mr. A's employer.

Steven was referred to the Santa Cruz County Diagnostic and Counseling Center in October of 1967 and went through the Clinic in November of 1967. At that time the Clinic staff recommended that Steven be placed in the Farm Training Program conducted by the County Superintendent of Schools. On November 27, 1967, Steven was enrolled at the Farm Training School. At first, Steven was extremely difficult to handle, however, he made a slow but steady progress and in a matter of months Steven had adjusted very well to the program and was developing good social and work attitudes. Steven, as of this date, February, 1969, is still at the Farm Training School and making excellent progress.

In February of 1969, three of Steve's teachers had this to say about the boy:

"Steve has a pleasant personality and gets along with the other students . . . .He can follow directions and remembers them for more than one day. . . .Steve is one of the better workers in the group."

"...he is consistently attentive and productive. He impresses me as thoroughly enjoying the program designed for him. . . .The Farm program is well suited to a student like Steven. It is hoped that Steven will go through the entire program and be well prepared for the Sheltered Workshop."

"Steve worked with me for approximately two months in ornamental horticulture. I would consider him one of my better students during that time . . . .I definitely feel that the program at the Farm is beneficial to him and he, in turn, is an asset to the Farm program."

On January 28, 1969, the case of Steven A came up at the Farm staff meeting. Eve Pecchenino, Steve's teacher, reported that Steve expected to leave the Farm the 8th or 9th of February and that he had informed her his father is placing him in Porterville. Len Thigpin, Farm coordinator, reported that he had called Steve's father because Steve had been very upset at school and had said that they were going to move. The father said that there was no truth to this, but would not let himself become engaged in conversation about Steve's future. Len promised to investigate further.

There was general agreement at this time that institutionalization would be a very detrimental thing to Steve and this should be avoided if at all possible.

On January 31, 1969, Len Thigpin found out that a court hearing would be held on Monday, February 3, 1969, to determine if Steven should be placed at Agnews State Hospital. Mr. Thigpin learned this information from the Probation Department and immediately arranged for Bill Carmichael, a teacher at the Farm, to contact Mr. A this date and arranged an afternoon visit. Mr. A. stated to both Bill and Len that he really did not want to place the boy in an institution; however, because he works such long hours and the boy was getting to be more of a responsibility, he could not provide the proper care of supervision that Steven would require. At this

7. "You Can't Get There From Here", Office of Education, Santa Cruz County, Santa Cruz, California.

time, Mr. A was asked if he would allow Steven to stay in the community if there was another alternative; Mr. A. answered in the affirmative. Plans were made for Len Thigpin to attend the court hearing and explain the position of the Farm staff to the Judge.

John Tuck, Social Welfare representative for the Diagnostic and Counseling Center, at this time attempted to find a home which could accept Steve. Eve Pecchenino, teacher at the school, tipped off Tuck about a space available in a Mental Hygiene Home in the area. Tuck contacted this home and the foster parent stated that she would hold this space open, however, she could not wait very long.

An attempt was made at this time to determine which funds would be available for Steve's care in the Mental Hygiene Home. Mr. A makes approximately \$4,000 a year, and of this he must pay his rent and usual expenses plus \$70.00 per month child support. Mr. A was not in a position to afford the \$200 plus amount it would take for a Mental Hygiene Home.

A call to Porterville Outpatient Clinic determined that the State Department of Mental Hygiene did not have the funds available under the State subsidy program. Tuck was informed that because this was a Mental Hygiene Home and was not licensed by the Bureau of Social Welfare Community Services, the cost could not be paid by that agency.

A call to Community Services Bureau of Social Welfare determined that a Mental Hygiene Home could not be double licensed or licensed as a family care home, and there were no vacancies available in the Santa Cruz area. After checking with the Santa Cruz office and the Salinas office of Community Services, it was determined there was not a licensed home available in the Watsonville area. The problem then began to shape up to one of who is going to fund foster home placement and whether anyone was really responsible. The interesting thing about the problem was that everybody involved knew that it would cost more to keep Steven in an institution, or have him admitted on paper and then have him farmed out, than it would to keep the boy in the very successful Farm Training Program where he was presently enrolled.

**February 3, 1969.** Len Thigpin attended the court hearing at 8:30 Monday morning, and after explaining to the judge what the situation was, the judge requested that Mr. A have him take this case off the calendar and put aside until such time as all the other alternatives could be investigated. Mr. A agreed but was still unsure until Len Thigpin informed him that a teacher at the Farm Training School would be willing to take Steven into her home until such time as a placement could be made. Mr. A was very happy with this arrangement and again stated that he really did not want the boy out of the community, however, he did not feel he had any choice because of the responsibility.

Driving back from the hearing, Steven turned to Len Thigpin and said, "They told me you were a good guy and they sure were right." Len asked him what he meant and Steven answered simply, "You came and got me."

On February 4, 1969, John Tuck contacted Irene Harkins of the Porterville Outpatient Clinic in San Jose. Mrs. Harkins stated that funds were not available through the Porterville Outpatient Clinic for Steven's care; however, she stated that she would refer the case to Community Services in Santa Cruz in an attempt to get Mental Hygiene home payment. Mrs. Harkins also stated that Mr. Goulet was in charge of the State subsidy program, whose office is in San Francisco, had informed her that funds were not available for foster care. Tuck again contacted Community Services and informed them the case would be referred. A telephone call to Agnews State Hospital also reiterated the information that funds were not available, nor did anyone know just exactly who was responsible. It should be noted, however, that if Steven were placed in an institution, funds would immediately become available.

At this time, the San Benito County Welfare Department was contacted and an appointment was made for Mr. A to apply for aid for Steven. The County Welfare Department's funds for foster care would amount to approximately \$95.00 per month for Steven, and Mr. A would have to find some way to dig up the other \$105.00 per month if the boy were to be placed in the local Mental Hygiene home available.

A memo received February 5, 1969 from Vocational Rehabilitation Services indicated that the Department could not help because Steven was not their client.

The number of agencies contacted had now grown; contact has been made with:

Porterville Outpatient Clinic  
Porterville State Hospital  
Agnews State Hospital  
Department of Mental Hygiene  
Bureau of Social Welfare Community Services (Santa Cruz and Salinas offices)  
Santa Cruz County:       Office of Education  
                                  Welfare Department  
San Benito County:       Welfare Department  
                                  Probation Office  
                                  Office of Education

On February 5, 1969, Jack Wendt, Clinic Coordinator, called Hans Kleinke, State Department of Mental Hygiene, and Jack Hicky, of the State Department of Community Services, in an effort to determine where funds were available for the care of Steven.

As of this date, February 7, 1969, Steven is residing in the home of one of the teachers at the Farm Training School, and it still has not yet been determined what, if any, funds are available for Steven's care in a local situation.

To place Steven in an institution, it would cost the State \$4,000.00 plus a year. To keep Steven in a good program in a Mental Hygiene home in the community, it would cost the State approximately \$2,500.00 a year. But there is something more important: Steven has made, and is making, excellent progress in his situation at the Farm School. This retarded youngster deserves a chance to meet his potential, *Because the channels of communication are muddy and because no one seems to want to accept the responsibility for the funding of Steven's care, this boy remains in limbo while agencies pass the buck or throw up their hands in helpless gestures. The tragedy is not that these agencies are not doing their job – the tragedy is that the agencies do not seem to be aware of one another and certainly are not aware of each others job.*

*I know you're not responsible, but what happens to Steven A?"*

## CHAPTER II

### SUMMARY OF THE PROBLEMS

1. THE FIRST AND PERHAPS THE MAJOR PROBLEM IS THAT, IN MOST AREAS OF THE STATE, THERE IS NO SINGLE AGENCY VESTED WITH THE RESPONSIBILITY, AND WITH APPROPRIATE FUNDS AND AUTHORITY TO ASSURE THE PROVISION OF NEEDED SERVICES TO RETARDED PERSONS.

As in the case of Steven A., families of retarded persons must go from one agency to another in seeking aid and frequently they find no agency authorized to accept responsibility for the provision of service. Even if the family locates a program, it finds there is no agency to coordinate services or to provide continuity if, and when, a new service becomes necessary.

- a. **The Need to "Shop Around"**

There was no single agency to which Steven A.'s father could go to obtain service for Steven, rather he had to go from agency to agency in the hope that one of them would have a program and money to pay for it. Hundreds of other families face the same problem: Unless they are fortunate enough to live in a regional center area, there is, in most instances, no central place to go.

A survey in Los Angeles County in 1963-65 showed:

The major gap in services for the mentally retarded in Los Angeles County is the lack of "case management" services which would provide continuous life supervision and guidance, and referral to appropriate services. The lack of counseling and referral services has resulted in considerable "shopping" for services and in frustration for the retarded and their families.

- b. **Lack of Continuity**

In most areas, there is no agency which can plan and provide continuity of care for a retarded person. Even the regional centers cannot provide this service for every retarded person in the region within their current budgetary limitations. If anything, the structure of state and local services for the retarded guarantees a lack of continuity.

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8. Ivy Mooring, Ph.D. and Robert J. Currie, *Mental Retardation Survey of Los Angeles County, 1963-65*, (Mental Retardation Joint Agencies Project, Welfare Planning Council, Los Angeles Region). pp 2 - 3.

Leslie C. Waldo, in a 1962 study of services for the mentally retarded in San Mateo and Santa Clara Counties, made the following observation:

There appears to be a range of services that exist, often unrelated to each other, in a fragmented rather than a coherently structured pattern. As a result, there is no clearly defined sequence of services or resources on which case by case planning can be based over time. Beginning with pre-school aged children there is no comprehensive diagnostic service available to everyone who might need it that brings to bear the wide range of skills required. There does not exist a center that makes available the counseling and planning services that should be recurrently available over the lifetime of an individual retardate. The pathways to services at present are unstructured and ill-defined. All too often services are unknown or are inaccessible to those who might benefit.<sup>9</sup>

Though these words were written in 1962, the same situation still exists in many areas of the state today, with those areas served by the regional centers providing the only notable limited exceptions.

In the case of Steven A., there is no agency which is planning for his future. His father must shop for care now and, when it becomes necessary for another change in his program, he will have to shop again.

Another related problem clearly revealed in the case of Steven A. is that a retarded person's entry point into the system, rather than his needs, often determines the nature of the service that will be given. An unimpeded flow from one program to another is lacking since each agency has different eligibility requirements, different fee requirements, and serves different geographical areas.

As the Legislative Analyst's recent report states:<sup>10</sup>

. . . The number of different entry points into the system of mental retardation services . . . causes understandable confusion among parents.

## 2. THERE IS A LACK OF FUNDS FOR THE PURCHASE OF SERVICE FOR RETARDED PERSONS

There is a lack of funds for the purchase of service even when services are available. The case of Steven A. provides a typical example. Steven is participating and doing well in a program in the community but he requires out-of-home placement. Such placement is available, but the father cannot afford the cost and there is no agency with funds available to pay for it, even though the alternative of placement in the state hospital would be considerably more expensive and considerably less suitable for Steven. This situation occurs time and time again.

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9. Leslie C. Waldo, *The Mentally Retarded and Community Services: A Report on Services for the Mentally Retarded in San Mateo and Santa Clara Counties, California, 1961*, (Palo Alto, California, Stanford University School of Medicine, 1962), p. 123.

10. *Analysis of the Budget Bill*, p. 945.

Even in those counties where there is a local agency responsible for finding placement, and which is able, to a degree, to coordinate services for a client, such agencies generally do not have funds with which to purchase needed service.

A case in point is the Alameda County Short-Doyle mental retardation program. This program provides diagnosis and counseling as well as an information and referral service, and attempts to coordinate services for mentally retarded individuals. However, the program has no funds with which to purchase needed service.

3. THERE IS A LACK OF ESSENTIAL SERVICES IN MANY PARTS OF THE STATE.<sup>11</sup>

a. Lack of Services

The Waldo report stated:

“The capacity of all types of community special services other than special classes is so limited as to provide for the needs of only a very, very few retarded persons. Many services can only be considered to be experimental, exploratory, or demonstrational efforts at this time . . . The lack of these facilities leaves no alternative to institutionalization for many.<sup>12</sup>”

While this situation has been improved in some sections of the state during the past six years, the state hospital still remains the only place where many can turn for service.

Certain services are lacking in *all* areas. Perhaps the biggest gap in service is programs for the young adult. There is virtually nothing available for the over 18 year old retardate who may have had the benefit of public school programs until that time. An article from the Alameda-Contra Costa *MRIC Compass* states:

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11. The general term services, as used in this report, includes day care, residential care, rehabilitation services, educational services, respite care, home-making services, etc.

12. Waldo, *loc cit.*

Now that parents can expect to find programs for their school age retarded children, the lack of parallel programs for those over 18 or 21 is striking. Sheltered workshops, mainly operated by parents' organizations with a minimum of financial support from Adult Education and hardly any from the State Departments of Rehabilitation and Social Welfare, scarcely begin to serve all who leave school only to find nothing more available to them than their own homes and their TV sets. Activity programs for those not capable of sheltered workshop services are even more scarce.<sup>13</sup>

This lack of resources in the community, particularly for the young adult, results, to a large extent, from the lack of funds, both for the development of new services and for the purchase of care from existing programs. The dearth of programs also stems from the lack of planning and coordinating activities to determine where services are necessary and to coordinate client needs with services available.

**b. Rates Paid to Private Facilities**

Another problem which impedes the development of certain services stems from the confusion regarding the rates paid to private institutions. There are two reasons for the confusion:

**Fragmentation of rate-setting authority.**

Several state departments are involved in the rate-setting. The Health and Safety Code designates the Secretary of Human Relations as the agency responsible for setting rates, the Governor's Reorganization Plan (No. 1) gives this same authority to the Department of Mental Hygiene; and the Department of Public Health, as the Administrator of the Regional Center Program is also involved in the process. In actual practice, it appears that the Department of Finance, in exercising its broad powers under the Government Code, plays the primary role in rate setting. This fragmentation has confused vendors of service and others as to who has the final authority at the state level. It is difficult to fix responsibility and the vendors of service are passed from one agency to another when they attempt to negotiate rates.

**Lack of a uniform rate-setting policy.**

There is no uniform method of determining rates to be paid to vendors of service. Rates are arrived at by negotiation between the vendor and the several state departments involved in rate-setting.

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13. Quoted in: (San Francisco Coordinating Council on Mental Retardation), *MR Coordinator*, January, 1969, p. 4.

When such negotiations are taking place, the Department of Finance or the Secretary of Human relations will often request the vendor to submit a cost statement for analysis. Since the State does not have an established "cost plus" policy this cost statement is then used for further negotiations rather than as a uniform basis for establishing a rate.

The method of establishing rates solely through negotiation has resulted in inequities whereas a policy of "cost plus" or some other uniform method of determining rates would result in a more uniform, equitable rate scale.

The result of this confusion and lack of a clear policy tends to discourage the private sector from initiating and expanding community-based resources. The financial risks are simply too great to attract the capital required to construct facilities and initiate programs.

#### 4. THERE IS EXCESSIVE RELIANCE ON THE STATE HOSPITAL SYSTEM

Poor use of the state hospital results from all of the difficulties previously mentioned and affects two groups of retarded persons at the present time: those who are now being inappropriately placed in the state hospital because no community placement can be arranged for them and those who are living in the state hospital who could be more properly served in the community.

##### a. The State Hospital as a Place of First Resort

The lack of awareness of community alternatives and the lack of available community services and funds for their purchase have produced a situation where the state hospital seems the *only* alternative for many. Steven A. is a perfect example — his father was no longer able to provide the supervision he required and, lacking knowledge of community services, he took steps to have him placed in the state hospital. Fortunately, in Steven's case his teachers were interested enough to attempt to assist his father in finding community placement. In this case, even though Steven could do well in the community, the hospital staff seemed to be bringing subtle pressure to bear in favor of state hospital admission. The following is a quote from a letter from a state hospital staff member to a Santa Cruz County Social Worker written in regard to Steven A.:

It seems to me that those of you who are involved with Steven, particularly the father, are going to have to decide whether to take advantage of the course that is open (i.e., admission to Agnews) or gamble that some, as yet unknown, source of funds for that particular placement will become available. This does seem unlikely.

Though this is only one case, involving one State hospital, this statement raises questions concerning the extent to which parents may be influenced by such comments when determining whether or not to place a child in the state hospital and when determining whether to return a child from a state hospital into the community. We believe it would be very useful to conduct a study of the factors which influence the decisions that families make.

b. **Those Who Could Be Returned to the Community**

In addition to the fact that persons are still being placed in the state hospital for lack of readily available community services, the Department of Mental Hygiene has confirmed the fact that there are still many who are now in state hospitals who could be served in the community, despite the fact that severe overcrowding of state hospital facilities exists.<sup>14</sup>

According to the Department of Mental Hygiene, as of January 1969, the following numbers of state hospital mentally retarded patients are improperly placed:<sup>15</sup>

Total state hospital mentally retarded population . . . . .	13,000
Those who could be placed in nursing homes (require some medical attention) . . . . .	1,267
Those who could be placed in non-medical residential facilities . . . . .	2,799
Total who could be placed in community . . . . .	4,066
Percent of total mentally retarded state hospital population who could be be placed in community . . . . .	31%

The Community services Division of the Department of Social Welfare is responsible for the placement of persons on leave from the state hospitals. The placement referral process may be divided into four phases:

1. In-hospital identification of persons who may be considered appropriate for placement.
2. Referral of those persons so identified to the Community Services Division with placement needs information.
3. Identification and location of appropriate resources for the person in the community by the Community Services Division.
4. Placement by the Community Services Division's Psychiatric Social Worker.

The Community Services Division indicated that as of December 1968 approximately 205 mentally retarded patients had been referred by the state hospitals for whom the Division was pursuing placement planning as evidenced by its having opened the case on a "prerelease" basis.

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14. See Appendix E.

15. See Appendix F, for breakdown by hospital.

The Community Services Division has four placement programs for the mentally retarded:

1. **Family Care** – Care in Social Welfare licensed homes for which \$150.00 is paid per month.
2. **Out-of-home Placement Program** – Utilizes other funding available to the patient (e.g., Public Assistance, Private and State) for his placement in community licensed facilities, boarding homes, residential hotels, etc., for those persons capable of sustaining themselves under minimal care and supervision with the aid of the full range of follow-up services of the Community Services Division.
3. **Private Institutions at State Expense** – A specialized program for the community placement of retarded persons into total care licensed facilities in lieu of maintaining them in state hospitals. The majority of these persons are placed in facilities licensed by the State Department of Mental Hygiene (type “N” facilities).
4. **Special Employment Services Program** – Offers training in protected settings (such as sanatoriums and ranches) to those retarded patients who are capable of becoming either self-supporting or partially self-supporting.

In addition, the Division services some 873 (December 1968) mentally retarded patients who are living in their own homes.

The Division had the following numbers placed in these programs as of December 1968:<sup>16</sup>

Family Care <sup>17</sup>	–	2,566
Private Institution	–	368
Special Employment	–	44

Even though the Community Services Division is able to make community placements at considerably less cost than maintenance in the state hospitals,<sup>18</sup> large numbers remain in the state hospitals who could be more properly placed in the community. There appear to be three major factors accounting for this problem:

#### **Lack of Funds**

The Community Services Division is limited in the number of persons whom it can place by the funds budgeted for the purchase of certain types of service. The greatest lack is in funds for placement in private institutions. In 1968-69, \$912,950.00 was originally budgeted for the care of 300 patients in the private institutions program. The program experienced unanticipated rapid growth the first six months of the year to its current level (368 cases) and expansion has been somewhat curtailed due to this additional growth. Recognizing this problem, the Governor authorized \$275,000.00 to be transferred from family care funds to the program to provide sufficient funds for the remainder of the year.

16. See Appendix G.

17. This represents an increase of 200 over the number of patients in the Program at the end of the last fiscal year. The Division places into family care an average of 63 mentally retarded persons from state hospitals per month.

18. See Appendix H.

## **Lack of Resources**

There is a lack of community placement resources in some areas of the state, particularly for certain types of more difficult placements. Community placements are lacking for the teen-age mentally retarded, particularly for boys.

While the statewide availability of community residential placements seems adequate to meet current needs for the less difficult cases, if substantially larger numbers of persons were moved from the state hospitals, these resources would be rapidly depleted.

Since it takes a period of two or three months to develop additional Family Care homes (due to the need to recruit, certify and train new caretakers), the need for this type of placement often outpaces the resources available.

