

# **Regional Centers for the Mentally Retarded**

**the first two years**



State of California  
Department of Public Health  
Bureau of Mental Retardation Services  
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## Foreword

Over the years, approximately 2,000 to 3,000 California families at the point where they were no longer able to care for their retarded member applied annually for services from one of the four State hospitals for the mentally retarded. Until 1965, the State hospital and post-hospital leave programs were the only alternatives open to families, whether or not hospital care was needed by the individual or desired by his family.

During the 1965 legislative session, the Regional Center program was established to answer the pleas of families who were eager to keep their mentally retarded family member home and/or in the community.

In 1965, two Regional Centers were established in California -- the Golden Gate Regional Center, which serves persons residing in Alameda, Contra Costa, Marin, San Francisco and San Mateo Counties, and Childrens Hospital, Los Angeles Regional Center, serving persons residing in Los Angeles County. This is a report of the first two years' experience of these Centers.

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This is a report of the Regional Center Program, established by the 1965 Session of the Legislature, under Assembly Bill 691, Chapter 1242, Statutes of 1965.

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PART I

INTRODUCTION

Jerry, a 12-year-old retarded child, for years had suffered severe seizure disorders and behavior problems. His parents, exhausted from caring for him at home, requested his admission to a state hospital for the mentally retarded. The bill which established the two Regional Centers provided that the Centers offer alternatives to state hospital placement to persons who do not require this care and whose families do not wish hospitalization. One of the new Centers offered services to Jerry and his family and after careful evaluation and thorough discussion with the boy's parents, the Center recommended and began providing residential schooling in an emotionally supportive environment. Jerry's self-concept and behavior have improved tremendously, and he is making progress intellectually. It is probable that with the kind of help Jerry is receiving, he will be able to return to his home and attend public school.

The mother of a 6-year-old cerebral palsied, nonambulatory child, Jane, was divorced and living on a small income which nonetheless made her ineligible for assistance through any public program (other than the Regional Center). Since the mother preferred to have Jane live at home, the Regional Center assisted in the enrollment of the child in a day care program which focuses on her special needs. This new arrangement made it possible for the mother to obtain full-time employment and support Jane, herself and her non-mentally retarded child. The Center also guided the family to take advantage of an existing resource, the Crippled Children Services Program, which purchased braces enabling Jane to walk. With treatment of the orthopedic problems and the help she is receiving in the day care program, it is hoped that Jane will soon move into a public school program such as a Development Center for Handicapped Minors.

Jane and Jerry are two of the mentally retarded individuals who with their families have received needed help from the two existing Regional Centers.

In pre-regional center days, these retarded persons might have remained on the hospital waiting list. Not only that, Jane, Jerry and many others awaiting admission were not actually in need of hospital care, and their requirements could be met more appropriately and at less cost to the State by other facilities and services. Until passage of the bill setting up the Regional Center program, the state hospitals were the only resource for many parents who had reached the end of their strength and means in caring for a retarded child or adult.

The Regional Center program was established by the 1965 Session of the Legislature under AB 691, Chapter 1242, Statutes of 1965. The legislation resulted from the findings of two study groups, the Study Commission on Mental Retardation and the Subcommittee on Mental Health Services of the Assembly Ways and Means Committee, which had reviewed the needs, available services and problems of the mentally retarded. (For details about the study groups and the creation of the Mental Retardation Program and Standards Advisory Board, see APPENDIX A.)

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The functions of a Regional Center are outlined in detail in Sections 415-416.1 of the State Health and Safety Code (APPENDIX B). Briefly, a Center will provide or cause to be provided: 1) diagnosis; 2) counseling on a continuing basis; 3) assistance to purchase services; 4) maintain a registry and maintenance of case records; 5) systematic follow-up; 6) assistance in state hospital placement when necessary; and 7) to call attention to unmet needs in community care and services and stimulation of the community to develop such services as needed.

## PART II

### THE REGIONAL CENTER

The legislation reinforced the conclusions reached by the study groups, bringing the Regional Center concept into being as an additional resource for families with retarded individuals. The legislative intent was not that the Center would become the total service available for the mentally retarded, but it would assist families to use existing services and provide services only when no other resource existed.

