A Tale of Two Settings

Institutional And Community-Based Mental Health Services In California Since Realignment In 1991

Michael Stortz
Disability Rights California
433 Hegenberger Road, Suite 220
Oakland CA 94621
510-430-8033
January 2003

Table of Contents

A Tale of Two Settings 1

Table of Contents i

Executive Summary 1

Introduction 5

I. Overview of State Mental Health System 6

II. Overview of ADA & *Olmstead* Decision 7

III. The Number of Beds in Segregated, Long-term Psychiatric Settings Increased between 1991 and 2001. 8

1. State Hospitals 8
   a. Decreased Placement of LPS Conservatees 8
   b. Increased Placement of Forensic Patients 9
   c. Decreased Levels of Care for LPS Conservatees 9
   d. Increased Cost of Care for LPS Conservatees 9
2. Skilled Nursing Facilities with Special Treatment Programs (SNF/STPs) 10
   a. Few SNFs have Special Treatment Programs (STPs) 10
   b. Increased SNF/STPs Facility Beds 11
   c. Conversion of SNF/STP Facility Beds to MHRCs 11
   d. County Supplement to SNF/STP Cost of Care 11
3. Mental Health Rehabilitation Centers (MHRCs) 12
   a. Few MHRCs are New Programs 12
   b. Most MHRCs are Comparable in Size to SNF/STPs 12
4. Community Treatment Facilities (CTFs) for Minors 13

IV. The Number of Involuntary Holds and Administrative Day Services in Segregated, Short-term Psychiatric Settings Has Increased Despite a Decrease in the Number of such Facilities, which Reflects Inadequate Home- and Community-based Options. 15

1. Decrease in the Number of Beds 15
2. Increase in Number of Hospitalizations 15

V. Counties Have Developed Home- and Community-based Services but Access to Such Assistance Remains Very Limited. 17
1. Integrated Service Systems 17
   a. Children's Systems of Care 17
   b. Adult and Older Adult Systems of Care 18
   c. Inclusion of Persons who are Homeless and/or at Risk of Jail/Prison 19
2. Self Help and Peer Support 20
3. Supported Housing Programs 21
4. Certified Residential Treatment Services (CRTS) 22
   a. Extremely Limited Access to Crisis Residential Services 22
   b. Very Limited Access to Transitional Residential Services 23
5. Targeted Case Management/Brokerage Services 23
6. Individual (One-to-One) Mental Health Rehabilitation Services 23
   a. Rehabilitation is Distinct from Personal Care Services 24

VI. Funding for Voluntary Mental Health Services in Home- and Community-based Settings is Inadequate. 26
1. Capped Funding for Medi-Cal Mental Health Entitlement 26
2. Limited Funding for Bronzan-McCorquodale Act Services 27
3. Disparate Funding and Size of Facilities under Community Care Facility Act 27

VII. Criminalization of Persons with Psychiatric Disabilities Continues. 30

VIII. Inter-county Transfers of Persons with Psychiatric Disabilities Continue. 32

IX. Recommendations 34

Appendix One: Medi-Cal Specialty Mental Health Services Available under the California State Medicaid Plan 40

Appendix Two: Patient Bed Capacity* at Four Segregated, Long-Term Psychiatric Settings in California: 1991/1992 – 2001 44

Appendix Three: State Hospital Bed Allocations/ Purchases: FY 1991 – 92 to FY 2000 – 01 45

Appendix Four: State Hospital Census & Legal Commitments 6/27/01 48

Appendix Five: Types of Legal Commitments for Residents at State Hospitals 6/27/01 49

Appendix Six: Level of Care for LPS Conservatees at NSH, MSH, and CSH FY 1992-93 & FY 2000-01........50

Appendix Seven: Level of Care for all State Hospital Residents - 2001...........51

Appendix Eight: State Hospital County Bed Daily Rates FY 1991-92 & FY 2001-02........52

Appendix Nine: Skilled Nursing Facilities w/ Certified Special Treatment Programs (SNF/STPs) – June 2001........53

Appendix Ten: Mental Health Rehabilitation Centers (MHRCs): 1995 -2001 55

Appendix Eleven: Community Treatment Facilities (CTFs) in Operation as of July 12, 2001........56

Appendix Twelve: Certified Residential Treatment Services (CRTS): 2001...57

Appendix Thirteen: Medi-Cal Short Term Crisis Residential Treatment Facilities - 2001........58

Appendix Fourteen: Medi-Cal Adult Transitional Residential Facilities -2001 59

Appendix Fifteen: 19 of 35 Largest State Correctional Facilities Providing Mental Health Care to Inmates on June 30, 2000, Were in California..60

Executive Summary

Contrary to state and federal policies that support access to home- and community-based services, California's mental health system has increased the number of beds in segregated, long-term psychiatric facilities since realignment in 1991. Total capacity in state hospitals, Skilled Nursing Facilities with Special Treatment Programs (SNF/STPs), Mental Health Rehabilitation Centers (MHRCs), and Community Treatment Facilities (CTFs) for minors increased by 1,765 beds (or 22.6%) between 1991/92 and 2001.

In addition to an overall increase in segregated, long-term psychiatric facility beds in California, the legal classification of persons placed in these facilities has changed. In 1991, state hospitals mainly housed persons subject to involuntary commitment under the Lanterman-Petris-Short (LPS) Act. Since realignment, counties reduced the number of beds they purchase at state hospitals, which now mainly house persons subject to Penal Code commitments.

The reduced number of state hospital beds contracted by counties correlates with the increased number of other institutional settings for persons subject to long-term LPS commitment. For example, between FY 1991-92 and FY 1993-94, there was an 821 bed reduction in the number of state hospital beds contracted by counties. Between 1991 and 1993, however, the California Department of Mental Health (DMH) approved certification for an additional 1,043 SNF/STP beds. Further, between 1995 and 2001, DMH increased the number of MHRC beds available for counties from zero (0) to 1,283 beds, as this was a new facility designation. In 1994, another new institutional setting emerged — CTFs for minors, for whom DMH certified 82 beds as of mid-2001.

The impact of changes in facility certification or designation is unclear given that many of the "new" facilities are old facilities that have adopted new certifications or designations. For example, as of 2001, most MHRCs were not new facilities but previously operated as SNF/STPs. They were also comparable in size to SNF/STPs, which have an average capacity of about 100 beds. There is a need for evaluation of the quality of care provided in all segregated, long-term psychiatric settings, as well as a need to determine if persons placed in these facilities could be assisted in home- and community-based settings with appropriate services. (*See* Recommendation Number One at page 34 of this report.)

The use of segregated, *short-term* psychiatric settings also has changed since realignment in 1991. DMH reports that there was a 12.6 percent decrease in the number of acute psychiatric facility beds statewide between 1989 and 1998.

Between FY 1990-91 and FY 1998-99, the number of involuntary, short-term hospitalizations under the LPS Act increased statewide. The number of persons readmitted within 30 days of discharge from inpatient services increased by 26 percent between FY 1993-94 and FY 1998-99. Increased involuntary hold and readmission rates reflect a lack of integrated, system of care services (that is, self-help and peer support; supported housing; crisis residential services; case management/brokerage services; therapeutic behavioral services; individual (one-to-one) mental health rehabilitation services; substance abuse services; and other dual diagnosis services) to meet individual needs at home and in the community.

The California Legislature has repeatedly recognized the benefits of integrated service systems for persons with psychiatric disabilities. In 1992, it enacted the Children's Mental Health Services Act to expand the Children's System of Care model to all counties. In 1996, it enacted the Adult and Older Adult Mental Health System of Care Act for integrated services for adults and older adults across the state. In 1999, in recognition of "the long-standing problem of the under funded community mental health system" and resultant experiences of "adults being homeless, incarcerated in jails, and hospitalized," the legislature amended the Adult and Older Adult Mental Health System of Care Act to promote client-directed outreach to persons homeless and at risk of incarceration. The legislature has repeatedly recognized that integrated service programs have demonstrated quality and cost-effectiveness. But very limited state funding for these initiatives has met only a fraction of the need.

In 1993, the state amended its Medicaid (Medi-Cal in California) plan to include optional, rehabilitative mental health services (so-called "Rehab Option" services). Under the Rehab Option amendment, Medi-Cal eligible persons have rights to - among other services - crisis residential treatment and adult transitional residential treatment to prevent hospitalization and other institutional placement. But access to such assistance is extremely limited. In 2001, only 16 of 58 California counties had Medi-Cal crisis residential facilities; there were 29 facilities statewide with a total capacity for 340 persons. Only 19 of 58 counties had Medi-Cal adult transitional facilities; there were 49 facilities statewide with a total capacity for 608 residents. Medi-Cal mental health services also include Targeted Case Management/Brokerage Services to help a person access needed medical, educational, social, prevocational, rehabilitative, or other community services. Further, Medi-Cal Rehab Option services include individual (one-to-one) mental health rehabilitation to assist with activities of daily living, socialization, vocational or educational goals, and interpersonal skills at work, at school, at home, or elsewhere in the community. Persons with psychiatric disabilities, and their family members or advocates, may be unaware of their right to request and

receive such assistance on a voluntary basis. (*See* Recommendation Number Two at page 36 of this report.)

Funding for voluntary access to mental health services in home- and community-based settings is inadequate. With regard to Medi-Cal, the federal government provides financial reimbursement for covered services provided to eligible persons; a state's share of financial reimbursement is referred to as the "state match." In California, the total state match for Medi-Cal covered physical health services is based on individual need and is open-ended (from the General Fund) or "capitated" based on sound actuarial data concerning individual need. For Medi-Cal mental health services, however, the state match is "capped" based on the amount of sales tax and vehicle license fee revenues deposited in the mental health trust account under the realignment legislation. Counties have assumed the financial risk for funding services to adults, but supplemental county funding is unrealistic at best. As a result of the state cap on funds for adult services, counties do not recognize that Medi-Cal-covered mental health services are part of a federal entitlement program for adults as well as children.

With regard to other services, counties are required to serve persons who are not Medi-Cal eligible, or to provide assistance that is not covered by Medi-Cal, only "to the extent resources are available." This means that counties have a responsibility to provide non-entitlement services only to the extent that there is funding in the realignment trust accounts after serving Medi-Cal-eligible persons.

Further, rates for private residential facilities that serve persons with psychiatric disabilities appear inequitable. In 2001, the basic residential rate for providers serving persons with psychiatric disabilities was $771.00 per month, whereas residential care facility rates for providers serving persons with developmental disabilities ranged from $771.00 to $1,877.00 per month for owner operated facilities, and from $771.00 to $4,938.00 per month for staff operated facilities. This suggests a grossly inequitable system of rates for facilities serving persons with psychiatric disabilities, contrary to state law requiring DMH to establish equitable rates. (*See* Recommendation Number Three at page 37 of this report.)

As a result of the limited number of home- and community-based service slots available on a voluntary basis, persons with psychiatric disabilities too often find themselves with no choices: they are left to find their own way through the revolving door of hospitalization and discharge to the streets; they are forced into an institutional setting, including jail or prison; they are resigned to move from their home community to avoid homelessness or institutionalization; and they are scapegoated for the inadequacies of the home- and community-based mental health

system, as the recent struggle against AB 1421 illustrates. The evidence in this report and elsewhere suggests that a significant percentage of persons with psychiatric disabilities who need home- and community-based services are not getting them, and those who do get services get very few. (*See* Recommendation Number Four at page 38 of this report.)

This report includes four recommendations for policy makers to ensure access to voluntary housing and community support for persons with psychiatric disabilities as follows:

(1) DMH and California County Mental Health Directors should conduct a statewide evaluation of need for persons placed in institutional settings and implement a statewide integration plan;

(2) DMH should conduct a statewide audit of the extent to which county Mental Health Plans (MHPs) are providing Medi-Cal Specialty Mental Health Services consistent with statewide medical necessity criteria;

(3) The California Mental Health Planning Council should review and propose changes concerning several statewide access issues; and

(4) The California Legislature should review, assess and make recommendations to eliminate fiscal and other incentives that perpetuate the unnecessary confinement of persons with psychiatric disabilities in institutional settings.

We encourage all members of the mental health community to work together rather than against one another toward increasing access to and the quality of home- and community-based mental health settings.

Introduction

In 1991, the California Legislature shifted many responsibilities for the provision and funding of mental health services from the state to the counties. Assembly Bill (AB) 1288 (the so-called "Realignment" legislation)[1] also incorporated key components of the California Mental Health Master Plan, which was prepared by the Mental Health Planning Council.[2] California reiterated its policy that local governments provide mental health services and rehabilitation "in the most appropriate and least restrictive environment, preferably in [persons'] own communities."[3] Congress set a similar policy under the Americans with Disabilities Act (ADA), described in the *Olmstead* decision and discussed further below. This report[4] reviews the use and development of institutional and community-based mental health services since realignment and has six findings:[5]

1. The number of beds in segregated, long-term psychiatric settings increased in California between 1991 and 2001;
2. The number of involuntary holds and administrative days in segregated, short-term psychiatric settings has increased;
3. Access to home- and community-based service slots is very limited;
4. Funding for voluntary home and community services is inadequate;
5. The criminal justice system continues to serve as a major provider of services for persons with psychiatric disabilities; and
6. Persons with psychiatric disabilities often have no choice but to leave their home communities and counties to obtain assistance.

We make four recommendations to the California Department of Mental Health, California County Mental Health Directors, California Mental Health Planning Council and California Legislature for: (1) client-directed evaluations of persons in institutional settings for the provision of appropriate, home- and community-based mental health services; (2) audits of county Medi-Cal Mental Health Plans (MHPs) to ensure service access consistent with statewide criteria; (3) review and proposed changes concerning several statewide access issues; and (4) identification and elimination of incentives that perpetuate unnecessary institutional care.

