

STATE OF CALIFORNIA  
STANDARD AGREEMENT NO. LCB 17655

A REPORT TO:  
THE ASSEMBLY SELECT COMMITTEE  
ON MENTALLY ILL AND HANDICAPPED CHILDREN

PART I: SERVICES FOR THE HANDICAPPED  
PART II: MENTALLY DISORDERED CHILDREN

MARCH 1, 1970

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PART ONE

SERVICES FOR THE HANDICAPPED

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## I. METHODOLOGY

On September 1, 1969, the Assembly Select Committee on Mentally Ill and Handicapped Children contracted for a feasibility study "to pin-point problems and obstacles to change" in the potential reorganization of state services to the handicapped. The result of this initial effort was to describe the existing system, outline its problems, and make recommendations as to the feasibility and direction of further legislative activity as a basis for possible major legislation in the 1971 session.

Among the specific questions to be answered were:

1. What is the cost of programs for the handicapped?
2. What statutory obstacles prevent reorganization?
3. What major duplications and gaps in service exist?
4. What is the possibility of integrating various groups of handicapped persons in the same program? How do the organizations representing the various handicapped groups feel about integrated services?
5. What is the feasibility of reorganizing a variety of separate programs into a more uniform, integrated system?

To answer these questions, project staff undertook the following tasks:

### A. Background Research At The State Level

1. Review of the professional literature and previous studies on services to the handicapped.

2. Search and organization of all legal authority for California's programs and services to the handicapped.
3. Compilation of actual expenditures on state programs for the handicapped.
4. Determination of actual caseloads of all state programs for the handicapped.
5. Interviews with administrative personnel in state departments to determine the availability of data:

Charles E. Lundholm, Bureau of Biostatistics,  
Department of Mental Hygiene

Paul F. C. Mueller, Ph.D., Chief of Research  
and Statistics, Department of Rehabilitation

Frank Norris, Senior Statistician, Bureau of  
Maternal and Child Health, Department of  
Public Health

Howard J. Ohmart, Chief of Corrections, Planning  
and Development, California Youth Authority

David Webber, Bureau of Program Studies,  
Department of Social Welfare

Joseph P. Rice, Ph.D., Chief, Bureau for Excep-  
tional Children, State Department of Education

B. Alameda County Case Studies

Two post-graduate students in the School of Social Welfare at the University of California at Berkeley undertook a study of providers and consumers of services to the handicapped in Alameda County in fulfillment of their field work requirement. (See Appendix B)

Under the direction of Dr. Marc Pilisuk, the Alameda County researchers accomplished the following:

1. Compilation of a list of all agencies, private and public, serving handicapped residents of Alameda County.
2. Collection of program statements and statistics from these agencies.
3. Interviews with the administrators of twenty agencies representing a broad cross-section of types of service and "category" of clientele.
4. With the cooperation of the agencies, location of families whose handicapped children were not being properly served.
5. In-depth interviews with 22 of these families.

C. Securing Professional Viewpoints

Project staff talked personally with the following service personnel to pinpoint the problems of present services:

Herbert Bauer, M.D., Yolo County Department of Public Health

Donald R. Calvert, Ph.D., Executive Director, San Francisco Hearing and Speech Center

L. Wayne Campbell, Curriculum Specialist in Education of Mentally Retarded Children, Bureau for Educationally Handicapped and Mentally Exceptional Children, State Department of Education

Peter Cohen, M.D., Director, Golden Gate Regional Center for the Mentally Retarded

Gunnar Dybwad, Ph.D., Professor, Heller School of Social Welfare, Brandeis University, Waltham, Massachusetts

Barrie L. Dyer, Executive Director, Industrial Services, Inc.

Robert T. Elliott, Ed.D., Professor of Special Education, Sacramento State College

Charles Gardipee, M.D., Chief, Bureau for Mental Retardation, State Department of Public Health

Daniel E. Johnson, Ph.D., Coordinator of Special Education, Alameda County School Department

Leon Lefson, Chief, Field Support Division, State Department of Social Welfare

Carlo Peitzner, Director of Camphill Village, Copake, New York

Joseph P. Rice, Ph.D., Chief, Bureau for Exceptional Children, State Department of Education

Allan Simmons, Consultant in Education of the Educationally Handicapped, State Department of Education

Henry Smith, M.D., Chief, Crippled Children's Services, State Department of Public Health

Sister Stephana, Catholic Welfare Bureau, Sacramento Diocese

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

Leonti Thompson, M.D., Program Chief, Contra Costa County Mental Health Services

D. Field Observations

Project staff visited the following facilities:

1. Northwood School (Sacramento) special education classes;
2. Learning Resource Center, Sacramento Unified School District;

3. Santa Cruz County special education facilities, workshop, developmental center, and MANRESA Diagnostic and Counseling Center;
4. Contra Costa County Short-Doyle program facilities, developmental center, and special schools;
5. East Bay Association for the Retarded workshop, San Leandro; and
6. Golden Gate Regional Center.

E. Involvement of Consumer Organizations

Through the course of the study, representatives of citizens organizations were consulted and interviewed both to help identify problems and discuss alternative solutions.

Luther Bergdall, Executive Director, Easter Seal Society for Crippled Children and Adults of California

James Black, Executive Director, United Cerebral Palsy Association of California

Bela Clark, Executive Director, East Bay Association for Retarded Children

Harold E. Conklin, President, United Cerebral Palsy Association of California

Mrs. Pat Hobbs, Hope for Retarded Children and Adults

John W. Howe, Ph.D., President, California Association of School Psychologists and Psychometrists

Norman Kaplan, Foundation for the Junior Blind

Mrs. Gene Marchi, Executive Director, National Aid to the Visually Handicapped

Mrs. Mary Palm, Legislative Chairman, California Council for Retarded Children

David Sokoloff, President, California Council for Retarded Children

Mary Swaggerty, Muscular Dystrophy Association of America

Chester A. Taft, Council for Exceptional Children

Lester Ternapol, California Association for Neurologically Handicapped Children

Project staff also met with:

The Mental Retardation Programs and Standards Advisory Board;

The Interagency Committee on Legislation for Exceptional Children;

A meeting of consumer organization representatives organized by Mr. Barrie L. Dyer, Industrial Services, Inc., in Los Angeles.

F. The Feasibility of Change

To test the accuracy of our perceptions of the problems and to determine professional and interest-group reaction to various alternatives, project staff mailed questionnaires (see Appendix A) to over 100 experts in a broad range of relevant fields.

II. SUMMARY OF FINDINGS, CONCLUSIONS,  
AND RECOMMENDATIONS FOR LEGISLATIVE ACTIVITY

FINDINGS:

1. Seven state departments administer 44 distinct programs serving the handicapped.
2. These programs have a duplicated caseload exceeding 926,000.
3. Over \$825,000,000 state, federal, and local money<sup>1</sup> is spent every year on state programs and services for the handicapped.
4. Programs for the handicapped are financed by 21 separate funding mechanisms.
5. Eligibility for state programs is governed by a total of 14 different age requirements, 14 different financial tests, 25 separate diagnostic categories, and a mass of miscellaneous requirements ranging from parental consent to prohibitions against "seeking alms".
6. The responsibility for licensing residential facilities for the handicapped is divided among three state departments whose jurisdictions are based on inconsistent, overlapping categories.
7. There is no local or state mechanism to coordinate services for handicapped people.

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1. This total does not include: private expenditures, local expenditures for special education, and AFDC support of handicapped children in boarding homes and institutions.

8. Only two programs for the handicapped out of 44 consistently evaluate their accomplishments in terms of stated goals. The rest merely describe their activities (see page 29).
9. There are no comprehensive evaluations or studies of the cost-effectiveness and impact of state services to the handicapped.
10. Of 44 state programs, 8 keep records consistent with programs of another department, and 4 of these 8 are Department of Rehabilitation cooperative programs.

CONCLUSIONS:

1. State services for the handicapped are disorganized, their efforts sporadic, and the results chaotic.
  2. Disconnected services, different eligibility requirements, and inconsistent funding mechanisms result in duplication of costs and unmet needs.
  3. Because services are structured around "categories" of handicap, some people are eligible for a range of services unavailable to equally disabled persons with different kinds of handicaps.
  4. The lack of a uniform record-keeping system and inconsistent reporting results in the following information gaps:
    - We do not know how many people are currently being served;
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- We cannot assess the total needs of handicapped people;
  - We have no cost-effective means of evaluating either the cost or the effectiveness of existing programs;
  - We cannot structure our priorities for expenditures for the handicapped.
5. Our fragmented services to the handicapped are paralleled by equally fragmented interest groups and service professions.
  6. Present services are conceived and structured in a way that reinforces the stigma of being handicapped. Specialized, separate programs emphasize the "differentness" of the handicapped and discourage their entrance into regular activities of society.

RECOMMENDATIONS FOR LEGISLATIVE ACTIVITY:

1. Information

We need information that is currently unavailable if we are to evaluate the effectiveness of existing programs and structure priorities for expenditures. We suggest that the Legislature undertake a study during the next year to determine the following:

- Prevalence of various handicapping conditions -- including the multihandicapped - projected forward for several years;

- Care and service impact of various handicapping conditions;<sup>2</sup>
- The projected cost of meeting the total life needs of a handicapped person;
- The total public and private resources available to fulfill the needs of the handicapped;
- The effectiveness of the services now provided in meeting the life needs of the handicapped;
- Estimates of projected manpower requirements.

The results of such a study could provide the basis for the reorganization of the entire service system during the 1971 Legislative Session.

## 2. Coordination of Services

We suggest that the Legislature initiate a series of pilot projects in limited areas of the state during the next year to test the following alternative means of delivering services to the handicapped:

- A. The expansion of at least one Regional Center for the Mentally Retarded<sup>3</sup> to include all categories of handicapped persons of all ages.

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2. A model for this research would be, "The Community Impact of Handicaps of Prenatal or Natal Origins", (Jessie M. Bierman, M.D.; Earl Siegel, M.D., MPH; Fern E. French, Dr. Ph.; and Angie Connie, M.D., MPH, Public Health Reports, Vol. 78, No. 10, October, 1963). Followup of Kauai Pregnancy Study of children from birth to two years enabled the authors to calculate incidence rates of physical and mental handicaps of prenatal and natal origin and thus to delineate type and duration of care required.

3. See pp. 70-71 for discussion.

- B. The creation of a caseworker unit in a representative county (i.e., a county containing both rural and urban areas) with the responsibilities of locating all handicapped persons in the county, helping them find the services they need, and acting as "consumer advocates" for the handicapped.<sup>4</sup>
- C. The initiation of an "optional use" project, with a representative sample of handicapped persons, to determine how much money would be spent for them in state programs over a two-year period. (This group would be given the option of continuing to use state services or receiving the same amount as would otherwise be spent on services in monthly cash grants. Those accepting the cash grant would be compared with a parallel sample of handicapped people receiving state services in a series of follow-up interviews and questionnaires.<sup>5</sup>) The project would include safeguards to ascertain that mentally incompetent recipients were meeting their basic food, shelter, and clothing requirements.

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4. The model for this alternative is developed in the Handicapped Person's Pilot Project, Bureau of Chronic Diseases, Department of Public Health, Residential Care Needs, A Report to the California State Legislature, January, 1969. See p. 68 in this report.

5. See pp. 72-73 for discussion.

### 3. Funding

- A. The Legislature should undertake a study to determine the fiscal implications and service impact of establishing a single state-county matching formula for: Short-Doyle programs, Aid to the Blind, Aid to the Disabled, Aid to Families with Dependent Children, and Crippled Children's Services.<sup>6</sup>
- B. Study the impact of providing special education apportionments on the basis of numbers of handicapped children in the school district or county, rather than on the basis of categorical program to which a child can be fitted. To continue to qualify for apportionments, a district or county would have to demonstrate effectiveness under quantifiable goals and standards developed by the State Department of Education. Current A.D.A. apportionments will determine the proportions of reimbursements allotted for each handicapped child (i.e., districts now can receive \$435/A.D.A. for E.M.R. students and \$795/A.D.A. for T.M.R. students, thus the apportionment for the education of a severely retarded child would be about 1.8 times the amount allotted for a mildly retarded child). This would provide the

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6. See pp. 74-75 for discussion.

flexibility needed for individual educational programming and would be a strong incentive for school districts and counties to integrate handicapped pupils into regular classrooms.<sup>7</sup>

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7. See pp. 75-77 for discussion

### III. BACKGROUND

The disarray of state services for the handicapped confuses legislators who must evaluate and fund programs, hinders administrators responsible for delivering services, and confounds efforts of handicapped people to meet their needs. During the fiscal year 1967-68, the most recent period for which complete statistics are available, 7 state departments administered 44 distinct programs serving the handicapped.<sup>6</sup> These programs cost over \$825,000,000 of state, federal, and local money and served a combined caseload exceeding 926,000. Twenty-one separate funding mechanisms provide money for services to the handicapped. Eligibility for state programs is governed by 14 different age requirements, 14 different financial tests, 25 separate diagnostic categories, and a mass of miscellaneous requirements ranging from parental consent to a prohibition against "seeking alms".

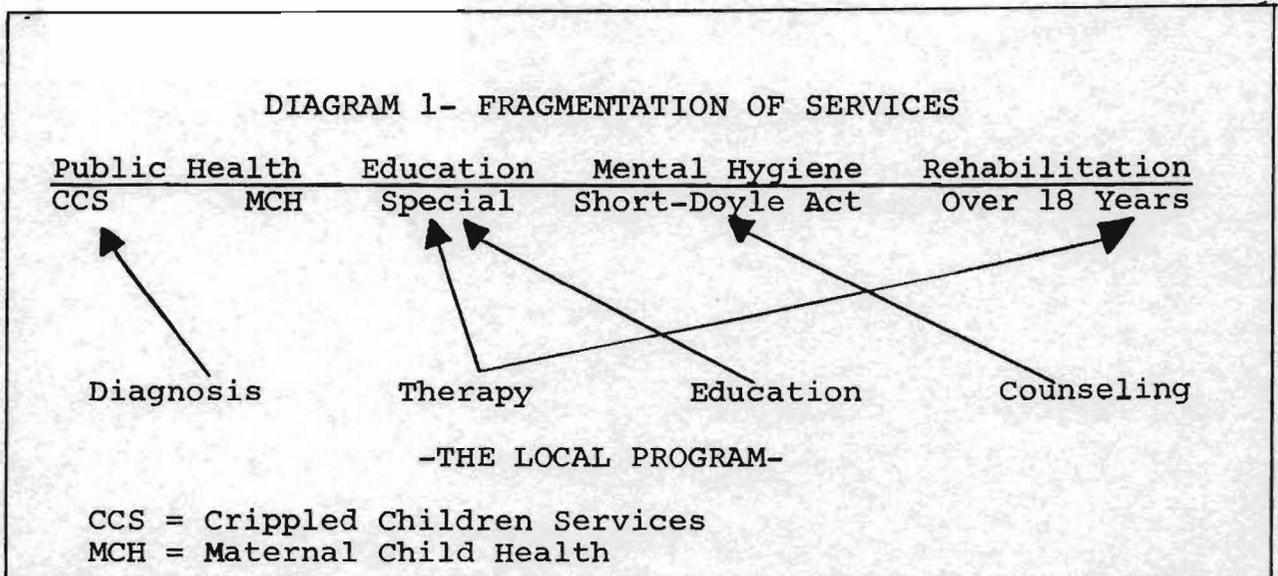
Professional, administrative, and legislative studies have continually emphasized what they call the "fragmentation" of our services to the handicapped.

In 1961, a respected California pediatrician constructed the following diagram to show that the "financing and execution" of a planned program for the physically handicapped child "is well nigh impossible":<sup>7</sup>

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6. See pp. 23-30 for a summary of programs, funding mechanisms, eligibility requirements, expenditures and caseloads for FY 1967-68.

7. H. E. Thelander, M.D., "Children, the Victims of Fragmentation", California Journal of Medicine, 94: 193-195, March, 1961.



In 1962 an article about medical services in California's Health stated, "The outstanding characteristic of our present patchwork quilt of public medical care for children is uncoordinated fragmentation...."<sup>8</sup> A former deputy director of the State Department of Public Health warned that "...we are entering a period of more rather than less fragmentation...."<sup>9</sup>

Legislative attention was focused on the whole problem by H.R. 180 (Unruh and Waldie, 1965) which referred to "the increasing fragmentation of activity on behalf of children's needs" and called for an interim committee study of children's services.<sup>10</sup> In 1967 a subcommittee of the Assembly Interim Ways and Means Committee reported: "...there are many, often more difficult, problems, ...

8. Leslie Corsa, Jr. and Bruce Jessup, "Tax-supported Medical Care for California's Children: Where Should It Be Going", California Medicine, 96: 98-101, Feb., 1962.

9. Harold M. Erickson, "Can Public Health Fragmentation Be Contained Or Coordinated", California's Health, California State Department of Public Health, Vol. 22, No. 12, Dec. 15, 1964.

10. H.R. 180, California State Assembly, February 18, 1965. Relative to an interim study of health, welfare, and educational services for children.

which involve fragmentation of services and poor coordination of total program efforts." 11

The preliminary draft of the Governor's Reorganization Plan Number 1 of 1970 points out that the consumer "has been left with the formidable task of threading his way through a maze of services in attempting to find the types of assistance appropriate to his needs." 12

The California situation is not unique. Our problems are reflected -- sometimes considerably magnified -- at the federal level and in other states. The Joint Commission on Mental Health of Children looked at the nationwide problem and concluded that many handicapped children "go untreated because the services are fragmented, or nonexistent, or because they discriminate by cost, class, or color. Others are diagnosed and labeled without regard to their level of functioning". 13

Why did we develop such a vast, complicated, expensive, and ineffective number of services for our handicapped citizens?

#### The Historical Background Of Our Present Problems

The term "handicapped" dates from the Middle Ages when a man would voluntarily put himself at a disadvantage in the crude games

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11. Assembly Interim Committee on Ways and Means, Report of the Subcommittee on Health, Education, and Welfare Services on Services for Handicapped Children, Vol. 21, No. 19, 1967.

12. Reorganization Plan Number 1 of 1970, a preliminary draft of the reorganization actions and general provisions of the Plan submitted to the Commission on California State Government Organization and Economy, January 16, 1970.

13. Report of the Joint Commission on Mental Health of Children, Inc., June 30, 1969, Harper & Row, New York, p. 7.

of that time by holding his hand in his cap. But now, when we speak of a handicapped person, we do not refer to a chivalrous self-containment, but to the relative disadvantage placed upon a person by accident, genetics, or disease. As success and survival have come to depend less on physical prowess and more on intelligence, the concept of handicap has expanded to include mental disabilities. Today, a handicapped person is one whose physical and/or mental performance is not adequate to the demands that society places on everyone.

Originally, the response of western society was to hide the "misfits" away -- to exile them from the mainstream of social activities. This was done more for the alleged protection of society than for the benefit of the "misfit". The almshouse, the Elizabethan poor laws, the leper colony, and the insane asylum were examples of this "solution".

The first public efforts on behalf of the handicapped in California were of this nature. In 1851 the "Insane Asylum" of California at Stockton established the precedent for concentrating the mentally ill in relatively remote, self-sufficient institutions. This approach represented a new twist to the old saying -- "Out of mind - out of sight!" In 1860 a special school was established at Berkeley to educate deaf children, and in 1865 funds were authorized to provide instruction for the blind at this institution. In 1891 the state opened its first Hospital for the Mentally Retarded at Sonoma. Thus the retarded, like the mentally ill, were to be conveniently isolated from the rest of society.

In the first half of the twentieth century the federal government and the State of California began to establish specific, categorical programs and "services" to either provide directly, some of the necessities of life, or to assist handicapped people to obtain them through "normal" channels.

In California, recognition of specific problems, and the efforts of special-interest organizations led to the formation of "categorical" special education programs for handicapped children.

School Programs for the "Educationally Handicapped"  
A Case Study

By the late 1950's school districts and county superintendents throughout California provided special education programs for mentally retarded children and for most categories of physically handicapped children. But, as Dr. Samuel A. Kirk, head of the University of Illinois Institute for Research on Exceptional Children pointed out: "There is one group of children who were not deaf but could not hear, or who were not blind but could not see, or who had difficulty in learning but were not retarded. It was obvious that these children had difficulties -- but their difficulties were hard to label...."

Entrance to special education programs depended on acquiring one or another of the categorical labels and there was no "label" for the children we call "neurologically handicapped". In 1955 and 1957 the State Legislature appropriated funds to study the needs of "educationally handicapped" children who were not included in existing programs. Meanwhile, two pilot projects, one in Los Angeles, the other in San Mateo, were developing methods for teaching the "neurologically handicapped". In the spring of 1959 the first parents groups were formed in Los Angeles and Orange County, and the next year the California Association for Neurologically Handicapped Children was incorporated as a statewide organization.

In 1961 the result of all this activity was the introduction of S.B. 616 (McBride) to provide special education for the neurologically handicapped. When the bill was defeated, CANHC focused its attention on including neuro-

logically handicapped children in the existing provisions for the education of "physically handicapped" pupils. However, when the Attorney General ruled that the law would not permit this interpretation, the need for new legislation became overwhelmingly apparent. In 1963, A.B. 464 (Waldie) included both neurologically handicapped and emotionally disturbed children in a special education program for the "Educationally Handicapped". With the combined support of both the California Association for Neurologically Handicapped Children and the California Mental Health Association, "hardening of the categories" in special education was maintained by establishing yet another category.

The same special interest forces at work at the federal level produced funds for specific health and health-related programs. In 1936, the Federal Social Security Act, at the insistence of active women's organizations, delegated responsibility to a separate agency to administer special funds for maternal and child health programs. The Social Security Act also made crippled children's services funds available to the states. In subsequent years, Congress earmarked funds for a variety of specific purposes and special programs, all of which had to be accounted for separately and were administered by different state departments.

Two powerful incentives promote the development of services limited in scope for limited categories of clients. One incentive is the public relations factor. Dr. Erickson describes it this way:

"Special programs designed to meet specific needs seem to be more visible, more dramatically explained, and more vigorously justified. People, whether they are legislators or the public, do not get excited about generalized services which they have come to take for granted. The whole voluntary agency movement with groups rallying around specific problems are examples of this and are related to it. We all know from our own experience that community action takes place most

quickly when people are faced with a specific understandable concern which provides motivation to deal with it. These same dynamics are really what are at play in the legislative processes."<sup>14</sup>

The other incentive is the legitimate and necessary legislative concern for limiting and predicting expenditures. One major question about any new program is "How much will it cost?" A program designed to do everything for everyone defies cost analysis. The cost of a limited program (e.g., to provide up to \$120 a month for anyone living in California, sixteen years of age or older, who is unable to provide himself with the necessities of life due to loss or impairment of eyesight, who does not receive OAS or ATD funds or live in a public institution for tuberculosis or mental illness and does not seek alms) is considerably easier to assess.<sup>15</sup>

There are several other factors operating to preserve disconnected, categorical services. Mr. Niall Tabor, the author of a proposal to restructure services to the handicapped and a parent of a handicapped child, identified two major roadblocks:

"Public and private agencies and the individuals staffing them all exhibit the very human trait of defending their existing realm of operation and their particular approach or technique of handling a given problem."

"The fact that an activity has been always conducted in a certain fashion is accepted as proof that this must be the only way to conduct such a function. Often functions are conducted in observance of tradition that is totally ritualistic in nature."<sup>16</sup>

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14. Erickson, op. cit., p. 90.

15. See Aid to the Blind, California W. & I. Code Sections 12502, 12550, 12552, 12556, 12559, and 12560.

16. Niall E. Tabor, "A Proposal for a Responsive Program for Handicapped Children in California", November 16, 1964, pp. 32-33.

Some professionals defend existing categorical programs in near-cosmic terms:

You cannot think without categorizing. The essence of thinking is to separate out those aspects of a situation which are relevant to an event from those which are not pertinent. Thinking is categorizing.<sup>17</sup>

Others are naturally very anxious about the possibility of "losing" the programs they have worked to establish:

We are very impressed with the results of the present diagnostic services available to the physically handicapped and would be loath to see them moved into "centers" without a great deal more testing and evaluation of the program.<sup>18</sup>

Categorical programs and "Balkanized" consumer organizations capture the allegiance of parents of handicapped children. The diagnostic "label" attached to their children has become a determining factor in shaping their participation in public affairs. A recent survey of the membership of the California Council for Retarded Children solicited the following reply to a question concerning the future intentions of members:

One half year ago our child was finally diagnosed correctly as autistic rather than retarded. We now have joined the Society for Autistic Children and will give our time and effort to that group because there is a tremendous need for help for the autistic child.

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17. Daniel Johnson, Coordinator of Special Education, Alameda County, paper presented to the Inter-Agency Committee on Legislation for Exceptional Children, prepared December 5, 1969.

18. Letter from Mrs. Esther Elder Smith, former Executive Director of Easter Seal Society to Mr. Leo Lippman in re. expanding regional centers to serve all handicapped dated September 21, 1967.

In summary, there are many reasons for the piece-by-piece development and durability of disconnected services for the handicapped:

- The recognition of specific problems;
- The development of interest groups around these problems;
- The need to organize support for a definite issue;
- The necessity of predicting and limiting expenditures for each program; and
- The organization of professional disciplines around categorical programs.

The result is a chaotic situation badly in need of reform. During the course of this study, the following tables were developed to illustrate the extent and complexity of California's services to the handicapped (see Tables on next eight pages).

<u>DEPARTMENT</u>	<u>PROGRAM</u>	<u>FUNDING</u>	<u>DELIVERING AGENCY</u>	<u>ELIGIBILITY REQUIREMENTS</u>	<u>CASELOAD</u> (For FY 1967-1968)	<u>COST</u>
Department of Education	1. Educationally Handicapped		School District or County opting to provide program	Minor of school age residing in district or in County providing program. On basis of education of multi-discipline team finding neurological handicap or emotional disturbance	(a) 11,972 (b) 12,762 (c) 1,064	\$23,275,540 (State Apportionment)
	(a) Learning Disability Groups	\$13,680/class or 1,880/ADA				
	(b) Special Day Classes	\$1,140/ADA				
	(c) Home or Hospital Instruction	\$1,590/ADA (State Apportionment)				
	2. Educable Mentally Retarded	\$435/ADA or \$7,820/class (State Apportionment)	School District of 900 ADA & over or County Superintendent for Districts under 900 ADA	Minors of school age (permission for 5 1/2 - 8 yrs. & 16-21 yrs.) for mentally retarded capable of becoming "economically useful & socially adjusted". On basis of psychological examination showing incapable of being educated efficiently & profitably in regular classroom	57,483	\$30,909,223 (State apportionment)
	(a) Special Classes or Schools					
	(b) Integrated Programs					
	3. Trainable Mentally Retarded	\$795/ADA or \$9,540/class (State Apportionment)	School District of 8,000 or more ADA or County Superintendent for districts under 900 ADA	Minors of school age (5-8 and 8-18 permissive) for training to further "individual acceptance," "social adjustment," employment in homes and sheltered workshops. On basis of psychological exam showing incapable of being educated efficiently and profitably in regular classroom.	8,173	\$ 7,393,106 (State apportionment)
	(a) Special Training Classes or Schools					

<u>DEPARTMENT</u>	<u>PROGRAM</u>	<u>FUNDING</u>	<u>DELIVERING AGENCY</u>	<u>ELIGIBILITY REQUIREMENTS</u>	<u>CASELOAD</u> (For FY 1967-1968)	<u>COST</u> (State apportionment)
Department of Education (cont'd)	4-14. Physically Handicapped (Orthopedically Handicapped, Aphasic, Deaf, Severely Hard of Hearing, Moderately Hard of Hearing, Blind, Partially Seeing, Speech Handicapped, Health Impaired, Pregnant, Multi-handicapped)		School District of 8,000 ADA or County Superintendent	Physically handicapped minors in need of education, who cannot receive the full benefit of ordinary educational facilities. May be admitted at age 3. Actually living in school district 5 or more days a week.	143,979 (enrollment)	\$34,471,771
	(a) Special Training Classes or Schools	(a) \$1,018/ADA or \$12,215 class				
	(b) Special Day Classes or Schools	(b) \$1,018/ADA or \$12,215 class				
	(c) Individual Instruction	(c) \$1,300/ADA				
	(d) Regular Day Classes	(d) \$1,018/ADA or \$12,215 class				
	(e) Integrated Programs	(e) \$1,018/ADA				
	(f) Remedial Physical Education	(f) \$775/ADA				
	(g) Other Remedial Classes	(g) \$2,000/ADA or \$12,215 class				
	15. Transportation for TMR and Physically Handicapped Pupils	\$389 & 75% of additional up to maximum of \$73/ADA				\$ 7,698,487 (State apportionment)
	16. Developmental Centers for Handicapped Minors	Annual General Fund Appropriations	School Districts or County Superintendents opting to provide	Minor between ages or 3-21 with severe impairment of locomotion, severe mental retardation, or both	770	\$ 2,926,481

<u>DEPARTMENT</u>	<u>PROGRAM</u>	<u>FUNDING</u>	<u>DELIVERING AGENCY</u>	<u>ELIGIBILITY REQUIREMENTS</u>	<u>CASELOAD</u> (For FY 1967-1968)	<u>COST</u>
Department of Education (cont'd)	17-19. Special schools for the Physically Handicapped	Annual General Fund Appropriations, Payments by School Districts, ASEA Title I.	At the State Schools			
	(a) California School for the Blind		(a) Berkeley	(a) Any blind person of suitable age and capacity	142	\$ 876,879
	(b) California Schools for the Deaf		(b) Berkeley, Riverside	(b) Any deaf person of suitable age and capacity	1,060 (enrollment)	\$4,864,451
	(c) Diagnostic Schools for Neurologically Handicapped Children	(c) San Francisco Los Angeles	(c) Diagnosis of Neurological Handicap ages 3-21	459	\$1,131,853	
	20. Administration: Division of Special Schools and Services	General Fund Annual Appropriations				\$ 821,996
21. Title VI: Educational Improvement for the Handicapped	Federal Funds				\$1,688,718	
22. Grants to Teachers of Physically Handicapped Minors	General Fund Annual Appropriations				\$ 150,000	
Department of Mental Hygiene	23. Hospitals for the Mentally Ill	General Fund Annual Appropriations and patient fees (1967-68) Now 90%-10% State-County Matching funds from Short-Doyle agencies purchasing hospital care.	At State Hospitals (1967-68) Now only through S-D programs or judicial commitment	Mentally ill persons requiring full-time care and therapy. (Now commitments are limited to those dangerous to themselves or others or unable to provide themselves with food, shelter, and clothing)	62,413  (Number discharged and number in hospitals last Wed. FY 67-68) & 2,319 (mentally retarded)	\$122,886,994
	24. Hospitals for the Mentally Retarded	General Fund Annual Appropriations and patient fees (1967-68) As of 1971, new placements paid for by Regional Centers for Mentally Retarded	At State Hospitals. 1971 only through Regional Centers	Mentally Retarded persons needing full-time residential care.	13,129	\$54,159,910

