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San Francisco's Special/Minority Populations and Chronic Mentally Ill: Components of the Crisis

Senate Subcommittee on the Rights of the Disabled

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CALIFORNIA LEGISLATURE

SENATE SUBCOMMITTEE ON
THE RIGHTS OF THE DISABLED

SENATOR MILTON MARKS, CHAIRMAN

SAN FRANCISCO'S SPECIAL/MINORITY POPULATIONS AND CHRONIC MENTALLY ILL: COMPONENTS OF THE CRISIS

JULY 13, 1987

SAN FRANCISCO, CALIFORNIA

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California Legislature

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SAN FRANCISCO'S SPECIAL/MINORITY POPULATION AND CHRONIC MENTALLY ILL: COMPONENTS OF THE CRISIS

July 13, 1987

San Francisco, California

87-9-221

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Hearing Summary

In July 1987, the Senate Subcommittee on The Rights of The Disabled, chaired by Senator Milton Marks, held a public hearing to examine the current state of San Francisco's mental health system. The hearing was a response to public outcry, lack of support and guidance from the State, and a recent alarming series that appeared in the San Francisco Chronicle (see appendix A).

All witnesses agreed that San Francisco's mental health system, and mental health systems across the State are in crisis and are in fact a non-system. Funding is woefully inadequate, programs are overburdened, new populations are entering the system, and there is a serious lack of long term progressive planning. It is clear that without major restructuring and reforms millions will be unable to receive desperately needed care.

Over 25 individuals, including Mayor Dianne Feinstein, the Director of Public Health, and a City Health Commissioner, testified as to the nature of the dilemma. The testimony focused on two of the components of the crisis: special/minority populations, and the chronic mentally ill. A general consensus emerged -- more funding from the state directed to counties in crisis, such as San Francisco is the most important approach to any solution.

In her testimony, Mayor Feinstein outlined the roots of today's crisis, and provided some appalling statistics on mental health care in California.

When the state closed down mental hospitals, protected the mentally ill from unnecessary involuntary commitment, and emphasized deinstitutionalized care, the Mayor claims, care for the mentally ill was entirely turned over to individual counties with only minimal assistance from the state.

The statistics speak for themselves. In the early 1960's, there were 37,000 beds in state hospitals for the mentally ill, and California had a total population of 17 million. Today, with a total population of 26 million, there are only 5,000 beds in state facilities, and counties have not picked up the difference for the homeless mentally ill. In fact, San Francisco lost over 800 beds in local board and care facilities over the past ten years.

It is clear that an inadequate commitment from the state, and serious underfunding, is at least partially to blame for this lack of services. In the 1980-81 budget, San Francisco spent $26.4 million on mental health, only $3.6 million of which came from local revenues. This year, the mental health budget has mushroomed to $55.6 million, 43 percent of which is local funding. Although

local support has grown to meet an even faster growth in need, state funding has remained virtually static.

The result: in one study, California was rated 42nd of the 50 states in the provision of mental health services. "Housing for the seriously mentally ill varies from dreadful to atrocious," this study said.

However, funding is not the only problem. The demographics of the mentally ill population in California have changed dramatically over the past twenty years, reflecting the increasing diversity of our state. More specifically, we are faced with new and growing special populations, each with diverse needs. Our mental health system must now accommodate many new pressures of these groups, each placing unprecedented demands on the swelling crisis.

Director of San Francisco Public Health David Werdegar outlined six contributing factors that have positioned our system to it's current state. Each witness who testified addressed at least one of these categories.

- San Francisco is currently faced with a homeless population numbering over 6,000 people, which is increasing by 15 percent annually. Many of these people are mentally ill, and are virtually locked out of the system that was intended to meet the needs of the mentally ill. Basil Plastiras, President, Mental Health Association of San Francisco stated that homelessness is due to the State's failure to employ a housing program and larger plan. In a recent report on housing for the homeless issued by the Association, it was found that all state agencies seem to ignore the housing problem. This problem and solution cannot be geographically isolated. And as Hilda Bernstein, Community Advisory Board - San Francisco General Hospital, cautioned, we cannot warehouse the homeless.

- Children have become a tragic and growing part of the mental illness equation. Emotional, physical, and sexual abuse, alcohol and drug use, drop-out rates, and juvenile crime have created a population of children in need. The problem is magnified by a mental health system that is designed to serve adults and refuses to acknowledge the needs of children. Sharon George-Perry, Children's Mental Health Policy Board, stated that a special hearing should be held focusing solely on the needs of children.

- Immigration has added a complex component to mental health programs. With growing populations of Southeast Asian and Central American refugees, programs must adapt to the needs of new populations inexperienced with American life and burdened with language and cultural barriers. "A Tagalog family will not seek services from an agency if no one there speaks Tagalog", Anne Almendral, Asian Mental Health Task Force.

- Seniors represent approximately 15 percent of San Francisco's population -- a greater proportion than any other urban community in California. Older individuals need special attention in coping with and understanding the aging process itself. Seniors often require specialized supportive services in addition to medical and nutritional care, and risk degenerative diseases that have created a need for new public health programs.

- The growing abuse of drugs and alcohol, and the increasing awareness of the problem, have forced the mental health system to develop new programs -- treating individuals facing addiction to an increasing variety of chemicals, and educating younger populations about substance abuse.

- The AIDS epidemic has caused increasing strains on the mental health system. Since the first diagnosis, an ever growing number of individuals have needed counseling and support services, and drug or alcohol abuse therapy. In addition, the number of individuals suffering AIDS related dementia is growing, placing a new and unique burden on long term care facilities.

It is clear the state has failed not only to cope with the new system of deinstitutionalized care, but also has refused to recognize the changing nature of mental illness and mental health needs. Dr. Reiko True, Deputy Director, Health for Mental Health Programs advocated for more self-help groups, categorical funding for minority populations and increased training opportunities for minority populations. Moreover, funding is desperately needed, and increased programmatic planning taking into consideration new populations in need must be developed.

However, winning new funding from the state is a virtual catch-22. Yes, we can, and have demonstrated that there is a growing need, and that the state has refused to live up to its commitment to fund local programs -- which we must do to win new funding.

The legislative budget has attempted to address this need year after year. This year, Senator Marks won approval for an additional one million dollars for counties, $350,000 of which would have come to San Francisco, in the final legislative budget sent to the Governor.

The Governor, unfortunately, has refused to recognize the growing need in this area. Despite the evidence, despite bi-partisan support in the Legislature and from local governments, the Governor has reduced new funding for mental health, including the appropriation that Senator Marks fought for this year.

Although new money is only part of the solution, it is the most important part. Without increases in funding, no long term plans and reforms can work effectively. Without more money, the mental health crisis in San Francisco will only fester.

****

THE SUBJECT OF TODAY'S HEARING IS A VOLATILE AND SENSITIVE ISSUE THAT CONCERNS US ALL. MENTAL HEALTH AND THE SERVICE DELIVERY SYSTEM IS STILL MISUNDERSTOOD BY MANY AS IT HAS BEEN A SUBJECT OF TABOO FOR SO LONG. IT IS ONLY RECENT THAT OUR SOCIETY HAS BEEN ABLE TO STUDY, BEGIN TO UNDERSTAND AND ACT RESPONSIVELY TO HELP THIS SPECIAL POPULATION.

TODAYS HEARING DEMONSTRATES A RESPONSE TO A LOCAL SITUATION WITHIN OUR STATE. AS CHAIR OF THIS STATEWIDE COMMITTEE AND AS THE SENATOR REPRESENTING SAN FRANCISCO AT THE CAPITOL, I FEEL THAT IT I MY RESPONSIBILITY TO PROVIDE THIS FORUM TO INVESTIGATE THE ISSUES THAT CONTRIBUTE TO THE CURRENT STATE OF OUR MENTAL HEALTH SYSTEM.

SELECTING THE TOPIC OF TODAYS HEARING WAS NOT DIFFICULT. MANY OF YOU HAVE KEPT ME WELL APPRISED AS TO THE STATUS OF THE SYSTEM AS IT AFFECTS YOUR GROUPS AND HAVE SHARED YOUR EXPERIENCES. THE CHRONICLE RECENTLY CONDUCTED AN EXCELLENT AND COMPREHENSIVE STUDY THAT PAINFULLY REVEALED OUR SYSTEM. THE LEGISLATURE IS CURRENTLY REVIEWING MANY BILLS THAT WILL AFFECT THE SYSTEM AND THE 87-88 FISCAL YEAR HAS JUST BEGUN.

WE MUST REALIZE THAT THERE ARE MANY CONTRIBUTING COMPONENTS

THAT MAKE UP THIS SYSTEM, AND GOOD OR BAD THEY CARRY A CERTAIN AMOUNT OF WEIGHT. FOR TODAYS HEARING WE HAVE SELECTED TWO COMPONENTS THAT PLAY AN ESPECIALLY SIGNIFICANT ROLE IN SAN FRANCISCO, NAMELY THE SPECIAL/MINORITY POPULATIONS AND THE CHRONIC MENTALLY ILL.

WE MUST ALSO REALIZE THAT THERE ARE OTHER VARIABLES WHICH AFFECT THIS SYSTEM. THE POLITICAL AND FISCAL REALITIES FACING OUR STATE CANNOT BE IGNORED OR TAKEN LIGHTLY. THE GOVERNOR, THE DEPARTMENT AND THE REPUBLICAN MEMBERS OF THE LEGISLATURE NEED TO KNOW ABOUT YOUR REALITIES AND CONCERNS.

LET ME STRESS THE IMPORTANCE OF THIS. THIS YEAR I AUTHORED A BUDGET AUGMENTATION FOR $1 MILLION TO REAPPROPRIATE ANY UNEXPENDED MENTAL HEALTH FUNDS TO PAY FOR OVERUSE OF STATE HOSPITAL DAYS. SAN FRANCISCO WOULD HAVE RECEIVED APPROXIMATELY $350,000. I WORKED WITH THE DEPARTMENT AND CITY ON THIS. UNFORTUNATELY GOVERNOR DEUKMEJIAN VETOED THAT AUGMENTATION. HE NEEDS TO KNOW HOW YOU FEEL ABOUT THIS.

WITH THIS DELICATE POPULATION WE NEED TO LOOK LONG RANGE AT THE ENTIRE SYSTEM AND PLAN OUR STRATEGIES. LET US LOOK AT THE CHANGES RELATED TO SPECIFIC POPULATIONS SO THAT WE MAY ARRIVE AT THE BEST SOLUTION TO SERVE SAN FRANCISCO WHICH IS HIGHLY IMPACTED.

YOUR TESTIMONY IS INSTRUMENTAL IN THAT IT WILL EDUCATE THE COMMITTEE, THE DEPARTMENT, THE CITY AND COUNTY. THIS WILL ASSIST

ME IN ASCERTAINING EFFECTIVE LEGISLATION TO CARRY NEXT YEAR.