---

[1] *See* California Welfare and Institutions Code (Welf. & Inst. Code) §§ 5600-5751, 5900, 17600 *et seq.*.
[2] S*ee* Welf. & Inst. Code §§ 5771-5772 (role and responsibilities of the Mental Health Planning Council).
[3] Welf. & Inst. Code § 5600.2(a)(4).
[4] This report is based on data obtained from the California Departments of Mental Health (DMH) and Social Services (CDSS) under the California Public Records Act (Government Code § 6250 *et seq.*).
[5] *See also* California Mental Health Planning Council, "Effects of Realignment on the Delivery of Mental Health Services" (January 1995).

I. Overview of State Mental Health System

Two primary state statutes govern procedural and substantive access to mental health services in California: the Lanterman-Petris-Short (LPS) Act[6] and the Bronzan-McCorquodale Act.[7] Enacted in 1967, the LPS Act contains procedures for the involuntary treatment of persons with psychiatric disabilities. The LPS Act focuses on procedural rights rather than on substantive rights to mental health services and rehabilitation. Enacted in 1991, the Bronzan-McCorquodale Act[8] contains substantive provisions for community mental health programs, including standards for access to "client directed"[9] and "culturally competent"[10] services.

Various state and federal laws and regulations govern mental health services funded under the federal Medicaid program (called "Medi-Cal" in California), which provides coverage for mandatory and optional services as state specified in the State Medicaid plan.[11] In 1993, California amended its State Medicaid plan to include optional Rehabilitative Mental Health Services (the so-called "Rehab Option").[12] In 1994, as part of its Medi-Cal Managed Care initiative, the state began to consolidate the private, fee-for-service Medi-Cal (FFS/MC) program and the county-based, Short-Doyle Medi-Cal (SD/MC) program within county operated Medi-Cal Mental Health Plans (MHPs).[13] The services provided by Medi-Cal MHPs are called "Specialty Mental Health Services," which include the following: Rehabilitative Services; Psychiatric Inpatient Hospital Services; Targeted Case Management; Psychiatrist Services; Psychological Services; and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Specialty Mental Health Services, such as Therapeutic Behavioral Services (TBS). (*See* Appendix One, Medi-Cal Specialty Mental Health Services Available under the California State Medicaid Plan.)

---

[6] Welf. & Inst. Code §§ 5000-5500; *see also* Welf. & Inst. Code §§ 5585-5587 (Children's Civil Commitment and Mental Health Treatment Act of 1988).
[7] Welf. & Inst. Code §§ 5600-5751, 5900.
[8] The Bronzan-McCorquodale Act replaced the Short-Doyle Act, which was enacted in 1957 to establish the state's community mental health system. Now the Short-Doyle Act only refers to services that are funded and provided under the Short-Doyle Medi-Cal program, referenced further below. (Welf. & Inst. Code § 5600(b)).
[9] *See* Welf. & Inst. Code §5600.2(a).
[10] *See* Welf. & Inst. Code § 5600.2(g).
[11] The Individuals with Disabilities Education Act (IDEA) is a federal statute governing special education services, which can include mental health services, but the availability of this assistance is not considered in this report.
[12] *See* Welf. & Inst. Code § 14021.4.
[13] *See* Welf. & Inst. Code § 5775-5780 (Mental Health Managed Care Contracts).

II. Overview of ADA & *Olmstead* Decision

The federal Americans with Disabilities Act (ADA) requires the integration of persons with disabilities into the economic and social mainstream of American life.[14] Title II of the ADA prohibits discrimination by governmental entities in the provision or administration of public services, programs or activities.[15]

Under federal regulations implementing Title II, persons with disabilities must be provided services "in the most integrated setting appropriate" to their individual needs.[16] The U.S. Attorney General has defined "most integrated setting" as one "that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[17] In addition, Title II regulations require that "[a] public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability …"[18]

In 1999, the U.S. Supreme Court recognized that the isolation and segregation of people with disabilities is a serious and pervasive form of discrimination in violation of the ADA. In *Olmstead v. L.C.*, the Court held that public entities are required to provide community-based services for persons with psychiatric disabilities when: (1) the provision of services at home and/or in the community would be appropriate, (2) the affected person does not oppose such assistance, and (3) the provision of such assistance can be reasonably accommodated.[19]

Professional evaluations to determine the most integrated setting appropriate to an individual's needs must be conducted in accordance with standards governing a state's programs and services.[20] (*See, e.g.,* Welfare and Institutions Code §§ 5600 (purpose of mental health system); 5600.2(a) (client-directed approach); 5600.4 (non-entitlement service options); 5670 (residential options); Cal. Code Regs., tit. 9 §§ 1810.100-1810.254 (Medi-Cal Specialty Mental Health entitlement services)).

---

[14] 42 U.S.C § 12101 *et seq.*
[15] 42 U.S.C. § 12132.
[16] 28 C.F.R. ' 35.130(d) (integration regulation).
[17] 28 C.F.R. Pt. 35, Appendix A, § 35.130.
[18] 28 C.F.R. § 35.130(b)(7) (reasonable modification regulation; *see also* 28 C.F.R. ' 35.130(b)(1)(iv)).
[19] *Olmstead v. L.C,,* 527 U.S. 581 (1999).
[20] *Olmstead v. L.C.,* 527 U.S. at 602, fn 13.

III. The Number of Beds in Segregated, Long-term Psychiatric Settings Increased between 1991 and 2001.

Despite state and federal laws intended to promote the development and use of home- and community-based mental health services and rehabilitation, the California mental health system has increased the number of segregated, long-term psychiatric facility beds since realignment. In 2001, the total patient capacity in the largest categories of segregated, long-term psychiatric settings was 9,577 beds. Total patient bed capacity in the state's largest, long-term psychiatric facilities increased by 1,765 beds (22.6%) between 1991/1992 and 2001. (*See* Appendix Two, Patient Capacity at Four Segregated, Long-term Psychiatric Facilities in California: 1991/1992 – 2001.) Below is additional information about the four segregated, long-term psychiatric settings in California that have increased bed capacity: (1) State Hospitals, (2) Skilled Nursing Facilities with Special Treatment Facilities (SNF/STPs), (3) Mental Health Rehabilitation Centers (MHRCs), and (4) Community Treatment Facilities (CTFs) for minors.

1. State Hospitals

Total patient bed capacity at state hospitals remained about the same for the decade after realignment, despite the closure of Camarillo State Hospital (CSH) in 1997.[21] Realignment sparked several remarkable trends in utilization of state hospital beds. First, counties reduced state hospital placement of individuals on conservatorship under the Lanterman-Petris-Short (LPS) Act (hereinafter "LPS conservatees"). Second, state agencies increased state hospital placement of individuals under the Penal Code and section 6600 *et seq.* of the Welfare and Institutions Code (hereinafter "forensic patients"). Third, levels of care or services at state hospitals decreased. Finally, the cost of care at state hospitals increased.

a. Decreased Placement of LPS Conservatees

County utilization of state hospitals for LPS conservatees decreased 64.5% between 1991 and 2001. In FY 1991-92, the state allocated 2,496.8 beds to counties. By FY 2000-01, the counties contracted with the state for 887 beds. (*See* Appendix Three, State Hospital Bed Allocation/Purchases: FY 1991-92 to FY 2000-01.) The biggest reduction occurred in the first year post-realignment when there was a 20.8% reduction in beds contracted by counties. Reductions of between 11% and 15% occurred until FY 1999-2000, when there was less than 2% reduction.

[21] The total state hospital bed capacity will increase by nearly 30% from 4,828 beds to about 6,328 beds with the opening of Coalinga State Hospital, proposed to open in early 2005.

The downward trend in county contracts for state hospital beds may be reversing. In FY 2000-01, the total number of state hospital beds contracted by counties *increased* by less than 1%. The following fifteen counties increased the number of state hospital beds between FY 1999-2000 and FY 2000-01: Contra Costa (2 beds), Kern (2 beds), Kings (3 beds), Lake (0.5 beds), Merced (1 bed), Sacramento (2 beds), San Diego (3 beds), San Francisco (4 beds), San Joaquin (3 beds), San Luis Obispo (1 bed), Santa Barbara (3 beds), Santa Clara (14 beds), Solano (1 bed), Stanislaus (3 beds), Tulare (3 beds). Santa Clara County, with the addition of 14 beds, had the largest increase between FY 99-00 and FY 00-01.

b. Increased Placement of Forensic Patients

While counties decreased the number of LPS conservatees they placed at state hospitals, the number of forensic patients placed at state hospitals increased. On June 27, 2001, there were 4,353 patients at California's four state hospitals; four out of five (or 80%) of these individuals were forensic patients. (*See* Appendix Four: State Hospital Census & Legal Commitments – 6/27/01; Appendix Five: Types of Legal Commitments for Residents at State Hospitals – 6/27/01.)

c. Decreased Levels of Care for LPS Conservatees

Levels of care[22] with designated programs for LPS conservatees at state hospitals have decreased since realignment. In FY 1992-93, counties contracted for three (3) different levels of care (acute, sub-acute/intermediate, skilled nursing facility) with two (2) specialized programs (rehabilitation, and youth). (*See* Appendix Six, Level of Care for LPS Conservatees at NSH, MSH, and CSH.) By FY 2000-01, the specialized "rehabilitation" programs apparently were eliminated. In 2001, all state hospitals residents (both LPS conservatees and forensic patients) resided on units licensed as acute, intermediate care or skilled nursing facility, without reference to a "rehabilitation" program. (*See* Appendix Six; Appendix Seven: Level of Care for All State Mental Residents – 2001.) In FY 2000-01, Metropolitan State Hospital (MSH) continued to have a designated "youth" program with 117 beds, which apparently were licensed as acute beds.

d. Increased Cost of Care for LPS Conservatees

The daily rates paid by counties for LPS conservatees placed at state hospitals increased since realignment. For example, while the annual cost of care for a patient on a skilled nursing unit at Napa State Hospital (NSH) in FY 1991-92 was approximately $94,860, the annual cost of such care in FY 2001-02 increased

---

[22] Levels of care have distinct licensing requirements and standards. (*See* Cal. Code Regs., tit. 22 §§ 71001-71667 (acute psychiatric hospitals); 73001-73727 (intermediate care facility); 72001-72713 (skilled nursing facility)).

to $126,031.00, or $10,503.00 a month. (*See* Appendix Eight: State Hospital County Bed Daily Rates FY 1991-92 & FY 2000-01.) The annual cost of care for a child placed at MSH's youth program was approximately $127,856.00, or $10,655.00 a month in FY 2001-02.

2. Skilled Nursing Facilities with Special Treatment Programs (SNF/STPs)

Total patient bed capacity at Skilled Nursing Facilities with Special Treatment Programs (SNF/STPs) increased by 433 (or 14.7%) between 1991 and 2001. (*See* Appendix Two.) There are several remarkable trends in the use of SNF/STP beds since realignment. First, few SNFs have STPs for persons with psychiatric disabilities. Second, the number of SNF/STP facility beds increased when counties decreased LPS conservatee placement at state hospitals. Third, SNF/STPs have converted to MHRCs. Finally, counties pay a supplemental rate for the placement of some persons in SNF/STPs.

a. Few SNFs have Special Treatment Programs (STPs)

The California Department of Health Services (DHS) licenses skilled nursing facilities (SNFs), which provide 24-hour nursing and supportive care to persons whose primary need is for availability of nursing care on an extended basis.[23] An SNF may be a freestanding facility or a distinct part (DP) of a hospital. SNF admission requires a physician's order and facility screening.[24] SNF admission of a Medi-Cal-eligible person requires approval of a treatment authorization request (TAR), which must specify qualification criteria.[25]

DMH certifies Special Treatment Programs (STPs) at SNFs. STP certification requires the provision of "programs aimed at improving the adaptive functioning of chronically mentally disordered patients to enable some patients to move into a less restrictive environment and prevent other patients from regressing to a lower level of functioning."[26] STP programs must provide a minimum of 27 hours per week of direct group or individual rehabilitative services in the following areas: self-help skills, behavior adjustment, interpersonal relations, prevocational preparation, and prerelease planning.[27]

Very few of California's skilled nursing facilities have certified STPs. In 2001, California had approximately 1,450 nursing homes with a total of 132,000

---

[23] Cal. Code Regs., tit. 22 § 72103.
[24] Cal. Code Regs., tit. 22 §§ 72513, 72515.
[25] Cal. Code Regs., tit. 22 § 51335.
[26] Cal. Code Regs., tit. 22 § 72445(a).
[27] Cal. Code Regs., tit. 22 §§ 72443(a), 72445.

beds.[28] Nationally, an estimated 80% of nursing home residents have psychiatric conditions, with dementia being the most prevalent condition. Fewer than a fifth of persons with psychiatric conditions receive assistance from a mental health clinician.[29] In 2001, there were 34 SNF/STPs with a total of 3,384 beds. (*See* Appendix Nine: Skilled Nursing Facilities with Certified Special Treatment Programs (SNF/STPs) – June 2001.) The facilities ranged in size from 30 beds to 202 beds; the median capacity was nearly 100 persons.

b. Increased SNF/STPs Facility Beds

The number of SNF/STP beds increased from 2,951 to 3,384, or by 14.7%, between 1991 and 2001. (*See* Appendix Two.) The increase in the number of SNF/STP beds correlates with the decrease in the number of state hospital beds contracted by counties for LPS conservatees. For example, between FY 1991-92 and FY 1993-94 there was an 820.8 bed reduction in the number of state hospital beds contracted by counties. (*See* Appendix Three.) Between 1991 and 1993, DMH approved STP certification for an additional nine (9) SNFs, thereby resulting in a 1,043 bed increase.[30] Most, if not all, individuals placed in SNF/STPs are on LPS conservatorship.

c. Conversion of SNF/STP Facility Beds to MHRCs

Eleven of 18 Mental Health Rehabilitation Centers (MHRCs) licensed by DMH in June 2001 were previously licensed and certified as SNF/STPs. (*See* Appendix Ten: Mental Health Rehabilitation Centers (MHRCs): 1995-2001.) These 11 facilities had 1,023, or approximately 80%, of the total number of MHRC beds. The median size of these facilities was 93 beds. The median size of MHRC facilities that were not previously SNF/STPS was much smaller, with 37 beds.

d. County Supplement to SNF/STP Cost of Care

The state sets an average daily private pay rate for nursing facilities, which does not include charges for ancillary services such as physical therapy, speech therapy, audiology, laboratory, patient supplies or prescription drugs.[31] In addition, SNFs receive a per capita daily rate for the specialized treatment program. A county may also pay the facility a supplemental rate (so-called “patch”) for certain

---

[28] Medi-Cal Policy Institute, “Understanding Medi-Cal: Long Term Care” (April 2001), p.12.
[29] Barthels, et al., “Models of Mental Health Service in Nursing Homes: A Review of the Literature,” *Psychiatric Services* Vol. 53, No. 11, 1390-1396 (November 2002).
[30] Disability Rights California does not have information on the number of persons with psychiatric disabilities placed in these facilities prior to STP certification.
[31] Cal. Code Regs., tit. 22 § 58002.

individuals placed at SNF/STPs, although the amount (perhaps as much as $3,000.00 a month) and frequency of such subsidies is unclear.