One of the two major principles guiding Regional Center operation is that of integration of the mentally retarded into the community. The statewide study groups had found that mentally retarded persons were often denied services for which they were eligible because they were retarded, and the Regional Centers, from the beginning, followed the legislative intent of not duplicating or preempting any existing program. Community resources are thoroughly explored so that service funds are not spent when there is an existing program providing a service to which a retarded individual is entitled. Frequently a considerable amount of Center counseling time is spent working out arrangements with another agency.

The second major principle of the Center concept is that of maximum family involvement in care of the retarded individual and in selection of services to be provided. This encourages and helps a family to maintain its responsibilities for the retarded member.

Assembly Bill 691 became effective September 17, 1965. In October the State Department of Public Health established the Bureau of Mental Retardation Services to administer the program. With the assistance of an advisory committee of experts in the field of mental retardation, the Bureau immediately began to develop standards and specifications for a Regional Center. Since there was no available experience with the model of the Regional Center concept as created by law, it was necessary to draw upon the experiences of various established programs to develop a pattern of services for implementation of the legislation.

The next step was to publicize the specifications and seek applicants to administer a Regional Center. The law specified that the State Department of Public Health shall contract with "appropriate agencies" to administer a Center. The term "appropriate agencies" was not defined in the law, but it was the intent of the authors of the legislation that this could be a governmental or a voluntary nonprofit agency. Special

attention was given to the possibility of contracting with nongovernmental agencies in order to involve the private sector in delivering services to the retarded and to demonstrate that public and private agencies can work together creatively in furthering common objectives.

Six applications were received. The Childrens Hospital of Los Angeles and San Francisco Aid Retarded Children, Inc. were selected because they were able to assemble competent personnel and begin operation in the shortest possible time. The contracts were signed January 6, 1966, and the Centers initiated services to their first clients in mid-March 1966. No new Centers were added during the period of this report.

#### State Department of Public Health

The Department of Public Health develops standards and procedures for Regional Centers, negotiates contracts with appropriate agencies for Regional Centers and furnishes consultation to Center staff.

In addition the Department reviews Center invoices for payment and maintains a central registry of individuals served in the program by all Centers. These duties as well as liaison between Centers and other departments of State government is carried out by the Bureau of Mental Retardation Services, in the Preventive Medical Program.

#### Center Administration

Each Center's administrative structure is based upon the organization of the contracting agency and the demography of the area served. Childrens Hospital of Los Angeles, which serves as the pediatric teaching facility of the University of Southern California School of Medicine, administers the Regional Center as a unit in the Hospital's Division of Child Development, and serves residents of Los Angeles County. The Center director is guided by an advisory committee representing a broad base of local public and voluntary agencies serving the retarded. Counselors are stationed at Childrens Hospital and by subcontracts with the Kennedy Child Study Center, Exceptional Children's Foundation and the Pediatrics Department of the California College of Medicine at White Memorial Hospital. The central unit at Childrens Hospital supervises the counselors and controls purchased services.

The Mental Retardation Services Board of Los Angeles County coordinates the activities of the Center with those of other community agencies. A policy committee composed of representatives of the Childrens Hospital and the subcontractors meet under sponsorship of that Board.

The Golden Gate Regional Center serves five Bay Area counties: Alameda, Contra Costa, Marin, San Francisco and San Mateo. It is administered by San Francisco Aid Retarded Children, Inc. The Board of Trustees of that organization has appointed an executive committee to advise on administrative and policy matters. This executive committee consists of five members of the Board and five representatives nominated by the coordinating councils on mental retardation in each of the counties served.

The committee members provide liaison between county political and social forces and the Center; bring regional strength to the broad purposes of the program; and help to strengthen the Golden Gate Regional Center's operation by individually and collectively consulting with the director and staff.

#### Center Staffing

A Regional Center is a Center in an administrative sense. The services provided directly are diagnosis, evaluation and counseling. All other services, including specialized medical diagnostic examination and tests, are obtained or purchased from existing community resources. Center staff is not housed in one location but throughout the areas to be served. While each Center has its own administrative structure and operating procedures adapted to meet local needs, there are certain common elements.