AS I CLOSE I WOULD LIKE TO SHARE A QUOTE FROM MY LOOK-A-LIKE HUBERT HUMPHREY WHO PUT IT BEST WHEN HE ELOQUENTLY SAID: "THE MORAL TEST OF EVERY GOVERNMENT IS HOW IT TREATS THOSE WHO ARE IN THE DAWN OF LIFE, THE CHILDREN; THOSE WHO ARE IN THE TWILIGHT OF LIFE, THE ELDERLY; AND THOSE WHO ARE IN THE SHADOWS OF LIFE, THE SICK, THE NEEDY AND THE HANDICAPPED."

Witness List

A. City and County of San Francisco

1. Mayor Dianne Feinstein*

2. Commissioner Naomi Gray*
Health Commission

3. David Werdegar, M.D., M.P.H.*
Director of Public Health

4. Reiko True, Ph.D.
Deputy Director
Health for Mental Health Programs

B. Walter Watson*
State Department of Mental Health

C. Community

1. Basal Plastiras, President*
Mental Health Association of San Francisco

2. Ira Okun
Family Service Agency

3. Kenneth Ladeira*
Mental Health Advisory Board

4. Dick Shandoan, M.D.*
San Francisco Psychiatric Society

5. Rhoda Duckett
Society of California Carehome Operators

6. Sharon George*
Children's Mental Health Policy Board

7. Anne Almendral
Asian Mental Health Task Force

8. Shirley Gross
Black Mental Health Task Coalition

9. Michio Kusama*
Japenese Mental Health Task Force

10. William Margolis
San Francisco Alliance for the Mentally Ill

11. John Price*
    San Francisco Network of Mental Health Clients

12. Maryann Weathers
    Tenderloin Self-Help,
    a program of Hospitality House

13. Hilda Bernstein*
    Community Advisory Board
    San Francisco General Hospital

In addition to those who testified, written testimony was submitted by Ethan Nebelkopf, Laura Grandin, Ph.D., Janice Kramer, and Joseph McInerney.

* - witness testimony reprinted

Office of the Mayor
San Francisco

DIANNE FEINSTEIN

July 13 1987

TESTIMONY BY MAYOR DIANNE FEINSTEIN
California Senate Subcommittee On the Rights of the Disabled

I am pleased to provide testimony for this committee. I believe the issue before you is having devastating effects on the cities and counties of California -- and on the lives of thousands of unfortunate people in our state.

Twenty years ago, California launched what then became a nationwide revolution in the care of the mentally ill. Having seen the failures of large mental hospitals, the state proclaimed that the mentally ill could be better cared for in their home communities. At the time it was considered an enlightened reform.

California took a long step that has since been followed by state after state: it closed almost all of its mental hospitals. That momentous action was done with humanitarian concern, and in fact one may not necessarily disagree with its logic -- while bemoaning what has happened since.

Unfortunately, as with with so many well-intentioned actions, that one did not go far enough. While closing its own institutions, the state failed to send money to cities and counties to help pay for community institutions. In other words, care of the mentally ill was in fact dumped on cities and counties.

Now let us look at another and related "reform": involuntary commitments of the mentally ill. The 1969 Landerman, Petris, Short Act -- again well-intentioned -- severely limited involuntary commitments and imposed strict guidelines for due process for the mentally ill.

Again, it was expected that those not involuntarily committed would receive local community care. And again, adequate funding never followed the state's good intentions.

The result of these reforms -- which reversed the state's historical role in mental health ? California today has a non-system. For all practical purposes, the state has abandoned mental health care.

Twenty years ago there were 37,000 beds for California's mentally ill -- with a state population of 17 million. Today, with a population of 26 million, there are just 5,000 beds -- and half of them are for the criminally insane. If the State was still operating 37,000 State hospital beds, today's cost would be $2.09 billion. Instead the State is spending $803. million; a savings of $1.2 billion.

A recent report indicts California, saying its "housing for the seriously mentally ill varies from dreadful to atrocious" and ranking California 42nd among the 50 states in quality and availability of care.

Furthermore, the local board and care facilities that were expected to do the job have also been closing rapidly. San Francisco alone has lost 800 beds in the last ten years and now has only 500.

Involuntary detentions by our police in 1979-80 numbered 3,563. This year, that number has increased 114 percent to 7,649.

Yet short-term detentions do not deal with the serious underlying problems of mental health. Law enforcement agencies are not mental health agencies. And Landerman-Petris has also made it practically impossible for the police to protect the public from potential danger. Thus today, California communities are immobilized in the face of felonies waiting to happen. Let me give you some examples I have previously cited:

** In Los Angeles, a young man with a history of mental hospital commitments was released. His family was frightened, knowing his mental disorder had recurred and would again. Just a few days after his release, he murdered his mother.

** In Santa Cruz County, a family watched a boy's mental condition deteriorate -- but the county didn't have enough beds or programs or legal jurisdiction to commit him. Finally, he became violent and sheriff's deputies were called. The result: he was killed -- and so was a sheriff's deputy.

Just two cases among many. In San Francisco, we estimate we have an average of 30 cases a month of people so disturbed they threaten others. They should be monitored daily. Yet under the law, they cannot be committed.

Thousands of homeless mentally ill crowd our facilities and our jails. They wander our streets, sleep in our doorways and fall in our gutters. At least one-third of the people we call homeless are mentally ill. Many receive little or no care, and their conditions can only deteriorate. Some actually become a danger to the public.

Visit San Francisco jails and the jailers will tell you there is a revolving door of the mentally ill who often act up in desperation for a place to rest their heads, get off the streets and hopefully receive some kind of limited, emergency treatment.

Now let me talk about the dollars. California's cities have not been callous to the plight of the mentally ill -- or unwilling to spend vast amounts of money on it. Quite the contrary.

San Francisco is an example of one city that cares. We have spent millions of dollars on a wide variety of programs which seek to help the mentally ill. In my years as Mayor, spending of local money on thes programs has increased 544 percent. But that has not been enough to deal effectively with the problem or to reduce the soaring costs.

Let me be specific. In Fiscal Year 1980-81, San Francisco was spending $3.6 million in local dollars for a mental health budget of $26.4 million. That was 14 percent of the budget. This year, the entire budget has more than doubled to $55.6 million -- and the local dollars or 43 percent -- or $23.7 million. So while spending twice as much on the problem, we have tripled the percentage of local dollars.

In addition, we will ask San Franciscans in November to vote on a $26 million bond issue to build a 185-bed skilled nursing center for the mentally ill at San Francisco General Hospital.

Such spending is inequitable, it strains city resources, and yet it does not dealing adequately with the human tragedy of the mentally ill. We are putting out the fires, but not facing up to the longterm and continuing difficulties faced by these unfortunate people and their families.

As a city doing more than its share and trying desperately, we are succeeding only in proving that a social problem of such magnitude cannot -- and should not -- be dealt with by local governments alone.

The State of California must once again accept its responsibilities to the mentally ill -- and to the rest of us. Only the state can assume this geat burden. Only the state can commit the money and the facilities to treat the mentally ill. Only the state can provide hospitalization when necessary, or sheltered community environments. Only the state can carefully license and monitor such facilities. Only the state can unify all its cities and counties in consistent, long-range programs.

I call upon the state Legislature to act urgently to reverse the unfortunate "reforms" in mental health -- which instead have created today's mental health crisis and left mental patients to pitifully wander our streets.

Specifically, I propose that the state legislature consider these initial steps to revitalize California's treatment of the mentally ill:

1 -- Develop a system of regional hospitals to serve large populations up and down the state -- thereby allowing local governments to use their dollars for prevention, counselling, case management and day care.

Medical experts estimate 420 beds are needed now to deal with the needs of the San Francisco Bay Area.

San Francisco health authorities estimate there are now 2,000 homeless people in the City who have mental problems. San Francisco spends $2.5 million for the homeless mentally ill -- of which $1 million is from state funds.

Non-acute, specialized care beds are needed for the physically disabled, pregnant women, substance abusers and difficult-to-manage patients who are now falling between the cracks.

2 -- Provide increased funding for community services. Present reimbursements do not adequately cover the cost of skilled nursing, board and care services, and case management services.

3 -- Change the laws governing involuntary commitments, to permit more discretion by health authorities.

4 -- Increase state funding for foster care placement in agencies which provide mental health services.

Several pieces bills dealing with the mentally ill are now pending before the legislature. I urge members of this committee to give their support to these bills:

> AB 1371 -- which would eliminate newly-required county match for supplemental board and care funds;
>
> SB 375 -- which would provide Medi-Cal reimbursement for case management services;
>
> SB 377 -- which would fund the "Ventura model" program to increase inter-agency coordination in services to children.
>
> Finally, legislation is needed to remedy the prohibitive costs of insurance for private, non-profit providers.

These steps will not solve the problems. They will simply be the first steps on the long road back to full state participation in this terribly important field of human services.

Again, I applaud the objectives of this committee. I wish you success with this hearing and with the legislation I hope will result.

Thank you.

# # #

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TESTIMONY OF COMMISSIONER NAOMI GRAY

HEARING ON MENTAL HEALTH NEEDS IN SAN FRANCISCO
Conducted By
STATE SENATOR MILTON MARKS
Chairman, California Legislature Sub-Committee on
The Rights of the Disabled
July 13, 1987

My name is Naomi Gray; and as a San Francisco Health Commissioner, I welcome this opportunity to testify at this hearing on the mental health needs and concerns of the chronic mentally ill and minority populations in the City and County of San Francisco.

As the chair of the Commission's Joint Conference Committee on Mental Health and with my fellow Commissioner, Rosabelle Tobriner, as part of our oversight responsibilities, we hold monthly meetings with our mental health administrators and community advocates on issues related to the provision and delivery of mental health services through the San Francisco Health Department.

The Health Commission is the governing body for the San Francisco Department of Public Health. We establish policy for mental health services. At its meeting on October 21, 1986, the Commission unanimously passed a resolution establishing a policy for our mental health programs. A copy of this resolution is appended for the record. I will review its contents.

> The California Short-Doyle Mental Health Health Services Act mandates provision of humane, least restrictive care for the mentally ill within each local community.
>
> However, the funding allocated from the State to pay for mental health services is grossly inadequate to provide needed services for acute hospitalization as well as community based mental health services, and the cost of providing an adequate level of mental health services is increasingly funded through the San Francisco City and County General Fund appropriations. However, this is limited to the amount of funds that will be available for children, youth, adults, senior programs and substance abuse services. The demands increase with each year. The cost for acute services has historically constituted a significant share of the Community Mental Health Services (CMHS) resources and restricted the development of community based alternatives.
>
> Nonetheless, CMHS was directed to increase sub-acute mental health services, increase community based residential services by funding a dual diagnosis program for persons with both mental health and substance abuse disorders, and increase 24 hour mental health care by increasing the number of co-op flats available to mental health clients.

A careful assessment of needs and program planning will be made in order to effectively allocate and distribute limited financial resources available for mental health services in the future.

The Health Commission declared that it is the policy of the Department of Health to increase sub-acute mental health services, based on a plan to be considered and approved by the Commission as part of its budget.

Such a plan would identify the goals and objectives for the provision of mental health services, the needs of the community including special populations, an assessment of the appropriate level of acute and sub-acute bed utilization, and the range and type of community programs needed to reduce the reliance of acute care services.