In addition, there are problems in developing community placement facilities in some locations because of zoning restrictions. A recent attempt to permit family-care type facilities in single-family residence neighborhoods in San Francisco met with vehement opposition from homeowners.<sup>19</sup>

## **Resistance of Parents**

Another factor influencing the lack of movement from the state hospitals may be resistance on the part of parents. Many parents seem unwilling to accept the uncertainty which results when their child is removed from the state hospital. When the child is in the hospital, the parent is assured of a certain level of lifetime care, outside, he is not certain.

Discussions with parents have also indicated that it is not only the uncertainty of community care which bothers them. It is the feeling of many parents that the supervision of retarded persons placed in community facilities is not adequate, and they are hence reluctant to permit their child to be placed. Although there have been numerous evaluations of the quality of care in state hospitals, little has been done to systematically study the adequacy of community programs and we believe that such an evaluation would be useful.

### **5. THERE IS A LACK OF EFFECTIVE COORDINATING AND PLANNING ON BOTH REGIONAL AND STATE LEVELS PLANNING ON BOTH REGIONAL AND STATE LEVELS**

#### **a. State Planning**

There currently exists no mechanism for effectively planning and coordinating programs for the retarded at the state level. Priorities cannot be established since various programs for the mentally retarded are contained in the budgets of several departments and hence are considered as part of a departmental budget rather than as part of an overall program budget for the retarded.

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19. See Appendix I.

One of the major problems now existing is the lack of statewide planning:

In the search for means of filling these and other gaps, we find a lack of statewide planning. Our hopes of 1965 that the work of the State Study Commission on MR would lead to a comprehensive Master Plan and clearly defined coordination among the several agencies serving the retarded have not materialized. Thus, the greatest gap of all is seen in the lack of a plan of how the Legislature, the Departments of Mental Hygiene, Public Health, Rehabilitation, Social Welfare, Education and Employment will each play a role in developing the services which can close the many current gaps.<sup>20</sup>

The Legislative Analyst's Report also notes that:

At the present time, and for the past year, the Secretary for Human Relations has himself been acting as coordinator [Coordinator of Mental Retardation Programs] with staff being supplied on an "as available" basis. This fact, combined with the relative impotence of the Mental Retardation Program Advisory Board, has resulted in minimal coordination and relatively unrelated development of mental retardation programs. <sup>21</sup>

**b. Regional Planning**

The situation is no better on the local level. Even though many counties now have coordinating councils, these do not exist in all counties and even in those counties where they do exist, they vary greatly in their ability to develop new services and coordinate existing ones.

The major problem relating to the provision of all types of services to the retarded is a lack of coordination and communication among the public and private agencies rendering such services.<sup>22</sup>

**6. THERE IS A WIDE DISPARITY AMONG FEES IMPOSED UPON PARENTS OF RETARDED CHILDREN DEPENDING UPON WHERE THE CHILD IS RECEIVING SERVICE, THUS RESULTING IN INEQUITIES.**

Fees paid by parents of retarded children vary greatly depending upon whether the child is receiving care through a state, county, or private agency. Additionally, fees vary even among programs provided by state departments. Currently, parents have no obligation to the state for any portion of the cost of care if their mentally retarded child is being treated in a state hospital. The county, however, is obligated to pay \$20.00 per month for every retarded patient in a state hospital or on leave from a state hospital regardless of the age of the patient. Many counties in turn collect this \$20.00 from the parent, so that parents of children receiving treatment in a state hospital or on leave from a state hospital pay a maximum of \$20.00 per month to the

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20. MR Coordinator, *January 1969*, p. 4.21.

21. *Budget Analysis*, p. 946,

22. *Mooring and Currie, op cit*, p. 1.

county.<sup>23</sup> The law, however permits a charge of up to \$40.00 per month, if this were made the monthly fee for the state hospital. The parents of a child being treated through the regional center pay on a voluntary basis according to their ability and desire to contribute. Depending upon their means, they may and many do pay far in excess of \$20.00 per month. We find no sound explanation for this disparity.

7. FULL ADVANTAGE IS NOT BEING TAKEN OF ALL SOURCES OF FEDERAL FUNDS AVAILABLE FOR SERVICES TO THE RETARDED.

First, the State is not taking maximum advantage of the broad provisions of the Social Security Amendments of 1967 (P.L. 90-248) which permit the expanded use of federal welfare funds for mental retardation activities. Under this law, matching funds can now be made available for services to "potential welfare recipients" as well as those already directly receiving public assistance benefits.

An estimated two-thirds of the existing caseload in the regional diagnostic centers can be categorized as "potential welfare recipients".

Another source of federal funding which can be utilized is Federal Comprehensive Health Planning Funds authorized by P. L. 89-749. Under this law funds are available for planning functions at the state and local level, for direct services to the retarded, and for special studies and demonstration projects. Currently, none of the funds available under this law are being used for mental retardation programs.

8. OTHER PROBLEMS

A variety of other problems were uncovered in the course of this study. Such problems include: fees paid to private facilities by various public agencies vary; licensing standards for private facilities vary according to the licensing agencies; standards of care in the state hospitals have been criticized; and the transformation of state hospitals for the Mentally Ill into facilities for both the mentally ill and the mentally retarded is being questioned. In view of the time limitations faced by the Committee in conducting this project, these issues were not included within the scope of this study. The project has focused on certain structural problems in the state system, and the proposals for legislation do not attempt to resolve a wide variety of other important issues.

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23. See Appendix J, for report of revenue to DMH Mental Retardation Program.

## CHAPTER III

### YOU CAN GET THERE FROM HERE: PROPOSED SOLUTIONS

#### PROGRAM

1. IT IS PROPOSED THAT WITHIN THE NEXT FEW YEARS THE STATE WILL FULLY IMPLEMENT THE POLICY ADOPTED IN 1965 WHICH PROPOSED THE ESTABLISHMENT OF A STATE-WIDE NETWORK OF REGIONAL CENTERS FOR THE MENTALLY RETARDED.

The network of Centers will provide in all areas of the state a focal point for mental retarded persons needing special services. With assistance from the Centers, it will be possible for retarded persons and their families to receive continuous, lifetime help. The Centers will, in addition, be given new responsibilities to eliminate the lack of continuity in service, coordinate fragmented services, and develop needed services on a priority basis.

#### A. Regional Center Responsibility

Regional Centers will be responsible for the provision of **diagnosis, counseling, referral, purchase of service and guardianship** for those retarded persons who are unable, without the professional help and assistance of the Regional Centers, to receive the care, training and supervision they require.

#### B. Screening for State Hospitals

The Regional Centers will be required to do all screening for admission to the State Hospitals for the Mentally Retarded. They will also assume responsibility for securing care for persons leaving the state hospitals.

The Regional Centers will thus serve as the *only* point of entry to and egress from the state hospitals. Regional Centers will utilize the state hospital system for placement in the same way they utilize other service resources and state hospitals will, in effect, become vendors to the Regional Centers. To the fullest extent feasible, state funds now allocated to state hospitals for the retarded will be allocated to Regional Centers which will contract with appropriate agencies, including state agencies, for the provision of out-of-home placement.

As a central referral and purchasing agent for mental retardation services, the Regional Center will explore every alternative for care available both within and outside of the region. The option most likely to attain the desired goal at the least possible cost shall be chosen. Only those persons who need the specialized medically-oriented services of the state hospital will be placed there.

**C. Pre-Hospital and After-Care Placement**

As the focal point for mental retardation services the Regional Centers will assume responsibility for purchasing out-of-home pre-hospital care and post-hospital (after-care) services for the retarded.

To the fullest extent feasible, state funds now allocated to the Department of Social Welfare for this purpose will be allocated to Regional Centers which will contract with appropriate agencies for the provision of all out-of-home services.

For the present, the Regional Centers can contract with the Department of Social Welfare (Community Services Division) for placement services, and secure the Federal matching funds which are available through the Department of Social Welfare. Efforts should be made to implement the new federal policy permitting the waiver of the single state agency requirement (Intergovernmental Cooperation Act of 1968). When this policy is implemented, the same amount of federal support will be available if agencies other than Social Welfare are used to perform this same placement service.

These proposals are intended to give the Regional Centers the maximum flexibility to utilize the best possible program for each retarded person. The Centers should not be forced to use any single program to provide residential, foster care, hospital or other services.

Wherever possible the Centers should *contract for services* of a long term nature, including case management, rather than attempting to provide such services themselves. The Centers should devote their energies to solving the problems of new patients while maintaining a "guardianship" concern for long term cases and supervising the quality of services provided by contracting agencies.

As a focal point, the Centers should not duplicate the services of other agencies but should utilize them to the fullest extent. Whenever possible the Centers should contract agencies (i.e. Short-Doyle, Health & Welfare Departments), private agencies, and state agencies. The Centers should, endeavor to utilize the services of volunteers for such duties as maintaining guardianship and visiting facilities to ascertain the conditions there.

**D. Regions**

Regions will be designated by the State Department of Public Health for the purpose of Regional Centers. These regions will, whenever possible correspond with Comprehensive Health Planning regions.

**E. Standards**

Statewide standards for Regional Centers shall be set by the State Department of Public Health. These shall include requirements for all agencies acting as contractors, the operation of the Centers, parental fee schedules, and other general policy matters.

**F. Regional Center Contracts**

Regional Centers may be operated under contract by private or public agencies, including county agencies through existing programs. Regional Mental Retardation Program Boards will recommend the most appropriate agencies to perform the Regional Center tasks\* in each area and will be responsible for the selection of a Regional Center agency subject to the approval of the Department of Public Health. In no case may there be more than one Regional Center agency in a region, although there may be several locations at which Regional Center services are provided and one or more sub-contractors to the Regional Center Agency who provide Regional Center services.

**PLANNING**

**2. IT IS PROPOSED THAT PLANNING FOR MENTAL RETARDATION SERVICES BE REQUIRED ON THE REGIONAL AND STATE LEVEL.**

The Regional Center program will be planned for and funded on a regional basis through contracts between the Department of Public Health and a Regional Mental Retardation Program Board (a Joint Powers Agency) to be formed in each region.

In multi-county regions, counties will join together in joint powers agreements for the purpose of planning for mental retardation services and supervising the operation of Regional Centers. The joint powers agency will have a Board with representation from each participating county, the members to be appointed by each county Board of Supervisors. This Board will function in three capacities:

1. It will be the Mental Retardation Program Board and will be *responsible for operating the Regional Center* either directly or by contract.
2. It will be the mental retardation planning body for the region and will *develop a regional plan* for mental retardation services, including but not limited to Regional Center activities.
3. Each Regional M. R. Program Board will also act as a sub-unit of the Comprehensive Health Planning body for its region and Federal (Comprehensive Health Planning) funds will be used for the required planning activities of the Board.

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\* Diagnosis, counseling, referral, purchase of service, guardianship.

**A. The Regional Plan**

The regional plan will indicate the services required by retarded persons in the region, the number of persons needing such services, the available service resources, priorities for the development of needed services, anticipated costs and revenues.

The regional plan may include individual county plans which have been submitted to the Regional Mental Retardation Program Board.

Regional and county mental retardation planning bodies shall also have the responsibility for coordinating existing programs and developing new services as required.

Regional mental retardation plans will be submitted to the State Department of Public Health for approval and transmission to the State Comprehensive Health Planning Council and may be incorporated as part of the California Comprehensive Health Plan, after having been approved by the State Mental Retardation Program Board.

**B. State Program-Planning Budgeting**

The Human Relations Agency will also be required to develop a statewide plan and a total program budget for services to the mentally retarded which crosses over departmental lines. To the fullest extent possible, funding for services to the retarded would be based upon this program budget rather than separate appropriations for each department.

These requirements for budgeting and planning will establish a system whereby coordination can be achieved and priorities established. This proposed system should meet the requirements called for by the Legislative Analyst who said:

Regardless of where the authority to coordinate mental retardation services is placed, the coordinating agency must be given the power to develop and implement a realistic and viable program for the efficient rendering of these services. This will require the administration and the Legislature to work together in the formation of an overall plan for the development of an efficient program. This plan must include the establishment of priorities so that the expenditure of the state's resources, now approaching \$160 million annually, is accomplished on a basis that best benefits not only the mentally retarded, but all the citizens of the state. The present expenditure of \$43 million for special education at a time when graduates from special education classes cannot find employment because of lack of facilities is unrealistic. The continued provision of high-cost institutional care for persons who would be better suited for lower cost community-based services requires a reassessment of priorities.<sup>24</sup>

In developing the state plan and program budget, the Human Relations Agency will be required to consult with the departments involved and will, in addition, be required to seek the advice of the Statewide Mental Retardation Program Board.

Ultimate responsibility for the coordination of mental retardation services will rest with the Secretary for Human Relations.

**C. The Statewide Mental Retardation Program Board**

The present Mental Retardation Program and Standards Board will be reorganized to include as voting members only private persons, with representatives of the state departments and other agencies acting as vendors of service serving only in an advisory capacity to the Board.

The Board will be broadly based with representatives of the various disciplines serving the retarded, parents of the retarded, and the general public.

The Statewide Mental Retardation Program Board will also be a sub-unit of the State Comprehensive Health Planning Council. The Board should advise and make recommendations to the Comprehensive Health Planning Council regarding all planning, construction, service, and demonstration projects affecting the mentally retarded.

The Board will also be advisory to the Human Relations Agency, the Governor, and the Legislature. The Board will have the responsibility for making recommendations regarding the state plan for mental retardation services as well as all other matters concerning mental retardation.

**FINANCING**

3. THE REGIONAL CENTER PROGRAM SHALL BE FUNDED BY THE STATE ON A REGIONAL BASIS WITH A MAXIMUM OF AVAILABLE FEDERAL FUNDING.

FAMILY PARTICIPATION IN THE COST OF SERVICES PROVIDED TO MINORS SHOULD BE MADE EQUITABLE.

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24. *Analysis of the Budget Bill*, p. 946.

COUNTY PARTICIPATION SHOULD BE LIMITED TO A MAXIMUM OF \$20 PER MONTH FOR ALL OUT-OF-HOME CARE PURCHASED BY REGIONAL CENTERS, AND ONLY IN CASES WHERE FAMILIES ARE UNABLE TO CONTRIBUTE THIS AMOUNT.

**A. State Funding**

State funds for Regional Centers will flow through the State Department of Public Health to each Regional Mental Retardation Program Board.

**B. Family Participation in Cost of Service**

Families of children under the age of 18 who are receiving out-of-home services purchased by the Regional Center, will be required to contribute to the cost of services depending upon their ability to pay, but not to exceed the cost of caring for a normal child at home.<sup>25</sup> Fees charged to families will be as flexible as possible and will take into account any unusual family expenses that have resulted from the cost of providing services for a retarded child, as well as continuing family expense related to the child's card.

Family contributions will be made *only* to the Regional Center and the fees will be the same in all counties and whether the child is placed in the state hospital or in a public or private community facility. Such additional fees collected shall be used to expand the services available to the retarded.

**C. County Participation in Cost of Service**

Counties will be required to pay *no more than \$20.00 per month* for each person receiving purchased out-of-home care through the regional center regardless of whether a state hospital or non-state facility is providing the service, unless this amount has been paid by the parent. Counties will not be required to pay for those persons living in their own homes and receiving some purchased service or those receiving only the staff services of the Regional Center.

At present, counties are required to pay the state \$20.00 per month for every patient the county has placed in the state hospital. The counties in turn collect from the parents of these patients. Under the proposed plan, counties will be spared the administrative expense of collecting from parents. Counties will be billed for cases under 18 years of age only when the families are unable to pay at least \$20.00 per month.

**SUMMARY**

Although the proposals offered in this report will certainly not solve all the problems of fragmentation, they do seem to constitute a logical "next step" in the development of a more rational approach. If the proposals are adopted, California will have established a mental retardation *system*.

25. Department of Mental Hygiene, *Charges to Parents of Mentally Ill and Mentally Retarded Minors in the State Hospitals*, Program Review Unit Project No. 35, December 4, 1968.



A P P E N D I X



OFFICE OF THE DIRECTOR



STATE OF CALIFORNIA  
**Department of Public Health**

2151 BERKELEY WAY  
BERKELEY, CALIFORNIA 94704

February 27, 1969

Arthur Bolton, Director  
Office of Research  
California State Legislature  
State Capitol, Room 3173  
Sacramento, California 95814

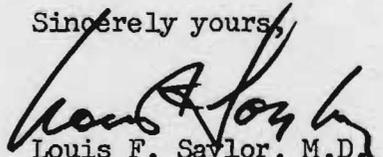
Dear Mr. Bolton:

This is in response to your letter of February 25, 1969 requesting data concerning the Regional Center program.

I am sending you the attached statistics which are for fiscal years 1966-67 and 1967-68. They are taken from a biennial report which is about to be published. We have not included in this report the number of persons who could not be served due to lack of funds; however, we have estimated that as of January, 1969 the Los Angeles Childrens Hospital and Golden Gate Regional Centers have a list of approximately 975 clients who are being provided some staff services but who would be provided additional services if additional funds were available.

If you desire any further information, please let me know.

Sincerely yours,

  
Louis F. Saylor, M.D.  
Director of Public Health

Attachments

cc: Spencer Williams

BUREAU OF MENTAL RETARDATION SERVICES STATISTICS  
FOR FISCAL YEARS 1966-67 AND 1967-68

Introduction

The statistics contained in this report represent those for the first two full fiscal years of operation, July 1 to June 30, 1966-1967 and 1967-1968, for the two Regional Centers which were initiated in January 1966. During June 1966 the Regional Centers provided services to 165 persons and/or families. One year later, June 1967, the number had risen to 559, and during the last month of the second full fiscal year of operation, June 1968, to 770 persons. During this period the Centers increased staff and caseload to the point where they have reached their budgetary maximum.

Population Served

During the first 30 months of operation there were 2,898 requests for Regional Center assistance made on behalf of persons known to be, or suspected of being, mentally retarded. Of these, 1,003 were registered in the central registry as appropriate cases for Regional Center services. Four out of five of these individuals (770) received services during the last month of this report, June 1968. Fifteen cases were closed during the first 30 months of Regional Center operation; four were found to be not mentally retarded and eleven deceased.

The 1,003 persons represent those who were accepted for more intensive services and who added to the statistical registry of the Bureau. Many of the 2,898 whose names were not added to the registry were given a substantial service consisting of an exploration of the nature of their problem by staff and referral to an appropriate agency. Statistics are related to the number who received a service in any one month. There is a continuing process of case activation and inactivation which was not measured by the statistics collected during the years reported.

The type of residence of the 1,003 cases was determined at the time of first interview. Three out of four (760) of the retarded persons resided with their parents; 156 were in a residential facility; 24 in a foster home; 18 in other living arrangements, and 45 for whom this item was not reported. Of these cases 507 were on one of the waiting lists for state hospital placement; 257 were on active waiting lists, that is,

the parents or guardians were requesting hospital placement, and 250 were on the deferred waiting lists. This latter group included those whose parents were not seeking immediate hospital placement because the parents were maintaining their retarded family member in the community in preference to hospitalization but wished to remain on a waiting list.

The Centers provided one or more of the following services to 770 individuals and/or families during June 1968: diagnosis, counseling, purchased service and/or registration for the purpose of guardianship. Three out of five (457) were receiving a purchased service, that is, a service purchased from a provider of care certified by the administrator of the Health and Welfare Agency.

Appendix Tables 1 and 2 review the services purchased during 1966-67 and 1967-68. During 1966-67, 471 cases received one or more purchased services at some time during the year, and in 1967-68, 589 received such services. The major purchased service was residential care which was provided for about 55% of the cases in 1966-67 and 52% in 1967-68. About 35% of the cases received professional services in each of the two years. Many of the families received services from other agencies or paid for services themselves. For example, one in eight individuals received physician's services which were paid for by the Regional Centers during 1967-68. It is assumed that many more received medical care because of the health needs of this group and the requirements for periodic preventive examinations.

Since the Centers were increasing their caseloads during the two years covered by this report, it is not possible to estimate costs on a case year basis. Case-months of care is used instead, and costs are related to monthly average rather than an annual average. The case-months of care provided represent the time period starting when a case was classified as an active case and ending at the close of the fiscal year or the time when a case is inactivated or closed. Thus a case that receives counseling throughout the fiscal year represents 12 case-months of care. A case which became active on February 1, 1967 and continued to be active through June 30, 1967 would represent five case-months of Center services. The months are not rounded but are calculated to the exact date when the Center initiated services. For recording purchased services only those months in which a service is purchased are counted. For professional services a full month was counted, however, even if the service was rendered on only one day of the month as the best basis for planning future budgets and Centers.