Each of the two Centers has a director who is a physician. He is also the chief of the diagnostic and evaluation unit. There are also one or more staff physicians on a full or part-time basis; a chief counselor; a supervising counselor; staff counselors; a nursing consultant; and administrative assistant with clerical and accounting staff. In addition, each Center has a vocational rehabilitation counselor by contract between the Department of Public Health and the Department of Rehabilitation. Staff counselors are stationed in local agencies providing services to the retarded in the Los Angeles area and in each of the five Bay Area counties served in the north.

#### Center Procedure

When a family contacts a Center, they are immediately referred to a counselor who discusses the problem and outlines the services available from the Center. If the counselor and family determine Center service is appropriate, an interview is scheduled. Often the initial interview reveals that the family does not need Center services but can be assisted by another agency. The counselor then devotes his time in assisting the family to obtain services from the other agency. This may involve many hours depending upon the complexity of the need and the structure of community resources. These are called "information and inquiry" cases. Approximately two "information and inquiry" cases are assisted for every one that becomes an "active" case.

The Golden Gate Regional Center receives consultation to select priorities of families to be served from a county screening committee composed of representatives of various agencies who serve the retarded. This committee presents existing information about the family and determines if they have exhausted all available resources offered by existing county agencies.

Following an intake interview (and the above outlined procedure by the Golden Gate Regional Center) the information about a family is reviewed by the Regional Center multidisciplinary "core" staff which determines

additional information needed to complete the diagnosis and evaluation process. Extensive diagnostic work-ups were not needed by most of the retarded served during this fiscal year because most were either on a Department of Mental Hygiene hospital waiting list, which means a preadmission work-up had already been done, or had recently been evaluated by other diagnostic groups. The Center staff did not repeat the diagnostic work-up but simply completed those diagnostic tests which were necessary to bring the information up to date. It is anticipated that the Centers will increase the number of diagnostic and evaluative studies in the future when the focus can be directed to the prevention of family crisis by early intervention of individuals suspected of retardation.

After completion of the evaluation process, the case is again reviewed by the staff, a plan for the individual developed, and responsibility for continuing care assigned. If no services are required, or if another agency assumes primary responsibility, the case is "inactivated". If at any time the individual needs further services, his case is reactivated as directed under Section 415 of the Health and Safety Code.

Cases are closed under the following conditions: death of the patient, and the patient is found not to be mentally retarded.

Active cases are regularly reviewed by the evaluation team. They are assigned to a counselor who is responsible to provide direct counseling services to the family and to supervise the program for the retarded individual. The counselors maintain regular contact with those individuals who are placed in 24-hour foster care facilities.

#### PART III SERVICE STATISTICS

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 not mentally retarded and eleven expired.

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.

A percent distribution of the age of individuals who were served in the active caseload is listed below:

AGE	PERCENT
0-4	18
5-9	38
10-14	24
15-19	11
20-29	6
30 and Over	3

About three out of five of these individuals were males.

The type of residence of the 1,003 cases was determined at the time of the 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 1966-1967 and 1967-1968. During 1966-1967, 471 cases received one or more purchased services at some time during the year, and in 1967-1968, 589 received such services. The major purchased service was residential care which was provided for about 55 percent of the cases in 1966-1967 and 52 percent in 1967-1968. About 35 percent 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 1967-1968. 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; however, as the best basis for planning future budgets and Centers, a full month was counted for professional services even if the service was rendered on only one day of the month.

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

	FISCAL YEAR 1966-1967	FISCAL YEAR 1967-1968
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 1966-1967 and 7417.5 in 1967-1968. 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 the 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 1967-1968 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:

	FISCAL YEAR 1966-1967	FISCAL YEAR 1967-1968
Total	\$223.76	\$195.52
Purchase of Services <sup>1</sup>	135.48	130.70
Counseling and Diagnosis	74.78	54.99
Administration	13.50	9.83

<sup>1</sup> 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 1966-1967 and \$64.82 in 1967-1968. Family reimbursements for purchase of services amounted to \$6.90 per case-month in 1966-1967 and \$7.99 in 1967-1968. In addition families assumed the obligation for necessary services and paid for them directly. No record was kept of these services.