<u>DEPARTMENT</u>	<u>PROGRAM</u>	<u>FUNDING</u>	<u>DELIVERING AGENCY</u>	<u>ELIGIBILITY REQUIREMENTS</u>	<u>CASELOAD (For FY 1967-1968)</u>	<u>COST (State and local funds)</u>
Department of Mental Hygiene (cont'd)	25. Short-Doyle Community Mental Health Services	State-local matching funds: 75%-25% and 50%-50% (1967-68) Now 90%-10% for expenditures on services approved in local plan.	Local Short-Doyle Agencies	Mentally dis- ordered persons residing in County. Plan may include Mentally Re- tarded persons	162,456 (Number dis- charged from inpatient, outpatient, and partial hospitaliza- tion programs)	\$34,155,248
	(a) Outpatient treatment					
	(b) Inpatient treatment					
	(c) Rehabilitation					
	(d) Consultation					
	(e) Education					
	L.P.S. Act combines (d) and (e) and adds:					
	(f) Partial hospitalization					
	(g) Diagnostic services					
	(h) Precare and aftercare services					
	(i) Emergency 24 hr. service					
	(j) Research & evaluation					
26. Neuro-Psychiatric Institutes	General Fund Appropriations	Langley-Porter Hospital in San Francisco. UCLA Neuro- psychiatric Institute	Mentally ill and Mentally Retarded admitted in accor- dance with re- search objectives.	990	\$8,837,721	
(a) Research						
(b) Training						
(c) Hospital and clinical services related to research and training						
27. Research	General Fund Appropriations and Federal Funds				\$1,457,019	
28. Administration	General Fund Appropriations and Federal Funds				\$5,710,831	

<u>DEPARTMENT</u>	<u>PROGRAM</u>	<u>FUNDING</u>	<u>DELIVERING AGENCY</u>	<u>ELIGIBILITY REQUIREMENTS</u>	<u>CASELOAD</u> (For FY 1967-1968)	<u>COST</u>
Department of Health Care Services	29. Medi-Cal: Payment for health care and related remedial and preventative services.	50%-50% State-Federal matching funds	Card issued by Health Care Services used at direct service.	(a) Recipients of Aid to the Blind	14,092	(a) \$8,006,874
				(b) Medically Indigent Blind		(b) \$451,436
				(c) ATD Recipient	133,126	(c) \$117,819,451
				(d) Medically indigent Disabled		(d) \$18,805,247
						\$135,083,008 (Medical payments to identified handicapped.)
Department of Public Health	30. Crippled Children's Services.	State reimburses County 3:1 Federal funds used to reimburse.	County Dept. of Public Health or State Dept. if County has no D.P.H.	Under 21. Physical defects resulting from Congenital Anomalies or acquired through disease, accident, or faulty development.	60,873	\$16,507,718
	(b) Treatment					
	31. Handicapped Persons of Normal Intelligence Pilot Project	General Fund Appropriations	Units in Sacramento and Long Beach	Clients selected by Unit Staff	100	\$153,032
	32. Regional Centers for Mentally Retarded	General Fund Appropriations	Regional Centers	Any mentally retarded person in region.	1,003	\$1,513,000
(b) Counseling						
(c) Out-of-home placement						
(d) Referral						
(e) Purchase of Services						
33. Comprehensive Services: Patients with epilepsy	General Fund Appropriations				\$82,740	
34. Services and Studies of Heritable Diseases of Newborn	General Fund Appropriations				\$139,664	

<u>DEPARTMENT</u>	<u>PROGRAM</u>	<u>FUNDING</u>	<u>DELIVERING AGENCY</u>	<u>ELIGIBILITY REQUIREMENTS</u>	<u>CASELOAD</u> (For FY 1967-1968)	<u>COST</u>
Department of Social Welfare	35. Aid to the Blind and Aid to the Potentially Self-supporting Blind.	Federal Funds:50% Remaining 50% 3/4 State: 1/4 County.	County Departments of Social Welfare	Over 16, who by reason of loss or impairment of eyesight, is unable to provide the necessities of life. Not receiving OAS or ATD. Not soliciting alms. Not resident of T.B. or Mental Institution. Means test. Over 18 for Potentially Self-support Blind with more lenient means test.	14,092	\$33,882,391
	(a) Money to bring monthly income to a minimum (143.50 in 1968)				14,778	(all expenditures)
	(b) Up to \$300 for attendant.					
	(c) Additional funds for self-support plan (12 months)					
	(d) Low interest loans up to \$5,000.					
	36. Aid to the Needy Disabled.	Federal Funds:50% Remaining 50% 3/4 State. 1/4 County.	County Dept. of Social Welfare	Over 18, major physical or mental impairment, verified by medical findings, which will last through life. Medicare recipient in Nursing Home or hospital. Not resident of T.B. or mental hospital. Not recipient of OAS, Aid to Blind, AFOC. Not convicted of acts against U.S.	158,239	\$198,939,889
	(a) Money to bring monthly income to a minimum.					
	(b) Up to 300 for attendant					
	(c) Payment to public medical institution.					

DEPARTMENT	PROGRAM	FUNDING	DELIVERING AGENCY	ELIGIBILITY REQUIREMENTS	CASELOAD (For FY 1967-1968)	COST
Department of Social Welfare (cont'd)	37. Aid to Families with Dependent Children  (a) Financial Assistance determined by number of eligible children in family.	Federal Funds 50% Remaining 50% 67 1/2 % State 32 1/2% County	County Dept. of Social Welfare	Children under 18 deprived of parental support due to (among other things) <u>mental or physical incapacity</u> . Aid can be continued to age 21 if (among other things) child is <u>physically or mentally disabled</u> .	Estimate: (a) \$26,477,505 (Estimate of Mentally Retarded & Chronic Emotional Problems category applied to FY 67-68 Expenditures for AFDC family groups.  (a) 14,036 (Derived from applying current % "Mentally Retarded" and "Chronic Emotional" Problems" categories of AFDC to 67-68 caseloads. This does not even include <u>physically disabled</u> who are under "Other Health Problems" category.	
	(b) Payment for maintenance of child in institution or boarding home.	State pays \$80, balance from local funds			(b) DSW say they would like to know what kinds of children are in this program but they haven't broken it down. We thus have no estimates of caseload and expenditures for the handicapped.	
	38. Community Services Division.	General Fund Appropriations	Regional Community Services Division Office	Patient discharged or on leave from State Hospital, inpatient Mentally Retarded and Mentally Ill.	a, b, & c, 2 \$11,777,793	
	(a) Placement and service to patients on leave from State Hospitals for Mentally Ill and Mentally Retarded.			Currently MR under MR-PI program can only be post hospital cases	(a) 36,068	
	(b) Consultation cases.				(b) 948	
	(c) Inpatient and Potential Patient Services (MR and Mentally Ill)				(c) 3,888	
	(d) Precare			Persons who are at risk of being institutionalized.		
	(e) Prerelease cases from state hospitals.			Patients in residence at the state hospital.		

<u>DEPARTMENT</u>	<u>PROGRAM</u>	<u>FUNDING</u>	<u>DELIVERING AGENCY</u>	<u>ELIGIBILITY REQUIREMENTS</u>	<u>CASELOAD</u> (For FY 1967 - 1968)	<u>COST</u> (Estimate: 21% expenditures for intake & residential programs.)
Department of Youth Authority	39. Diagnosis, Residential Care and Control, and Treatment of Wards committed to the CYA.	General Fund Appropriations Some Federal Funds (about .5% for this program)	Four Reception Center-Clinics Conservation Camps for Boys Schools for Boys School for Girls	Under 18, Judicial Commitment as (1) Offender (2) Incurable	1,129 (From 1969 internal report identifying four categories of CYA wards, three of which can be considered handicapped- (1) Mentally Retarded (2) Mentally Disturbed (3) In need of Protection (Includes physical handicaps) Adjusted by - 7.9% for general increase in CYA population.)	\$8,226,385
Department of Rehabilitation	40 - 44. Basic Program and four cooperative programs: (a) Evaluation (b) Counseling (c) Medical, surgical, psychiatric care and treatment, drugs and appliances. (d) Training & education (e) Workshop experience & consultation (f) Maintenance, transportation, during rehabilitation (g) Job placement	80% - 20% Federal - State Funds. But Federal Funds pay 100% cost of rehabilitating persons receiving Social Security for disability.	Rehabilitation Counselors, School districts, Corrections facilities, DPH, mental health agencies, Regional Centers for Mentally Retarded in Co-op programs.	Persons of "employable age" or reaching same on completion of program who have condition "which constitutes, contributes to, or if not corrected will probably result in an impairment of occupational performance"	20,573 (Accepted 67-68 10,389 "Rehabilitated" and receiving job placements)	\$38,928,82

## Attempts To Coordinate A Chaotic System

In 1961 the Legislature attempted to achieve a degree of cooperation and integration by establishing the Coordinating Council on Programs for Handicapped Children. The directors of the departments responsible for programs for handicapped children were to "make a continuous review of programs and services being offered to the physically and mentally handicapped persons under age 21 in California, both by state and local agencies; and coordinate and evaluate the existing programs". Perhaps because the Council was composed of agency heads with commitments to their own particular programs, the Council never achieved its purpose.

Looking at the Council in 1967, the Assembly Subcommittee on Health, Education, and Welfare Services concluded that, ".... It is thus difficult to envisage how any major changes that might affect adversely one or more of the departments involved could emerge from the deliberations of such a body...."<sup>19</sup>

The Subcommittee recommended abolishing the Council, which was accomplished by the 1969 Legislature. At present, there is no agency for planning and evaluating programs for all the handicapped at the state level.

The (1967) Subcommittee also put forth two important proposals directed at the eventual coordination of programs for handicapped children. The first was to analyze the feasibility of broadening the scope of services provided by the Regional Centers for the

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19. Subcommittee on Health, Education, and Welfare Services, op. cit., p. 17.

Retarded to include all handicapping conditions.<sup>20</sup> The second supported Assemblyman Leroy Greene's recommendation that a master plan be developed:

(1) to determine the actual numbers of handicapped children in California, the nature of their disabilities and the total array of services required to meet these needs; (2) to analyze in terms of these benchmarks the effectiveness of existing programs; (3) to recommend both new programs and reorganization of existing ones; and (4) to pinpoint administrative responsibility at every level for the implementation and evaluation of programs for handicapped children.<sup>21</sup>

There has, to date, been no administrative or legislative attempt to include other handicapping conditions in the Regional Center programs, nor has anyone undertaken the formulation of a master plan for the handicapped.<sup>22</sup>

California has no body or agency responsible for the planning, evaluation, or coordination of services for handicapped people.

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20. Ibid., p. 18.

21. Ibid.

22. In 1967, Leopold Lippman, then Coordinator of Mental Retardation Programs for the Health and Welfare Agency, corresponded with representatives of private associations with regard to expanding the regional centers, but no substantive action followed.

#### IV. THE EFFECTS OF DISORGANIZATION

##### Lack of Information

Any study of state programs would have to address itself to the basic question: How well are we meeting the needs of handicapped people? Our most important finding is that there is simply no way to find out. The first consequence of disconnected services is a lack of consistent and relevant information.

Most programs can produce caseload figures for a given year: the Department of Education knows the enrollments of special education programs and attendance at Developmental Centers; the Department of Mental Hygiene knows how many patients are admitted to, residing in, and discharged from the state hospitals and the numbers of patients discharged from local inpatient, outpatient, and partial hospitalization programs; the Department of Public Health can tell how many children received diagnostic and treatment services under CCS; the Department of Social Welfare knows how many people are receiving Aid to the Blind, Aid to the Needy Disabled, numbers of disabled AFDC parents, and how many persons are counseled and placed by the Community Services Division. But, the Department of Social Welfare does not know how many handicapped children are receiving AFDC support in boarding homes and institutions.<sup>23</sup>

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23. Mr. Dave Webber, Bureau of Program Studies, State Department of Social Welfare.

Two departments keep records in conjunction with other programs for the handicapped: the Department of Health Care Services knows how many Medi-Cal recipients are Aid to the Blind and ATD recipients or are linked to these programs; the Department of Rehabilitation can produce caseloads of cooperative programs operated with the schools, the California Youth Authority, the Department of Public Health, and the Department of Mental Hygiene.

One department -- the California Youth Authority -- keeps no official records concerning the handicapped minors within its jurisdiction. The caseloads on page 30 are based on estimates taken from a recent in-house report that the Department declines to make public.<sup>24</sup>

Only one program -- the Regional Centers for the Mentally Retarded -- is designed to keep records of all the services received by a client.

A handicapped child or adult will probably appear in the "caseload" of more than one program in any given fiscal year. This is particularly true of the multihandicapped. If we were to expand our analysis over a number of years, we would find handicapped people moving from one group of services to another as their needs change.

The caseloads of individual programs give no indication of the numbers of handicapped people being served. The records of most programs provide no link with other services or with the

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24. Interview with Howard J. Ohmart, Chief of Corrections, Planning and Development, California Youth Authority, January 13, 1970

past and future needs of their clients. This crucial lack of information has serious consequences for evaluation, planning, and budgeting at the state level.

### Evaluation

In order to begin to evaluate state efforts for the handicapped, we need: (1) concrete goals for specific programs, (2) information linking services to each other and to the stated goals, and (3) a means of relating expenditures to these goals wherever possible. At this time, we have no priorities, no goals, and little relevant information. A cost-effective assessment of total state efforts is thus impossible.

It is also impossible to construct an evaluation of total efforts from individual program evaluations. Most "evaluations" published by state departments are merely descriptions of program activities. There is rarely any attempt to relate these activities to even the most limited objectives -- perhaps because statutory goals are often vague. (For example, "individual acceptance" and "social adjustment" are two statutory purposes of special education programs for the "trainable mentally retarded". We have found no evaluation of the program in these terms or by any other criterion.)

A few programs are evaluated within their specific frames of reference. The Department of Rehabilitation, for instance, continues

to evaluate its activities in terms of two specific quantifiable criteria: the number of "rehab" or clients placed on the job, and the number of clients removed from welfare.<sup>25</sup> Unfortunately, the Department does not know how long the placements stay on the job and cannot tell us what supportive services these clients continue to need after having been placed. It would also be important to compare the costs of rehabilitating a handicapped person, and maintaining him on the job, with the number of dollars he generates. Is this really less expensive than welfare? The "Educationally Handicapped" special education program, whose statutory goal is return to the normal classroom, is reviewed on this basis by the State Department of Education. The two pilot Regional Centers for the Mentally Retarded reduced the waiting lists for the state hospitals for the retarded.

Thus, the evaluation of either total state effort on behalf of the handicapped, or the effectiveness of individual programs, depends on data that is currently unavailable.

### Planning

Planning involves committing present and future resources to the accomplishment of a given task. The two major resources for services for the handicapped are manpower and money. Planning

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25. This type of follow-up would not be difficult and would certainly prove useful to the Department of Rehabilitation in planning its own activities.

will require a determination and projection of the population to be served, a decision concerning the kinds of services to be provided, and devising ways of developing these services.

One approach for developing such information was designed for a study done on the Hawaiian Island of Kauai published in 1963.<sup>26</sup> The authors included congenital defects, mental retardation, prematurity, birth injuries, cerebral palsy, and convulsive disorders of natal and prenatal origin in a sample of 1,922 single pregnancies and 41 liveborn twins. The Island was described as having "environmental factors that influence health" which "compare very favorably with the most progressive mainland communities".<sup>27</sup>

The most unusual aspect of the Kauai study was the classification of handicapped children according to the types of care required. The authors devised four classes: (1) Minor handicaps requiring little or no specialized care; (2) Handicaps amenable to relatively short-term specialized care; (3) Handicaps requiring long-term specialized care and rehabilitation; (4) Handicaps requiring long-term medical, educational, and custodial care. This system of classification obviously provides a means of planning services once accurate prevalence and incidence figures are available.

We asked Mr. Frank Norris, Senior Statistician in the Bureau of Maternal and Child Health, State Department of Public Health, if it would be possible to apply the principles of the Kauai study

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26. Bierman, et al., op. cit., pp. 839-55.

27. Ibid., p. 840.

to obtain an estimate of numbers of handicapped minors in California in the four "care" classes. These calculations were performed, but Mr. Norris cautions us that these estimates are not to be regarded as official or necessarily accurate determinations. With these caveats in mind, we present the following table as an example of possible methodology for planning services for the handicapped.

ESTIMATE OF NUMBER OF CALIFORNIA CHILDREN  
(BORN 1949-1969)  
WHO ARE HANDICAPPED BASED ON KAUAI PREGNANCY STUDY

<u>ALL CHILDREN</u>	(a) California Live Births 1949-1969	6,940,038
	(b) California Neonatal Deaths 1949-1969	118,500
	(c) Survived 1st Month of Life (a-b)	6,821,528
<hr/>		
<u>HANDICAPPED CHILDREN</u>	(d) Handicapped Children Total (14.6% of c)	995,943
	(e) Class 1: Minor Handicaps Requiring Little or No Specialized Care (45.9% of d)	457,138
	(f) Class 2: Handicaps Amenable to Relatively Short-Term Specialized Care (37.5% of d)	373,479
	(g) Class 3: Handicaps Requiring Long-Term Specialized Care and Rehabilitation (8.5% of d)	84,655
	(h) Class 4: Handicaps Requiring Long-Term Medical, Educational and Custodial Care (8.1% of d)	80,671

Assuming, then, that we can identify the number of handicapped Californians accurately, according to type of care required, we must then ascertain how many will need state services, of what type, and what time. Unfortunately, our planning efforts are stymied by the same information problems that plagued attempts to evaluate state efforts. We do not know how many handicapped people are meeting their needs through private efforts. We do not know how many handicapped people are using state services, in what sequence, and at what times of their lives. Presently, we cannot tell how handicapped people "flow" between the private and public sectors. There is, thus, no way of assessing the capabilities of present services even if we can assess incidence and prevalence and classify these figures according to type of care needed.<sup>28</sup>

We have no accurate base for planning the allocation of our manpower and financial resources.

### Budgeting

Budgeting is the allocation of financial resources. The concept of "program budgeting" involves the grouping of all expenditures related to a given purpose. "Cost-effective" budgeting seeks to apply the proper amount of funds for a given objective.

But fragmented programs produce fragmented budgeting. The departments document past caseloads and costs, estimate the next

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28. Dr. Martin Wolins, D.S.W., Professor of Social Welfare, U. C. Berkeley suggests that a scientifically designed sampling technique could deliver an accurate picture of incidence and flow.

year's caseloads and costs on this basis, and ask for the determined amount -- occasionally within the limits set by the Department of Finance.

If the 1969-70 proposed budget is any indication, the installation of PPBS (Program and Planning Budgeting System) in California has done little to facilitate the grouping of all expenditures for a given purpose or to permit a "cost-effective" allocation of funds. The "program" budget for 1969-70 merely groups the "program elements" of the activities of each department. Thus, Section III-A of the "program" budget for the Department of Mental Hygiene is, "Treatment, Mental Illness", under which the Hospitals for the Mentally Ill, and Short-Doyle inpatient, outpatient, and partial hospitalization activities are discussed. But, "mental illness" is also "treated" in E. H. programs in the schools, at C.Y.A. and Corrections facilities, at any number of private and public sources under Department of Rehabilitation programs, or with Medi-Cal funds. We have, as yet, no systematic way to relate all state expenditures for the mentally ill or any other handicapped group.

There is, however, an impending model in the budgeting requirements of the Lanterman Mental Retardation Act of 1969 (A. B. 225). The law provides:

The secretary [of the Human Relations Agency] ...shall submit a program budget annually to the Department of Finance, including ... expenditures proposed to be made under any related program or by any other state agency....

The grouping of expenditures for the mentally retarded can provide a methodological basis of a true program budget for expenditures for all the handicapped. At first, anticipating the caseloads and flow of clients will be extremely difficult, and a true program budget will have to await the accumulation of sufficient experience, information, and case-finding.

Cost-effective budgeting seeks the maximum result for the least expenditure. This type of analysis depends heavily on adequate evaluation mechanisms. Although we presently do not have such mechanisms, administrators, professionals, and others involved in the delivery of services agree that some strategic expenditures can result in long-term savings. For instance, the operation of the Regional Centers for the Mentally Retarded has reduced waiting lists for the state hospitals for the retarded and has avoided the immense expense of expanding these institutions. The successful rehabilitation of a handicapped person may remove him from the public welfare rolls. The skills taught in Child Development Centers are designed to obviate the need for expensive custodial care. Do they actually accomplish this? Until we have the information needed to evaluate programs and relate all expenditures in different agencies, cost-effective budgeting will remain an impressionistic process generally based more on wishful thinking than on hard fact.

## V. THE EFFECTS OF DISORGANIZATION: REPLICATION

One result of maintaining 44 distinct and disconnected programs for the handicapped is that some general functions are duplicated. The administration, clerical work, and general overhead of repetitive services is a waste of the taxpayer's money. At the operational level such replication is at best frustrating and at worst harmful to handicapped people. The two areas we will explore are diagnosis and licensing.

### Diagnosis

Diagnosis is the assessment of a person's problems. There can, and should be, medical, psychological, educational, and social components of an effective diagnosis. But, because most state services are organized around a particular disability, diagnosis has become an eligibility requirement. Diagnosis in this sense is no longer a service -- it is a barrier to service. Access to state programs is determined by a total of 25 diagnostic categories and variations of categories.<sup>29</sup> The diagnostic process is performed repeatedly, even for the same person. For instance, someone suspected of mental retardation now has the opportunity to be labelled "retarded" seven times to qualify for seven different state programs.

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29. See pp. 23-30 of this report.

In his preschool years our hypothetical case could appear severely retarded and his parents might take him to a Developmental Center for Handicapped Minors. If the Center staff diagnoses him as severely retarded he would qualify.

If he lives in an area that operates a Regional Center he can receive a free diagnosis of mental retardation and obtain counseling, out-of-home placement, and other services.

When he reaches school age his functioning may have improved and his parents might want to enroll him in a class for the "trainable mentally retarded". Again, an admissions committee would have to find that he qualified for this category of retardation.

Every time the family moves from one school district to another, their retarded child will have to be re-diagnosed to enter special education programs.

If our hypothetical case had been deprived of parental support for any of the reasons accepted by Aid to Families with Dependent Children, he could be supported by this program until he was 21 -- if his family could prove his mental retardation or enrollment in a vocational program.

When he reaches "employable age" he can receive the services of the Department of Rehabilitation if his retardation is diagnosed as constituting a correctable employment handicap.

At age 18 he can begin to receive monthly cash grants (ATD) if "medical findings" can verify that his retardation is a major mental impairment which will last through life. Until 1971, when

admissions to state hospitals for the retarded will be channeled through the Regional Centers, the parents or guardians of our hypothetical case can have him admitted to a state hospital where his retardation will again be diagnosed.

Every handicapped person attempting to use more than one state service goes through a similar process. For the multihandicapped the problems are multiplied. The establishment of diagnostic centers for separate categories of handicap does not really solve the problem. As Assemblyman MacDonald said in a speech to the Ventura County Council for Exceptional Children last fall, "Since diagnosis is, by definition, the determination of the nature of a problem, it is contradictory to have a diagnostic center or program arranged around a predetermined disability. The issue may be prejudged."

Apart from the dubious benefits of forcing the handicapped and their families to repeat the diagnostic process for service after service, this is a tremendous waste of scarce, skilled manpower, money, and supportive administrative and clerical work.

#### Licensing

"...our tripartite system of licensing operates to make some placements impossible...."

The Honorable Frank Lanterman  
California State Assemblyman  
State Capitol Building  
Sacramento, California 95814

October 7, 1969

I would like to call to your attention a case of a retarded child in Sonoma State Hospital who does not need to be in the hospital but is kept there because procedures for getting him out are

blocked by illogical rules and regulations.... \_\_\_\_\_ is a 15 year old moderately retarded patient from Alameda County. Family problems make it inadvisable for him to live with his parents. He is a good candidate for family care placement through the Community Services Division (CSD) of the Department of Social Welfare. He has no special medical or behavior problems, and would be able to attend special classes in any local public school district.

\_\_\_\_\_ is a 15 year old moderately retarded patient from Alameda County. Family problems make it inadvisable for him to live with his parents. He is a good candidate for family care placement through the Community Services Division (CSD) of the Department of Social Welfare. He has no special medical or behavior problems, and would be able to attend special classes in any local public school district.

He has been referred to CSD offices in Oakland and Vallejo, and to the Regional Office in San Francisco, but all report there are no family care homes available which could care for him.

Why is this true? Apparently because not enough homes are being recruited, evaluated and certified. Why not? Because staff is not allocated for this function, but only on the basis of caseloads. A CSD staff worker carrying a full caseload of clients in placement has very limited time to recruit new homes. Regulations should be changed to allow the allocation of CSD staff specifically to recruit homes.

There are several private foster homes in this area licensed by the Department of Mental Hygiene which have vacancies and would be glad to care for our patient, \_\_\_\_\_. But regulations do not allow CSD to place children in DMH licensed homes except under the special Private Institutions Placement program. There is money in the budget for this type of placement, but \_\_\_\_\_ doesn't qualify for this program because he doesn't have any severe medical or physical problems.

If \_\_\_\_\_ were placed in a CSD certified home, there would be money from the Social Welfare and Mental Hygiene budgets to pay for his care. (\$160 per month plus clothing allowance). Regulations do not allow this same money to be used to purchase care from a private DMH licensed home.

For a child like \_\_\_\_\_, private foster home care might well be available for \$160 per month plus clothing, but a charge of \$175-\$200 per month is more typical. The higher fee could be paid from the budget for private institution placement, but, as stated, Harry does not qualify for such placement because that is reserved for children with special medical or physical problems....

.....  
\_\_\_\_\_ has already been in Sonoma many months longer than he need be, at a cost of perhaps \$450 per month. We don't know when a

family care home will be found for him. In the meanwhile, he is occupying a place sorely needed by other urgent cases on the waiting list. And there are more patients in Sonoma like him who could be placed in foster homes if rules and regulations were more flexible.

Very truly yours,

Carl Verduin, M.S.W.  
County Coordinator of  
Mental Retardation Services

ALAMEDA COUNTY  
MEDICAL INSTITUTIONS

Currently, licensing is divided among three state departments, as indicated by the chart below.

LICENSING DEPARTMENTS, FACILITIES LICENSED,  
AND CODE AUTHORIZATIONS

Department of Public Health

Clinics and dispensaries	(Health & Safety Code, Ch. 1, Sec. 1200, et.seq.)
Hospitals, including sanitariums, nursing and convalescent homes, and maternity homes	(Health & Safety Code, Ch. 2, Sec. 1400, et.seq.)
Establishments for handicapped persons	(Health & Safety Code Ch. 3, Sec. 1500, et. seq.)
Home health agencies	(Health & Safety Code Ch. 8, Sec. 1725, et seq.)
County psychopathic hospitals	(Welfare & Institutions Code, Pt. 3, Sec. 6300, et seq.)

Department of Mental Hygiene

Private institutions, including hospitals, sanitariums, homes or other places which care for any mentally ill or other incompetent persons

(Welfare & Institutions Code, Pt. 2, Sec. 6200, et. seq.)

Department of Social Welfare

Institutions for child care and home-finding agencies

(Welfare & Institutions Code, Ch. 1, Sec. 16000, et. seq.)

Institutions and boarding homes for aged persons, and certification of family care homes for patients on leave of absence from state hospitals

(Welfare & Institutions Code, Ch. 3, Sec. 16200, et. seq.)

Despite the legal provision permitting the Departments of Social Welfare, Mental Hygiene, Rehabilitation, and Public Health to "enter into an agreement whereunder any such department may administer all or any portion of the licensing functions of any or all of the other departments",<sup>30</sup> such coordination and cooperation is far from a reality.

In 1967 the Assembly Ways and Means Subcommittee on Health, Education, and Welfare Services recommended that "present state institutional licensing functions be consolidated and that the Legislature consider creating a unified state licensing service linked with the responsibility for setting rates."<sup>31</sup>

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30. California Health and Safety Code Section 1424.

31. Subcommittee on Health, Education, and Welfare Services, op. cit., p. 9.

Despite continued legislative urgings, licensing residential care facilities still is the responsibility of the three departments, at unnecessary cost to the taxpayers, and with considerable confusion and discomfort for the providers and users of licensed facilities.

In 1968, a study of licensing by the Senate Social Welfare Committee identified the source of numerous difficulties:

...When the licensing laws were enacted, and licensing responsibilities were placed under the jurisdiction of a specific department, two separate methods were used, without consistency, to designate the types of programs or the facilities to be licensed.

To illustrate, current responsibilities assigned to 1) the Department of Public Health are based on licensing facilities which provide a specific type of service -- medical; 2) responsibilities assigned to the Department of Mental Hygiene are based on licensing facilities which provide services to a group of persons, namely the mentally ill and the mentally retarded; and 3) the responsibilities assigned to the Department of Social Welfare are based on the licensing of facilities which provide a specific type of service to a specific group, namely, nonmedical care to the aged or to children.

This has created vague and overlapping licensing responsibilities in some program areas.

The purpose of licensing is to assure that people placed in private institutions will have safe, clean, appropriate physical surroundings and adequate personal care. However, our tripartite system of licensing operates to make some placements impossible. A handicapped person becomes the victim of conflicting placement regulations, confused licensing requirements, and unrealistic, arbitrary rules. A major problem of any new licensing system will be to make sure that the "health" requirements of the licensing

department (which are obviously more stringent for a foster home than for a family caring for a handicapped child of its own) do not operate to further limit the availability of facilities.

The new Reorganization Plan contemplates that "the state's functions related to licensing of out-of-home care facilities can best be accomplished by consolidating these functions in the Department of Health".<sup>32</sup> Hopefully, in addition to combining overlapping functions, reorganization will also include a complete reassessment of the standards and practices now in effect.

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32. Governor's Reorganization Plan #1, op. cit., p. 11.

VI. AN UNINTENDED CONSEQUENCE: STIGMA

"A handicapped person of proven abilities and potential productiveness is often rejected because of the 'image' perpetuated by categorical programs."

"I started college in the hope of becoming some kind of professional. I worked in three different fields before I was able to find a profession that would accept me. During my first three years of college I worked to acquire a teaching credential. The school allowed me to work up to the time I was to do my student teaching. They even allowed me to contact an institution for the retarded to see if I could do my student teaching in that facility. In my interview with the director of the institution, I first faced the problem I was to come up against repeatedly for the next ten years. The director informed me that he had once hired a cerebral palsied person as a teacher, but found that this woman demanded too much personal attention and was too dependent to be a good teacher. At this time he made the decision that the cerebral palsied could not teach and informed me this was his reason for not allowing me to do student teaching at his school."