The CMHS, under the direction of the Director of the Health Department, Dr. David Werdegar, is working to implement the Commission's policy. However, if we are to successfully implement the plan, we are committed to meeting the needs of our citizens who desperately need services to improve their mental health status, and we are looking to the State for increased financial support as we struggle to meet the increasing costs of these services.

We appreciate the Senator's awareness of the problems by holding this hearing to learn first-hand of our needs and concerns

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO

RESOLUTION NO. 075-86

RESOLUTION OF THE HEALTH COMMISSION DECLARING POLICY THAT THE MENTAL HEALTH DEPARTMENT SHALL EXPAND SUB-ACUTE AND COMMUNITY BASED SERVICES IN THIS FISCAL YEAR, AND THAT A MENTAL HEALTH PLAN BE DEVELOPED PRIOR TO THE DEVELOPMENT OF THE BUDGET EACH YEAR.

WHEREAS, The California Short-Doyle Mental Health Services Act mandates provision of humane, least restrictive care for the mentally ill within each local community, and

WHEREAS, The funding allocated from the State to pay for mental health services is not sufficient to provide needed services for acute hospitalization as well as community based mental health services and cost of providing an adequate level of mental health services has been increasingly funded through County General Fund appropriations; and

WHEREAS, The cost for acute services has historically constituted a significant share of the CMHS resources and restricted the development of community based alternatives;

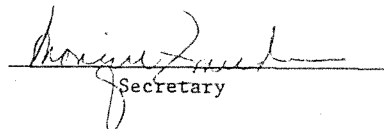
WHEREAS, CMHS has plans to increase sub-acute mental health services by purchasing additional locked facility beds, increase community based residential services by funding a dual diagnosis program for persons with both mental health and substance abuse disorders, and increase 24 hour mental health care by increasing the number of co-op flats available to mental health clients in this fiscal year; and

WHEREAS, Careful assessment of needs and program planning are needed in order to effectively allocate and distribute limited financial resources available for mental health services in the future; now therefore be it

RESOLVED: That the Health Commission declares that it is the policy of the Department of Health to increase sub-acute mental health services and increase non-institutionalized mental health services in this fiscal year within existing resources and be it

FURTHER RESOLVED: it is the policy of the Health Commission that a mental health plan shall be considered and approved prior to consideration of the mental health budget. This plan shall identify the goals and objectives for the provision of mental health service, the needs of the community including special populations; an assessment of the appropriate level of acute and sub-acute bed utilization, and the range and type of community programs needed to reduce the reliance of acute care services.

I hereby certify that the foregoing resolution was adopted by the Health Commission at its meeting of October 21, 1986.



Secretary

Testimony Before the California Senate Subcommittee
Hearing on the Mentally Ill

David Werdegar, M.D., M.P.H.
Director of Health
San Francisco

July 13, 1987

I greatly appreciate this opportunity to present testimony to Senator Marks and members of the the Subcommittee concerning the San Francisco Health Department's programs in mental health

We believe our programs could be greatly benefited by increased attention and support from the California legislature and State government in Sacramento. This is an area where you, Senator Marks, have made important contributions, through legislation, in the past - and we would welcome new assistance from you, and your colleagues, to strengthen mental health services in San Francisco, and throughout the State.

Mayor Feinstein has traced the continuous erosion in State support of mental health programs, which began in the late 60's, when dismantling of the State mental hospital system was initiated. As the state hospitals closed down, and patients were returned to care in their own communities, adequate funding was never provided to help local government build a substitute system of care. The state hospital system deserved reform. Mental illness care in huge hospitals at great distance from home and family had many undersirable features. But there was no plan for building a new and better system in the local community nor the necessary funding. The State's abandonment of mental health services and financing has been over the ensuring years, the principal factor affecting the local community's ability to ope with the problems of mental illness.

San Francisco government has been generous in trying to address the City's mental health needs. Between 1980/81 and 1987/88, the City's funding for mental health services rose by 544%; from $3.7 million to $23.7 million. At the same time, State funding for San Francisco's mental health services rose by 40%, from $22.7 million to $31.9 million. During this period, the problems and needs have grown.

San Francisco has developed a public sector program for mental health services which has many fine attributes. During the past several years there has been considerable progress in reducing reliance on acute psychiatric hospitalization, moving energy and resources more heavily into residential care programs in the community. This is shown by the great reduction in acute beds utilized, and the elimination of acute hospitalizations in out-of-county facilities. However, there continue to be significant gaps in service. The most conspicuous is the lack of any subacute or skilled nursing mental health facility in our community. We are also short of facilities for psychiatric services to children and adolescents. In recent times, the mental health system has had to accommodate to many new pressures, which I will describe:

The homeless"

The number of homeless, many with mental health problems has grown ana estimated 15% a year over the last several years. Today, we estimate there are 6,000 homeless in San Francisco/ Lack of affordable housing may be, of itself.

The needs of children and families

The needs for services to children have increased dramatically. This is reflected in the increasing rates of child abuse and neglect, school drop-out rates, teen pregnancies, adolescent alcohol and substance abuse cases, and in the number committing crimes. They parallel reduced access to medical care for families, and opportunity for prevention and early intervention with family counseling services. This is especially true for minority groups.

The needs of new immigrants:

The many new immigrants to San Francisco, principally from Southeast Asia and from Central America, face the many tasks of economic, social and psychological adaptation to their land. Many are in need of support services and counseling, best provided by bilingual staff who have understanding of and sensitivity to the client's cultural background.

The needs of the elderly:

The number of San Francisco residents over age 65 has risen steadily and now stands at approximately 110,000 or about 15% of the population. This is an unusually high proportion - greater than any other urban community of California, and is on the increase. The elderly require a variety of supportive social services including psychological support, counseling and mental health services. Alzheimer's disease, and various "organic brain syndromes" with confusion and dementia often receive most attention in the media, but the greatest need of mental health services is to help in coping with aging itsel with loss of function, loss of family, loss of sense of purpose and tendency to increasing isolation.

Needs related to substance abuse and alcoholism:

Use of addicting drugs and alcohol has been on increase and continue to require a full range of services from earliest preventive eductional efforts to detoxification, regular outpatient care and counseling, and residential treatment in community-based settings. The urgency has been heightened by the association of IV drug use with AIDS and recognition of addiction as a factor undermining safe sex behaviors in persons at risk of AIDS.

Needs related to AIDS:

The AIDS epidemic has placed unprecedented demands on the mental health system for counseling services to help individuals cope with threat of the illness, with the illness itself, with the grief over loss of loved ones. The number of individual seeking antibody testing for AIDS has been rising sharply, placing increasing call on counseling services regardless of test outcome. Clinicians caring for patients with AIDS recognize increasingly signs of neurological involvement with dementia and psychotic behaviors requiring psychiatric attention. The AIDS epidemic will continue to require increasing mental health resources over ensuing years.

We need substantially more help from the State in a number of areas:

(1) Medical reimbursement for subacute psychiatric hospitalization. Current rates are wholly unrealistic. We must pay a "patch" of up to $75 above the reimbursement rate to find a bed in community facilities.

(2) The situation is worse for residential care. Some of the most effective services, in terms of both patient outcomes and in terms of cost, are community based residential and outpatient programs. Yet State Medi-Cal funding for such services ranges from little to none. One patient-day of acute psychiatric services could buy up to 5 days of residential care or ten outpatient visits. Yet Medi-Cal provides no reimbursement at all for residential care and funding for only 8 outpatient visits a year.

(3) The State's psychiatric hospitals - what is left of them - still have a useful role to play, complementing the resources of local government. Services at Napa State Hospital, for example, are of great help to our local system in caring for the severely disturbed requiring longer term care. The State hospital system, at this point, should be strengthened and more effective working relationships with local Mental Health departments encouraged.

(4) Children's mental health services are grossly under funded by the State and impair opportunities for early assessment and intervention starting at school age. Although San Francisco has increased its own expenditures for children's services (from $5 million to $8 million over the last two years). The needs outstrip the capability of local government and call for considerably augmented help from the State. These include foster care services and services to youth in the Juvenile Justice system.

(5) Substance Abuse Services: The need for vastly increased substance abuse services is critical. Persons at risk of spreading AIDS through needle-use must be brought into treatment programs as soon as possible. In addition, we need to increase services geared towards special categories of substance abusers who are not now receiving an adequate level of services.

(6) Support for AIDS counseling services - as part of antibody testing programs, and in Medi-Cal reimbursements for patient care.

I would offer these recommendations:

(1) That the State reexamine in entirety its support of mental health services with a view to developing a comprehensive statewise mental health system, representing a fair balance of responsibilitoes and funding between state and local government. Greatest attention should be given, initially, to services for children.

(2) Seek increased federal support wherever possible for help in mental health services related to AIDS, to Substance Abuse.

(3) Seek increased federal support, shared with State government in medical program support for mental health services - particularly for ambulatory care and community-based residential care.

I would point out to San Francisco citizens that they can help greatly when the go to vote next November. There will be a ballot measure asking the voters to support a bond issue to build a mental health skilled nursing care facility at San Francisco General Hospital. We have no such facility at present. It will have a special separate wing for care of adolescents. Building this facility is one of the single most important steps we could take, as a community, to improve care of the mentally ill in San Francisco and conduct a more effective and economicalmental health program.

Senate Subcommittee on the
Rights of the Disabled
Senator Milton Marks, Chairman

MENTALLY DISABLED MINORITY POPULATIONS
and
CHRONICALLY MENTALLY ILL

July 13, 1987

State Department of Mental Health
D. Michael O'Connor, M.D., Director

MENTALLY DISABLED MINORITY POPULATIONS

A. Definition of a Minority Client

The California Department of Mental Health has adopted the definition of a "minority" as indicated by Government Code 1113.5, as a person or group protected under this section of the code, which includes, but is not limited to: Blacks, Hispanics, Asians and Native Americans, as well as the physically impaired and hearing impaired.

B. Special Needs of Minority Clients

The special needs of minority clients include clinical staff who are able to communicate effectively with a particular minority population. These communication skills, combined with a sensitivity to cultural differences, are crucial for the delivery of caring and compassionate treatment. Studies have indicated that it is difficult for certain minority groups, particularly those who have emigrated recently to the United States, to assimilate easily into the American culture. The resulting stress and anxiety are exacerbated by the difficulty of finding employment, the lack of education and the frustration of language barriers.

C. Existing Resources

The California Department of Mental Health has initiated several innovative programs to address the needs of minority patients. Among those programs are:

1. The Asian-Pacific Unit at Metropolitan State Hospital in Los Angeles County is the only one of its kind in any state hospital in the nation. Patients from several Asian nations - China, Japan, Thailand and Vietnam - are treated on this 25-bed unit by professional staff who speak various Asian languages and who understand the complexities and subtleties of different Asian cultures. The program was developed in cooperation with the Asian-Pacific Planning Council and the Los Angeles County Department of Mental Health. After-care planning and case management services also are developed by Asian community agencies in the Los Angeles area. Moreover, the program was patterned after a similar unit at San Francisco General Hospital, which is affiliated with the University of California, San Francisco.