#### Program Trends

The second fiscal year showed increased numbers of case-months of both Center care and purchased services. The active cases increased 37.7 percent and the actual numbers of case-months of Center services, 77.1 percent and case-month of purchased services, 58.1 percent. Appendix Table 3 presents a comparison by the type of program activity and Table 4 by the type of service purchased. All of the indices show anticipated increases as the Center capacity expanded. The 99 percent decrease in the use of rehabilitation centers shown in Table 4 reflects the small number of cases involved and a change in program.

#### Other Services

The service statistics relate to active cases as the major program objective of the Centers. It should be pointed out that for each active case at least three families contact a Center. The individuals and families, who are not registered and do not become active cases for statistical purposes, often require considerable amounts of time as the counselor and family examine a problem and determine the appropriate agency to serve the family. A study will be undertaken to determine the costs of this important information and referral service.

In addition, all of the professional staff is engaged in interpretation of the Center services to the community. This requires time at meetings not directly related to service to any one client. The staff has been active in creating additional community resources for the retarded. The costs of these other services are not identified and are apportioned to active cases.

#### PART IV

#### EVALUATION

The Regional Center program has become a major resource for mentally retarded residents of Los Angeles County and the five Bay Area counties served by the Golden Gate Regional Center.

The evaluation of the program is subjective inasmuch as our limited staff has not had time to do an analysis of the effectiveness of the various alternatives for services to an individual offered by the program; however, our impressions are that the program is of high quality, and families are satisfied and feel that their needs are being met. The best indication of this is the continued interest and involvement of families with their retarded member. Other indications are that voluntary family reimbursements increased from 4.8% of total purchase of services in fiscal year 1967 to 5.8% in fiscal year 1968. Also, many services are being supplied by families in addition to those purchased for them. The average costs per case-month of diagnosis and counseling, and administration decreased during the second year of the program; it is not known at this time if the decline has leveled off. However, we think that the decline will continue for another year or so until the optimal counselor, administration and service expenditure ratio is reached.

The Regional Center program is flexible and alternative directions will be explored in those areas which appear not to be meeting the needs of the mentally retarded. All available community resources are utilized before Regional Center funds are used to purchase services for the mentally retarded. This practice will continue and efforts will be made to utilize Federal funds in the program as provided by the Muskie amendments to the Social Security Act. In future years, the Bureau of Mental Retardation Services will make studies of the effectiveness of the program, including Center administration, standards of care provided by vendors and cost effectiveness.

APPENDIX TABLE 1

AVERAGE MONTHLY COSTS OF PURCHASED SERVICES BY TYPE  
REGIONAL CENTER PROGRAM, FISCAL YEAR 1966-1967

	NUMBER OF ACTIVE CASES	CASE-MONTHS OF PURCHASED SERVICES	EXPENDITURES	AVERAGE PER MONTH	PERCENT	
					Cases	Expenditures
Total	471	2,505.33	\$596,352.80	\$238.03	100	100
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
Dentists	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 percent.

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.

APPENDIX TABLE 2

AVERAGE MONTHLY COSTS OF PURCHASED SERVICES BY TYPE  
REGIONAL CENTER PROGRAM, FISCAL YEAR 1967-1968

	NUMBER OF ACTIVE CASES	CASE-MONTHS OF PURCHASED SERVICES	EXPENDITURES	AVERAGE PER MONTH	PERCENT	
					Cases	Expenditures
Total	589	4,248.68	\$1,028,608.73	\$242.10	100	100
Residential Care, Total	307	2,969.15	890,542.84	299.93	52.1	86.6
Resident Schools	140	1,293.55	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	*
All Other	43	135.13	7,625.69	56.43	7.3	0.7

\* Less than 0.1 percent.

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.

APPENDIX TABLE 3  
PROGRAM INCREASES BETWEEN FISCAL YEARS  
REGIONAL CENTER PROGRAM  
FISCAL YEARS 1966-1967 AND 1967-1968

PROGRAM SEGMENT	PERCENT INCREASE BETWEEN FISCAL YEARS
Active Cases *	37.7
Active Cases Receiving Purchased Services *	25.2
Active Cases Receiving Purchased Services During Year	25.1
Case-Months of Care	77.1
Case-Months of Purchased Services	58.1
Parent Reimbursements	105.2
Purchase of Service Expenditures, Total	72.5
Purchase of Service Expenditures Less Family Reimbursements	70.8
Diagnostic and Counseling Expenditures	30.2
Administrative Expenditures	29.0

\* Proportional increase in the number of clients/families receiving Regional Center assistance during the last month of the fiscal year (June).

