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CALIFORNIA LEGISLATURE

Senate Subcommittee on the Disabled

Milton Marks, Chairman

HEARING ON

MENTAL HEALTH AND THE DISABLED

STATE CAPITOL
ROOM 113
SACRAMENTO, CALIFORNIA

THURSDAY, MAY 16, 1985

1:00 P.M.

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1 HEARING
2 BEFORE THE
3 SENATE SUBCOMMITTEE ON THE DISABLED
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5 Hearing in re:)
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6 MENTAL HEALTH AND THE)
DISABLED.)
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18 THURSDAY, MAY 16, 1985
19 1:00 P.M.
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26 Nadine J. Parks
Shorthand Reporter
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28

86-7-409

MEMBERS

Senator Milton Marks, Chairman

Senator Barry Keene
Senator Dan McCorquodale

Dorothy Epstein, Coordinator

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1 P R O C E E D I N G S

2 --o0o--

3 CHAIRMAN MARKS: We're going to bring this meeting
4 to order. Let me tell you that this is a meeting of the
5 Subcommittee on the Disabled. I'm Senator Milton Marks, and
6 this is Dorothy Epstein, who has been the coordinator of this
7 committee for a number of years.

8 And I have a short statement I'd like to read at
9 this time; then, we'll hear our witnesses. The other members
10 of the subcommittee are involved, unfortunately, in committee
11 meetings of their own. So, we'll record this testimony and
12 they will see it.

13 The care of the mentally ill has been recognized
14 as a responsibility of State government. The Legislature
15 encouraged the creation of a system of treatment options so
16 that mentally ill persons could obtain the proper services
17 within their own community. The Short-Doyle Act provided a
18 fiscal mechanism to implement this policy, and the Lanterman/
19 Petris/Short Act, passed in 1968, has always been recognized
20 as one of the most important pieces of mental health
21 legislation.

22 This is our past, and I acknowledge we've come a
23 long way in the last 17 years, but not far enough, because
24 some of the problems that existed then exist now.

25 In the deaf community, for instance, there are not
26 enough in-patient clinical programs and not enough therapists
27 who understand the deaf consumer, and some additional problems
28 exist today -- such as the large numbers of street people and

1 refugees needing mental health services.

2 The reason that I am holding this hearing is in my
3 discussions with the disabled community, I am constantly
4 reminded that there are a number of critical needs not being
5 addressed such as the quality of mental health services,
6 patients' rights, adequate treatment for children, stigma, and
7 more self-help services, just to mention a few.

8 Over the years, the changing state and federal
9 regulations, economic distress, and funding reductions and
10 lack of statewide standards are some of the issues that have
11 combined to threaten the mental health system.

12 Today, advocates and taxpayers,who pay millions to
13 help finance the public mental health services, are demanding
14 more accountability, efficiency, and effectiveness in mental
15 health services than ever before. I hope that today's hearing
16 will address these concerns of the disabled community so that we
17 may move on to provide the services needed.

18 We have a number of witnesses to testify on the
19 subject. Let me first call on Ferd Shaw. Ferd Shaw here? I
20 won't call him. Kathryn Ross.

21 MS. ROSS: My name's Kathryn Ross and I'm the
22 administrator for special education in the State Department of
23 Education.

24 CHAIRMAN MARKS: You saw the letter that I sent?

25 MS. ROSS: (Nodding her head). Okay. I'd like to
26 attempt to answer the questions you asked us to address, the
27 first one being, "Is the Department of Mental Health
28 cooperating with the Department of Education in providing

1 mental health services for residential schools?"

2 I surveyed our State residential schools, the

3 two schools for the deaf -- the one in Riverside and the one in

4 Fremont -- and discussed with their superintendents what kind

5 of services they were getting from State Mental Health.

6 At this time, they indicated in the school for the

7 deaf in Riverside that they are getting some services from

8 St. John's Hospital. And I understand that Mental Health

9 directly contracts for those services for deaf emotionally

10 disturbed there.

11 They did indicate, though, that because of

12 changing population -- this is true for both schools for the

13 deaf -- they are getting many more multiple-handicapped

14 children and have much more need for intensive services. The

15 school for the deaf in Fremont is contracting with Dr. William

16 Evans and he's from the University of California Center for

17 Deafness.

18 And, again, they have a grant from the Department

19 of Mental Health. And Dr. Klopping indicated also that they

20 have about 50 children now in need of intensive services at the

21 school.

22 I know they're also trying BCP to try to get some

23 services directly, State support, too, but they aren't getting

24 that kind of services. They are not getting very many services

25 from Alameda County Mental Health. They have contacted them;

26 have been working with them. Alameda County has -- well, as we

27 know, limited amount of funds, and also, the youngsters at the

28 school for the deaf are from many other counties, not just

1 Alameda.

2 They do serve them, but they are not a priority.

3 They do not come ahead of any other deaf children at their

4 center.

5 The school for the blind has not used nor have they

6 pursued giving services for mental health, and nor have the

7 three diagnostic centers. They have not pursued it. It might

8 have been a good idea, but that has not been in their history.

9 A number of private residential schools have

10 contracts with local mental health agencies, but that's

11 individual private schools contracting for individual

12 children with departments of mental health.

13 Your other question was on the impact of

14 Assembly Bill 3632. Right now we don't know the fiscal

15 impact or really the programmatic. We're gathering data and

16 the data's coming in. We are trying to find out who is

17 actually serving which youngsters' schools could be more

18 properly served by Mental Health. That data is not available

19 yet.

20 CHAIRMAN MARKS: When was the bill passed?

21 MS. ROSS: The bill was passed last year. It was

22 supposed to be effective -- I don't know the passage date.

23 We have been working with -- we're supposed to have

24 a report into the Legislature on April 15th. We don't have

25 that in yet on the cost. To Finance. We don't have that in

26 yet. The cost data collecting -- the forms, I guess, didn't

27 give us the kind of information that we really needed.

28 I understand that Mental Health has resubmitted

1 too, because there's been a lot of misunderstanding about what
2 was going to happen. The implementation date of 3632 is July
3 1. It was September 30, 1984.
4 The -- what we have been doing with the Department
5 of Mental Health very recently, working very diligently within
6 our staff with members of their staff to complete draft
7 regulations. Those regulations are almost completed. And
8 we're looking forward to what we hope will be joint hearings
9 on the regulations. So we're both -- we're looking at the
10 needs together instead of separate agencies, so we can
11 coordinate better.
12 The big problem appears to be adequate funding.
13 As you probably are aware, there's still a stalemate, I think,
14 on 105, on the follow-up bill. That's pretty much where we're
15 at.
16 CHAIRMAN MARKS: Thank you very much.
17 MS. EPSTEIN: Could I ask you a question?
18 CHAIRMAN MARKS: Put the microphone up.
19 MS. EPSTEIN: In terms of children receiving
20 services, are there enough therapists now?
21 MS. ROSS: I don't think so.
22 CHAIRMAN MARKS: Okay. Thank you very much. We
23 appreciate your being here.
24 Is Ferd Shaw here?
25 Moss Nader.
26 MR. NADER: Good afternoon. I'm Moss Nader from
27 the State Department of Mental Health. I will attempt to
28 respond to the questions that you have posed for us.

1 And if there are any other questions, I'll be glad
2 to address them.
3 You'd asked that -- whether the Department of
4 Mental Health is putting its financial resources -- where we
5 are putting our financial resources for the mentally ill
6 population other than in the Short-Doyle county block grant
7 and hospital bailout.
8 As you may be aware, the Department of Mental
9 Health has no other financial resources besides the funds that
10 we are spending for our community programs and the cost of
11 the State psychiatric hospital operations.
12 At the present time, we spend roughly $438 million
13 for the local assistance, the funds that goes to counties.
14 We have about $4.2 million that goes to the judicially
15 committed county programs for programs that deal with
16 mentally ill offenders.
17 Then, we -- in the State hospitals, we have the
18 Atascadero State Hospital and Patton State and other programs
19 that deal with judicial offenders, the Penal Code patients --
20 we spend about $98 million for the operation of those
21 hospitals and other State hospital programs for psychiatric
22 Lanterman/Petris/Short Act type of patient, we spend almost
23 $46 million.
24 In addition to that in recent years we have
25 managed to obtain $15.7 million from the federal government
26 which we block grant to the community mental health centers
27 and agencies. But in a nutshell, most of the funds, except
28 for a very small percentage that is for the administrative

1 are basically funnelled to the local government agencies for
2 the administration of mental health programs.
3 The second question was: Is there a Department
4 of Mental Health priority for doubly handicapped such as
5 mentally ill/hearing impaired or visually impaired, orthoped-
6 ically handicapped, developmentally disabled?
7 Recently enacted AB 2381 of last year mandates
8 that in developing and providing the services of a county --
9 a county mental health program, the county shall consider
10 and make provision for all of the following priority
11 populations. Priority populations are then enumerated as
12 chronically mentally ill, mentally disturbed children and
13 adolescents, mentally ill elderly, mentally ill jail inmates,
14 MDO's, and underserved populations.
15 The State Department of Mental Health has
16 interpreted the physically and developmental handicapped to be
17 among the underserved population.
18 We have communicated that to the counties. And we
19 are doing our utmost to ensure that counties consider this
20 group as a priority population; that is, the duly diagnosed
21 mentally ill, the clients who have physical handicaps, as well
22 as the hearing impaired. We have articulated that and
23 indicated that to all the counties.
24 But, basically, at this moment, the identification
25 of priorities has to come from the local county mental health
26 program. Usually, each county through its own constituency
27 group and mental health advisory board identify their own
28 local needs and priorities. They submit it to us and then, of