2. In addition, at Metropolitan State Hospital, a 61-bed unit has been designated for Hispanic patients, most of whom are recent emigrants from Southern Mexico, Latin America and Central America. The program was initiated

more than 10 years ago as a day-treatment unit, and has evolved as the need for Hispanic services increased. Most of the therapy on the unit is conducted in Spanish. The population is composed of both short and long-term patients.

3. The Black and Hispanic Projects at Atascadero State Hospital in San Luis Obispo County have made significant progress in addressing the concerns of Black and Hispanic patients in a state hospital setting. The programs, each with about 40 patients, are designed for patients who have difficulty interacting with Caucasian clinicians, and who relate more successfully with minority staff. Patients may be referred to these units either by the admissions team soon after the patient's arrival at the hospital, or later by staff on other units. The goals of the treatment in these programs include the establishment of an atmosphere that allows patients the opportunity to better understand cultural differences and, generally, to better function in society.

4. The Department, working with local mental health agencies, has established a committee of minority mental health coordinators from all 58 counties. This committee is divided into three regions in California, each of which holds monthly meetings to discuss outstanding treatment programs on the county level, various concerns, or problems in serving minority populations and other issues. In addition, in October, the California Conference of Local Mental Health Directors, the statewide organization of county mental health directors, will hold a special day-long session on minority issues, at which exemplary programs will be presented. It is the hope of this Department that other county directors, after learning about these programs, will initiate similar services in their communities.

5. The State Department of Mental Health, with funding from the National Institute of Mental Health and the Federal Office of Refugee Resettlement, has initiated a wide ranging, two-year project involving the largest group of refugees to the United States - Indochinese. First, with $180,000, the Department, working with Asian Community Mental Health Services in Oakland, is nearing completion of the largest and most comprehensive study on the mental health needs of this population ever conducted in this country. The study covered the 10 counties in California, including San Francisco, most significantly affected with Indochinese refugees. In addition, the second year of this project (cost: $208,000) entails the development of training modules

for mental county health professionals to more effectively treat Indochinese patients, as well as materials for the Indochinese community to better understand the mental health system.

6. The Department's Office of Prevention has developed numerous materials - print and video - on the physical and mental health of minorities, including Blacks, Hispanics, Filipino, Chinese and Native American. These materials discuss the cultural needs of these populations, various ways in establishing good health habits and alleviating stress and anxiety. They are available free of charge from the Department.

It is without question that the California Department of Mental Health has provided leadership in the area of mental health services for minorities. It is the commitment of Governor Deukmejian to address the needs of all patients served in the mental health system, including all minorities.

D. Gaps in Current Resources and Services

The Department recognizes that not all minority, and non-minority individuals in need of treatment are receiving care. Such a system is probably an impossibility. The Department understands the need for more mental health professionals, both in community programs and in state hospitals, who are fluent in foreign languages, who are sensitive to the cultural needs of various minorities, and who offer these talents with the knowledge and experience to provide compassionate care. To address this need, our Department over the last several months has initiated an intensive Hispanic hiring program, with coordinators at each of the state hospitals. The Department is aggressively seeking the placement of qualified Hispanics in all hospital positions, from psychiatrists to custodians. Moreover, with the programs noted above, particularly the Indochinese project, we are working closely with counties to improve their efforts at addressing the mental health needs of minorities.

THE CHRONICALLY MENTALLY ILL

A. Definition of a Chronic Client

The chronically mentally disabled client is an individual with a severe and persistent mental disorder, such as

4,900 chronically mentally ill patients currently being treated in the five state hospitals for the mentally ill.

B. Needs of the Chronically Mentally Ill

The chronically mentally ill, to varying degrees depending on the individual patient, need care and assistance in a wide range of areas: treatment, medication, socialization and housing. In addition, depending on the patient's level of functioning, vocational skills and transitional living services also may be needed.

C. Existing Resources

The California Department of Mental Health is responsible for the administration of four state hospitals serving the mentally ill. In addition, the Department works closely with the California Department of Developmental Services on the administration of one state hospital which serves both mentally disabled and developmentally disabled. The Administration of Governor George Deukmejian has made a major commitment to improve the quality of care in our state hospitals to achieve national accreditation. With more than 700 new treatment staff over the past three years, combined with a $150 million multi-year renovation program, our state hospitals for the mentally ill have made tremendous progress toward the Governor's goal. Large warehouse-like wards have been remodeled into smaller, more private units, each housing four patients and providing privacy and dignity for the patients. An innovative program of Planned Scheduled Treatment (PST) has been initiated to give patients more individualized treatment and medication, which are monitored carefully by teams of clinicians. In addition, a new and innovative computer-based system, the most advanced in the nation, allows treatment staff to coordinate the PST program of patient care. Two of the five hospitals, Napa and Atascadero (San Luis Obispo County) already have been accredited; the other three are well on their way to achieving JCAH accreditation.

Regarding community programs, the Governor, during his first term, has made unprecedented increases in funding for mental health services. Counties today, through State Short-Doyle funding, are receiving approximately $500 million for local mental health programs, in addition to the counties' contributions to community services. The Governor has added special categories of funding, particularly for children's services, the homeless mentally ill and rates for reimbursement of funds to operators of residential care facilities.

D. Gaps in the Current Resources or Services

While tremendous efforts have been made in raising the quality of care, the Department recognizes not all chronically mentally ill individuals in the community are being served with comprehensive treatment. Some counties need to provide more aftercare services for patients who are released from intensive in-patient programs. Other communities, however, with adequate out-patient and aftercare services, may have to address the improvement of the quality of care in intensive in-patient programs. The model county system would offer a comprehensive continuum of programs, ranging from crisis intervention services, long-term residential, case management, transitional residential programs, day treatment, out-patient therapy and on-going assessments. The programs in Yolo and San Joaquin Counties frequently are cited for their quality of care in a range of areas.

E. Strategies for Improving the System

The State has been and will continue to encourage counties to further develop comprehensive treatment systems for the mentally ill. In some areas, particularly programs for the homeless mentally ill, the State Department of Mental Health reviews and approves program proposals before funding is delivered to the individual county.

One issue many critics of the system frequently cite is the Lanterman-Petris-Short Act, the law governing the civil commitments. Last year, State Senator Newton Russell authored SB 1708, which mandated the California Conference of Local Mental Health Directors to evaluate the L-P-S Act and to make recommendations to the Legislature next year.

HOW MINORITY POPULATIONS AND THE CHRONICALLY MENTALLY ILL FIT TOGETHER

It is clear that many of the individuals who suffer from chronic mental illness are minorities. Those patients in special units in state hospitals designated for minorities are chronically mentally ill. County mental health agencies throughout California have tens of thousands of minority patients, many of whom suffer from chronic mental illness. Many of the homeless mentally ill, about one-third of the total homeless population, are minorities and need bilingual and/or bicultural services.

Without question, the decline of the mental health system in California has been reversed by the Administration's

commitment to funding and program improvements. For the first time, this State is determined to achieve national accreditation for its state hospitals for the mentally ill. Tremendous increases have been made in funding for both state hospitals and community programs, with particular emphasis on the homeless, children's services and the mental health needs of minorities. The Administration is confident that as counties develop special programs for the needs of minorities and special populations - and the State Department of Mental Health continues its efforts in research and program development - that chronically mentally ill minority patients will receive increasingly better services.

Mental Health Association of San Francisco

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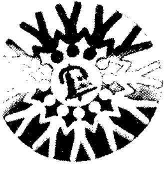

TESTIMONY FOR THE SENATE SUB-COMMITTEE
ON THE RIGHTS OF THE DISABLED

July 13,1987

Senator Marks:

My name is Basil Plastiras and I am President of the Mental Health Association of San Francisco. I wish to confine my testimony today to one special population -- the homeless mentally ill -- and one important gap in services -- the lack of housing for this population.

Current estimates indicate that there are at least 3,000 individuals on the streets of San Francisco who are mentally ill and homeless. By all accounts this number is increasing. The human toll is tragic and large, ending for all too many in death and for others in needless suffering. When expenses for shelters, police time, treatment in jails and emergency rooms, and prevantable acute hospitalizations are calculated, the cost to the City of maintaining a large population of the homeless mentally ill is staggering.

There is no solution on the horizon to the problem of homelessness among the mentally ill. We would like to look with optimism to the homeless legislation that is in the Federal pipeline. However we feel that it will only treat the symptoms, not the causes of homelessness. It is the strong conviction of the Mental Health Association that until policy makers fully grapple with the fact that housing policy must be a cornerstone of any solution to homelessness among the mentally ill, the problem will continue to overwhelm our cities.

It sounds obvious that a solution to homelessness is housing. Yet we maintain that this so-called obvious solution has not at all pervaded public consciousness or the policy arena, particularly for the homeless mentally disabled population.

Let me give just a few examples of this.

One of the most common and potentially pernicious contemporary myths is that homelessness among the mentally disabled is the sole and direct result of deinstitutionalization. Certainly the shift in treatment from State hospitals to communities was dramatic. But we have become so focused on changes in mental health policy that we have lost a focus on the impact of housing policies or sometimes the lack of housing policy that have created homelessness among the mentally ill.

When mental hospitals were emptied, many vulnerable individuals were moved into communities. Mental health clients and former mental health clients are, for the most part, low income. The same time period that has seen more clients and former clients living in communities has also seen the dismantlement of many forms of low income housing supports. To cite two examples of the dismantlement of low income housing at the Federal level that has affected availability in San Francisco:

--HUD (the Department of Housing and Urban Development) is the governmental agency that has traditionally borne responsibility for low income housing. The budget for HUD plunged from $35.7 billion in 1980 to $14.2 billion in this current year. Its Director has publicly stated that he wants to see HUD get out of the housing business.

--The number of households slated for new housing aid fell to about 74,000 this year, compared to 192,000 new units in 1980 and a peak of 393,000 new units three years before that.

The national picture of a dramatic drop in support for low income housing has been intensified locally by the real estate market in San Francisco that has driven prices through the roof. The result has been tremendous losses of affordable units either for rent or purchase in San Francisco.

A recent report by the San Francisco Housing and Tenants Council, for instance, reports that in the last decade over 17,000 housing units have been lost by conversion to other uses, leaving the City with 5,000 units less than it had ten years ago. Fully 7,600 of these units were lost from Single Room Occupancy (SRO) hotels, which housed many mentally ill individuals.

The result of these losses to all consumers has been skyrocketing housing prices . A recent report by the Bay Area Council reports that the median renter must allocate a whopping 60% of all income for housing. For the mentally ill, the majority of whom live on disability income that pays approximately $600 per month, the result has been catastrophic. Many have been priced out of the housing market altogether.

Let me give one more example of the impact of housing policy, or in this case the lack of it, on the growth of homelessness among the mentally ill. The primary housing resource aside from returning to families that sprang up to house those who were deinstitutionalized was the board and care sector of mental health housing. Board and care homes, more correctly referrred to as residential care homes, are private, proprietary businesses in which operators take mental health clients into their homes in return for payment. In a report published jointly by the Mental Health Association and the Family Service Agency two years ago, we documented the net loss of over 500 beds, fully 41% of the City's Board and Care inventory, in the previous five years.