3. Mental Health Rehabilitation Centers (MHRCs)

Total patient capacity at Mental Health Rehabilitation Centers (MHRCs) has increased 100% since realignment because this type of facility did not exist until 1995. The state intended to establish MHRCs to address inadequate access to home- and community-based mental health services in California. In 1994, the California Legislature authorized MHRCs as pilot projects in Placer County and up to six other counties "for the provision of community care and treatment for persons with mental disorders who are placed in a state hospital or another health facility because no community placements are available to meet the needs of these patients."[32] In 1998, the legislature authorized MHRCs in up to 15 other counties.

DMH certifies MHRCs, which DMH describes as providing "intensive services to persons, 18 years or older, who would have been placed in a state hospital or another mental health facility to develop skills to become self-sufficient and capable of increasing levels of independent functioning."[33]

Between 1995 and 2001, the number of MHRC beds increased from 0 to 1,283. (*See* Appendix Ten: Mental Health Rehabilitation Centers (MHRCs): 1995-2001.) There are a couple of remarkable trends in the use of MHRCs. First, few MHRCs are new programs. Second, most MHRCs are comparable in size to SNF/STPs.

a. Few MHRCs are New Programs

As of June 2001, there were 18 MHRCs in 15 counties with a total capacity of 1,283 beds. (*See* Appendix Ten.) Only three of these MHRCs were new programs: Oasis Mental Health Center in Riverside County, Las Posadas Casa I and Las Posadas Casa II in Ventura County. The other 15 facilities converted to MHRC status from other licensure categories (e.g., SNF/STPs). It is unclear how MHRCs that were formerly operating as SNF/STPs differ from SNF/STPs that are still in operation.

b. Most MHRCs are Comparable in Size to SNF/STPs

As of June 2001, MHRCs ranged in size from 190 beds to 15 beds. The average MHRC size was about 71 beds. The average MHRC size for facilities

---

[32] Welf. & Inst. Code § 5675.
[33] *See* DMH website: www.dmh.ca.gov/Admin/regulations/facilities.asp (1/17/2003); *see also* Cal. Code Regs., tit. 9 § 781 *et seq.*

previously licensed as SNF/STPs (n=11) or as a PHF (n=1) was 93 beds and 80 beds, respectively. Thus, the average MHRC size for facilities that formerly operated as SNF/STPs was comparable to existing SNF/STPs. The average MHRC size for facilities that were not previously licensed as an SNF/STP or PHF, however, was 30 beds. Three MHRCs had 16 or fewer beds: Las Posadas I and Las Posadas II in Ventura County, and Fresno County Mental Health Rehabilitation Center.[34]

4. Community Treatment Facilities (CTFs) for Minors

The California Legislature directed DMH to develop regulations prior to December 31, 1994 to govern Community Treatment Facilities (CTFs), which may be secured facilities.[35] The target population for CTFs is minors who have been identified as seriously emotionally disturbed children[36] for whom less-restrictive mental health interventions have been tried, or who are currently placed in an acute psychiatric hospital or state hospital or in a facility outside the state for mental health treatment, and who may require periods of containment to benefit from mental health treatment.[37] CTF admission requires either that a juvenile court ward has an application under section 6552 of the Welfare and Institutions Code or that the minor's parent, guardian, conservator or other person having custody of the minor has given informed consent to admission. The California Legislature instructed DMH to limit the number of CTF beds to not more than 400 statewide and to ensure that there is at least one facility in each of the California Department of Social Services' (CDSS') four (4) regional licensing divisions.[38]

DMH reported three (3) CTFs in operation as of July 12, 2001. (*See* Appendix Eleven: Community Treatment Facilities (CTFs) in Operation as of July 12, 2001.)[39] For FYs 2001-02 and 2002-03, the CTF programs were paid a supplemental rate of $2,500.00 per child per month under the statute.[40]

In sum, 10 years after realignment, the number of segregated, long-term psychiatric facility beds increased. Counties contracted for 1,610 fewer state hospital beds, but the reduced availability of state hospital beds for adult, LPS conservatees was almost proportionately offset by an additional 1,716 SNF/STP and MHRC beds that became available. (*See* Appendix Two.) State hospital beds filled with forensic patients placed by state agencies. In addition, "youth" programs

---

[34] The Fresno County MHRC closed in September of 2001.
[35] Welf. & Inst. Code § 4094(a); Cal. Code Regs., tit. 9 §§ 1900-1938, tit. 22 §§ 84110-84188.
[36] As defined under section 5699.2 of the Welfare and Institutions Code.
[37] Welf. & Inst. Code § 4094.5(a).
[38] Welf. & Inst. Code § 4094.7(a).
[39] There may be two additional CTFs now in operation including one in Contra Costa County.
[40] Welf. & Inst. Code § 4094.2(d).

at state hospitals decreased by 53.2%. (*See* Appendix Six.) The largest portion of this decrease is attributable to the closure of Camarillo State Hospital (CSH) in FY 1997-98. But it appears that Metropolitan State Hospital (MSH) increased its capacity to serve some CSH residents. For example, in FY 1992-93, MSH did not have any "youth" program beds, while CSH had 156 such beds. In FY 2000-01, MSH had 117 youth program beds. (See Appendix Six.) Further, the decline in state hospital "youth" programs at CSH, as well as Napa State Hospital, was also likely offset by the creation of beds at Community Treatment Facilities (CTFs) for minors. [41]

Funding increased for institutional services, even in the worst of budgetary times. For example, under the governor's proposed budget issued on January 10, 2003, state hospital funding would increase by $71.6 million, so that the number of state hospital residents can increase to 4,800. Further, the governor proposed an additional $1.2 million to provide a supplemental rate for CTFs.

---

[41] *See also* Welf. & Inst. Code §4094.8 (In 1996, the legislature authorized a four-year pilot project for the 30-bed "secured perimeter" Van Horn Regional Treatment Facility in Riverside County. The facility was for minors from one of the following five counties: Riverside, San Bernardino, Orange, San Diego, and Los Angeles. Placement was limited to minors adjudicated by the juvenile court as wards of the court under section 602 of the Welfare and Institutions Code, with the voluntary, informed consent of the minor. The pilot was repealed January 1, 2000).

IV. The Number of Involuntary Holds and Administrative Day Services in Segregated, Short-term Psychiatric Settings Has Increased Despite a Decrease in the Number of such Facilities, which Reflects Inadequate Home- and Community-based Options.

Medi-Cal psychiatric inpatient hospitals provide acute care services to eligible persons.[42] In 1991, the California Legislature authorized DMH to license Psychiatric Health Facilities (PHFs) to provide "innovative and more competitive and specialized acute care services."[43] Segregated, short-term psychiatric settings include psychiatric inpatient hospitals and PHFs. There are a couple of remarkable trends in the development and use of these facilities since realignment. First, there has been a decrease in number of acute psychiatric beds. Second, there has been an increase in the number of hospitalizations in acute psychiatric settings.

1. Decrease in the Number of Beds

DMH reports that between 1989 and 1998, there was an overall decrease of 1,326 psychiatric hospital beds, or 12.6%, statewide.[44] Patient days decreased from 2,171,127 in 1989 to 1,604,575 in 1998, or by 26.1%. The occupancy rate went from 57.1% in 1989 to 47.4% in 1998. The number of patient discharges increased over 30%, from 153,280 in 1989 to almost 200,000 in 1998. The length of stay decreased from 14.2 days in 1989 to 8 days in 1998. The California Institute for Mental Health (CIMH) reports that 81% of psychiatric hospitals experience shortages in beds for children and adolescents, and 57% of hospitals experience shortages in beds for adults.[45]

2. Increase in Number of Hospitalizations

DMH reports that between FY 1990-91 and FY 1998-99, the number of involuntary holds under both sections 5150 (72-hour hold) and 5250 (14-day hold) of the Welfare and Institutions Code increased in all areas (i.e., California, Los Angeles County, and California less Los Angeles County), except for a slight decrease in 14-day holds for California less Los Angeles County. [46] Los Angeles County consistently showed the highest rates of increase in involuntary holds for both children and adults. The number of 72-hour holds for children statewide

---

[42] Cal. Code Regs., tit. 9 §§ 1700-1799.
[43] Welf. & Inst. Code § 4080(h)(1).
[44] DMH, Data Regarding Medi-Cal Mental Health Services – Inpatient Hospital Services (2/22/00), Table 7, Trends in Use of Public and Private Psychiatric Beds Calendar Years 1989 Through 1998.
[45] California Institute for Mental Health, "Psychiatric Hospital Beds in California: Reduced Numbers Create System Slow-Down and Potential Crisis" (August 30, 2001), p.14 (hereinafter "CIMH Psychiatric Hospital Bed Study").
[46] DMH, Data Regarding Medi-Cal Mental Health Services – Inpatient Hospital Services (2/22/00), Table 4A 72-Hour Evaluations and 14-Day Certifications by Area Fiscal Years 1990-91 Through 1998-99.

during this period increased by 117.4% (from 5,717 to 12,428). The number of 72-hour holds for Los Angeles children increased 428.7% (from 1,039 to 5,493). The number of 72-hour holds for adults statewide increased by 41.5 percent (from 78,548 to 111,111). The number of 72-hour holds for Los Angeles adults increased by 79.4% (from 22,160 to 39,758). The number of 14-day detentions statewide increased by 30.2% (from 33,266 to 43,328), but this increase is due to the increase in Los Angeles County, where 14-day holds increased by 66.7% (from 11,736 to 19,562); the number of 14-day holds statewide during this period decreased by 2.6%.

In sum, the number of acute psychiatric settings has decreased while the number of psychiatric holds in segregated, short-term psychiatric settings has increased. Between FY 1993-94 and FY 1998-99, the number of persons readmitted within 30 days of discharge from inpatient services increased by 26%.[47] Los Angeles County had the largest readmission increase although the readmission rate increased statewide. The increased number of hospitalizations may be attributed to the shortage of and need for home- and community-based services.

According to CIMH, there have been increases in administrative day services at Medi-Cal psychiatric inpatient hospitals. "Administrative Day Services" means services authorized by a county Mental Health Plan's point of authorization for a person residing at an acute care setting when, "due to a lack of residential placement options at appropriate, non-acute treatment facilities identified by the Mental Health Plan, the beneficiary's stay … must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services."[48] This reflects a lack of aftercare options, especially for adults; administrative day services for children and adolescents are reportedly much lower than they are for adults.[49]

CIMH recommends assessment of the use of administrative day beds to determine the types of alternatives (for example: crisis residential; intensive case management services; child residential; adult and children's systems of care; therapeutic behavioral services; substance abuse services; and other dual diagnosis services) needed to meet individual needs.[50]

---

[47] DMH, Data Regarding Medi-Cal Mental Health Services – Inpatient Hospital Services (2/22/00), Table 2, Medi-Cal Inpatient Clients Readmissions to Inpatient Service By Area Fiscal Years 1990-91 Through 1998-99.
[48] Cal. Code Regs., tit. 9 § 1701.
[49] CIMH Psychiatric Hospital Bed Study, p.15.
[50] CIMH Psychiatric Hospital Bed Study, pp. 7, 28-34

V. Counties Have Developed Home- and Community-based Services but Access to Such Assistance Remains Very Limited.

The mission of California's community mental health system is to enable persons with psychiatric disabilities, including children, "to access services and programs that assist them, in a manner tailored to each individual, to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive settings."[51] The mental health system should develop client-directed, culturally competent systems of care to meet the needs of children and youth, adults and older adults.[52] Among other things, these systems of care should include: pre-crisis and crisis services, individual service plans, rehabilitation and support services, and vocational services.[53] More specifically, systems of care should include the following: (1) Integrated Service Systems, (2) Self-Help and Peer Support, (3) Supported Housing, (4) Certified Residential Treatment Services, (5) Targeted Case Management/Brokerage Services, and (6) Individual (One-to-One) Mental Health Rehabilitation Services, discussed further below.

1. Integrated Service Systems

a. Children's Systems of Care

In 1984, the California Legislature established a model comprehensive, interagency system of care for children labeled as seriously emotionally disturbed in Ventura County.[54] It expanded to the counties of Santa Cruz, San Mateo and Riverside in 1989. The programs successfully met the performance outcomes required by the statute.