1 course, the State Department through some formal mechanism
2 approves the county plan.
3 In general, the State does not identify specific
4 priorities for specialized types of clientele. These
5 priority groups are usually identified on a local basis based
6 on local needs. That's the way the current laws are and
7 we're just complying with them.
8 The next question was: Because the Department of
9 Mental Health is block-granting the dollars to the counties
10 on equity formula (sic), what standards of excellence does
11 the Department of Mental Health expect from these counties?
12 If by standards of excellence you mean standards
13 of excellence as far as programs are concerned, we have a
14 number of formal monitoring and reviewing procedures. A
15 special group of headquarter's staff from the Department of
16 Mental Health on a regular basis conduct monitoring of local
17 programs. The review protocol is designed to ensure some
18 degree of excellence.
19 Furthermore, the Department has got a formal
20 quality assurance mechanism. Quality assurance ensures that
21 some degree of quality are adhered to in all of the 24-hour
22 psychiatric facilities. We now have medication monitoring
23 procedures. We have utilization monitoring and peer review
24 for the in-service programs within the 24-hour psychiatric
25 facilities.
26 As far as the individual -- delivery of individual
27 services to a given clientele, of course, the way the mechanism
28 is set, most of the clinicians in the field are licensed,

1 bona fide licensed professionals. And assurances of quality
2 of their practice is the function of the -- another agency,
3 the Medical Assurance Quality (sic) or the licensing agencies.
4 But in general, the Department does have ongoing
5 reviewing, monitoring procedures and also quality assurance.
6 The last question,you have asked whether the
7 Department of Mental Health plans to give categorical aid
8 direction to the counties for multiple-handicapped persons.
9 If by categorical aid direction you mean by
10 dollars earmarked for specific category, the answer is no.
11 This would be against the recently enacted mental
12 health laws. We have no specific categorical funding per se
13 for any specialized type of target group for specialized
14 services. However, the Department will continue providing
15 technical assistance to the counties for the provision of
16 specialized services. But technical assistance that we
17 provide is merely technical assistance.
18 The current trend is to rely on the local programs,
19 local governments to identify and administer their own
20 programs. The State has taken the lead in providing technical
21 assistance.
22 At the present time we have one regional program
23 that is funded directly from the State Department of Mental
24 Health; that is, the small program we have at St. John's
25 Hospital in Southern California for the hearing impaired.
26 It appears that that particular program may at some
27 point be incorporated into the Los Angeles County overall
28 mental health program.

1 CHAIRMAN MARKS: I've heard your testimony and I
2 appreciated it. There are a lot of people who come to me
3 in the constituency who are very concerned about how people
4 are being handled. Can you give me the reason why that
5 happens, that a lot of people are looked upon as developmentally
6 disabled before there's concern as to whether or not they have
7 mental problems? A lot of problems that are still going on.
8 It seems to me that if your Department is doing
9 what it's supposed to be doing, I wouldn't have all those
10 questions.
11 DR. NADER: We are, at the present time, working
12 on some of these issues, Senator. Currently, there is a task
13 force that is -- has identified some of the problem of the
14 delivery of mental health services to the dually diagnosed.
15 The task force is going to submit its recommendation for our
16 Department. We'll be looking at those and working with them.
17 The --
18 CHAIRMAN MARKS: Who composes the task force?
19 DR. NADER: The task force is -- the Association
20 of California Regional Centers have created this task force.
21 There are a number of members from mental health and
22 developmental disability as well as constituency groups
23 participating in that task force.
24 We do recognize that there are some problems with
25 this particular target group. These are the people who are
26 developmentally disabled and for some reason in the community
27 they are developing emotional problems. And because of the
28 nature of their problems, they are falling in the cracks. And

1 we are aware of it and in the process of developing possibly
2 some sort of a pilot project to see how we can address this
3 problem.
4 CHAIRMAN MARKS: Well, let me read you a letter.
5 DR. NADER: Okay.
6 CHAIRMAN MARKS: From the Marin County
7 Developmental Disabilities Council.
8 DR. NADER: Okay.
9 CHAIRMAN MARKS: It's addressed to me. (Reading)
10 The materialistic needs of the developmentally
11 disabled, food, shelter, clothing, et cetera, are the needs
12 which are easy to respond to.
13 It's the nonmaterialistic needs, the mental
14 health problems, which are difficult to see and respond to.
15 To know that you are different from other people creates
16 all sorts of emotional and behavioral problems. It is
17 these problems that are not being cared for at this time.
18 The programs which serve the mental health population will
19 not accept persons who are developmentally disabled. They say
20 they do not fit into the system.
21 The few programs that will accept the disabled have
22 a very long waiting list. The present mental health service
23 and delivery system is not sufficient nor is it capable of
24 meeting the needs of the developmentally disabled. More funds
25 and more facilities are urgently needed.
26 The people are very much concerned. And if I may
27 say so, with all due respect, a task force is not an answer
28 and is oftentimes a way to delay a solution.

1 DR. NADER: We would like to embark on some
2 action plans to remedy the problems of the dually diagnosed.
3 CHAIRMAN MARKS: Can you present anything to the
4 Budget Committee?
5 DR. NADER: Not as of this moment.
6 CHAIRMAN MARKS: It's a little late. The
7 budget meeting just ended today.
8 DR. NADER: For -- but we are planning to submit
9 a pilot project to develop regionalized programs.
10 CHAIRMAN MARKS: When do you plan to submit that?
11 DR. NADER: This forthcoming summer.
12 CHAIRMAN MARKS: To whom?
13 DR. NADER: It will be submitted for next year's
14 Governor's budget hopefully for the fiscal year 86-87.
15 CHAIRMAN MARKS: Go ahead.
16 MS. EPSTEIN: When you start out not knowing
17 anything about the whole mental health picture, and you start
18 having someone come in and you're saying to them -- who are
19 all the groups in the mental health picture -- you start out
20 as we started out doing. You have someone put this on a
21 wall for you, it just starts at the top and goes all the way
22 down to the floor (indicating). And then you go through and you
23 say, to whom is each group responsible? Well, there are lots
24 of different State groups that operate throughout the State,
25 part of which we found there is no real responsibility where
26 people are required to report back to someone. So that what you
27 see are layers after layers of groups each doing their own
28 thing. And what we're particularly concerned with is where

1 does it get down to the DD person or the deaf person? How
2 are they affected? I mean, they're all great groups. And
3 they all meet. But where does it all funnel down and into
4 what?

5 DR. NADER: I'm afraid that was the target group
6 that was identified as underserved. Unfortunately they've
7 been underserved. We recognize that and we're trying to
8 remedy that.

9 But, again, the identification of a target group,
10 as the laws are today, ought to be made at the local level
11 through the Mental Health Advisory Board. And groups need
12 to be vocal in those places and make sure that --

13 CHAIRMAN MARKS: Have you seen this?

14 (Thereupon a schematic was shown to the
15 assemblage and Dr. Nader.)

16 MS. EPSTEIN: This is the person who deals with
17 DD people (indicating) from here to here. That's the local
18 level.

19 DR. NADER: Right.

20 CHAIRMAN MARKS: I'm not critical of you
21 personally, but it seems to me that the State of California
22 should do more in this area. And this is something I'm just
23 not bringing to your attention for the first time. It's been
24 brought to your attention I'm sure a number of occasions.
25 I'm reminded of a hearing in 1980 so I presume it had your
26 attention at least at that time. I just can't see how this
27 can go on and on and on without any determination of what's
28 going to be done. I'm really sort of disturbed that nothing

1 was done in this budget session, nothing.

2 I mean, you're evidently going to wait till the

3 next budget session.

4 DR. NADER: Well, Senator, we have this particular

5 year -- the Governor has allocated extra funds for mental

6 health for next fiscal year. The existing fiscal year we

7 have extra funds. We are encouraging the counties to pay

8 attention to these target groups. But, as you know, our

9 hands are tied because by law local county mental health

10 directors have the complete jurisdiction over their

11 administration of their programs. It's a double-bind that we

12 are in. We would like to take leadership and tell local

13 governments what to do, but on the other hand, we want to

14 stay away from direct intervention.

15 CHAIRMAN MARKS: Why don't you write a letter

16 telling me what your problem is. I'd like to know your

17 problem.

18 DR. NADER: Okay.

19 CHAIRMAN MARKS: Why don't you write me a letter.

20 DR. NADER: Okay.

21 CHAIRMAN MARKS: Let me see what your problem is.

22 DR. NADER: We'll send you a letter, Senator.

23 CHAIRMAN MARKS: And what you are doing to

24 eradicate those problems.