A chief factor in this loss of a very important housing resource to the City is that current operators are aging and going out of business, and current real estate prices make it economically untenable for new operators to get into the business. Although this type of housing for other disabled groups has been maintained through providing State-sponsored subsidies as economic incentives to offset the impact of changes in the real estate market, the lack of a mental health housing policy has allowed this form of housing to be seriously eroded for the mentally ill.

So fixated are policy makers, the press, and most citizens on the impact of mental health policies on the growth of homelessness that many fail to consider the alternative direction of causality -- that homelessness creates mental illness. And yet in talking with shelter operators, we have heard time and time again of the increasing disorientation and trouble martialing thoughts that they observe among the shelter residents as they experience the sad trajectory of homelessness. We believe that although there are many who have had serious mental illnesses before they become homeless, homelessness itself is a stress of major magnitude that can and does result in mental illness.

You ask in your questions that we define "chronic" mental illness. When talking about a homeless population, we feel that neither we nor anyone else can in most cases hazard a guess as to what is an enduring, long-term mental disability and what is the result of situational stresses caused by homelessness that, if clients were able to stabilize in safe, decent, long-term housing would prove to be transient. For some, the chronicity of mental illness will endure as long as the chronicity of homelessness.

As these examples have shown, the loss of housing for the mentally ill is the result of changes in housing policy or lack of housing policy at all levels of government. Solutions will ultimately require concerted action at all levels of government -- the Federal, State, and local levels --and require substantial public-private cooperation to fully remedy the intolerable situation that currently exists.

Today, it is upon the role of State government that the Mental Health Association wants to focus your attention.

I would at this time like to draw your attention to a report that has recently been published by the Mental Health Association of San Francisco called, A Place to Be. This report is the result of nearly a year's worth of investigation by a Housing Task Force convened by the Mental Health Association. The Task Force was drawn from housing providers, developers, people with financial expertise, and volunteers and was chaired by former Board President Allan Moltzen and Board Member Ira Okun. I wish to use this occasion to transmit this report to you and to ask you to take leadership in implementing its recommendations for steps that need to be taken at the State level of government to create adequate housing for the mentally ill.

This report identifies in August, 1986 the need for between 1500 and 2000 units of long-term housing. It also develops an action plan to parcel out responsbility for meeting this need.

Our first major recommendation at the State level of government is for the establishment of an inter-agency, inter-county task force for the homeless mentally disabled and charge the task force with the production of a statewide plan addressing the housing of the homeless mentally ill and coordinating the work of the state departments of health, social services, community development and vocational rehabilitation.

Let me make two comments about the significance of this strategy. First, one of the historical reasons that there has been no housing policy for the mentally ill is that it is a need that falls between jurisdictions of responsibility. Whether it is at the local, state, or federal levels of government, departments of mental health tell us that they are not responsible for housing, housing says that they are not responsible for a disabled population, and social services says that it is not a problem for their domain. We strongly maintain that if this problem is to be solved, responsibility has to be lodged and that it will take cooperation among these departments.

Second, solutions cannot exist in geographic isolation. This is truly an arena in which any solution that truly qualifies as a solution has to be regional and state-wide. Unless resources and responsibilities are shared equitably, municipalities such as San Francisco that do provide adequate services will become a mecca for people living in jurisdictions that do not design adequate services.

The second major recommendation at the State level, and here, especially, is where we call for your leadership, is for an omnibus housing bill that does the following:

a. Creates tax incentives for developers to engage in partnerships with non-profit agencies to develop permanent housing for the mentally disabled;

b. Creates subsidies for developiong and operating low income housing designated for the mentally disabled;

c. Issues tax exempt bonds to provide capital for construction and rehabilitation of facilities for the mentally disabled on a statewide basis;

d. Develops legislation that prohibits housing discrimination on the basis of mental disabilities;

e. In the absence of adequate Federal Section 8 rental assistance programs, expands the state mental health aftercare program to provide rental assistance to the mentally disabled;

f. Develops a State-financed, locally managed emergency assistance fund to help mentally disabled persons remain in their homes through the variety of emergencies that may occur;

g. Provides tax incentives and funds to assist existing privately-owned Single Room Occupancy (SRO) unit owners to correct violations and make major renovations when such SROs would be dedicated to the needs of the mentally disabled;

h. Appropriates sufficient funding to underwrite a State plan for the chronically mentally disabled.

It will take leadership to accomplish these goals. There are States, like Massachusetts, where there has been effective leadership in dealing with the development of housing for the mentally disabled, even in the absence of a strong Federal partnership. We believe that California can be a leadership state, and we ask you to take the initiative to make it so. The situation for the thousands of mentally disabled living on the streets in San Francisco and throughout California is intolerable. It does not need to be so.

Thank you.

MENTAL HEALTH ADVISORY BOARD OF SAN FRANCISCO

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STATEMENT TO
SENATE SUBCOMMITTEE ON THE RIGHTS
OF THE DISABLED
JULY 13, 1987
BY: KENNETH LADEIRA

In the past weeks, the news media have reported extensively on the overloading of acute treatment services in San Francisco; on the increasing use of involuntary treatment; and on the inadequacies of services to a large group of persons with severe long-term or recurring mental disabilities. The more overloaded the services become, the more pressure there is to pour money into the most expensive kinds of care. This leads to cuts in alternative community support services, which are the only hope for solving the problem. It has meant, for example, a 40 percent cut in the budget of the Tenderloin Self Help Center after less than a year in operation.

There are many needs. In the brief time allotted today, we can do little more than list them. They include:

More residential treatment beds, increased assisted independent living programs and more coop apartments.

Adequate funding and support for the eroding residential care -- that is, board and care -- system.

Affordable regular housing for those who may not need treatment or sheltered living situations, but who do need, like all of us, a place to live at a rent they can afford.

Meaningful vocational and other rehabilitation-focused services, which help people ultimately to move away from dependence on the mental health system and into independence.

Help in securing entitlements such as SSI and Medi-Cal, which allow people to meet their basic needs and maintain themselves in the community.

Community-based assistance should be delivered in a way which involves the recipients in the making of decisions about

their treatment plans and what will be done to help them meet their basic needs.

Focus on the so-called chronically mentally ill as a special population sometimes obscures the fact that many of these persons are also members of other special populations and therefore have the same special needs.

For example, providing effective community-based treatment and support for San Francisco's multi-ethnic and multi-racial population means that service needs to be provided by staff who are bilingual and able to deliver these services in a culturally relevant manner.

In similar fashion, service providers must have sensitivity to the special needs and experiences of gay persons.

There is an extremely urgent need to reach and work with the mental health client population at risk of AIDS and ARC, particularly those who are isolated and therefore have little access to knowledge or understanding of the issues. We need to move quickly to establish special services to persons with the difficult combination of mental disability, substance abuse, and diagnosed AIDS or ARC.

Finally, no one can afford to ignore the important special population made up of San Francisco's children and adolescents, many already suffering from severe emotional disturbances. The grim crisis in child and adolescent services has also been well publicized in recent weeks. It is basically the same as the crisis in adult services -- except there are even fewer community alternatives and acute treatment services for children and youth.

* * *

There is no one solution for all of these problems, and no one action that assures all of these needs are filled.

There are a number of things that the State legislature can do, however, and we want to urge you to proceed on at least five of them.

Our first three recommendations relate to funding issues:

(1) YOU CAN ENCOURAGE THE STATE DEPARTMENT OF MENTAL HEALTH TO CANCEL THE $1.2 MILLION DEBT IMPOSED ON SAN FRANCISCO FOR SO-CALLED "OVER-USE" OF THE STATE HOSPITAL

> There's only one place from which the payment can come -- from the budget for community mental health services. The problem is simply perpetuated if we are unable to maintain and expand community follow-up care and alternative services which can begin to reduce our use

of the State hospital and of expensive local inpatient services.

(2) YOU CAN SEE THAT SAN FRANCISCO GETS ITS EQUITABLE SHARE OF AB 3632 FUNDS FOR CHILDREN

Under AB 3632, Counties were originally mandated to screen, identify and provide services to severely emotionally disturbed children, without also being provided with funds to serve the children who do get identified.

There are funds for service in this year's budget, although they and were drastically cut by the Governor. But a formula for distributing the funds is proposed which would penalize San Francisco and reduce its share of funds by not taking into account our very early and aggressive move to do the mandated screening of children. We urge you to make sure this doesn't happen, and that San Francisco gets its fair share of funds.

(3) MAKE SURE THAT CASE MANAGEMENT SERVICES BECOME REIMBURSABLE UNDER MEDI-CAL

Federal legislation now authorizes Medicaid reimbursement for case management services. Similar legislation is needed in California and has been introduced, to authorize Medi-Cal reimbursement of these services, and thus the use of Federal funds to help defray the costs. This will take the burden off badly-stretched Short-Doyle dollars.

Our other two recommendations do not call for additional funding, but do require special sensitivity to the welfare of the mentally disabled.

(4) LEGISLATIVE INITIATIVES ARE NEEDED TO DEVELOP AND MAKE AFFORDABLE HOUSING AVAILABLE.

The lack of affordable housing is not unique to San Francisco, but it is particularly critical here. Nor is the need for housing unique to the mentally disabled population. In our experience, however, it will be important for the legislature to make sure that there is equal access to housing for the mentally disabled, or they will not get it.

(5) CONTINUING VIGILANCE IS NEEDED TO PROTECT THE RIGHTS OF THE DISABLED

There is a danger that community reaction will lead us on a backward path toward re-institutionalization and a greater ability to impose treatment on people without their consent.

It is particularly important for this Subcommittee, charged with a focus on the rights of the disabled, to be vigilant in preserving the careful balance worked out so painstakingly in LPS between the rights of the disabled to freedom and the right of the community to detain and treat people involuntarily.

TESTIMONY BY RICHARD SHADOAN, M.D.

SAN FRANCISCO PSYCHIATRIC SOCIETY

7/13/87

Senate Subcommittee on the Rights of the Disabled

The San Francisco Psychiatric Society which represents nearly 300 private psychiatrists in San Francisco is acutely aware of the problems in delivering care to the mentally disordered. This immense problem needs all sectors of the community involved. Unfortunately, the private sector all too often is not adequately included in the planning for the care of the severely mentally disordered.

It is a myth that dies hard that the private sector treats only neurotic patients, because of our bio-social-psychological training we are probably best prepared to address the needs of the severely mentally disordered.

A problem both the county and the State should be very concerned about is the low Medi-Cal reimbursement rate for private psychiatrists. We should fight the Governor's proposed rate reduction and work for a more equitable reimbursement rate. Unfortunately as malpractice increase rates and costs of running a practice goes up, fewer psychiatrists are willing to treat Medi-Cal patients.

The private sector is essential in 4 areas of care:

1) Out-patient Therapy

Because they are available (1) 24 hours a day, 7 days a week. (2) They are stable often in practice for years and they offer a full range of services including psychotherapy, medication management, crisis intervention and case management. They are a critical asset to our system. The National Award Winning Family Service MIA Program is a prime example of an effective use of private psychiatrists treating the "public" patient.