APPENDIX TABLE 4

AVERAGE NUMBER OF CASE-MONTHS OF PURCHASED SERVICES  
REGIONAL CENTER PROGRAM  
FISCAL YEARS 1966-1967 AND 1967-1968

TYPE OF SERVICE	FISCAL YEAR 1966-1967	FISCAL YEAR 1967-1968	PERCENT CHANGE
Total	5.32	7.21	+ 12.4
Workshops	3.30	9.31	+182.1
Professional Services	2.74	4.21	+ 53.6
Respite Care	3.19	4.68	+ 46.7
Resident Schools	6.55	9.24	+ 41.1
Day Care	3.98	5.30	+ 33.2
Family Care Homes	5.18	6.87	+ 32.6
Resident Facilities	7.37	9.73	+ 32.0
Nursing Care Facilities	7.52	9.60	+ 27.7
Camps	0.34	0.31	- 8.8
Rehabilitation Centers	3.62	0.22	- 99.4
Other Services	3.06	3.14	+ 2.6

Note: Only those services which were provided during both fiscal years are included in the table.

#### APPENDIX A

The Regional Center program (AB 691, Chapter 1242, Statutes of 1965) resulted from the findings of two study groups which held statewide public hearings to review the needs, available services and problems of the mentally retarded. One of these study groups was the Study Commission on Mental Retardation which was established by legislation introduced during the 1963 Session of the Legislature. The other was the Subcommittee on Mental Health Services of the Assembly Ways and Means Committee under the chairmanship of former Assemblyman Jerome Waldie. Both of these study groups recommended, among other types of assistance for the retarded, the establishment of a statewide network of regional diagnostic, counseling and service centers as an additional resource for the retarded to provide, or cause to be provided, services in the local community.

Simultaneously legislation was enacted to create the Mental Retardation Program and Standards Advisory Board (AB 769, Chapter 1244, Statutes of 1965) to function as an advisory body to the Administrator of the Health and Welfare Agency on all matters concerning the retarded; and a Coordinator of Mental Retardation Programs to provide, in addition to other responsibilities, staff services to the Board. This legislation also required the Administrator of the Health and Welfare Agency to establish standards and rates for providers of care for participation in the Regional Center program, and to certify prior to purchase of service that the provider of care meets the established standards. This objective evaluation by an Administrator who is not directly involved with the details of program operation and who is advised by a Board representing broad interests in the care of the retarded, assures a high quality of service for mentally retarded persons.

APPENDIX B1

HEALTH AND SAFETY CODE

Article 7.5. Mentally Retarded Persons

*(Article 7.5 added by Statutes 1965, Chapter 1242)*

415. As used in this article, "regional centers" means regional diagnostic, counseling, and service centers for mentally retarded persons and their families.

415.1. It is desirable that there be a shift in state responsibility for mentally retarded persons from the time they enter a state hospital to the time when they are diagnosed as needing specialized care.

In order to provide fixed points of referral in the community for the mentally retarded and their families; establish ongoing points of contact with the mentally retarded and their families so that they may have a place of entry for services and return as the need may appear; provide a link between the mentally retarded and sources in the community, including state departments, to the end that the mentally retarded and their families may have access to the facilities best suited to them throughout the life of the retarded person; and offer alternatives to state hospital placement, it is the intent of this article that a network of regional diagnostic, counseling, and service centers for mentally retarded persons and their families, easily accessible to every family, be established throughout the state.

415.2. The State Department of Public Health, within the limitations of funds appropriated, shall contract with appropriate agencies for the establishment of regional centers.

415.3. Regional centers shall be near centers of population where most needed and wherever possible connected to or in close proximity to institutions of higher learning and research.