25 DR. NADER: In regard to the dually diagnosed

26 and developmentally disabled, we have to be specific because --

27 CHAIRMAN MARKS: Well, I'd like you to be specific.

28 Tell me what your problem is and what you're doing.

1 DR. NADER: Okay.
2 MS. EPSTEIN: In the past couple of years there
3 have been some very large community meetings. One in
4 particular was put together by Independent Living in San
5 Francisco. It was enormous.
6 At that time the theme that we seemed to hear out
7 of that talked about types of medication, self-help groups,
8 stigma.
9 My question is when the Department is making its
10 decisions about how to help these people, is it talking to
11 people from any of these consumer groups as well as the
12 government bodies?
13 DR. NADER: We are indeed. We now have a
14 representative of these consumer groups in a number of our
15 committees, action, working committees. Things are changing
16 tremendously. The consumer groups are becoming very vocal
17 through a program that we have had. We've managed to bring
18 in an awful lot of consumer groups to our planning,
19 organizational committees, a number of our action committees.
20 I just don't want to mention the task force, but they are
21 expressing their voices.
22 CHAIRMAN MARKS: One of the reasons we formed the
23 subcommittee on the disabled was to try to get a group
24 together that would hopefully be the ones that the disabled
25 community in every aspect of society would be able to turn to.
26 And when I tell you I'm not satisfied, I'm not satisfied. I'd
27 like an expression from you as to what you think the problem
28 is and what you're doing to resolve this.

1 DR. NADER: Okay, Senator. I appreciate your
2 concern. We'll work on it and I will be sending you a letter.
3 CHAIRMAN MARKS: Thank you.
4 DR. NADER: Thank you.
5 CHAIRMAN MARKS: Collis Kimbrough here? Dexter
6 Lane? Do you want to testify together or separately?
7 Why don't you both come up?
8 MR. KIMBROUGH: My name is Collis Kimbrough. I'm
9 coordinator of program development for United Cerebral Palsy
10 Association of San Francisco. I only have a few brief
11 comments to make.
12 Developmentally disabled people in California,
13 like everywhere else in the world, present a cross-section
14 of our culture in our society. They run the gamut of people
15 racially, ethnically, vocationally, et cetera.
16 As California, like other states, moves towards
17 serving these people in the community, increasing problems
18 such as mental health needs are going to be exposed, expressed,
19 and hopefully dealt with.
20 I don't have any prepared testimony for you today.
21 Dexter Lane does.
22 CHAIRMAN MARKS: Okay.
23 MR. LANE: I'm going to read from a letter that I
24 prepared and I also would like to follow it up with some other
25 comments.
26 A 1981 study by the State Department of Mental
27 Health among California Regional Centers concluded that ". . .
28 one-third of the developmentally disabled were . . .

1 handicapped to a significant degree by disturbances in thought,
2 emotion, or behavior."
3 If this percentage holds true for Golden Gate
4 Regional Center clients, well over 1,000 persons in its
5 caseload have significant mental health needs.
6 In San Francisco, one person in the Department
7 of Health is currently responsible for coordinating services
8 to an estimated 550 persons with mental health and
9 developmental disability dual diagnoses. One person, however
10 well qualified, is insufficient to provide comprehensive
11 coordination of services for these clients. Simply stated,
12 the vast majority of these persons are underserved for their
13 mental health needs if they are being served at all.
14 Compounding the inadequate level of professional
15 coordination of services for these clients is the under-
16 developed state of counseling methods for the dually
17 diagnosed.
18 Again, from the 1981 study, quote, ". . .Research
19 into the causes, incidence, prevalence, and treatment of
20 mental illness in those without developmental disabilities
21 has produced much information and has contributed to the devel-
22 opment of widely distributed and sophisticated programs of
23 restorative care. More modest gains have been made in
24 understanding the same issues for the developmentally
25 handicapped; consequently, treatment resources are in a
26 primitive state compared with what is available for others."
27 Treatment for psychiatric needs of dually diagnosed
28 clients currently available through the Golden Gate Regional

1 Center case management coordination are behavioral
2 evaluations and treatment, private psychotherapy funded by
3 Medi-Cal, and a behavioral treatment program at the
4 recreational center for the handicapped.

5 The behavioral evaluations are reactive rather
6 than preventive, and are generally provided in response to
7 severe behaviors such as violence or destructive acting out.

8 The recreation center program has 28 clients and
9 a waiting list. For reasons which will be described shortly,
10 a private psychiatrist, funded by Medi-Cal, is the treatment
11 of choice usually only for the very highest functioning
12 clients.

13 Roughly speaking, it is usually the dually
14 diagnosed person who most severely disrupts the lives of
15 others or the very highest functioning who receive specific
16 treatment for their mental health needs.

17 Those clients whose major diagnosis the Regional
18 Center has determined is primarily psychiatric in nature
19 have been shuffled back and forth between the developmental
20 disability system and the mental health system, neither
21 system wanting to assume primary responsibility for treatment.

22 Fortunately, a very recent agreement between the
23 Regional Center and the Department of Health has been reached
24 which clarifies responsibility for the coordination of services
25 to these clients.

26 For most mental health service providers, clients
27 with developmental disabilities are not as attractive to work
28 with as are clients with a single mental health diagnosis.

1 Clients with retardation are usually not as verbal
2 and potentially amenable to insight as are clients without
3 retardation. Few mental health service providers are aware
4 of issues raised by the developmental disability diagnosis.
5 The client with the dual diagnosis is simply short-changed
6 between two separate service provision systems, one for
7 mental health and one for developmental disabilities, neither
8 of which has sufficient expertise to work in the other's
9 domain.

10 As the social worker for United Cerebral Palsy
11 of San Francisco, I see a very small percentage of the many
12 dually diagnosed clients and their families who fall between
13 the large cracks in the system. The population I see is even
14 further narrowed by the requirement that my clients have a
15 physical disability, generally cerebral palsy.

16 For some clients I have devised behavioral treatment
17 programs, some I work with in individual psychodynamic-based
18 counseling and some in family therapy.

19 In two cases I do not even see the identified
20 dually diagnosed client, but provide supportive counseling
21 to the single mothers of the clients with the goal of
22 stabilizing their chaotic family environments.

23 My education and seven years of hospital and
24 halfway house work experience did not address the developmental
25 disability issues which are important to my current work.

26 I have had to integrate information from two largely
27 separate service methodologies to provide treatment to my
28 clients.

1 Clients dually diagnosed with developmental
2 and psychiatric disabilities need more flexible and informed
3 responses to address their treatment needs than is
4 currently available.
5 The developmental disabilities and the mental
6 health service systems need much greater coordination and
7 much greater information sharing before the majority of
8 dually diagnosed persons will be adequately served.
9 CHAIRMAN MARKS: Thank you very much. We appreciate
10 your both being here. Thank you.
11 MR. LANE: I have copies.
12 CHAIRMAN MARKS: Would you, please.
13 Ladonnis Elston.
14 MS. ELSTON: Okay. My name is Ladonnis Elston.
15 I am the coordinator for services to people who are disabled
16 for the San Francisco Community Health Services.
17 My report is going to be very brief today, but
18 it has to do primarily with some of the statements that was
19 previously made by the speakers, such as lack of continuum of
20 services for the disabled people who have recently been
21 discharged from State Hospitals without developing programs
22 in the community prior to discharging them in the community.
23 So, we find that we are experiencing a lot of disabled people
24 coming back to the community without having adequate
25 programs.
26 A lot of times we find that we are having to
27 keep people in acute places, such as hospitals, San Francisco
28 General, Mount Zion Hospitals, longer than necessary because

1 there are not places to put them such as halfway houses or
2 programs where people who are developmentally disabled cannot
3 go into halfway houses with people who are higher functioning
4 and those who are psychiatrically disabled.
5 They often need some kind of specialized treatment,
6 so we find that we're spending a large sum of money on people
7 in acute services where, if they were able to have some kind
8 of community programs, it would better meet the needs of the
9 client in addition to less cost for the community.
10 CHAIRMAN MARKS: Let me ask you a question about
11 spending money. Is all the money coming from the State or
12 does the city --
13 MS. ELSTON: The city puts in money.
14 CHAIRMAN MARKS: What percentage would you say
15 comes from the city approximately?
16 MS. ELSTON: Oh, I really -- about 20 percent from
17 the city and county. I mean --
18 CHAIRMAN MARKS: And some comes from the federal
19 government?
20 MS. ELSTON: Some come from the federal government
21 and some comes from the State. We have ad valorum, which is
22 money that comes from the city and county that is not State
23 money.
24 CHAIRMAN MARKS: Thank you.
25 MS. ELSTON: This is approximate. I don't have
26 the --
27 CHAIRMAN MARKS: I won't hold you to it.
28 MS. ELSTON: Okay. Don't hold me to it.

1 Okay. So this is what we have been finding. The
2 recent trend is to keep people who are possibly able from --
3 in the community without putting them into the hospitals. What
4 has happened is that there has been a decrease in the number
5 of beds of people in hospitals. However, when the people
6 are in the community, the money that was allocated for the
7 hospitals did not trickle down or follow the client into the
8 community. So we have it very difficult, because the
9 traditional mental health models was not set up to deal with
10 clients who have special needs. The primary focus was on
11 people who could benefit from the traditional psychotherapy.
12 In San Francisco we have recently done some
13 surveys and found that some people -- some groups of clients
14 can be mainstreamed with the existing mental health programs.
15 The survey identified the groups having the most
16 difficulty are those clients who are violently mentally ill.
17 They are violent. They have fights and so forth. And people
18 who are substance abusers and they are also mentally ill,
19 and people who are developmentally disabled and they are
20 mentally ill. This is the -- these are the high user groups
21 identified.
22 Of the three groups, the developmentally disabled
23 who are mentally ill continues to be the most difficult group
24 to provide mental health services. With the increase in the
25 number of developmentally disabled who are mentally ill
26 returning to the community from State hospitals without funds
27 for follow-up programs, they continue to go between the systems
28 of the Regional Center system, and the community mental health

1 system.