2) In-Patient Care

All hospitals except SFGH use private psychiatrists in the hospital care. Many private physicians travel out of San Francisco to treat patients in "L" facilities.

3) The 700 patients in Board and Care are all treated by private psychiatrists. They also treat many patients in our residential treatment system.

4) The private sector works closely with crisis clinics.

This important resource can be utilized more effectively if we bring it more into our planning. County Government all too often fail to include the role of private psychiatrists in planning the delivery of services.

I recommend that your office:

1) work to obtain adequate Medi-Cal reimbursement rates for private psychiatrists;
2) require counties to actively include private psychiatrists in their ongoing mental health planning.

IN MY OPINION

Susan Hogeland
Assistant Executive Director

Medi-Cal Patients Don't Vote?

If you believe the State Department of Health Services, Medi-Cal patients can practically go to any physician they want, whenever they need services, and physicians are getting rich from the Medi-Cal program.

Physicians should be proud of the lawsuit undertaken by California Medical Association on behalf of Medi-Cal beneficiaries and physicians. The suit would stop the Administration's 10% cut in payments to physicians and other providers in the Medi-Cal program because of the serious impact such a cut would have on access and quality of care.

Shocking instances of the true impact of past cuts on access and quality of health services for Medi-Cal are clearly demonstrated in CMA's brief (prepared by Legal Counsel Catherine I. Hanson and Astrid G. Meghrigian, filed in the US District Court, Eastern District of California). These instances, which in the opinion of CMA appear to have been deliberately ignored in DHS's defense of itself, violate both Federal Medicaid law and State law.

CMA charges that DHS, given a unique second opportunity by the Court to defend its proposed action, chose instead to offer an "'assessment'...which only obfuscated the inadequate information it had already presented to this Court." The real impact of the access problem, CMA contends, was demonstrated repeatedly by the Department's own data.

For example, CMA cites:

- A massive decrease in utilization of physician services between 1981 and 1986 from an average rate of 29.4% to 25.6%, or a decrease from 3.53 claims per eligible Medi-Cal beneficiary per year in 1981 to a mere 3.07 claims in 1986. CMA estimates utilization rates in the general, and usually healthier population, are 50% greater than the number of physician contacts in the Medi-Cal program.
- A 16% decrease in the number of physicians who billed the program between 1981 and 1983 (38,120 to 31,901) in response to reductions in reimbursement levels.
- DHS ignored the real participation rates of providers by eliminating marginal providers or addressing the dramatic increase in concentration of Medi-Cal services among a few providers and the dramatic upsurge in ER visits and billings.
- DHS failed to compare the rate of procedures performed on Medi-Cal beneficiaries to that of the general population. Otherwise, a bleak access picture would have appeared: the utilization rate of cardiovascular surgeries is more than 87.6% lower; the rate of eye surgery 30% lower.
- The number of Medi-Cal eligibles declined by nearly 100,000 from 1982 to 1986, but emergency room visits increased from 77,1609 to 336,313, more than 400%. The figures clearly indicate the increased difficulty of Medi-Cal beneficiaries in obtaining physician care. Surgeries dropped from 903,220 to 640,934. Additionally, CMA charges that as many as two-thirds of all "participating" physicians may be viewed as marginal participants. A meaningful specialist participation rate is more like 21.6% than the state's figure of 63.5% because so many specialists actually bill less than $600 annually.

Can the state argue "greedy" physicians don't care about Medi-Cal beneficiaries? According to the Department's data, the average internist collects 50.4% of total billings for services provided to Medi-Cal patients, while a surgeon collects 42.1%. CMA calculates that an internist seeing only Medi-Cal patients could look forward to realizing a net income of slightly under $15,000 per year. The proposed decrease in reimbursement rates could bring that down even lower. Another great, get-rich-quick scheme?

Meanwhile, CMA accuses DHS of: obfuscation, failure to consider its own data or present an accurate portrayal of the access problems faced by Medi-Cal beneficiaries, presenting information in a biased fashion, offering information riddled with unsupported statements, inaccurate data, material misrepresentations and omissions, failure to conduct a

Ever seen a headline that reads "747 Lands Smoothly with 350 Aboard?"

Given all this, what do you do if you're interested in making people aware, through the media, that physicians really are good people, engaged in good works?

You find a blotch and use it. That means you make a tacit bargain with the media. In effect, you say: "Look, here is something that your readers will find unusual, or interesting, or amusing, or useful. I'm going to provide it to you. I'm banking on the fact that you will find it necessary to tuck into your story somewhere that this information comes from or reflects favorably upon, my profession, (or organization, or candidate or ballot initiative).

"Rewarding day, time well spent ... I feel this was an introduction to the subject, designed to build confidence ..." Joshua H. Rassen, MD

"I have only been that tired maybe six times in my life .:. I now feel more confident, more knowledgeable ... Thanks." Cyril M. Ramer, MD

The trick, of course, is to find something that is interesting (on the reporter's terms) and that at the same time will draw favorable attention to whatever you have in mind.

How do you do that?

There are ways.

- **Statistics:** Bring some of them to the attention of reporters if they present little-known information that flies in the face of conventional wisdom. For instance, the basic per-capita charge for Medi-Cal patients has remained flat over the years, if you figure in the inflation factor. "Soaring Medi-Cal Costs" come from the increasing number of patients and from hospitalization costs, not from increased physician fees. **Make sure your statistics are accurate.** They'll be scrutinized in places you never dreamed possible.
- **Comments:** Make comments on the issues that are making headlines; piggyback what you have to say onto the notoriety of the issue. This may take a bit of research and soul-searching. You must settle on something you believe in, no matter what. It must capture media mention by virtue of being associated with a hot topic. And it must be couched in a way that will attract favorable attention. Pick your issue carefully. There are some topics that, no matter what you say, are going to anger 50% of those who've heard anything about them.

I have a friend who rose to national prominence as an educator. Time and time again, he would remind audiences and reporters that "after all, children are what the whole enterprise is all about. We have to think of the children." First of all, he really loves children and believes they are too frequently overlooked in all the hoopla over education reform, budgets and buildings. But second, that reminder always made him look good in the media because almost no one else was saying it.

A few additional pointers:

- **Don't say "no comment."** I know, you've seen people say it in the movies and you've heard the phrase all your life. Don't use it. It's like waving a red flag in front of a bull. Everyone (including reporters) knows there are times when you cannot comment on a subject. So tell reporters, "Look, I'd really like to say something about this, but I can't, because ... " Follow up with, "When ... , I'll certainly be available for comment." You can level with reporters about why you can't say anything about a

Continued on Page 25

"...the cost per Medi-Cal recipient in this state is 30% below the national standard ... CMA calculates that an internist seeing only Medi-Cal patients could look forward to realizing a net income of slightly under $15,000 per year."

meaningful inquiry and to use data it had properly, mathematical errors, fallacious reasoning, questionable estimates, ludicrousness, callousness, patent inadequacy, one-sidedness, arbitrariness, being self-serving and manipulative.

Not a pretty picture for the department entrusted with meeting the health care requirements of our state and its needy, even if you discount for the hyperbole of the courtroom. In fact, CMA says: "Perhaps winning this lawsuit is more important to the Department than recognizing the problems of the delivery of health care in this State and taking steps to rectify them." That would indeed be shocking.

Physicians do themselves a disservice by promoting Medi-Cal abuse horror stories which reinforce the idea that the Medi-Cal program is a rip-off rife with patients being Rolfed and having breast implants and nose jobs.

At the recent CMA Legislative Leadership Day in Sacramento, an impressive 11-page piece on Medi-Cal myths was distributed. Physicians were asked to read it and then not contribute to the incorrect beliefs that many legislators, particularly on the Republican side, have about the extravagant nature, uncontrolled spending and abuses in the Medi-Cal system. The answer to these misperceptions traditionally has been so-called Medi-Cal "reform." "Reform" always begins with serious budget slashing ($300 million is proposed in the next budget) but is rarely followed by meaningful ideas for true program improvement.

Serious problems in the Medi-Cal program occurred this year because, against all advice and heavy lobbying by the CMA, the Administration deliberately chose the low budget figure for the program, instead of a middle range figure which has been selected traditionally. Funding was then inadequate (surprise!), and the Governor's response was to impose a 10% cut on physicians and other providers mid-year.

No doubt the Medi-Cal program can do with some revisions. But the reality is the cost per Medi-Cal recipient in this state is 30% below the national average, despite the fact that California is among the nation's wealthiest states. Utilization is tight, but access is an increasingly serious problem. A glance at the SFMS referral service data supports the CMA's claim that while many physicians have, and bill, for some Medi-Cal patients in their practices (85% of SFMS's physicians say they do so), the percentage of patients may be very small. A majority no longer accept new Medi-Cal patients because of low reimbursement levels and the bureaucratic hoops one must jump through to get the measly Medi-Cal payment. Can anyone blame physicians for not participating?

It makes me proud -- and I hope it does physicians as well -- that CMA, with the support of its component medical societies, truly is acting as the advocate for the needy in our State on this issue. SFMS's recent survey on under- and uncompensated care demonstrated that physicians are already bearing more than their fair share of caring for indigent patients and those in public programs, and that they will continue doing so even if it means not billing at all (which many do not).

My greatest concern is that CMA will lose its case because the courts will decide the State may have the right to make a decision based solely on financial considerations, which have nothing to do with access or quality of care for Medi-Cal beneficiaries.

Or perhaps because Governor Deukmejian doesn't believe Medi-Cal patients vote. sfm

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The Senate Subcommittee on
the Rights of The Disabled

Testimony
July 13, 1987

I am here on behalf of the Children's Mental Health Policy Board. I wish to begin by thanking Senator Marks, as well as Senators Ayala and Craven and staff, Juli Winesuff, for turning their attention to the consideration of the special needs of the chronically mentally ill and minority populations in San Francisco.

The Children's Mental Health Policy Board defines a special population in the following terms: A discrete set of people with specific, measurable mental health needs which are not present in the general population and for which services are not provided for under existing legislation or regulations.

As we understand the term, children meet the criteria of a "special population" and deserve and require specific legislative attention and specific fiscal allocation to ensure appropriate, effective, and cost-effective service delivery.

Historically children and youth have been largely ignored by the mental health establishment. Evidence of the failure to recognize their special needs is widespread:

* Neither the Short-Doyle nor Lanterman-Petris-Short legislation refers to children nor makes provision for them. Indeed, under a strict interpretation of LPS, all children meet the criteria for involuntary commitment as "gravely disabled" simply because they are children!

* Children and youth comprise 35% of the population statewide and more than 24% in San Francisco, yet we spend no more than 15% of our mental health funds on them.

* The Egelund language requires that 50% of all new mental health funds be allocated to children's services until the goal of 25% is reached. Until last year, more than seven years after its passage, the Egelund language was not enforced.

During the past year since enforcement, we have made the first steps, but we have a long way to go to reach the goal of appropriate, proportionate fiscal allocation for children's mental health services.

The children of California have not always had a higher percentage of mental illness than children in other states. Now, however, the system of care for California's children has been neglected for so long that we now have proportionately more children suffering from more severe disturbance than other states. The question we on the Policy Board ask ourselves and the question I pose to you is this: How long must they wait?