"I returned to the college and they informed me that they had received an interpretation of my case from the State Department of Education. They told me I could not receive a teaching certificate in this state because there was a law which stated, 'To receive a teaching certificate in this state, a person had to be mentally, morally and physically qualified', I am not sure in which category I failed, but I assumed it was due to my physical disability."

"My next experience was an attempt to enter a school of librarianship. None of the five schools to which I applied would accept me as a candidate. They all gave the same basic reason, which was...they knew I could do the school work but they weren't sure they could place me on a job. One of the frankest directors of a library school came right out and stated, 'We have a responsibility to keep librarianship a pure and clean field'. I have found this attitude prevails in many of the other professions including my own...social work."

"When I finally applied to a school of social work, the dean of the school was very open-minded during my

interview. He frankly told me of the trouble I would have getting a job in the field, but the school was willing to help me in every way possible. They accepted me as a student and were willing to help me with any special needs. I graduated from this school and immediately faced a new level of rejection which surprised and shocked me. During my last year of school I started looking for work as a professional social worker. As you know, social work is a field that is crying for qualified workers. There are about 10 jobs for every trained worker, but I had over 40 job interviews before I was finally able to find a job. Remember, I had just completed two years of field work which my school said was satisfactory. Over and over again, supervisors, heads of agencies, and personnel officers, all of whom were professional social workers, showed that they were completely unaware of the personal problems of the handicapped person. They acted as if they were unaware of my training and experience. All they could focus on was the disability they saw in front of them."

Rolf Ryan Williams, ACSW  
Speech given at Seminar  
on the Handicapped, San Diego  
State College, Oct., 1969

There are many unpleasant consequences of being handicapped. The most painful consequence is having to live with a degree of stigma.<sup>33</sup> By definition, the handicapped person is always informally -- and often officially -- labelled DEFICIENT, INADEQUATE, INFERIOR. General ignorance, inherited traditions of superstition, and social norms that place a premium on conformity and "normality" make handicapped persons the objects of distrust and fear. We react to the label pinned on a handicapped person. He is "blind",

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33. Erving Goffman, Stigma, Prentice-Hall, Inc., Englewood Cliffs, N.J. 1963, pp. 2-3. "Society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories.... We lean on these anticipations that we have, transforming them into normative expectations, into righteously presented demands.... Such an attribute is a stigma, especially when its discrediting effect is very extensive, sometimes it is also called a failing, a shortcoming, a handicap."

"retarded", "epileptic", "deaf", "crazy", "spastic". We expect the handicapped person to look a certain way, to do certain things, and to require special efforts on our part. Naturally, he tends to adjust his behavior to our expectations. The presumption of inadequacy, the undercurrents of fear and uneasiness, and the stereotypes attached to specific categories of handicap are reflected in the personal relations and the activities of the handicapped. The handicapped individual is no longer a person -- he is a condition.

Stigma is both a social and psychological problem. The reason we have a crazy-quilt of special services and agencies for the handicapped is that the "normal" social and economic institutions could not and would not accommodate those who were different enough to be regarded as marginally productive or unproductive. A free and expanding economy simply has no room for the "misfit". The harshness of a competitive society is reflected in the attitudes and actions of individuals. A handicapped person of proven abilities and potential productiveness is often rejected because of his "image".

The past development of services for the handicapped in California served to perpetuate the effects of social stigma. Hiding the mentally ill and the mentally retarded away in remote hospitals and sending blind, deaf, and cerebral palsied children off to special schools assured that the public would have limited contact with "different" people and that the handicapped would

have few chances to develop social skills. As a result, the handicapped have become severely restricted in their range of choices.<sup>34</sup> The social benefits that most of us can obtain from a plurality of sources are available to the handicapped at relatively few "institutional" sources under specific, inflexible conditions. The status of handicapped people as "second-class citizens" is underlined by the title of a recent Department of Rehabilitation publication: The Hidden Minority.<sup>35</sup>

But California has also been in the vanguard of the trend to provide community services to the handicapped. The Short-Doyle Act of 1957, and its recent revisions, emphasize the development of a complete array of services for the mentally ill in the counties. State hospitals are now conceived as a backup resource and involuntary commitments have been severely limited by procedural safeguards. Our system of community mental health services is based on the discovery that it is both cheaper and more effective to treat emotional disturbances in a normal setting.

Another step in this direction was A.B. 225 (Lanterman) which, in 1969, established a system of Regional Centers for the Mentally Retarded. Mentally retarded persons will no longer be committed

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34. Goffman, Ibid., p. 5, "The attitudes we normals have toward a person with a stigma, and the actions we take in regard to him, are well known, since these responses are what benevolent social action is designed to soften and ameliorate. By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances."

35. We would like to thank the California State Department of Rehabilitation for the term "hidden minority" which appears as the title of its "Final Report of the California Rehabilitation Planning Project July 1, 1969.

to state hospitals, and entrance to a state hospital is determined by the Regional Center, which is charged with exploring all other opportunities beforehand. But, the Regional Centers, and the services to which they will refer their clients are clearly labeled: FOR THE RETARDED. To single out one category of handicap for the benefits of such a system seems unfair. To channel people into services that perpetuate separateness and limit their alternatives is undesirable.

By attempting to meet the needs of the handicapped in the community, we have begun to move away from the institutionalization of social stigma. The next step should be in the direction of integrated, noncategorized services in the community.

## VII. THE SPECIAL PROBLEMS OF SPECIAL EDUCATION

The following issues justify a separate chapter on special education:

1. Minority group representatives -- particularly Mexican-American organizations -- have complained that a disproportionate number of minority group children were being placed in classes for the retarded. Studies in the school districts have confirmed their charges, and the Assembly, by passing H.R. 444 (Deddeh) last year, has recognized the problem.
2. Citizens organizations representing various handicapped groups have become increasingly critical of the quality of special education programs, the differential financing of various categorical programs, and the discriminatory eligibility requirements.
3. In 1969, in reaction to the fact that some school districts were misusing special education programs to secure additional state funds, the Legislature enacted A.B. 606, a portion of which limits the expansion of special education programs and requires greater accountability. One effect of A.B. 606 is to increase legislative pressures for a clarification of the goals and effectiveness of special education programs. But, A.B. 606 does not solve the basic

problems in the field, and based on past performance, it is unlikely that the education "establishment" will come forth with new approaches despite these additional pressures.

Special education is the largest and most expensive single state-supported program for handicapped children. The problems of special education reflect those of state services to the handicapped in general. Soaring costs, unmet needs, inappropriate placement, and professional manpower shortages stem directly from the basic (categorical) structure of the system which encourages duplication, a rigid approach to educational need, and a tendency to segregate the handicapped from the nonhandicapped. Funding mechanisms for special education are designed to reward failure by providing extra funds for the child maintained in special classes.

Currently, California elementary and secondary schools provide a total of fourteen programs for handicapped children. Entrance is governed by fulfilling the diagnostic requirements for each category. Unfortunately, the diagnostic tests are imperfect, the criteria are often vague, medical designations (required by law in some of the programs) may have no bearing on educational needs, and the quality of diagnostic work varies widely from one school district to another.<sup>36</sup>

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36. See: California Association of School Psychologists and Psychometrists (CASPP) "Position Paper on Supplementary Education", Feb., 1969, "Diagnostic, admissions, and placement procedures lack clear-cut functional definitions of the child's disability."

According to the State Department of Education, almost a quarter of a million children (245,753) were enrolled in 14 different kinds of special education programs in 1967-68. State costs in that year were \$109 million dollars and exceeded \$130 million in 1968-69. (The State Department of Education is unable to provide information on the total -- state plus local -- cost.)

The present system (of categorical programs) developed mainly as the result of citizen pressures by different special interest groups representing specific kinds of handicapped children. As these groups were successful in securing -- first permissive and then mandatory -- school services for their children, the system grew by layering one category on top of another. To compound the problem, the universities and colleges developed separate teacher training programs and a special credential for each of the categorical programs.<sup>37</sup>

Although it is a fact that several handicaps may occur with a greater-than-chance frequency in the same individual, special education bases its programs around, at most, two "categories" of handicap. The Developmental Centers serve severely physically and/or retarded children; the E.H. program combines emotionally disturbed and neurologically handicapped; and the experimental program for the deaf-blind is developing techniques for this particular combination. The rest of special education, however, concentrates on single categories, a fact that has made it difficult for many

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37. The Certification Office, State Department of Education, can provide a list of 18 different special education credentials -- none of which include the "Educationally Handicapped" program.

multihandicapped children to receive appropriate education. Flora M. Daly (State Department of Education) says that usually the "major" or "worst" handicapping condition will determine the program. Cases from the districts, however, indicate that a multihandicapped child is often refused entrance to any program.

Alameda County: Case No. 17

Born premature, \_\_\_\_\_ was blinded and maimed at birth by the excessive use of oxygen. She is retarded. The cause of her severe emotional problems and allergic reactions is much more vague and has never been pin-pointed for her parents. The parents were not informed by the physicians at the time of \_\_\_\_\_ birth that she was blinded or that there was any other possible problem. A neighbor alerted them to \_\_\_\_\_ blindness, understandably an emotional shock to the parents. Seeking advice from their pediatrician, they were advised to "wait awhile and not to get all upset". The neighbor then recommended the Blind Babies Variety Club. \_\_\_\_\_ was 1½ years old when the Club sent a social worker who was ultimately to be referred to by the mother as the "only person in the whole nightmare of 16 years that seemed to care what happened to \_\_\_\_\_ or me".

This worker tried many referrals in an attempt; to secure educational and counseling services. \_\_\_\_\_ was starting to learn controls during her 6 months at a private nursery school, but the school closed for lack of funds. Neither the School for the Blind nor special education programs would accept her emotional problems, the Children's Clinic of the East Bay was "cold, unfriendly and expensive", and Lincoln Child Center was unwilling to accept \_\_\_\_\_ because of her frequent illnesses. She began to respond at Clearwater Ranch but they could not work with her allergy problems, so \_\_\_\_\_ was sent home. The family went to their church, who couldn't handle the blindness or temper tantrums. Finally, when \_\_\_\_\_ was 10, she was "far beyond the age of service" according to the Blind Babies social worker who discontinued her visits.

\_\_\_\_\_ family has given up trying to find education for her.

It is becoming increasingly apparent that classes for the Educable Mentally Retarded are being used to relieve the normal classroom teacher of the difficulties involved in teaching culturally

disadvantaged and Spanish-speaking children. A report in Sacramento showed, "While students of Spanish surname comprise only 11.6% of the student population, they comprise 21% of the total enrollment in classes for the educable mentally retarded....While Negro students comprise only about 13.7% of the student population, they represent 37.6% of the mentally retarded student body."<sup>38</sup> A study in San Francisco emphasizes that Spanish-speaking children are indeed misplaced--not simply more retarded: "Forty-five percent of the Spanish surname children in elementary school classes for mentally retarded have been found to be of average intelligence or better when retested in Spanish."<sup>39</sup>

When the fact of misplacement is considered with findings showing that placement in special classes can lead to social and intellectual regression,<sup>40</sup> we must face a startling possibility: special education may be creating a class of functional retardates.

In 1969, as a result of concern about the inappropriate placement of large numbers of minority group children in special education classes for the retarded, the State Assembly passed H.R. 444 (Deddeh):

Whereas, The Members of the Assembly have learned of mounting criticism from representatives of certain minority groups, most particularly culturally bilingual groups, to the effect that a disproportionate number of children from such groups are assigned to classes for the mentally retarded.... RESOLVED IN THE ASSEMBLY OF THE STATE OF CALIFORNIA, That the Assembly...(2) strongly urge the State Board of Education to give attention and aid to proposals for changes in the structure of special education categories...;"

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38. The Sacramento Bee, November 4, 1969.

39. San Francisco Chronicle, January 1, 1970.

40. Orville Johnson, Exceptional Children, Vol. 19, 1962, pp. 62-69.

As we have noted in Chapter VI, segregation and isolation of handicapped people reinforces social stigma. This process begins with special education, where "different" children are separated from the others, labeled "inferior" or "deficient", and hidden away in mysterious (to other children) parts of the building, mobile classrooms, or completely separate schools. An editorial in the newsletter of the California Association for Neurologically Handicapped Children decries the "requirement that forces a child to wait on a street corner for a special education bus while being taunted and teased by his neighborhood playmates."<sup>41</sup> Children are notably intolerant of differences, and the handicapped child will have to learn to cope with a degree of intolerance. But attempts of the adult world to shelter the handicapped child may actually accentuate his differences and result in legitimizing stigma.

Many progressive educators are now proposing that handicapped children can best be educated by providing the resources and supports necessary to integrate them into the regular classroom. There are many examples of physically handicapped pupils participating successfully in regular programs. Experimental programs are beginning to show that the mentally exceptional can be integrated as well. In Temple City, California, seventy-eight children previously classified "educable mentally retarded", "educationally handicapped", and "speech handicapped" have been enrolled in regular classes. The district school psychologist anticipates a

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41. CANHC-GRAM, August, 1969.

25% learning gain for these children.<sup>42</sup> At Northwood School in Sacramento, Dr. Robert Elliott works with an experimental class of 28 third-graders including 3 "EMR" and 3 "EH" pupils. This class is not "structured" in the traditional sense, but consists of groups who "rotate" from one subject to the next every hour. Dr. Elliott reports encouraging results for all the children.

Recently the California Association of School Psychologists and Psychometrists distributed a paper proposing that:

...the present structure of special education which concerns itself with placement of children into single categorized classes should be abolished, and in its place a set of multiple processes be coordinated into a specific Supplemental Education Plan for a specific child when and for as long as the child's need is less adequately met by the regular classroom procedures.<sup>43</sup>

Thus, there is pressure for changing the categorical structure of special education among education professionals, spokesmen for cultural minorities, legislators, and parents of children who are refused education.

The movement to integrate handicapped children into regular school programs could have more immediate and far-reaching effect if the funding structure did not reward failure. Apportionments are now granted for maintaining a special class of a certain size or on an A.D.A. basis for children enrolled in special classes. This system rewards the schools for failing to accommodate handicapped children in regular classes.

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42. Ibid.

43. California Association of School Psychologists and Psychometrists, "Position Paper on Supplementary (Special) Education", February, 1969.

There is evidence that some districts will place children in the most lucrative programs, regardless of their actual educational needs. The Auditor General found, in 1967, that, "Funds received by school districts for special education are not being used in all instances for the particular purpose for which they were levied or apportioned."<sup>44</sup>

Special education leaders state that there is a shortage of funds, that children are being denied services, and that programs are being diluted due to lack of adequate funding. It is quite possible that these claims are valid; however, the mere appropriation of additional money to maintain and perpetuate the present system would seem to be unsound public policy in view of the serious questions that have been raised concerning the misuse of present appropriations. At best, additional funds at this time would merely be a stop-gap measure.

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44. Assembly Interim Committee on Education, Subcommittee on Special Education, Final Report, January, 1965, p. 40.

### VIII. THE HUMAN EFFECTS

There would be little point in listing the number of state services for the handicapped, determining caseloads and expenditures, discussing financing mechanisms and comparing eligibility requirements if all these factors had no impact on real people. The disorganization of our programs results in serious human problems.

We have mentioned that entrance to state programs is determined by an overwhelming maze of eligibility requirements. The most crucial criterion of eligibility is diagnostic category. If a handicapped person cannot "fit" any category there are times in his life when he can get no appropriate services. Once a child acquires a diagnostic label, the range of services available is immediately predetermined. These two points are illustrated by the following cases. The first is from our Alameda County research team, the second reproduces a letter to Assemblyman Frank Lanterman.

There may be no appropriate services for the person who does not "fit" a diagnostic category:

Alameda County: Case No. 15

\_\_\_\_\_ was born in 1953. The birth was easy and uncomplicated. His problem is unique and "undiagnosable". His endocrine system is functioning strangely and he began to mature sexually at 6 years old; on the other hand he has never become completely mature and is short and strangely proportioned with a large head and bulging forehead. He is something of a musical genius and plays the "trumpet and coronet like an angel" according to one outside listener. However, his speech and ability to communicate are so poor that he may not really have a future in the musical world either.

The parents have run the gamut of diagnoses, desperate in their search for educational and medical service and in their effort to help this boy live an acceptable existence. They have used 29 agencies and private professionals in this search but have never really found any kind of continuing concern. They found the "neighborhood beastly, the schools helpful but not accepting of him as a person, and the medical services inadequate, confused, and conflicting".

Since the father is a middle-echelon professional, the income in the family has exceeded eligibility for any kind of public help with the tremendous bills this child's care has entailed. CCS refused to consider their case at all.

The family's experiences with the professional community, especially the medical and teaching professions, have been traumatic. His mother feels they have been baffled by his case and have been evasive and often punitive.

Once a child acquires a diagnostic label, the range of services available is immediately predetermined:

Oct. 5, 1969

Dear Assemblyman Lanterman,

We read that you had been named to head a subcommittee on mentally ill and handicapped children, and to investigate State programs in this field. We would like to bring our case to your attention, ask your advice about it, and suggest legislation to reduce its burden upon us and others.

Our daughter \_\_\_\_\_ was born three years ago in Los Angeles County with spina bifida -- a spinal deformity which leaves her paralyzed below the waist, having no bowel or bladder control, and suffering from hydrocephalus.

We have a normal child of eight, and are unable to provide in our home the constant care, treatment, attention, and therapy which \_\_\_\_\_ requires.

However, we were forced to apply to the Los Angeles County Bureau of Public Social Services in order to find a place for \_\_\_\_\_ to live. They have placed her with a foster mother who is providing excellent care for her in her home. She does not require hospitalization at present. This care costs nearly \$300 per month. We pay about one-fourth of that in cash monthly. But because we have a "middle income" and are not separated or divorced, we are not eligible for State or Federal funds to pay for this care. Therefore, the entire amount must be advanced by the County, and is wholly "reimbursable". In order to secure this "loan", the County literally forced us, with the threat of returning \_\_\_\_\_ to our doorstep, to sign a mortgage upon our home in the \_\_\_\_\_ district. The debt is now over \$7,000, and equals our equity in our home. If we were to sell the house, the entire amount would go to the County. Nor can we purchase another home, even if we could raise another down payment, because the mortgage is transferable to any property we might buy in the future.

The paradox here is that if \_\_\_\_\_ were mentally retarded or mentally ill, she could be admitted to a State Hospital, or her care would be paid for by the State or Federal governments in a home placement. We understand that parents of mentally ill or retarded children pay only \$20. per month for their care, in or out of a hospital.

Apparently, the State Dept. of Social Welfare allows County Depts. to require client reimbursement for this sort of care. This seems to be unfair because it applies only to children who are handicapped, and not mentally retarded.

We ask you to examine legislation and State regulations in this field and see if this case is being handled properly. If it is, then we urge you to introduce legislation to correct this inequity, and allow State welfare funds to be used for maintenance costs for handicapped children as well as mentally retarded children. The human and financial burden is no different upon us than upon parents of retarded children.

The other inequity is that if we were poor, separated, divorced, or unfit parents, the State would pay the entire amount for this care. However, a debt of this sort not only will quickly make us poor, but also prevent us from owning a home, or acquiring any substantial assets.

The two preceding cases illustrate the problems of families victimized by the quirks of eligibility requirements.

Discontinuity of services can be equally perplexing. The next two cases were clients of the Handicapped Person's Pilot Project from 1965-1969.<sup>45</sup> Each provides an example of how some services can spend time and money to achieve a purpose but then fail to provide the one crucial ingredient. In the first case, one service provided a wheelchair but no one would finance the necessary ramp. In the second case, VRS financed an entire business but could not supply the one thing necessary for legal operation -- a toilet. The Pilot Project staff had to intervene to overcome these bureaucratic barriers to service.

\_\_\_\_\_, the sole support of her three children, worked as a domestic. One day as she paused to rest on a second floor balcony, the railing gave way and she plummeted to the sidewalk below. Both thigh bones and both knee caps were compoundly fractured, and the spine in the neck was injured. Infection developed in the left thigh bone and she was hospitalized for four years. She had fair return of use of her right side and in 1962, was discharged from \_\_\_\_\_ Hospital in a wheelchair. She returned to a rented home and children on ATD and Aid to Families with Dependent Children (AFDC) assistance. At that time a ramp was needed in order for her to manipulate the wheelchair safely, but the hospital could not build one onto a rented house.

Four years later a nurse from the VNA referred her to the project; the referral was for a ramp. In the interim she had several times toppled off a still extant makeshift ramp, a plywood board placed over a broken door frame laid across steps at an angle of 45 degrees. At least twice she had received injuries serious enough to be taken by ambulance for emergency treatment.

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45. Handicapped Persons Pilot Project, Bureau of Chronic Diseases, California State Department of Public Health, Residential Care Needs, A Report to the California State Legislature, January, 1969.

\_\_\_\_\_, age 40, broke his neck in an automobile accident and is classified a quadriplegic although he can walk with assistance and has total sensation.

Helped by the Vocational Rehabilitation Service, he established a "Do-It-Yourself" automobile repair garage. The VRS financed most of the business costs but the plan nearly failed at the last minute because of that agency's restrictions. It was necessary that a toilet be installed on the business premises before permission could be given to open the garage. Vocational Rehabilitation Service could not spend the needed \$25 for this because it would improve someone else's property.

The fragmentation of "professional" groups also takes its toll. The following case from Alameda County illustrates the consequences of professional infighting:

Alameda County: Case No. 2

Everyone thought \_\_\_\_\_ was an exceptionally "good" baby until she was three when an aunt noticed that she seemed not to hear.

Her mother, then recently widowed and beset by problems, could not believe in such an idea but on the insistence of her aunt, finally consulted the family doctor. He sent them to an ear specialist and they were immediately started on specialized training. In spite of this direct and straight-forward diagnosis and attention, the young widow received no counseling, had no one to talk to and received no financial assistance. She was caught in a professional struggle between one group of educators who pushed for the use of manual training and another who insisted on a purely lip-reading approach. She was forced to decide which was "best" for her daughter and made to feel guilty and excluded by the other group.

These cases provide examples of the human dimension of the analysis of state services for the handicapped. In the next section, we will propose some alternative ways of organizing these services, and make recommendations for additional legislative activity.

## IX. THE FEASIBILITY OF CONSTRUCTIVE CHANGE

We have identified the problems of disconnected services for the handicapped: lack of information for evaluation, planning, and budgeting; uncoordinated programs; duplication of efforts; confusing, irrational eligibility requirements; and categorical programs that reinforce social stigma. The next step is to fashion some alternative ways of thinking about services to the handicapped and organizing these services.

### Requirements of a "Good" System

There are two essential ingredients of a "good" system of services for handicapped people. On the one hand services should be coordinated, continuous, and appropriate to individual need. On the other hand, services should be structured in a way to minimize labeling, isolation, and social stigma.

How can we coordinate and rationalize services to the handicapped without perpetuating stigma and lack of personal freedom? The reason we have a crazy-quilt of special services and agencies for the handicapped is that the "normal" social and economic institutions could not, and would not, accommodate those who are different enough to be regarded as marginally productive or unproductive. The State of California thus spends close to a billion dollars every year on "special" services designed to meet the minimal needs of the handicapped. An alternative would be to persuade the "normal" system -- both public and private -- to respond to the needs of the handicapped.

Money is a powerful incentive. The mechanisms for its allocation and distribution are the natural instruments of coordination and planning. We therefore propose, as a basic principle, that whenever possible, funds be spent for the handicapped in the "normal" system according to a rational plan based on individual needs.

Our conversations, interviews, and questionnaire returns have led us to the following conclusions:

- There is general agreement that the problems outlined in this report are the major difficulties of current services.
- Lack of adequate information is unanimously deplored. Some means of storing and retrieving information for purposes of evaluating, planning, and budgeting services is desirable. The only reservations are, (1) keeping such a system up to date, and (2) assuring that governmental access to personal information does not violate civil rights.
- State-county programs (Aid to the Blind, Aid to the Disabled, Crippled Children's Services, Aid to Families with Dependent Children, and Short-Doyle programs) should at least have the same funding arrangements.
- A method of funding special education permitting flexible programming and assuring continual evaluation is necessary and desirable.
- The approach developed in the Regional Centers for the Mentally Retarded constitute an acceptable model for delivery of services to all the handicapped.

## Proposal #1 - Alternatives for Coordination

### A. The Regional Center Model

The Regional Center concept is one mechanism for assuring coordination and continuity of services. It provides a constant point of access to a multitude of programs and it can develop the case experience necessary for continued counseling and referral. The Regional Center is designed to keep up-to-date records necessary for planning and budgeting. The Center also avoids replication of administrative overhead for intake procedures and operational expenditures and manpower for diagnostic services.

The Regional Center, thus, solves many of our problems of coordination, continuity, information, and replication. However, the danger increases that a Regional Center for all handicaps will, by concentrating the diagnostic, counseling, and referral services under one organizational umbrella, emphasize the problems of isolation and stigma. To overcome this difficulty, we suggest that funds spent by the Centers for direct services be spent, insofar as possible, in those programs that also serve the non-handicapped. In this way, the Regional Center becomes a "pipeline" to channel state funds for the handicapped into the "normal" system.

We further propose that one of the existing Regional Centers be selected on a pilot basis to expand its caseload to include (100-200) nonretarded handicapped people. This suggestion was discussed with staff of the Golden Gate Regional Center which now provides services to large numbers of multihandicapped retarded. To assure that existing services are not diluted, it is suggested that a research grant be sought for this project.

In these cases, according to the director of the Center, the individual's total needs are assessed and met. This Regional Center is experienced in a variety of problems, and an expansion of intake policy would mean no significant reorientation. (Additional caseload would thus require hiring some "generalist" social workers and medical personnel.)

The staff of the Golden Gate Regional Center also anticipates that the cost of serving a number of other handicapped persons would not differ significantly from the cost of serving the same number of retarded people. The Center has developed sophisticated cost figures by types of service and needs of client that can be used to project expenditures for additional nonretarded caseload.

There is considerable support for expanding the Regional Centers. A recent California Council for Retarded Children survey of its own membership discovered that 56% of 1,480 respondent's agreed that "CCRC should encourage Regional Centers to provide services to all handicapped".<sup>46</sup> A past president of the Council for Exceptional Children recently wrote Assemblyman Frank Lanterman:

In my opinion we should enlarge the function of the Regional Centers to provide diagnosis and counseling for all handicapped and disordered children. The extent of multiple disability is expanding and we need a planning agency that takes into account a variety of solutions to problems and also would be able to purchase the type of varied services needed.<sup>47</sup>

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46. California Council for Retarded Children, Pilot Study 1969, funded by Social and Rehabilitation Services, Department of Health, Education, and Welfare.

47. Chester A. Taft, letter of February 10, 1970 to Assemblyman Frank Lanterman, Chairman, Assembly Select Committee on Mentally Ill and Handicapped Children.

## B. Consumer Advocate

The model for this sort of operation was developed by the Department of Public Health's Handicapped Person's Pilot Project. Although this project was categorically limited to severely physically disabled persons of normal intelligence, it provides some useful concepts for serving all handicapped people. (This project also demonstrated how much could be done on a very limited budget.)

Project staff, consisting of a public health nurse, a social worker, and a clerical worker were established in two areas to:

obtain background information from client, family and personal physician on previous medical, nursing, educational, social, and other needs and services received;

evaluate present situation to determine need for additional assistance and how to provide it;

plan with the participant a solution to meet immediate and long-term needs, arrange for required services, determine their costs, evaluate benefits to client and his family;

develop a discharge plan with client, and evaluate the situation after discharge from project and;

stimulate local agencies and organizations to develop appropriate high quality services for these people.<sup>48</sup>

This approach derives its major strengths from the fact that the staff was not subject to the service limitations of any one department or program. Their experience in, and knowledge of, our

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48. Bureau of Chronic Diseases, California State Department of Public Health, Op.Cit., p. 5.

complex system permitted the staff to find services the clients did not know existed. The project staff provided a continuous point of reference and source of advice for its clients. As consumer advocates, they were able to negotiate successfully with agency personnel.

The weakness of the approach lies in the fact that project staff had to deal with the existing disconnected services. In several instances the only way these experienced professionals could surmount structural difficulties was by providing direct services and spending project money. Still, this alternative had the advantage of least disturbing the bureaucratic status quo.

#### C. Consumer Sovereignty (Optional Use Project)

This approach has its roots in the unorthodox economics of Milton Friedman. Friedman's solution to the problem of funding public education was to pay every family a flat amount for each child and permit the family to patronize any private or public educational institution. Competition would destroy the least desirable institutions and reward the most satisfactory -- from the consumer's point of view.

Our services to the handicapped are based on the needs professionals, interest group representatives, bureaucrats, and legislators perceive. These perceptions may, or may not, coincide with the desires and priorities of the handicapped. One way to determine if we are providing what the handicapped need is to permit some handicapped people to spend money currently spent on state services in any way they choose -- and to evaluate the results.

This approach obviously has its disadvantages for the mentally incompetent, but these obstacles can be surmounted. Emotionally disturbed people who do not come under present commitment criteria -- harmful to oneself or others, unable to provide the basic necessities of life -- could spend these experimental state dollars as they please. Mentally retarded persons and their families could also be given freedom of expenditure after Regional Center staff has determined that their food, shelter, clothing, and medical requirements have been fulfilled.

This project would be to select a sample of handicapped persons representing a broad spectrum of disabilities. For every person opting for cash grants, a similarly handicapped person would be identified as part of a control sample. An effort would be made to assure that both groups had similar information about services. The cash-grant group and the group continuing to use regular programs would be compared in a series of follow-up studies and evaluations. Interviews, questionnaires, and service records would provide information concerning, (1) patterns of service utilization, and (2) consumer satisfaction.

#### Proposal #2 - A Uniform Funding Mechanism

We have mentioned that state services to the handicapped are funded by 21 different mechanisms (see pp. 23-30). Among these mechanisms are the following 6 different formulae:

<u>Program</u>	<u>State %</u>	<u>County %</u>
Short-Doyle Community Mental Health Services	90%	10%
Crippled Children's Service	Three to One	
Aid to the Blind	50%	50%
Aid to the Disabled	75%	25%
Aid to Families with Dependent Children	67½%	32½%
Regional Centers	100%	0% <sup>49</sup>

This situation creates excessive paperwork and confusion at the local level, and provides incentives to the counties to concentrate on developing services under the program bringing them the most state money.

We, therefore, propose an analysis of the cost and service impact of a consistent rate of state-county sharing for these programs.

#### Proposal #3 - Normalizing Special Education

We have shown that many of the problems of special education stem from the maintenance of categorical programs and special classes (pp. 55-62). The funding of special education rewards the failure of the regular classroom to accommodate the handicapped child and provides incentives to keep him in a special, separate class.

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49. Counties pay \$20 for state hospital placement.