The combined expenditure for the Regional Centers for Center personnel and services are listed below:

	<u>Fiscal Year 1966-67</u>	<u>Fiscal Year 1967-68</u>
Total	\$ 369,753	\$ 480,743
Diagnosis and Counseling	313,220	407,832
Administration	56,533	72,911

The total case-months of care provided were 4189.5 in 1966-67 and 7417.5 in 1967-68. The average costs per case-month for diagnosis and counseling were \$74.78 in the first year and \$54.99 in the second. The costs of administration per case-month were \$13.50 the first year and \$9.83 the second. This represents the costs of administrative personnel and services and the time professional personnel spent in administrative duties.

Decreases in the average monthly expenditures in the 1967-68 year were due to the increase in caseload. It is necessary to recruit and train personnel before the caseload can be increased hence the relatively higher costs in the beginning years. There is also a greater amount of time spent in informing the community about services at the onset of a program.

The average monthly State expenditures per case-month of cases who received a purchased service were:

	<u>Fiscal Year 1966-67</u>	<u>Fiscal Year 1967-68</u>
Total	\$ 223.76	\$ 195.52
Purchase of Services <u>1/</u>	135.48	130.70
Counseling and Diagnosis	74.78	54.99
Administration	13.50	9.83

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1/ Less family reimbursements.

Forty percent of the families received no assistance other than diagnosis and counseling. The cost per case-month of these services was \$88.28 in 1966-67 and \$64.82 in 1967-68. Family reimbursements for purchase of services amounted to \$6.90 per case-month in 1966-67 and \$7.99 in 1967-68. In addition families assumed the obligation for necessary services and paid for them directly. No record was kept of these services.

AVERAGE MONTHLY COSTS OF PURCHASED SERVICES BY TYPE  
Regional Center Program, Fiscal Year 1966-67

	No. of active cases	Case-months of purchased services	Expenditures	Average per month	Percents	
					Cases	Expenditures
<u>TOTAL</u>	<u>471</u>	<u>2,505.33</u>	<u>\$ 596,352.80</u>	<u>\$ 238.03</u>	<u>100 %</u>	<u>100 %</u>
Residential Care, Total	257	1,878.57	526,728.95	280.39	54.6	88.3
Resident Schools	127	831.28	250,416.33	301.24	27.0	42.0
Nursing Care Facilities	81	609.21	154,774.62	254.06	17.2	26.0
Residential Facilities	40	294.62	75,514.04	256.31	8.5	12.7
Rehabilitation Centers	21	76.08	32,838.23	431.63	4.5	5.5
Family Care Homes	13	67.38	13,185.73	195.69	2.8	2.2
Day Care	43	171.35	16,671.05	97.29	9.1	2.8
Workshops	54	178.18	14,702.56	82.52	11.5	2.5
Camps	101	35.11	6,205.25	176.74	21.4	1.0
Respite Care	18	57.38	3,627.24	63.21	3.8	0.6
Professional Care, Total	164	449.18	24,119.08	53.70	34.8	4.0
Physicians	79	168.18	5,733.91	34.09	16.8	1.0
Psychologists	49	50.50	2,121.50	42.01	10.4	0.4
Pharmacies	40	178.00	2,321.48	13.04	8.5	0.4
Hospitals	38	56.00	7,394.53	132.05	8.1	1.2
Clinical Laboratories	23	26.00	1,361.70	52.37	4.9	0.2
Dentist	18	27.00	2,222.22	82.30	3.8	0.4
Homemaker Programs, Home Health Agencies	8	14.14	1,590.44	112.48	1.7	0.3
Occupational Therapists	2	5.00	217.75	43.55	0.4	*
Physical Therapists	2	3.00	146.00	48.67	0.4	*
Clinics	2	3.00	135.50	45.17	0.4	*
Dispensing Opticians	2	2.00	46.80	23.40	0.4	*
Speech Therapists	1	1.00	17.25	17.25	0.2	*
Social Workers	1	6.00	600.00	100.00	0.2	0.1
Private Nurse Practitioners	1	2.00	180.00	90.00	0.2	*
Speech and Hearing Centers	1	2.00	30.00	15.00	0.2	*
All Other	27	82.55	4,298.67	52.07	5.7	0.7

\* Less than 0.1%

Note: Since more than one type of service was provided some clients during a given month only the expenditures will add to the totals shown.

SDPH-BMRS  
112668

AVERAGE MONTHLY COSTS OF PURCHASED SERVICES BY TYPE

Regional Center Program, Fiscal Year 1967-68

	No. of active cases	Case-months of purchased services	Expenditures	Average per month	Percents	
					Cases	Expenditures
<u>TOTAL</u>	<u>589</u>	<u>4,248.68</u>	<u>\$1,028,608.73</u>	<u>\$ 242.10</u>	<u>100 %</u>	<u>100 %</u>
Residential Care, Total	307	2,969.15	890,542.84	299.93	52.1	86.6
Resident Schools	140	1,293.65	421,984.22	326.20	23.8	41.0
Nursing Care Facilities	80	768.22	218,885.60	284.93	13.6	21.3
Residential Facilities	70	680.96	195,428.18	286.99	11.9	20.0
Family Care Homes	23	158.00	34,371.54	217.54	3.9	3.3
Boarding Home Facilities	5	58.00	15,125.00	260.78	0.8	1.5
Rehabilitation Centers	3	0.66	343.60	520.61	0.5	*
Children's Treatment Centers	2	9.66	4,404.70	455.97	0.3	0.4
Day Care	134	710.10	67,880.29	95.59	22.8	6.6
Workshops	10	93.13	6,783.70	72.84	1.7	0.7
Camps	58	17.75	3,848.07	216.79	9.8	0.4
Respite Care	40	187.00	10,491.70	56.11	6.8	1.0
Professional Services, Total	205	862.18	41,436.44	48.06	34.8	4.0
Physicians	98	228.00	6,627.00	29.07	11.9	0.6
Psychologists	44	50.00	2,328.50	46.57	7.5	0.2
Pharmacies	42	307.60	4,450.58	14.47	7.1	0.4
Hospitals	31	38.00	4,703.91	123.79	5.3	0.5
Homemaker Programs, Home Health Agencies	17	94.44	12,602.39	133.44	2.9	1.2
Dentists	17	25.00	2,188.37	60.48	2.9	0.2
Clinical Laboratories	16	16.00	1,080.35	67.52	2.7	0.1
Nutritionists	9	25.00	437.88	17.52	1.5	*
Physical Therapists	5	26.00	1,199.60	46.14	0.8	0.1
Speech Therapists	5	20.00	426.80	21.34	0.8	*
Private Nurse Practitioners	3	14.14	3,447.68	243.82	0.5	0.3
Speech and Hearing Centers	2	2.00	36.00	18.00	0.3	*
Occupational Therapists	1	9.00	1,590.00	176.67	0.2	0.2
Social Workers	1	4.00	220.00	55.00	0.2	*
Optometrists	1	1.00	32.50	32.50	0.2	*
Orthotists and Prosthetists	1	1.00	49.88	49.88	0.2	*
Orthoptic Technicians	1	1.00	15.00	15.00	0.2	*
Occupational Therapists	1	9.00	1,590.00	176.67	0.2	0.2
All Other	43	135.13	7,625.69	56.43	7.3	0.7

\* Less than 0.1%

Note: Since more than one type of service was provided some clients during a given month only the expenditures will add to the totals shown.

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112668

ESTIMATED REGIONAL CENTER CASELOAD, AVERAGE MONTHLY COST OF CARE PER CLIENT, AND TOTAL ANNUAL PROGRAM COST, 1969-70 THROUGH 1974-75, BY YEAR.

<u>Year</u>	<u>Estimated Regional Center caseload</u> <sup>a/</sup>	<u>Average monthly cost of care</u> <sup>b/</sup>	<u>Total annual expenditures</u>
1969-70	2,820	\$224.37	\$ 7,592,680.80
1970-71	3,516	235.59	9,940,013.28
1971-72	4,213	247.37	12,506,037.72
1972-73	4,910	257.74	15,303,880.80
1973-74	5,605	272.73	18,343,819.80
1974-75	6,302	286.37	21,656,444.58

<sup>a/</sup> Presumes a linear program expansion of the two original Regional Centers based on the growth of the program from June, 1966 through June, 1968 with an additional increment, based on the relation of staff sizes, added to the caseload of the Los Angeles Childrens Hospital Regional Center, by the assignment of the functions of the Van Nuys Pre-admission Unit to that Center. It also presumes that the caseload increase throughout those portions of the State not covered by the two original centers will increase in relationship of the population in the unserved to the population served during 1967-68. Ten percent of the total projected caseload is assumed to be over 17 years of age and receiving ATD. This 10% has been deducted from the estimates.

<sup>b/</sup> Includes purchase of services, counseling, diagnosis, and administrative expenses. Average monthly expenditure of 1967-68 has been increased by an annual increment of 5% each year to obtain these figures. Parent reimbursements have neither been estimated nor deducted.

ESTIMATES OF THE NUMBER OF MENTALLY RETARDED IN CALIFORNIA WITH INTELLIGENCE QUOTIENTS OF LESS THAN 55 AND THE NUMBER BEING CARED FOR IN REGIONAL CENTER AND OTHER SELECTED PROGRAMS, 1969-70 THROUGH 1974-75, BY YEAR.

<u>Year</u>	<u>Total a/</u> <u>(IQ 0-54)</u>	<u>Regional Centers b/</u>	<u>Other programs c/</u>
1969-70	66,660	2,820	34,764
1970-71	68,376	3,516	35,659
1971-72	70,092	4,213	36,554
1972-73	71,808	4,910	37,449
1973-74	73,542	5,605	38,344
1974-75	75,240	6,302	39,239

a/ Retardation estimates assume that 3% of the total population is mentally retarded and that, of these, 11% (0.33% of the total population) have IQ's of under 55 (6% moderately retarded, IQ 40-54; 3.5% severely retarded, IQ 25-39; 1.5% profoundly retarded, IQ 0-24). These estimates were obtained from MR 67: A First Report to the President on the Nation's Progress and Remaining Great Needs in the Campaign to Combat Mental Retardation. For the purposes of this report it was presumed that all retardation attributable to socio-environmental and/or psychological factors would be classified as mild or borderline.

b/ See Footnote (a) of Table 1 for assumptions underlying these estimates.

c/ Includes State hospital patients, patients in post-hospital placement, and persons receiving ATD. Estimates are based on actual and estimated numbers of persons under care in these programs during 1967-68, 172.1 per 100,000 total State population.

Note: California population data used for the projections in this table were obtained from the State Department of Finance.

ANALYSIS OF THE BUDGET BILL, 1969 - 1970

Estimated Cost and Caseload of State-Supported Services for the Mentally Retarded

	1967-68	1968-69	Caseload July 1, 1968
<i>Department of Mental Hygiene</i>			
In-hospital services—full range of medical and social services in four hospitals for the mentally retarded and mental retardation units in five hospitals for the mentally ill-----	\$58,439,543	\$65,242,046	12,993
Neuropsychiatric institutes—conducts research into the nature, causes and treatment of mental retardation-----	1,354,153	2,400,000	--
Short-Doyle services—wide variety of in and outpatient services in 35 county programs-----	1,131,981	1,700,000	1,325
<i>Department of Public Health</i>			
Bureau of Mental Retardation and Regional Center Program—administers and provides funds to two regional centers which provide diagnostic, counseling and treatment services on contractual basis in specified areas. (Four additional centers have been authorized by the Legislature and will be in full operation during the 1969-70 fiscal year.)-----	\$1,650,352	\$2,434,868	780
Bureau of Maternal and Child Health—administers various federal special project grants which provide for research and treatment of mental retardation. Federal funds -----	633,395	624,835	--
Bureau of Crippled Children services—receives and disburses funds for treatment of crippling conditions in eligible mentally retarded. General Fund ----- Federal funds -----	\$1,123,310 404,857	\$1,351,912 415,855	
Total -----	\$1,533,167	\$1,767,767	--
Bureau of Health Facilities Planning and Construction—allocates state and federal funds to public and private agencies for hospital construction. Allocations for mental retardation facilities. General Fund ----- Federal funds -----	\$1,140,987 1,140,987	\$564,071 993,084	
Total -----	\$2,281,974	\$1,558,071	--
<i>Department of Social Welfare</i>			
Division of Protective Social Services—provides for purchase of medical and social services for mentally retarded patients on leave from state hospitals. General Fund ----- Federal funds ----- County funds -----	1967-68 \$3,041,580 2,150,082 50,441	1968-69 \$3,296,004 2,329,934 56,327	Caseload July 1, 1968
Total -----	\$5,244,103	\$5,682,765	4,369
Aid to Needy Disabled (ATD)—available to qualified mentally retarded persons over 18 years of age. General Fund ----- Federal funds ----- County funds -----	\$9,696,728 10,301,839 1,618,020	\$10,893,200 11,575,100 1,818,000	
Total -----	\$21,616,587	\$24,288,300	19,460
<i>Department of Rehabilitation</i>			
Offers wide variety of vocational rehabilitation services in cooperation with local school districts, under contract with regional centers, in state hospitals and residential centers. General Fund ----- Federal funds -----	\$500,000 1,900,000	\$661,908 1,984,373	
Total -----	\$2,400,000	\$2,646,281	2,395
<i>Department of Education</i>			
Division of Special Schools and Services—administers school programs for educable and trainable mentally retarded. General Fund ----- Federal funds -----	1967-68 \$699,622 160,000	1968-69 \$714,147 160,000	Average daily attendance
Total -----	\$859,622	\$874,147	--
School programs for educable mentally retarded. State School Fund <sup>1</sup> -----	\$30,909,223	\$32,763,776	58,308
School programs for trainable mentally retarded. State School Fund <sup>1</sup> -----	\$7,393,106	\$7,836,692	8,496
Special transportation for trainable mentally retarded. State School Fund -----	\$3,022,530	\$3,203,881	8,236
Development centers for handicapped minors—provide day care at 29 centers statewide. General Fund -----	\$2,531,500	\$3,056,500	1,020
Grand Total -----	\$140,999,236	\$156,079,013	
Recapitulation:			
General Fund -----	\$81,314,756	\$92,316,656	
School Fund (General Fund) -----	41,324,859	43,804,349	
Federal funds -----	16,691,160	18,083,181	
County funds -----	1,668,461	1,874,827	117,382 <sup>2</sup>

<sup>1</sup> Represents direct transfer from the General Fund.

<sup>2</sup> Duplications are included due to persons on more than one program.

APPENDIX-C

4548

ASSEMBLY JOURNAL

June 18, 1968

By Assemblyman Lanterman :

**House Resolution No. 372**

Relative to study of the use of facilities and programs  
in the care of the mentally retarded

WHEREAS, Significant changes are occurring in the care of the mentally retarded in California; and

WHEREAS, Two Regional Diagnostic Centers for the Mentally Retarded have been established in San Francisco and Los Angeles and it is expected that eventually these will grow into a network providing care in the community for many of the retarded who otherwise might be placed in a state hospital; and

WHEREAS, The population in the state hospitals for the mentally ill is declining and is expected to continue to decline; and

WHEREAS, Many of the hospitals for the mentally ill are now being converted into multipurpose facilities, caring for both the mentally ill and the mentally retarded; and

WHEREAS, These conversions are occurring in the absence of a long-range master plan and without legislative study; and

WHEREAS, Many questions have arisen as to what the future role of the state hospitals should be and how they might be used most efficiently while providing the best care possible for the mentally ill and mentally retarded; now, therefore, be it

*Resolved by the Assembly of the State of California*, That the Assembly Rules Committee assign to the appropriate committee for interim study the subject of the delineation of the role and responsibility of the state hospitals and of community programs for the care of the mentally retarded, including but not limited to a consideration of how the state hospitals can be most efficiently used, with the view of establishing a framework in which a master plan for the use of these various resources might be developed; and be it further

*Resolved*, That such committee is directed to submit a report of its findings and recommendations to the Assembly not later than the fifth legislative day of the 1969 Regular Session.

Resolution read, and referred by the Acting Speaker to the Committee on Rules.

APPENDIX-D

PARTIAL LIST OF PERSONS INTERVIEWED

The following individuals contributed to discussions held by the Ways and Means Committee staff during the course of this study:

Dr. Ivy Mooring, Executive Director, Mental Retardation Services Board of Los Angeles County

Dr. Richard Koch, Director, Los Angeles Children's Hospital Regional Center

Bay Area Mental Retardation Coordinating Council, with the following persons present:

Rosalind Wofsy, Council for Coordinating Services to the Mentally Retarded of Contra Costa County

Carl Verduin, Alameda County Mental Health Services

Al Taylor, Bay Area Social Planning Council, Marin County

Ed Pye, Golden Gate Regional Center

Don Miller, Department of Mental Hygiene

David Sokoloff, First Vice President, California Council For Retarded Children

Mrs. Mary Palm, District Director, C.C.R.C.

Fred Krause and Rolf Williams, C.C.R.C. staff

Dr. Gunnar Dybwad, Professor of Humanities, Brandeis University

Golden Gate Regional Center personnel, including:

Dr. Peter Cohen, Director

Mrs. Margarete Connelly, Director, San Francisco Aid Retarded Children

Ed Pye, Chief, Counseling Service

Carl Verduin, County Coordinator of Mental Retardation Services, Alameda County

Richard Struck, Director of Programs for Exceptional Children and Pupil Personnel Services, Office of Education, Santa Cruz County

Mental Retardation Program and Standards Advisory Board

California Council for Retarded Children Executive Committee.

H.E. Hogan, Director of State Relations, County Supervisors Association of California

Dr. Charles Gardipee, Chief, Bureau of Mental Retardation Services, Department of Public Health

William Wilsnack, Department of Social Welfare

Department of Mental Hygiene personnel, including:

Dr. James V. Lowry, Director

Dr. Elmer F. Galioni, Deputy Director, Division of State Services

Andrew G. Robertson, Deputy Director, Administrative Services

Dr. William B. Beach, Jr., Deputy Director, Local Programs

Dr. Roswell H. Fine, Assistant Deputy Director, Retardation Services

APPENDIX-E

RATED CAPACITY AND POPULATION COMPARISON  
HOSPITALS FOR THE MENTALLY RETARDED

---

<u>Hospital</u>	<u>Rated Capacity</u> <u>September 30, 1968</u> *	<u>Patients in Hospital</u> <u>(including visits)</u> <u>October 6, 1968</u>
TOTAL	10,480	13,175
AGNEWS	467	446
CAMARILLO	481	475
DeWITT	743	882
FAIRVIEW	1,915	2,476
NAPA	---	13
PACIFIC	1,996	2,696
PATTON	408	501
PORTERVILLE	2,095	2,428
SONOMA	2,375	3,258

---

\* Based on allocation of 70 square feet per bed.