There is no answer to the question. They've waited too long already. So we have some suggestions for strategies for serving children and youth. In general we believe the mental health needs of children and youth are best served through the coordination and integration of all the services that ordinarily provide for them: homes, schools, day care programs, social services and juvenile courts. Their mental health needs must be met within the context of their childhood developmental needs. We have made a start statewide with AB3632/882 and our Social Service and Health Commissions and our Board of Education and Staff have worked hard to begin coordinated effort. So we recommend several additional specific measures:

* Supplemental mental health funds for seriously mentally ill children placed out of home by the Department of Social Services or the courts. This mental health "patch" would ensure that their particular mental health needs could be addressed over and above their needs as abused and neglected children.

* Strong support services for families to enable them to maintain the traditional family responsibility for the care of their disturbed children.

* Mental health should serve in a consulting capacity to the service systems in which children and families ordinarily seek service. They should expand outreach and early intervention services through these systems to reduce the frequency and severity of childhood and adolescent disturbances.

* The California Department of Mental Health should create a department for children's services. Presently there are eleven categories of special populations with a director and five support staff. With so many special needs groups and so few resources, children's needs can never be appropriately addressed.

Today's hearing is focused on the needs of the chronically mentally ill including those who are homeless. Each of those folks was a child neglected or mistreated by our system not so very long ago. Unless we include today's children in these deliberations we continue to apply band-aids while we raise the next generation who will shortly take their places on the streets of our cities.

So our request and demand today is that we invest in the future mental health and stability of our children. Through an appropriate treatment system we expect to see important changes:

* Reduced costs of care of the next generation.

* More efficient use of public funds.

* More intact families able to provide full or partial care for their disturbed family members.

* Increased capacity for independent living and decreases in life-long handicapping conditions.

* Reduced pain and suffering for the mentally ill and their families.

In closing, we want to thank you again for taking this look at the special needs of the chronically mentally ill. We laud your efforts to understand and meet those needs. We urge you to look at the children and determine to break the cycle and affirm that the children will no longer be required to wait and wait.

Dear Senator Marks,

I would like to express my appreciation for allowing me this opportunity to speak before you this morning.

My name is Michio Kusama. I am a psychologist by training and profession. I am a naturalized American citizen. But, most importantly, I am one of those who have benefited from the support of bilingual and bicultural services.

Today I am representing the Japanese Mental Health Task Force that was the key advocate group to establish San Francisco's only mental health outpatient program for both Japanese- and American-born Japanese in the city. The Task Force's original intent was to change the trend of low utilization of mental health services among Japanese individuals and families due to the lack of accessibility and availability of bilingual and bicultural mental health services.

In the course of eight years of existence, there has been a gradual but definite rise of reported severe and chronic mental health disorders among Japanese. Still more frightening is the lack of our knowledge as to how many additional individuals are kept away from social contact and assitance for various cultural reasons.

A recent report shows that there has been a surprising surge in new cases of AIDS among Japanese individuals. We have also been witnessing the rise of substance abuse, domestic violence and other mental health issues that have not been paid attention to previously.

We need to identify issues and problems, and find ways to cope with them in an expedient but effective fashion.

Your support for this effort is of utmost importance and urgency.

Thank you very much for your time and concern.

Respectfully submitted,

Michio Kusama, Ph.D.

Representing the Japanese Mental Health Task Force, July 13, 1987

P.S. For further information, please contact Nan Senzaki, LCSW, Japanese Family Service Program, 1010 Gough st., San Francisco, CA, 94109, 474-7310.

MK/mk

JOHN G. PRICE
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JULY 13, 1987

SENTATE SUBCOMMITTEE ON THE RIGHTS OF THE DISABLED:

We are appreciative for this opportunity to speak to and submit to the SUB-COMMITTEE this statement.

We will try to answer your questions about the chronically mentally ill and what their special needs are and what gaps there are in current services and resources and how those gaps could be addressed.

The SAN FRANCISCO NETWORK OF MENTAL HEALTH CLIENTS operate a client-run center called SPIRITMENDERS and it serves the chronically mentally ill-but we prefer to refer to ourselves as consumers or survivors or ex-inmates (of mental institutions). Some of us believe that we are mentally ill and have a disease but many believe that what we are is a response to the environment and if that environment was supportive we would not be having so many symptoms and we would not be diagnosed as mentally ill.

So, the statement we are submitting here is our own as we attempt to represent the NETWORK and mental health clients.

We cannot address all the chronically mentally ill here, the subject is too broad. To your questions: DEFINE the CHRONICALLY MENTALLY ILL, WHAT ARE THE SPECIAL NEEDS OF THIS POPULATION, WHAT ARE THE GAPS IN SERVICES AND RESOURCES, ETC., we can only address one part, one population, of the chronically mentally ill: the person diagnosed paranoid schizophrenic.

We will do so because we have lived that part most of our adult life and we are 52 years old. We have been through more professionally-run mental health programs that we can remember and all through those programs we have observed much-both on the part of the mental health client and what works for them and what doesn't and also on the part of the professional and what they have to offer in the way of services and resources.

Also, the reason we are attempting to address the issue of paranoid schizophrenia is that they, we, comprise roughly 80% of the schizophrenic population and this population, as you know, is huge..it consists of the majority of the chronically mentally ill.

What follows is mostly taken from a book we are writing about our emotional disability. Certainly, not all people concerned with mental illness will agree with everything that is written here. There has been a big push in the last decade to consider schizophrenia biologically based and induced.

This, we believe, is incorrect. In the book there's time to go into these things more convincingly but here we can only touch upon them. But it is an important issue to consider because if it is a disease then it becomes an entity entirely in the provience of medicine and the implication that follows is that one then can be cured of this disease and, failing that, one should be treated for it..by medicine.

Then too, there are certain advantages to consider if it is a disease and treated only by medicine. Society recognizes medicine as a legitimate entity to be reinbursed monetarily by that society. The trouble with that is that it doesn't work. That is, treating the schizophrenic with medications- the common mode of treatment- does not "treat" the person at all; it suppresses the thoughts and feelings and they do it so well that most people on these neuroleptics cannot adequately think straight.

Also, other side-effects are really detrimental to a lot of people. Tardive dyskinisa is an irreversible condition that leaves a person with uncontrollable jerky movements and shakiness and without control of their tongue, which will pertrude from the mouth and many times there will be drooling. This condition really adds to a person's dilemma; people usually will not want to be around a person exhibiting these features.

We would have no objections to these medications if they eventually did the things that they were supposed to do..that is, help restore the individual. But they don't. The person will often be on these the rest of his life. And the longer a person is on them the worse these side-effects can become.

Here is a tremendous gap: there is no present adequate solution available to address the problem of a person needing temporarily some medications, and a support system adequate enough to restore the person to a reasonably functioning level and lesson his needs on those medications.

Until now. Now there is the resource of the client himself. Up to now, this has been a huge gap because the client has never been tapped as a resource. Now, that is beginning to change, a little. All accross this country clients have been involved in self-help. Clients are helping other clients and it is working.

It is working because clients have a chance to be around people who have had and are having similar experiences. They share those experiences and the outcome is that they get better. They get better because they are not put in a position of appearing to be the sick person. Everyone is sick; at least they have been there, if not at present then yesterday or last week or last month. And by sharing, clients learn that others have been through the same kinds of things. This in itself works wonders.
The client at a self-help center does not feel like he is being observed and believe me, if there is anything that a paranoid schizophrenic feels, it is this feeling of being observed and evaluated. This is the single most effective thing that goes on at a client self-help center.

After a client has come around for a while and begins to feel like everyone else there is more or less just like him and that he is not being observed and evaluated but accepted and treated equally..treated just like everyone else, then another strange thing happens that does not usually happen to someone labeled paranoid schizophrenic. And that is he also begins to trust!

When this happens, the client also begins to lose his fears. He begins to have less and less delusions and hallucinations-the hallmark of paranoid schizophrenia. People then are at a position to partake in a number of options that here-to-fore were unavailable to him because of his symptoms of delusions and hallucinations.

Some people feel so confident that they start volunteering at the center and some go to school or do volunteer work in the community. Some leave the center and are able to return to work. Sometimes people will stay and volunteer at the center for some time, gradually increasing their confidence and then return to work.

Many people will utilize the center as a lifestyle and/or make friends and lovers and go about their life in a pretty good functioning way-and the key here is that they pretty much stay out of the costly hospitals and also relie on medications less and less and their doctors too.

The important thing here is that we relie on each other. We make friends, sometimes for life. This, for the most part, does not happen with the resources and services that are currently available in the mental health system.

People come to the treatment programs and are "treated" but they do not get well. True, the recidivism rate is somewhat lower while the person is attending the treatment program but this is usually only while they are attending. Once the person leaves because others have to have a chance to be served or the program closes down or they leave because the staff they have become used to have long been gone to other endeavers, then it is usually not long before the person is going through another crisis and has to be hospitalized again.

This happens because a person is left without support suddenly and completely. The person may be feeling OK when first leaving his mental health support system. But then, because of his basic nature of being non-agressive and non-assertive, he will gradually begin to isolate himself. And the longer this goes on, the more of a chance he has of becoming the person he was before, that is, a person with fears and distrust and delusions and hallucinations and when they become pronounced and more noticible, others in his environment will sometimes call the police or mental health-care workers and the person is admitted into the hospital, or he himself will go in.

When this happens, oftentimes the person will lose his housing because of a missed rent payment requiring a longer stay in the hospital than is many times necessary. Needless to say this is quite an unnecessary drain on society's resources.

What is needed here is prevention and the mental health system cannot provide it. Society cannot provide it. It would be too costly. There would have to be treatment centers large enough to accommendate large numbers of people and provide them with these mental health support systems on an ongoing basis.

The usual alternative is hospitalization. The usual alternative up to now.

There is this tremendous gap between hospitalization and returning to live in the community. It needs to be filled and clients themselves can fill it. This is not to say that current resources and services should be done away with. But much of it can be refocused.

There is a need for clients to be able to do something constructive and worthy. This is especially true for the clients who make so much progress at the client self-help centers. There soon comes the time when the client feels not quite strong enough to return to work but is strong enough to do activities that are more advanced than what the client self-help center or the typical treatment center has to offer.

Many of us are unskilled because of our disability occuring so early in life. Many already have some skills but because of repeated failures in the general job market are very reluctant to pursue that; there needs to be some kind of comprimise available.

The current mental health system is like a holding zone. Many people are able to stay out of the hospital but they are far from well enough to try anything else. But the client does show dramatic improvment through the self-help model but here too-excluding those who do go back to work or school-there is just so much available to the client.

There should be a refocus on the part of the mental health system toward job training, toward client self-help centers, toward client self-help groups throughout the local and regional areas, there should be a strong focus on adequate housing..low-cost housing.

This is also not to say that professionals should be done away with. Ask any doctor or psychologist and they will say that there is not much they can do to alleviate a client's suffering. Clients, when they are having repeated sysmptoms, are not in the "right place" to receive these kinds of services.