There is presently no mechanism by which either the Legislature or the public can assess the performance of special education. Varying funding formula, means of admittance to programs, permissive district over-rides, and the wide variation of quality between districts, counties, and even within these units cost-effective evaluation impossible. Only the Educationally Handicapped Program states a measurable goal -- the return of the child to the normal classroom. (The provisions of A.B. 606 attempt to make this goal effective through annual review. According to Richard Struck, Special Education Chief of Santa Cruz County, performance levels and goals can be established for every aspect of special education.)

An analysis of the present use of funds and the cost implication of possible alternative programmatic changes is required as a basis for informed cost projecting.

We therefore propose that the Legislature initiate a study to determine the feasibility of providing special education apportionments on the basis of numbers of handicapped children in the school district or county rather than on the basis of categorical program to which a child can be fitted. To continue to qualify for apportionments, a district or county would have to demonstrate effectiveness under quantifiable goals and standards developed by the State Department of Education. Current A.D.A. apportionments will determine the proportions of reimbursements allotted for each handicapped child. (For example, in 1967-68 districts received \$435/A.D.A. for E.M.R. students and \$795/A.D.A. for T.M.R.

students. Thus the apportionment for the education of a severely retarded child would be about 1.8 times the amount allotted for a mildly retarded child.) This would provide the flexibility needed for individual educational programming and would be a strong incentive for school districts and counties to integrate handicapped pupils into regular classrooms. A school district may decide that a special class is the only way to educate some children. But the districts will probably find it less expensive to provide the resources and supports in programs that integrate the handicapped into regular classrooms.

Such a program could, and should, be tied to a teacher training project designed to encourage "regular" teachers to acquire the skills to work with handicapped children.

Such a study could also include the following activities:

1. A review of the literature and survey of "model" special education programs in the United States and selected nations.
2. On-site observations of selected programs in all 14 categories by experts in special education and child development.
3. A follow-up survey of children previously enrolled in special education classes and an evaluation of relevant program components.
4. Indepth interviews with special education personnel on all levels.

5. Questionnaires and interviews with parents of children enrolled in special classes and also organizations representing the various handicapped groups.
6. An analysis of current patterns of expenditures and cost implications of various program changes.

Proposal #4 - Securing Information for  
Planning, Evaluation and Structuring Priorities

We need information that is currently unavailable if we are to evaluate the effectiveness of existing programs and structure priorities for expenditures. We suggest that the Legislature undertake a study during the next year to determine the following:

- Prevalance of various handicapping conditions projected forward for several years;
- Care and service impact of various handicapping conditions;
- The projected cost of meeting the total life needs of handicapped persons;
- The total public and private resources available to fulfill the needs of the handicapped;
- The capabilities of present services to handle the projected caseload;
- Estimates of projected manpower requirements and sources of trained manpower.

PART TWO

MENTALLY DISORDERED CHILDREN

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## I. PROCEDURE

During the six-month period (September 1, 1969 - February 28, 1970) the following activities were conducted to provide a factual base for analyzing services for mentally disordered children and adolescents:<sup>51</sup>

1. Staff conducted a search of the literature dealing with the problems of mentally ill children. Special emphasis was given to materials describing the success or failure of different types of programs. Several "model" programs were contacted to gather information about services and techniques utilized.
2. In order to define the existing system of services for mentally ill children, it was necessary to conduct a community inventory of programs currently being provided at the local level. (This information had never been gathered in a systematic way.) The California Association for Mental Health, through its chapter organizations, cooperated in conducting the survey on a county-by-county basis throughout the State.
3. A questionnaire was sent to all county probation departments to secure information and opinions from this major child placement agency. In addition, interviews were conducted with numerous judges and probation

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51. Copies of all questionnaires, survey forms, and lists of agencies visited and interviewed are available upon request.

personnel and several state- and county-operated facilities were visited.

4. A questionnaire survey of all state hospitals was conducted to secure data and opinions regarding more than 1,200 youngsters under age 21, in state hospitals.
5. A questionnaire was sent to all parents of children now in or on the waiting list to Napa State Hospital. In addition, personal interviews were conducted with a group of these families. Medical records of these children were also analyzed for pertinent information.
6. Extensive field visits were conducted at both Napa and Camarillo State Hospitals (both adolescents' and children's programs). Interviews were conducted with personnel at all levels and with patients.
7. A questionnaire was sent to all county mental health directors to assess Short-Doyle programs for children and secure opinions from program directors.
8. Over 50 voluntary residential treatment centers were surveyed to determine the capacities of community residential care facilities. In addition, several of these facilities were visited as a basis for comparison with state-operated programs. Many directors of these programs were interviewed, and two formal meetings were held with the members of the California Association of Children's Residential Centers.

9. Several outstanding community-based programs for severely disturbed children were visited, including: San Fernando Valley Child Guidance Center, Julia Ann Singer School, Cedars-Sinai Department of Child Psychiatry (Los Angeles), Orange County Probation Department, Youth Guidance Center (Santa Anna), Sacramento Children's Home, Lincoln Child Center (Oakland).
10. Two progress reports were prepared for the Select Committee and a "Preliminary Report" was circulated to provide the basis for the Select Committee's public hearing on January 27, 1970.
11. Finally, reactions to the "Preliminary Report" were analyzed and discussions were held with various public officials, state and county health and welfare administrators, and private citizens as a basis for the preparation of the final report and recommendations.

## II. BACKGROUND AND HISTORY

The care and treatment of emotionally disturbed children has been a recognized national responsibility since the beginning of this century. The 1930 White House Conference on Child Health and Protection proclaimed:

The emotionally disturbed child has a right to grow up in a world which does not set him apart, which looks at him not with scorn or pity or ridicule...but which welcomes him exactly as it welcomes every child, which offers him identical privileges and identical responsibilities.<sup>52</sup>

Over the years, various study groups have repeatedly announced the need to create services and programs to care for these children. The Joint Commission on Mental Health of California, in surveying the progress made since the 1930 White House Conference, reports:

In the four decades since the issuance of that report, the care of the emotionally disturbed child in this country has not improved...it has worsened considerably.<sup>53</sup>

The proclamation of children's rights and the good intentions of concerned citizens and professionals have yet to be transformed into an effective system of services for mentally disordered children.<sup>54</sup>

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52. Joint Commission on Mental Health of Children, Inc., op. cit., p. 7.

53. Ibid., p. 8.

54. The terms "mentally ill", "mentally disordered", and "emotionally disturbed" will be used interchangeably in this report. We will follow the definition used by the Joint Commission (p. 403): "An emotionally ill child is one whose progressive personality development is interfered with or arrested by a variety of factors so that he shows impairment in the capacity expected of him for his age and endowment: 1) for reasonably accurate perception of the world around him; 2) for impulse control; 3) for satisfying and satisfactory relations with others; 4) for learning; or 5) any combination of these."

It is the purpose of this report to describe the services presently available in California for the mentally disordered child and to offer some recommendations as to how they might be improved.

An analysis of services for the mentally disordered child in California is especially timely in light of the recommendations of the National Joint Commission on Mental Health of California, and the lack of any California legislative studies of this problem. In order to examine the service system for such children, the Assembly established the Select Committee on Mentally Ill and Handicapped Children.<sup>55</sup>

#### HISTORY

The development of services for mentally disordered children is a fairly recent phenomenon in California. Admissions to the state hospitals for the mentally ill in the years 1910, 1920, and 1930 show that persons under 20 accounted for 4.4%,<sup>56</sup> 2.6%,<sup>57</sup> and 4.0%<sup>58</sup> of the total number admitted, respectively, in those years. However, there were no separate provisions for mentally disordered children available through any public agency, including the state

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55. The membership of the Select Committee on Mentally Ill and Handicapped Children are: Frank Lanterman, Chairman; Gordon Duffy, Vice Chairman; Carl Britschgi, Leon Ralph, Yvonne Brathwaite, Kent Stacey, and George Zenovich.

56. H. Adler, M.D. and F. Cahn, Study of Admissions to California State Hospitals and Institutions for Mental Disorders, Bureau of Public Administration of the University of California and State Department of Institutions, 1934, p. 52.

57. Ibid., p. 56.

58. Ibid., p. 60.

hospitals.<sup>59</sup> Children with mental disorders whom the community could not tolerate were either placed on adult wards in state hospitals, in facilities for the "feebleminded" (mentally retarded) or for juvenile delinquents.<sup>60</sup> On February 25, 1930, there were 14,451 patients in the six state hospitals for the mentally ill,<sup>61</sup> about 578 of whom were under 20. Mentally disordered children would have to wait for more than another decade before programs for children were developed in the state hospitals. Special programs were initiated in 1943 at both Napa State Hospital and Camarillo State Hospital. Of the approximately 300 young patients between the ages of 10 (there were no patients younger than 10)<sup>62</sup> and 19 years in the state hospitals in 1946, 50% were under treatment in the two juvenile units at Napa and Camarillo State Hospitals.<sup>63</sup> The majority of those in the two juvenile units were either wards of the juvenile courts or the California Youth Authority who were sent to the hospitals for 90-day observation and diagnosis.<sup>64</sup>

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59. F. Cahn and Valeska Bury, Welfare Activities of Federal, State and Local Governments in California, 1850-1934, University of California Press, Berkeley, California, 1936, p. 126.

60. H. Adler, M.D., "A Note on Admissions to State Institutions," American Journal of Psychiatry, Vol. XII, No. 6, May, 1933, p. 1341

61. G. Myers, "The California State Mental Hygiene Survey," California and Western Medicine, Vol. 33, No. 6, December, 1930, p. 873.

62. California Department of Mental Hygiene, Statistical Report of the Department of Mental Hygiene, 1946, p. 30.

63. Ibid., p. 103.

64. Ibid.

Now, more than twenty years later, the juvenile units at Camarillo and Napa State Hospitals are serving 289 patients. Camarillo State Hospital has recently developed (started in 1966) an Adolescent Unit with a current (11/30/69) patient population of 171. DeWitt, Napa, and Mendocino State Hospitals have also begun small adolescents' programs (all of them with fewer than 30 patients involved). The major referral agencies, until very recently, were county probation departments who sent juveniles to state hospitals for the 90-day Juvenile Court Observation period.

The state hospital system is only one small part of the service system for these children. Services for mentally disordered children have also developed within the private sector during the last fifty years. Most private institutions began as orphanages and homes for dependent and neglected children under the auspices of various religious and charitable organizations after the Civil War. Private specialized schools and correctional institutions also flourished during the period before World War I. With the organization of the juvenile courts at the beginning of the century, greater numbers of children were placed in these private institutions for behavioral and emotional problems or because their parents were considered unfit. These were the only placement facilities available.<sup>65</sup> However, with the rise of the foster home movement in the 1920's and the establishment of probation systems by the juvenile courts, the private institutions were forced to reexamine

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65. Sidney Cahn, A.C.S.W., "The Program for Adolescents in Mendocino State Hospital - An evaluative Study," (unpublished paper), p. 7.

their programs and functions. The State also began operating its own special schools and correctional institutions. As a result, private institutions had to determine what services they should offer which were not being offered by the public sector. Many began to make a difficult transition to residential treatment facilities for mentally disordered juveniles. Each institution's history and development was different, and it is difficult to generalize about this transition period. However, today there are over fifty voluntary, private children's residential facilities in California, and most of them offer services for the mentally disordered child and/or adolescent.

Our discussion, to this point, has centered on the history of inpatient and residential facilities for mentally disordered children. But what about the more recent development of outpatient services? What types of services are available at the community level? Where can the emotionally disturbed child and his family go for guidance, counseling, and treatment before the problems become so severe that the child must leave the home? There are some very fine public and private outpatient services for children and adolescents in California. But, on the whole, outpatient services are the least plentiful resource at the community level. These problems will be discussed in depth in other sections of this report.

### III. PROGRAM GOALS AND METHODS FOR ACHIEVEMENT

In order to evaluate services for mentally disordered youth in California, it is useful to define the purposes for which they were created. The merits of programs cannot be discussed without first making explicit the goals of the program and the means used to achieve those goals.

"Mental Health is exceptionally difficult to define, partly because it is a complex state of being -- a sense of confidence in one's self and one's world. The mentally healthy person is able to see and generally deal with the realities concerning himself and his world; he is able to relate to other people in ways that are satisfying both to him and them; he is able to accept and control his impulses for sexual and aggressive expression; he is able to learn and apply what he has learned. He has confidence in his competence as a person. He has acquired a set of values upon which he builds his life; he has a sense of community with others and a sureness of his own identity..."<sup>66</sup>

If mental health, as defined above, is the goal, what methods are considered best suited to achieving it for the mentally disordered child?

Perhaps the most concise statement was developed by the California State Department of Mental Hygiene in its 1962 Long Range

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66. Joint Commission on Mental Health of Children, Inc., op. cit., pp. 226-27.

Plan.<sup>67</sup> They list "special guidelines for emotionally disturbed children":

A. Organization and location of treatment facilities and services

1. Where psychiatric outpatient services are present, adequate provisions must be made to serve children and for specially trained personnel to provide services to the Zone IV<sup>68</sup> children.
2. Hospital treatment services are required for children, and must include emergency services as well as hospitalization for more definitive treatment. The number of beds for such services are subject to future study.
3. Any treatment program for a child must consider his ties to the family and appropriate relationships must be sustained with parents and other significant adults in his life. Facilities must be located near enough to home to allow this.
4. The caseloads for workers in agencies providing services to Zone IV children must be reasonable, and policies must be flexible enough to allow continuity of contact with the significant professional workers in each child's case even though he may enter a hospital for a period of time.
5. The Zone IV child must maintain contact with other children in small groups so that he can utilize these relationships in developing appropriate socialization techniques.

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67. California Department of Mental Hygiene, A Long Range Plan for Mental Health Services in California, March 12, 1962.

68. Ibid., p. D-1. The Long Range Plan postulates four "Zones" as a means of classifying people and their needs. Persons in Zone IV include: "...persons with mental illness and mental retardation caused by defects of unknown origin or by developing emotional responses to stress situations to such a serious degree that they need clinical services, i.e., consultation, diagnosis, referral and treatment."

B. Residential Services

1. Protective residences for children by public agencies and communities are necessary.
2. Therapeutically oriented protective residential facilities for children, such as in juvenile halls, small children's homes, or in other facilities connected with welfare services, should be provided for the emergency care of Zone IV children. At a minimum, these facilities should be prepared to give emergency treatment for 72 hours while plans can be made to return the child to his home or provisions made for suitable placement.
3. Residential treatment facilities for children should be small.
4. Specially selected and supervised foster homes for Zone IV children are important adjuncts to any treatment service.

C. Education

1. Small classes for retarded and emotionally disturbed children in public school systems are necessary. Teachers must be provided in inpatient settings as well, when they are established.
2. Caseloads for teachers should be of a manageable size. Zone IV children need individual attention which can best be provided through small classes or separate classes, more intensive service and special resources with consultation and special training for teachers.

D. Other Services

1. Religious (sic) counseling specifically suited to the child's needs.
2. Community recreation facilities including special services for Zone IV children.
3. Special financial aid programs, such as Aid to Needy Children, for parents with Zone IV children to allow care in the home situation and minimize the need for residential dislocation of the child.

Three generalizations about the proper methods of treating the emotionally disturbed children characterize these guidelines:

1. A wide range of services should be available for the child and his family in order to treat a wide range of disturbances.
2. Whenever and wherever possible, the child should be treated in his community.
3. Services for the emotionally disturbed child should provide for the normal needs of childhood, that is, they should promote health.

The Joint Commission's definition of mental health provides a goal that can be used to evaluate services for mentally disordered children in California. The State Department of Mental Hygiene's "guidelines" serve as criteria by which to judge the methods being used to reach the goal. We have discussed the history of services and the goals and guidelines for the delivery of these services. The balance of this report measures the existing service system according to these goals and guidelines.

#### IV. COMMUNITY SUPPORTS FOR THE FAMILY

Any treatment program for a child must consider his ties to the family and appropriate relationships must be sustained with parents and other significant adults in his life. Facilities must be located near enough to home to allow this.<sup>69</sup>

Keeping a mentally disordered child in his own home whenever possible has been a primary goal of treatment programs for some time. Yet a close look at the situation in California indicates that this goal is far from being realized.

Our survey of parents who had children at the Napa State Hospital Children's Unit and on the waiting list showed a great desire on the part of parents to keep their troubled children at home, if appropriate supportive services were available.<sup>70</sup>

Local mental health program directors who answered a Select Committee questionnaire unanimously cite a need for better services to children on the local level.<sup>71</sup>

An inventory of services available for mentally ill children, conducted for the Select Committee by the California Association for Mental Health, demonstrates that there is a lack of programs in California which would enable disturbed children to remain with their parents while they are receiving help.<sup>72</sup>

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69. Ibid., p. D-6.

70. See Appendix for results of Confidential Family Survey.

71. In response to a Select Committee questionnaire, all community mental health program directors reporting cited weaknesses in their services to children. See Appendix for a copy of the questionnaire.

72. See Appendix for a summary of the results of the CAMH-conducted Community Survey of Resources for Mentally Ill Children.

## Parents Survey

A questionnaire was sent to all parents who had either children at the Napa Children's Unit or on the waiting list to the hospital. These are parents who have exhausted all community resources and must place their children away from home. Ninety families responded. The income of these families was distributed quite evenly from below \$4,000 per year to \$15,000 per year. When asked what services might have helped keep their child out of the state hospital:

- 47% cited Special Education;
- 30% cited Daytime Supervision;
- 19% cited Family Counseling.

Early diagnosis was also cited by several parents as a service that would have been of great help. One mother commented:

All of these would have helped earlier when we had far less money and when [our child's] problems were less grave--we used up savings finally on private care for five years.<sup>73</sup>

In some cases the problem was a lack of services while other families were unable to enroll their child into existing programs due to rigid eligibility standards and extensive waiting lists. As one parent stated:

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73. Comment from Confidential Family Survey by the parent of a girl at Napa Children's Unit.

...we found it impossible to get our child into any type of program anywhere.<sup>74</sup>

### CAMH Survey

With the help of the California Association for Mental Health, a questionnaire was developed to secure an inventory of services. The local CAMH chapters in each county worked for three to four months preparing their responses. We received returns from 20 rural, urban, and suburban counties with a combined population of over 8,250,000.

### Community Mental Health Directors Survey

The Select Committee distributed a questionnaire to all community mental health (Short-Doyle) program directors. The survey asked the directors to describe their services for mentally disordered youngsters. Plans for the future and comments on obstacles to progress were also solicited.

Combined with the returns from the CAMH survey, responses to the community mental health directors' questionnaire give a picture of children's and adolescents' services in 35 counties with a total population of 17,587,600 or about 90% of the State.

All three surveys confirm the serious shortage of various community programs throughout the State.

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74. Comment from Confidential Family Survey from parent of a six-year-old child at Napa Children's Unit.

## Preschool Screening and Diagnostic Centers

The importance of preschool programs was discussed at the Select Committee's public hearing by Mr. Bert Smith:

We take children now--we have changed our age limit-- from the age of 2½ to 6 on admission, and we hold them until age of 8. We have had about a 70% effective treatment on children who have been very severely emotionally disturbed because we are getting them early enough to do something about it.<sup>75</sup>

According to Department of Mental Hygiene estimates there are over 57,000 mentally disturbed children and adolescents in the 20 counties where the CAMH inventory was conducted.<sup>76</sup> Perhaps this figure would be reduced if adequate services for detecting emotionally disturbed children were available in the community. For example, only 15 of the CAMH counties reported having any preschool

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75. Bert Smith, Vice President, Zonta School for Emotionally Disturbed Children, San Jose; Vice President, Foundation to Aid Mentally Ill Children, Santa Clara County; Member, Comprehensive Health Planning Board, Santa Clara County; Member, Mental Health Advisory Board, Santa Clara County.

76. The DMH reported that in 1967 a "typical California county with a population of 500,000" had 3,260 children "in need of psychiatric treatment." This figure was based on an estimated 2.4% of the school enrollment. (California Department of Mental Hygiene, "California Mental Health Progress," May, 1967, p. 19.) The total population of the 20 counties reporting on the CAMH survey as of July 1, 1969, was 8,255,500. According to the Department of Finance, 37% of California's population is 18 years of age or younger. This means there are roughly 3,054,535 children and adolescents under 19 in the 20 CAMH counties. According to the DMH figures, 78% of this total or 2,382,537 youngsters are enrolled in school in the 20 counties. And 2.4% of this figure gives us 57,181 children and adolescents "in need of psychiatric treatment" in the counties reporting to CAMH.

screening programs. Seven of these 15 counties reported waiting lists for such services.

Speaking at the Select Committee hearing on January 27, 1970, Howard Gurevitz, M.D., program director for San Mateo County's Mental Health Center, commented on the importance of preschool screening and nursery school programs:

These kinds of programs are essential if we're going to look at the programs in terms of early identification.... I think problems exist in the community that could be dealt with if there was some facilitation. I think it might take some legislative action to enable counties to establish collaborative programs with schools more easily than is possible at the present time.

Models for effective programs do exist. In Los Angeles the Cedars-Sinai Department of Child Psychiatry has been operating a preschool diagnostic/treatment program for seriously emotionally disturbed children the past two years.<sup>77</sup> It is staffed primarily by nursery school teachers and social workers, supervised by psychiatrists and psychologists. Frank S. Williams, M.D., Psychiatric Director, explains the school's objectives:

At the Julia Ann Singer Preschool Psychiatric Center--the primary prevention unit of the Cedars-Sinai Department of Child Psychiatry--every effort is made to train parents, school teachers, and doctors to carry out corrective therapeutic approaches that can most quickly interrupt severe psychopathology in the formative preschool years. A primary objective is to maintain children in regular school settings where they can learn and gain strengths from healthier children in wholesome, natural environments.<sup>78</sup>

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77. Julia Ann Singer Preschool Psychiatric Center, Los Angeles, California.

78. Frank S. Williams, M.D., "Julia Ann Singer Preschool Psychiatric Center--A Descriptive Statement," November 1, 1969, pp. 1-2.

One of the main reasons for the lack of adequate community programs is the professional manpower shortage. In his testimony before the Select Committee, James V. Lowry, M.D., pointed out that there is a considerable manpower problem in the area of children's services.<sup>79</sup> The dilemma Dr. Lowry cites with regard to the shortage of child psychiatrists extends to all children's services personnel. One means for dealing with this problem is suggested by Zanwil Sperber, M.D., also of the Cedars-Sinai Department of Child Psychiatry.<sup>80</sup> Dr. Sperber suggests that we review the present allocation of resources for diagnostic services for children in light of their efficiency.

...existing psychological studies suggest that allotting large amounts of clinic staff time to a multiprocedure, multistaff, multicontact diagnostic endeavor, may not yield a commensurate return in valid data for use in diagnostic decision making.<sup>81</sup>

It is obvious that in the light of the extreme shortage of professional manpower, many new techniques and programs will have to be developed.

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79. James V. Lowry, Director, Department of Mental Hygiene in testimony given at Select Committee hearing on January 27, 1970. "One of the points which is extremely important and well deserves initial viewing in the report is the matter of the shortage of personnel and just for comparative purposes I would like to point out that there are about 32,000 positions in California and of these there are about 2,000 who are psychiatrists who are members of the American Psychiatric Association. Now some of these are not certified as specialists because they can have that kind of membership before actual certification, but in the whole State of California, we have between 55 and 60 certified child psychiatrists for the entire State. So you go from 32,000 to 60 and for 20 million people you can see that this is not a large number."

80. Zanwil Sperber, M.D., "Psychodiagnostic Appraisal of Children in One Interview," 1969, 22 pages.

81. Ibid., p. 7.

## School Screening and Diagnostic Centers

Of the 20 CAMH counties reporting, 15 listed school screening as an available service. Yet, 31.4% of the resident population at Napa Children's Unit came to the state hospital directly out of a regular public school class.<sup>82</sup> This is partly due to a lack of appropriate school programs and poor coordination between the schools and other agencies.

In its recent report on children's services, the West Area Welfare Planning Council of Los Angeles made the following statement:

The Los Angeles County Mental Health Department in developing its plan for services as required under A.B. 1454 should give full weight to provisions for the complete range of mental health services for children...present consultation services to school personnel should be increased and be expanded to include emergency consultation with school personnel on individual problems with children. Diagnostic services for children should be developed in a centralized and coordinated manner. The close liaison with school personnel should be developed so that referrals

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82. The following table was submitted on request to the Select Committee staff by Mr. Barry Wendel, Teacher in Charge, Napa Children's Unit School:

SCHOOL PLACEMENT PREVIOUS TO HOSPITALIZATION AT NAPA  
STATE HOSPITAL OF CHILDREN NOW ENROLLED DEC. 1969

<u>CLASS</u>	<u>N</u>	<u>%</u>
Regular Classes	45	31.4
Residential School	22	15.4
No Information	20	14.0
EMR or TMR	19	13.3
No School	19	13.3
Educationally Handicapped	18	12.6
TOTAL	<u>143</u>	<u>100.0%</u>

are not made in a haphazard and accidental basis depending largely on which services school personnel are familiar with and find readily available.<sup>83</sup>

While more than one-third of the local mental health directors agree that there is a need for better relations between school and mental health agencies,<sup>84</sup> experts disagree about the role mental health agencies should play. Some believe that mental health agencies should act as consultants to the schools in planning and training. Others claim that there is sufficient consulting, and what is needed is more direct services to children and adolescents. The following two excerpts from letters to the Select Committee illustrate these points of view:

...it should be pointed out that the direct treatment of children is one but only one form of prevention. Certainly if we can identify disturbances early and then treat such children adequately, we will have gone a long way toward preventing those children from being disturbed adults in the future.

What I wish to bring to your attention, however, is the whole gamut of children's services which are focused primarily on children who are not yet identified as mentally or emotionally disturbed but who are, in my opinion, another appropriate target population for a community mental health program. These are the services which are traditionally called "indirect services" and include consultation, education and direct preventative services per se. It is through services such as these that mental health professionals in community mental health programs can have a significant impact on large numbers of children indirectly with relatively low numbers of professional man hours.

Leon Wanerman, M.D., Director  
Marin County Mental Health Services

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83. West Area Welfare Planning Council, Los Angeles Region, "Study of Mental Health Needs of Children," January, 1969, p. 6.

84. Of the community mental health directors who responded to the Select Committee questionnaire, 36% cited better relations with schools as a change they desired in their present children's program.

...from my experience there are many more agencies dealing with the mentally ill who provide consultation rather than direct service. With a few telephone calls, I could have thirteen (13) mental health consultants in my office by tomorrow and yet with a seriously disturbed or handicapped child, weeks or even months could elapse before the families would be able to obtain direct service.

Harry N. Zelinka, District Director  
Family Service of Los Angeles

Perhaps, in order to resolve this conflict in each community, the county Short-Doyle agency should solicit from schools and other agencies their opinions about which psychiatric services they believe to be most needed. The priorities for "direct services" as compared to "consultation" service in the county plan, should be based primarily on the needs stated by the major child care agencies in the community. Under ideal (unlimited funds and manpower) circumstances this difficult choice could be avoided. However, due to a lack of resources, it seems necessary to adopt some procedure for establishing priorities. The suggested procedure has the additional advantage of providing mechanism for coordinating the planning of all community services to disturbed youngsters.

The desire of the Legislature and the Department of Mental Hygiene to coordinate programs was articulated at the Select Committee hearing:

ASSEMBLYMAN LANTERMAN: Doctor, do you think we should consider the concept of the coordination of all of these related child service agencies for mentally ill children? Do you think we should have some sort of machinery that would convert these to a more directed program? We don't have that. Everything we're doing right now seems to be the result of a dilemma and this does not make much sense to me. Somewhere we should be able to have this thing flow as a program.

DR. BEACH:<sup>85</sup> This is what I meant about a flowing. Even at the county level you do have your programs, for example, through education of the educationally handicapped in the public schools. Very frequently these aren't linked or tied in any way with your psychiatric treatment programs, nor are they linked or tied with probation department programs and many others. I think there is some need for tying this together.

Each county's Short-Doyle plan is a means of tying various program elements together. However, in many counties this planning mechanism has not yet been used to full advantage.

Special Classes in Public School  
(Educationally Handicapped Classes)

The only special classes for mentally disturbed children and adolescents in California public schools are called "EH" classes (Educationally Handicapped) and learning disability groups (small supplementary classes designed to overcome specific problems, i.e., dyslexia). Because this is not a mandatory state program, many school districts participate in a marginal fashion or not at all. Those districts which are anxious to participate as fully as possible are now limited to 2% of their total school district enrollment. Therefore, it is not surprising to find that for the more than 57,000 mentally disturbed youngsters (DMH estimate) in the 20-county CAMH survey, there was a capacity of only 20,066 in the EH classes. Ten counties reported waiting lists for EH classes.

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85. William Beach, M.D., a Board-certified Child Psychiatrist and Deputy Director of the Department of Mental Hygiene in charge of Local Programs.

When the EH program came into being in 1963, it was intended to serve a broad range of needy students. Assemblyman Jerome R. Waldie explained:

What I had in mind was that if a child can't learn in the ordinary classroom but the child can learn under other techniques that are able to be utilized within the public school system, that the State of California should assist those local school districts who are willing to do so.<sup>86</sup>

There is a lack of compulsory elements in the program, and the selection criteria are vague.<sup>87</sup> As a result, many school districts assume that EH classes do not have to be used to serve seriously disturbed students. Thus, many students with the greatest need are not served.<sup>88</sup> Of the 90 children at Napa or on the waiting list (whose families reported to the Select Committee) 63% had not attended special public school classes for the "educationally handicapped."

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86. Jerome R. Waldie (former member of the California Assembly, presently a member of the United States Congress), "A.B. 464, Background and Implications," speech delivered at Concord, Calif., October 31, 1963, p. 8 of the text.

87. California, Education Code, Section 6750, contains the entrance criteria for EH classes, to wit: "...'educationally handicapped minors' are minors who, by reason of marked learning disability or behavior disorders...require special education programs...such learning or behavior disorders shall be associated with a neurological handicap or emotional disturbance..."

88. In a letter to Select Committee staff (December 10, 1969), Pauline Hanson, Program Assistant for the Sacramento Area Mental Health Association, drew the following conclusion about entrance into special education classes from her work on the CAMH survey: "It appears that the emotionally disturbed even in the school situation get no professional attention unless they are delinquent or downright disruptive."

But the issue of availability is not the only problem. The fact remains that 31% of the Napa families reporting did have their child in an EH class. Explanations for the failure of these special classes to keep the child in the community, focus on three points:

- The general inability of any program to deal with every case successfully;
- A lack of defined qualifying criteria for EH teachers;
- The debilitating effects of concentrating emotionally disturbed students in separate classes.