2 However, we have tried to address this with the
3 State Interagency Agreement. And I think that that is
4 beginning to address some of the issues that is between
5 clients who are Regional Center clients and clients who are
6 Mental Health clients. That seems to be starting to work
7 better than it had in the past.

8 Funding to the developed community programs should
9 be allocated prior to discharge of persons into the community.
10 The mental health system has been and is focused on the
11 short-term treatment orientation. And many of these clients
12 if they were -- are to benefit from the Medi-Cal system have
13 to be in a short term kind of program. In other words, we
14 have to have them in treatment for six weeks at a maximum
15 or so many visits. And a lot of these clients need to have
16 extended visits. They might need maybe three more visits, but
17 due to the Medi-Cal system and the funding, the way it's
18 set up now, we are not able to just automatically extend
19 their treatment without having quality assurance review,
20 which means we have to go through some people to say, well,
21 this person needs to extend treatment; therefore, would you
22 approve so many days. And this gets to be a real issue a lot
23 of times in terms of how you develop a treatment plan for
24 people who need extensive treatment. And because the
25 mental health system has been focused on the short-term crisis
26 or short-term treatment program, I think one of the areas
27 that needs to be addressed is in terms of disabled people who
28 need mental health services should be looked at with maybe a

1 different point of view in terms of extension or amount
2 of time that one should be able to receive treatment.
3 And in conclusion, I think the major efforts that
4 the San Francisco Community Mental Health Services is
5 providing at this time is to do some training with our staff
6 in terms of trying to sensitize our staff about the needs of
7 people who are disabled and develop programs that would be
8 modified to work with disabled people.
9 Again, I would like to ask that legislation and
10 funding sources should be considered in terms of allowing
11 for some more flexibility with funding for the mental health
12 system or, if that's not possible, create some kind of
13 special funding whereby people who need -- disabled people
14 who need specialized treatment can benefit from this kind of
15 services.
16 I believe that the State policies must demonstrate
17 and reinforce the fact that disabled-mentally ill persons
18 have personal value and that they will be provided with the
19 necessary resources, social, medical, and vocational, to help
20 the disabled develop to their potential.
21 The other thing that we discovered is that public
22 education promoted on a statewide basis providing accurate
23 information through the media and to the general public about
24 mental health and disability issues will help to improve the
25 services to disabled people.
26 MS. EPSTEIN: So, what you're saying is that we
27 need to go back to some of the things we did before, which is
28 a lot of public awareness.

1 MS. ELSTON: Absolutely.
2 MS. EPSTEIN: I'm not sure in terms of -- the
3 Senator's office, many years ago, was able to do public
4 awareness in terms of physical disabilities by everybody
5 taking on -- in terms of people being allowed to work who had
6 disabilities.
7 MS. ELSTON: Right.
8 MS. EPSTEIN: And in mental health, where people
9 also have disabilities but still need to work to get back
10 into the system, that's still true.
11 MS. ELSTON: This is true. And the thing about
12 people who have emotional problems and disabilities, they have
13 so many stigmas in addition to having the mental illness
14 stigma, they're also --
15 MS. EPSTEIN: Disabled.
16 MS. ELSTON: -- there are also disabilities. There's
17 also a double disability.
18 MS. EPSTEIN: That's right.
19 MS. ELSTON: That really makes it very difficult
20 for families, our social agencies who are traditionally
21 accustomed to dealing in -- with this only kind of disability,
22 having to deal with a double disability, sometimes more than
23 one, multiple disabilities.
24 MS. EPSTEIN: Would it be wise, then, that perhaps
25 the Senator's office, perhaps if they can take on some kind
26 of project that might make the public more aware?
27 MS. ELSTON: I think that would be very helpful.
28 And I think for people who have these kinds of stigmas it is --

1 a lot of them it's kind of hidden and it becomes even more
2 difficult to. And I think it would be very helpful if people
3 started to understand or to start to even look at and
4 realize that there are these disabilities.
5 CHAIRMAN MARKS: How many people are in your
6 office?
7 MS. EPSTEIN: Her.
8 MS. ELSTON: There are several offices. So, we
9 have about 40 people working in the community mental health
10 system.
11 CHAIRMAN MARKS: Thank you very much.
12 MS. ELSTON: Okay.
13 CHAIRMAN MARKS: We appreciate you being here.
14 Is Dr. Ken Brynjolfsson here?
15 DR. BRYNJOLFSSON: It's an Icelandic name.
16 CHAIRMAN MARKS: Well, that was pretty close.
17 DR. BRYNJOLFSSON: Yes, indeed. I'm going to
18 defer to Mr. Dennis Ferrell who is the project director
19 of our project regarding the dually diagnosed client in the
20 area of Far Northern Regional Center, which is nine counties
21 in the northeastern corner of the State of California.
22 CHAIRMAN MARKS: Okay.
23 MR. FERRELL: My name is Dennis Ferrell. I'm a
24 staff psychologist for the Far Northern Regional Center serving
25 the developmentally disabled.
26 Our testimony today represents the Association
27 of Regional Center Agencies and their preliminary report on the
28 mental health needs of the developmentally disabled. And our

1 testimony will also represent the activities of our pilot
2 project at Far Northern Regional Center, which is an outgrowth
3 of the mental health task force.
4 The problems of the mentally -- mental disorders
5 in the mentally retarded and otherwise developmentally
6 disabled population, as other speakers have discussed before,
7 are problems which have only begun to come to light in the
8 last ten to fifteen years.
9 Services to each of these populations by
10 themselves have been developing, especially in the State of
11 California, at a fairly rapid pace much -- quite a bit before
12 that. The reasons for this particular population, dually
13 diagnosed population being underserved I think fall into
14 two primary categories. One has to do with the clinical
15 state of the art. Diagnosis and treatment of the dually
16 diagnosed individual has lagged far behind clinical advances
17 in other areas of mental health and other areas of developmental
18 disability.
19 It's an emerging field. There are beginning to be
20 national experts and hard empirical data which are showing that
21 there can be effective clinical diagnosis and there are
22 effective clinical treatments for this population and it's
23 very recent that these developments have occurred.
24 The second major reason specific to California
25 are the -- what I see as the fundamental philosophical
26 differences between the mental health system and the regional
27 center system.
28 The mental health system, as I see it, was conceived

1 of as a system which was to deliver in the most efficient
2 way possible direct services to the consumer at the local
3 level. This is the way the local mental -- the county mental
4 health agencies were organized. They consist primarily of
5 direct services personnel with less personnel at the top,
6 at the administrative level.

7 However, the regional center system was conceived
8 of to be a broker of services at the community level to
9 integrate the mentally retarded and otherwise developmentally
10 disabled persons into the existing service system of the
11 community, part of which from our point of view at the
12 regional centers is the community mental health agency.

13 We fully -- the system was created fully expecting
14 that we could refer our clients with mental health needs to
15 county mental health agencies and they would be served. It's
16 a wonderful idea. It has not worked.

17 These people have not been served. By and large,
18 the county mental health agencies are not aware of the
19 procedures for how to diagnose mental disorders in a mentally
20 retarded individual or any other disabled individual who cannot
21 speak or otherwise communicate clearly. There are biases and
22 prejudices which were existing in graduate school when I was
23 training which lead a lot of mental health professionals to the
24 point of view that a mentally retarded person is not amenable
25 to treatment. If they have a mental disorder, it is directly
26 related to the mental retardation or developmental disability.
27 And, therefore, that person is not a good candidate for
28 treatment by traditional psychotherapeutic means.

1 As a result of this, there have been accusations
2 flying back and forth between the two systems at the State
3 level and the local level for the past 15 years regarding
4 inappropriate referrals and a lack of responsiveness and a
5 lack of cooperativeness between the two systems and this has
6 led directly to this population being inadequately served,
7 and in many, many cases in these individuals being forced
8 to be institutionalized.
9 CHAIRMAN MARKS: Do you think the State's doing
10 enough?
11 MR. FERRELL: I think only now has the State
12 at the State level begun to recognize this problem by the
13 fact that the Department of Developmental Services was willing
14 to fund a $40,000 six-month pilot project at Far Northern
15 Regional Center. I have to say I believe that in my view
16 the leadership has come from the Regional Center side of the
17 system to the agitation, if you will -- equate that with
18 leadership -- for funds to be directed for this purpose and
19 for staff time to be directed for this purpose also.
20 DR. BRYNJOLFSSON: If I could, Senator, it is to
21 the credit, however, of the task force, the joint task force
22 under ARCA's leadership between Mental Health and
23 Developmental Disabilities -- it is to their credit that they
24 did endorse and support this pilot project and have been
25 fully behind it. And Mr. Nader, in his capacity, has been
26 entirely supportive of this effort.
27 CHAIRMAN MARKS: I'm not specifically opposed to
28 task forces, but oftentimes a task force is a way to avoid

1 an issue.