415.4. The regional centers shall provide and perform or cause to be performed services including, but not limited to, the following:

- (a) Diagnosis.
- (b) Counseling on a continuing basis. Counseling shall include advice and guidance to any mentally retarded person and his family, to assist them in locating and using suitable community facilities, including, but not limited to: special medical services; nursery and preschool training; public education; recreation; vocational rehabilitation; and suitable residential facilities.
- (c) Provide state funds to vendors of service to the retarded, when failure to provide such services would result in state hospitalization.
- (d) Maintain a registry and individual case records.
- (e) Systematic followup of the mentally retarded and reactivation of cases as indicated.
- (f) Assist, where necessary, in state hospital placement of the mentally retarded.
- (g) Call public attention to unmet needs in community care and services, defining and interpreting standards of community care and services as used by the regional center, and stimulating the community to develop such services as needed.
- (h) Maintain a staff according to standards set by the State Department of Public Health.

415.5. Upon referral by a physician, or other qualified professional person authorized by the regional center, any person suspected of mental retardation shall be eligible for initial intake and for diagnostic and counseling services in the regional centers.

415.6. The State Department of Public Health may receive and expend all funds made available to the department by the federal government, the state, its political subdivision, and other sources, and, within the limitation of the funds made available, shall act as an agent for the transmittal of such funds for services through the regional centers. The department may use any funds received under Article 2 (commencing with Section 249) of this chapter for the purposes of this article. The State Department of Public Health may contract with the Department of Rehabilitation to provide vocational diagnostic and rehabilitative services in regional centers.

416. The parents or guardian of a mentally retarded person may designate the Director of Public Health as guardian of the mentally retarded person on the death of the parents or guardian, if the state has assumed responsibility for providing care to the retarded person, through the regional center. Such guardianship shall be for the purpose of carrying out the recommendations of the regional center and to provide the retarded person with the assurance of continuity of care.

416.1. This article does not authorize the care, treatment, or supervision or any control over any mentally retarded person without the written consent of his parent or guardian.

416.2. The agency operating a regional center may enter into agreements with parents, guardians, persons responsible for the care of the mentally retarded, or estates of mentally retarded persons, to use such amounts as they may be able to pay toward the cost of services for such mentally retarded persons. In no event, however, shall there be any charge for diagnosis or counseling.

APPENDIX B2

Assembly Bill No. 769

CHAPTER 1244

*An act to add Division 25 (commencing with Section 38000) to the Health and Safety Code, and to add Section 6514 to the Government Code, relating to mental retardation and the Mental Retardation Program Advisory Board, and making an appropriation therefor.*

Approved by Governor July 14, 1965. Filed with  
Secretary of State July 15, 1965

*The people of the State of California do enact as follows:*

Section 1. Division 25 (commencing with Section 38000) is added to the Health and Safety Code, to read:

DIVISION 25. SERVICES FOR THE  
MENTALLY RETARDED

CHAPTER 1. MENTAL RETARDATION PROGRAM  
AND STANDARDS ADVISORY BOARD

Article 1. Purpose

38000. The State of California accepts a responsibility for its mentally retarded citizens and an obligation to them which it must discharge. Affecting hundreds of thousands of children and adults directly, and having an important impact on the lives of their families, neighbors, and whole communities, mental retardation presents social, medical, economic, and legal problems of extreme importance.

The complexities of mental retardation require the services of many state departments as well as the community. Frequently there are gaps beyond the present duties and powers of departments in the development of state and community services.

Services should be planned and provided as a part of a continuum. A pattern of facilities and eligibility should be established which is so complete as to meet the needs of each retarded person, regardless of age or degree of handicap, and at each stage of his life's development.

Article 2. Establishment of Board

38050. In order to insure the continuity of services, develop a creative interdepartmental and community approach, and coordinate all efforts of federal, state, local, and voluntary agencies, there is in the Health and Welfare Agency the Mental Retardation Program Advisory Board, hereinafter referred to as the board.

The board shall consist of 15 members, namely:

- (a) The Superintendent of Public Instruction.
- (b) The Director of Employment.
- (c) The Director of Mental Hygiene.
- (d) The Director of Public Health.
- (e) The Director of Rehabilitation.
- (f) The Director of Social Welfare.