The first problem is certainly unavoidable, but the others deserve more attention. If teachers are to deal effectively with disturbed youngsters, they must be given specialized training. When such training is not required it does not occur in most cases. Dr. Robert Elliott of the Center for Psychological and Educational Services makes the following observation:

At the present time, there is no required special credential, and consequently no well developed or accepted teacher training program. Therefore, teachers are still picking up most of their training through in-service or other hit and miss type programs.<sup>89</sup>

The third issue--segregation--raises a basic question.

Dr. Frank Williams, psychiatric director of the Julia Ann Singer

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89. Excerpt from memo to Select Committee staff from Robert Elliott, Ed.D., Project Educational Consultant, February 10, 1970, p. 2.

School, is one of the most articulate critics of the type of isolation found in EH programs:

Once children who manifest faulty behavior are labeled as emotionally disturbed, they are less likely to have further consistent exposure to more healthy models. During the course of their development, but particularly in the early years, when either the ego is most malleable, and habit patterns most tractable, they are segregated. Their identification with others like themselves limits the potential for learning or imitating more healthy behavior. Our program attempts to maximize the use of healthier models and corrective experiences with adults and children as well as to teach the parents and school teachers to provide the corrective experiences. We feel that the potential significance of peer relationships and significant adults outside the home has not been fully exploited as a health inducing stimulus for young children.<sup>90</sup>

Dr. Williams' point of view was reenforced during the Select Committee hearing:

MR. BERT SMITH:<sup>91</sup> If that child were treated by the aid of say a normal classroom in school or in a normal situation, he could function, he would observe and he would benefit from the other child, the normal child.

CHAIRMAN LANTERMAN: He would reflect the normalcy that surrounds him.

MR. SMITH: Right. The expectation of performing on the same level as these other children, they do improve remarkably...

MR. BRITSCHGI: I think you are absolutely right in trying to do it the other way, integrate--if you want to use that word--in the program.

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90. Frank S. Williams, "Introduction to NIMH Project Description," October 1, 1969, p. 3.

91. Bert Smith, Zonta School, op. cit.

An additional perspective was offered on this issue at the hearing by Dr. Martin Wolins.

DR. WOLINS:<sup>92</sup> I'm talking about a model in which a sick person, or a person who is defined as ill is brought into some kind of large facility where many other sick persons are concentrated for the convenience of various types of technical specialists. It is true that in some instances this is a necessity if we need large x-ray equipment or an operating room, or some very highly skilled specialists who need to serve only small proportions of the sick population this makes sense. In the treatment of the disturbed child as you have heard before, this really makes no sense at all. Because it turns out that sickness, mental disturbance, is contagious. Contagious not in the usual sense of the word, but it is contagious none the less. And congregating or aggregating large numbers of sick children in one place hoping that they will learn to get better from each other is in essence a foolish idea. And yet we have not been able to overcome it.

Public school programs for the mentally disordered child are in need of reform. In 1967 the Orange County program was in such poor condition that a study of emotionally disturbed children concluded:

Orange County schools are indeed in a dilemma when it comes to professional help for the seriously emotionally disturbed child. On the one hand they are not permitted to refer to private services, but on the other hand, there are no publicly financed services available.

The dilemma of the schools and the troubled child was expressed by one principal who made the analogy, 'We find a flat tire and throw away the car.'<sup>93</sup>

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92. Martin Wolins, D.S.W., Professor of Social Welfare, University of California, Berkeley.

93. Charles G. Bell and Margaret Pollack, "A Survey of Emotionally Disturbed Children in Orange County Public Schools," a joint study by The League of Women Voters of Orange County and The Center for Governmental Studies, Political Science Dept., California State College at Fullerton (Anaheim), 1967, p. 67.

Fortunately, there are indications that these problems can be solved. In a letter to the San Diego County CAMH survey committee, Mr. James W. Terry made the following encouraging statement about the San Diego school program:

Our entire system of total service to youngsters is so interrelated that it is difficult to distinguish between services for all children and services for children with special needs. This is to say that we believe each child at one time or another has special needs to which we must attend.<sup>94</sup>

#### Special Schools (Other Than EH Programs)

As pointed out above, there are insufficient public school programs for mentally disturbed children and adolescents and not all of the available places in EH classes are utilized by mentally disordered students. If parents want to keep their troubled child at home with the help of special education--as almost half the Napa parents said they would have--they must turn to private "special schools." But these schools are scarce.

Fifteen of the CAMH counties reported having some sort of special schooling for mentally ill children with a total capacity of only 2,860.

Costs in such programs range up to \$1,000 per month. Middle class families who do not qualify for public assistance find themselves unable to use such schools. Often, a majority of the pupils come from outside the county. With programs scarce,

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94. Excerpt from letter from James W. Terry, Guidance Consultant, Ramona Elementary School, Ramona, California, to Mrs. Harry Stoltnow, San Diego County Mental Health Association, November 20, 1969.

wealthier families or those with an agency's support are fortunate to have their child involved in any kind of intensive treatment experience--even if it means placing the child far from home. (63% of the Napa parents responding said they would rather have their child in a private facility than a state hospital.)

Schools like Zonta (Capacity, 24) and Julia Ann Singer (Capacity, 9) are few and far between.

### Day Care Centers

The day care center can serve two very important functions in the life of a mentally disturbed child:

- It can relieve the family of some of the responsibility for continuous care. In cases of more advanced or obnoxious symptomatology, such respite can contribute enormously to the family's ability to continue to care for the child.
- Day care centers can also provide integrated experiences with normal children.

There is a desire and need for such programs. (30% of the Napa parents responding said that daytime supervision would have helped keep their child out of the hospital.)

The availability of day care programs is even more limited than special schools. Of the 20 CAMH counties surveyed, only 12 reported having any day care programs which would accept mentally disordered children. Although the total capacity of these centers

is 1,089, only 5 or 10% of the enrollment is open to disturbed youngsters.

The cost issues are the same as with special schools. Day care may cost up to \$300 per month (and most such programs leave the educational needs of the child up to the parents).

The Regional Centers for the Retarded, which provide funds for day care for retarded children and the public schools' Child Development Centers, which now excludes the mentally ill child, are two approaches that could be utilized to meet this need.

#### Outpatient Treatment Clinics

According to consumers and providers, outpatient services for children and adolescents in California are, for the most part, either too expensive for most people, ineffective, or nonexistent.

Of the Napa parents responding, 19% stated that their children could have been kept out of the state hospital if they had been able to receive family counseling in their communities soon enough.

Of the 20 CAMH counties responding, 16 reported having outpatient services available to children and adolescents. Of these 16 counties, 7 reported having waiting lists. The total capacity of the available services was approximately 5,100 cases; however, in most counties children and adolescents must compete with adults for existing services.

Fees in publicly administered programs are based on the family's ability to pay, but private programs may run as high as \$50 per visit.

In answer to the Select Committee's questionnaire to community mental health program directors, the following information was provided:

- More than half of the directors cited no strengths in children's and adolescents' services.
- All directors reported weaknesses in their programs for children and adolescents.
- Only 20% of the respondents cited strong outpatient services for children and adolescents.
- Of the directors responding, 40% reported no distinct programs for children or adolescents.

There are two basic factors contributing to this situation: lack of personnel and poor organization of existing resources.

#### Personnel

During the (Select Committee) hearing, Howard Gurevitz, M.D. defined the problem:

To begin with there is a very significant manpower problem which cannot be ignored. I think there was some mention of the need to develop new categories of personnel. It may not have been referred to exactly in that fashion but certainly the whole area of professional roles is one that is coming under examination and one that needs drastic change. The traditional child-trained mental health professional can command a much higher salary or income, because of the shortage, than the adult psychiatrist. As a result we find, I speak from the experience of my nine years in the San Mateo program, that it is very difficult to retain child psychiatrists. It is very difficult to retain people who specialize in this area. There is a need, I think, for the development of certain new roles-- child development specialists, child care specialists,

and the use of paraprofessionals have promise and I would encourage this committee to look into this to alleviate some of the problems of manpower.<sup>95</sup>

One solution to the problem of finding new child care personnel has been successfully explored in Palo Alto by Josephine R. Hilgard, M.D., and Ursula S. Moore, M.S.W. Working in the area of affiliative therapy, Hilgard and Moore have shown how college undergraduates can be used to successfully supplement outpatient treatment programs for seriously disturbed adolescents. They drew the following conclusions after more than two years of work:

We have found sufficient gains under the program of affiliative therapy to urge its wider use, but it is not a panacea. Affiliative therapy will lend itself to a variety of situations. Patients who need extensive contact with an interested caring person can experience, often for the first time in depth, a meaningful play-structured relationship. As a preliminary to psychiatric treatment with patients who do not interact on a verbal level, it can open communication and prepare a patient for psychotherapy. It answers a need for children who are psychiatrically ill and who lack adequate parental models. In the child guidance clinic, it may well accelerate the process of therapy and shorten the need for psychiatric time. A word of caution: it is essential that affiliative therapists be carefully chosen and well supervised. Indiscriminate or careless use may bring disappointment to patient, affiliative therapist, and to the team effort. Close and regular collaboration between team members is essential.<sup>96</sup>

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95. Howard Gurevitz, M.D., Program Chief, San Mateo County Mental Health Services; Chairman, Children's Services Committee, Conference of Local Mental Health Directors.

96. Josephine R. Hilgard, M.D., and Ursula S. Moore, M.S.W., "Affiliative Therapy with Young Adolescents," Journal of The American Academy of Child Psychiatry, Vol. 8, No. 4, October, 1969, p. 605.

Other similar work has been done with children and adolescents of varying ages in several other projects across the country.<sup>97</sup> But present civil service regulations present obstacles to improving services in these new ways.

There have been difficulties in utilizing staff flexibly. The same problem is true in the counties. Civil service personnel practices have become rigidified. Practices that, at one point in time, were meant to protect soon fail to do this but instead are used to uphold traditions or practices and have long outworn their usefulness. Greater flexibility in terms of personnel practices is of great interest.<sup>98</sup>

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97. For reports on the various affiliative therapy studies see: E. C. Brehman, "College Students and Mental Health Programs for Children," (paper presented at the annual meeting of the American Public Health Association, Community Mental Health Section), 1966. E. L. Cowen, M. Zax, and J. D. Laird, "A College Student Volunteer Program in the Elementary School Setting," University of Rochester, (mimeographed), 1965. G. M. Goodman, "Companionship as Therapy: The Use of Nonprofessional Talent," New Directions in Client-Centered Psychotherapy, ed. J. T. Hart and T. M. Tomlinson (New York: Houghton Mifflin, 1965). H. Hartmann, Ego Psychology and the Problem of Adaptation, (New York: International Universities Press, 1958). J. R. Hilgard, Personality and Hypnosis: A Study of Imaginative Involvement, (Chicago: University of Chicago Press, in press). ----et al., "Better Adjusted Peers as Resources in Group Therapy With Adolescents," (in preparation). W. E. Mitchell, "Amicotherapy: Theoretical Perspectives and an Example of Practice," Comm. Mental Journal, 1966, 2:307-14. ----"The Use of College Student Volunteers in the Outpatient Treatment of Troubled Children," Mental Health With Limited Resources, ed. H. R. Huessy (New York: Grune and Stratton, 1966), pp. 28-37. H. Reinherz, "The Therapeutic Use of Student Volunteers," Children, 1964, 11:137-42.

98. Gurevitz, op. cit.

## Organization of Existing Resources

Services to children and adolescents at the community level suffer from poor organization. The inability of children and families to secure needed services in a coordinated, economical, and uninterrupted way was brought out during the Select Committee hearing:

DR. BEACH: Now, there was, at one time, a coordinating council on handicapped children...that existed at the state level. But it was a group--I know I went to several meetings at different times--and...everything was so compartmentalized as far as everybody's programs and their budgets and statutes that about all people could do was talk about things and maybe try to effect a few changes. It never really...

ASSEMBLYMAN LANTERMAN: All they wanted to do was emphasize their area of interest.

DR. BEACH: Right.

ASSEMBLYMAN LANTERMAN: And we did not create a "flow" that would utilize all of the facilities in the most orderly manner.

DR. BEACH: And maximize the manpower that you have out there, which, if directed in a coordinated fashion, could avoid a lot of the fragmentation.

ASSEMBLYMAN LANTERMAN: It seems to me we're going to have to get a little more flexible in our program concepts to get a little bit more coordination because we aren't getting it for the kids and that is one of the problems this committee has had brought to its attention, as a result of the difficulties at Napa of recent notoriety. There is a lack of flowing the services to the child and this I think is one of the things we should take into cognizance as quickly as possible.

ASSEMBLYMAN LANTERMAN: Mr. Britschgi.

ASSEMBLYMAN BRITSCHGI: Yes, Mr. Chairman. Doctor, on page 18 of the report it says that the Short-Doyle agencies have chosen to fund their diagnostic services in other county agencies and it gives an example of

Alameda, but down a line further it says the Short-Doyle administrator has very little control over the operation of the quality of the service. Now, it seems to me that if we're going to put in 90% of the money we ought to have a better method of controlling it. It looks like we're tied up in a lot of red tape between departments and we don't seem to have any focal point of any administrative power. Isn't there any way we can solve that?

DR. BEACH: I guess I wonder a little bit too. The control should really be exercised at the county level where they are putting their money into the agencies.

A final area of special concern at the community level is the dearth of effective programs for youth who need help with drug problems. This serious issue could not be encompassed within this six-month project, however, some useful data were developed. For example, the CAMH survey reported finding some drug treatment programs in 16 of the 20 counties reporting. However, only 2 of the 25 community mental health directors reported having strong drug treatment services.

In summary, all sources of information confirm the weakness of our network of community educational, care, and treatment programs.

In the previous chapter, we discussed the resources or support services available to the family with a mentally disordered child. Those services represent the most desirable methods of dealing with the problem--reinforcement of the family's capacity to maintain the child in his own home.

There are several reasons, however, why this "first line of defense" may not meet the needs of a particular child or family. First, some communities do not have services such as family counseling, outpatient clinics, and homemaker services to aid parents with disturbed children. Second, even where some of these programs are available, many times families are unable to afford the costs of the service. Third, where programs do exist, effective techniques may not have been developed to deal with certain types of disorder, and fourth, some disturbed children come from situations where family breakdown is so severe that it may be hazardous to the child to keep him with his natural family.<sup>99</sup>

The family's problem is further compounded by the fact that there is no central source in the community where a parent may

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99. T. Lidz, C. Hotchkiss, and M. Greenblatt, "Patient-Family-Hospital Interrelationships: Some General Considerations," The Patient and the Mental Hospital (Glencoe, Ill.: The Free Press, 1957), pp. 535-543. The following quote (p. 540) is germane: "The family of a schizophrenic patient usually contains one or more seriously disturbed persons aside from the patient....Many of these families have been rent by serious schisms for years. In some instances, the patient's disorganization appears to reflect directly the schisms that exist in the family."

cratic maze which the family must penetrate is often frustrating and defeating.<sup>101</sup>

Because of the failure of support services to maintain the child in his own family or because of severe family breakdown, many disturbed children are removed from their own homes and placed in a variety of other living arrangements either in the community or in remote private or public institutions.

#### Placement Mechanism

There are several ways a child may be removed from his own home and placed in a treatment or foster care facility. The agencies which implement this placement will be described in subsequent chapters. The legal provisions relating to the placement of mentally disordered children are quite clear.

Prior to August 8, 1969, (the effective date of AB 986-1969) one of the most commonly used procedures for placing children in a state hospital was the "Juvenile Court Observation". Once a minor was identified by the probation department as being disturbed

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100. Several of the parents with children in Napa suggested that an information center is desperately needed, so that a parent can find out what kinds of services are available in dealing with the child.

101. A Short-Doyle director from a central valley county summed it up this way: "The greatest weaknesses of services for the mentally disordered children and adolescents in our county are the consequence of an absence of a system for the delivery of these services. No system exists; it is a nonsystem."

2) place the child in a state hospital for a 90-day Juvenile Court Observation.<sup>102</sup> As of June 30, 1969, there were 201 Juvenile Court Observation patients shown on the records of the state hospitals. Of these patients, 117 were at Napa (58.2%) and 62 at Camarillo (30.8%).<sup>103</sup>

It was possible--under the old law--to extend the first 90-day period for subsequent 90-day periods. The term "observation" was somewhat of a misnomer considering that some of these patients stayed in the hospital up to six months and beyond. The J.C.O. commitment in practice became a method for obtaining a diagnosis and placement where services were not available in the community.

In 1969, the Legislature passed Assembly Bill 986. That bill contained a provision which repealed the Juvenile Court Observation procedure because it was an unnecessary, separate involuntary procedure for juveniles which duplicated the Lanterman-Petris-Short Act provisions for involuntary treatment. The law now allows the juvenile court to utilize the involuntary procedure outlined in L-P-S for adults (effective July 1, 1969) and stresses that appropriate use should be made of local Short-Doyle agencies in providing involuntary services.

In order to place a juvenile in a state hospital under current law, the parent or guardian of the child may "volunteer" him in;

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102. A J.C.O. could also be placed in a California Youth Authority diagnostic facility but this was a very limited resource.

103. Department of Mental Hygiene (Memo to Andrew Robertson from T. L. Thatcher) re: Juvenile Court Observations, September 4, 1969.

the child must first be screened and referred by the local Short-Doyle agency.

Placement in private or county facilities may be carried out using the above procedures. However, if the child is to be placed under the provisions of L-P-S, the facility must be one approved by the Department of Mental Hygiene to provide such services. Placement by probation and welfare departments will be discussed in subsequent chapters.

### The Placement System

#### Probation

Several agencies in the community may remove a disturbed child from his own home. One of the most commonly used is the county juvenile probation department. Though this agency's main function is generally thought to be the handling of juvenile offenders, it plays a major role in the placement of disturbed children--both offenders and nonoffenders.

Because of a lack of funding in other programs and a lack of diagnostic and referral agencies, the probation departments fill a vacuum in providing placements for disturbed children. The criteria of "incorrigible" and "delinquent tendencies" are so vague that it is a fairly simple process to qualify a minor for probation

San Francisco - "...welfare, the schools, and even community mental health services will refer 'incurable' youngsters whose disturbance takes the form of acting out rather than withdrawal. Sometimes such children could be handled in properly designed day care facilities; often they require residential care. They do not appear to be typical delinquents and in most cases would not be referred to the juvenile court if other resources were available."

Santa Clara - "The juvenile court should not be involved in these cases unless the parent is unwilling or unable to locate proper care. At the present time desperate parents (as well as private agencies) may 'dump' these sick children on the juvenile probation department as their only recourse."

The amount and kind of probation funding available for supporting children in out-of-home placement varies from county to county. If a child is eligible for welfare (dependent child) the AFDC program may supply a portion of the support. Where probation can place the child in a Short-Doyle financed service, then the State may pay 90% of the cost and the county 10%. A large share of the money for placement of disordered juveniles, however, is paid out of the county's general fund. The cost of placing an individual child may range anywhere from \$100 to \$1,000 per month.

Even when probation departments have the staff and experience to deal with hard-to-place children, they face another serious problem--the shortage of facilities. Their placement decisions--

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104. Unless otherwise indicated, quotes from probation departments throughout this section were taken from the Select Committee's survey of California juvenile probation departments.

child is fitted to the resource rather than the other way around."

Los Angeles - "The shortage of beds in the Camarillo Children's Unit is one of our main problems. Camarillo is still the only facility for this age group in this half of the state. When it comes to our alternatives, we are faced with the fact that almost none, including psychiatric hospitals, really want to provide services for youths who have been labeled as mentally disordered especially if they are management problems (acting out)."

On the basis of what criteria are placements of mentally disordered children made?

Alameda - "...whatever seems to be the best available. Unfortunately this often means choosing the least damaging available."

In some areas the shortage of programs is so acute that probation departments are forced to place children hundreds of miles from the home community--sometimes in another state.

Sacramento<sup>105</sup> - "In my opinion there is a serious lack of beds for mentally disordered children in California. We travel up and down the state every week and our officers are flying to Los Angeles almost every week. Most of our children in placement are in the Los Angeles area primarily because that's where the beds are and we're competing for beds--we're competing with Los Angeles County, Riverside, San Bernardino, and all of them because we don't have the beds in Northern California....We're now negotiating with Pine Rock School in Durango, Colorado....Contra Costa has one

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105. Paul DiRusso, Supervisor in Placement, Sacramento County Probation Department, in testimony given at Select Committee hearing on January 27, 1970.

aspect of it is that with some kids we've literally stuck them away in facilities that are highly inappropriate."

The supply of available facilities at any given time also indicates the amount of time a child may have to spend in juvenile hall without treatment.

Alameda - "...in cases where there has been an ability to make a plan quickly, where openings exist in private institutions, et al.--time in juvenile hall is minimal. Unfortunately, this is not always the case and time averages from three to six months in detention pending planning, unless there is the possibility of returning the child to his own home pending further placement plans."

Los Angeles - "Mentally disordered juveniles under 14 years of age may have to stay in juvenile hall for as long as six months before being accepted at Camarillo."

Riverside County indicated that the average length of stay in juvenile hall for mentally disordered children was from four to six months, and San Mateo stated that the average time for disturbed girls was from four to five months and for boys, three to four months. This is compared to four to six weeks for other juveniles.<sup>106</sup>

A paucity of appropriate programs and funding also affects the success of the placements made by probation.

San Mateo - "[The success of] placement is directly related to availability of appropriate placements. Of course, those who are successful were 'appropriately'

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106. For examples of damaging effects of juvenile hall confinement see, "A Long Range Juvenile Program for San Joaquin County," Stanford Research Institute, October, 1969, pp. 6, 33-40.

programs."

San Francisco - "Mentally disordered juveniles not only wait longer to be placed, but are more apt to fail in placement and to experience numerous replacements."

With respect to probation's relationship with Short-Doyle agencies and the adequacy of this program's services to mentally disordered children, most of the departments surveyed agreed that Short-Doyle was generally interested in providing back-up consultation to their caseloads. There was some question, however, as to the usefulness of some of Short-Doyle's direct services for children:

Orange - "What we would like to see, with regard to Short-Doyle is a greatly expanded and less rigid and formalistic setting of inpatient and outpatient services. Very often, we find that they either refuse to treat or are unsuccessfully treating those mentally disturbed juveniles referred to them. The multi-problem case, which is typical of mentally disordered juveniles referred to the probation agency, requires a more comprehensive and creative approach than is typically afforded by any one agency or department such as Mental Health, or that is made available through the traditional psychiatric inpatient/outpatient care."

Finally, probation departments are faced with a scarcity of professionals who are willing and able to provide rapid diagnostic services.

San Bernardino - "Generally, disturbed children may be in our system up to six months before being correctly diagnosed or identified."

can't get it all done at one place....We wait maybe two or three weeks--sometimes with a child in custody--for an appointment time (with a psychiatrist or a neurologist)... We've tried many, many times to get a child in one location to get a thorough diagnostic workup done."

### Protective Services (Social Welfare)

In addition to probation departments, many counties also utilize the Protective Services agency for the placement of mentally disordered children.<sup>108</sup> This agency--which was mandated under provisions of the 1966 amendments to the Social Security Act--is eligible for 75% federal reimbursement for casework and operational costs.

Protective services are available to families on welfare or who qualify as potential welfare recipients. Only those families on welfare, however, qualify for non-casework services such as homemaker and day care programs, or out-of-home care.

The state statute which implements the Protective Services program in California<sup>109</sup> allows counties to transfer "dependent and neglected"<sup>110</sup> children from the jurisdiction of the probation department to the Protective Services agency. Los Angeles County--

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107. DiRusso, op. cit.

108. It is estimated that as many as 50% of those children currently in placement in Los Angeles are emotionally disturbed and in need of psychiatric care.

109. California, W. & I. Code, Part 6, Ch. 4, Sections 18250-18252.

110. Ibid., Section 600.

program. In doing so, they were able to claim 75% federal reimbursement for casework services, whereas identical services in the county's probation department were funded 100% by the county.

Funding for the maintenance of these children in out-of-home placement, however, remains the same regardless of which agency has jurisdiction. (If the child is eligible for AFDC, the State will advance \$80 per month toward the cost of out-of-home placement--no matter what facility or program is utilized. Federal funding for the maintenance of the AFDC child is discontinued once the child is removed from his own home. Thus, the county, out of its general relief funds, is responsible for all costs over \$80 for the maintenance of an AFDC child out of his own home and 100% of his care if he is not eligible for AFDC.)

The intact family not on welfare but in need of help to maintain a disturbed child at home or temporarily in a treatment facility is currently unable to do so with the aid of protective services funding. The family may receive all the casework and counseling available but protective service workers can offer no more. If the father in this hypothetical family leaves the home, then the remaining members would be eligible for non-casework services.

The problem of who is eligible and who is not eligible for services seems to hinge on the "deprivation" criteria used to

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111. There are approximately ten counties in the State which have made this transfer or are in the process of planning for the transfer.

economics only and does not take into account the family's needs and its ability to cope with a seriously disturbed or handicapped youngster.

Despite the problems and limitations of the protective services program, federal monies for casework services should provide counties with sufficient inducement to utilize welfare funding for services to "dependent and neglected" children who are now being served at 100% county cost in probation departments. If this were done, not only would counties be relieved of unnecessary costs, but overloaded probation departments and juvenile halls could be used more efficiently.

#### County Departments of Mental Health (Short-Doyle)

Though the county mental health department is the central public agency for organizing mental health services at the county level, it is the impression of the project staff that their involvement in the placement of mentally disordered children is minimal compared to the efforts of probation departments. In some counties the mental health departments assist probation departments--through funding of their diagnostic clinics and other probation services--rather than providing residential treatment services for mentally disordered children.

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112. For recommendations on the procedure for such transfer, see National Study Service, Planning for the Protection and Care of Neglected Children in California, State Social Welfare Board, August, 1965.

way to provide children's services, but children's programs make up only a small portion of services financed by county mental health departments. There is little Short-Doyle money allocated to children's residential or inpatient services and even less for group treatment homes, halfway houses, and foster home programs. (Short-Doyle services to families were discussed in the previous chapter.)

Though current Department of Mental Hygiene regulations permit the inclusion of group homes and foster homes as reimbursable items in the county mental health plan, the State Department of Mental Hygiene has been cautious in approving contracts when, according to William Beach, M.D., Chief of the Division of Local Programs, state regulations do not stipulate staffing and program requirements for such services. Foster or group homes for mentally disordered children are legitimate mental health services, but few Department of Mental Hygiene guidelines are currently available as to how they may be utilized. The Department states they have kept these categories open to negotiation to permit flexible use of the many variations which exist in this form of service, but perhaps because of the vague criteria, few of these services are being used.

The problem of making use of these out-of-home living facilities for disturbed children is further complicated by the fact that the Department's regulations (Title IX, Article IV, Administrative Code) governing precare and aftercare, stress "rehabilitation"

ment of mental health in Los Angeles County, Marvin Rains, M.D., states that the vagueness of the "rehabilitation" criteria has made his program hesitant about contracting for such children's services. Rehabilitation services are usually construed to mean vocational training or retraining in an adult program, whereas children's services should be built on the "developmental" needs of the growing child.

An additional problem arises from the fact that regulations governing the use of inpatient facilities are rigid with respect to staffing patterns. For every 20 patients in residence, the potential contract facility must employ one full-time psychiatrist and for every 50 patients, one full-time psychologist and one full-time social worker. These staffing patterns are based on a traditional medical model for inpatient services which has been generally accepted by the psychiatric profession for several years. However, in recent years, due to a shortage of trained mental health professionals and new concepts of treatment for the mentally disordered, this old model tends to be a hindrance to the development of creative facilities for adults and children.

Even though privately operated residential treatment centers follow more standard staffing patterns than smaller homes, very few of these facilities are currently funded with Short-Doyle money.<sup>113</sup>

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113. Of the 38 private residential care facilities for children in California answering our questionnaire pertaining to their services for mentally ill children and adolescents, only 5 had substantial contracts with the local Short-Doyle agency.

Another serious difficulty in developing residential services at the local level results from zoning restrictions which may be based, in part, on community fears of disturbed children. County mental health departments should, as a part of their public education responsibility, help to change public attitudes regarding the needs of the mentally disturbed child--especially his need to live in the community.<sup>114</sup>

The county mental health department is now responsible by law (Assembly Bill 1454 - 1968) to screen all children and adults prior to their admission to a state hospital. Many of these agencies, however, have not yet developed trained staff to carry out this mandate as it relates to children. Los Angeles County, because of a shortage of personnel, has contracted the screening of children who are potential state hospital patients to the state hospitals themselves!

County mental health directors cite several reasons why their programs for the placement of children are progressing more slowly than those for adults:

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114. Gurevitz, op. cit., "After all these children come from all the communities, but yet the services aren't provided elsewhere. And by and large the communities that develop foster homes are communities that are impoverished....In our county the bulk of foster homes....[are in these impoverished communities]"

24-hour care and supervision. This is a level of care and responsibility beyond what can reasonably be expected of Family Caretakers or foster home parents.... Persons interested in providing foster or group homes find it easier to take care of other kinds of mentally handicapped persons who have fewer management problems.<sup>115</sup>

Many studies<sup>116</sup> of the difficulties of finding suitable foster homes, document the fact that the lack of sufficient economic incentive for prospective foster parents severely limits both the quantity and quality of suitable homes.

The fact that foster parents of emotionally disturbed children are poorly paid<sup>117</sup> compounds the difficulty encountered in placing these youngsters. Additional complications result from the peculiar structure of California's conflicting funding systems.

Different agencies on the local and state level compete for these scarce foster homes and group or halfway homes, though each agency--welfare, probation, the private institutions, Short-Doyle, etc.--serves similar types of children, each maintains a separate placement staff. Not only do various agencies within a county

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115. Statement presented by Richard Middlebrook, Chief, Community Services Division, State Department of Social Welfare, to Select Committee, January 27, 1970, pp. 1-2.

116. See Martin Wolins, Selecting Foster Homes, The Ideal and the Reality (New York: Columbia University Press, 1963).

117. The Community Services Division of the State Department of Social Welfare pays a maximum of \$160 per month to place a child or adolescent in one of its family care homes upon his release from a state hospital.

2. Lack of public pressure for improvement of services;
3. Lack of adequate local funding;
4. Shortage of residential facilities;
5. Need for improvement in the quality of foster home care;
6. Existence of restrictive zoning ordinances.

### Placement Resources

Once the decision is made by an agency to remove the disturbed child from his own home, there are several different placement alternatives. These alternatives have been divided into three major categories: foster homes, residential treatment facilities, and state hospitals.

#### Foster Homes

The foster home serves as an intermediate step between living with one's natural parents and living in an institution. A child may be placed in a foster home directly from his own natural home or he may go to a foster home after being in an institution. For the emotionally disturbed child or adolescent, the foster home is often used to separate him from what is considered to be destructive home environment, or it may be the first step towards reintegration into the community after being institutionalized. But it is difficult to arrange successful foster home placements for disturbed children.

facility. Counties which can afford to pay higher rates are in a position to preempt most of the resources in the poorer counties.