In 1992, the California Legislature enacted the Children's Mental Health Services Act to expand the system of care model to all counties "to provide greater benefits to children … at a lower cost to the taxpayers."[55] It found that the systems of care in the initial four counties annually accrued "substantial savings to the state and these four counties … as documented by the independent evaluator …"[56]

The legislature intended that expansion of interagency systems of care would, among other things, "[e]nable children to remain at home with their

---

[51] Welf. & Inst. Code § 5600.1.
[52] Welf & Inst. Code § 5600.2(a), (c), (g).
[53] *See* Welf. & Inst. Code § 5600.4 (treatment options); *see also* Welf. & Inst. Code § 5690 *et seq.* (community vocational rehabilitation system).
[54] Welf. & Inst. Code § 5851(b).
[55] Welf. & Inst. Code § 5851(b).
[56] Welf. & Inst. Code § 5851(b).

families whenever possible."[57] It specified performance standards for counties awarded funds, which include cost avoidance in state hospital and acute inpatient programs[58] and increased access to services by ethnic minority and gender proportionate to the county's school-age population.[59] Each county system of care must also develop a county interagency policy and planning committee, which includes family members of children who are receiving or have received county mental health system services.[60]

Under the act, DMH has a responsibility to contract with a county-awarded system of care funding. [61] When funds are provided for expansion, DMH has a duty to request applications for funding new Children's System of Care programs to non-participating counties.[62] Eligibility criteria are set by statute.[63] Systems of care serving children age 15 to 21 must have individual service plans that "identify the needs of the youth in the area of employment, job training, health care, education, counseling, socialization, housing, and independent living skills…"[64]

Under the governor's proposed budget issued on January 10, 2003, responsibility for funding Children's System of Care programs would be shifted from the state to the counties for projected general fund savings of $20 million. The impact of this new form of realignment on access to system of care services is unclear, but there is a risk that counties would cut system of care services during difficult budget times, absent state standards for providing such assistance.

b. Adult and Older Adult Systems of Care

In 1988, the California Legislature passed AB 3777, which provided for integrated services for adults in two different forms. [65] One model was the Integrated Service Agency (ISA). The other was a reorganized county mental health model with some enhanced funding for establishing interagency cooperation, known as the County Interagency Demonstration (CID) project. Pursuant to a bidding process, the Mental Health Association of Los Angeles was selected for the urban ISA (called the "Village ISA"), Community Transitional Resources for the rural ISA serving Stanislaus County (Stanislaus ISA or SISA), and Ventura County for the CID. The ISA's were to have between 100 and 200

---

[57] Welf. & Inst. Code § 5851(c)(3)(A).
[58] Welf. & Inst. Code § 5852.5(a)(2).
[59] Welf. & Inst. Code § 5880(a)(8).
[60] Welf. & Inst. Code § 5866(b).
[61] Welf. & Inst. Code § 5855.5(b).
[62] Welf. & Inst. Code § 5857(a).
[63] Welf. & Inst. Code § 5856.2.
[64] Welf. & Inst. Code § 5865.1(c).
[65] *See* California Institute for Mental Health, "Guidebook to Client-Directed Integrated Services."

clients who were identified as persons with "serious and persistent mental disorders."

In 1996, the California Legislature enacted the Adult and Older Adult Mental Health System of Care Act.[66] It found that a mental health system of care for adults and older adults with psychiatric disabilities "is vital for the success of mental health managed care in California."[67] It recognized that "[a] comprehensive and coordinated system of care includes community-based treatment, outreach services and other early intervention strategies, case management, and interagency system components."[68] Further, it called for "[s]ystem of care services which ensure culturally competent care for persons with severe mental illness in the most appropriate, least restrictive level of care are necessary to achieve desired performance outcomes."[69] It found that the integrated service agency model developed in Los Angeles and Stanislaus Counties, and the Ventura County CID met performance outcomes required by the legislature, and should be systematically replicated.[70]

The legislature has instructed DMH to establish system of care service standards for expansion of integrated system of care programs, which include: (a) the number of clients to be served and the programs and services that will be provided to meet their needs, (b) plans for considering the cultural, linguistic, gender, age, and special needs of minorities in the target population, (c) provision of services to target population clients who have physical disabilities, (d) provision of services to meet the special needs of older adults, (e) provision for services to be client-directed and that employ psychosocial rehabilitation and recovery principles, (f) provision for services reflecting the special needs of women from diverse cultural backgrounds, including housing that accepts children, and (g) provision for housing for clients that is immediate, transitional, and permanent, or all of these (for example, rental housing subsidies and/or security deposits).[71]

c. Inclusion of Persons who are Homeless and/or at Risk of Jail/Prison

In 1988, citing the shortage of adequate facilities for people with psychiatric disabilities, the California Legislature recognized that people "are forced to be sent out on the street" and that they "are not receiving the care that they are entitled

---

[66] Welf. & Inst. Code § 5800 *et seq.*
[67] Welf. & Inst. Code § 5802(a).
[68] Welf. & Inst. Code § 5802(a)(1).
[69] Welf. & Inst. Code § 5802(a)(4).
[70] Welf. & Inst. Code § 5802(b).
[71] Welf. & Inst. Code § 5806.

to."[72] In 1991, it enacted the Community Support System for Homeless Mentally Disabled Persons "to assist homeless mentally ill persons to secure, stabilize, and maintain safe and adequate living arrangements in the community…"[73] Programs that received funding were instructed to assist with establishing self-help groups and peer counseling, and to offer each individual served "a written individualized service plan that will specify the services to be provided as a result of discussions with the client and the rights of the client, as well as the expected results or outcomes of the services."[74]

In 1999, the legislature passed AB 34, again recognizing that "the long-standing problem of the under funded community mental health system" and inadequate access to services results in "adults being homeless, incarcerated in jails, and hospitalized."[75] It found that there were an estimated 50,000 homeless Californians with psychiatric disabilities, including 10,000 to 20,000 veterans.[76]

AB 34 (and AB 2034 in 2000) amended the Adult and Older Adult System of Care Act to provide funds for counties to establish outreach programs and provide mental health services, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and other nonmedical services to help people get off the street, or to provide access to veterans' services that will also provide for treatment and recovery.

Under the governor's proposed budget issued on January 10, 2003, responsibility for Integrated Services for the Homeless (AB 34/AB 2034) programs would be shifted from the state to the counties for projected general fund savings of $54.9 million. As with Children's Systems of Care, the impact of this new form of realignment on access to Adult and Older Adult Systems of Care is unclear, but there is a risk that counties would cut system of care services during difficult budget times, absent state standards for providing such assistance.

2. Self Help and Peer Support

Integrated systems of care should include peer support or self-help group support.[77] In addition, community mental health systems under the realignment legislation should promote the development and use of self-help groups by persons with psychiatric disabilities so that these groups are available in all areas of the

[72] Welf. & Inst. Code § 4026(a)(2)&(3).
[73] Welf. & Inst. Code § 5680 *et seq*.
[74] Welf. & Inst. Code § 5694.
[75] *See* Historical and Statutory Notes, Welf. & Inst. Code § 5814.
[76] *See* Historical and Statutory Notes, Welf. & Inst. Code § 5802.
[77] Welf. & Inst. Code § 5806(a)(5).

state.[78] Further, each community support program for homeless persons with psychiatric disabilities should establish self-help groups and peer counseling.[79]

3. Supported Housing Programs

Integrated systems of care should include "housing for clients that is immediate, transitional, permanent, or all of these."[80] Persons with psychiatric disabilities who have children should "live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children…"[81] In addition, community mental health programs under the realignment legislation should provide a range of alternatives to institutional settings, with emphasis on programs designed "to reduce the dependence on medications as a sole treatment tool" and that "have a rehabilitation focus which encourages clients to develop the skills to become self-sufficient and capable of increasing levels of independent functioning."[82] County mental heath departments have used realignment funds to develop cooperative living arrangements, single room occupancy hotels, and other residential options. But we are not aware of any systematic reporting on these housing options.

In 1998, the Legislature enacted the California Statewide Supportive Housing Initiative Act (SHIA).[83] Its findings and declarations included the following: (1) at least 150,00 people are homeless in California, at least 50% of whom are disabled; (2) very low income people with disabilities cycle through costly, short-term crisis programs, such as emergency hospital rooms, psychiatric hospitalization, emergency shelters, and jails, and fail to make a long-term transition to stability and permanent housing; (3) supportive housing has been shown to decrease the use of emergency medical services and incarceration by 50%, reduce recidivism among substance abusers by more than 50%, increase employment rates by 100%, and successfully retain tenants at rates exceeding 80%; (4) supportive housing is currently available to only one or two of every 10 Californians who could benefit from it.

The SHIA program provided grants for the development of supportive housing across California. "Supportive housing" was defined as "housing with no limit on length of stay, that is occupied by the target population, and that is linked to onsite or offsite services that assist the tenant to retain the housing, improve his

---

[78] Welf. & Inst. Code § 5600.2(i).
[79] Welf. & Inst. Code § 5694.
[80] Welf. & Inst. Code § 5806(a)(10).
[81] Welf. & Inst. Code § 5806(c)(1).
[82] Welf. & Inst. Code §§ 5670, 5670.5(c), 5671.
[83] Health & Safety Code § 53250 *et seq.*

or her health status, maximize their ability to live and, when possible, to work in the community. This housing may include apartments, single-room occupancy residences, or single-family homes." Support services included but were not limited to the following: health care services; mental health services; substance abuse prevention and treatment services; family support and parenting education; vocational, educational and employment services; counseling; case management services; payment for housing costs; evaluation costs.

The "target population" for SIHA programs was adults with one or more disabilities, including mental illness, HIV/AIDS, or other chronic health conditions, substance abuse, or individuals eligible for services under the Lanterman Developmental Disabilities Services Act, and may include families with children, elderly persons, young adults aging out of the foster care system, individuals leaving institutional settings, veterans or homeless people.

Implementation of the statute is contingent on appropriation of funds in the annual Budget Act for that purpose. For SHIA Grant 2000-2002, DMH recommended funding for 20 projects in 11 counties, totaling some $22 million.

4. Certified Residential Treatment Services (CRTS)

Under the Rehab Option amendment to the State Medicaid Plan, persons with psychiatric disabilities who are eligible for Medi-Cal have rights to crisis residential treatment and adult transitional residential treatment programs to prevent hospitalization or other institutional placement.[84] State regulations contain standards for these programs, which are called "Certified Residential Treatment Services (CRTS)."[85] A person may reside in a crisis residential treatment program generally for up to 30 days, but may stay for up to three (3) months. Length of stay in an adult transitional residential program is based on individual need, generally not to exceed one year, but may continue for up to 18 months.

a. Extremely Limited Access to Crisis Residential Services

In 2001, only 16 of 58 California counties had Medi-Cal crisis residential facilities; statewide there were 29 crisis residential facilities with a total capacity for 340 persons. (*See* Appendix Twelve: Certified Residential Treatment Services (CRTS): 2001.) Four counties had more than one short-term crisis residential facility: San Diego (6); San Francisco (4); Santa Clara (4); and Los Angeles (3). Twelve counties had one crisis residential facility. These facilities ranged in size

---

[84] *See* Cal. Code Regs., tit. 9 §§ 1810.208 (crisis residential treatment services), 1810.203 (adult residential treatment services).
[85] Cal. Code Regs., tit. 9 § 531(a)(1).

from six to 16 beds. (*See* Appendix Thirteen: Medi-Cal Short-Term Crisis Residential Treatment Facilities – 2001.) The average facility capacity was 12 persons. The vast majority of these facilities were initially licensed between 1991 and 1996. Only one existing facility was initially licensed from 1997 to 2001.

b. Very Limited Access to Transitional Residential Services

In 2001, only 19 of 58 California counties had Medi-Cal adult transitional residential facilities; statewide there were 49 transitional residential treatment facilities with a total capacity for 608 residents. (*See* Appendix Fourteen: Medi-Cal Adult Transitional Residential Treatment Facilities – 2001.) The programs ranged in size from 5 to 40 beds. The average size was 12.4 beds. Twenty of the 49 facilities were in two counties: San Francisco and Los Angeles. Most (27 of 49) were located in the Bay Area Counties. The majority (39 of 49) opened between 1991 and 1994.

5. Targeted Case Management/Brokerage Services

Integrated systems of care should include "a clearly designated mental health personal services coordinator … who is responsible for providing or assuring needed services."[86] In 1987, California Legislature moved to include optional Targeted Case Management/Brokerage Services under its State Medicaid plan for Medi-Cal eligible persons.[87] State regulations define "Targeted Case Management/Brokerage" as services that "assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring the beneficiary's progress; and plan development."[88]

6. Individual (One-to-One) Mental Health Rehabilitation Services

In 1999, a California Superior Court judge ruled that Individual (One-to-One) Mental Health Rehabilitation Services are available under the Medi-Cal program for Medi-Cal-eligible persons. In 2001, DMH issued an Information Letter to county mental health programs outlining one-to-one mental health services available under the Rehab Option. (*See* DMH Letter No: 01-01, One-To-One Mental Health Services.) The DMH Letter states that: (1) individual mental health rehabilitation services are available under the Medi-Cal program *without*

[86] Welf. & Inst. Code § 5806(b).
[87] *See* Welf. & Inst. Code § 14021.3.
[88] Cal. Code Regs., tit. 9 § 1810.249.

any cap on the number of hours per day or days per week that it can be provided; and (2) individual mental health rehabilitation services are directed at the person's goals for rehabilitation or recovery and are available up to 24 hours a day, 7 days a week if medically necessary.

a. Rehabilitation is Distinct from Personal Care Services

Rehabilitation is distinct from personal care services (e.g., In Home Support Services), which can also be provided to help a person with a psychiatric disability live more independently. Personal care services perform activities that the person is unable to do for himself or herself. Rehabilitation involves activities to enable someone with a psychiatric disability to perform activities for himself or herself. Examples include:

- Teaching the person to shop, and prepare and eat meals, and reviewing the effectiveness of the instruction at periodic intervals. Personal care services might include shopping, meal preparation and feeding.
- Planning socialization activities with the person consistent with his or her socialization goals and encouraging/monitoring his or her participation in these activities.
- Explaining and ensuring that the person understands the importance of taking medications, consistent with his or her recovery goals, and working with him or her to develop a system that would help with taking medications on time. Personal care services might include reminding the person to take the medications at the proper time.
- Helping a person learn how to use mass transit systems to attend medical, social, vocational and/or educational activities. Personal care services may include accompanying a person to medical, social, vocational and/or educational activities.
- Helping a person develop interpersonal skills at work, at school, at home, or elsewhere in the community.