- (g) The Director of the Youth Authority.
- (h) Two county supervisors appointed by the Governor.
- (i) Two persons appointed by the Governor, representing nongovernmental agencies providing services for the mentally retarded.
- (j) Two persons appointed by the Governor, representing the general public.
- (k) One person appointed by the Speaker of the Assembly, representing consumers of services for the mentally retarded.
- (l) One person appointed by the Senate Committee on Rules, representing consumers of services for the mentally retarded.

38051. The chairman of the board shall be designated by the Governor from among the members of the board. The first chairman shall serve until January 1, 1967 and thereafter be designated for a one-year period.

38052. The members of the board shall meet at such times as may be determined by resolution of the board, but not less than twice yearly. Special meetings may be called by the chairman. He may appoint subcommittees.

38053. Members of the board designated in subdivisions (h) to (k), inclusive, of Section 38050, shall serve four years. Initial appointments shall be staggered with two such members serving until January 1, 1966; two members serving until January 1, 1967; two members serving until January 1, 1968; and two members serving until January 1, 1969.

38054. Any member of the board who is a person designated in subdivisions (a) to (g), inclusive, of Section 38050, may delegate his powers and duties to a representative who shall serve on the board in the place of such member.

#### Article 3. Advisory Responsibilities of the Board

38100. The board shall advise the Administrator of the Health and Welfare Agency on the initiation, coordination, and implementation of programs and projects for the mentally retarded, including, but not limited to, the following:

- (a) Present and proposed programs of service for the mentally retarded of state, local governmental, and voluntary agencies.
- (b) The development of a coordinated plan of state and local services for the mentally retarded, and the development and formulation of a master plan for establishing responsibilities for the total array of mental retardation services.
- (c) Standards for services in various facilities that are now being operated or which will hereafter be created.
- (d) Standards and rates of state payment for any services purchased with state funds for mentally retarded persons through the regional diagnostic, counseling service centers as may be defined in Article 7.5 (commencing with Section 415) of Chapter 2, Part 1, Division 1 of the Health and Safety Code.
- (e) The development of uniform recordkeeping in all services for the mentally retarded.
- (f) The coordination of services and research activities in the field of mental retardation, including the evaluation of services and programs, studies of the prevalence of mental retardation, and the development of experimental programs.
- (g) The stimulation of planning for professional training in the state universities and colleges.

38101. The board shall, to the extent possible, collaborate and cooperate with any board, commission, or council concerned with programs for handicapped persons.

38102. The board shall prepare and render annually a written report of its activities and its recommendations to the Governor through the Administrator of the Health and Welfare Agency.

38103. The departments of state government shall cooperate with and furnish such information, records, and documents, as the board may request.

38104. All meetings of the board shall be open to the public.

Article 4. Standards and Rates of State  
Payment for Services

38200. The Administrator of the Health and Welfare Agency shall adopt rules and regulations prescribing standards of service which shall be satisfied and maintained as a condition to the payment of state funds for residential care of the mentally retarded by a regional diagnostic, counseling service center.

The Administrator of the Health and Welfare Agency shall adopt standards for all nonresidential professional services which may be purchased for mentally retarded persons with state funds by a regional diagnostic, counseling service center for the mentally retarded.

The Administrator of the Health and Welfare Agency shall provide regional centers with current lists of approved facilities and services. Regional centers may not expend state funds for services which are not approved by the Administrator of the Health and Welfare Agency, notwithstanding any other certification, licensing, or approval of the facility or service.

The Administrator of the Health and Welfare Agency shall not adopt standards which are in conflict with those adopted by the State Board of Education with regard to special classes for the mentally retarded in the public schools.

38201. If there is evidence that a vendor of services does not meet the standards prescribed by the Administrator of the Health and Welfare Agency, the regional centers may immediately withdraw payment of state funds to such vendor.

38202. The Administrator of the Health and Welfare Agency shall establish rates of state payment for services purchased by regional centers for mentally retarded persons.

Rates of state payment shall be based on the value of units of service rendered.

Article 5. Coordinator of Mental Retardation Program

38300. To carry out his responsibilities for mental retardation under this division and other pertinent statutes, the Administrator of the Health and Welfare Agency shall designate a Coordinator of Mental Retardation Programs and such staff as is required.