2 DR. BRYNJOLFSSON: Yes, sir. In this case --

3 CHAIRMAN MARKS: It would not be the case?

4 DR. BRYNJOLFSSON: Yes, sir. In this case, the

5 task force has seen fit to see that something is implemented

6 at the grass roots level and has seen that a project has been

7 developed that results in direct services to clients.

8 MR. FERRELL: I'd like to echo Mrs, Epstein's

9 statements that there exists no clear responsibility. I have

10 read the memorandum of understanding between the Department

11 of Mental Health and the Department of Developmental

12 Services. I have read the memorandum of understanding

13 between my agency and each of our county mental health

14 agencies as well as others around the State. All of those

15 on paper -- when I ask people who does it work, nobody knows.

16 Very few people actually follow what has been written down

17 on these pieces of paper.

18 CHAIRMAN MARKS: I wonder if you'll write me a

19 letter and tell me what you think your problem is.

20 MR. FERRELL: We have submitted a letter that I

21 primarily wrote which comes from ARCA, which summarizes our

22 position as well as the preliminary report from ARCA. And

23 those have been submitted. I will also give you extra copies

24 today.

25 I believe that the primary needs at this point

26 four months into our project -- almost five months into our

27 project -- we must come up with a jointly acceptable clinical

28 definition of dual diagnosis, a pragmatic definition of

1 somebody who needs services from both systems.

2 However, one of the problems is that there are

3 clinicians in both systems who make these decisions and they

4 are used to using empirical clinical data to make these

5 decisions on the primacy of the disability, on treatment

6 decisions as well.

7 MS. EPSTEIN: Up to very recently part of the

8 problem that we seem to hear about is that in making a

9 clinical decision for a person, very often the doctor making

10 that decision really looks at the person as being -- in the

11 case of DD people, developmentally disabled, and couldn't

12 look beyond that to understand that there was a second problem.

13 MR. FERRELL: Absolutely. Clinical research

14 literature has shown. The concept is called overshadowing

15 in the literature.

16 There have been clinical studies where professionals,

17 psychiatrists, et cetera, looked at case studies, written-up

18 studies as the only difference between two cases was the I.Q.

19 score, which indicated one person was mentally retarded and

20 the very same description of symptoms in another vignette.

21 Without that I.Q. score indicating that that person was

22 mentally retarded, the diagnosis was entirely different. The

23 professionals by and large could not see beyond the

24 definition of the diagnosis of mental retardation the clinical

25 symptoms. And the symptoms do present differently in many

26 cases. I want to emphasize it is an emerging field and the

27 clinical skills are not out there.

28 In my time with the pilot project, I have been

1 absolutely appalled at the lack of information that each
2 service system has about the other. One of the things that
3 we have done in our pilot project is to initiate interagency
4 training, getting agencies together to talk about the
5 services and make contacts at the line level, the people
6 who see the clients, the mental health line workers and
7 the Regional Center line workers to establish lines of
8 communication directly between them and not necessarily having
9 to talk through the administration and director to talk to
10 director.
11 That's not the most effective way to get
12 administrative decisions made and it's not the most
13 efficient way that clinical decisions are made. And it's
14 important to have the agencies work together in any kind of
15 efficient way to meet the human needs of these folks.
16 Additional clinical training is needed as well.
17 Administrative flexibility must be there as well as adequate
18 funding. We're identifying a population whose needs are
19 substantially different from solely mental health needs and
20 solely needs based on developmental disabilities. This is a
21 new population of different needs. There must be more
22 funding in order to adequately serve these folks.
23 I would say the two biggest problems -- the
24 two biggest programmatic problems, at least in our region,
25 and I think all over the State lie in the prescription and
26 monitoring of psychotropic medication for the developmentally
27 disabled who also have mental disorders and in-patient crisis
28 services for the developmentally disabled persons who, as a

1 result of a mental disorder, act in ways that render them a
2 danger to themselves and others in the community.
3 Monitoring psychotropic prescription medications
4 for our clients -- Regional Centers are not staffed with
5 psychiatrists. These are the people who have appropriate
6 clinical training to monitor these things. Mental health
7 agencies in our area are also by and large not staffed
8 to handle these extra people. We refer to psychiatrists
9 whenever we can. Psychiatrists in our area have Medi-Cal
10 quotas. They don't take -- they take only so many persons
11 who are funded by Medi-Cal. Quite often by the 5th of each
12 month they have reached their quota. Therefore, we cannot
13 get these folks seen.
14 What has resulted is that general practitioners,
15 family practitioners have ended up prescribing and monitoring
16 psychotropic meds because they know they are needed, but they
17 also are aware that it's outside their clinical expertise.
18 CHAIRMAN MARKS: I'm a member of the Budget
19 Committee and we have the ability to increase or decrease
20 the budget. And I would be glad to do something about it
21 if I'm given the information at the appropriate time.
22 MR. FERRELL: As a result of our pilot project,
23 sir, you'll get some very specific recommendations from our
24 point of view about what can be done to solve these problems.
25 CHAIRMAN MARKS: Okay.
26 MR. FERRELL: And our final report will be
27 generated conjointly with the directors of the --
28 CHAIRMAN MARKS: When will this report be ready?

1 MR. FERRELL: We'll be forwarding it to the
2 Department of Developmental Services no later than August
3 31st.
4 CHAIRMAN MARKS: Why don't you send me a copy?
5 MR. FERRELL: Yes, sir, certainly. I certainly
6 will.
7 Our pilot project has several pages of objectives
8 which I won't go through. But I would like to group them
9 into four main categories which relfect, I hope, the comments
10 that I've made thus far.
11 One of our primary activities is in the area of
12 training, the interagency training I mentioned, the clinical
13 training I mentioned. We've contracted with an expert in the
14 field from Northern Illinois University to come to our area
15 and to do two two-day workshops in our area on diagnosis and
16 treatment of dually diagnosed individuals. We also are in
17 the midst of setting up what I'm calling administrative
18 training which boils down to being the directors of the four
19 county mental health agencies we're working with, our
20 director, Walter Baldo, and the directors of the Department
21 of Mental Health and the Department of Developmental Services,
22 all in the same room at the same time with these issues laid
23 out on the table in front of them and let them discuss it on
24 an administrative level.
25 CHAIRMAN MARKS: When and where is the hearing?
26 MR. FERRELL: The where is in Sacramento. The date
27 I am not sure has been set yet.
28 DR. BRYNJOLFFSON: We'll inform your office of the

1 time.

2 MR. FERRELL: The second primary activity is data
3 collection regarding the mental health needs of the
4 developmentally disabled. Only very recently -- as recently
5 as March, '85 issue of the Journal of American Society of
6 Mental Deficiency has there been instruments designed to
7 assess the mental health needs of the mentally retarded.

8 We are involved right now in a project assessing
9 in a systematic way exactly what are the mental health needs
10 of our clients at Far Northern.

11 The third activity is crisis intervention. I've
12 made myself available on a 24-hour basis to each of the
13 in-patient units in our four county mental health agencies.
14 When one of our clients shows up in an in-patient crisis,
15 they call me. And I go. And I see what's going on. And I
16 interview that client. If that client is in such a state, I
17 interview the family, the care provider where that client
18 lives, and I interview the sheriff's officers wherever
19 possible who brought that client in in a crisis and --

20 CHAIRMAN MARKS: What county is this?

21 MR. FERRELL: We serve nine counties. The four
22 counties that are involved in our mental health project
23 with us are Butte, Glenn, Tehama, and Shasta.

24 CHAIRMAN MARKS: I'm glad you're in Northern
25 California.

26 MR. FERRELL: Thank you. The fourth primary mode
27 of activity is the administrative mode. We are reviewing the
28 memorandum of understanding between ourselves and each of

1 these four counties, as well as the rest of our nine counties
2 in our area. We will revise those at the outcome of this
3 project to reflect the plans and procedures we want to put
4 into place.
5 We are reviewing the memorandum of understanding
6 between the Department of Mental Health and the Department
7 of Developmental Services at the State level and will
8 make recommendations in our final report as to changes we
9 feel need to be made.
10 We will also make recommendations regarding
11 legislative changes that need to be made.
12 And I'd like to quickly point out one change --
13 one legislative problem that hamstrings Regional Centers in
14 dealing with our clients.
15 Welfare and Institutions Code Section 6500 gives
16 Regional Centers the power to petition Superior Court to
17 involuntarily detain a mentally retarded individual who has
18 shown themselves to be a danger to themselves or others.
19 The law says specifically mentally retarded
20 individual. This excludes a great many developmentally
21 disabled individuals for whom the Regional Centers have
22 primary case management responsibility -- the cerebral palsy
23 individual, the epileptic individual, the autistic individual.
24 Just during the course of this pilot project, we
25 have run across several cases in which we, as a Regional
26 Center, had absolutely no standing to intervene in spite of
27 the most gross assaultive or self-injurious behavior on the
28 part of these individuals. We have been very fortunate with

1 our four county mental health agencies because they have
2 begun to work with us to pursue conservatorships on these
3 individuals. But it's a very cumbersome process. By and
4 large, some of these folks really do not get immediately
5 into their system either. We believe -- at least I believe
6 and I'm going to recommend in my final report -- that
7 legislative changes need to be made so that Regional Centers
8 can have this standing also with all of our clients and not
9 just the mentally retarded.
10 This section of the W & I Code has been very
11 effective in protecting the rights of the developmentally
12 disabled. Unfortunately, it has also prevented them from
13 getting certain services which they need.
14 Thank you.
15 DR. BRYNJOLFSSON: Thank you for your patience
16 in hearing us out, Senator.
17 CHAIRMAN MARKS: Thank you. We appreciate you
18 coming before us and I hope you'll furnish us with the
19 information I have requested. Maybe hopefully we can do
20 something in the area of training and improve the system.
21 DR. BRYNJOLFSSON: Thank you, Senator.
22 CHAIRMAN MARKS: Okay. Is Wendall Fingar here?
23 MR. FINGAR: Yes, sir.
24 CHAIRMAN MARKS: You're representing Mr. Shaw?
25 MR. FINGAR: Yes, sir, I am.
26 CHAIRMAN MARKS: Let me say this. This completes
27 the testimony of those who are on the agenda. There are a
28 couple of other people who wish to testify and we will give

1 you that opportunity. Go ahead.