October 9, 1968  
Dept. of Mental Hygiene



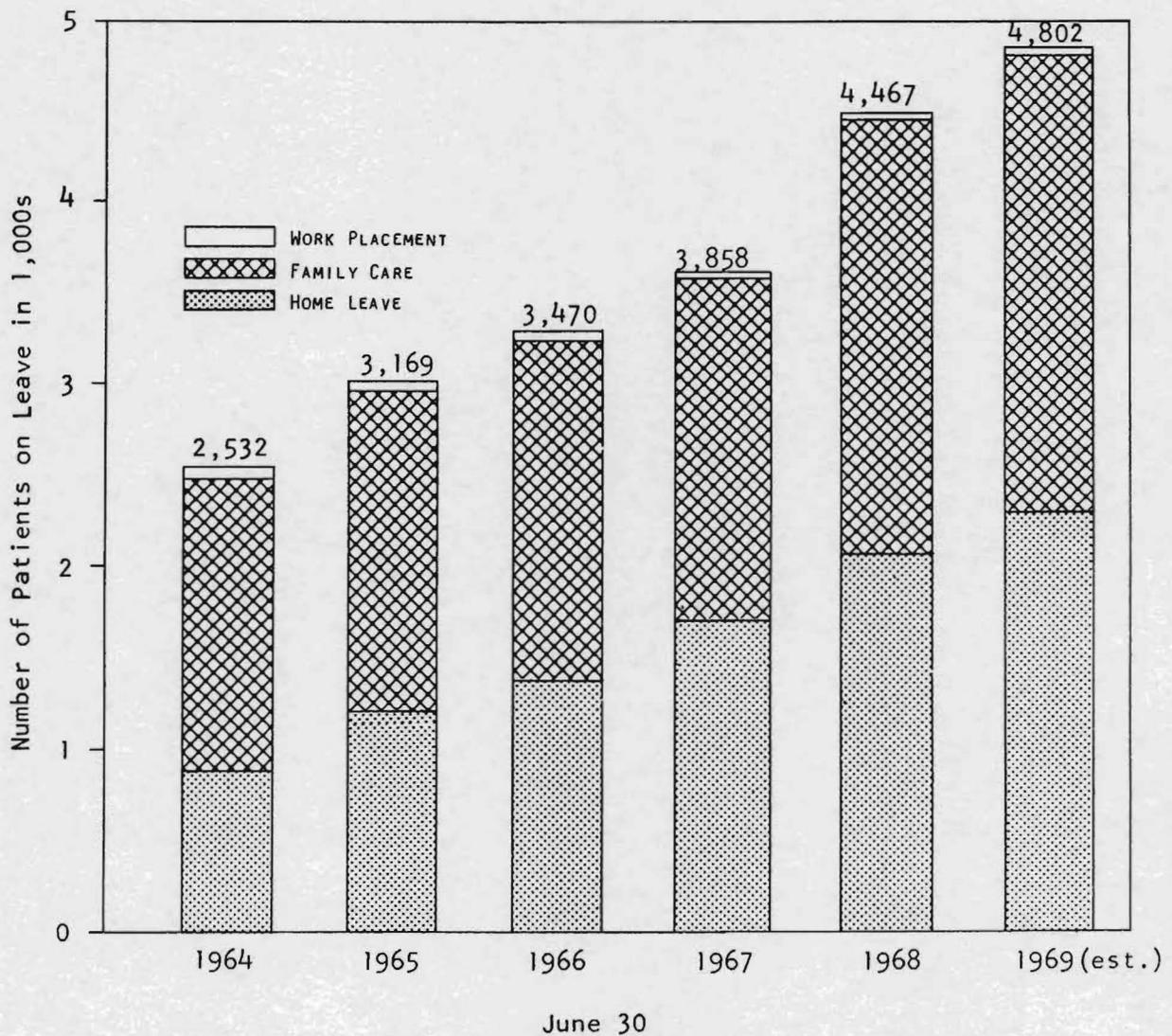
- <sup>1</sup> These patients are a selected group who are presently being prepared for return to the community by the joint efforts of the Department of Mental Hygiene and the Department of Vocational Rehabilitation.
- <sup>2</sup> Camarillo's population is a selected group of adult patients from the southern part of the state of whom 10% might be placed at this time, and approximately 10% or more annually.
- <sup>3</sup> The nursing home patients are primarily older patients who need some medical supervision as might be provided by a DMH private institution. Approximately 10% of the remaining population can be placed in a non-medical setting at any given time.
- <sup>4</sup> The percentages were derived from the WICHE data including patients definitely identified as referred, identified as placeable, and half of the patients who it was thought might possibly be placed.
- <sup>5</sup> The percentages were derived by slightly reducing the lowest percentages utilized for the other hospitals from the WICHE data.

BSS  
1-10-69

APPENDIX-G

PATIENTS ON LEAVE, BY TYPE OF LEAVE  
HOSPITALS FOR THE MENTALLY RETARDED

<u>June 30</u>	<u>Total indefinite leaves</u>	<u>Home leave</u>	<u>Family care</u>	<u>Work placement</u>
1964	2,532	855	1,599	78
1965	3,169	1,203	1,894	72
1966	3,470	1,379	2,029	62
1967	3,858	1,706	2,115	37
1968	4,467	2,057	2,371	39
1969 (est.)	4,802	2,266	2,497	39



APPENDIX-H

COMPARISON OF DAILY COSTS  
STATE HOSPITAL CARE AND STATE DEPARTMENT OF SOCIAL WELFARE  
POST-HOSPITAL CARE

MENTALLY ILL	STATE HOSPITAL	STATE DEPT. OF SOCIAL WELFARE	
		TOTAL COST	STATE COST
Intensive Nursing - Geriatric Care	\$19.70	\$ -	\$ -
Continuing Psychiatric Care	15.10	-	-
Out-of-Home Placements	-	9.51	4.68
Total Leave Load	-	6.39	3.14

MENTALLY RETARDED	STATE HOSPITAL	STATE DEPT. OF SOCIAL WELFARE	
		TOTAL COST	STATE COST
Intensive Treatment, Mentally Retarded Children	\$16.85	\$ -	\$ -
General Mentally Retarded	13.80	-	-
Out-of-Home Placement	-	8.02	4.72
Total Leave Load	-	7.63	4.34

Community Services Division  
State Department of Social Welfare  
Sacramento  
November 29, 1968

COST FACTORS  
 PATIENTS SERVED BY COMMUNITY SERVICES DIVISION  
 STATE DEPARTMENT OF SOCIAL WELFARE

MENTALLY RETARDED PATIENTS IN OUT-OF-HOME CARE

	DAILY COSTS			
	Combined Federal, State, County	State Share	Federal Share	County Share
1. Administrative Costs, Protective Social Services	1.17	.51	.66	-
2. Public Assistance Grant	3.01	1.29	1.51	.22
3. Administrative Costs, Eligibility and Grand Determination	.39	.01	.24	.14
4. Special Placement Costs (Family Care, Mentally Retarded in Private Institutions)	2.11	2.11	-	-
5. Special Needs: tranquilizers, medical supplies, clothing, personal expenses (Depart- ment of Mental Hygiene)	.225	.225	-	-
6. Medi-Cal	1.04	.52	.52	-
7. State Department of Social Welfare Administrative Overhead	.039	.039	-	-
8. Miscellaneous	.040	.016	.016	.008
TOTAL	8.02	4.72	2.95	.37

Community Services Division  
 State Department of Social Welfare  
 Sacramento  
 November 29, 1968

COST FACTORS  
 PATIENTS SERVED BY COMMUNITY SERVICES DIVISION  
 STATE DEPARTMENT OF SOCIAL WELFARE

ALL MENTALLY RETARDED PATIENTS

	DAILY COSTS			
	Combined Federal, State, County	State Share	Federal Share	County Share
1. Administrative Costs, Protective Social Services	1.17	.51	.66	-
2. Public Assistance Grant	3.10	1.33	1.55	.22
3. Administrative Costs, Eligibility and Grant Determination	.37	.01	.22	.14
4. Special Placement Costs (Family Care, Mentally Retarded in Private Institutions)	1.76	1.76	-	-
5. Special needs: tranquilizers, medical supplies, clothing personal expenses (Depart- ment of Mental Hygiene)	.195	.195	-	-
6. Medi-Cal	.96	.48	.48	-
7. State Department of Social Welfare Administrative Overhead	.039	.039	-	-
8. Miscellaneous	.032	.012	.012	.605
TOTAL	7.63	4.34	2.32	.37

Community Services Division  
 State Department of Social Welfare  
 Sacramento  
 November 29, 1968

P-3

# Flap Over S.F. Foster Children

*S.F. Chronicle 1-22-69*

Residents from several middle - class areas in San Francisco filled the chambers of the Board of Supervisors yestersay to protest against plans that woulr permit more foster children and retarded children to live in their neighborhoods.

The proposal, sponsored by several social agencies and church groups, would permit up to six such children to live in a house in areas zoned for single - family residences.

Helen Herrick, president of the San Francisco Coordinating Council on Mental Retardation and a social welfare professor at San Francisco State College, said the system would reduce the "inhumane practice" of sending children away from their

families and into outlying areas.

## SUBURBS

At present, she said, the city is spending \$650,000 to place children outside the city, mostly in suburbs but in some cases as far away as Los Angeles. As a result, she added, they see their parents far less often than they should.

A succession of speakers from the standing-room - only audience protested to the supervisors' planning committee that the proposed amendment to the Municipal Code would hurt their property values.

Leon Markell of the Balboa Terrace Home Owners Association said admitting the children would be "the first irreversible step" toward

turning San Francisco into "a succession of dreary streets bulging with occupants."

He said hotels, boarding houses and shums would follow in the children's wake.

## TRESPASSING

A woman who said she was speaking for Anza Vista residents said, "We're absolutely against this type of trespassing in our family neighborhoods."

Walter Swanson, representing the Forest Hill Association, said the proposed change in the city's Municipal Code, would encourage the presence of more children in San Francisco.

"Your city is not hospitable for children anyway," Swanson said. He claimed the city's lots were too small

and its topography too varied.

At one point, during an exchange between Supervisor Jack Morrison and a real estate broker, Committee Chairman Ronald Pelosi threatened to clear the chambers if the audience did not quiet down.

## APPLAUSE

The residents gave loud applause for their spokesmen.

There was no such response, however, when the Rev. John F. Duffy, director of the social services department of the San Francisco Council of Churches, told the committee that passage of the ordinance "would give us the opportunity to show that San Francisco cares more about human values than material values."

APPENDIX-J

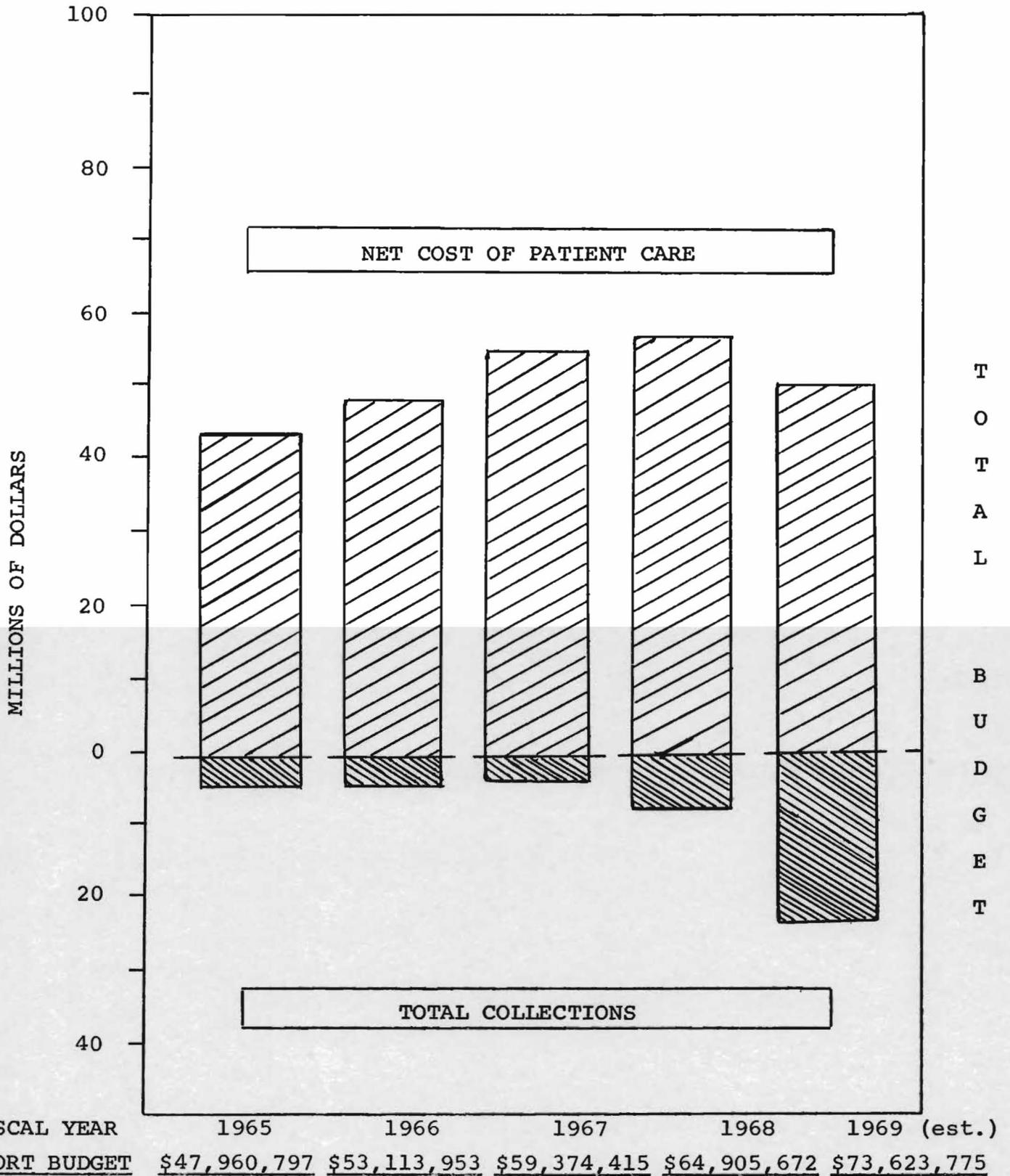
DEPARTMENT OF MENTAL HYGIENE  
MENTALLY RETARDED SUPPORT BUDGET AND RELATED REVENUE

Fiscal Year	Mentally Retarded Hospital Budget*	**Revenue	**Percentage	**Net Cost of Patient Care
63/64	\$ 44,857,044	\$ 4,157,500	9.3	\$ 40,699,544
64/65	47,960,797	4,217,109	8.8	43,743,699
65/66	53,113,953	4,496,638	8.5	48,617,315
66/67	59,374,415	4,036,539	6.8	55,337,876
67/68	64,905,672	7,736,490	11.9	57,169,182
68/69 (est.)	73,623,775	23,352,234	31.7	50,271,541
 	<hr/>	<hr/>	<hr/>	<hr/>
TOTAL	\$343,835,656	\$47,996,510	14.0	\$295,839,146

\* Hospitals for the Mentally Retarded plus mentally retarded patients in Mentally Ill Hospitals.

\*\* Revenue, Percentage, and Net Cost of Patient Care information provided by Bureau of Patients' Accounts 1-23-69.

SUPPORT BUDGET  
HOSPITALS FOR MENTALLY RETARDED  
NET COST AND COLLECTIONS



FISCAL YEAR	1965	1966	1967	1968	1969 (est.)
<u>SUPPORT BUDGET</u>	<u>\$47,960,797</u>	<u>\$53,113,953</u>	<u>\$59,374,415</u>	<u>\$64,905,672</u>	<u>\$73,623,775</u>

**A PROPOSAL TO REORGANIZE**

**CALIFORNIA'S  
FRAGMENTED SYSTEM  
OF SERVICES  
FOR THE  
MENTALLY RETARDED**



**ASSEMBLY OFFICE OF RESEARCH  
CALIFORNIA LEGISLATURE  
SACRAMENTO  
MARCH 1969**

1969 - California's  
Fragmented Services  
for the Mentally  
Retarded

**A. PROPOSAL TO REORGANIZE**

**CALIFORNIA'S  
FRAGMENTED SYSTEM  
OF SERVICES  
FOR THE  
MENTALLY RETARDED**



**ASSEMBLY OFFICE OF RESEARCH  
CALIFORNIA LEGISLATURE  
SACRAMENTO  
MARCH 1969**

California State Assembly

**A PROPOSAL TO REORGANIZE CALIFORNIA'S  
FRAGMENTED SYSTEM OF SERVICES FOR THE MENTALLY RETARDED**

**A staff report prepared for the  
ASSEMBLY WAYS AND MEANS COMMITTEE**

**Ways and Means Subcommittee on Mental Health Services**

**September 1968 – 1969**

**Frank Lanterman, Chairman**

**Carl A. Britschgi**

**John L. Burton**

**Stewart Hinckley**

**Charles Meyers**

**Leon Ralph**

**George Zenovich**

**Staff:**

**Dennis Amundson, Consultant, Assembly Ways and Means Committee**

**John Simons, Committee Assistant, Assembly Ways and Means Committee**

**Gloria Ross, Research Analyst, Assembly Office of Research**

**MARCH 1969**



MEMBERS

JOHN L. BURTON  
JOE A. GONSALVES  
JOHN P. QUIMBY

# California Legislature

MEMBERS

RAY E. JOHNSON  
WILLIAM M. KETCHUM  
ERNEST N. MOBLEY

## Assembly Rules Committee

ROOM 3173, STATE CAPITOL

EUGENE A. CHAPPIE  
CHAIRMAN

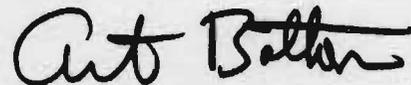
Honorable Frank Lanterman  
Member of the Assembly  
Room 3120, State Capitol  
Sacramento, California

Dear Assemblyman Lanterman:

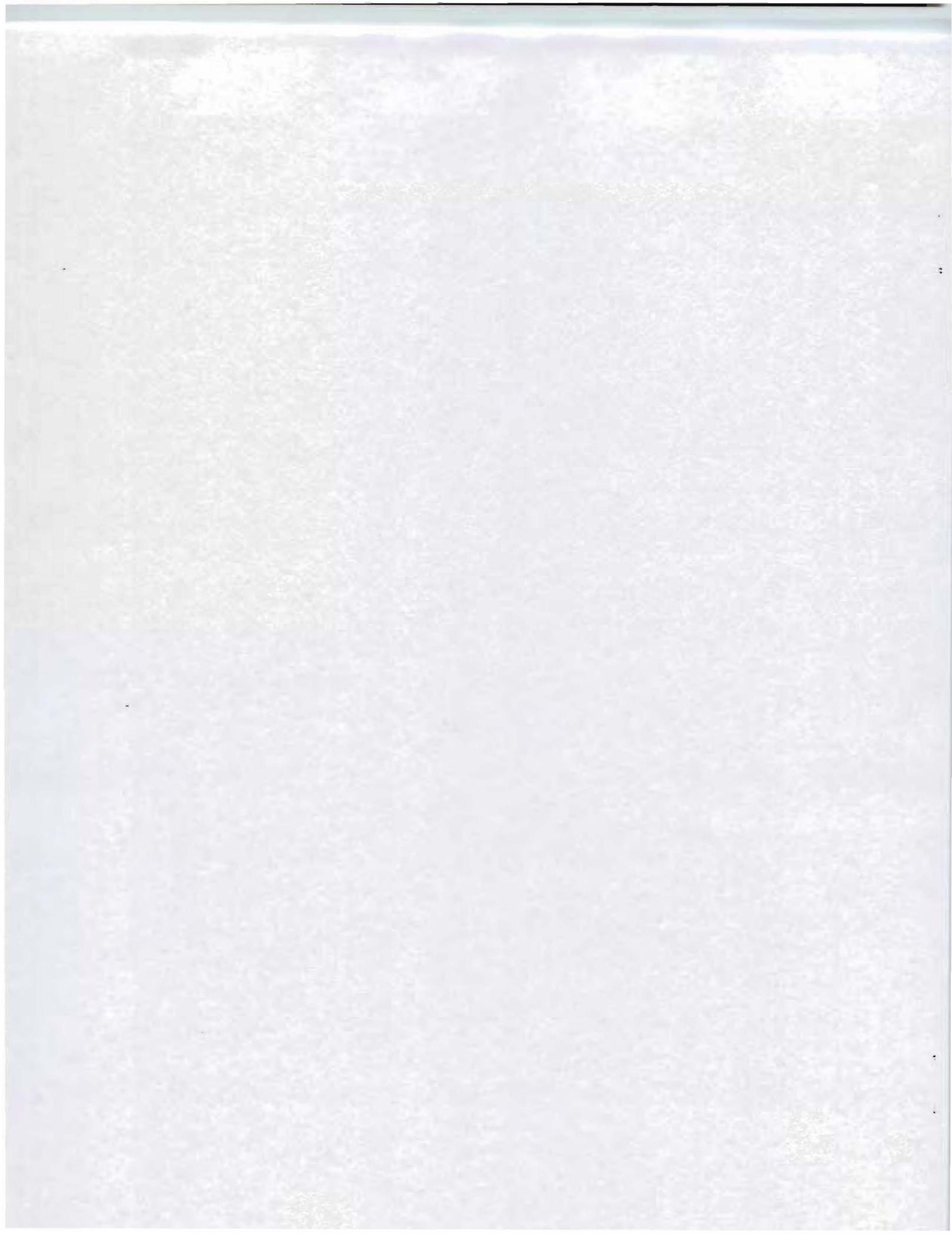
This report was prepared by the Assembly Office of Research and the staff of the Assembly Ways and Means Committee. The report is the result of a six month study conducted pursuant to your request and House Resolution 372 (1968).