SEC. 2. Section 6514 is added to the Government Code, to read:

6514. Any state department or agency concerned with the provisions of services or facilities to mentally retarded persons and their families may enter into agreements under this chapter.

SEC. 3. There is appropriated from the General Fund to the Health and Welfare Agency the sum of one hundred thousand dollars (\$100,000) to be used for expenses of the Program and Standards Advisory Board and to employ a Coordinator of Mental Retardation Programs and such other staff as is required to enable the Administrator of the Health and Welfare Agency to carry out his responsibilities for mental retardation programs and standards.

## APPENDIX C

### SOURCES OF STATISTICAL DATA

#### Regional Center Program

##### I. New Case Reports

Sent to State central registry at time of first personal interview, persons known to be, or suspected of being, mentally retarded and/or their parent(s) or guardian, and Regional Center staff member(s). These reports detail the full identifying information of the individual, including birthplace and mother's maiden name, and the present housing of the individual.

##### II. Case Closed Reports

Sent to the central registry when a client dies or is diagnosed as not mentally retarded.

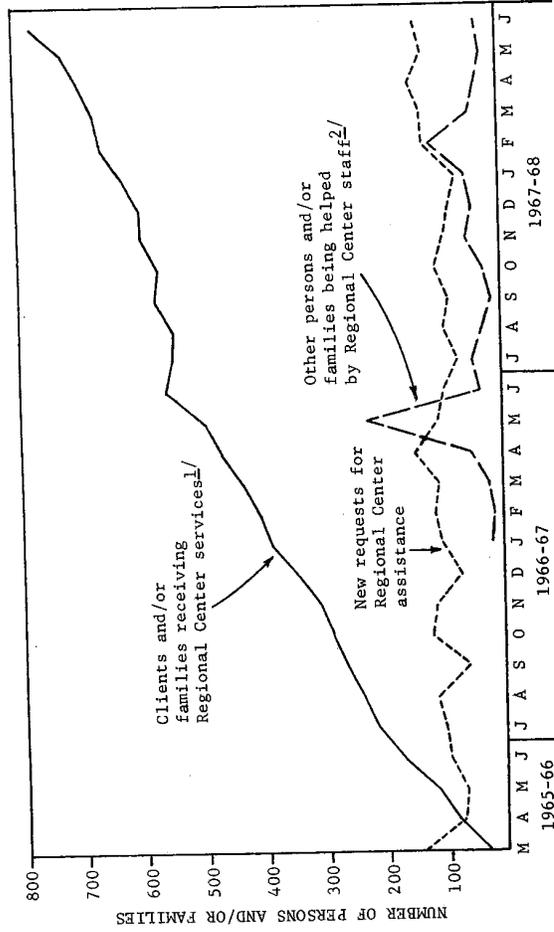
##### III. Monthly Summary Reports

These reports include, among other items, the number of new requests for assistance and the number of clients and/or families who received diagnosis, and/or counseling and/or purchased services, and/or registered with the Regional Center for the purposes of guardianship during the report month. These are considered the "active" cases during the month and this figure is used to calculate man-months of care. (See Appendix for the method used to calculate this latter item.) Also included in this report is the number of persons and/or families "helped" by the Regional Center staff members, for example, assistance given to a family inappropriately referred to the Center.

##### IV. Disbursement Records

These records accompany each purchase of service invoice and detail the month of service, client identifying information, type of services purchased, names of providers of care from whom the services were purchased and the amounts expended.

FIGURE 1.  
 PERSONS AND/OR FAMILIES RECEIVING REGIONAL CENTER ASSISTANCE AND NEW REQUESTS FOR ASSISTANCE,  
 BY MONTH, MARCH, 1966 THROUGH JUNE, 1968.



1/ Regional Center services include diagnosis, counseling, purchased services, and registration with the Regional Center for the purposes of guardianship.  
 2/ Regional Center help includes referral of inappropriate referrals to appropriate agencies, assistance provided prior to first personal interviews, and guidance to those who did not require Center services to obtain the help requested. (Not tabulated prior to January, 1967.)