Under this Rehab Option covered service, job coaching is reimbursable to help a person obtain and maintain employment.[89] Further, county Medi-Cal MHPs may hire persons with psychiatric disabilities to provide such assistance. This assistance must be provided under the direction or supervision of a physician, psychologist, clinical social worker, marriage or family therapist, or registered

[89] *See* President's New Freedom Commission on Mental Health, "Meeting Minutes November 12-14, 2002, Los Angeles, California" (recommendation at November 12, 2002 meeting).

nurse, but need not be directly provided by the licensed professional.[90] Community mental health constituents may not be aware of this one-to-one assistance, or of other services within the county's system of care.

In sum, California's community mental health system is a patchwork of state initiatives that ebb and flow with the will of the state's legislative and executive branches. Services that are tied to realignment funding streams, such as Medi-Cal Specialty Mental Health Services, develop based on the strength or weakness of the state's economy rather than personal need. County assumption of funding services beyond state realignment allocations appears to be unrealistic at best. Limited state and county allocations for home- and community-based services result in a relatively small number of service slots at the local level. Persons with psychiatric disabilities and their advocates (including family members) may not be aware of programs and services that should be available in the community. They also may not know what funds come into the county and where that money is spent, nor how local entities decide how to allocate some of their most precious resources (for example, crisis residential services, supported housing, or integrated services).

---

[90] *See* DMH Letter No.: 01-02 (May 4, 2001).

VI. Funding for Voluntary Mental Health Services in Home- and Community-based Settings is Inadequate.

1. Capped Funding for Medi-Cal Mental Health Entitlement

Medi-Cal-eligible individuals have an entitlement claim to covered services that are medically necessary.[91] This entitlement is based on federal requirements, which include the following: (a) the right to receive services with reasonable promptness;[92] (b) the right to services that are comparable in amount, scope and duration to those services received by other eligible persons in the same or another county;[93] and (c) the right to receive services sufficient in amount, scope and duration to achieve their purpose.[94] The purpose of rehabilitative mental health services is "for the maximum reduction of mental disability and restoration of a recipient to his [or her] best possible functional level … in accordance with a coordinated client plan or service plan ..."[95]

Medicaid is a collaborative program between the federal and state governments. The federal government provides financial reimbursement for covered services provided to eligible persons; a state's share of financial reimbursement is referred to as the "state match." In California, the state match for Medi-Cal-covered physical health services is based on individual need and is open-ended (e.g., from the General Fund) or "capitated" based on sound actuarial data of individual need. For Medi-Cal-covered mental health services, however, the state match is "capped" based on the amount of state sales tax and vehicle license fee revenues deposited in the mental health trust account under the realignment legislation. Counties have assumed the financial risk for funding services to adults beyond the amount of funds deposited in the trust account.[96] An exception is the availability of additional state funding for Early Periodic Screening and Diagnosis and Treatment (EPSDT) Supplemental Services (such as therapeutic behavioral services), which are provided to children and youth under age 21. As a result of the state cap on funds for adult services, counties do not recognize that Medi-Cal Specialty Mental Health Services are part of a federal entitlement program for adults as well as children.

---

[91] Medical necessity is defined under state regulations. (*See* Cal. Code Regs., tit. 9 §§ 1830.205 (adults over age 21), 1830.210 (persons under age 21).

[92] 42 U.S.C. § 1396a(a)(8).

[93] 42 U.S.C. § 1396a(a)(10)(B).

[94] 42 C.F.R. § 440.230(b).

[95] *See* Supplement 2 to Attachment 3.1-B of California State Medicaid Plan at p.1; *see also* Welf. & Inst. § 14021.4(a)(4) ("remedial services directed at restoration to the highest possible functional level for persons with psychiatric disabilities and maximum reduction of symptoms of mental illness").

[96] Welf. & Inst. Code § 5777(a)(1).

2. Limited Funding for Bronzan-McCorquodale Act Services

The Bronzan-McCorquodale Act provides for a variety of services that are available to persons who are not Medi-Cal eligible, as well as services that are not covered under the Medi-Cal program. For example, persons who are not Medi-Cal eligible should have access to a comparable scope of community mental health services as covered under the Medi-Cal program.[97] In addition, all persons should have access to a "range of alternatives to institutional care based on principles of residential, community-based treatment."[98]

Access to services under the Bronzan-McCorquodale Act is limited "to the extent resources are available." The statute defines "to the extent resources are available" to mean "the extent that funds deposited in the mental health account of the local health and welfare fund are available to an entity qualified to use those funds."[99]

Counties have a contractual obligation with the state to ensure access to all covered services that meet medical necessity criteria for all Medi-Cal-eligible persons.[100] The statute provides that "[t]he county's obligation to persons not eligible for Medi-Cal shall be no more than the amount of funds remaining … after fulfilling the Medi-Cal contract obligations."[101] Thus, counties are required to serve individuals who are not Medi-Cal eligible, or whose assistance is not Medi-Cal covered, only "to the extent resources are available."

3. Disparate Funding and Size of Facilities under Community Care Facility Act

In 1973, the California Legislature passed the Community Care Facilities Act to promote "a coordinated and comprehensive statewide service system of quality community care" for persons with disabilities.[102] A large number of persons with psychiatric disabilities reside in residential care facilities (often also referred to as "board and care homes"), which are licensed under the Community Care Facilities Act. Licensing classifications for these facilities include: Adult Resident Facility,[103] Group Home,[104] Residential Care Facility for the Elderly

---

[97] *See* Welf. & Inst. Code §§ 5600.4 (treatment options), 5600.5 (array of services for children and youth), 5600.6 (array of services for adults), 5600.7 (array of services for older adults).
[98] Welf. & Inst. Code § 5670(a); *see also* Welf. & Inst. Code §§ 5670.5 (residential treatment system – program criteria), 5671 (residential treatment system – program elements).
[99] Welf. & Inst. Code § 5601(c).
[100] Welf. & Inst. Code § 5777(a)(3).
[101] Welf. & Inst. Code § 5777(j).
[102] *See* Health and Safety Code § 1500 *et seq.*
[103] Cal. Code Regs., tit. 22 § 85000 *et seq.*
[104] Cal. Code Regs., tit. 22 § 84000 *et seq.*

(RCFE),[105] Residential Care Facility for the Chronically Ill (RFCI),[106] Small Family Homes,[107] and Social Rehabilitation Facilities (which are CRTS, discussed above).[108]

Facilities may specialize in care to particular groups of persons with disabilities. In October 2001, for example, there were 4,683 Adult Residential Facilities (ARFs) with a total capacity for 38,714 residents. Approximately 35% of these facilities (with some 13,700 beds) were listed as being for persons with mental disabilities. Only a small percentage of the other facility types were categorized as serving people with mental disabilities (Group Homes 10%; RCFEs 0.04%; Small Family Homes 0.8%). Not all residential care facilities, however, hold themselves out as serving persons from particular groups, so it is uncertain how many persons with psychiatric disabilities actually reside in residential care facilities statewide or in a particular county.

In 1985, the California Legislature recognized the insufficiency of rates set for private residential care facilities for persons with psychiatric disabilities and enacted SB 155.[109] The bill provided for supplemental rates for such private residential care facilities. State funding for these supplemental rates ceased, but the statute still requires that DMH maintain an equitable system of payment for such facilities. In addition, some counties continue to pay a supplemental rate to private residential care providers, although the amount (perhaps as much as $1,800.00 a month) and frequency of such subsidies is unclear. Mental health stakeholders (for example, county mental health staff, family members, and mental health consumers) often mention that private residential care providers for persons with psychiatric disabilities are going out of business. The facilities allegedly are opting to serve persons with developmental disabilities because of higher rates. The extent of the alleged decreased capacity is unclear.

Clearly, however, there is an enormous disparity in rates between the mental health and developmental disability systems, which suggests an inequitable system of payment in private residential care facilities for persons with psychiatric disabilities. Rates of payment for community living facilities for persons with developmental disabilities are set annually by the Department of Developmental Services, as proposed by the State Council on Developmental Disabilities and

---

[105] Cal. Code Regs., tit. 22 § 87100 *et seq.*
[106] Cal. Code Regs., tit. 22 § 87800 *et seq.*
[107] Cal. Code Regs., tit. 22 § 83000 *et seq.*
[108] Cal. Code Regs., tit. 22 § 81000 *et seq.*; *see also* Cal. Code Regs., tit. 9 § 531 *et seq.* (standards for certification of social rehabilitation programs).
[109] Welf. & Inst. Code § 4075.

subject to approval by the California Legislature.[110] Rates must include consideration of each of the following costs: basic living needs, direct care, special services, indirect costs, and property costs.[111] Direct care service costs are based on the individual program plan (IPP) developed pursuant to section 4646 of the Welfare and Institutions Code for each person.[112] Rates may also be based on facility size, geographic differentials, and serving residents with dual diagnoses. In 2001, the basic SSI/SSP residential rate for providers serving persons with psychiatric disabilities was $771.00 a month, whereas residential care facility rates for providers serving persons with developmental disabilities ranged from $771.00 to $1,877.00 a month for owner-operated facilities, and from $771.00 to $4,938.00 a month for staff-operated facilities.

Further, contrary to state policies, California's residential care facilities may be nearly as large as segregated, long-term psychiatric settings (such as state hospitals, SNF/STPs, MHRCs, CTFs), discussed above. The California Legislature has stated policy goals in support of residential care facilities of six or fewer beds for persons with disabilities generally[113] and residential care options of 15 beds or less for persons with psychiatric disabilities.[114] In 2001, residential care facilities ranged in size from 1 to 874 beds; there were some 427 facilities with over 100 beds.

In sum, state support for funding community mental health services is often quixotic: it is based on programs that have been demonstrated to be effective in practice, but the state fails to provide for funding and monitoring necessary to ensure successful, systemic implementation.

---

[110] Welf. & Inst. Code § 4681.
[111] Welf. & Inst. Code §4681.1.
[112] Welf. & Inst. Code § 4681.1(a)(1)&(3), b(3).
[113] *See* Welf. & Inst. Code § 5116 (property used for care of six or fewer persons with disabilities, including children, treated as residential use for zoning purposes).
[114] *See* Welf. & Inst. Code § 5670.5(a)(2).

VII. Criminalization of Persons with Psychiatric Disabilities Continues.

Jails have become the treatment facilities of last (or first) resort for persons with psychiatric disabilities. This is attributed to the inadequate mental health and social support services.[115] Police contact with persons with psychiatric disabilities is most likely *not* to have been the result of that person having committed a crime. Further, persons with psychiatric disabilities have a greater chance of being arrested than persons without psychiatric disabilities for similar offenses.[116]

In 1999, the California Legislature found that the California Department of Corrections (CDC) expends $400 million annually for the incarceration and treatment of people with psychiatric disabilities.[117] In addition, CDC is responsible for about 3,000 of the approximately 4,500 people placed at state hospitals, for an additional annual state cost of over $300 million.

In July 2001, the U.S. Department of Justice reported that of some 150,000 inmates in California's correctional facilities, 2.1% (3,144) received 24-hour psychiatric care; 12.5% (18,863) received therapy/counseling; and 10.5% (15,831) received psychotropic medications.[118] As of June 30, 2000, California had 19 of the 35 largest state correctional facilities providing mental health care in the U.S. (*See* Appendix Fifteen: 19 of 35 Largest State Correctional Facilities in the U.S. Providing Mental Health Care, June 30, 2000, were in California.)

State policies have attempted to respond to the costly and traumatic placement of persons with psychiatric disabilities, including children, in California's criminal and juvenile justice systems. In 1998, the California Legislature passed Senate Bill (SB) 1485, which created the Mentally Ill Offender Crime Reduction Grant Program (MIOCRG).[119] The MIOCRG program awards grants supporting the implementation and assessment of multi-agency demonstration projects to reduce recidivism. Projects provide an array of services, including jail-based interventions and enhanced services in the community (such as assistance in securing housing, vocational training, employment, and federal entitlements). As of November 2001, the Legislature provided $104 million to the MIOCRG program, which involved 30 projects in 26 counties. Funding has been

---

[115] California Board of Corrections, "Mentally Ill Offender Crime Reduction Grant Program" (Annual Legislative Report, June 2002).

[116] *See* John Q. La Fond and Mary L. Durham, "Back to the Asylum: The Future of Mental Health Law and Policy in the United States" (Oxford University Press 1992), p.218 (Notes 10-12)

[117] *See* Historical and Statutory Notes to Section 5802 of the Welfare and Institutions Code, citing Section 1 of Stats.1999, c. 617 (A.B. 34).

[118] *See* U.S. Dept. of Justice, Bureau of Justice Statistics, "Mental Health Treatment in State Prisons, 2000" (July 2001) (Appendix table C).

[119] California Penal Code § 6045.

recommended to all interested counties on a permanent basis.[120] In 2001, an estimated 15% of the more than 74,000 inmates in California jails, or approximately 11,000 persons, were diagnosed with psychiatric conditions. During the same year, 2,911 individuals were enrolled in MIOCRG programs, with slightly over half receiving enhanced services.