Placement costs may vary from 100% county money in the probation departments to 90% state-10% county in the Short-Doyle agencies. Local residential treatment facilities often contract with as many as three different public agencies at the same time. This causes confusion, inequity, and inefficiency.

The basic problem is the urgent need for the development of a funding mechanism to ensure payment for the necessary level of care for mentally ill youngsters in appropriate community care settings. This is particularly important for mentally ill children and adolescents who are not eligible for AFDC financial assistance and are without sufficient private resources to meet the costs of their placement care.<sup>118</sup>

The case of an older adolescent in Southern California is illustrative of this dilemma. This boy had been hospitalized for over three years. His family did not meet the legal definition of "deprivation", and he did not qualify for AFDC linkage. The hospital recommended an out-of-home placement, but his parents could only afford the cost of care for six months. There are no sources of funding after the six months are up, and the boy is probably in need of care and supervision for at least a year. This is not an isolated example.<sup>119</sup>

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118. Middlebrook, op. cit.

119. Case illustration provided by the Community Services Division, State Department of Social Welfare.

who are ready to leave. Though most of the state hospital patients under 21 are released to their families,<sup>120</sup> many children remain in the hospital well past the time hospital staff believes they should, because of a shortage of placement resources in the community. State hospital cost of care for children averages approximately \$1,000 per month,<sup>121</sup> yet staff at Napa and Camarillo indicated that many children are currently on the wards who should and would be released tomorrow if there were foster homes, halfway houses, or group homes in the home community--which are much more economical.

In 1966, a survey of patients' disposition on the adolescents' service at Camarillo State Hospital showed that 62% (89 of the 144) of the adolescents in the hospital were ready for release.<sup>122</sup>

Both Dr. Spratt, the medical director of Napa State Hospital, and Dr. Kogl, director of the Children's Center of Napa State Hospital commented, in an interview October 9, 1969, that about 1/5 of the population of the Children's Center was ready to be released,

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120. See Appendix ("Release Referral Study Percentage by Category and Age"). 65% of those released during 1969 were released to their families.

121. James W. Whitsell, Assistant Deputy Director, Office of Administrative Management of DMH reported to staff that the total costs (per diem) of the children's programs at Camarillo and Napa were \$31.79 and \$32.86 respectively.

122. Survey conducted by John T. Olson, Clinical Psychologist, Camarillo State Hospital, 1966, in published paper.

is therapeutically advisable has been shown to be deleterious for the patient, not to mention the unnecessary expense to the State.<sup>123</sup>

Our studies revealed a different kind of problem in securing proper foster home care for children ready to leave private institutions. Though many private residential institutions serve welfare and probation cases in their residential program, public agencies in some counties refuse to continue the contract with the voluntary agency once a child is ready for foster care. Many private residential treatment agencies have developed their own network of foster and group homes as aftercare resources for their graduates in order to guarantee continuity of treatment. Some county agencies, however, have established a policy that private placement should be limited to services which the county itself cannot provide and therefore, because most counties have developed public foster homes, they refuse to maintain a child in private aftercare placement thereby destroying continuity of care for the child who has been in the private institution.

Besides these problems in the delivery of foster care services in California, foster home services generally are inappropriate for emotionally disturbed children and adolescents. Studies done throughout the nation during the last decade indicate that the quality of foster care services leaves a great deal to be desired. If

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123. Robert Z. Apte, Halfway Houses (Occasional Papers on Social Administration), No. 27, (London, England: G. Bell & Sons, Ltd.), p. 19.

for emotionally disturbed children is no more appropriate for children in California than it is for children in other states.

Placement alone, without continued professional counseling and guidance, is insufficient to maintain and to maximize social adjustment.<sup>124</sup> Several studies show that neither the natural nor the foster parents receive the counseling<sup>125</sup> and guidance necessary for the child's social adjustment.

...About one-third of the [foster] mothers said that there have been times when they didn't know who their caseworker was!<sup>126</sup>

...In consistently fewer than one-third (usually less than one fourth) of the cases did either father or mother have an adequate relationship with the agency responsible for the child.<sup>127</sup>

More than 70 percent of the fathers and mothers of the children in this study either had no relationship with the agencies responsible for the care of their children or their relationship was erratic or untrusting. In many instances the agencies' resources were such that their staff's time was entirely consumed with the day-to-day job of caring for the children. They had no time for the kind of continuous work with the parents of the children which could effect the rehabilitation of the home.<sup>128</sup>

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124. Middlebrook, op. cit.

125. Zira DeFries, Shirley Jenkins, and E. C. Williams, "Treatment of Disturbed Children in Foster Care," American Journal of Orthopsychiatry, 1964, Vol. 34, No. 4, pp. 615-24.

126. A Kadushin, Child Welfare Services, (New York: Macmillan Co., 1967), p. 420.

127. H. S. Maas and K. F. Engler, Jr., Children in Need of Parents, (New York: Columbia University Press, 1959), p. 351.

128. Ibid., pp. 389-90.

Treatment experts agree that a new kind of professional foster home would be effective for many mentally disordered children. Foster homes would be backed up with day treatment and education programs. Better paid, better trained foster parents would replace the existing custodial services now provided.<sup>139</sup> The professional foster home would replace the institution as the child's home during residential treatment. Many private institutions are also moving in this direction, but they are thwarted by the present licensing regulations of the Department of Mental Hygiene.<sup>140</sup> Dr. Rieger, in testimony before the Select Committee explained the importance of making the foster homes an essential part of a residential treatment facility. "I do not mean for satellite homes to be a part of the institution. I mean for the child to have a home in the community. And a home, even if it's not his own home, should be a home with substitute parents; the original family model to be effective and be retained. I'm certain that

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139. Dr. Kogl, Medical Director, Children's Center, Napa State Hospital, and Dr. Rieger, Medical Director, Children's Center, Camarillo State Hospital, heartily endorse this suggestion for their own services. As Dr. Kogl put it in his testimony before the Select Committee on Mentally Ill and Handicapped Children hearing on January 27, 1970: "What should be phased in are: (1) Napa Children's Center as a day educational and treatment center with children living in satellite professional group homes..."

140. One can either be licensed to operate a Children's Treatment Center with a bed capacity for seven or more emotionally disturbed children--an "E" type facility; or one can operate a Family Home with beds for not more than six emotionally disturbed children--an "H" type facility. However, if the children resided in several Family Homes in the community (as recommended by Dr. Rieger and Dr. Kogl) and used the Center for outpatient care and schooling, the facility could not be licensed under present regulations. California Department of Mental Hygiene, Division of Local Programs, Bureau of Private Institutions, Private Institution Licensing Act and Regulations Relating to Private Institutions, pp. 7-8.

this can be worked out for a period of years to be as effective, more effective, than a treatment center, for far less money."

### Residential Treatment

The second general category of out-of-home placement resources for disturbed children is the residential institution. This type of program is usually characterized by a population of less than 100 children, small cottage-like living units, and treatment techniques which deemphasize the medical-hospital approach<sup>141</sup> and follow more eclectic child care principles.

There is no single residential model--the various facilities in California offer several different kinds of services, are located in both urban and rural areas, and serve children with varying types and levels of disturbance. In many instances residential children's institutions have evolved during the past forty or fifty years from orphanages to sophisticated centers providing therapeutic services.

The majority of referrals to these institutions come from juvenile probation and county welfare departments. Other agencies, such as the California Youth Authority and the public schools also refer children to these agencies.

Residential treatment agencies serve children with a wide range of behavioral problems and family backgrounds. The following

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141. Over 90% of the executives of residential children's institutions received their training in disciplines other than psychiatry.

table shows the range of disturbance and family patterns of the children in these facilities.<sup>142</sup>

	<u>No. of Children</u>	<u>% of Total</u>	<u>Number of Agencies With Children in a Given Category</u> (38 respondents)
A. <u>Normal Children</u>		(10%)	
Normal children from disturbed or unfit families	124	7%	16
Normal children from stable families unable to provide care	55	3%	5
B. <u>Children with Some Problems</u>		(22%)	
Children with some problems from disturbed or unfit families	341	19%	21
Children with some problems from stable families unable to provide care	58	3%	11
Children with some problems from stable families unable to cope with child	72	4%	15
C. <u>Children with Serious Problems</u>		(64%)	
Children with serious problems and disturbed or unfit families	971	53%	25
Children with serious problems and stable families unable to cope with child	197	11%	19

These figures indicate that 64% are children with "serious problems" and that 53% or 971 children have serious problems and are also from "disturbed or unfit families."

Though it appears that these agencies are caring for a large number of very disturbed children, there is very little information available about the effectiveness of the residential treatment center.

142. Margaret A. Watson, Private Children's Institutions in California: Data on a service system and the forces which shape it, Stanford Research Institute, 1968, pp. 20-21.

Despite the great quantity of literature about residential treatment of emotionally disturbed children, the field remains extremely experimental. Several treatment approaches are being used, but there are few certainties about them. The most common factor among the programs is their costliness. The majority are very expensive to operate, which creates a problem not only for the parents but for professionals and society as a whole.<sup>143</sup>

One of the few available studies of the effectiveness of residential treatment of disturbed children was made at the Emma Pendleton Bradley Hospital by Davids, Ryan, and Sabatori:

The authors were concerned with what they felt was the rapidly increasing numbers of children needing residential psychiatric treatment. They wanted to find out what factors affect the course as well as long-range outcomes of residential treatment...the most interesting conclusions the authors made were that treatment variables, especially conventional psychotherapy, seemed to have little relationship to later adjustment involving children diagnosed as schizophrenic, atypical, or passive-aggressive personalities. They felt that a good predictor of later adjustment was the presenting symptom at time of intake. Apparently what the authors were suggesting was that the environment, social, physical, cultural, that children are placed into from their homes has, on a three or four year experiential time factor, more to do with helping them through a particularly difficult period of their life than any specific modality of therapy that may have been employed.<sup>144</sup>

This study indicates that the formal treatment at these institutions is not as important to the success of the program as the social and physical milieu in which the children live.

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143. A. J. Montanari, "A Community-Based Residential Program for Disturbed Children," (reprint from Hospital and Community Psychiatry, American Psychiatric Association, April, 1969), p. 23.

144. Antony Davids, et al., "Effectiveness of Residential Treatment for Psychotic and Other Disturbed Children," American Journal of Orthopsychiatry, Vol. 38, No. 3, April, 1968, pp. 46-47.

This finding with regard to the value of psychotherapy, can be extended by an assessment of the usefulness of casework methods. A study of casework services in Bellefaire, a residential treatment center, near Cleveland, Ohio, concludes:

Casework was found to be effective in about 37% of the children at discharge but only 16% were considered to be meeting all modification casework demands. Thus it appears that casework cannot be the main pillar upon which one predicts success or effectiveness of an institution. The authors felt that, 'In general, results of current evaluative research in the mental health specialties point up the need for experimentation with new and varied approaches for setting more limited and concrete goals, and for a more balanced and integrated view of the psychological and environmental factors involved.'<sup>145</sup>

To review the practical problems faced by residential treatment centers, research staff met with the California Association of Executives of Children's Institutions on several occasions. The following series of questions and answers summarize the issues discussed:

#### Education

Question: Would the private facilities be willing and able to take more seriously disturbed children--such as those currently treated in state hospitals--into their programs?

Summary of Responses: Many voluntary facilities are now serving a number of these children. The major obstacle to expanding service

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145. Melvin E. Allerhand, Ruth Weber, and Marie Haub, Adaptation and Adaptability: The Bellefaire Follow-up Study (New York: Child Welfare League of America, 1966). Description of findings, University of California, Berkeley, Graduate School of Social Welfare, op. cit.

to this type of case is the lack of adequate education resources. Most of the residential treatment facilities rely on the public school system in the community to provide education services to their children. If a child cannot function in public school, the agency must reject that child unless they can provide him with a school experience in their own facility. Most of these agencies cannot do this because of financial limitations. Several suggestions were made to resolve this problem:

1. Allow the voluntary agency to include an educational component in its contracts with local public agencies (i.e., probation and welfare) so that the facility could purchase education services. Most county agencies currently will not allow this as a reimbursable item.
2. Increase budgetary provisions of the State's "Educationally Handicapped" program for teachers in children's institutions. Such teachers are currently included in the law as reimburseable program elements, but funding has not always been available. Because of this shortage of funds, EH classes in some counties are not available for the disturbed child unless he is at least two years behind grade level. Thus, a seriously disturbed child, when only one year behind in his schooling, is not eligible.
3. Allow residential treatment centers the autonomy to administer publicly funded education programs within

the institution. Currently, education programs within such institutions are at the mercy of local school districts. Many districts have chosen not to fund any programs within voluntary agencies and those few districts that have appropriated monies maintain control over the management of the program. If state education funds (and federal funds) were allocated directly to the voluntary agency then individualized programs could be built around the needs of the institutionalized child rather than the school district.

4. Encourage further implementation of an existing Education Code provision (6952) which stipulates that a local school district which has costs in excess of the normal per capita student costs for institutionalized children may be reimbursed for such costs from the county superintendent of schools. In this way costs are spread to all the taxpayers in the county rather than just the property owners in one district. The county tax base provides a more equitable basis for financing institutional costs because it is more representative of the residences of the children than the local district in which the institution happens to be located.

### Licensing

Question: Do you feel there should be a state agency with direct responsibility for licensing and standard setting for voluntary children's institutions?

Summary of Responses: They agreed that this would be a valuable function and that such supervision was needed to guarantee the quality of care. It was also felt that such a state agency should also set uniform standards for contractual relationships between voluntary agencies and all public agencies.

#### Short-Doyle

Question: To what extent have the voluntary children's institutions been included in the provision of public mental health services under contract with county mental health departments?

Summary of Responses: Only a few institutions reported having sizeable Short-Doyle contracts. Both San Diego Children's Home (San Diego County) and Lincoln Child Center (Alameda County) stated they had developed close relationships with county mental health directors and had contracted a substantial number of beds to the county. Most of the agencies, however, especially those located in Los Angeles County, reported very little contact with the county mental health department, though most displayed a willingness to enter into a closer working relationship.

#### Group Homes

Question: To what extent are voluntary agencies involved in the development of group homes (i.e., homes for up to five disturbed children supervised by professional mental health workers--such homes are usually used as follow-up resources after a child has been institutionalized and before he is able to return to his own family or to a foster home)?

Summary of Responses: Many of the voluntary agencies are in the process of setting up such units as satellites to the residential facility. They indicated that group homes provided an excellent transition from the institution back to the community. However, many counties will not contract with the voluntary sector for this type of aftercare program.

In summary, the voluntary residential treatment facility is a resource capable of expanding to provide additional service to more seriously disturbed children if certain legal and funding obstacles can be resolved.

## California's State Hospital Programs For Minors

### Trends and Developments

The state hospitals have, since the beginning of the century, served patients who were under 20. From 1910 through 1930, patients under 20 constituted under 5% of those admitted to the state hospitals.<sup>146</sup> In the 18 years from 1936 to 1954 patients under 20 were approximately 1% of the resident population.<sup>147</sup> (The actual population fluctuated considerably from a low of about 136 in 1939 to a high of 453 in 1954.) Throughout these years both the total resident population and the median age of that population rose steadily.

The first year in which the total resident population did not grow was 1957; and the years from 1960 through 1969 show an impressive decline in the state hospital population.<sup>148</sup> During the last ten years the resident population dropped by 20,440 patients. Of that decline, 8,575 came from the group of patients 65 years of age and over. This group constituted 31.3% of the resident population in 1960 while it only comprised 17.8% of the state hospital population in 1969. The decline in the oldest group of patients accounts for 42% of the decline in the total population during the last ten-year period.

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146. See footnote number 56, page 84.

147. See Appendix C.

148. Ibid.

In contrast to this shift to community treatment and services for the aged, an opposite trend seems to have developed with regard to the younger patients. During the same ten-year period (1960-69) the patient population under 21 in state hospitals rose considerably. The number of patients under 21 in 1960 was 923 and they constituted 2.5% of the total population of the hospitals.<sup>149</sup> The number of patients under 21 in the state hospitals in June 1969 was 1,486 and they constituted 9.2% of the total population. While the total population of the hospitals was declining, the population under 21 was rising steadily, both in absolute numbers and even more so as a percentage of the total population. During the past 10 years, the total state hospital population fell 56.4%, the 65 and over group decreased 13.5% or 8,575 patients. However, the under 21 population rose by 563 patients, an increase of 6.7%. California's investment in community services for the mentally ill and the concomitant development of those services at the local level appears to have had little effect in reducing state hospital placements of minors. It appears as if the passage of A.B. 986 (1969) eliminating Juvenile Court Observation placements, produced the most significant decrease in state hospital admissions of minors during the last ten years.<sup>150</sup>

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149. In 1954 there were 453 patients under 20 in the state hospitals and they comprised 1.3% of the total patient population. The figures for the under 20 population were not available by age groupings for the years 1955-59.

150. In contrast to the ten year rise in state hospital population in the 0 - 17 age group, (from 461 in June of 1960 to 818 in June of 1969) by November of 1969, the population in this category had dropped precipitously to 685.

Children's and Adolescents' Programs (Ages 0 - 17)<sup>151</sup>

In the two Children's Units at Camarillo and Napa State Hospitals, 271<sup>152</sup> patients under 15 were being served as of November 30, 1969. There are no children's programs established at the other eight hospitals for the mentally ill. According to the Legislative Analyst, children under 15 admitted to these hospitals are admitted for short stays only. If further state hospital treatment is required, the child is transferred to Napa or Camarillo. On November 30, 1969 there were only 15 children under 15 in residence in any of these eight other hospitals.

Separate adolescent programs--ages 15-17--have been established at two of the state hospitals for the mentally ill, Napa and Camarillo. The Napa program began in 1967 and is limited to a maximum of 25 patients and offers day treatment only. Patients return to adult wards in the evening.

The Camarillo (Lewis R. Nash) Adolescent Center was established in 1966 and serves a maximum of 172 patients. Adolescent programs have also been initiated at DeWitt and Mendocino, although they have not been funded separately. As of November 30, 1969,

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151. Figures are derived from Analysis of the Budget Bill, July 1, 1970 to June 30, 1971, Legislative Analyst, California Legislature, p. 638.

152. This is the total number of patients in these two hospitals under 15 years of age. However, in tables supplied to the Select Committee by the DMH the total number in residence in the two Children's Units was 312 as of November 30, 1969. We assume that the difference of 41 represents those children in the Napa Children's Unit who were 16 years of age.

226 adolescents were being served in special adolescent programs, while 173 adolescents were in adult programs.<sup>153</sup>

Several of the responses from state hospital personnel<sup>154</sup> indicated that the state hospital may not be an appropriate place to treat mentally ill children and adolescents.

#### Metropolitan

"Children and adolescents have different emotional, psychological, social, and rehabilitation needs than adults."

"Treatment programs for children will need an increase in treatment personnel in all categories. The personnel also would need special training and experience in order to effectively deal with children and young adolescents."

"Some remodeling would be needed of our existing facilities. For instance; special play areas, special toilet facilities, small dormitories and individual rooms."

#### Agnews

"The Department of Mental Hygiene has not authorized a child/adolescent program at Agnews State Hospital."

#### Atascadero

"We do not believe that our hospital is an appropriate place to treat mentally ill children and adolescents; this belief must be qualified by practical considerations, the major consideration being that apparently there is no other place to send patients of the nature received here."

Even when the hospitals were considered appropriate, some administrators had reservations.

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153. Legislative Analyst, op. cit., p. 639.

154. Copy of the questionnaire sent to the state hospitals available upon request.

## Mendocino

"The institution is appropriate in that it has a competent staff interested in the treatment of adolescents in the face of a dearth of such residential treatment facilities in the northern California area. It might be considered an inappropriate place in that for most of the adolescent patients it is remote from their families and communities."

## The Physical Environment

The information contained in this section was derived from on-site scrutiny at the Children's and Adolescents' Units at Napa and Camarillo State Hospitals.<sup>155</sup>

With the exception of the Camarillo Children's Unit, facilities in these two hospitals for adolescents and children are dull, and similar to the institutional adult wards. The wards at the Camarillo Children's Unit are warm and "home-like" in comparison to the other wards observed. (Dr. Norbert I. Rieger, Director for Children's Services at Camarillo explained that this was a result of private contributions of funds, furniture, draperies, etc.)

Hospital staff interviewed during the study agrees that the physical environment of the hospitals hampers, rather than enhances, the treatment program. These findings are supported by a recent independent study conducted by the California Association for Mental Health. The Professional Advisory Committee of the C.A.M.H.,

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155. Project staff conducted site visits to the children's and adolescents' programs at Napa State Hospital on October 9, 27-31 and Camarillo State Hospital children's and adolescents' programs on November 5-7, 18-19, 1969.

in their report evaluating the Children's Center at Napa, concluded (page 8):

The barrenness and dullness of the surroundings on Unit M-3 approach sensory deprivation. Unit M-1 had a variety of pictures and decorations some time ago, but a routine paint job by the maintenance department required a removal of this "color" and a monotonic application of paint.

The lack of personal property and places for personal possessions is judged undesirable for the processes of individuation and identity formation in the children, but the staff states that procurement is difficult and the low staff-patient ratio has made it difficult to manage destructive children.

In general, the evaluation team felt that the surroundings were clean but very drab and depressing, this latter problem seemingly related to a paucity of innovativeness, poor understanding of the unit function by maintenance personnel and a lack of energy to accomplish change, because of limited leadership, staff-patient ratio, and energy.

As Dr. Norbert Rieger pointed out in a recent address to the California Association of Mental Health:

The impact of the physical environment on the well being and on the behavior of the mentally ill child, is far greater than we have been led to believe by the casual and scant attention which this has received by hospital planners and hospital administrators in the past. I consider it to be an important factor which influences the child's behavior during his residence in such a facility--it is ubiquitous, and therefore, it affects the child's behavior 24 hours a day and it is the least costly tool of ego support in such a residential setting.

"Bettelheim and Sylvester (1948, 1949) conceptualized the fundamental therapeutic effect in the residential setting as stemming from 'milieu therapy'. The therapist was no longer to be

found in an office, he was continuously involved in all facets of daily living."<sup>156</sup>

Most experts agree that "milieu therapy" begins with the physical milieu. If his physical surroundings are impoverished they serve to lessen, rather than enhance therapeutic interaction.<sup>157</sup> Physical space, if structured properly, can be used to support therapeutic activity. The physical environment in the children's and adolescents' programs at Napa and the adolescents' program at Camarillo has not been utilized for therapeutic purposes.

In addition to the drab and depressing nature of the surroundings, the actual physical layout of the wards at these two facilities makes adequate supervision of the units extremely difficult. Not only do the floor plans create the need for additional supervising personnel, but they also prevent easy interaction between staff and patients.

#### Personnel Issues

"Ambiguity and duplicity are deleterious influences in the residential treatment of children that cannot easily be overcome, even by the most sophisticated and knowledgeable arrangement of relationships between the function of administration, caretaking,

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156. See Saul I. Harrison, M.D., John F. McDermott, Jr., M.D., and Morton Chethik, M.S.W., "Residential Treatment of Children", Journal of American Academy of Child Psychiatry, Vol. 8, No. 3, July, 1969, p. 391.

157. Norbert I. Rieger, M.D., "The Hospitalized Mentally Ill Child", presented at the California Association for Mental Health Conference on Childhood Mental Illness, San Francisco, March 25-26, 1966, pp. 5-7.

and psychotherapy. It is our observation that therapeutic teams have a rich potential as long as everyone, including the patient, is clear as to what they and everyone else is doing."<sup>158</sup>

Due to the vertical lines of authority in state hospitals, each professional group (i.e., psychologists, psychiatric technicians, etc.) is responsible, through a chain of command, to a supervisor in the main (adult) hospital. This makes it extremely difficult for administrators of children's programs to maintain control over the assignments and qualifications of personnel working under them, and creates problems in utilizing the various categories of personnel in a single integrated treatment program.<sup>159</sup>

If the therapist administering a treatment program does not have complete control over the selection, supervision, and training of personnel, it is exceedingly difficult to create a team to treat the disturbed child. The directors of the children's and adolescents' programs have the responsibility to treat and care for the mentally disordered children in those programs. But, they state that they lack the authority necessary to accomplish these tasks. The programs at Napa and Camarillo appear to suffer because of this separation of responsibility and authority.

The report on an Evaluation of Children's Services of Camarillo

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158. Harrison, op. cit., p. 409.

159. Norbert I. Rieger, M.D., A Proposal for Staffing the Children's Treatment Center of the Camarillo State Hospital, Dec. 18, 1969, p. 11, "The internal authority of the Children's Treatment Center should be that of an umbrella type of authority rather than line authority....All disciplines should be directly responsible to the Medical Program Director of Children's Services rather than to the representative supervisors in the hospital at large."

State Hospital by the Professional Advisory Committee of the California Association of Mental Health, October 8, 1969, suggested (page 9) that:

The line-type organization of the over-all hospital be removed with respect to children's services and adolescent services, so that the chiefs of these services can procure and control their personnel and so that the chiefs of these services may be directly responsible for on-the-job training programs, to the end that maximum amount of consistency and maximum amount of therapeutic confrontation can be made by a staff and its living with a child.

The medical directors of the Children's Centers at Napa and Camarillo are also concerned about the broader implications of treating children in a state hospital designed for adults. Dr. Richard Kogl, Medical Director of the Children's Unit at Napa, prepared the following statement about the Unit:

A hospital implies illness. It is a valid debate as to whether the illness model is a productive or counter-productive model for adults with emotional problems. However, with the child and adolescent, the issue is less debatable....Whether the child is emotionally disturbed or not, the central event of his life is growth (and factors which might impede growth). A program for youngsters must be built upon the growth and development model not upon the illness model. Therefore, a hospital is not the best way to meet the needs of young people. The Napa Children's Center should not be a hospital but a center. We must encourage and use what is healthy in the child rather than focus on what is 'sick'.

Can the Children's Center be anything but a hospital when it functions as part of the Napa State Hospital? No. If it remains part of the Napa State Hospital, the Napa Children's Center will remain a hospital. One thousand and one Napa State Hospital policies are based on the premise of it being a hospital. There is a lush tropical tangle of policies tying the Children's Center to the parent institution.

Dr. Norbert Rieger states this same opinion:

To maintain the gains which we have made at our Children's Treatment Center and to expand our programs and to be flexible enough to do so, it is essential that the Children's Center becomes autonomous and gets a budget separate from the rest of the hospital.<sup>160</sup>

One result of past failure to appreciate the separate requirements of children is the shortage of qualified personnel. Both Dr. Kogl and Dr. Rieger suggested, in their testimony before the Select Committee on January 27, 1970, that inservice training focused on the needs of children was essential to improving the quality of services they provided.

SENATOR TEALE: You want an inservice training.

DR. RIEGER: Inservice training, and I would like to emphasize clinical training on a practical everyday level, because I find that only those who are experienced with daily crises of those children are capable of teaching those students how to deal with children. Because even the nursing staff who come to us who have been trained to take care of adult patients are completely helpless in dealing with a child. There is a great deal of movement going on and you get the illusion that treatment takes place but no treatment takes place. I have to go time and again to demonstrate to the nursing staff and to the nursing supervisors how you deal with a child in distress....The severely disordered children have such crises almost daily and sometimes several times a day and it takes a technique to deal with those children....

SENATOR TEALE: Well, they have to learn some things.

DR. REIGER: Some of them have to. Most of them, and this is what I refer to. They see the pathology but they don't see the whole child and the normal aspect of the child. They lose their spontaneity. But the students who are completely unprejudiced--they are people and treat children like children, and there is a spontaneity--

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160. Norbert I. Rieger, M.D., "On Treatment of Mentally Ill Children in a State Hospital", a paper presented at the California Mental Health Association Conference on Childhood Mental Illness, San Francisco, Oct. 17-18, 1969, p. 12.

and I've seen a great deal happening even during a period of two or three months during the summer period when they come to us. I have throughout the year, students who will come to us for two or three days a week. I feel that this is one of the potentials for training child care workers and to make them available to the community...and I hope I could train those people to become what I call career foster parents.

DR. KOGL: ...the shortage of staff and the need for better trained staff. I would agree with Dr. Rieger, that it's not only a matter of better training, but sometimes the appropriateness of the training is involved here. That people who are trained....

ASSEMBLYMAN LANTERMAN: If you could recruit the staff, can you get them?

DR. KOGL: In most categories we've been fortunate, yes. Where the difficulty has been greatest is in areas of the people that have the most contact with the youngsters. Psychiatric technicians, we need more of them, but we need them trained differently. Perhaps trained in an entirely different way.

ASSEMBLYMAN LANTERMAN: In other words, they just don't have training for the specific purpose for which you want them?

DR. KOGL: Right. The staff--especially in that category--is seen as interchangeable with the staff on the adult units.

ASSEMBLYMAN LANTERMAN: Well, they're not interchangeable and that's what one of our problems is.

DR. KOGL: Correct.

ASSEMBLYMAN LANTERMAN: And where we have a medical authority in charge of the hospital who has adult concepts of staff qualifications and, in order to keep those staff as a reservoir for use where the greatest emphasis may be necessary in his judgment, he wants them interchangeable. But, in fact, they can't be a service to you unless they are specially trained with a child orientation. Is that your general concept?

DR. KOGL: Yes.

Problems exist in the management and training of the present staff within the hospital and in recruiting qualified personnel for children's services. Dr. Rieger's suggestion of an inservice training program for child care workers offers one solution to both the problems of the quantity and quality of treatment personnel available for children's services.

## Treatment Programs at Napa and Camarillo

The California Association for Mental Health's evaluation of the Napa program (pp. 11-12) indicates numerous deficiencies of a longstanding nature:

The evaluating group did not perceive a strong, effective leadership or the presence of a unifying concept and program within the context of which the work with children was moved along from one age level to the next, and within a context on which a unifying program could be built. Instead, the group perceived a looseness of direction, with evidence of differing orientations and differing approaches on the several units. The impression gained was that of a fragmentation of program. It appears that a portion of this problem stems from the "water-logged" condition of the overextended staff. They seemed to be doing the best that they could on an individual basis.

The evaluating group did not feel that the staff was highly informed about the nature of children's pathologies and the nature of their work.

No evidence came through clearly that clinical supervision was active. References to upper echelon relations appeared to be chiefly administrative.

However, the situation at the Children's Center at Camarillo State Hospital was in sharp contrast. Dr. Lowry, in his testimony before the Select Committee, quoted the CAMH report on Camarillo:

At this point, I would like to pay special tribute to Dr. Rieger's child unit by quoting from the CAMH report. This is what they had to say. The overall impression of the evaluating group was that this children's psychiatric service has achieved a high level of quality which seems everywhere evident. Four or five evaluators have had eminent acquaintance in their professional career with nine residential services for children and none remembered any service where children would reach an order of sickness in their lives as to require this kind of hospitalization--were perceived so much as people and so little as psychotic. The group compared the services at Camarillo with the Langley-Porter, the Neuropsychiatric Institute at Los Angeles, Los Angeles County, University

of Michigan Service, Boston Children's Hospital, Judge Baker Clinic in Boston, Illinois Juvenile Research, and Psychiatric Institute in New York City.