2 MR. FINGAR: My name is Wendall Fingar. I'm a
3 staff assistant with the State Department of Rehabilitation
4 here in Sacramento testifying for Ferd Shaw, our Deputy
5 Director for field operations.

6 Fortunately I prepared the notes for Mr. Shaw
7 not being aware at the time that I would be using them
8 personally.

9 But I think having listened to your presentations,
10 that it might be a better use of your time if I were to share
11 a copy of these background notes with you and to concentrate
12 on the one problem area that seems to be most related to your
13 concerns.

14 CHAIRMAN MARKS: You'll give us a copy?

15 MR. FINGAR: Yes, I will.

16 CHAIRMAN MARKS: Give it to the Sergeant.

17 MR. FINGAR: Right there.

18 Our program serves about 60,000 people statewide
19 at any one time through about a system of 600 vocational
20 rehab counselors.

21 In all the categories that I looked at, about
22 one-third of the total represents the mentally ill, whether
23 it's a referral or writing a plan to resolve a person's
24 problem, or the end result of our system, of course, is
25 employment in the labor market. But the figure of 33 to 35
26 percent seems to come up over and over when we're looking at
27 those represented by the mentally ill, not including the
28 DD and MR. That's a separate category in our system.

1 I asked our program consultant who works with the
2 mentally ill, alcoholism, drug abuse, and who has experience
3 of about 25 years in that system to review your announcement
4 and the three questions you had.
5 And we kept coming back to the same thing. The
6 problem in his perspective and our receiving fewer numbers
7 of mentally ill in recent years and a more severely disabled
8 group, that we have a harder time succeeding with seems to,
9 he feels, resulted from the shortage of funds in the community
10 mental health service system statewide in the sense that the
11 funds that are available have had to be geared more into the
12 acute and continuing care patients as just heard by our
13 earlier witnesses, and more attention, therefore, away from
14 the outpatient service area. And dovetail more directly
15 with the outpatient services. That's where the referrals to
16 our system tend to come from other than those that are
17 self-referred to our field offices.
18 The reason we identified so closely with the
19 outpatient services component of the system throughout the
20 State is that we depend very heavily upon the continuation
21 of counseling, therapy, and medication for the mentally ill
22 client that we're serving while our vocational rehab counselor
23 is working with them to develop a plan to get them back to
24 work.
25 So often our vocational client falls apart if the
26 ongoing underpinning of therapy and medication is not kept
27 available for maybe the 12 to 15 months that we're serving him.
28 CHAIRMAN MARKS: Let me ask you a question. I'm on

1 one of the subcommittees but not on that particular
2 subcommittee that handles your funding. But did you make
3 requests for additional funds to those subcommittees?
4 MR. FINGAR: To serve mentally ill specifically?
5 CHAIRMAN MARKS: Yes.
6 MR. FINGAR: I do not know. I'm not -- I'm new in
7 this assignment. I don't really know.
8 CHAIRMAN MARKS: It's hard to do anything unless
9 we get requests.
10 MR. FINGAR: We are working, for example, with
11 L. A. County to try to increase the number of specialist
12 counselors in a special co-op contract.
13 CHAIRMAN MARKS: I'd like to find out if you
14 made requests to a subcommittee to get additional funds. If
15 you didn't make the request, I cannot conceive of how you
16 espect to get them.
17 MR. FINGAR: Right. But that relationship to the
18 outpatient services and the difficulty of receiving referrals
19 who are continuing to receive therapeutic support services
20 have been a problem in recent years for sure. That was the
21 one pint I wanted to make most urgently.
22 I think our success because of that in recent
23 years has tended to be with those mentally ill referrals who
24 are less severely disabled and does not need the ongoing
25 supportive services and medication after they come into our
26 system. We tend to be able to serve them better because of
27 the facts I mentioned earlier.
28 Other than that, I did take a look at the

1 double handicaps that was mentioned in your announcement.
2 That's a little hard to get a handle on in our
3 statistical system, but I found that -- I talked about
4 one-third of our cases earlier. If we look at mental illness
5 combined with any other physical disability, such as the
6 hearing, visual, or orthopedic problem, that percentage goes
7 up to about 38 percent; you add another five percent to that
8 group that we're serving if we try to identify them in that
9 way and that's one way of getting a handle on that.
10 It was an interesting thing that I have never
11 looked at before. We do code both the primary and the
12 secondary disability and do have retrieval of that
13 information.
14 CHAIRMAN MARKS: Well, what I don't quite under-
15 stand is why they're so hard to find. You just said a
16 moment ago that it's hard. Why should it be hard? Yours
17 is a department which is designed to help people
18 presumably. Why should it be hard to find?
19 MR. FINGAR: My understanding from talking with the
20 consultants that I referred to is that the peo ple are there
21 but the ease of identification referral to our field offices
22 is what has been more a problem in recent years. They
23 aren't as identifiable in outpatient services programs in
24 many of the counties as they were in the past. We don't
25 have the same volume and support services provided by the
26 community mental health services programs that we had.
27 And, therefore, even though we may get them into our system,
28 it tends not to be as successful as they fall apart once we

1 try to develop a written rehab plan to get them back to
2 work. That's my understanding.
3 CHAIRMAN MARKS: I would presume that the local
4 agencies must know about the problem and must notify you
5 about these problems. I cannot conceive of how they don't.
6 MR. FINGAR: I think what happens more is they
7 tend to continue to refer the same volume of people but
8 the severity of the disability is greater and the supportive
9 services from the mental health system that we rely on
10 heavily tends to not be as thorough as it was in the past.
11 And that's what causes that success ratio.
12 MS. EPSTEIN: What's happening with some of these
13 people who are the dual diagnosed in terms of the Department
14 putting them into either workshops or places where they would
15 go and start to be rehabilitated and go back into the commun-
16 ity?
17 MR. FINGAR: I do not know what happens in terms
18 of outcomes because that would take quite a bit more of
19 investigation to really tell what has been happening. All
20 I can tell is within our active caseload there is this
21 percentage and these numbers by disability groups and you will
22 see the variation in the size of the group there. So, I
23 don't really know if our success rate has been more successful
24 with one of these subgroups or another. I really don't know.
25 CHAIRMAN MARKS: It would seem to me that your
26 Department can come up with more information about this
27 particular problem and should do so. I'm very concerned
28 that you did not. You obviously don't have the information.

1 It's inconceivable to me that the local agencies
2 that are handling these problems are not informed of these
3 problems. I find it very difficult to believe.
4 MR. FINGAR: Are you referring specifically to the
5 persons with a double disability or --
6 CHAIRMAN MARKS: I'm referring to any or all the
7 problems that are relating to people in this category.
8 We've heard witnesses. We heard the gentleman right down
9 there talk about the problems that he has. I'm sure he must
10 have notified you.
11 MR. FINGAR: We have the counseling staff
12 available to serve the persons referred. What I was
13 referring to is that the change in the mental health system in
14 funding has caused more of a shift toward emphasis to the
15 acute and away from outpatient. And that kind of causes
16 a dislocation on those being referred to us. The volume
17 may be the same, you know, as in the past, but the results
18 I think are not as good.
19 MS. EPSTEIN: I think the questions that keep
20 coming back to us is that there are a number of people who
21 have the double diagnosis and who just seem to float from one
22 place to the next place and don't seem to get help.
23 MR. FINGAR: We also have, apart from our
24 mainstream program, we also have an habilitation services
25 program with many DD persons identified there. It's a State
26 funded separate program. I don't know that for sure, but
27 I'm certain it must be a large block of MI/DD combinations
28 represented in those other programs, too. So that shouldn't

1 be overlooked. But I was thinking more of our mainstream
2 vocational rehab program which is what I was referring to.
3 CHAIRMAN MARKS: Does that complete your
4 testimony?
5 MR. FINGAR: Right.
6 CHAIRMAN MARKS: I would like the people who
7 represent local agencies to indicate -- to send to me copies
8 of the information that you've sent to the State Departments.
9 I'd like to see what they received. I'd like to see whether
10 they acted upon it because I'm very much concerned that --
11 I've heard a lot of the problems that the people are having
12 and I'm very much concerned that a lot of the problems are
13 not being resolved.
14 You have plenty of money. If you don't have
15 enough money, you should ask the budget committee for more
16 money. If the Governor or the administration doesn't like
17 the appropriation, you should still ask for it.
18 MR. FINGAR: That's on a policy level that I'm
19 not familiar with. I assure you.
20 CHAIRMAN MARKS: Talk to your chief. Talk to the
21 chief of your Department if there's not enough money. We may
22 not approve it. We may or may not approve it. We'd have to
23 look at it. We can't do anything at all unless you ask for
24 additional funding. If a specific problem exists, you're to
25 tell it to us.
26 MR. FINGAR: Well, our Department I don't think is
27 usually that very bashful about asking for money. But in this
28 case, the money is outside of our system that would, I think,