In 2000, the California Legislature also enacted AB 2885, which included $121,300,000.00 to counties for juvenile justice programs, including mental health services. The governor deleted funding for these juvenile justice programs, finding that the programmatic justification for them was insufficient. [121]

As mentioned above, AB 34/AB 2034 increased funding for adult systems of care to reduce CDC, criminal justice system, and local law enforcement expenditures for individuals with psychiatric disabilities. State funding for such systems of care has been extremely limited and, therefore, such programs have met only a fraction of the need. The governor's proposed shifting of funding responsibility to the counties threatens to eliminate such assistance altogether.

In sum, police intervention in psychiatric crises treats persons with psychiatric disabilities as criminals rather than as persons who may need health care and social supports. While crisis intervention is a Medi-Cal covered service (*See* Appendix One), access to such assistance is extremely limited at the local level. Public and media misconceptions of "the violent and incompetent mental patient" pressure elected leaders to pass public safety measures rather than to ensure funding for services consistent with real public health needs.

[120] California Board of Corrections, "Federal Disability Benefits: A Key To Curbing Recidivism Among Persons with Severe Mental Illness – Recommendations of the SSI/SSDI Work Group (November 2001).
[121] *See* Historical and Statutory Notes to Government Code § 30061.

VIII. Inter-county Transfers of Persons with Psychiatric Disabilities Continue.

In 1988, the California Legislature found that the shortage of adequate facilities for persons with psychiatric disabilities "is demonstrated by the current practice of … transferring [individuals with psychiatric disabilities] from county to county…"[122] The practice of inter-county transfers of persons with psychiatric disabilities continues today due to inadequate home- and community-based services.

Many persons with psychiatric disabilities are residents of one county but are placed in another county. Sometimes such placement is involuntary under the LPS conservatorship statutes. Other times it is "voluntary" without the involvement of an LPS conservator.

There are several serious problems associated with inter-county transfers, including the following:

- A person who is placed out of county can lose contact with his or her family, friends and social support systems back home;
- Transportation of the person to and from his or her home community is difficult to arrange;
- Discharge planning back to the home community is difficult because social workers and other staff at the out-of-county facility may not be familiar with the resources in the person's home community;
- Social workers or conservators from the home community may not have frequent contact with the person placed out of county;
- The person may agree to go to the out-of-county facility without realizing that his or her home county mental health services may be terminated;
- Counties may enter inter-county agreements under which the person is discouraged or prohibited from seeking assistance outside the facility in the county of placement;
- Health maintenance organizations may not provide healthcare coverage for persons placed in another county; and
- A person may not be provided an opportunity to visit a proposed out-of-county facility to see if it is suitable as a living environment, unlike in the regional center system for people with developmental disabilities.[123]

[122] Welf. & Inst. Code § 4026(a)(4).
[123] Cal. Code Regs., tit. 17 § 56018 (preadmission visits).

In sum, there are a very limited number of home- and community-based service slots in California, including for entitlement Medi-Cal Specialty Mental Health Services (crisis residential treatment). Persons with psychiatric disabilities too often find themselves with no choices: they are left to find their own way through the revolving door of hospitalization and discharge to the streets; they are forced into an institutional setting; they are resigned to move from their home community to avoid homelessness or institutionalization; and they are scapegoated for the inadequacies of the home- and community-based mental health system, as the recent struggle against AB 1421 illustrates.

In 2002, the California Legislature passed AB 1421, which permits counties to expand involuntary outpatient commitment.[124] But it is the state's mental health system that is gravely disabled (that is, unwilling or unable to provide support to enable persons with psychiatric disabilities to find food, shelter, clothing and dignity in the community). The evidence in this report and elsewhere suggests that a significant percentage of persons with psychiatric disabilities who need home- and community-based services are not getting them, and those who do get services only get very few. [125]

---

[124] Prior to going forward with optional implementation of AB 1421, a county is required to show that it has sufficient housing and community support services available on a voluntary basis. It would also have to show that it has sufficient funding such that no voluntary services for children or adults would be reduced if it expanded forced treatment. (*See* CARES Coalition, "Policy Reasons Against Implementation of AB 1421" and "Inadequate Mental Health System Capacity Precludes AB 1421 Implementation").

[125] *E.g.,* RAND Corporation, *The Effectiveness of Involuntary Outpatient Treatment, Empirical Evidence and the Experience of Eight States* (2001).

IX. Recommendations

We offer the following recommendations for increasing access to voluntary housing and community support. These recommendations are directed to governmental entities that have responsibility to ensure access to home- and community-based services within the state's mental health system. Because service systems should be directed by persons with psychiatric disabilities, we encourage these entities to collaborate with people with disabilities as they implement the recommendations. [126]

1. **DMH and the California County Mental Health Directors should conduct a statewide evaluation of need for persons placed in institutional settings, and implement a statewide integration plan that includes the following:**

   a. Identification of the number of persons whose needs could be appropriately met in the home- or community-based setting of their choice with the provision of home- and community-based services, including but not limited to: (i) integrated system-of-care services; (ii) self-help and peer counseling; (iii) public and subsidized housing programs, such as public housing units and section 8 subsidies, shelter plus care, or the California Statewide Supportive Housing Initiative Act (which includes rental subsidies and/or security deposits); and (iv) Medi-Cal Specialty Mental Health Services (which include crisis residential services and one-to-one mental health services).

   b. Client-directed evaluations of all persons placed in institutional settings, including: state hospitals (for both LPS conservatees and forensic patients[127]); Skilled Nursing Facilities with Special Treatment Programs (SNF/STPs); SNFs without STPs; Mental Health Rehabilitation Centers; Community Treatment Facilities; short-term acute care facilities (which includes persons held on administrative day status); private, residential care facilities with

---

[126] State law provides that persons with psychiatric disabilities are the central and deciding figures, except where specifically limited by law, in all planning for treatment and rehabilitation based on their individual needs. (Welf. & Inst. Code § 5600.2(a)). Even if a person has a duly appointed conservator, the conservator has a duty to make health care decisions in accordance with the conservatee's known wishes, consistent with applicable health and legal standards. (Probate Code §§ 2355(a), 4654).

[127] State law provides for mental health treatment and supervision in the community for forensic patients under the Forensic Conditional Release Program (CONREP). (Welf. & Inst. Code § 4360). Recommendations for CONREP program placement should be based on the full scope of home and community based services available, including but not limited to Medi-Cal covered crisis residential and adult transitional residential services.

16 or more beds; prisons, jails and juvenile detention facilities; and homeless shelters.

c. Evaluation should also include and identify persons who are at risk of placement in a segregated setting (such as children at home who are at risk of out-of-home placement; adults residing in single room occupancy hotels; older adults residing in board-and-care homes).

d. Conducting a preliminary cost estimate for the provision of long-term services and programs for persons who are evaluated, consistent with their preferences and rehabilitation or recovery goals. This cost estimate should include information about the current, total cost of service provision (such as supplemental rates to SNF/STP and CTF providers).

e. Implementing a plan, including funding requirements, to ensure the system capacity is increased so that persons with psychiatric disabilities have reasonably prompt access to needed home- and community-based services.

Rationale: As early as 1988, the California Legislature recognized that there was a severe shortage of adequate facilities for persons with psychiatric disabilities of all ages since the closure of 48 out of 94 mental health program facilities in 1968.[128] It found that DMH had been instructing counties to commit individuals to skilled and long-term nursing facilities.[129] It recognized the value of "ensuring that adequate facilities exist for housing [individuals with psychiatric disabilities]" who need long-term care so that they would not be placed in skilled and long-term nursing facilities.[130] The legislature ordered DMH to identify the number of such individuals, make a preliminary estimate of costs of providing long-term health care services and programs for those patients, and report to the legislature by January 1, 1990.[131] In the FY 2002-03 Budget Trailer Bill, the Legislature instructed state agencies to develop an *Olmstead* plan. According to the U.S. Supreme Court, a state or county may defend against ADA integration claims by showing both that it

---

[128] *See* Welf. & Inst. Code § 4026(a)(1).
[129] Welf. & Inst. Code § 4026, subd. (a)(6).
[130] Welf. & Inst. Code § 4026(a)(8).
[131] Welf. & Inst. Code § 4026(b).

has a *comprehensive, effectively working plan* for assisting persons with psychiatric disabilities to live in home- and community-based settings and that its waiting lists for community support services move at a reasonable pace not controlled by endeavors to keep its institutions fully populated.[132] Adults and children who are currently institutionalized or at risk of institutionalization are covered by the *Olmstead* decision.[133]

2. DMH should conduct a statewide audit of the extent to which county Mental Health Plans (MHPs) are providing covered Medi-Cal Specialty Mental Health Services consistent with statewide medical necessity criteria, including but not limited to the provision of the following services:

a. Individual Mental Health Services.

b. Targeted Case Management/Brokerage Services.

c. Crisis Residential Treatment Services.

d. Adult Transitional Residential Treatment Services.

e. Crisis Intervention Services.

Rationale: Some counties use service eligibility criteria that are more restrictive than statewide medical necessity criteria. For example, one county MHP reportedly uses a criterion that a Medi-Cal-eligible person must cost the county mental health system at least $20,000.00 annually to qualify for targeted case management and/or individual mental health services.

In addition, most counties do not have Medi-Cal covered crisis residential and adult transitional residential services, and access to covered crisis intervention services is also very limited. DMH should clarify what these counties are providing as an alternative to these covered services.

---

[132] *Olmstead v. L.C.*, 527 U.S. at 605-606.

[133] *See* Technical Assistance Collaborative, Inc., "Strategies to Help People with Disabilities Be Successful in the Housing Choice Voucher Program – Guidelines for Public Housing Agencies Administering Housing Choice Vouchers Targeted to People with Disabilities through Mainstream, Certain Developments, or Designated Housing Programs (April 2002) at p. 33, *citing* the U.S. General Accounting Office.

These service access considerations are not currently included in DMH's protocol for annual reviews of county Medi-Cal MHPs.

3. The California Mental Health Planning Council should review, assess, and make systemic recommendations regarding the following:

a. The adequacy and equity of rates for private, residential care facilities that serve persons with psychiatric disabilities. In addition, this review should assess and make recommendations regarding the current and future role of private, residential care facilities in the state's mental health system.

b. The statewide frequency of and reasons for inter-county (and interstate) transfers of persons with psychiatric disabilities, including children.

c. The development of performance standards governing access to home- and community-based service options for all persons placed at state hospitals.

d. The development and use of self-help and peer supports by persons with psychiatric disabilities in all areas of the state.

Rationale: The California Mental Health Planning Council has the powers and authority to report on all components of California's mental health system, to approve performance outcome measures, and to report on model programs and services that should be available in all areas of the state. There is widespread concern about the inadequacy of existing rates for private residential care facilities that serve persons with psychiatric disabilities. There is also anecdotal information about private residential care facilities that serve persons with psychiatric disabilities going out of business to serve persons with developmental disabilities. There is no consensus, however, on the role of private residential care facilities in California's mental health system.

While one goal of the system-of-care model is to reduce the number of children placed out of county,[134] children, adults and

[134] Welf. & Inst. Code § 5852.5(b)(2)&(5).

older adults continue to be forced to move out of county or even out of state due to the lack of resources locally.

Based on information obtained pursuant to Public Records Act requests for this report, DMH is failing to comply with its obligation to prepare annual updates of its catalogue of state hospital services as required under section 4334 of the Welfare and Institutions Code. In addition, while DMH adopted the Biopsychosocial Model for all state hospital patients in 1992,[135] it is unclear what standards have been adopted and are being implemented in these facilities to help patients achieve optimum personal and social functioning and well being in both hospital and community environments.

There is consensus on the benefits of self-help and peer support, but there is a need to ensure that funding for the availability of self-help and peer support is not cut back during the budget crisis, and that funding is available for further development of self-help and peer support in all areas of the state.

4. The California Legislature should review, assess, and make recommendations to eliminate fiscal and other incentives that perpetuate the unnecessary confinement of persons with psychiatric disabilities in institutional settings, including but not limited to the following:

a. Rates of reimbursement for care in institutional settings.

b. Rates of reimbursement for home- and community-based services.

c. State and county supplements for care in institutional settings.

d. State and county supplements for home- and community-based services, including but not limited to state rates for supplemental security income (SSI).

Rationale: The California Legislature has repeatedly recognized that inadequate funding of home- and community-based mental health services results in unnecessary placement of persons with psychiatric disabilities in institutional settings. Nonetheless, the state appears to favor funding for institutional care rather than for home- and community-based services. For example, while increasing state hospital funding and

[135] *See* DMH, Bio-Psych-Social Rehabilitation Major Goals and Treatment Modalities (May 27, 1992).

Community Treatment Facility supplemental rates, the governor's proposed budget calls for shifting further responsibilities to county mental health programs and reducing state SSI supplemental rates. The legislature should analyze these proposals and other state and county policies in terms of whether they create incentives for institutional care.

Appendix One: Medi-Cal Specialty Mental Health Services Available under the California State Medicaid Plan

ADULT RESIDENTIAL TREATMENT - Rehabilitative services provided in a non-institutional residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in a residential treatment program. The service is available 24 hours a day, 7 days a week. Service activities include assessment, plan development, therapy, rehabilitation and collateral. (Cal. Code Regs., tit. 9 § 1810.203.)

ASSESSMENT - Service activity that may include clinical analysis of the history and current status of the beneficiary's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures. (Cal. Code Regs., tit. 9 § 1810.204.)

COLLATERAL - A service activity to a significant support person in a beneficiary's life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this activity. The activity may include helping significant support persons understand and accept the beneficiary's condition and involving them in service planning and implementation. Family counseling or therapy provided on behalf of the beneficiary is considered collateral. (Cal. Code Regs., tit. 9 § 1810.206.) Significant support person means persons, in the opinion of the beneficiary or the person providing services, who have or could have a significant role in the successful outcome of treatment, including a person living in the same household as the beneficiary, the beneficiary's spouse, parents, and relatives. (Cal. Code Regs., tit. 9 § 1810.246.1.)