The Professional Advisory Committee of CAMH, in evaluating the Camarillo Adolescent Unit, interviewed the medical director of the Unit and visited the wards with him. Their impression of the program from the interview, and their guided tour, was that it was entirely adequate. However, when project staff visited the wards and talked to the staff informally, they observed a less than effective program.

In contrast to the type of staff interaction on the Children's Unit, on the adolescents' wards we saw staff congregated around the nursing station and paying little heed to the requests or the activities of the adolescents. Indeed, in many instances, attitudes of certain nursing personnel could be categorized as unsympathetic and indifferent to the children under their supervision.

On three of the wards (565, 566, 567) adolescents with drug problems are living with the seriously disturbed youngsters. Because of the lack of any organized ward program, some of these boys told us that the less seriously disturbed tend to gang up on the more disturbed boys and tease and provoke them. Under a more organized program these more adequate boys could be used to work with the sicker patients, but no such attempt is being made. (At Napa, some of the adolescent patients may volunteer to help supervise children on the autistic unit.)

This mixture of several levels of disturbance was particularly apparent on the only girls unit (565). Here we observed forty-five girls with levels of disturbance from adolescent autism to minor

drug problems. Though some experts agree that a careful mixture of various problems may be therapeutic in some programs, it was obvious that because there is only one girls' ward, the combination we observed is not a product of a calculated treatment program, but rather an expedient dictated by lack of space and qualified staff.

#### State Hospital Education Programs

The educational programs at Napa and Camarillo do not meet the standards established for educationally handicapped classes in regular public schools. The facilities, equipment, and funding are all below the standards set for E.H. classes. It is also very difficult to recruit qualified teachers to work in remote institutions.

There is a great need to upgrade these programs in view of the importance of the developmental needs in the treatment of these children.<sup>161</sup> This emphasis on the educational component as the core of the treatment process is not shared by all professionals in the field. Dr. James T. Shelton, Medical Director of Porterville State Hospital, a hospital for the mentally retarded, takes issue with this emphasis. "Obviously, if the child is ill, he cannot be educated appropriately until he is well and healthy."<sup>162</sup> Dr. Norbert Rieger, Medical Director of the Children's Center at

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161. See statement of Dr. Richard Kogl, page 153, of this report.

162. Quoted from a letter to Assemblyman Frank Lanterman dated February 11, 1970, written in response to the Select Committee Preliminary Report.

Camarillo State Hospital for almost two decades, obviously does not agree:

We found the structured classroom to be the most effective way in rehabilitation of schizophrenic children. In such an educational setting, the young schizophrenic child not only receives the education which every child is entitled to in order to develop whatever potential he has, but we consider it the most effective approach to his rehabilitation.<sup>163</sup>

According to Dr. Rieger, an appropriate education is "the most effective approach" to developing the health of a seriously disturbed child.

#### Lack of Evaluation

Dr. Martin Wolins, Professor of Social Welfare and one of the nation's leading authorities on child welfare services, stated the issue cogently in his testimony before the Select Committee on January 27, 1970.

We do not know whether the programs for which this Legislature or any other legislature, by the way, is spending all these funds, work. We just don't know. There is, of course, evidence in specific cases. What we find out about specific cases is that some people get well, some without being treated. In essence, what we know today is that the rate of spontaneous remission of mental illness particularly among children is as high as the rate of children in cohorts who are being treated by standard procedures....In reviewing California programs and reviewing programs in other states--California was no worse than others--one is shocked to find that the purchasers of service have at no point required or received an evaluation of the merit of the program for which they were paying.

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163. Rieger, op. cit., p. 8.

There are many methodological and theoretical difficulties with evaluative studies, but the existing evidence is so damaging to notions of how to treat mentally disordered children that it must be faced. (For further discussion, see: Jane W. Kessler, Psychopathology of Childhood, Prentice-Hall, Inc., Englewood Cliffs, N.J., 1966, page 393.)

## VI. SUMMARY AND RECOMMENDATIONS

The system of services for emotionally disturbed children in California resembles a pinball machine.

- The child is catapulted into a sea of competing and conflicting agencies and programs. He is bounced from one service to another, depending on openings and eligibility.
- Diagnostic services, among others, are constantly replicated. Each new service means new personnel, new procedures and new surroundings.
- Funding priorities are inverted. One thousand dollars a month is spent to maintain a child in a state hospital, while much less is allocated to maintain him in the community.
- Each child follows a path through the system that is dictated by the availability of space and money. The needs of the child are defined in terms of his ability to qualify for programs--very rarely are evaluation studies done of any program or agency. If the child is helped by the services he has received, then few are aware of it since no follow-up data is available. The pinball machine delivery system is the reality for the mentally disordered child in California.
- Accountability and responsibility for the child are disorganized and scattered. No one is accountable for

the treatment of the emotionally disturbed child because no one agency is responsible for seeing that he is cared for.

- The system is extremely complex. A family seeking information about the treatment alternatives available, often seeks in vain. There is no one agency with responsibility to disseminate information to the family with an emotionally disturbed child. Each agency handles its emotionally disturbed children differently. Theoretical and therapeutic orientations differ radically in different agencies. To put it quite simply, services have neither the coordination nor the continuity necessary to meet the child's needs. What we do have is a highly wasteful and expensive system which is not doing the job for the child and his family or for the taxpayer.

We propose that the State take steps to shift the responsibility for the mentally disordered child to one agency which has the authority to contract with vendors of the appropriate services at the community level. State responsibility should begin when expert diagnosis establishes that special care is needed which the family cannot provide. We are proposing a delivery system which would offer a wide range of family services aimed at supporting the child in the community and in his home. Priority spending would begin with early diagnosis and services. By responding to the problems early and offering services at that point, the heavy economic and psychological burden may be reduced.

## RECOMMENDATIONS

### Coordination

Part I - "Services For The Handicapped" - shows that current programs for all handicapped are in a state of disarray and clients become lost in a maze of laws and regulations tailored more to the needs of the providers rather than the consumers. The mentally disordered child, and his family, have these same problems.

#### Proposal #1

Regional Centers for the Retarded currently provide the families of retarded persons with a central community information, diagnostic and referral service. They are also empowered by law to represent the family as a purchasing agent in locating and helping to pay for appropriate services to meet the needs of the retarded. (It should be pointed out that Regional Centers do not provide treatment services and, thus, do not duplicate other direct service programs.) These Centers have proven to be effective "expiditers" in aiding families to choose among the various program alternatives. The findings in Part II of this study - Mentally Disordered Children - reinforce the proposal (made in Part I) that one of these Regional Centers be chosen as a "pilot center" to demonstrate the feasibility of utilizing this mechanism as a resource for all handicapped persons, including the mentally disordered child.

There is a sharp division of opinion as to whether or not the Regional Centers for the Retarded are the most appropriate mechanism to serve other handicapped groups. Representatives of

various Regional Centers around the State (see Part I for a discussion of these conferences) have agreed that their programs could be adapted to serve all handicapped persons. A subcommittee on children's services of the Conference of Local Mental Health Directors states an opposite opinion:

Separating the diagnostic, referral, and other services for children from the local mental health programs would lead to chaotic, fragmented, and woefully ineffective services. The idea that these services should be coordinated with the Regional Centers for the retarded is a regressive suggestion (and only partly because it reverses the well-established trend toward local assumption of responsibility) and would be extremely deleterious to the development of local mental health programs throughout the state.<sup>164</sup>

Because of these different points of view, the recommendation is limited to one pilot center to test the validity of this approach. To assure that existing services are not diluted, it is suggested that a research grant be sought for this project.

#### County Mental Health Departments

Services for mentally disordered children at the community level have been slow to develop. Most of those programs currently offered by local mental health agencies follow traditional inpatient/outpatient patterns. The problems of the mentally disordered child do not fit within this adult-oriented framework. Trained personnel available to work with children is extremely scarce. Current Department of Mental Hygiene regulations regarding reimbursable programs under Short-Doyle tend to inhibit the flexibility of local programs in developing more creative services for the mentally disordered

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164. Letter to Assemblyman Frank Lanterman from the Subcommittee on Children's Services, Conference of Local Mental Health Directors, 2/20/70

child. Emphasis on vaguely defined "rehabilitative" criteria for precare and aftercare services and rigid requirements for inpatient facilities, limits local discretion to more formal, medically-oriented treatment services, while aggravating the critical medical manpower shortage.

#### Proposal #2

The Department of Mental Hygiene has recognized the need for flexibility in its regulations. "The Department may and does waive the requirements in certain instances permitting more flexible approaches where appropriate."<sup>165</sup>

It is proposed, however, that the regulations themselves provide this needed flexibility -- especially for children's services. The Department should be directed to review its regulations, keeping in mind the special needs of children, and should prepare such revisions as may be necessary. By law, these revisions would be submitted to the Conference of Local Mental Health Directors for approval and to the Citizens' Advisory Council for review.

#### Proposal #3

Few Short-Doyle programs are currently utilizing the voluntary, private sector, in the provision of children's services. The Department of Mental Hygiene has recognized this failure to involve

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165. Letter to Assemblyman Frank Lanterman from Robert T. Hewitt, M.D., Acting Director of the Department of Mental Hygiene, February 10, 1970, p. 7.

more fully the private sector at all levels and proposes to review current contracts.

The Department of Mental Hygiene proposes this year to obtain information in each county plan which will provide an inventory of all facilities in the county. Each facility which does not have a contract with the county will be identified and reasons given as to why it was not used in the contractual arrangement. This will give the Department of Mental Hygiene information as to whether or not appropriate utilization is being made of existing private resources.

In order to stimulate the further development of contractual relationships in the Short-Doyle program, it is proposed that the current funding formula be made more flexible to allow potential contract facilities to advance one-half of the county's 10% contribution for the provision of contract services in that facility.<sup>166</sup> Thus, optional funding for contractual programs would be 90% state, 5% county, and 5% contract facility. This change in the statute would provide for a cooperative fiscal arrangement between the county government and the private sector for the provision of mental health services. Such contracts under this optional funding mechanism would be received and approved by the local governing body, the local mental health director, and the Department of Mental Hygiene

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166. This proposal has already been introduced as formal legislation by Assemblyman Gordon Duffy, Vice-Chairman, Assembly Select Committee on Mentally Ill and Handicapped Children (A.B. 457).

#### Proposal #4

The current priorities for funding under the revised Short-Doyle Act (1968) do not identify children's services as a specific priority.

The development of children's services under the provisions of existing law falls into the third priority for funding. Several Short-Doyle directors, in responding to the Select Committee's survey, stipulated that one of the major reasons for the paucity of local children's services is a lack of funding which is, in part, a result of the statutory priorities.

Therefore, the current statutory language regarding funding priorities should be changed to allow for special emphasis on the development of services for mentally disordered children.

It is also suggested that the entire priorities section be reviewed to determine the need for more comprehensive changes that may be needed to bring priority requirements into line with local needs for all mental health services.

#### Proposal #5

Within each county, several different agencies provide services for the mentally disordered child -- probation, Short-Doyle, welfare, and public schools. Each agency, in order to evaluate the needs of the mentally disordered children under its jurisdiction, maintains a separate diagnostic program. The problems of these children are similar and their involvement in various agencies is a function of program requirements and logistics rather than need.

Diagnostic services should be unified under a single agency. Such unification would provide greater continuity, a simplified funding base and would maximize the utilization of scarce manpower.

It is proposed that one county Short-Doyle agency be designated to serve as a "pilot program" to demonstrate the feasibility of unifying diagnostic services for mentally disordered children in one county under the Short-Doyle program. We are not suggesting that the Short-Doyle agency should simply fund diagnostic services in other agencies, but rather that the pilot program should take on the direct responsibility for providing diagnosis for a sample (100-200) group of children who would otherwise be diagnosed in several different agencies (i.e., schools, probation, welfare, etc.).

The pilot study should evaluate the results, costs, and the usefulness of the integrated diagnostic service to the various agencies serving these children. The results should be compared to the results obtained with a similar--matched group--who would receive their diagnostic evaluations in the standard way. An additional comparison should be made with those mentally disordered children served in the proposed pilot Regional Center project. The results of this analysis should be useful in determining the feasibility of unifying diagnostic services for the mentally disordered child and in testing the feasibility of integrating such services in a comprehensive program with other types of handicapped persons.<sup>167</sup>

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167. Letter from Robert T. Hewitt, M.D., Department of Mental Hygiene, op. cit., pp. 7-8, "...unification should extend beyond the diagnostic services to treatment services, aftercare services, and other types of services so there is a completely coordinated comprehensive program which provides continuity of care and eliminates duplication and overlap."

The subcommittee of the Conference of Local Mental Health Directors responded to this proposal as follows:

The unification of diagnostic services for children and adolescents within the counties is an important and worthwhile recommendation. The community mental health programs are the logical place to locate and develop such a service.... This recommendation highlights the need not only to look at the current laws and regulations pertaining to mental health and the Department of Mental Hygiene but also to existing education codes, juvenile justice laws, and other statutes which regulate and define responsibilities, duties, and operations of all systems which have direct relevance to mental health.<sup>168</sup>

#### Proposal #6

In the Preliminary Report submitted to the Select Committee, it was proposed that in addition to the five-year plan currently required under the revised Short-Doyle Act, county mental health directors are also required to submit an additional five-year plan for children's mental health services. In this way, children's services would have a higher degree of visibility and planners would be required to give direct attention to the special needs of children.

The subcommittee of the Conference of Local Mental Health Directors supports this need for a sharper planning focus:

The recommendation that the Short-Doyle programs submit five-year plans for program development, including a separate children and adolescent component, seems desirable. Along with the recommendation that there be

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168. Letter to Assemblyman Frank Lanterman from the Subcommittee on Children's Services, Conference of Local Mental Health Directors, February 20, 1970, p. 17.

greater visibility of children's services in the Department of Mental Hygiene, this seems consonant with the recommendations of the children's advocacy proposal of the Joint Commission Report.<sup>169</sup>

### Foster Home Care

The traditional foster home model is inappropriate for the needs of the mentally disordered child. The use of professional group homes and the training of "professional foster parents" have been discussed in this part as ways of developing more specialized small living arrangements for disordered children who must be placed out of their own homes either as an alternative to or following institutionalization. In order to stimulate the creation of these new programs, several steps must be taken.

#### Proposal #7

Current Social Welfare and Mental Hygiene regulations regarding the licensing of foster homes and group homes should be changed to allow for the development of more specialized and innovative small residential settings for the mentally disordered child.

#### Proposal #8

Current foster home placement of mentally disordered children -- both at the state and local level -- should be evaluated to determine the appropriateness of such placement and follow-up studies should be conducted to determine if the children benefit from such placement over a period of time.

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169. Ibid.

Proposal #9

In order to facilitate the creation of professional group homes for institutionalized children, state civil service and Department of Mental Hygiene requirements should be altered to allow for the employment of personnel to staff professional group homes. Present regulations do not contain provisions for employing trained "child care" workers as foster parents.

Proposal #10

The State Department of Social Welfare, through its Division of Community Services, has direct responsibility for the placement of state hospital patients -- including children -- in certified family care homes. Current statutes limit reimbursement to family caretakers to \$160 per month. As was pointed out in the chapter on foster home care, mentally disordered children, in contrast to adult and retarded patients, are more difficult to place in family care. These children present special demands on the caretakers and more incentives are needed to recruit persons willing and able to take on this responsibility.

Therefore, it is proposed that the statutory \$160 limit be eliminated for family care homes serving mentally disordered children. It is further proposed that substitute language be added in the law to allow the Community Services Division to reimburse specialized family care homes up to, but not to exceed, the cost of state hospitalization.

## State Hospitals

### Proposal #11

The Department of Mental Hygiene has a major responsibility for the provision of services to mentally disordered children, yet there is no person with full-time responsibility for such services in the Department.

In the preliminary report on mentally disordered children (January 1970), it was proposed that a position of "Deputy Director of Children's Services" be established in the Department of Mental Hygiene. The Department has responded to this proposal as follows:

The Department of Mental Hygiene agrees that there is a need for coordination of children's services in the State hospitals with the development of children's services in local programs. At the present the Department has a project for the development of geriatric services in local programs and coordination of State hospital geriatric programs with those of local programs, with the eventual purpose of having all patients cared for at the local level. This pattern is working well and the Department proposes to take similar action in the area of children's services. A professional staff member at headquarters will be the Coordinator of Children's Services.' ... The emphasis of the job will ...be on the promotion of the development of children's services in local programs so that State services will no longer be needed.

The Coordinator will also be responsible for (1) improving the manpower situation by stimulating training programs both in the Department of Mental Hygiene and in local programs, and (2) providing liaison with other departments concerned with children's programs, such as Social Welfare, Education, and Public Health.

The projected position of "Coordinator of Children's Services" is consistent with the proposal made in the Preliminary Report. It is further recommended, however, that the coordinator be responsible directly to the director of Mental Hygiene rather than to either the Division of Hospitals or Local Programs. In this way, the coordinator would have an overview of both state and local children's programs while serving as a liaison between both.

#### Proposal #12

As pointed out in the chapter dealing with state hospital programs, the children's and adolescents' units at both Napa and Camarillo are greatly hampered in developing creative programs by the adult-oriented state hospital tradition and administration. These findings are reinforced in the independent report on these two hospitals submitted by the California Association for Mental Health to the director of the Department of Mental Hygiene (October 27, 1969, and November 13, 1969).

In the preliminary report, it was proposed that the children's and adolescents' units at Napa and Camarillo State Hospitals be made administratively separate from the main state hospital. It was further proposed that a single administrator be appointed at each of the two hospitals to supervise both children's and adolescents' services with responsibility directly to the central office of the Department of Mental Hygiene.

The Department responded to this proposal as follows:

"It is the opinion of the Department of Mental Hygiene that the children's units and adolescents' units in the state hospitals should each be administered by a Program Director responsible to the Medical Director of the hospital rather than to headquarters as recommended.

"The Program Directors of the children's and adolescents' units should be responsible to the Medical Director of the hospital because their primary identification is with the hospital and they must have access to the general hospital services. The Coordinator of Children's Services at headquarters will have the responsibility of assisting the children's and adolescents' programs in the hospitals and of coordinating their activities with local mental health programs.

"Under present Department of Mental Hygiene plans, children's and adolescents' units will have enough autonomy to give control of the program to the units' Program Directors. The Program Directors of the units will have control over:

- "1. selection and assignment of personnel.
- "2. the use of physical facilities and their maintenance, and
- "3. admission, release, and treatment of patients within agreed Department of Mental Hygiene policy guidelines.

"Services from the main hospital will be utilized as needed by the children's unit."

If the Department's proposals are implemented, a major step will be taken in providing these units with needed flexibility and autonomy. However, in keeping with the findings in this report and those of the CAMH, the following two areas of control should be added to the jurisdiction of the Program Directors:

A. In addition to "selection and assignment of personnel", it is recommended that the Program Directors also be responsible

for supervision of the staff on the children's and adolescents' units. This supervisory control would eliminate the current vertical lines of authority for each professional group which tie the children's staff to adult service supervisors in the central hospital administration.

B. Program directors should also be responsible for developing and administering separate training programs designed specifically for the children's units.

Though the Department's proposals, with the suggested additions (above), do not constitute a total budgetary and program separation from the main hospital (as recommended by Norbert Rieger, M.D., and Richard Kogl, M.D.), they do represent steps toward establishing program authority at the children's and adolescents' programs in these two hospitals. It is suggested that the Department implement these changes immediately. (They have limited, if any, fiscal implications and could be effected administratively at this time.)

It is further recommended that the Select Committee on Mentally Ill and Handicapped Children conduct a hearing in February of 1971 to determine whether or not a more complete separation is necessary after securing experience under these administrative changes.

#### Proposal #13

Despite the fact that the percentage of youngsters in state hospitals has gone up over the years, state hospital programs for the treatment of mentally disordered children have been shown to be one of the least desirable program alternatives. Several suggestions have been made throughout the body of this report regarding ways in which these programs might be made more responsive to the needs of the children.

In addition to the organizational changes proposed, we suggest consideration of the following:

- Funds should be appropriated to bring the educational programs in the state hospital into line with current standards maintained in programs for the educationally handicapped in the public schools.
- Though current salaries for teachers in the state hospital are roughly comparable to those in the public school, it has been difficult to recruit qualified personnel in the hospitals. Therefore, it is proposed that teachers recruited for these positions be brought into the system at a step or two higher than the entry level in order to attract the needed qualified personnel.
- Present Department of Mental Hygiene staffing requirements prevent the development of flexible, effective programs within reasonable budgetary limits, in both state hospitals and local programs. The legislature should investigate these Department staffing requirements and, if necessary, enact procedures to enable children's program directors on the state and local level to develop programs that are responsive to the needs of children and adolescents.
- Plans should be made and funds should be appropriated to develop satellite professional group homes as outlined in this report. All possible use of federal funding should be made in creating such homes.

Proposal #14

One of the major recommendations in the Preliminary Report to the Select Committee was that current state hospital programs for mentally disordered children and adolescents be phased out based on a plan which would be submitted to the Legislature by the Department of Mental Hygiene. Several persons, and groups, have suggested that this proposal is too inflexible and does not take into account the continuing needs for children's services in the state's rural areas. The subcommittee of the Conference of Local Mental Health Directors' makes this alternate suggestion:

The proposal that the children's programs in the state hospitals be completely phased-out may well be an over-reaction, not in keeping with a meaningful, orderly, and systematic approach to planning services and programs. The subcommittee would prefer a selective redefinition and re-programming of state hospital services for children, much as has been envisioned in conjunction with state hospital roles in mental retardation by your A.B. 225. It is not likely that all counties, particularly the small rural counties, will be able to provide services within their communities for certain categories of children. Some chronically ill children, such as the extremely regressed autistic child, may require highly specialized programs which are, for the foreseeable future, well beyond the means of communities to provide. Those hospitals located in close proximity to communities may be taken over in whole or in part, by the community for the development of local services.<sup>170</sup>

In keeping with the recommendation of the Conference, it is therefore recommended that the Department of Mental Hygiene -- in

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170. Letter to Assemblyman Frank Lanterman from the Subcommittee on Children's Services, Conference of Local Mental Health Directors, February 20, 1970, p. 13.

conjunction with the Conference of Local Mental Health Directors -- be requested to prepare a plan for the most appropriate use of the state hospital for services to mentally disordered children. Such a study should include consideration of the county's ability to stimulate specialized children's services and the future role of the state hospital as a regional resource. Plans for the future use of the state hospitals for children should be presented to the Legislature no later than the 1971 Session.

#### Residential Treatment Centers

Private, non-profit, residential treatment centers--as pointed out in the report--are currently serving many seriously mentally disordered children. Their capacity to provide an alternative to state institutionalization, however, could be expanded if they were provided with the ability to educate those children who cannot benefit from programs in the public school.

#### Proposal #15

In order to strengthen the private facility's capacity to meet the educational needs of seriously disturbed children within the institution, a cooperative program needs to be developed and funded. We suggest the program take the following form:

- The private institution and local school district should work together to develop an educational plan for those children who cannot function in the local public school.

- The local districts would submit these educational plans to the county superintendent of schools.
- The county superintendent should then bill the school district of residence of each institutionalized child for that child's ADA support.
- The county superintendent would then bill the State Department of Education for supplementary funds to meet the needs outlined in the educational plan for each child.
- Such monies would then be reallocated to the local district for provision of services to institutionalized children.
- The county superintendent would also have the responsibility of conducting a periodic review of the education programs in private institutions.

This mechanism will allow the additional fiscal burden of educating such children to be spread to all taxpayers in the State, not just to those taxpayers in one school district.

#### Child Development Centers

#### Proposal #16

Child Development Centers currently provide education services for multiply handicapped and mentally retarded children who are

unable to function in a public school. These programs now exclude the mentally disordered child who may be similarly incapable of performing in the school system.

It is proposed that one or more Child Development Centers be designated as pilot centers to demonstrate the feasibility of including mentally disordered children in the current program. Such a demonstration would be evaluated to determine whether or not Development Center techniques are appropriate for this group of handicapped children.

### Zoning

#### Proposal #17

One of the major obstacles to the development of local facilities for mentally disordered children -- as well as other handicapped groups -- is restrictive zoning ordinances which prohibit the establishment of residential treatment programs in many communities throughout the State.

Because local treatment for children is preferable to care in remote facilities and because many local jurisdictions have chosen to ignore their responsibilities to foster the growth of such resources, it is proposed that the State Legislature declare its intent in this area by passing legislation to prevent local communities from discriminating against handicapped persons through restrictive zoning practices.

That this issue should be of legislative concern is reiterated by the Subcommittee on Children's Services, Conference of Local Mental Health Directors:

Since local criteria used in setting municipal and county land-use patterns almost universally fail to assure adequate attention to needs of specialized facilities serving impaired populations of all kinds, it is absolutely essential that state legislative leadership be given to efforts to modify local zoning practices. ...It is strongly urged consideration be given to legislative or administrative guidelines which clearly put local jurisdictions (including, most importantly, local municipal councils and planning commissions) that state policy requires adequate local attention to planning criteria which makes it possible for localities to supply within their own boundaries, in appropriate and convenient locations, such facilities as specialized supportive and rehabilitative residences, including group homes, foster homes, child day care homes, halfway houses, and the like.<sup>171</sup>

The following language is suggested for consideration by the Legislature:

The community care of the mentally and physically handicapped persons is of utmost concern to the State.

No city or county shall deny any permit, license, variance or exception to any family or facility who provides care for persons who are mentally or physically handicapped.

#### Probation

#### Proposal #18

The Legislature should conduct an analysis of the multiple functions of the probation departments. A solution to the chronic

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171. Letter to Assemblyman Frank Lanterman (2/20/70), Conference of Local Mental Health Directors, op. cit., pp. 20-21.

probation caseload and judicial overload problems could be found if legislation can be developed to shift responsibility for non-delinquent cases from the "juvenile justice" to other child care systems.

Proposal #19

County mental health agencies should be required to provide for rapid diagnostic services to all suspected mentally disordered Juvenile Court wards when requested to do so by Juvenile Court judges.

Proposal #20

Juvenile Court judges and referees should visit the placement facilities they now use for mentally disordered children.

County probation departments should initiate conferences with the private agencies, community mental health agencies, and neighboring probation departments to examine ways of developing additional child care resources. These efforts should include inter-agency planning to make better use of the various sources of funds which are available but are not now being fully used (i.e., Medi-Cal, Short-Doyle, special education, compensatory education, child welfare, etc.).

Proposal #21

Those counties currently serving "dependent and neglected" children in probation departments should be encouraged to transfer such children to the jurisdiction of the county protective services

agency in order to make maximum use of 75% federal reimbursement for casework services.

### Welfare

#### Proposal #22

The State currently pays \$80 per month toward the maintenance of an AFDC child in out-of-home placement. Costs for out-of-home care may vary from \$160 for a foster home to \$700 or \$800 in a residential treatment center. The State's contribution, however, remains constant no matter what service is being purchased and the county's are faced with picking up the balance of the cost of care out of the local general relief budget.

If the welfare program is truly a partnership arrangement between the State and the county, then the State's share of out-of-home care should be a proportional rate of the actual cost. Such a funding formula is presently being used in the Short-Doyle program (90% state - 10% county) and in the categorical aid program.

The State Department of Social Welfare should be requested to provide a study of the cost implications of setting up such a proportional funding formula.

APPENDIXES

PART I

- Appendix A: Questionnaire - Proposals Regarding Services To The Handicapped
- Appendix B: Alameda County Researchers

PART II

- Appendix C: State Hospital Statistics
- Resident Population In State Hospitals For Mentally Ill - 1936-1954
  - Admissions In State Hospitals For Mentally Ill - 1965-1969
  - Patients In Hospitals For Mentally Ill 1960-1969
  - Resident Population In State Hospitals For Mentally Ill (under 25) 1955-1959
  - Resident Population In State Hospitals For Mentally Ill (under 21) 1960-1969
  - Release Referral Study Percentage By Category And Age Group - Year Ending June 30, 1969
- Appendix D: Counties Responding To Select Committee Surveys
- Appendix E: Summary Of Results Of The Survey Conducted By The California Association For Mental Health
- Appendix F: Results of Confidential Family Survey
- Appendix G: Select Committee Questionnaires\*
- California Association For Mental Health Survey Of Community Resources For Mentally Ill Children

\* Questionnaires and survey forms are available upon request.

Appendix G: Select Committee Questionnaires (continued)

- Survey Of Private Facilities For Mentally Ill Children And Adolescents
- Survey Of Short-Doyle Services For Mentally Ill Children And Adolescents
- County Probation Questionnaire
- Survey Of Families Of Children At Napa State Hospital And Families Of Children On The Waiting List To Napa State Hospital
- Select Committee Patient Record Form (Napa Children's Unit)
- Survey Of Services For Children And Adolescents In State Hospitals For The Mentally Ill

APPENDIX A

QUESTIONNAIRE:\* PROPOSALS REGARDING SERVICES TO THE HANDICAPPED

Name: \_\_\_\_\_

Affiliation: \_\_\_\_\_

I. Information and Records

Currently, there is no way of determining how the handi-  
capped individual is meeting all his needs, what agencies  
are involved, and at what times. This type of information  
is vital for rational planning of services.

1. Do you consider this a problem?

YES (why) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NO (why) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROPOSED: A Data Bank and Information Retrieval System on  
the State and Local Level.

2. Is this a good idea? YES \_\_\_\_\_ NO \_\_\_\_\_

\*Please return questionnaire to Mr. Dale Carter, % Arthur Bolton  
Associates, 1731 I Street, Sacramento, California.

3. If the answer to Number 2 is "NO", do you have any other suggestions?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. If the answer to Number 2 is "YES", who should administer the data collection and processing?

- a) Regional Centers \_\_\_\_\_
- b) Short-Doyle Agencies \_\_\_\_\_
- c) Department of Rehabilitation \_\_\_\_\_
- d) Department of Public Health \_\_\_\_\_
- e) Department of Social Welfare \_\_\_\_\_
- f) Human Relations Agency \_\_\_\_\_
- g) County Superintendents \_\_\_\_\_
- h) School Districts \_\_\_\_\_
- i) Private Agency or Association \_\_\_\_\_
- j) All the Above \_\_\_\_\_
- k) Other \_\_\_\_\_

5. How should this system be funded?

- a) Money now spent on research components of existing programs \_\_\_\_\_
- b) New appropriations \_\_\_\_\_
- c) Agencies using the service \_\_\_\_\_
- d) Other (specify) \_\_\_\_\_

II. Coordination and Continuity of Services

Statutory and other constraints limit agencies to providing partial services or services limited to specific "categories" of handicap. Sometimes the services of these programs overlap; sometimes they are completely unconnected. Lack of coordination is particularly painful for the multi-handicapped who must deal with a multiplicity of agencies, programs, and requirements and who are often denied services by the manipulation of "primary" and "secondary" diagnoses.