1 cause the change that we would benefit from. It would be
2 money in outpatient services in the community mental health
3 system.
4 CHAIRMAN MARKS: You could make some suggestions
5 to us.
6 MR. FINGAR: Sure.
7 CHAIRMAN MARKS: And we in the budget committee
8 cannot do anything unless we know what you want.
9 MR. FINGAR: Certainly.
10 CHAIRMAN MARKS: Okay.
11 MR. FINGAR: Thank you.
12 CHAIRMAN MARKS: Thank you.
13 MS. EPSTEIN: I have just one question for you.
14 MR. FINGAR: Certainly.
15 MS. EPSTEIN: Do you know if people within the
16 Department in the local levels who deal with dual diagnosed
17 people are trained sufficiently to be able to understand
18 their problems when dealing with the individuals?
19 MR. FINGAR: I would -- my personal opinion is
20 that only in part. And I'm thinking of the example of
21 the co-op contract we have with the Department of Mental
22 Hygiene. Those 14 specialists counselors -- excuse me -- 15
23 in 14 different counties I think receive some good specialized
24 training in working not only with the mentally ill but
25 other disability groups that also are mentally ill.
26 There I feel more secure that they would have it.
27 Generally speaking, I don't know. I doubt that that's the
28 case throughout the whole Department.

1 MS. EPSTEIN: I ask the question specifically
2 because in the San Francisco office where the Senator's
3 subcommittee is located very often people come into the
4 office seeking advice. We, in turn, send them down to the
5 Department. And, in turn, we get the people back seeking the
6 same advice.
7 MR. FINGAR: Right.
8 I'm familiar with that problem. I just do not
9 know, but I think it's generally only the special programs
10 that have been identified, specialty training would be
11 better.
12 MS. EPSTEIN: Is there a way that the Senator's
13 office could help the Department see that people on a local
14 level are more attuned to the needs of these people that come
15 in?
16 MR. FINGAR: The way it would seem to help would be
17 to increase the coordination between those agencies and yet I
18 don't -- I'm not that familiar to know what the best vehicle
19 to do that would be at the actual service level, you know, how
20 to accomplish that. I'm not sure.
21 CHAIRMAN MARKS: Okay. Thank you.
22 MR. FINGAR: Thank you.
23 CHAIRMAN MARKS: We have a couple more witnesses
24 I believe. Mr. Art Segal and Elizabeth Swain. Is there
25 anybody else who wishes to testify at this hearing? Okay.
26 I'll call on you.
27 MR. SEGAL: I have a prepared statement which I'll
28 read. I also have a number of comments which I've taken in the

1 past ten minutes which I'd like to --
2 CHAIRMAN MARKS: How long is your prepared
3 statement?
4 MR. SEGAL: Three or four minutes at most. Then
5 I'd like to tell you a little bit about Marin County.
6 CHAIRMAN MARKS: I think I know a little bit
7 about it.
8 MR. SEGAL: I hope so.
9 I think I need to say, first of all, that Marin
10 Community Mental Health has a full contingent of staff that
11 serves disabled people and always has since its inception in
12 the mid-sixties. I need to say this because I need to be able
13 to point out that the problem is not limited to mental health
14 centers not having the staff or having different attitudes.
15 It's much deeper than that. And I want to get into that.
16 It does also include in some parts of the State
17 at least that mental health centers do not want to serve
18 disabled people.
19 I also need to say for the record that I have
20 served as a psychotherapist with disabled people for almost
21 35 years now. And I can support anyone who says that
22 disabled people respond to psychotherapy in just about the
23 same way as a nondisabled person does.
24 Just a little bit of information about what
25 happens when a person has a disability. What happens is that
26 it places all members of the family in a high risk category
27 for serious depression. In taking a look at what happens
28 to families, we find that disability is prevalent in divorce

situations, in suicide. A recent study in San Mateo County of suicide in adolescents found that more than half the adolescents who committed suicide that one year had learning disabilities. There is a high prevalence of disability in criminality and in mental illness. This does not suggest a cause and effect relationship; that disability creates these problems. However, it does suggest that the findings provide evidence that disability creates situations that are beyond the disabled person's coping abilities. This is true.

The mental health system today lacks the resources to prevent the deterioration of the disabled person. We don't have them. Furthermore, and for the same reason, we are unable to help disabled persons gain the emotional strength requisite for independent living. We can't even do the prevention work that needs to be done.

Since Proposition 13 went through, I have witnessed a slow yearly deterioration of my ability in Marin County and we have a strong focus on certain disabled people and people in high risk categories -- I have witnessed services fall apart because of lack of funds, not because of a negative attitude, because of lack of funds.

And as a consequence of lack of funds, I have been part of I guess a thrust from the State I would think to serve the most severely mentally ill person or the chronically ill person. This has resulted in decrease in prevention, has resulted in pretty much wiping out our outpatient department, not just for the disabled, but for everybody.

1 Outpatient services are available if you're
2 seriously mentally ill. If you are a parient who has an
3 autistic child and need supportive help, five years ago
4 that was available through community mental health. That is
5 no longer available.
6 If you are an adult who has a brain injury and you
7 have a spouse who needs some help -- what do I do next? --
8 that used to be available. That is no longer available. It's
9 not only attitude. It's priority. The priority comes from
10 the State. We cannot simply close down the crisis --
11 CHAIRMAN MARKS: Proposition 13 didn't come from
12 the State. It came from the people who voted for Proposition
13 13.
14 MR. SEGAL: Well, it came from the people, but
15 there's no money available.
16 CHAIRMAN MARKS: What I'm saying is that Proposition
17 13 was adopted by the people.
18 MR. SEGAL: Okay. True. Yeah. Okay. I agree.
19 I have some recommendations that I want -- before
20 I get to those, I want to read some notes that I took while
21 people were talking. I find myself in some disagreement as
22 well as in agreement.
23 CHAIRMAN MARKS: You're not required to agree.
24 MR. SEGAL: Good. Thank you.
25 I agree with Mr. Nader that localities set
26 priorities rather than the State in many instances. This is
27 true. And it's also true that I work in Marin County where
28 the locality has its priorities and we are serving disabled

1 people. So, that needs to be said.
2 We also need to remember that we talk about
3 dually diagnosed and we're not limiting ourselves to persons
4 who are served by Regional Centers. And that sometimes we
5 seem to limit our thinking to that category.
6 The problem for the brain injured and the learning
7 disabled and the physically disabled people who are not
8 served by Regional Centers are manyfold greater than the
9 persons served by the Regional Centers. And there is no
10 commitment anywhere in the State or Federal Government to
11 serve persons with these other disabilities. Medi-Cal
12 funds are decreasing. Private agencies don't have the
13 resources to do it.
14 The other problem that is exists exists within the
15 State Department of Developmental Services. I think that
16 needs to be looked at as well. As a -- what I like to think
17 as forward looking mental health system -- several years
18 ago, I received permission from Beverly Abbott, who was then
19 our mental health director, to work with the Golden Gate
20 Regional Center to develop a group home to serve dually
21 diagnosed where we would provide the mental health service.
22 And we tried to encourage agency people in the county to do
23 this. We went to the group homes and the residential programs
24 who serve the developmentally disabled and they didn't want
25 anything to do with developmentally disabled who have
26 behavior problems because they were not getting enough
27 reimbursement from the State to serve that population.
28 I went to professional agencies that serve the

1 mentally ill. I found one that said, yeah, it really makes
2 sense and we really ought to have a group home for the
3 developmentally disabled. That person sat down with me, the
4 Executive Director of the Regional Center and talked about
5 reimbursement and said, "I can't afford to do it. I'll go
6 broke."
7 That is part of the problem.
8 CHAIRMAN MARKS: Well, last year I authored
9 legislation to give a lot more money to local governments.
10 Maybe you don't know about that. And it provided additional
11 funding for each agency in local government, more money
12 than they had anticipated for many years. You ought to go
13 to the Board of Supervisors and ask them for some of that.
14 MR. SEGAL: Okay. Marin County Board of
15 Supervisors does contribute far greater than the 10 percent
16 than they're required to.
17 CHAIRMAN MARKS: Each city, and the supervisors,
18 and the county, and each agency in each county and city
19 throughout the State of California, each county in the State
20 of California has additional funding so maybe some of it can
21 come from them.
22 MR. SEGAL: Two or three other notes I have here,
23 one has to do with resources. You know, community mental
24 health, at least in Marin, works under the philosophy that we
25 would like private agencies to provide the service and we will
26 contract with the private agencies. You know, private
27 agencies do not want to serve this population from either
28 system. So, when we have on our crisis unit a developmentally