CRISIS INTERVENTION - Subdivision (e) of section 5008 of the Welfare and Institutions Code defines "Crisis intervention" as consisting of "an interview or series of interviews within a brief period of time, conducted by qualified professionals, and designed to alleviate personal or family situations which present a serious and imminent threat to the health or stability of the person or the family. The interview or interviews may be conducted in the home of the person or family, or on an inpatient or outpatient basis with such therapy, or other services, as may be appropriate. Crisis intervention may, as appropriate, include suicide prevention, psychiatric, welfare, psychological, legal, or other social services." State regulations further provide that "Crisis intervention" is a service lasting less than 24 hours to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. The service includes, but is not limited to, assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization, as it is delivered by providers who are not eligible to deliver

crisis stabilization, or who are eligible but deliver the service at a site other than a provider site certified to provide crisis stabilization. (Cal. Code Regs., tit. 9 § 1810.209.)

CRISIS RESIDENTIAL - Therapeutic and/or rehabilitation services provided in a 24-hour non-institutional residential treatment setting providing a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis, and who do not present medical complications requiring nursing care. Individuals are supported in their efforts to restore, maintain and apply interpersonal and independent living skills, and access community support systems. This is a structured, packaged program with services available day and night, seven days a week. Service activities may include assessment, plan development, therapy, rehabilitation, collateral and crisis intervention. (Cal. Code Regs., tit. 9 § 1810.208.)

CRISIS STABILIZATION - A service lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include, but are not limited to, assessment, collateral and therapy. Crisis stabilization must be provided on site at a 24-hour health facility or hospital-based outpatient program, or at other provider sites which have been certified by the department or a Mental Health Plan to provide crisis stabilization services. (Cal. Code Regs., tit. 9 § 1810.210.)

DAY REHABILITATION - A structured program of rehabilitation therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries and is available at least 3 hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. (Cal. Code Regs., tit. 9 § 1810.212.)

DAY TREATMENT INTENSIVE - A structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting, with services available at least 3 hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. (Cal. Code Regs., tit. 9 § 1810.213.)

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SUPPLEMENTAL MENTAL HEALTH SERVICES - Those services defined in Title 22, Section 51184, that are provided to beneficiaries under age 21 to correct or ameliorate the diagnoses listed in section 1830.205, and that

are not otherwise covered services (such as Therapeutic Behavioral Services). (Cal. Code Regs., tit. 9 § 1810.215.)

MEDICATION SUPPORT SERVICES - Those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, obtaining informed consent, medication education and plan development related to delivery of the service and/or assessment of the beneficiary. (Cal. Code Regs., tit. 9 § 1810.225.)

MENTAL HEALTH SERVICES - Those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation, and collateral. (Cal. Code Regs., tit. 9 § 1810.227.)

PLAN DEVELOPMENT - A service activity for development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress. (Cal. Code Regs., tit. 9 § 1810.232.)

PSYCHIATRIST SERVICES - Services provided by licensed physicians, within their scope of practice, who have contracted with the MHP to provide specialty mental health services or who have indicated a psychiatrist specialty as part of the provider enrollment process for the Medi-Cal program, to diagnose or treat a mental illness or condition. For the purposes of this chapter, psychiatrist services may only be provided by physicians who are individual or group providers. (Cal. Code Regs., tit. 9 § 1810.240.)

PSYCHOLOGICAL SERVICES - Services provided by licensed psychologists, within their scope of practice, to diagnose or treat a mental illness or condition. For the purposes of this chapter, psychologist services may only be provided by psychologists who are individual or group providers. (Cal. Code Regs., tit. 9 § 1810.241.)

REHABILITATION - Service activity which includes assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education. (Cal. Code Regs., tit. 9 § 1810.243.)

TARGETED CASE MANAGEMENT/BROKERAGE - Services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development. (Cal. Code Regs., tit. 9 § 1810.249.)

THERAPEUTIC BEHAVIORAL SERVICES (TBS) - A new EPSDT mental health service. TBS involves having a trained, experienced staff person available on a one-to-one basis to work with a child with severe emotional or mental disabilities in his or her own home or community. TBS is a short-term service intended to prevent a young person from having to go into a more restrictive placement, or to support the transition of a young person from an institutional placement back to the child's home or community.

THERAPY - A service activity which is a therapeutic intervention that focuses primarily on symptoms reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present. (Cal. Code Regs., tit. 9 § 1810.250.)

Appendix Two: Patient Bed Capacity* at Four Segregated, Long-Term Psychiatric Settings in California: 1991/1992 – 2001

Facility Category	1991/1992	2001	Change
State Hospitals	**4,861**[1]	**4,828**[2]	**-33 (-0.68%)**
ASH	973	1,001	+28 (+2.88%)
CSH	621	Closed	-621 (-100%)
MSH	960	1,184	+224 (+23.33%)
NSH	1,318	1,362	+44 (+3.34%)
PSH	989	1,281	+292 (+29.52%)
Skilled Nursing Facilities with Special Treatment Programs (SNF/STPs	**2,951**[3]	**3,384**[4]	**+433 (+14.67%)**
Mental Health Rehabilitation Centers (MHRCs)	**0**	**1,283**[5]	**+1,283 (+100%)**
Community Treatment Facilities (CTFs) for Minors	**0**	**82**[6]	**+82 (+100%)**
Total Capacity	**7,812**	**9,577**	**+1,765 (22.59%)**

[1]Source: 1992 patient capacity reported in DMH, "State Hospital Clinical Services Directory" (1992).

[2]Source: DHS licenses for ASH, MSH, NSH, PSH in effect June 2001 (including beds in suspense).

[3]Source: STP certification records reported in DMH, "Certified Special Treatment Programs" (June 2001).

[4]Source: DMH, "Certified Special Treatment Programs" (June 2001).

[5]Source: DMH, "Mental Health Rehabilitation Centers (MHRCs) 1995 to Current Year" (2001).

[6]Source: DMH report on Community Treatment Facilities in operation as of July 12, 2001.

* Note that total bed capacity data may differ from actual patient census data (e.g., Appendices Four and Five).

Appendix Three: State Hospital Bed Allocations/ Purchases: FY 1991 – 92 to FY 2000 – 01

Counties	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001
Alameda	164.80	89.00	76.00	76.00	47.00	28.00	24.00	18.00	18.00	17.00
Alpine	1.00	0.80	0.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Amador	1.50	0.50	0.25	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Butte	6.80	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Calaveras	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Colusa	2.00	1.00	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00
Contra Costa	84.70	71.00	39.00	37.00	31.00	23.00	18.00	8.00	6.00	8.00
Del Norte	1.00	1.00	0.50	0.25	0.25	0.25	0.25	0.25	0.25	0.25
El Dorado	2.40	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00
Fresno	15.00	22.30	22.00	15.00	12.00	8.00	8.00	21.00	21.00	18.00
Glenn	0.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Humboldt	7.60	2.00	2.00	2.00	2.00	2.00	1.50	1.00	1.00	1.00
Imperial	2.70	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
Inyo	3.80	1.00	0.50	0.50	0.50	0.50	0.25	0.00	0.00	0.00
Kern	42.40	34.00	14.00	5.00	2.00	2.00	1.00	1.00	1.00	3.00
Kings	2.80	2.00	1.00	1.00	1.00	1.00	1.00	0.00	0.00	3.00
Lake	3.00	3.00	1.00	0.75	2.50	1.50	1.50	1.00	1.00	1.50
Lassen	1.70	2.00	0.25	0.25	1.25	1.25	0.50	1.00	1.00	1.00
Los Angeles	1080.10	844.00	759.00	725.00	708.00	715.00	629.00	560.00	555.00	522.00
Madera	1.30	3.00	3.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Marin	30.20	15.00	12.00	9.00	4.00	4.00	3.00	3.00	3.00	2.00
Mariposa	1.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Mendocino	4.90	5.00	4.00	3.00	1.00	1.00	1.00	1.00	0.00	0.00
Merced	4.20	2.00	2.00	1.00	1.00	0.00	1.00	2.00	2.00	3.00
Modoc	1.00	1.00	0.50	0.00	0.00	0.00	0.25	0.25	0.25	0.25
Mono	1.00	1.00	1.00	0.50	0.00	0.00	0.00	0.00	0.00	0.00
Monterey	21.90	17.00	10.00	9.00	7.00	6.00	6.00	5.00	5.00	5.00
Napa	24.60	16.00	14.00	13.00	10.00	9.00	6.00	6.00	4.00	4.00

Counties	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001
Nevada	5.20	5.00	3.00	2.00	1.50	0.50	0.50	0.50	0.50	0.50
Orange	148.20	148.00	142.00	51.00	46.00	46.00	46.00	46.00	46.00	46.00
Placer	8.90	8.00	5.00	5.00	5.00	4.00	3.00	2.00	3.00	3.00
Plumas	1.30	1.00	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25
Riverside	51.50	52.00	48.00	47.00	38.00	32.00	27.00	26.00	26.00	26.00
Sacramento	47.90	48.00	32.00	32.00	32.00	32.00	32.00	31.00	31.00	33.00
San Benito	2.70	1.00	0.50	0.25	0.25	0.25	0.25	0.25	0.25	0.25
San Bernardino	58.90	56.00	38.00	36.00	36.00	32.00	30.00	29.00	29.00	29.00
San Diego	71.00	91.00	71.00	38.00	28.00	17.00	14.00	14.00	16.00	19.00
San Francisco	213.90	117.00	97.00	87.00	71.00	40.00	46.00	36.00	38.00	42.00
San Joaquin	9.70	9.00	5.00	5.00	4.00	1.00	1.00	1.00	1.00	4.00
San Luis Obispo	7.50	7.00	7.00	6.00	3.00	1.00	0.00	1.00	0.00	1.00
San Mateo	68.40	55.00	51.00	39.00	27.00	18.00	12.00	11.00	7.00	7.00
Santa Barbara	22.80	18.00	19.00	19.00	14.00	3.00	0.00	1.00	3.00	6.00
Santa Clara	74.90	75.00	58.00	57.00	55.00	54.00	54.00	33.00	23.00	37.00
Santa Cruz	14.70	10.00	7.00	5.00	4.00	1.00	0.00	0.00	1.00	1.00
Shasta	12.30	7.00	6.00	6.00	6.00	6.00	6.00	4.00	4.00	3.00
Sierra	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Siskiyou	1.30	1.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Solano	48.40	38.00	36.00	32.00	22.00	9.00	9.00	9.00	9.00	10.00
Sonoma	26.10	18.00	16.00	12.00	7.00	4.00	3.00	3.00	4.00	4.00
Stanislaus	18.30	15.00	14.00	12.00	8.00	8.00	6.00	6.00	4.00	7.00
Sutter/Yuba	3.80	4.00	4.00	4.00	2.00	2.00	2.00	2.00	2.00	2.00
Tehama	3.80	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
Trinity	1.00	0.50	0.50	0.50	0.50	0.50	0.25	0.25	0.00	0.00
Tulare	7.10	7.00	7.00	7.00	6.00	5.00	3.00	2.00	3.00	6.00
Tuolumne	3.20	3.00	2.25	2.00	1.00	0.00	0.00	1.00	1.00	1.00
Ventura	35.60	30.00	29.00	27.00	20.00	9.00	2.00	1.00	2.00	1.00

Counties	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001
Yolo	12.30	9.00	8.00	8.00	7.00	4.00	4.00	3.00	3.00	3.00
TOTALS	2496.8	1977.3	1676	1446.3	1282	1138	1009.5	897.75	881.5	887

Appendix Four: State Hospital Census & Legal Commitments 6/27/01

Hospital Census		Forensic Patients		LPS Patients	
ASH	1,010	1,004 Patients	(99%)	6 Patients	(1%)
MSH	968	379 Patients	(39%)	589 Patients	(61%)
NSH	1,094	865 Patients	(79%)	229 Patients	(21%)
PSH	1,281	1,214 Patients	(95%)	67 Patients	(5%)
4,353 Patients		3,462 Patients (80%)		891 Patients (20%)	

Appendix Five: Types of Legal Commitments for Residents at State Hospitals 6/27/01

Hospital	Atascadero	Metropolitan	Napa	Patton
LPS Commitments	**6**	**589**	**229**	**67**
Pre-Conservatorship	0	14	2	2
Temp. LPS Conserv.	1	10	3	0
LPS Conservatorship	1	522	190	34
Murphy Conserv.	0	4	34	31
Voluntary	0	39	0	0
Dept. Dev. Services	4	0	0	0
Penal Code Commitments	**1,004**	**379**	**865**	**1,214**
Not Guilty by Reason of Insanity (NGI)	62	105	523	459
Incompetent to Stand Trial (IST) (DD)	73 (2)	243	236	350
Mentally Disordered Offender (MDO)	314	31	97	344
Mentally Disordered Sexual Offender (MDSO)	7	0	9	17
Sexually Violent Predator (SVP)	380	0	0	1
Cal. Dept. of Corrections transferee under section 2684 (CDC 2684)	168	0	0	43
Total Population	**1,010**	**968**	**1,094**	**1,281**

Appendix Six: Level of Care for LPS Conservatees at NSH, MSH, and CSH FY 1992-93 & FY 2000-01.[136]

Acute			Sub-Acute/ICF			Youth			SNF			Rehab		
FY	**92-93**	**00-01**	**FY**	**92-93**	**00-01**	**FY**	**92-93**	**00-01**	**FY**	**92-93**	**00-01**	**FY**	**92-93**	**00-01**
NSH	40	0	NSH	404	209	NSH	94	0	NSH	124	16	NSH	35	0
MSH	477	117	MSH	227	377	MSH	0	117	MSH	0	51	MSH	86	0
CSH	149	N/A	CSH	89	NA	CSH	156	NA	CSH	96	NA	CSH	0	NA
Total	**666**	**117**	**Total**	**720**	**586**	**Total**	**250**	**117**	**Total**	**220**	**66**	**Total**	**121**	**0**
82% Reduction			**19% Reduction**			**53% Reduction**			**70% Reduction**			**100% Reduction**		

[136] Source: DMH, County State Hospital Beds Number and Mix of Beds Purchased in FY 1992-93 and FY 2000-01.