The report contains an analysis of certain problems in the structure of California's Mental Retardation system and recommendations for legislative reform.

Respectfully submitted,



Art Bolton



## TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION . . . . .	i
SUMMARY . . . . .	iii
 CHAPTER I	
"You Can't Get There From Here" -- A Case History . . . . .	1
 CHAPTER II	
Summary of the Problems . . . . .	4
1. No Single Responsible Agency . . . . .	4
a. The Need to "Shop Around" . . . . .	4
b. Lack of continuity. . . . .	4
2. Lack of Funds . . . . .	5
3. Lack of Services. . . . .	6
a. Lack of Services. . . . .	6
b. Rates Paid to Private Facilities. . . . .	7
4. Excessive Reliance on State Hospital System . . . . .	8
a. The State Hospital as a Place of First Resort . . . . .	8
b. Those Who Could Be Returned to the Community . . . . .	9
5. Lack of Effective Coordinating and Planning on both Regional and State Levels . . . . .	11
a. State Planning. . . . .	11
b. Regional Planning . . . . .	12
6. Disparity Among Fees Charged Parents. . . . .	12
7. Full Advantage Not Taken of Federal Funds . . . . .	13
8. Other Problems. . . . .	13
 CHAPTER III	
You Can Get There From Here: Proposed Solutions. . . . .	14
1. Program . . . . .	14
A. Regional Center Responsibility. . . . .	14
B. Screening for State Hospitals . . . . .	14

	<u>Page</u>
C. Pre-hospital and After-Care Placement . . . . .	15
D. Regions . . . . .	15
E. Standards . . . . .	16
F. Regional Center Contracts . . . . .	16
2. Planning . . . . .	16
A. The Regional Plan . . . . .	17
B. State Program-Planning-Budgeting. . . . .	17
C. The Statewide Mental Retardation Program Board. . . . .	18
3. Financing . . . . .	18
A. State Funding . . . . .	19
B. Family Participation in Cost of Service . . . . .	19
C. County Participation in Cost of Service . . . . .	19

APPENDIX A

Department of Public Health, Bureau of Mental Retardation  
Services Statistics for Fiscal Years 1966-67 and 1967-68

APPENDIX B

Estimated Cost and Caseload of State-Supported Services for  
the Mentally Retarded

APPENDIX C

House Resolution No. 372

APPENDIX D

Partial List of Persons Interviewed

APPENDIX E

Rated Capacity and Population Comparison, Hospitals for  
the Mentally Retarded

APPENDIX F

Potential MR Placements 1-1-69

APPENDIX G

Patients on Leave, By Type of Leave, Hospitals for the  
Mentally Retarded

APPENDIX H

Comparison of Daily Costs, State Hospital Care and State  
Department of Social Welfare Post-Hospital Care

APPENDIX I

"Flap Over S.F. Foster Children"

APPENDIX J

Department of Mental Hygiene, Mentally Retarded Support  
Budget and Related Revenue



## INTRODUCTION

The California Legislature acted in 1965 to change the state government's responsibility for providing mental retardation services in California. The determination was made to develop a state-assisted, community-oriented system of services in lieu of constructing additional state hospital facilities. Assembly Bill 691 (Waldie) of the 1965 Regular Session created the Regional Diagnostic Centers for the Mentally Retarded and initiated this new approach for caring for the mentally retarded.

The legislation creating the centers was proposed in a study report prepared by the Assembly Ways and Means Subcommittee on Mental Health Services which found that community-located service alternatives to state hospital care were both necessary and desirable.<sup>1</sup>

Implementation of the legislation followed when two pilot regional centers were placed in operation in 1966—one in Los Angeles and one in San Francisco.

Funds for an additional four centers were included in the 1968-69 State Budget. The new centers are to be located in San Diego, Sacramento, San Jose, and Fresno. As of March 1, 1969, the new San Diego center was in operation.

The evidence clearly shows that the 1965 legislation and the resulting two pilot regional centers have solved many of the problems they were designed to solve. For example, *in the first year alone, 230 persons on the state hospital waiting list were served by the Los Angeles Regional Center, and all but 39 of these were cared for in community facilities rather than being sent to the state hospital;* other persons who were served were prevented from reaching the state hospital waiting list and are now receiving service in the community.<sup>2</sup>

Yet major problems remain: Those areas of the state not served by the regional centers still have all the problems which led to the creation of the regional centers, and even in areas served by the two centers many problems still exist despite the fact that California is spending almost \$160 million annually for mental retardation services.<sup>3</sup>

It was apparent to the Legislature that there are still serious problems requiring further action despite the significant progress which has been made since 1965. Consequently, HR 372<sup>4</sup> of the 1968 Regular Session was adopted to set in motion a study of California's mental retardation services. Subsequent to the passage of this Assembly Resolution, the Legislative Analyst also saw the need for a study and recommended that:

1. See Assembly Ways & Means Subcommittee on Mental Health Services, *A Redefinition of State Responsibility for California's Mentally Retarded* (Assembly of the State of California, 1965). Also, Study Commission on Mental Retardation, *The Undeveloped Resource: A Plan for the Mentally Retarded of California* (Sacramento, State of California, 1965).
2. See Appendix A for statistics regarding the Regional Centers.
3. See Appendix B.
4. See Appendix C.

..... the Legislature reassess and reevaluate all existing programs for the mentally retarded with the specific goal of creating a genuine program approach for the more efficient and coordinated rendering of these services.<sup>5</sup>

The staff of the Assembly Ways and Means Committee and the Assembly Office of Research worked on the study and, in addition to other fact-finding activities, interviewed many persons involved in the provision of services to the mentally retarded.<sup>6</sup>

This report presents, in summary form, the major findings. The proposed legislation is largely the result of these interviews and the Committee wishes to extend its deep appreciation to all those who participated in developing the proposals offered in this report.

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5. California Legislature, *Analysis of the Budget Bill of the State of California for the fiscal year July 1, 1969 to June 30, 1970* Report of the Legislative Analyst, p. 936.

6. See Appendix D for list of persons interviewed.

A PROPOSAL TO REORGANIZE CALIFORNIA'S FRAGMENTED  
SYSTEM OF SERVICES FOR THE MENTALLY RETARDED

SUMMARY

A. PROBLEMS EXISTING IN THE SYSTEM OF SERVICES FOR THE MENTALLY  
RETARDED

1. In most areas of the state, there is no single agency vested with the responsibility, and with appropriate funds and authority to assure the provision of needed services to retarded persons.
2. There is a lack of funds for the purchase of service for retarded persons.
3. There is a lack of essential services in many parts of the state.
4. There is excessive reliance on the state hospital system.
5. There is a lack of effective coordinating and planning on both regional and state levels.
6. There is a wide disparity among fees imposed upon parents of retarded children, depending upon where the child is receiving service, thus resulting in inequities.
7. Full advantage is not being taken of all sources of federal funds available for services to the retarded.

B. PROPOSED SOLUTIONS

1- Program: It is proposed that the state fully implement the policy adopted in 1965 which proposed the establishment

of a statewide network of regional centers for the mentally retarded.

- a. Regional centers will be responsible for the provision of diagnosis, counseling, referral, purchase of service, and guardianship.
- b. The regional centers will be required to do all screening for admission of the State Hospitals for the Mentally Retarded, and will also secure care for persons leaving the state hospitals.
- c. The regional centers will assume responsibility for purchasing out-of-home pre-hospital care and post-hospital services for the retarded.
- d. Regions will be designated by the State Department of Public Health.
- e. Statewide standards shall be set by the State Department of Public Health.
- f. Regional centers may be operated under contract by private or public agencies, including county agencies.

2- Planning: It is proposed that planning for Mental Retardation Services be required on the Regional and State Levels.

- a. Regional Mental Retardation Program Boards (established through a joint powers agreement in multi-county regions) will be formed in each region to function in three capacities:
  1. It will be the MR Program Board and will be responsible for operating the regional center

either directly or by contract.

2. It will be the planning body for the regional and will develop a regional plan for mental retardation services.
  3. It will act as a sub-unit of the Comprehensive Health Planning body for its region.
- b. The regional plan will indicate the services required by retarded persons in the region, the number of persons needing such services, the available service resources, priorities for the development of needed services, anticipated costs and revenues.
  - c. On the state level, the Human Relations Agency will be required to develop a statewide plan and a total program budget for services to the mentally retarded which crosses over departmental lines.
  - d. The Statewide Mental Retardation Program Board will include as voting members only private persons and will be broadly based with representatives of the various disciplines serving the retarded, parents of the retarded, and the general public. This board will act as a sub-unit of the State Comprehensive Health Planning Council and will be advisory to the Human Relations Agency, the Governor, and the Legislature.

3- Financing: It is proposed that the Regional Center Program be funded with state funds, parental contributions and county contributions.

- a. State funding shall be on a regional basis with

funds flowing through the State Department of Public Health to each Regional Mental Retardation Program Board.

- b. Families of children under the age of 18 who are receiving out-of-home services purchased by the regional center will be required to contribute to the cost of services depending upon their ability to pay, but not to exceed the cost of caring for a normal child at home. Fees shall be the same regardless of where the child receives care and shall take into consideration extraordinary family expense in the care of the child. All funds thus collected shall be used for additional service.
- c. Counties will be required to pay no more than \$20.00 per month for each person receiving purchased out-of-home care through the regional center regardless of whether a state hospital or non-state facility is providing the service, unless this amount has been paid by the parent.

## CHAPTER I

### "YOU CAN'T GET THERE FROM HERE" – A CASE HISTORY

The following is the actual case history of a retarded child prepared by the Santa Cruz County Office of Education.<sup>7</sup> This case is quoted in its entirety since it illustrates so well the problems faced by large numbers of families and clearly reveals many deficiencies of the system.

#### STEVEN A

"Steven A and his father moved to this area in 1966. Steven is a severely mentally retarded boy, 16 years old, who has been living with his father since 1966 when Mr. and Mrs. A got a divorce. Mrs. A presently lives in another part of the State with Steven's brother and sister.

Mr. A found employment in the Santa Cruz area and he and Steven lived in a small farm house provided by Mr. A's employer.

Steven was referred to the Santa Cruz County Diagnostic and Counseling Center in October of 1967 and went through the Clinic in November of 1967. At that time the Clinic staff recommended that Steven be placed in the Farm Training Program conducted by the County Superintendent of Schools. On November 27, 1967, Steven was enrolled at the Farm Training School. At first, Steven was extremely difficult to handle, however, he made a slow but steady progress and in a matter of months Steven had adjusted very well to the program and was developing good social and work attitudes. Steven, as of this date, February, 1969, is still at the Farm Training School and making excellent progress.

In February of 1969, three of Steve's teachers had this to say about the boy:

"Steve has a pleasant personality and gets along with the other students . . . .He can follow directions and remembers them for more than one day. . . .Steve is one of the better workers in the group."

"...he is consistently attentive and productive. He impresses me as thoroughly enjoying the program designed for him. . . .The Farm program is well suited to a student like Steven. It is hoped that Steven will go through the entire program and be well prepared for the Sheltered Workshop."

"Steve worked with me for approximately two months in ornamental horticulture. I would consider him one of my better students during that time . . . .I definitely feel that the program at the Farm is beneficial to him and he, in turn, is an asset to the Farm program."

On January 28, 1969, the case of Steven A came up at the Farm staff meeting. Eve Pecchenino, Steve's teacher, reported that Steve expected to leave the Farm the 8th or 9th of February and that he had informed her his father is placing him in Porterville. Len Thigpin, Farm coordinator, reported that he had called Steve's father because Steve had been very upset at school and had said that they were going to move. The father said that there was no truth to this, but would not let himself become engaged in conversation about Steve's future. Len promised to investigate further.

There was general agreement at this time that institutionalization would be a very detrimental thing to Steve and this should be avoided if at all possible.

On January 31, 1969, Len Thigpin found out that a court hearing would be held on Monday, February 3, 1969, to determine if Steven should be placed at Agnews State Hospital. Mr. Thigpin learned this information from the Probation Department and immediately arranged for Bill Carmichael, a teacher at the Farm, to contact Mr. A this date and arranged an afternoon visit. Mr. A. stated to both Bill and Len that he really did not want to place the boy in an institution; however, because he works such long hours and the boy was getting to be more of a responsibility, he could not provide the proper care of supervision that Steven would require. At this

7. "You Can't Get There From Here", Office of Education, Santa Cruz County, Santa Cruz, California.

time, Mr. A was asked if he would allow Steven to stay in the community if there was another alternative; Mr. A. answered in the affirmative. Plans were made for Len Thigpin to attend the court hearing and explain the position of the Farm staff to the Judge.

John Tuck, Social Welfare representative for the Diagnostic and Counseling Center, at this time attempted to find a home which could accept Steve. Eve Pecchenino, teacher at the school, tipped off Tuck about a space available in a Mental Hygiene Home in the area. Tuck contacted this home and the foster parent stated that she would hold this space open, however, she could not wait very long.

An attempt was made at this time to determine which funds would be available for Steve's care in the Mental Hygiene Home. Mr. A makes approximately \$4,000 a year, and of this he must pay his rent and usual expenses plus \$70.00 per month child support. Mr. A was not in a position to afford the \$200 plus amount it would take for a Mental Hygiene Home.

A call to Porterville Outpatient Clinic determined that the State Department of Mental Hygiene did not have the funds available under the State subsidy program. Tuck was informed that because this was a Mental Hygiene Home and was not licensed by the Bureau of Social Welfare Community Services, the cost could not be paid by that agency.

A call to Community Services Bureau of Social Welfare determined that a Mental Hygiene Home could not be double licensed or licensed as a family care home, and there were no vacancies available in the Santa Cruz area. After checking with the Santa Cruz office and the Salinas office of Community Services, it was determined there was not a licensed home available in the Watsonville area. The problem then began to shape up to one of who is going to fund foster home placement and whether anyone was really responsible. The interesting thing about the problem was that everybody involved knew that it would cost more to keep Steven in an institution, or have him admitted on paper and then have him farmed out, than it would to keep the boy in the very successful Farm Training Program where he was presently enrolled.

**February 3, 1969.** Len Thigpin attended the court hearing at 8:30 Monday morning, and after explaining to the judge what the situation was, the judge requested that Mr. A have him take this case off the calendar and put aside until such time as all the other alternatives could be investigated. Mr. A agreed but was still unsure until Len Thigpin informed him that a teacher at the Farm Training School would be willing to take Steven into her home until such time as a placement could be made. Mr. A was very happy with this arrangement and again stated that he really did not want the boy out of the community, however, he did not feel he had any choice because of the responsibility.

Driving back from the hearing, Steven turned to Len Thigpin and said, "They told me you were a good guy and they sure were right." Len asked him what he meant and Steven answered simply, "You came and got me."

On February 4, 1969, John Tuck contacted Irene Harkins of the Porterville Outpatient Clinic in San Jose. Mrs. Harkins stated that funds were not available through the Porterville Outpatient Clinic for Steven's care; however, she stated that she would refer the case to Community Services in Santa Cruz in an attempt to get Mental Hygiene home payment. Mrs. Harkins also stated that Mr. Goulet was in charge of the State subsidy program, whose office is in San Francisco, had informed her that funds were not available for foster care. Tuck again contacted Community Services and informed them the case would be referred. A telephone call to Agnews State Hospital also reiterated the information that funds were not available, nor did anyone know just exactly who was responsible. It should be noted, however, that if Steven were placed in an institution, funds would immediately become available.

At this time, the San Benito County Welfare Department was contacted and an appointment was made for Mr. A to apply for aid for Steven. The County Welfare Department's funds for foster care would amount to approximately \$95.00 per month for Steven, and Mr. A would have to find some way to dig up the other \$105.00 per month if the boy were to be placed in the local Mental Hygiene home available.

A memo received February 5, 1969 from Vocational Rehabilitation Services indicated that the Department could not help because Steven was not their client.

The number of agencies contacted had now grown; contact has been made with:

Porterville Outpatient Clinic  
Porterville State Hospital  
Agnews State Hospital  
Department of Mental Hygiene  
Bureau of Social Welfare Community Services (Santa Cruz and Salinas offices)  
Santa Cruz County:       Office of Education  
                                  Welfare Department  
San Benito County:       Welfare Department  
                                  Probation Office  
                                  Office of Education

On February 5, 1969, Jack Wendt, Clinic Coordinator, called Hans Kleinke, State Department of Mental Hygiene, and Jack Hicky, of the State Department of Community Services, in an effort to determine where funds were available for the care of Steven.

As of this date, February 7, 1969, Steven is residing in the home of one of the teachers at the Farm Training School, and it still has not yet been determined what, if any, funds are available for Steven's care in a local situation.

To place Steven in an institution, it would cost the State \$4,000.00 plus a year. To keep Steven in a good program in a Mental Hygiene home in the community, it would cost the State approximately \$2,500.00 a year. But there is something more important: Steven has made, and is making, excellent progress in his situation at the Farm School. This retarded youngster deserves a chance to meet his potential, *Because the channels of communication are muddy and because no one seems to want to accept the responsibility for the funding of Steven's care, this boy remains in limbo while agencies pass the buck or throw up their hands in helpless gestures. The tragedy is not that these agencies are not doing their job – the tragedy is that the agencies do not seem to be aware of one another and certainly are not aware of each others job.*

*I know you're not responsible, but what happens to Steven A?"*

## CHAPTER II

### SUMMARY OF THE PROBLEMS

1. THE FIRST AND PERHAPS THE MAJOR PROBLEM IS THAT, IN MOST AREAS OF THE STATE, THERE IS NO SINGLE AGENCY VESTED WITH THE RESPONSIBILITY, AND WITH APPROPRIATE FUNDS AND AUTHORITY TO ASSURE THE PROVISION OF NEEDED SERVICES TO RETARDED PERSONS.

As in the case of Steven A., families of retarded persons must go from one agency to another in seeking aid and frequently they find no agency authorized to accept responsibility for the provision of service. Even if the family locates a program, it finds there is no agency to coordinate services or to provide continuity if, and when, a new service becomes necessary.

- a. **The Need to "Shop Around"**

There was no single agency to which Steven A.'s father could go to obtain service for Steven, rather he had to go from agency to agency in the hope that one of them would have a program and money to pay for it. Hundreds of other families face the same problem: Unless they are fortunate enough to live in a regional center area, there is, in most instances, no central place to go.

A survey in Los Angeles County in 1963-65 showed:

The major gap in services for the mentally retarded in Los Angeles County is the lack of "case management" services which would provide continuous life supervision and guidance, and referral to appropriate services. The lack of counseling and referral services has resulted in considerable "shopping" for services and in frustration for the retarded and their families.

- b. **Lack of Continuity**

In most areas, there is no agency which can plan and provide continuity of care for a retarded person. Even the regional centers cannot provide this service for every retarded person in the region within their current budgetary limitations. If anything, the structure of state and local services for the retarded guarantees a lack of continuity.

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8. Ivy Mooring, Ph.D. and Robert J. Currie, *Mental Retardation Survey of Los Angeles County, 1963-65*, (Mental Retardation Joint Agencies Project, Welfare Planning Council, Los Angeles Region). pp 2 - 3.

Leslie C. Waldo, in a 1962 study of services for the mentally retarded in San Mateo and Santa Clara Counties, made the following observation:

There appears to be a range of services that exist, often unrelated to each other, in a fragmented rather than a coherently structured pattern. As a result, there is no clearly defined sequence of services or resources on which case by case planning can be based over time. Beginning with pre-school aged children there is no comprehensive diagnostic service available to everyone who might need it that brings to bear the wide range of skills required. There does not exist a center that makes available the counseling and planning services that should be recurrently available over the lifetime of an individual retardate. The pathways to services at present are unstructured and ill-defined. All too often services are unknown or are inaccessible to those who might benefit.<sup>9</sup>

Though these words were written in 1962, the same situation still exists in many areas of the state today, with those areas served by the regional centers providing the only notable limited exceptions.

In the case of Steven A., there is no agency which is planning for his future. His father must shop for care now and, when it becomes necessary for another change in his program, he will have to shop again.

Another related problem clearly revealed in the case of Steven A. is that a retarded person's entry point into the system, rather than his needs, often determines the nature of the service that will be given. An unimpeded flow from one program to another is lacking since each agency has different eligibility requirements, different fee requirements, and serves different geographical areas.