1 disabled person and we try to move that person through the
2 next step, a day treatment program or a residential program,
3 or an outpatient program, there's no place for that person in
4 Marin County.
5 When we have the money and say we'll pay for it,
6 there's no place to send that person, no agency wants to
7 provide the service.
8 The other problem is that the State Hospital
9 system -- if we put a developmentally disabled person in a
10 State Hospital for the mentally ill, the State Hospital for
11 the mentally ill tries as quickly as possible to get that
12 person out to a State Hospital for the developmentally
13 disabled.
14 The State Hospital for the mentally ill by and
15 large does not have the resources, they claim, to serve people
16 who are developmentally disabled.
17 I think the problem is a systems problem. And I
18 think it needs to be looked at that way.
19 CHAIRMAN MARKS: It's possible that the task force
20 could look at the last problem you're talking about.
21 MR. SEGAL: The task force went on for six years.
22 I was on it for two of them.
23 CHAIRMAN MARKS: Maybe I was right about the
24 delays. It delays things.
25 MR. SEGAL: I have five recommendations. One,
26 that there be a health and welfare agency commitment to
27 serve the dually diagnosed.
28 Two, that State Mental Health priorities include

1 serving high risk populations without the requirement that the
2 applicant be mentally ill and that additional funding for
3 this service be made available.
4 Three, that State Mental Health actively promote
5 the development of mental health services for the dually
6 diagnosed.
7 Four, that State Mental Health promote in-service
8 training for mental health service to developmentally
9 disabled and other disabled individuals.
10 Someone said earlier that a lot of people don't
11 know what to do. They're generally correct. Mental Health
12 people tend to look at the psychiatric side of people. They
13 don't see disability or any physical problem.
14 Five, that State Mental Health monitor local
15 community mental health services to the dually diagnosed.
16 I don't think it's correct that the State Department of Mental
17 Health has nothing to do with services on the local level or
18 that priorities are set on the local level is fully responsible.
19 The State Department of Mental Health does come
20 around periodically and does conduct program evaluations;
21 they do have coordinators for children's services, for adult
22 services, for disability services. These people do come
23 around. They do make demands on local mental health centers,
24 and I think those demands can be increased perhaps.
25 Thank you.
26 CHAIRMAN MARKS: Do you have a copy you're going
27 to give us?
28 MR. SEGAL: Yes.

1 CHAIRMAN MARKS: Thank you.
2 MR. FINGAR: Thank you.
3 CHAIRMAN MARKS: You want to testify?
4 MS. SWAIN: Yes. I'm Elizabeth Swain and I'm
5 speaking as a member of the Board of the Marin Brain Injury
6 Network.
7 And my concern -- I just have a couple of notes
8 on mental health needs for the traumatically brain injured.
9 Currently, there is no State or Federal funding
10 for psychotherapy for families of traumatically brain
11 injured individuals. It's been shown that the effect of such
12 an injury for family members is devastating to the family
13 often resulting in divorce, suicide of a family member,
14 severe psychological disturbances, and disabling depression.
15 The real cost to society over time is very severe.
16 We need to heal this problem at the point of trauma rather
17 than later after years of suffering where the resulting
18 problems -- medical, psychological, and social -- which do
19 fall under government funding become too severe for society
20 to ignore.
21 For the families also I believe that respite care
22 is very much needed for traumatically brain injured
23 individuals who are taken care of at home by the family.
24 There are many programs in existence, a growing
25 number right now, for Alzheimer victims, but it seems to me
26 that both the facilities and the staff could work in a
27 combined way that could be economically a good thing.
28 It should be, however, I think, productive respite

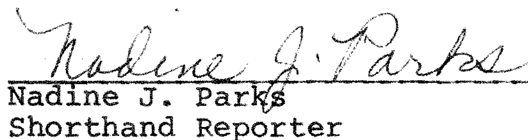
1 allowing the family to rest and heal and having some therapy
2 for the brain injured person during that stay.
3 Also, psychotherapy is needed for the brain
4 injured individual. Psychotherapy -- also done by a
5 psychotherapist who is knowledgeable about brain injury.
6 There is research showing that brain injured
7 patients given psychotherapy alone made a better recovery
8 over time than those given speech and physical rehabilitation
9 therapy with no psychotherapy. Dr. Roberts down in Orange
10 County (sic).
11 Also, it's shown that after a head injury, at the
12 point in recovery when the patient is beginning to have
13 self-awareness, to understand the nature of the damage to
14 themselves, stress, depression, and anxiety increase and
15 performance and I.Q. drop. And this is in spite of continued
16 improvement in cognitive and physical functioning.
17 Also, research by Marshall Levy at the Los
18 Angeles Department of Mental Health -- he was doing research
19 on the criminal justice system -- turned up that 30 percent
20 of the inmates in the State Prisons in California are brain
21 damaged. It seems to me that it would perhaps help the
22 prison system also to treat the brain damaged population
23 in a different way. These are behavioral byproducts of
24 lack of psychotherapy.
25 And I had a thought -- a final thought -- that it
26 took a long time for us to come to understand the benefits
27 of returning disabled people to a productive life in our
28 society. It took a long time for creating small changes that

1 make a big difference, like wheelchair ramps, curbsides, and
2 into buildings. And it seems to me that now we need ramps
3 for the mind.
4 CHAIRMAN MARKS: I like that. Thank you very
5 much. We appreciate your both being here.
6 MS. SWAIN: Thank you very much.
7 CHAIRMAN MARKS: Sharon George-Perry.
8 Good afternoon.
9 Ms. Perry: Thank you. I originally had not
10 planned to say anything, but I heard something that I think
11 needs some comment on. I made some notes, so I don't have
12 anything to give you in writing.
13 The first thing I want to say is in response to
14 something Mr. Ferrell said. The first thing he did that I
15 want to expand on was -- comes out of the experience that those
16 of us who have been involved with 3632 have found. That has
17 to do with the lack of horizontal linkages between systems.
18 And a part of the problem that we see with this -- I remember
19 meeting back with Dorothy as long as two years ago trying to
20 understand the communication systems as they affect the
21 disabled, and couldn't at that time understand, have since
22 come to understand that system linkages follow the flow of
23 funds.
24 We have found during this struggle over the
25 implementation of 3632 that since funds have to flow parallel,
26 horizontally. Horizontal linkages are being developed. And
27 I'm not sure how that's going to be done in the field of the
28 disabled. But it's clear that some specific system --

1 attention is going to have to be given to building those
2 linkages.
3 The second thing had to do with the prejudice
4 that Mr. Ferrell alluded to on the part of mental health
5 clinicians towards disabled people. In the mental health
6 field for a very long time mental health monies were held
7 to be wasted on people who weren't amenable to treatment.
8 Basically, that meant we didn't know how to cure them. They
9 were hard to deal with. Unlike other disability systems,
10 mental health put its money on the people with the best chance
11 of getting better. People then who are -- come from physical
12 disability systems have a different orientation. The
13 disability is classified by the degree of dysfunction and the
14 amount of public benefit available bears directly with the
15 degree of dysfunction (sic).
16 So, the physically handicapped person comes to the
17 mental health clinician looking for help and the clinician's
18 orientation is that we can't change the basic position.
19 They've got a hearing problem or a seeing problem or whatever.
20 It can't be changed, so why should we put money into it?
21 They're not amenable to treatment. That's a
22 system issue. And I don't think any individuals have to be
23 blamed for it. It has to do with treatment philosophies that
24 have existed.
25 The implication in the mental health field has
26 been that the most seriously mentally ill people were not
27 cared for by the counties at all. They were shunted out to
28 board and care homes. And, of course, the pressure of

1 mentally ill people on the streets is causing the mental
2 health system to reevaluate that some, but in my judgment not
3 enough.
4 But clearly, when you look at systems and design
5 systems that will address the mental health needs of
6 physically disabled people, there are going to have to be
7 specific provisions to address that prejudice on the part of
8 the mental health people.
9 And those two things just stood out to me,
10 something that needed to go into your thinking and your
11 process.
12 CHAIRMAN MARKS: Thank you very much. We
13 appreciate your being here. And your suggestions are very
14 good.
15 Ms. Perry: Thank you.
16 CHAIRMAN MARKS: Does anybody else wish to
17 testify?
18 Let me say that this hearing I think has been
19 a good one because we've got some idea of the problems and
20 also we had some idea of what the State should do to try to
21 resolve some of these problems and hopefully go forward to
22 try help, because I think this is a group that definitely
23 does need help.
24 And I would like to offer office anyway that I can
25 to assist in suggestions you made for legislation, for
26 budgeting, anything that can be of help will be beneficial.
27 And I'll do my very best to see this is done. Thank you very,
28 very much.

(The hearing was adjourned at 2:55 p.m.)

1
2 CERTIFCATE OF SHORTHAND REPORTER
3
4 I, Nadine J. Parks, a shorthand reporter of the
5 State of California, do hereby certify:
6 That I am a disinterested person herein; that
7 the foregoing hearing of the Subcommittee on the Disabled
8 was reported in shorthand by me and thereafter transcribed
9 into typewriting.
10 I further certify that I am not of counsel or
11 attorney for any of the parties to said hearing nor in any
12 way interested in the outcome of said hearing.
13 IN WITNESS WHEREOF, I have hereunto set my hand
14 this 11th day of June, 1985.
15
16 
17 Nadine J. Parks
Shorthand Reporter
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