Appendix Seven: Level of Care for all State Hospital Residents - 2001

Hospital	Atascadero	Metropolitan	Napa	Patton
Licensed Beds	1,001	1,184	1,362	1,281
Acute	132	1,082	151	388
Intermediate Care	869	0	1,175	893
SNF	0	102	36	0

Appendix Eight: State Hospital County Bed Daily Rates FY 1991-92 & FY 2001-02[137]

L.O.C. Acute		Sub-Acute/ ICF	Youth	SNF	Rehab
ASH & PSH					
FY 91-92	$259.89	?	NA	?	NA
FY 01-02	313.29	?	NA	?	NA
MSH					
FY 91-92	$259.89[138]	$259.89	NA	NA	NA
FY 01-02	355.68[139]	328.48	$350.29	$307.83	NA
NSH					
FY 91-92	$259.89	$259.89	259.89	259.89	NA[140]
FY 01-02	NA	313.29	NA	345.29	NA

[137] Source: DMH Program Policy and Fiscal Support (August 15, 2001).
[138] Note: This rate is for the following Hospital/Bed Category: Acute Psychiatric.
[139] Note: This rate is for the following Hospital/Bed Category: Acute Psychiatric Specialized; it is unclear how this differs from Acute Psychiatric, above.
[140] The Daily County Bed Rate for ICF – Psychiatric Rehabilitation in FY 1992-93 at NSH was $159.78; the rate for the same Bed Category at MSH in FY 1992-93 was $238.11.

Appendix Nine: Skilled Nursing Facilities w/ Certified Special Treatment Programs (SNF/STPs) – June 2001

[Title 42, C.F.R. §§ 483.1 et seq.; Cal. Code Regs., tit. 22 §§ 72001 et seq., 72443-72475]

COUNTY	FACILITIES	BEDS	NAMES (# OF BEDS)
Alameda	3	213	Crestwood Geriatric Treatment Center (88); Crestwood Manor-Fremont (50); Morton Bakar (75)
Fresno	1	99	Fresno Care & Guidance (99)
Los Angeles	12	1,283	Community Care Center (166), Downey Community Health Center (74); Foothill Health & Rehab Center (202); Harbor View Center (39); Landmark Medical Center (95); La Paz Geropsychiatric Center (130); Laurel Park (43); Meadowbrook Manor (63); Olive Vista (120); San Gabriel Valley Penn Mar (45); Sylmar Health & Rehab Center (190); View Heights Convalescent Hospital (116);
Marin	1	89	Canyon Manor (89)
Merced	1	96	Merced Manor (96)
Orange	2	170	Royale Therapeutic Residential Center (124); Westminster Therapeutic Residential Center (46)
Riverside	2	228	Beverly Manor (120); Vista Pacifica (108)
Sacramento	1	130	Crestwood Manor (130)
San Bernardino	2	163	Shandin Hills Behavior Therapy Center (47); Sierra Vista (116)
San Diego	1	99	Cresta Loma (99)
San Joaquin	1	174	Crestwood Manor - Stockton (174)
Santa Clara	2	146	San Jose Care & Guidance (116); Valley House Care Center (30)
Santa Cruz	1	99	Seventh Avenue (99)(*converted to MHRC in 9/2001)
Shasta	1	99	Crestwood Geriatric Treatment Center (99)
Solano	1	140	Crestwood Manor - Vallejo (140)

COUNTY	FACILITIES	BEDS	NAMES (# OF BEDS)
Sonoma	1	53	Creekside Convalescent Hosp. (53)
Stanislaus	1	103	Crestwood Manor - Modesto (103)
TOTAL: 17 Counties	34 Facilities	3,384 Beds	

Appendix Ten: Mental Health Rehabilitation Centers (MHRCs): 1995 -2001

[Cal. Code Regs., tit. 9 §§ 781.00-788.14]

COUNTY	FACILITIES	BEDS	NAMES (# OF BEDS)
Alameda	2	179	Gladman** (80);Villa Fairmont* (99)
Fresno (closed 9/01)	1	16	Fresno County Mental Health Rehab. Center*** (16)
Humboldt	1	69	Crestwood Behavioral Health* (69)
Kern	1	64	Crestwood Behavioral Health* (64)
Los Angeles	1	190	La Casa - Long Beach* (190)
Napa	1	54	Crestwood Center – Angwin* (54)
Orange	1	65	Royale Health Care Center*** (65)
Riverside	1	34	Oasis Mental Health Center**** (34)
Sacramento	1	80	American River Behavioral Health Center* (80)
San Diego	2	161	C.H.O.I.C.E.S.* (62); Alpine Special Treatment Center* (99)
San Mateo	1	68	Cordilleras Mental Health Center* (68)
Santa Clara	1	174	Crestwood Behavioral Health Center - San Jose* (174)
Solano	1	64	Crestwood Behavioral Health Center -Vallejo* (64)
Tulare	1	35	Cypress Mental Health Rehabilitation Center***(35)
Ventura	2	30	Las Posadas Casa I****(15); Las Posadas Casa II****(15);
TOTAL 15 Counties	18 Facilities	1,283 Beds	* Former SNF/STP ** Former Psychiatric Health Facility (PHF) *** Former Hospital/Other Health Care Facility **** New Facility

Appendix Eleven: Community Treatment Facilities (CTFs) in Operation as of July 12, 2001

(Welf. & Inst. Code 4094; Cal. Code Regs., tit. 9 1923; Cal. Code Regs., tit. 2284110-84188)

Facility Name	County	Licensed	Available Beds
Starlight Community Treatment Facility	San Jose	October 2000	36
Vista Del Mar Child and Family Services	Los Angeles	May 2001	24
San Francisco Alternative Center	San Francisco	June 2001	22
Total:			**82**

Appendix Twelve: Certified Residential Treatment Services (CRTS): 2001

[Cal. Code Regs., tit. 22 §§ 81000-81088, tit. 9 §§ 531-535, 1810.203, 1810.208]

Location	Crisis Res.		Transitional		Total	
	Facilities	Beds	Facilities	Beds	Facilities	Beds
Statewide	29	340	49	608	78	948
Alameda	1	15	2	28	3	43
Contra Costa	1	12	1	12	2	24
Fresno	0	0	1	16	1	16
Los Angeles	3	33	10	94	13	127
Monterey	1	11	1	10	2	21
Napa	1	7	3	28	4	35
Orange	0	0	1	6	1	6
Placer	0	0	2	30	2	30
Riverside	1	12	1	9	2	21
Sacramento	1	6	1	12	2	18
San Diego	6	77	1	14	7	91
San Francisco	4	42	10	157	14	199
San Joaquin	1	12	3	45	4	57
San Luis Obispo	0	0	1	12	1	12
San Mateo	1	16	3	43	4	59
Santa Barbara	0	0	1	12	1	12
Santa Clara	4	57	3	34	7	91
Santa Cruz	1	15	2	26	3	41
Solano	1	13	0	0	1	13
Sonoma	0	0	2	20	2	20
Stanislaus	1	6	0	0	1	6
Yolo	1	6	0	0	1	6

Appendix Thirteen: Medi-Cal Short Term Crisis Residential Treatment Facilities - 2001

[Cal. Code Regs., tit. 22 §§ 81000-81088, tit. 9 §§ 531-535, 1810.208]

County	# of Facilities	Total Beds	Facility Name (Bed #)
San Diego	6	77	Halcyon Center (14); Isis Center (12); Jary Barreto (10); New Vistas (14); Turning Point Ct. (11); Vista Balboa (16)
San Francisco	4	42	Avenues (10); Cortland House (10); Grove House (12); La Posada (10)
Santa Clara	4	57	Casa San Antonio (12); Goveia/Zeller (16); Litteral House (13); Sart Program (16)
Los Angeles	3	33	Compass House (12); Excelsior House (15); Jump Street (6)
Alameda	1	15	Woodroe Place (15)
Contra Costa	1	12	Nierika House (12)
Monterey	1	11	Manzanita (11)
Napa	1	7	Progress Place (7)
Riverside	1	12	Rancho Phoenix (12)
San Joaquin	1	12	Grant House (12)
San Mateo	1	16	Redwood House (16)
Sacramento	1	6	Turning Point (6)
Santa Cruz	1	15	Opal Cliffs (15)
Solano	1	13	Caminar Laurel Creek House (13)
Stanislaus	1	6	Turning Point - Modesto (6)
Yolo	1	6	Safe Harbor (6)

Appendix Fourteen: Medi-Cal Adult Transitional Residential Facilities -2001

[Cal. Code Regs., tit. 22 §§ 81000-81088; tit. 9 § 531-535, 1810.203]

County	# Facilities	Beds	Facility Name (Bed #)
San Francisco	10	157	Baker Street House (16); Carroll House (6); Clay House (16); Jackson Street House (30); La Amistad (13); Progress House (10); Robertson House (10); Rypins House (6); Shrader House (10); Westside Lodge (40)
Los Angeles	10	94	Glorieta Ardiente (6); Hacienda Retirada (6); Herrick House (6); Hillview Center (10); Primer Paseo (6); The Harbour (12); Torreno Nuevo (6); Transitional Living Center #1 (12); Transitional Living Center #2 (16); Twin Peaks (14)
San Joaquin	3	45	Bright House (15); SAFR House (16); Willow House (14)
San Mateo	3	43	Eucalyptus House (15); Hawthorne House (15); Wally's Place (13)
Santa Clara	3	34	Casa Del Puente (10); Jacobs Center (12); La Selva (12)
Napa	3	28	Laurel House (8); Randolph House (5); The Avenue (15)
Placer	2	30	Cedar House (15); Manzanita House (15)
Alameda	2	28	Bonita House (15); Casa De La Vida (13)
Santa Cruz	2	26	El Dorado (16); Transition House (10)
Sonoma	2	20	A Step Up (10); E Street Program (10)
Fresno	1	16	Appollo Residential (16)
San Diego	1	14	Casa Pacifica (14)
Contra Costa	1	12	Nevin House (12)
Sacramento	1	12	Crestwood Fruitridge Transitional (12)
San Luis Obispo	1	12	San Luis Obispo House (12)
Santa Barbara	1	12	Sanctuary House (12)
Monterey	1	10	Bridge House (10)
Riverside	1	9	Phoenix House (9)
Orange	1	6	Hearts Kober (6)

Appendix Fifteen: 19 of 35 Largest State Correctional Facilities Providing Mental Health Care to Inmates on June 30, 2000, Were in California

		Number of Inmates Receiving			Percent of Inmates Receiving		
19 of 35 Largest State Correctional Facilities Providing Mental Health Care	**Inmates on 6/30/00**	**In 24-hour Care**	**In therapy/ Counseling**	**Psycho-tropic Meds.**	**In 24-hour Care**	**In therapy/ Counseling**	**Psycho-tropic Meds.**
Total	90,841	2,277	15,516	11,714	2.5%	17.1%	12,9%
1. CA Men's Colony, San Luis Obispo	6,683	221	1,721	1,621	3.3%	25.8%	24.3%
2. CA Medical Facility, Vacaville	3,070	1,300	1,300	1,300	42.3%	42.3%	42.3%
3. CA Institute for Women, Corona	1,954	190	900	600	9.7%	46.1%	30.7%
4. Mule Creek State Prison	3,566	7	854	769	0.2%	23.9%	21.6%
5. Substance Abuse Treatment, Corcoran	6,284	14	817	450	0.2%	13.0%	7.2%
6. CA State Prison, Sacramento	2,975	16	794	763	0.5%	26.7%	25.6%
7. CA State Prison, Los Angeles	4,210	8	779	594	0.2%	18.5%	14.1%
8. Wasco State Prison	5,932	/[141]	735	525	0.0%	12.4%	8.9%
9. Correctional Training Facility, Soledad	7,223	7	726	497	0.1%	10.1%	6.9%
10. CA Correctional Institution, Tehachapi	5,243	118	719	539	2.3%	13.7%	10.3%
11. CA State Prison, Solano	5,863	9	708	610	0.2%	12.1%	10.4%
12. Salinas Valley State Prison	4,244	98	707	604	2.3%	16.7%	14.2%

[141] / = Not reported

		Number of Inmates Receiving			Percent of Inmates Receiving		
19 of 35 Largest State Correctional Facilities Providing Mental Health Care	**Inmates on 6/30/00**	**In 24-hour Care**	**In therapy/ Counseling**	**Psycho-tropic Meds.**	**In 24-hour Care**	**In therapy/ Counseling**	**Psycho-tropic Meds.**
13. CA Rehabilitation Center, Norco	4,795	7	705	278	0.1%	14.7%	5.8%
14. Valley State Prison for Women	3,476	4	691	392	0.1%	19.9%	11.3%
15. CA State Prison, San Quentin	5,802	14	689	517	0.2%	11.9%	8.9%
16. Avenal State Prison	6,555	250	686	428	3.8%	10.5%	6.5%
17. Centinela State Prison	4,569	2	685	11	0.0%	15.0%	0.2%
18. Central Women's Facility, Chowchilla	3,445	5	675	636	0.1%	19.6%	18.5%
19. North Kern State Prison	4,952	7	625	580	0.1%	12.6%	11.7%

* Source: U.S. Dept. of Justice (DOJ), Bureau of Justice Statistics Special Report "Mental Health Treatment in State Prisons, 2000" (July 2001) (Appendix table C). Note: Facilities were ranked based on the number of inmates receiving mental health therapy or counseling services in California facilities on June 30, 2000. Some of the non-California facilities listed by DOJ may have more inmates receiving mental health care than these California facilities.