6. Do you consider this a problem?

YES (why) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NO (why) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Which (if any) of the following alternatives would you prefer? (If you check more than one, indicate 1st, 2nd choice, etc.)

a) Expansion of Regional Centers for the Mentally Retarded to include all handicaps. YES \_\_\_\_\_ NO \_\_\_\_\_

- b) Establish case-worker and counseling units to assist all handicapped persons to locate and obtain the services they need. YES \_\_\_\_\_ NO \_\_\_\_\_
- c) Establish regional centers for each category of handicap. YES \_\_\_\_\_ NO \_\_\_\_\_
- d) Expand the functions of Short-Doyle agencies to serve more categories of handicap. YES \_\_\_\_\_ NO \_\_\_\_\_
- e) Expand the functions and funding of child development centers, remove age limitations to serve as resource centers for all handicapped. YES \_\_\_\_\_ NO \_\_\_\_\_
- f) Establish coordinating councils for the handicapped in every community to improve the flow of information and encourage cooperation. YES \_\_\_\_\_ NO \_\_\_\_\_
- g) Establish at the state level, a bureau or department for the handicapped with budgetary and policy authority over all programs now serving the handicapped. YES \_\_\_\_\_ NO \_\_\_\_\_

8. Who should be responsible for the administration of the program(s) you selected above? (state agency, private organization, etc.)

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8a. Should the program(s) you selected concentrate its priorities on early intervention and treatment?

YES \_\_\_\_\_ NO \_\_\_\_\_

9. How should the program(s) you selected be funded?

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10. How should the program(s) be staffed?

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11. Should such a program be subject to civil service requirements?

YES (why) \_\_\_\_\_

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NO (why) \_\_\_\_\_

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III. The Funding Problem

Presently, programs start and stop within various eligibility limits -- some rational, some irrational. As a result, funds are available for certain services for certain clients but not available to others with similar needs.

12. Do you think this is a problem?

YES (why) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NO (why) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROPOSED: Consolidate CCS, AB, APSB, and ATD Programs and Coordinate with Medi-Cal Funding to Assure that both the Medical and Support Needs of the Handicapped are met on a Continuing Basis. (Obviously this involves removing age restrictions.)

13. Do you think this is a good idea? YES \_\_\_\_\_ NO \_\_\_\_\_

14. If you do NOT think this is a good idea, why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROPOSED: Out-of-home Placement for any Handicapped Child Should Follow the Provisions of A.B. 225 (for the retarded) Which States That Charges to Parents Shall be According to Ability to Pay But in no Case Shall Exceed the Cost of Caring for a Normal Child at Home.

17. Do you think this is a good idea? YES \_\_\_\_\_ NO \_\_\_\_\_

18. If you do NOT think this is a good idea, why? \_\_\_\_\_

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IV. Licensing of Private Facilities

Three state departments (Mental Hygiene, Public Health, and Social Welfare) are responsible for licensing residential care facilities. The way the respective jurisdictions are defined creates problems of dual licensing, confusion for applicants, and difficulties in program supervision. The present system of licensing operates in such a way that a mildly retarded boy in a state hospital cannot return to the community and the public school program because available homes are licensed by the Department of Mental Hygiene rather than the Department of Social Welfare.

19. Do you consider licensing a problem?

YES (why) \_\_\_\_\_

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NO (why) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROPOSED: Facilities for Out-of-Home Placement Should be  
Licensed by a Single Agency on the Basis of Uniform  
Minimum Standards with such Special Requirements  
as Necessary for Special Problems.

20. Is this a good idea? YES \_\_\_\_\_ NO \_\_\_\_\_

21. If you do NOT think this is a good idea, why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

22. If you think this is a good idea, what agency should  
be responsible for inspection and licensing?

- a) Department of Public Health \_\_\_\_\_
- b) Department of Social Welfare \_\_\_\_\_
- c) Department of Mental Hygiene \_\_\_\_\_
- d) New licensing bureau \_\_\_\_\_
- e) Cooperative agreement as is now permitted by law \_\_\_\_\_
- f) Other \_\_\_\_\_

23. Should private associations play a part in licensing?  
YES \_\_\_\_\_ NO \_\_\_\_\_

24. If so, which ones and how?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

V. Special Education

We have found the major problems of special education to be 1) the great variations in quality, 2) placement of pupils in programs bringing the most favorable apportionments from the state, and 3) the misplacement of children in these programs -- particularly in the EMR programs.

25. Do you think these problems exist?

YES (which ones) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NO (why) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROPOSED: Make the E.H. (Educationally Handicapped) Program Mandatory.

26. Is this a good idea? YES (why) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NO (why) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROPOSED: Develop a Formula for Special Education Funding that  
1) Rewards Districts and Counties for Accomplishing  
Certain Objective Criteria (return to normal class-  
room for E.H., EMR, Physically Handicapped) and 2)  
Rewards Districts and Counties for Making Adjustments  
and Hiring Personnel to Integrate Handicapped Pupils  
into the Regular Classroom and School Activities.

27. Is this a good idea? YES \_\_\_\_\_ NO \_\_\_\_\_

28. If you do NOT think this is a good idea, why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

29. Should the county superintendent's office perform  
all the screening for special education? YES \_\_\_ NO \_\_\_

30. Could an educational component of a regional center  
(expanded to include all handicaps) perform the  
screening for special education? YES \_\_\_\_\_ NO \_\_\_\_\_

VI. Employment

Although many handicapped people are "rehabilitated" to the extent that their productivity can secure them job placement, more are considered never able to compete in the "normal" world. Both the "rehabilitated" handicapped and those whose productivity may actually be quite limited face a good deal of prejudice and discrimination in hiring practices.

31. Do you consider this a problem? YES \_\_\_\_\_ NO \_\_\_\_\_

32. If you do NOT consider this a problem, why? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PROPOSED: Require a Non-Discrimination Clause Relating to Handicapped in State Contracts.

33. Is this a good idea? YES \_\_\_\_\_ NO \_\_\_\_\_

PROPOSED: Aid to the Blind Provided for the Hiring of Blind Social Workers. Provide for the Hiring of the Handicapped in Suitable Capacities in Other Programs.

34. Is this a good idea? YES \_\_\_\_\_ NO \_\_\_\_\_

PROPOSED: A System of Tax Breaks for Business and Industry Employing the Handicapped.

35. Is this a good idea? YES \_\_\_\_\_ NO \_\_\_\_\_

PROPOSED: The State Should Pay the Difference Between Minimum Wage and Measured Productivity for Handicapped Persons Hired in Private Business and Industry.

36. Is this a good idea? YES \_\_\_\_\_ NO \_\_\_\_\_

37. If you do NOT think this is a good idea, why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

38. If you do think this is a good idea, who should administer such a program?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

39. How would you fund such a program?

- a) Support funds now spent for unemployed handicapped \_\_\_\_\_
- b) Additional appropriations \_\_\_\_\_
- c) Federal grants \_\_\_\_\_
- d) Other \_\_\_\_\_

PROPOSED: Persons Now Engaged in Public and Private Sheltered Workshop Programs Should be Employed in Private Industry and Businesses. Private Enterprise Training

and Hiring the Handicapped Should Have Access to the Resources of the Department of Rehabilitation. The State Will Pay Private Workshop Personnel as Consultants to and Resources for Private Enterprise Training and Hiring the Handicapped.

40. Is this a good idea? YES \_\_\_\_\_ NO \_\_\_\_\_

41. Please feel free to comment further on any of your responses: \_\_\_\_\_  
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\_\_\_\_\_  
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APPENDIX B

## ALAMEDA COUNTY RESEARCHERS

Bela J. Bognar and Jean C. Chastain, graduate students in Community Mental Health at the University of California, Berkeley, were placed with Arthur Bolton Associates to do their field work. Supervised by Dr. Marc Pilisuk of the School of Social Welfare at Berkeley, their field work was to provide an in-depth study of the services for the handicapped in Alameda County--a supplement to the feasibility study's look at the statewide services.

Examining the system from the perspective of the agency professionals was Bela Bognar, who conducted interviews with representatives of twenty agencies providing services to various handicaps. A naturalized U. S. citizen from Hungary, he has studied and trained extensively both in this country and abroad, in social work and social services. His credits and experience in these fields are vast, including an M.S. in social work from the University of Wisconsin, lecturer and authority on comparative social welfare systems, with practical experience as a caseworker, professional social worker, and Director of Social Services, International Institute of Milwaukee County. A member and contributor of service to numerous professional and community organizations, he was awarded the First Milwaukee County Citizenship Award. His current post-graduate training at Berkeley is under a scholarship from the National Institute of Mental Health.

Jean C. Chastain conducted interviews with 22 families in order to view the system of services to the handicapped from the eyes of the consumers. A clinical psychologist, her 18 years in practice includes having operated a private diagnostic and treatment clinic for children with learning problems and working on a neurological diagnostic team. Also a social worker, her experience encompasses having been a natural parent worker for an adoption agency and developing a program for services to unwed mothers. Private child and family counseling is yet another of her credits.

APPENDIX C

RESIDENT POPULATION IN  
STATE HOSPITALS FOR MENTALLY ILL  
1936-1954

<u>Fiscal Year</u> <u>Ending 6/30</u>	<u>Total</u>	<u>Under 20</u>	<u>% of Total</u>	<u>Median Age</u>
1936	20,105	221	1.1	48.4
1937	20,737	166	0.8	49.4
1938	21,884	175	0.8	49.6
1939	22,608	136	0.6	50.0
1940	22,953	139	0.6	50.4
1941	23,345	163	0.7	50.4
1942	23,617	189	0.8	50.5
1943	24,240	194	0.8	50.8
1944	24,903	274	1.1	51.4
1945	25,810	258	1.0	51.9
1946	26,388	314	1.2	52.1
1947	27,544	302	1.0	52.9
1948	29,048	330	1.1	52.5
1949	30,305	293	1.0	52.7
1950	31,544	337	1.0	52.7
1951	32,268	313	1.0	
1952	32,272	334	1.0	53.0
1953	34,845	425	1.3	53.3
1954	35,915	453	1.3	53.1

Sources: Statistical Report of the Department of Mental Hygiene, State of California, 1946, p. 30, Table 4.

Statistical Report of the Department of Mental Hygiene, State of California, 1947 through 1954.

ADMISSIONS IN STATE HOSPITALS FOR THE MENTALLY ILL

Fiscal Year Ending 6/30	Total	Ages 0-14	Ages 15-17	Ages 18-20	Total	Under 21	Median Age
					- Raw Figures	% of Total	
1965	27,231	445	779	1,104	2,328	8.5%	40.0
1966	26,800	437	737	1,227	2,401	9.0%	40.3
1967	28,834	433	821	1,437	2,691	9.3%	40.0
1968	31,481	455	933	1,815	3,203	10.2%	39.3
1969	35,739	483	1,351	2,315	4,149	11.6%	38.7

PATIENTS IN HOSPITALS FOR MENTALLY ILL

1960	36,556	213	248	462	923	2.5%	55.1
1961	35,690	259	260	498	1,017	2.8%	55.5
1962	35,743	266	320	566	1,152	3.2%	55.3
1963	34,955	341	352	654	1,347	3.9%	55.6
1964	32,622	---	---	---	1,302	4.0%	55.1
1965	30,193	361	390	595	1,346	4.5%	54.2
1966	26,552	361	373	606	1,340	5.0%	53.6
1967	21,966	344	376	616	1,336	6.1%	51.8
1968	18,831	339	378	683	1,400	7.4%	50.0
1969	16,116	343	475	668	1,486	9.2%	47.8

Source: Published annual tabulations for fiscal years ending 1965 through 1966, Statistical Bulletins and unpublished tables, Department of Mental Hygiene, Bureau of Biostatistics, February 11, 1970.



RELEASE REFERRAL STUDY  
PERCENTAGE BY CATEGORY AND AGE GROUP

(From 20 Percent Sample of Releases during Year Ending June 30, 1969)

Hospitals	N	Own home	Family care	Foster care	Group living	Nursing facility	Youth Au- thority	Juven- ile Court	Other	Un- known
	100.0									
Totals	720	65.0	3.6	2.4	2.1	0.1	4.0	9.0	11.9	12.0
Agnews	78	67.9	-	-	2.6	-	6.4	2.6	20.5	-
0-15	7	42.8	-	-	-	-	14.4	-	42.8	-
16-17	19	73.7	-	-	-	-	10.5	5.3	10.5	-
18-20	52	69.2	-	-	3.8	-	5.8	-	21.2	-
Atascadero	21	9.5	4.8	-	-	-	19.0	9.5	57.2	-
0-15	2	-	-	-	-	-	-	100.0	-	-
16-17	2	-	-	-	-	-	100.0	-	-	-
18-20	17	11.8	5.9	-	-	-	11.8	-	70.5	-
Camarillo	158	63.9	5.1	0.7	3.8	-	4.4	15.8	6.3	-
0-15	71	66.2	9.9	1.4	-	-	5.6	15.5	1.4	-
16-17	28	39.3	3.6	-	3.6	-	10.7	35.7	7.1	-
18-20	59	72.9	-	-	8.5	-	-	6.8	11.8	-
DeWitt	31	77.5	9.7	-	-	-	-	6.4	6.4	-
0-15	1	100.0	-	-	-	-	-	-	-	-
16-17	7	57.1	14.3	-	-	-	-	28.6	-	-
18-20	23	82.6	8.7	-	-	-	-	-	8.7	-
Mendocino	59	72.9	3.4	1.7	1.7	-	-	8.5	8.5	3.4
0-15	7	71.4	14.3	-	-	-	-	14.3	-	-
16-17	16	68.8	6.2	-	-	-	-	25.0	-	-
18-20	36	75.0	2.8	-	2.8	-	-	-	13.9	5.5
Metropolitan	100	69.0	-	5.0	-	1.0	6.0	2.0	6.0	11.0
0-15	2	100.0	-	-	-	-	-	-	-	-
16-17	17	76.5	-	-	-	-	5.9	-	-	17.6
18-20	81	66.7	-	6.2	-	1.2	6.2	2.4	7.4	9.9
Napa	159	66.0	3.1	3.8	3.8	-	1.3	11.3	10.7	-
0-15	60	53.3	6.7	8.3	1.7	-	-	28.3	1.7	-
16-17	26	65.4	-	3.8	3.8	-	-	3.8	23.1	-
18-20	73	76.7	1.4	-	5.5	-	2.7	-	13.7	-
Patton	82	62.2	8.5	3.7	-	-	2.4	6.1	17.1	-
0-15	4	100.0	-	-	-	-	-	-	-	-
16-17	27	59.3	7.4	-	-	-	-	18.5	14.8	-
18-20	51	60.8	9.8	5.9	-	-	3.9	-	19.6	-
Stockton	32	62.5	-	3.1	-	-	9.4	12.5	12.5	-
0-15	1	100.0	-	-	-	-	-	-	-	-
16-17	14	50.0	-	7.1	-	-	14.3	21.4	7.1	-
18-20	17	70.6	-	-	-	-	5.9	5.9	17.6	-

APPENDIX D

COUNTIES RESPONDING TO  
SELECT COMMITTEE SURVEYS

x - indicates CAMH Survey received

o - indicates Local Mental Health  
Directors (Short-Doyle) Survey  
received

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Alameda	x o	Madera	o	San Luis Obispo	o
Alpine		Marin	o	San Mateo	x
Amador	x	Mariposa		Santa Barbara	x o
Berkeley	x	Mendocino	o	Santa Clara	o
Butte	x	Merced	x o	Santa Cruz	
Calaveras		Modoc		Shasta	
Colusa		Mono		Sierra	
Contra Costa	x o	Monterey		Siskiyou	o
Del Norte		Napa	o	Solano	x
El Dorado	x	Nevada		Sonoma	x o
Fresno		Orange	o	Stanislaus	
Glenn	x	Placer		Sutter	
Humboldt		Plumas		Tehama	x
Imperial		Riverside	x o	Trinity	
Inyo		Sacramento	x o	Tulare	x
Kern	x	San Benito	x	Tuolumne	o
Kings	x	San Bernardino	x	Ventura	o
Lake	o	San Diego	x o	Yolo	x
Lassen		San Francisco	x	Yuba	
Los Angeles	x	San Joaquin	x o		

APPENDIX E

COMMUNITY RESOURCES FOR MENTALLY ILL CHILDREN

Summary of Results  
of the  
Survey Conducted by

The California Association for Mental Health

for

The Assembly Select Committee on Mentally Ill and Handicapped Children

PRE-SCHOOL SCREENING

Counties	Rate Range	Program Capacity	Age Range	Waiting List
Alameda	Free to \$15/visit	Open	0-6	Up to 6 mos.
Contra Costa	0 - \$350/mo.	33	0-6	Yes
Lake	N/R*	---	---	---
Madera	0	Open	3-6	Yes
Marin	Sliding	Open	All	No
Mendocino	N/R	---	---	---
Merced	0	60	4	No
Napa	0	15	2-7	---
Orange	---	225	3-5	---
Riverside	0	23	0-6	Yes
Sacramento	Sliding	30	3-7	Yes
San Diego	0	225	3-5	For 1 of 2 programs
San Joaquin	Sliding	30	0-6	No
San Luis Obispo	Sliding	Open	0-6	---
Santa Barbara	0	Open	2 up	No
Santa Clara	0	541	3-5	721
Siskiyou	N/R	---	---	---
Sonoma	N/R	---	---	---
Tuolumne	---	0	---	---
Ventura	0	Open	0-6	No

\*N/R - no response

SCHOOL SCREENING

Counties	Rate Range	Program Capacity	Age Range	Waiting List
Alameda	0 - \$15/visit	Open	5-18	Up to 6 mos.
Contra Costa	0 - \$350/mo.	33	0-6	Yes
Lake	N/R	---	---	---
Madera	0	Open	5-18	No
Marin	\$85	Open	5-18	No
Mendocino	N/R	---	---	---
Merced	Sliding	540	All	No
Napa	None	Open	All	79
Orange	None	Open	School age	---
Riverside	None	Open	5-21	No
Sacramento	N/R	---	---	---
San Diego	0	11 of 18 district open	5-18	---
San Joaquin	None	Open	All	No
San Luis Obispo	Sliding	Open	5-18	---
Santa Barbara	0	Open	5 up	0
Santa Clara	N/R	---	---	---
Siskiyou	0 - \$25/visit	Open	7-18	No
Sonoma	N/R	---	---	---
Tuolumne	None	Open	6-15	No
Ventura	None	Open	5-18	No

SPECIAL CLASSES - PUBLIC SCHOOLS  
(Educationally Handicapped)

Counties	Rate Range	Program Capacity	Age Range	Waiting List
Alameda	---	2,452	5-18	---
Contra Costa	None	2,417	5-18	Yes
Lake	None	65	6-12	Yes
Madera	0	82	6-18	Yes
Marin	No	935	5-18	---
Mendocino	None	304	5-18	Yes
Merced	None	169	8-14	---
Napa	0	371	5-21	Yes
Orange	None	2,144	School age	No
Riverside	None	540	5-18	For some
Sacramento	None	1,184	6-18	For placement
San Diego	0	3,438	5-19	9 of 18 Districts
San Joaquin	None	845	All	No
San Luis Obispo	None	276	5-18	No
Santa Barbara	0	155	5-18	2 of 6 Districts
Santa Clara	No	2,058	6-18	---
Siskiyou	None	124	8-18	5 of 8 classes
Sonoma	---	36	6-15	Yes
Tuolumne	0	71	6-21	No
Ventura	None	Unknown	---	---

**SPECIAL SCHOOLS**  
(Not Educationally Handicapped)

Counties	Rate Range	Program Capacity	Age Range	Waiting List
Alameda	0 - \$7/hr.	170	3-21	Open
Contra Costa	\$10/hr.-\$1800/yr.	227	5-19	No
Lake	None	102	6-20	No
Madera	---	0	---	---
Marin	Up to \$750	266	5-18	1 of 4 Programs
Mendocino	N/R	---	---	---
Merced	None	120	4-14	---
Napa	0	19	13-14	No
Orange	\$90-300/mo.	266	All	2 of 4 Programs
Riverside	None	537	5-18	For some
Sacramento	---	0	---	---
San Diego	0	158	6-14	1 of 3 Districts
San Joaquin	None	250	All	Yes
San Luis Obispo	---	0	---	---
Santa Barbara	\$200 - \$1,000	215	3 up	Yes
Santa Clara	No	195	All	No
Siskiyou	None	90	8-21	1 of 4 Classes
Sonoma	---	207	6-18	0
Tuolumne	---	0	---	---
Ventura	up to \$40	38	3-8 12-16	Yes

REHABILITATION & VOCATIONAL PROGRAMS

Counties	Rate Range	Program Capacity	Age Range	Waiting List
Alameda	0 - \$36.56/day	355 (200 (at Goodwill))	to 25	1 wk.-5 mos.
Contra Costa	---	0	---	---
Lake	N/R	---	---	---
Madera	---	0	---	---
Marin	Sliding	210	16 up	1 of 2 Programs
Mendocino	N/R	---	---	---
Merced	Sliding	Open	All	---
Napa	0	53	16 up	No
Orange	Sliding	190	All	No
Riverside	Sliding	98	2 up	200
Sacramento	Sliding	30	3-7	Yes
San Diego	0	20	---	None
San Joaquin	None	111	14 up	No
San Luis Obispo	---	98	12-21	No
Santa Barbara	0	Open	16-18	0
Santa Clara	\$5/day	23	3-6	Yes
Siskiyou	N/R	---	---	---
Sonoma	N/R	---	---	---
Tuolumne	---	0	---	---
Ventura	None	226	Open	Yes

OUTPATIENT CLINICS

Counties	Rate Range	Program Capacity	Age Range	Waiting List
Alameda	up to \$25/visit	328	0-18	up to 5 wks.
Contra Costa	\$1 - \$30/visit	Open	5-21	No
Lake	N/R	---	---	---
Madera	N/R	---	---	---
Marin	Sliding	590	All	2 of 7 Programs
Mendocino	N/R	---	---	---
Merced	Sliding	Open	All	---
Napa	---	50	6-21	No
Orange	Sliding	16 prog.	All	No
Riverside	Sliding	84	3-19	Yes
Sacramento	Sliding	200	to 18	Yes (very long)
San Diego	Sliding to \$50/visit	1,225	All	No
San Joaquin	Sliding	442	All	5 of 7
San Luis Obispo	Sliding	40	All	---
Santa Barbara	Sliding	317	2-21	---
Santa Clara	up to \$34/visit	579	All	7 of 10
Siskiyou	\$1 - \$25/visit	150	7 up	None
Sonoma	N/R	---	---	---
Tuolumne	Sliding	10	All	None
Ventura	up to \$60/mo.	780	3 1/2 up	For some

DAY CARE CENTERS

<u>Counties</u>	<u>Rate Range</u>	<u>Program Capacity</u>	<u>Age Range</u>	<u>Waiting List</u>
Alameda	Ability	20	4-12	3-6 mos.
Contra Costa	\$18/day-\$40/mo.	81	Infancy to teens	---
Lake	N/R	---	---	---
Madera	up to \$4/day	10	2-8	0
Marin	up to \$300/mo.	669	3-18	No
Mendocino	N/R	---	---	---
Merced	Sliding	30	All	---
Napa	0	60	3-5	120
Orange	---	0	---	---
Riverside	---	0	---	---
Sacramento	---	0	---	---
San Diego	\$25/visit	5	All	---
San Joaquin	Sliding	10	14 up	No
San Luis Obispo	---	0	---	---
Santa Barbara	Sliding	18	14-21	---
Santa Clara	\$8.33-\$26.40/day	105	All	3 of 8
Siskiyou	---	0	---	---
Sonoma	Sliding	30	3-5	Yes
Tuolumne	---	0	---	---
Ventura	Sliding	51	All	---

GROUP LIVING

<u>Counties</u>	<u>Rate Range</u>	<u>Program Capacity</u>	<u>Age Range</u>	<u>Waiting List</u>
Alameda	\$450-1100/mo.	61	8-18	4-6 mos.
Contra Costa	---	0	---	---
Lake	N/R	---	---	---
Madera	up to \$4/day	10	2-8	0
Marin	up to \$714/mo.	85	6-18	Yes
Mendocino	N/R	---	---	---
Merced	---	0	---	---
Napa	---	0	---	---
Orange	---	0	---	---
Riverside	Sliding to \$400/mo.	102	11-17	Yes
Sacramento	---	0	---	---
San Diego	up to \$600/mo.	60	to 16	---
San Joaquin	---	10	14-18	Yes
San Luis Obispo	---	0	---	---
Santa Barbara	Sliding	13	13-18	No
Santa Clara	\$270/mo.	178	13-18	No
Siskiyou	---	0	---	---
Sonoma	\$225/mo.	18	6-18	---
Tuolumne	---	0	---	---
Ventura	\$160/mo.	27	6-18	---

FOSTER CARE

<u>Counties</u>	<u>Rate Range</u>	<u>Program Capacity</u>	<u>Age Range</u>	<u>Waiting List</u>
Alameda	N/R	---	---	---
Contra Costa	\$160/mo.	28	5 up	No
Lake	N/R	---	---	---
Madera	N/R	---	---	---
Marin	None	Open	All	No
Mendocino	N/R	---	---	---
Merced	---	0	---	---
Napa	---	0	---	---
Orange	Sliding	Unknown	1-18	No
Riverside	None	12	6-18	None
Sacramento	Sliding	Open	to 21	No
San Diego	\$160/mo.	900	All	---
San Joaquin	up to \$275/mo.	61	All	None
San Luis Obispo	N/R	---	---	---
Santa Barbara	---	3	to 18	Yes
Santa Clara	\$20 - \$25.40	968	0-19	---
Siskiyou	---	0	---	---
Sonoma	N/R	---	---	---
Tuolumne	---	0	---	---
Ventura	---	0	---	---

PROTECTIVE SERVICES

<u>Counties</u>	<u>Rate Range</u>	<u>Program Capacity</u>	<u>Age Range</u>	<u>Waiting List</u>
Alameda	None	275	0-14	No
Contra Costa	None	260	Infant up	None
Lake	N/R	---	---	---
Madera	0	334	0-16	0
Marin	No	Open	All	No
Mendocino	N/R	---	---	---
Merced	Sliding	Open	0-21	---
Napa	0	Open	0-18	0
Orange	Sliding - \$10/day	142	to 18	No
Riverside	None	30	0-18	No
Sacramento	---	0	---	---
San Diego	None	Open	All	No
San Joaquin	None	65	0-18	None
San Luis Obispo	Sliding	91	All	Yes
Santa Barbara	---	Open	0-21	---
Santa Clara	0 - \$11/day	Open	0-20	No
Siskiyou	0	Open	0-18	0
Sonoma	N/R	---	---	---
Tuolumne	---	20	0-21	No
Ventura	---	Open	---	---

RESIDENTIAL TREATMENT FACILITIES

<u>Counties</u>	<u>Rate Range</u>	<u>Program Capacity</u>	<u>Age Range</u>	<u>Waiting List</u>
Alameda	\$650 - \$1100	64	6-18	4 to 5 mos.
Contra Costa	---	0	---	---
Lake	N/R	---	---	---
Madera	N/R	---	---	---
Marin	to \$714/mo.	142	13-19	Yes
Mendocino	N/R	---	---	---
Merced	---	0	---	---
Napa	---	0	---	---
Orange	---	0	---	---
Riverside	---	0	---	---
Sacramento	\$300-\$600/mo.	297	All	---
San Diego	\$18-\$35/day	99	6-17	Yes
San Joaquin	---	0	---	---
San Luis Obispo	---	0	---	---
Santa Barbara	Sliding	6	All	Yes
Santa Clara	\$12-\$25/day	107	5-19	No
Siskiyou	N/R	---	---	---
Sonoma	N/R	---	---	---
Tuolumne	---	0	---	---
Ventura	---	0	---	---

SHORT-TERM INPATIENT HOSPITAL

<u>Counties</u>	<u>Rate Range</u>	<u>Program Capacity</u>	<u>Age Range</u>	<u>Waiting List</u>
Alameda	Sliding to \$640 per week	39	14 up	No
Contra Costa	\$80/day	4	14-21	1 week
Lake	N/R	---	---	---
Madera	N/R	---	---	---
Marin	Sliding to \$70/day	8	All	1 of 2
Mendocino	N/R	---	---	---
Merced	Sliding	14	All	---
Napa	---	3	5-17	0
Orange	Sliding	10	0-8	No
Riverside	Sliding	Few	11 up	Yes
Sacramento	Sliding	75	0-21	No
San Diego	\$45-\$67/day	122	All	No
San Joaquin	up to \$35/day	4	14 up	Yes
San Luis Obispo	Sliding	4	12-18	---
Santa Barbara	Sliding to \$52/day	8	13 up	---
Santa Clara	\$49-\$74/day	13	12-19	No
Siskiyou	\$1-\$25/day	10	12 up	0
Sonoma	N/R	---	---	---
Tuolumne	---	0	---	---
Ventura	Sliding	20	All	No

<u>QUESTION</u>	<u>N</u>	<u>% OF TOTAL</u>
7. Who helped make the decision to place your child in the State Hospital?		
Probation Department	26	29
Welfare Department	12	8
Private Doctor	32	36
Public School	13	14
Other	38	42
(Community Mental Health Center)		
(Social Worker)		
(School Psychologist)		
8. What is your yearly family income?		
Less than \$4,000	22	24
\$ 4,000 - 5,000	13	14
\$ 6,000 -10,000	26	29
\$10,000 -15,000	21	23
Over \$15,000	4	4
Would not object to being interviewed by a member of the committee staff:	79	88

DRUG ABUSE

Counties	Rate Range	Program Capacity	Age Range	Waiting List
Alameda	0-\$650/wk.	1,590	4 up	to 1 yr.
Contra Costa	None	13 prog.	Open	No
Lake	N/R	---	---	---
Madera	0	Open	All	No
Marin	0-sliding	Open	All	No
Mendocino	None	Open	All	No
Merced	Sliding	35	13-19	---
Napa	---	10	12 up	---
Orange	None	6 prog.	All	No
Riverside	None	Open	All	No
Sacramento	None	Unknown	All	No
San Diego	0-sliding	Open	All	No
San Joaquin	Sliding	Open	All	No
San Luis Obispo	Sliding	1 prog.	All	---
Santa Barbara	Sliding	Open	All	No
Santa Clara	0	Open	All	No
Siskiyou	\$1-\$25/day	Open	All	No
Sonoma	No	Open	All	No
Tuolumne	0	Open	All	No
Ventura	Sliding	?	All	Yes