As the Legislative Analyst's recent report states:<sup>10</sup>

. . . The number of different entry points into the system of mental retardation services . . . causes understandable confusion among parents.

## 2. THERE IS A LACK OF FUNDS FOR THE PURCHASE OF SERVICE FOR RETARDED PERSONS

There is a lack of funds for the purchase of service even when services are available. The case of Steven A. provides a typical example. Steven is participating and doing well in a program in the community but he requires out-of-home placement. Such placement is available, but the father cannot afford the cost and there is no agency with funds available to pay for it, even though the alternative of placement in the state hospital would be considerably more expensive and considerably less suitable for Steven. This situation occurs time and time again.

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9. Leslie C. Waldo, *The Mentally Retarded and Community Services: A Report on Services for the Mentally Retarded in San Mateo and Santa Clara Counties, California, 1961*, (Palo Alto, California, Stanford University School of Medicine, 1962), p. 123.

10. *Analysis of the Budget Bill*, p. 945.

Even in those counties where there is a local agency responsible for finding placement, and which is able, to a degree, to coordinate services for a client, such agencies generally do not have funds with which to purchase needed service.

A case in point is the Alameda County Short-Doyle mental retardation program. This program provides diagnosis and counseling as well as an information and referral service, and attempts to coordinate services for mentally retarded individuals. However, the program has no funds with which to purchase needed service.

3. THERE IS A LACK OF ESSENTIAL SERVICES IN MANY PARTS OF THE STATE.<sup>11</sup>

a. Lack of Services

The Waldo report stated:

“The capacity of all types of community special services other than special classes is so limited as to provide for the needs of only a very, very few retarded persons. Many services can only be considered to be experimental, exploratory, or demonstrational efforts at this time . . . The lack of these facilities leaves no alternative to institutionalization for many.<sup>12</sup>”

While this situation has been improved in some sections of the state during the past six years, the state hospital still remains the only place where many can turn for service.

Certain services are lacking in *all* areas. Perhaps the biggest gap in service is programs for the young adult. There is virtually nothing available for the over 18 year old retardate who may have had the benefit of public school programs until that time. An article from the Alameda-Contra Costa *MRIC Compass* states:

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11. The general term services, as used in this report, includes day care, residential care, rehabilitation services, educational services, respite care, home-making services, etc.

12. Waldo, *loc cit.*

Now that parents can expect to find programs for their school age retarded children, the lack of parallel programs for those over 18 or 21 is striking. Sheltered workshops, mainly operated by parents' organizations with a minimum of financial support from Adult Education and hardly any from the State Departments of Rehabilitation and Social Welfare, scarcely begin to serve all who leave school only to find nothing more available to them than their own homes and their TV sets. Activity programs for those not capable of sheltered workshop services are even more scarce.<sup>13</sup>

This lack of resources in the community, particularly for the young adult, results, to a large extent, from the lack of funds, both for the development of new services and for the purchase of care from existing programs. The dearth of programs also stems from the lack of planning and coordinating activities to determine where services are necessary and to coordinate client needs with services available.

**b. Rates Paid to Private Facilities**

Another problem which impedes the development of certain services stems from the confusion regarding the rates paid to private institutions. There are two reasons for the confusion:

**Fragmentation of rate-setting authority.**

Several state departments are involved in the rate-setting. The Health and Safety Code designates the Secretary of Human Relations as the agency responsible for setting rates, the Governor's Reorganization Plan (No. 1) gives this same authority to the Department of Mental Hygiene; and the Department of Public Health, as the Administrator of the Regional Center Program is also involved in the process. In actual practice, it appears that the Department of Finance, in exercising its broad powers under the Government Code, plays the primary role in rate setting. This fragmentation has confused vendors of service and others as to who has the final authority at the state level. It is difficult to fix responsibility and the vendors of service are passed from one agency to another when they attempt to negotiate rates.

**Lack of a uniform rate-setting policy.**

There is no uniform method of determining rates to be paid to vendors of service. Rates are arrived at by negotiation between the vendor and the several state departments involved in rate-setting.

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13. Quoted in: (San Francisco Coordinating Council on Mental Retardation), *MR Coordinator*, January, 1969, p. 4.

When such negotiations are taking place, the Department of Finance or the Secretary of Human relations will often request the vendor to submit a cost statement for analysis. Since the State does not have an established "cost plus" policy this cost statement is then used for further negotiations rather than as a uniform basis for establishing a rate.

The method of establishing rates solely through negotiation has resulted in inequities whereas a policy of "cost plus" or some other uniform method of determining rates would result in a more uniform, equitable rate scale.

The result of this confusion and lack of a clear policy tends to discourage the private sector from initiating and expanding community-based resources. The financial risks are simply too great to attract the capital required to construct facilities and initiate programs.

#### 4. THERE IS EXCESSIVE RELIANCE ON THE STATE HOSPITAL SYSTEM

Poor use of the state hospital results from all of the difficulties previously mentioned and affects two groups of retarded persons at the present time: those who are now being inappropriately placed in the state hospital because no community placement can be arranged for them and those who are living in the state hospital who could be more properly served in the community.

##### a. The State Hospital as a Place of First Resort

The lack of awareness of community alternatives and the lack of available community services and funds for their purchase have produced a situation where the state hospital seems the *only* alternative for many. Steven A. is a perfect example — his father was no longer able to provide the supervision he required and, lacking knowledge of community services, he took steps to have him placed in the state hospital. Fortunately, in Steven's case his teachers were interested enough to attempt to assist his father in finding community placement. In this case, even though Steven could do well in the community, the hospital staff seemed to be bringing subtle pressure to bear in favor of state hospital admission. The following is a quote from a letter from a state hospital staff member to a Santa Cruz County Social Worker written in regard to Steven A.:

It seems to me that those of you who are involved with Steven, particularly the father, are going to have to decide whether to take advantage of the course that is open (i.e., admission to Agnews) or gamble that some, as yet unknown, source of funds for that particular placement will become available. This does seem unlikely.

Though this is only one case, involving one State hospital, this statement raises questions concerning the extent to which parents may be influenced by such comments when determining whether or not to place a child in the state hospital and when determining whether to return a child from a state hospital into the community. We believe it would be very useful to conduct a study of the factors which influence the decisions that families make.

b. **Those Who Could Be Returned to the Community**

In addition to the fact that persons are still being placed in the state hospital for lack of readily available community services, the Department of Mental Hygiene has confirmed the fact that there are still many who are now in state hospitals who could be served in the community, despite the fact that severe overcrowding of state hospital facilities exists.<sup>14</sup>

According to the Department of Mental Hygiene, as of January 1969, the following numbers of state hospital mentally retarded patients are improperly placed:<sup>15</sup>

Total state hospital mentally retarded population . . . . .	13,000
Those who could be placed in nursing homes (require some medical attention) . . . . .	1,267
Those who could be placed in non-medical residential facilities . . . . .	2,799
Total who could be placed in community . . . . .	4,066
Percent of total mentally retarded state hospital population who could be be placed in community . . . . .	31%

The Community services Division of the Department of Social Welfare is responsible for the placement of persons on leave from the state hospitals. The placement referral process may be divided into four phases:

1. In-hospital identification of persons who may be considered appropriate for placement.
2. Referral of those persons so identified to the Community Services Division with placement needs information.
3. Identification and location of appropriate resources for the person in the community by the Community Services Division.
4. Placement by the Community Services Division's Psychiatric Social Worker.

The Community Services Division indicated that as of December 1968 approximately 205 mentally retarded patients had been referred by the state hospitals for whom the Division was pursuing placement planning as evidenced by its having opened the case on a "prerelease" basis.

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14. See Appendix E.

15. See Appendix F, for breakdown by hospital.

The Community Services Division has four placement programs for the mentally retarded:

1. **Family Care** – Care in Social Welfare licensed homes for which \$150.00 is paid per month.
2. **Out-of-home Placement Program** – Utilizes other funding available to the patient (e.g., Public Assistance, Private and State) for his placement in community licensed facilities, boarding homes, residential hotels, etc., for those persons capable of sustaining themselves under minimal care and supervision with the aid of the full range of follow-up services of the Community Services Division.
3. **Private Institutions at State Expense** – A specialized program for the community placement of retarded persons into total care licensed facilities in lieu of maintaining them in state hospitals. The majority of these persons are placed in facilities licensed by the State Department of Mental Hygiene (type “N” facilities).
4. **Special Employment Services Program** – Offers training in protected settings (such as sanatoriums and ranches) to those retarded patients who are capable of becoming either self-supporting or partially self-supporting.

In addition, the Division services some 873 (December 1968) mentally retarded patients who are living in their own homes.

The Division had the following numbers placed in these programs as of December 1968:<sup>16</sup>

Family Care <sup>17</sup>	–	2,566
Private Institution	–	368
Special Employment	–	44

Even though the Community Services Division is able to make community placements at considerably less cost than maintenance in the state hospitals,<sup>18</sup> large numbers remain in the state hospitals who could be more properly placed in the community. There appear to be three major factors accounting for this problem:

#### **Lack of Funds**

The Community Services Division is limited in the number of persons whom it can place by the funds budgeted for the purchase of certain types of service. The greatest lack is in funds for placement in private institutions. In 1968-69, \$912,950.00 was originally budgeted for the care of 300 patients in the private institutions program. The program experienced unanticipated rapid growth the first six months of the year to its current level (368 cases) and expansion has been somewhat curtailed due to this additional growth. Recognizing this problem, the Governor authorized \$275,000.00 to be transferred from family care funds to the program to provide sufficient funds for the remainder of the year.

16. See Appendix G.

17. This represents an increase of 200 over the number of patients in the Program at the end of the last fiscal year. The Division places into family care an average of 63 mentally retarded persons from state hospitals per month.

18. See Appendix H.

## **Lack of Resources**

There is a lack of community placement resources in some areas of the state, particularly for certain types of more difficult placements. Community placements are lacking for the teen-age mentally retarded, particularly for boys.

While the statewide availability of community residential placements seems adequate to meet current needs for the less difficult cases, if substantially larger numbers of persons were moved from the state hospitals, these resources would be rapidly depleted.

Since it takes a period of two or three months to develop additional Family Care homes (due to the need to recruit, certify and train new caretakers), the need for this type of placement often outpaces the resources available.

In addition, there are problems in developing community placement facilities in some locations because of zoning restrictions. A recent attempt to permit family-care type facilities in single-family residence neighborhoods in San Francisco met with vehement opposition from homeowners.<sup>19</sup>

## **Resistance of Parents**

Another factor influencing the lack of movement from the state hospitals may be resistance on the part of parents. Many parents seem unwilling to accept the uncertainty which results when their child is removed from the state hospital. When the child is in the hospital, the parent is assured of a certain level of lifetime care, outside, he is not certain.

Discussions with parents have also indicated that it is not only the uncertainty of community care which bothers them. It is the feeling of many parents that the supervision of retarded persons placed in community facilities is not adequate, and they are hence reluctant to permit their child to be placed. Although there have been numerous evaluations of the quality of care in state hospitals, little has been done to systematically study the adequacy of community programs and we believe that such an evaluation would be useful.

### **5. THERE IS A LACK OF EFFECTIVE COORDINATING AND PLANNING ON BOTH REGIONAL AND STATE LEVELS PLANNING ON BOTH REGIONAL AND STATE LEVELS**

#### **a. State Planning**

There currently exists no mechanism for effectively planning and coordinating programs for the retarded at the state level. Priorities cannot be established since various programs for the mentally retarded are contained in the budgets of several departments and hence are considered as part of a departmental budget rather than as part of an overall program budget for the retarded.

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19. See Appendix I.

One of the major problems now existing is the lack of statewide planning:

In the search for means of filling these and other gaps, we find a lack of statewide planning. Our hopes of 1965 that the work of the State Study Commission on MR would lead to a comprehensive Master Plan and clearly defined coordination among the several agencies serving the retarded have not materialized. Thus, the greatest gap of all is seen in the lack of a plan of how the Legislature, the Departments of Mental Hygiene, Public Health, Rehabilitation, Social Welfare, Education and Employment will each play a role in developing the services which can close the many current gaps.<sup>20</sup>

The Legislative Analyst's Report also notes that:

At the present time, and for the past year, the Secretary for Human Relations has himself been acting as coordinator [Coordinator of Mental Retardation Programs] with staff being supplied on an "as available" basis. This fact, combined with the relative impotence of the Mental Retardation Program Advisory Board, has resulted in minimal coordination and relatively unrelated development of mental retardation programs. <sup>21</sup>

**b. Regional Planning**

The situation is no better on the local level. Even though many counties now have coordinating councils, these do not exist in all counties and even in those counties where they do exist, they vary greatly in their ability to develop new services and coordinate existing ones.

The major problem relating to the provision of all types of services to the retarded is a lack of coordination and communication among the public and private agencies rendering such services.<sup>22</sup>

**6. THERE IS A WIDE DISPARITY AMONG FEES IMPOSED UPON PARENTS OF RETARDED CHILDREN DEPENDING UPON WHERE THE CHILD IS RECEIVING SERVICE, THUS RESULTING IN INEQUITIES.**

Fees paid by parents of retarded children vary greatly depending upon whether the child is receiving care through a state, county, or private agency. Additionally, fees vary even among programs provided by state departments. Currently, parents have no obligation to the state for any portion of the cost of care if their mentally retarded child is being treated in a state hospital. The county, however, is obligated to pay \$20.00 per month for every retarded patient in a state hospital or on leave from a state hospital regardless of the age of the patient. Many counties in turn collect this \$20.00 from the parent, so that parents of children receiving treatment in a state hospital or on leave from a state hospital pay a maximum of \$20.00 per month to the

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20. MR Coordinator, *January 1969*, p. 4.21.

21. *Budget Analysis*, p. 946,

22. *Mooring and Currie*, *op cit*, p. 1.

county.<sup>23</sup> The law, however permits a charge of up to \$40.00 per month, if this were made the monthly fee for the state hospital. The parents of a child being treated through the regional center pay on a voluntary basis according to their ability and desire to contribute. Depending upon their means, they may and many do pay far in excess of \$20.00 per month. We find no sound explanation for this disparity.

7. FULL ADVANTAGE IS NOT BEING TAKEN OF ALL SOURCES OF FEDERAL FUNDS AVAILABLE FOR SERVICES TO THE RETARDED.

First, the State is not taking maximum advantage of the broad provisions of the Social Security Amendments of 1967 (P.L. 90-248) which permit the expanded use of federal welfare funds for mental retardation activities. Under this law, matching funds can now be made available for services to "potential welfare recipients" as well as those already directly receiving public assistance benefits.

An estimated two-thirds of the existing caseload in the regional diagnostic centers can be categorized as "potential welfare recipients".

Another source of federal funding which can be utilized is Federal Comprehensive Health Planning Funds authorized by P. L. 89-749. Under this law funds are available for planning functions at the state and local level, for direct services to the retarded, and for special studies and demonstration projects. Currently, none of the funds available under this law are being used for mental retardation programs.

8. OTHER PROBLEMS

A variety of other problems were uncovered in the course of this study. Such problems include: fees paid to private facilities by various public agencies vary; licensing standards for private facilities vary according to the licensing agencies; standards of care in the state hospitals have been criticized; and the transformation of state hospitals for the Mentally Ill into facilities for both the mentally ill and the mentally retarded is being questioned. In view of the time limitations faced by the Committee in conducting this project, these issues were not included within the scope of this study. The project has focused on certain structural problems in the state system, and the proposals for legislation do not attempt to resolve a wide variety of other important issues.

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23. See Appendix J, for report of revenue to DMH Mental Retardation Program.

## CHAPTER III

### YOU CAN GET THERE FROM HERE: PROPOSED SOLUTIONS

#### PROGRAM

1. IT IS PROPOSED THAT WITHIN THE NEXT FEW YEARS THE STATE WILL FULLY IMPLEMENT THE POLICY ADOPTED IN 1965 WHICH PROPOSED THE ESTABLISHMENT OF A STATE-WIDE NETWORK OF REGIONAL CENTERS FOR THE MENTALLY RETARDED.

The network of Centers will provide in all areas of the state a focal point for mental retarded persons needing special services. With assistance from the Centers, it will be possible for retarded persons and their families to receive continuous, lifetime help. The Centers will, in addition, be given new responsibilities to eliminate the lack of continuity in service, coordinate fragmented services, and develop needed services on a priority basis.

#### A. Regional Center Responsibility

Regional Centers will be responsible for the provision of **diagnosis, counseling, referral, purchase of service and guardianship** for those retarded persons who are unable, without the professional help and assistance of the Regional Centers, to receive the care, training and supervision they require.

#### B. Screening for State Hospitals

The Regional Centers will be required to do all screening for admission to the State Hospitals for the Mentally Retarded. They will also assume responsibility for securing care for persons leaving the state hospitals.

The Regional Centers will thus serve as the *only* point of entry to and egress from the state hospitals. Regional Centers will utilize the state hospital system for placement in the same way they utilize other service resources and state hospitals will, in effect, become vendors to the Regional Centers. To the fullest extent feasible, state funds now allocated to state hospitals for the retarded will be allocated to Regional Centers which will contract with appropriate agencies, including state agencies, for the provision of out-of-home placement.

As a central referral and purchasing agent for mental retardation services, the Regional Center will explore every alternative for care available both within and outside of the region. The option most likely to attain the desired goal at the least possible cost shall be chosen. Only those persons who need the specialized medically-oriented services of the state hospital will be placed there.

**C. Pre-Hospital and After-Care Placement**

As the focal point for mental retardation services the Regional Centers will assume responsibility for purchasing out-of-home pre-hospital care and post-hospital (after-care) services for the retarded.

To the fullest extent feasible, state funds now allocated to the Department of Social Welfare for this purpose will be allocated to Regional Centers which will contract with appropriate agencies for the provision of all out-of-home services.

For the present, the Regional Centers can contract with the Department of Social Welfare (Community Services Division) for placement services, and secure the Federal matching funds which are available through the Department of Social Welfare. Efforts should be made to implement the new federal policy permitting the waiver of the single state agency requirement (Intergovernmental Cooperation Act of 1968). When this policy is implemented, the same amount of federal support will be available if agencies other than Social Welfare are used to perform this same placement service.

These proposals are intended to give the Regional Centers the maximum flexibility to utilize the best possible program for each retarded person. The Centers should not be forced to use any single program to provide residential, foster care, hospital or other services.

Wherever possible the Centers should *contract for services* of a long term nature, including case management, rather than attempting to provide such services themselves. The Centers should devote their energies to solving the problems of new patients while maintaining a "guardianship" concern for long term cases and supervising the quality of services provided by contracting agencies.

As a focal point, the Centers should not duplicate the services of other agencies but should utilize them to the fullest extent. Whenever possible the Centers should contract agencies (i.e. Short-Doyle, Health & Welfare Departments), private agencies, and state agencies. The Centers should, endeavor to utilize the services of volunteers for such duties as maintaining guardianship and visiting facilities to ascertain the conditions there.

**D. Regions**

Regions will be designated by the State Department of Public Health for the purpose of Regional Centers. These regions will, whenever possible correspond with Comprehensive Health Planning regions.

**E. Standards**

Statewide standards for Regional Centers shall be set by the State Department of Public Health. These shall include requirements for all agencies acting as contractors, the operation of the Centers, parental fee schedules, and other general policy matters.

**F. Regional Center Contracts**

Regional Centers may be operated under contract by private or public agencies, including county agencies through existing programs. Regional Mental Retardation Program Boards will recommend the most appropriate agencies to perform the Regional Center tasks\* in each area and will be responsible for the selection of a Regional Center agency subject to the approval of the Department of Public Health. In no case may there be more than one Regional Center agency in a region, although there may be several locations at which Regional Center services are provided and one or more sub-contractors to the Regional Center Agency who provide Regional Center services.

**PLANNING**

**2. IT IS PROPOSED THAT PLANNING FOR MENTAL RETARDATION SERVICES BE REQUIRED ON THE REGIONAL AND STATE LEVEL.**

The Regional Center program will be planned for and funded on a regional basis through contracts between the Department of Public Health and a Regional Mental Retardation Program Board (a Joint Powers Agency) to be formed in each region.

In multi-county regions, counties will join together in joint powers agreements for the purpose of planning for mental retardation services and supervising the operation of Regional Centers. The joint powers agency will have a Board with representation from each participating county, the members to be appointed by each county Board of Supervisors. This Board will function in three capacities:

1. It will be the Mental Retardation Program Board and will be *responsible for operating the Regional Center* either directly or by contract.
2. It will be the mental retardation planning body for the region and will *develop a regional plan* for mental retardation services, including but not limited to Regional Center activities.
3. Each Regional M. R. Program Board will also act as a sub-unit of the Comprehensive Health Planning body for its region and Federal (Comprehensive Health Planning) funds will be used for the required planning activities of the Board.

\* Diagnosis, counseling, referral, purchase of service, guardianship.

**A. The Regional Plan**

The regional plan will indicate the services required by retarded persons in the region, the number of persons needing such services, the available service resources, priorities for the development of needed services, anticipated costs and revenues.

The regional plan may include individual county plans which have been submitted to the Regional Mental Retardation Program Board.

Regional and county mental retardation planning bodies shall also have the responsibility for coordinating existing programs and developing new services as required.

Regional mental retardation plans will be submitted to the State Department of Public Health for approval and transmission to the State Comprehensive Health Planning Council and may be incorporated as part of the California Comprehensive Health Plan, after having been approved by the State Mental Retardation Program Board.

**B. State Program-Planning Budgeting**

The Human Relations Agency will also be required to develop a statewide plan and a total program budget for services to the mentally retarded which crosses over departmental lines. To the fullest extent possible, funding for services to the retarded would be based upon this program budget rather than separate appropriations for each department.

These requirements for budgeting and planning will establish a system whereby coordination can be achieved and priorities established. This proposed system should meet the requirements called for by the Legislative Analyst who said:

Regardless of where the authority to coordinate mental retardation services is placed, the coordinating agency must be given the power to develop and implement a realistic and viable program for the efficient rendering of these services. This will require the administration and the Legislature to work together in the formation of an overall plan for the development of an efficient program. This plan must include the establishment of priorities so that the expenditure of the state's resources, now approaching \$160 million annually, is accomplished on a basis that best benefits not only the mentally retarded, but all the citizens of the state. The present expenditure of \$43 million for special education at a time when graduates from special education classes cannot find employment because of lack of facilities is unrealistic. The continued provision of high-cost institutional care for persons who would be better suited for lower cost community-based services requires a reassessment of priorities.<sup>24</sup>

In developing the state plan and program budget, the Human Relations Agency will be required to consult with the departments involved and will, in addition, be required to seek the advice of the Statewide Mental Retardation Program Board.

Ultimate responsibility for the coordination of mental retardation services will rest with the Secretary for Human Relations.

**C. The Statewide Mental Retardation Program Board**

The present Mental Retardation Program and Standards Board will be reorganized to include as voting members only private persons, with representatives of the state departments and other agencies acting as vendors of service serving only in an advisory capacity to the Board.

The Board will be broadly based with representatives of the various disciplines serving the retarded, parents of the retarded, and the general public.

The Statewide Mental Retardation Program Board will also be a sub-unit of the State Comprehensive Health Planning Council. The Board should advise and make recommendations to the Comprehensive Health Planning Council regarding all planning, construction, service, and demonstration projects affecting the mentally retarded.

The Board will also be advisory to the Human Relations Agency, the Governor, and the Legislature. The Board will have the responsibility for making recommendations regarding the state plan for mental retardation services as well as all other matters concerning mental retardation.

**FINANCING**

3. THE REGIONAL CENTER PROGRAM SHALL BE FUNDED BY THE STATE ON A REGIONAL BASIS WITH A MAXIMUM OF AVAILABLE FEDERAL FUNDING.

FAMILY PARTICIPATION IN THE COST OF SERVICES PROVIDED TO MINORS SHOULD BE MADE EQUITABLE.

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24. *Analysis of the Budget Bill, p. 946.*

COUNTY PARTICIPATION SHOULD BE LIMITED TO A MAXIMUM OF \$20 PER MONTH FOR ALL OUT-OF-HOME CARE PURCHASED BY REGIONAL CENTERS, AND ONLY IN CASES WHERE FAMILIES ARE UNABLE TO CONTRIBUTE THIS AMOUNT.

**A. State Funding**

State funds for Regional Centers will flow through the State Department of Public Health to each Regional Mental Retardation Program Board.

**B. Family Participation in Cost of Service**

Families of children under the age of 18 who are receiving out-of-home services purchased by the Regional Center, will be required to contribute to the cost of services depending upon their ability to pay, but not to exceed the cost of caring for a normal child at home.<sup>25</sup> Fees charged to families will be as flexible as possible and will take into account any unusual family expenses that have resulted from the cost of providing services for a retarded child, as well as continuing family expense related to the child's card.

Family contributions will be made *only* to the Regional Center and the fees will be the same in all counties and whether the child is placed in the state hospital or in a public or private community facility. Such additional fees collected shall be used to expand the services available to the retarded.

**C. County Participation in Cost of Service**

Counties will be required to pay *no more than \$20.00 per month* for each person receiving purchased out-of-home care through the regional center regardless of whether a state hospital or non-state facility is providing the service, unless this amount has been paid by the parent. Counties will not be required to pay for those persons living in their own homes and receiving some purchased service or those receiving only the staff services of the Regional Center.

At present, counties are required to pay the state \$20.00 per month for every patient the county has placed in the state hospital. The counties in turn collect from the parents of these patients. Under the proposed plan, counties will be spared the administrative expense of collecting from parents. Counties will be billed for cases under 18 years of age only when the families are unable to pay at least \$20.00 per month.

**SUMMARY**

Although the proposals offered in this report will certainly not solve all the problems of fragmentation, they do seem to constitute a logical "next step" in the development of a more rational approach. If the proposals are adopted, California will have established a mental retardation *system*.

25. Department of Mental Hygiene, *Charges to Parents of Mentally Ill and Mentally Retarded Minors in the State Hospitals*, Program Review Unit Project No. 35, December 4, 1968.



A P P E N D I X



OFFICE OF THE DIRECTOR



STATE OF CALIFORNIA  
**Department of Public Health**

2151 BERKELEY WAY  
BERKELEY, CALIFORNIA 94704

February 27, 1969

Arthur Bolton, Director  
Office of Research  
California State Legislature  
State Capitol, Room 3173  
Sacramento, California 95814

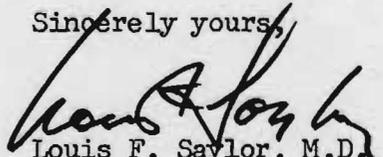
Dear Mr. Bolton:

This is in response to your letter of February 25, 1969 requesting data concerning the Regional Center program.

I am sending you the attached statistics which are for fiscal years 1966-67 and 1967-68. They are taken from a biennial report which is about to be published. We have not included in this report the number of persons who could not be served due to lack of funds; however, we have estimated that as of January, 1969 the Los Angeles Childrens Hospital and Golden Gate Regional Centers have a list of approximately 975 clients who are being provided some staff services but who would be provided additional services if additional funds were available.

If you desire any further information, please let me know.

Sincerely yours,

  
Louis F. Saylor, M.D.  
Director of Public Health

Attachments

cc: Spencer Williams

BUREAU OF MENTAL RETARDATION SERVICES STATISTICS  
FOR FISCAL YEARS 1966-67 AND 1967-68

Introduction

The statistics contained in this report represent those for the first two full fiscal years of operation, July 1 to June 30, 1966-1967 and 1967-1968, for the two Regional Centers which were initiated in January 1966. During June 1966 the Regional Centers provided services to 165 persons and/or families. One year later, June 1967, the number had risen to 559, and during the last month of the second full fiscal year of operation, June 1968, to 770 persons. During this period the Centers increased staff and caseload to the point where they have reached their budgetary maximum.

Population Served

During the first 30 months of operation there were 2,898 requests for Regional Center assistance made on behalf of persons known to be, or suspected of being, mentally retarded. Of these, 1,003 were registered in the central registry as appropriate cases for Regional Center services. Four out of five of these individuals (770) received services during the last month of this report, June 1968. Fifteen cases were closed during the first 30 months of Regional Center operation; four were found to be not mentally retarded and eleven deceased.

The 1,003 persons represent those who were accepted for more intensive services and who added to the statistical registry of the Bureau. Many of the 2,898 whose names were not added to the registry were given a substantial service consisting of an exploration of the nature of their problem by staff and referral to an appropriate agency. Statistics are related to the number who received a service in any one month. There is a continuing process of case activation and inactivation which was not measured by the statistics collected during the years reported.

The type of residence of the 1,003 cases was determined at the time of first interview. Three out of four (760) of the retarded persons resided with their parents; 156 were in a residential facility; 24 in a foster home; 18 in other living arrangements, and 45 for whom this item was not reported. Of these cases 507 were on one of the waiting lists for state hospital placement; 257 were on active waiting lists, that is,

the parents or guardians were requesting hospital placement, and 250 were on the deferred waiting lists. This latter group included those whose parents were not seeking immediate hospital placement because the parents were maintaining their retarded family member in the community in preference to hospitalization but wished to remain on a waiting list.

The Centers provided one or more of the following services to 770 individuals and/or families during June 1968: diagnosis, counseling, purchased service and/or registration for the purpose of guardianship. Three out of five (457) were receiving a purchased service, that is, a service purchased from a provider of care certified by the administrator of the Health and Welfare Agency.

Appendix Tables 1 and 2 review the services purchased during 1966-67 and 1967-68. During 1966-67, 471 cases received one or more purchased services at some time during the year, and in 1967-68, 589 received such services. The major purchased service was residential care which was provided for about 55% of the cases in 1966-67 and 52% in 1967-68. About 35% of the cases received professional services in each of the two years. Many of the families received services from other agencies or paid for services themselves. For example, one in eight individuals received physician's services which were paid for by the Regional Centers during 1967-68. It is assumed that many more received medical care because of the health needs of this group and the requirements for periodic preventive examinations.

Since the Centers were increasing their caseloads during the two years covered by this report, it is not possible to estimate costs on a case year basis. Case-months of care is used instead, and costs are related to monthly average rather than an annual average. The case-months of care provided represent the time period starting when a case was classified as an active case and ending at the close of the fiscal year or the time when a case is inactivated or closed. Thus a case that receives counseling throughout the fiscal year represents 12 case-months of care. A case which became active on February 1, 1967 and continued to be active through June 30, 1967 would represent five case-months of Center services. The months are not rounded but are calculated to the exact date when the Center initiated services. For recording purchased services only those months in which a service is purchased are counted. For professional services a full month was counted, however, even if the service was rendered on only one day of the month as the best basis for planning future budgets and Centers.

The combined expenditure for the Regional Centers for Center personnel and services are listed below:

	<u>Fiscal Year 1966-67</u>	<u>Fiscal Year 1967-68</u>
Total	\$ 369,753	\$ 480,743
Diagnosis and Counseling	313,220	407,832
Administration	56,533	72,911

The total case-months of care provided were 4189.5 in 1966-67 and 7417.5 in 1967-68. The average costs per case-month for diagnosis and counseling were \$74.78 in the first year and \$54.99 in the second. The costs of administration per case-month were \$13.50 the first year and \$9.83 the second. This represents the costs of administrative personnel and services and the time professional personnel spent in administrative duties.

Decreases in the average monthly expenditures in the 1967-68 year were due to the increase in caseload. It is necessary to recruit and train personnel before the caseload can be increased hence the relatively higher costs in the beginning years. There is also a greater amount of time spent in informing the community about services at the onset of a program.

The average monthly State expenditures per case-month of cases who received a purchased service were:

	<u>Fiscal Year 1966-67</u>	<u>Fiscal Year 1967-68</u>
Total	\$ 223.76	\$ 195.52
Purchase of Services <u>1/</u>	135.48	130.70
Counseling and Diagnosis	74.78	54.99
Administration	13.50	9.83

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1/ Less family reimbursements.

Forty percent of the families received no assistance other than diagnosis and counseling. The cost per case-month of these services was \$88.28 in 1966-67 and \$64.82 in 1967-68. Family reimbursements for purchase of services amounted to \$6.90 per case-month in 1966-67 and \$7.99 in 1967-68. In addition families assumed the obligation for necessary services and paid for them directly. No record was kept of these services.

AVERAGE MONTHLY COSTS OF PURCHASED SERVICES BY TYPE  
Regional Center Program, Fiscal Year 1966-67

	No. of active cases	Case-months of purchased services	Expenditures	Average per month	Percents	
					Cases	Expenditures
<u>TOTAL</u>	<u>471</u>	<u>2,505.33</u>	<u>\$ 596,352.80</u>	<u>\$ 238.03</u>	<u>100 %</u>	<u>100 %</u>
Residential Care, Total	257	1,878.57	526,728.95	280.39	54.6	88.3
Resident Schools	127	831.28	250,416.33	301.24	27.0	42.0
Nursing Care Facilities	81	609.21	154,774.62	254.06	17.2	26.0
Residential Facilities	40	294.62	75,514.04	256.31	8.5	12.7
Rehabilitation Centers	21	76.08	32,838.23	431.63	4.5	5.5
Family Care Homes	13	67.38	13,185.73	195.69	2.8	2.2
Day Care	43	171.35	16,671.05	97.29	9.1	2.8
Workshops	54	178.18	14,702.56	82.52	11.5	2.5
Camps	101	35.11	6,205.25	176.74	21.4	1.0
Respite Care	18	57.38	3,627.24	63.21	3.8	0.6
Professional Care, Total	164	449.18	24,119.08	53.70	34.8	4.0
Physicians	79	168.18	5,733.91	34.09	16.8	1.0
Psychologists	49	50.50	2,121.50	42.01	10.4	0.4
Pharmacies	40	178.00	2,321.48	13.04	8.5	0.4
Hospitals	38	56.00	7,394.53	132.05	8.1	1.2
Clinical Laboratories	23	26.00	1,361.70	52.37	4.9	0.2
Dentist	18	27.00	2,222.22	82.30	3.8	0.4
Homemaker Programs, Home Health Agencies	8	14.14	1,590.44	112.48	1.7	0.3
Occupational Therapists	2	5.00	217.75	43.55	0.4	*
Physical Therapists	2	3.00	146.00	48.67	0.4	*
Clinics	2	3.00	135.50	45.17	0.4	*
Dispensing Opticians	2	2.00	46.80	23.40	0.4	*
Speech Therapists	1	1.00	17.25	17.25	0.2	*
Social Workers	1	6.00	600.00	100.00	0.2	0.1
Private Nurse Practitioners	1	2.00	180.00	90.00	0.2	*
Speech and Hearing Centers	1	2.00	30.00	15.00	0.2	*
All Other	27	82.55	4,298.67	52.07	5.7	0.7

\* Less than 0.1%

Note: Since more than one type of service was provided some clients during a given month only the expenditures will add to the totals shown.

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AVERAGE MONTHLY COSTS OF PURCHASED SERVICES BY TYPE

Regional Center Program, Fiscal Year 1967-68

	No. of active cases	Case-months of purchased services	Expenditures	Average per month	Percents	
					Cases	Expenditures
<u>TOTAL</u>	<u>589</u>	<u>4,248.68</u>	<u>\$1,028,608.73</u>	<u>\$ 242.10</u>	<u>100 %</u>	<u>100 %</u>
Residential Care, Total	307	2,969.15	890,542.84	299.93	52.1	86.6
Resident Schools	140	1,293.65	421,984.22	326.20	23.8	41.0
Nursing Care Facilities	80	768.22	218,885.60	284.93	13.6	21.3
Residential Facilities	70	680.96	195,428.18	286.99	11.9	20.0
Family Care Homes	23	158.00	34,371.54	217.54	3.9	3.3
Boarding Home Facilities	5	58.00	15,125.00	260.78	0.8	1.5
Rehabilitation Centers	3	0.66	343.60	520.61	0.5	*
Children's Treatment Centers	2	9.66	4,404.70	455.97	0.3	0.4
Day Care	134	710.10	67,880.29	95.59	22.8	6.6
Workshops	10	93.13	6,783.70	72.84	1.7	0.7
Camps	58	17.75	3,848.07	216.79	9.8	0.4
Respite Care	40	187.00	10,491.70	56.11	6.8	1.0
Professional Services, Total	205	862.18	41,436.44	48.06	34.8	4.0
Physicians	98	228.00	6,627.00	29.07	11.9	0.6
Psychologists	44	50.00	2,328.50	46.57	7.5	0.2
Pharmacies	42	307.60	4,450.58	14.47	7.1	0.4
Hospitals	31	38.00	4,703.91	123.79	5.3	0.5
Homemaker Programs, Home Health Agencies	17	94.44	12,602.39	133.44	2.9	1.2
Dentists	17	25.00	2,188.37	60.48	2.9	0.2
Clinical Laboratories	16	16.00	1,080.35	67.52	2.7	0.1
Nutritionists	9	25.00	437.88	17.52	1.5	*
Physical Therapists	5	26.00	1,199.60	46.14	0.8	0.1
Speech Therapists	5	20.00	426.80	21.34	0.8	*
Private Nurse Practitioners	3	14.14	3,447.68	243.82	0.5	0.3
Speech and Hearing Centers	2	2.00	36.00	18.00	0.3	*
Occupational Therapists	1	9.00	1,590.00	176.67	0.2	0.2
Social Workers	1	4.00	220.00	55.00	0.2	*
Optometrists	1	1.00	32.50	32.50	0.2	*
Orthotists and Prosthetists	1	1.00	49.88	49.88	0.2	*
Orthoptic Technicians	1	1.00	15.00	15.00	0.2	*
Occupational Therapists	1	9.00	1,590.00	176.67	0.2	0.2
All Other	43	135.13	7,625.69	56.43	7.3	0.7

\* Less than 0.1%

Note: Since more than one type of service was provided some clients during a given month only the expenditures will add to the totals shown.

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ESTIMATED REGIONAL CENTER CASELOAD, AVERAGE MONTHLY COST OF CARE PER CLIENT, AND TOTAL ANNUAL PROGRAM COST, 1969-70 THROUGH 1974-75, BY YEAR.

<u>Year</u>	<u>Estimated Regional Center caseload</u> <sup>a/</sup>	<u>Average monthly cost of care</u> <sup>b/</sup>	<u>Total annual expenditures</u>
1969-70	2,820	\$224.37	\$ 7,592,680.80
1970-71	3,516	235.59	9,940,013.28
1971-72	4,213	247.37	12,506,037.72
1972-73	4,910	257.74	15,303,880.80
1973-74	5,605	272.73	18,343,819.80
1974-75	6,302	286.37	21,656,444.58

<sup>a/</sup> Presumes a linear program expansion of the two original Regional Centers based on the growth of the program from June, 1966 through June, 1968 with an additional increment, based on the relation of staff sizes, added to the caseload of the Los Angeles Childrens Hospital Regional Center, by the assignment of the functions of the Van Nuys Pre-admission Unit to that Center. It also presumes that the caseload increase throughout those portions of the State not covered by the two original centers will increase in relationship of the population in the unserved to the population served during 1967-68. Ten percent of the total projected caseload is assumed to be over 17 years of age and receiving ATD. This 10% has been deducted from the estimates.

<sup>b/</sup> Includes purchase of services, counseling, diagnosis, and administrative expenses. Average monthly expenditure of 1967-68 has been increased by an annual increment of 5% each year to obtain these figures. Parent reimbursements have neither been estimated nor deducted.

ESTIMATES OF THE NUMBER OF MENTALLY RETARDED IN CALIFORNIA WITH INTELLIGENCE QUOTIENTS OF LESS THAN 55 AND THE NUMBER BEING CARED FOR IN REGIONAL CENTER AND OTHER SELECTED PROGRAMS, 1969-70 THROUGH 1974-75, BY YEAR.

<u>Year</u>	<u>Total a/</u> <u>(IQ 0-54)</u>	<u>Regional Centers b/</u>	<u>Other programs c/</u>
1969-70	66,660	2,820	34,764
1970-71	68,376	3,516	35,659
1971-72	70,092	4,213	36,554
1972-73	71,808	4,910	37,449
1973-74	73,542	5,605	38,344
1974-75	75,240	6,302	39,239

a/ Retardation estimates assume that 3% of the total population is mentally retarded and that, of these, 11% (0.33% of the total population) have IQ's of under 55 (6% moderately retarded, IQ 40-54; 3.5% severely retarded, IQ 25-39; 1.5% profoundly retarded, IQ 0-24). These estimates were obtained from MR 67: A First Report to the President on the Nation's Progress and Remaining Great Needs in the Campaign to Combat Mental Retardation. For the purposes of this report it was presumed that all retardation attributable to socio-environmental and/or psychological factors would be classified as mild or borderline.

b/ See Footnote (a) of Table 1 for assumptions underlying these estimates.

c/ Includes State hospital patients, patients in post-hospital placement, and persons receiving ATD. Estimates are based on actual and estimated numbers of persons under care in these programs during 1967-68, 172.1 per 100,000 total State population.

Note: California population data used for the projections in this table were obtained from the State Department of Finance.

ANALYSIS OF THE BUDGET BILL, 1969 - 1970

Estimated Cost and Caseload of State-Supported Services for the Mentally Retarded

	1967-68	1968-69	Caseload July 1, 1968
<i>Department of Mental Hygiene</i>			
In-hospital services—full range of medical and social services in four hospitals for the mentally retarded and mental retardation units in five hospitals for the mentally ill-----	\$58,439,543	\$65,242,046	12,993
Neuropsychiatric institutes—conducts research into the nature, causes and treatment of mental retardation-----	1,354,153	2,400,000	--
Short-Doyle services—wide variety of in and outpatient services in 35 county programs-----	1,131,981	1,700,000	1,325
<i>Department of Public Health</i>			
Bureau of Mental Retardation and Regional Center Program—administers and provides funds to two regional centers which provide diagnostic, counseling and treatment services on contractual basis in specified areas. (Four additional centers have been authorized by the Legislature and will be in full operation during the 1969-70 fiscal year.)-----	\$1,650,352	\$2,434,868	780
Bureau of Maternal and Child Health—administers various federal special project grants which provide for research and treatment of mental retardation. Federal funds -----	633,395	624,835	--
Bureau of Crippled Children services—receives and disburses funds for treatment of crippling conditions in eligible mentally retarded. General Fund ----- Federal funds -----	\$1,123,310 404,857	\$1,351,912 415,855	
Total -----	\$1,533,167	\$1,767,767	--
Bureau of Health Facilities Planning and Construction—allocates state and federal funds to public and private agencies for hospital construction. Allocations for mental retardation facilities. General Fund ----- Federal funds -----	\$1,140,987 1,140,987	\$564,071 993,084	
Total -----	\$2,281,974	\$1,558,071	--
<i>Department of Social Welfare</i>			
Division of Protective Social Services—provides for purchase of medical and social services for mentally retarded patients on leave from state hospitals. General Fund ----- Federal funds ----- County funds -----	1967-68 \$3,041,580 2,150,082 50,441	1968-69 \$3,296,004 2,329,934 56,327	Caseload July 1, 1968
Total -----	\$5,244,103	\$5,682,765	4,369
Aid to Needy Disabled (ATD)—available to qualified mentally retarded persons over 18 years of age. General Fund ----- Federal funds ----- County funds -----	\$9,696,728 10,301,839 1,618,020	\$10,893,200 11,575,100 1,818,000	
Total -----	\$21,616,587	\$24,288,300	19,460
<i>Department of Rehabilitation</i>			
Offers wide variety of vocational rehabilitation services in cooperation with local school districts, under contract with regional centers, in state hospitals and residential centers. General Fund ----- Federal funds -----	\$500,000 1,900,000	\$661,908 1,984,373	
Total -----	\$2,400,000	\$2,646,281	2,395
<i>Department of Education</i>			
Division of Special Schools and Services—administers school programs for educable and trainable mentally retarded. General Fund ----- Federal funds -----	1967-68 \$699,622 160,000	1968-69 \$714,147 160,000	Average daily attendance
Total -----	\$859,622	\$874,147	--
School programs for educable mentally retarded. State School Fund <sup>1</sup> -----	\$30,909,223	\$32,763,776	58,308
School programs for trainable mentally retarded. State School Fund <sup>1</sup> -----	\$7,393,106	\$7,836,692	8,496
Special transportation for trainable mentally retarded. State School Fund -----	\$3,022,530	\$3,203,881	8,236
Development centers for handicapped minors—provide day care at 29 centers statewide. General Fund -----	\$2,531,500	\$3,056,500	1,020
Grand Total -----	\$140,999,236	\$156,079,013	
Recapitulation:			
General Fund -----	\$81,314,756	\$92,316,656	
School Fund (General Fund) -----	41,324,859	43,804,349	
Federal funds -----	16,691,160	18,083,181	
County funds -----	1,668,461	1,874,827	117,382 <sup>2</sup>

<sup>1</sup> Represents direct transfer from the General Fund.

<sup>2</sup> Duplications are included due to persons on more than one program.

APPENDIX-C

4548

ASSEMBLY JOURNAL

June 18, 1968

By Assemblyman Lanterman :

**House Resolution No. 372**

Relative to study of the use of facilities and programs  
in the care of the mentally retarded

WHEREAS, Significant changes are occurring in the care of the mentally retarded in California; and

WHEREAS, Two Regional Diagnostic Centers for the Mentally Retarded have been established in San Francisco and Los Angeles and it is expected that eventually these will grow into a network providing care in the community for many of the retarded who otherwise might be placed in a state hospital; and

WHEREAS, The population in the state hospitals for the mentally ill is declining and is expected to continue to decline; and

WHEREAS, Many of the hospitals for the mentally ill are now being converted into multipurpose facilities, caring for both the mentally ill and the mentally retarded; and

WHEREAS, These conversions are occurring in the absence of a long-range master plan and without legislative study; and

WHEREAS, Many questions have arisen as to what the future role of the state hospitals should be and how they might be used most efficiently while providing the best care possible for the mentally ill and mentally retarded; now, therefore, be it

*Resolved by the Assembly of the State of California*, That the Assembly Rules Committee assign to the appropriate committee for interim study the subject of the delineation of the role and responsibility of the state hospitals and of community programs for the care of the mentally retarded, including but not limited to a consideration of how the state hospitals can be most efficiently used, with the view of establishing a framework in which a master plan for the use of these various resources might be developed; and be it further

*Resolved*, That such committee is directed to submit a report of its findings and recommendations to the Assembly not later than the fifth legislative day of the 1969 Regular Session.

Resolution read, and referred by the Acting Speaker to the Committee on Rules.

APPENDIX-D

PARTIAL LIST OF PERSONS INTERVIEWED

The following individuals contributed to discussions held by the Ways and Means Committee staff during the course of this study:

Dr. Ivy Mooring, Executive Director, Mental Retardation Services Board of Los Angeles County

Dr. Richard Koch, Director, Los Angeles Children's Hospital Regional Center

Bay Area Mental Retardation Coordinating Council, with the following persons present:

Rosalind Wofsy, Council for Coordinating Services to the Mentally Retarded of Contra Costa County

Carl Verduin, Alameda County Mental Health Services

Al Taylor, Bay Area Social Planning Council, Marin County

Ed Pye, Golden Gate Regional Center

Don Miller, Department of Mental Hygiene

David Sokoloff, First Vice President, California Council For Retarded Children

Mrs. Mary Palm, District Director, C.C.R.C.

Fred Krause and Rolf Williams, C.C.R.C. staff

Dr. Gunnar Dybwad, Professor of Humanities, Brandeis University

Golden Gate Regional Center personnel, including:

Dr. Peter Cohen, Director

Mrs. Margarete Connelly, Director, San Francisco Aid Retarded Children

Ed Pye, Chief, Counseling Service

Carl Verduin, County Coordinator of Mental Retardation Services, Alameda County

Richard Struck, Director of Programs for Exceptional Children and Pupil Personnel Services, Office of Education, Santa Cruz County

Mental Retardation Program and Standards Advisory Board

California Council for Retarded Children Executive Committee.

H.E. Hogan, Director of State Relations, County Supervisors Association of California

Dr. Charles Gardipee, Chief, Bureau of Mental Retardation Services, Department of Public Health

William Wilsnack, Department of Social Welfare

Department of Mental Hygiene personnel, including:

Dr. James V. Lowry, Director

Dr. Elmer F. Galioni, Deputy Director, Division of State Services

Andrew G. Robertson, Deputy Director, Administrative Services

Dr. William B. Beach, Jr., Deputy Director, Local Programs

Dr. Roswell H. Fine, Assistant Deputy Director, Retardation Services

APPENDIX-E

RATED CAPACITY AND POPULATION COMPARISON  
HOSPITALS FOR THE MENTALLY RETARDED

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<u>Hospital</u>	<u>Rated Capacity</u> <u>September 30, 1968</u> *	<u>Patients in Hospital</u> <u>(including visits)</u> <u>October 6, 1968</u>
TOTAL	10,480	13,175
AGNEWS	467	446
CAMARILLO	481	475
DeWITT	743	882
FAIRVIEW	1,915	2,476
NAPA	---	13
PACIFIC	1,996	2,696
PATTON	408	501
PORTERVILLE	2,095	2,428
SONOMA	2,375	3,258

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\* Based on allocation of 70 square feet per bed.

October 9, 1968  
Dept. of Mental Hygiene



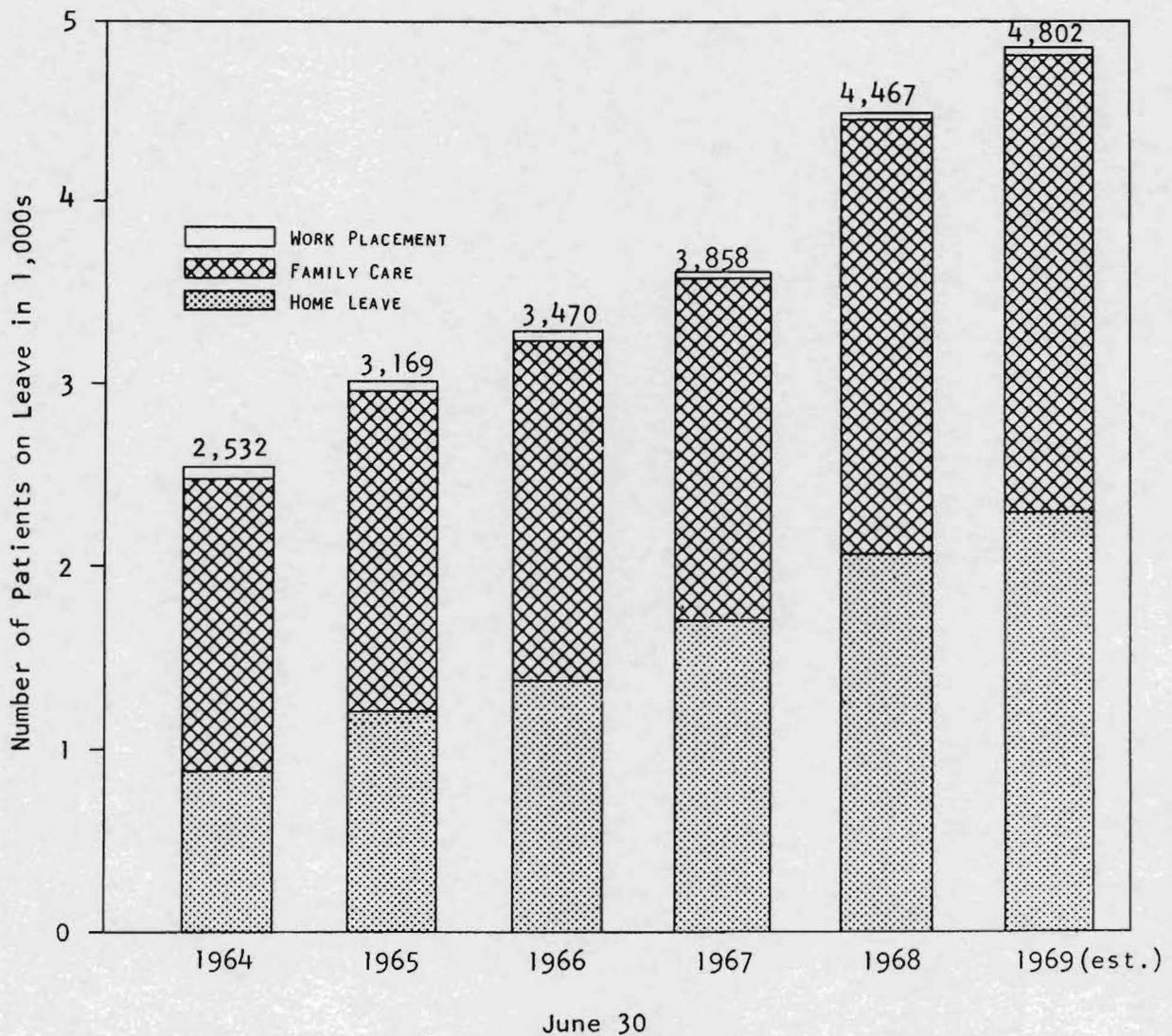
- <sup>1</sup> These patients are a selected group who are presently being prepared for return to the community by the joint efforts of the Department of Mental Hygiene and the Department of Vocational Rehabilitation.
- <sup>2</sup> Camarillo's population is a selected group of adult patients from the southern part of the state of whom 10% might be placed at this time, and approximately 10% or more annually.
- <sup>3</sup> The nursing home patients are primarily older patients who need some medical supervision as might be provided by a DMH private institution. Approximately 10% of the remaining population can be placed in a non-medical setting at any given time.
- <sup>4</sup> The percentages were derived from the WICHE data including patients definitely identified as referred, identified as placeable, and half of the patients who it was thought might possibly be placed.
- <sup>5</sup> The percentages were derived by slightly reducing the lowest percentages utilized for the other hospitals from the WICHE data.

BSS  
1-10-69

APPENDIX-G

PATIENTS ON LEAVE, BY TYPE OF LEAVE  
HOSPITALS FOR THE MENTALLY RETARDED

<u>June 30</u>	<u>Total indefinite leaves</u>	<u>Home leave</u>	<u>Family care</u>	<u>Work placement</u>
1964	2,532	855	1,599	78
1965	3,169	1,203	1,894	72
1966	3,470	1,379	2,029	62
1967	3,858	1,706	2,115	37
1968	4,467	2,057	2,371	39
1969 (est.)	4,802	2,266	2,497	39



APPENDIX-H

COMPARISON OF DAILY COSTS  
 STATE HOSPITAL CARE AND STATE DEPARTMENT OF SOCIAL WELFARE  
 POST-HOSPITAL CARE

MENTALLY ILL	STATE HOSPITAL	STATE DEPT. OF SOCIAL WELFARE	
		TOTAL COST	STATE COST
Intensive Nursing - Geriatric Care	\$19.70	\$ -	\$ -
Continuing Psychiatric Care	15.10	-	-
Out-of-Home Placements	-	9.51	4.68
Total Leave Load	-	6.39	3.14

MENTALLY RETARDED	STATE HOSPITAL	STATE DEPT. OF SOCIAL WELFARE	
		TOTAL COST	STATE COST
Intensive Treatment, Mentally Retarded Children	\$16.85	\$ -	\$ -
General Mentally Retarded	13.80	-	-
Out-of-Home Placement	-	8.02	4.72
Total Leave Load	-	7.63	4.34

Community Services Division  
 State Department of Social Welfare  
 Sacramento  
 November 29, 1968

COST FACTORS  
 PATIENTS SERVED BY COMMUNITY SERVICES DIVISION  
 STATE DEPARTMENT OF SOCIAL WELFARE

MENTALLY RETARDED PATIENTS IN OUT-OF-HOME CARE

	DAILY COSTS			
	Combined Federal, State, County	State Share	Federal Share	County Share
1. Administrative Costs, Protective Social Services	1.17	.51	.66	-
2. Public Assistance Grant	3.01	1.29	1.51	.22
3. Administrative Costs, Eligibility and Grand Determination	.39	.01	.24	.14
4. Special Placement Costs (Family Care, Mentally Retarded in Private Institutions)	2.11	2.11	-	-
5. Special Needs: tranquilizers, medical supplies, clothing, personal expenses (Depart- ment of Mental Hygiene)	.225	.225	-	-
6. Medi-Cal	1.04	.52	.52	-
7. State Department of Social Welfare Administrative Overhead	.039	.039	-	-
8. Miscellaneous	.040	.016	.016	.008
TOTAL	8.02	4.72	2.95	.37

Community Services Division  
 State Department of Social Welfare  
 Sacramento  
 November 29, 1968

COST FACTORS  
 PATIENTS SERVED BY COMMUNITY SERVICES DIVISION  
 STATE DEPARTMENT OF SOCIAL WELFARE

ALL MENTALLY RETARDED PATIENTS

	DAILY COSTS			
	Combined Federal, State, County	State Share	Federal Share	County Share
1. Administrative Costs, Protective Social Services	1.17	.51	.66	-
2. Public Assistance Grant	3.10	1.33	1.55	.22
3. Administrative Costs, Eligibility and Grant Determination	.37	.01	.22	.14
4. Special Placement Costs (Family Care, Mentally Retarded in Private Institutions)	1.76	1.76	-	-
5. Special needs: tranquilizers, medical supplies, clothing personal expenses (Depart- ment of Mental Hygiene)	.195	.195	-	-
6. Medi-Cal	.96	.48	.48	-
7. State Department of Social Welfare Administrative Overhead	.039	.039	-	-
8. Miscellaneous	.032	.012	.012	.605
TOTAL	7.63	4.34	2.32	.37

Community Services Division  
 State Department of Social Welfare  
 Sacramento  
 November 29, 1968

P-3

# Flap Over S.F. Foster Children

*S.F. Chronicle 1-22-69*

Residents from several middle - class areas in San Francisco filled the chambers of the Board of Supervisors yestersay to protest against plans that woulr permit more foster children and retarded children to live in their neighborhoods.

The proposal, sponsored by several social agencies and church groups, would permit up to six such children to live in a house in areas zoned for single - family residences.

Helen Herrick, president of the San Francisco Coordinating Council on Mental Retardation and a social welfare professor at San Francisco State College, said the system would reduce the "inhumane practice" of sending children away from their

families and into outlying areas.

## SUBURBS

At present, she said, the city is spending \$650,000 to place children outside the city, mostly in suburbs but in some cases as far away as Los Angeles. As a result, she added, they see their parents far less often than they should.

A succession of speakers from the standing-room - only audience protested to the supervisors' planning committee that the proposed amendment to the Municipal Code would hurt their property values.

Leon Markell of the Balboa Terrace Home Owners Association said admitting the children would be "the first irreversible step" toward

turning San Francisco into "a succession of dreary streets bulging with occupants."

He said hotels, boarding houses and shums would follow in the children's wake.

## TRESPASSING

A woman who said she was speaking for Anza Vista residents said, "We're absolutely against this type of trespassing in our family neighborhoods."

Walter Swanson, representing the Forest Hill Association, said the proposed change in the city's Municipal Code, would encourage the presence of more children in San Francisco.

"Your city is not hospitable for children anyway," Swanson said. He claimed the city's lots were too small

and its topography too varied.

At one point, during an exchange between Supervisor Jack Morrison and a real estate broker, Committee Chairman Ronald Pelosi threatened to clear the chambers if the audience did not quiet down.

## APPLAUSE

The residents gave loud applause for their spokesmen.

There was no such response, however, when the Rev. John F. Duffy, director of the social services department of the San Francisco Council of Churches, told the committee that passage of the ordinance "would give us the opportunity to show that San Francisco cares more about human values than material values."

APPENDIX-J

DEPARTMENT OF MENTAL HYGIENE  
MENTALLY RETARDED SUPPORT BUDGET AND RELATED REVENUE

Fiscal Year	Mentally Retarded Hospital Budget*	**Revenue	**Percentage	**Net Cost of Patient Care
63/64	\$ 44,857,044	\$ 4,157,500	9.3	\$ 40,699,544
64/65	47,960,797	4,217,109	8.8	43,743,699
65/66	53,113,953	4,496,638	8.5	48,617,315
66/67	59,374,415	4,036,539	6.8	55,337,876
67/68	64,905,672	7,736,490	11.9	57,169,182
68/69 (est.)	73,623,775	23,352,234	31.7	50,271,541
 	<hr/>	<hr/>	<hr/>	<hr/>
TOTAL	\$343,835,656	\$47,996,510	14.0	\$295,839,146

\* Hospitals for the Mentally Retarded plus mentally retarded patients in Mentally Ill Hospitals.

\*\* Revenue, Percentage, and Net Cost of Patient Care information provided by Bureau of Patients' Accounts 1-23-69.

SUPPORT BUDGET  
HOSPITALS FOR MENTALLY RETARDED  
NET COST AND COLLECTIONS