But I have had experience with clients who began to feel much better attending our self-help groups and began to be at that place where they would be receptive to the more traditional kinks of therapy that are usually reserved for the neurotic person. And they, some of them, did avail themselves to this kind of service.

Also, I have seen clients that wouldn't be caught dead in the office of a pschotherapist and after being in a client self-help group for a while they too have availed themselves to this service. The point is, that the mental health professional can go back to addressing those issues that they were originally trained for instead of beating their heads against the wall with techniques and approaches that have consistenly shown not to work.

To implement this, the state should begin to set-up client self-help centers throughout the state and in every county. But if this is done the way that sentence reads..the state should start-up..then it will be doomed to failure.

This is because when someone does things for the mental health client the client will NEVER come to that desirable place of thinking of himself as someone who can carry out those things necessary to conduct a self-help center. He will never gain confidence needed when there is someone else there to do his thinking for him. Setting things up for him. Providing the things he needs without the client exerting any effort.

As stated above, this does not happen in the self-help center where everyone is a client, (or has been a long-term chronically ill client). As soon as someone "normal" shows up and starts doing things that "will help" then the makings of disaster are in place.

Instead, money should be in place at the county level that is available to the client group..and sometimes this is only one or two people, in the beginning. The county could act as fiduciary or the client group can make some contacts with available nonprofit agencies to do this; agencies that have a tract record, of course.

No new money needs to be appropiated. The funds are already there. They are just being used for the wrong things and at the wrong times. The counties must be made to allocate-out of their present budgets-monies equal to, at the start, three percent of that part of their budget that is allocated for adult mental health services. This should exclude those monies allocated for drug and alcohol programs for the adult chemical abuser.

If the money designated for client use is not used at the end of the fiscal year then half of the remaining funds should be rolled-over for the next fiscal year for client use and the other half returned to the state to be redistributed to client groups in the other counties that have a use for it.

This should go on for a minimum of five years because it will come at a time when many areas and regions of the state have a population of clients that have been completely unexposed to the client self-help modality and it will sometimes take this long for an awarness to come about.

If, at the end of this five years, there are counties that have not been able to find interest from clients, then the monies should be available to other client groups that have demonstrated an ability to provide services to other clients. Hopefully, those services provided would include an attempt to establish low-cost housing.

This latter area is something that the state could be of great help. Housing is so desperately needed throughout California and the state may have the expertise necessary to provide client groups the skills and knowledge they would need to pursue this area.

Then too, there is available lands on state properties such as state institutions. This land could be put to good use in providing low-cost housing for the mental health client. There is, I believe, a current bill to set up a land-use commission. Clients should be well represented on this commisssion.

Those counties that have a client population that is capable to carry-out their own affairs can then be used as a resource for the other counties that have yet demonstrated that they also have this client group that can function at higher levels and take responsibility. The monies for this purpose can then be drawn from the funds available for this purpose in those counties.

Also, there needs to be access by clients to state institutions and county locked and unlocked facilities. Staff at these facilities should be very open in any client attempt to do reachout and hold activities and support groups at these institutions.

Counties should also be directed to work in partnership with client groups as those clients attempt to do reachout with the many clients who are on either conserveratorship or case-management.

Doctors who are treating clients should be encouraged to refer their patients to available client self-help groups. All doctors should be included in this endeaver but particularly those that relie on medical for payments for their services.

I would like to, at this point, get into why and how this client self-help approach is so effective. I would like to give specific examples, and there are many. It woild turn this statement into something that would start to get a little wordy but there is also the consideration that I had not that much time to prepare an adequate statement.

Please permit me to submit what I have and I can be availalbe for further questioning.

Respectfully,

John G. Price

John G. Price

JUL 21 REC'D

ommunity Advisory Board S.F. General Hospital Psychiatric Services

ite 7M, 1001 Potrero Avenue, San Francisco, CA 94110 (415) 821-8413

July 16, 1987

Senator Milton Marks
350 McAllister
San Francisco, CA 94102

Dear Senator Marks:

Thank you for the opportunity to address your committee on the Rights of the Disabled, concerning gaps in services and needs of special populations and the chronically mentally disabled.

The following is a summary of testimony given to your committee at the hearing on July 13, 1987.

Initially, I stated that our board does not see a return to warehousing the mentally ill in distant mental institutions as an acceptable or viable alternative to the problems we face today.

Secondly, we would like to state our support for the proposals already made to you by others testifying at this hearing:

- An inter-departmental agency to address providing proper housing for the mentally ill;
- Statewide levels and standards of care and services; solutions cannot be geographically isolated, (or local governments will raise the concern that if they provide better service, more of the mentally ill will flock to their area);
- Low cost loan funds for board and care facilities;
- Passage of state legislation to mandate MediCal reimbursement for case management services.

Finally, our board must emphasise that we are in full support of the shift away from costly acute hospital services to less costly and less restrictive programs. However, we must not cut existing acute services until adequate community residential, case management and support services are in place. Otherwise, we will be repeating the tragic problems caused by the precipitous "deinstitutionalism" of the 1960s. Our board believes that there must be double funding--of both acute and alternative services, before a shift is made.

Once again, our board wants to express its appreciation of the opportunity to share with you our City's severe mental health problems and the need for state financial assistance if we are to emerge from the current crisis.

Sincerely,

Hilda Bernstein
Chairperson, Legislation Committee

HB:nm

PUBLIC TESTIMONY

CALIFORNIA LEGISLATURE
Senate Subcommittee
on
THE RIGHTS OF THE DISABLED

Senator Milton Marks
Chairman

July 13, 1987
San Francisco, California

Presented by: Ethan Nebelkopf M.F.C.C.
Walden House, Inc.

Thank you, chairman. I'll be brief. I bring you news from the front line and wish to emphasize the role of substance abuse in mental health and mental illness. Walden House has been dealing with people who fall through "the cracks in the system" for almost 20 years. We have helped people who are homeless, mentally ill, who are children and adolescents, drug and alcohol abusers, co-dependents, family members of drug abusers and children of substance abusers.

One of the big problems is compartmentalization and bureaucratization of funding sources, which by their very nature can't perceive the "whole" problem. After ten years of lobbying, we are implementing a program for dual-diagnostic individuals, people with mental health as well as drug problems.

However, we have this same problem with adolescents who are both mentally disturbed and who have drug problems. In dealing with all of the agencies: the Department of Social Services, Mental Health, Probation, and Drug and Alcohol Division, it is very difficult to start up a new program. We need patch money from the Department of Mental Health to enhance the basic Department of Social Services funding.

In addition, the compartmentalization of outpatient and residential services, self-help and professional programs, adult and adolescent services, treatment and prevention, substance abuse and mental health, and even within substance abuse, alcohol and drug services, mitigate against providing quality services.

We need comprehensive programs to deal with the roots of the problem. Homelessness, mental illness and substance abuse are symptoms of greater problems in our society; the loss of values, the breakdown of families and the lack of economic opportunities. We need programs that utilize recovering people, whether they are recovering from mental illness or substance abuse, as role models and teachers for those still needing help.

We need to develop humane and innovative programs which teach people how to improve their quality of life; how to deal with feelings in appropriate ways, to educate people about the dangers of drugs and how to lead productive drug-free lives, to provide vocational training because people need to participate in meaningful work.

We need to deal with the root causes of homelessness, mental illness and substance abuse to improve individual lives as well as to give people a sense we are doing something to improve the society we are living in.

Laura Grandin, Ph.D.
1600 Clement Street #301
S.F., CA 94121

July 8, 1987

Senator Milton Marks
350 McAllister Street
S.F., CA 94102

Dear Senator Marks:

Professional obligations prohibit me from participating in your hearings on the crisis in San Francisco's mental health services, scheduled for Monday, July 13, 1987. The purpose of this letter is to draw your attention to matters of considerable community concern in San Francisco's children's mental health system.

I applaud Mr. Lempinen's excellent Chronicle articles describing the crisis in mental health services for S.F.'s mentally ill adults. However, I was disappointed that a three month investigation, included only passing reference to the equally serious crisis in S.F.'s mental health services for children and youth.

Mr. Lempinen's failure to include S.F.'s mentally ill youth in a series which purported to be a thorough review of the problems in S.F.'s mental health system, is illustrative of one of the key factors contributing to the current crisis in children's mental health in S.F., i.e., the consistent overshadowing of the needs of children and youth by the needs of adults, in Department of Public Health administrator's planning efforts, in the City and State's subsidy of mental health services, and in the eyes of the public.

San Francisco's children's mental health system lacks adequate numbers of crisis intervention resources, acute-care beds, psychiatric day treatment services, out-patient psychotherapy slots, and long-term, residential treatment resources. S.F. has no subacute psychiatric resources for children and youth and, as in the adult mental health system, mental health dollars are being drained from prevention and early intervention services to subsidize expensive, acute care resources (often in other counties, making it very difficult for families to visit or participate in their child's treatment.)

In the absence of an adequate continuum of appropriate children's mental health resources, S.F.'s emotionally disturbed children and youth "wait and wonder" in unnecessarily restrictive or inadequately structured settings, cared for by inadequate numbers of untrained childcare workers, while placement personnel monitor their slow progress on waiting lists. Too often these youngsters lack the intrapersonal resources to endure these protracted dispositions, deteriorating to the point where acute psychiatric hospi-

talization ($600.00 per day) becomes necessary.

Assuming that an opening in over-crowded, acute, psychiatric children's wards can be found, Medi-Cal will pay for hospitalization until a child has minimally stabilized (2-4 days), and then limited State "patch money" (Short-Doyle funding) is used to extend the child's stay a few days longer, (to provide an opportunity to consolidate the clinical gains achieved in the Medi-Cal-funded period.) When the "patch money" is used up children are knowingly discharged back to inappropriate settings. Many children go through this cycle several times while waiting for an opening in an appropriate setting.

State hospital utilization guidelines dictate that we cannot admit new S.F. residents to Napa State Hospital until we discharge some of the adult or child patients already there. The overreliance on State hospital beds by the adult mental health system effectively blocks access to those beds by seriously disturbed children.

Additionally, children currently in Napa who are ready to be returned home cannot be discharged because we lack the resources for their transition back to the community. The same resources needed by those children transitioning home from institutionalization are needed to prevent children and youth from deteriorating to the point that institutionalization becomes necessary, but the resources are just not available.

The State <u>recommends</u> that 25% of all State mental health dollars be allocated for the subsidy of children's services. In San Francisco, the Department of Public Health is spending only 9% of its State mental health dollars on children. Following considerable community advocacy efforts the S.F. Health Commission made a commitment to increase funding of children's mental health services by allocating an additional 5% of all <u>new</u> mental health dollars to children's services, until state recommended guidleines are met. This goal will take fifteen years to achieve.

San Francsico's children cannot wait fifteen years to get their full quarter of the pie. One recommendation that has considerable community support would be for community mental health advocates and program planners to encourage the State to <u>mandate</u> that counties spend at least 25% of State mental health dollars on mental health services for children and youth.

Another problem has to do with the State subsidy for children in residential treatment programs and group homes; i.e., the State has set a uniform reimbursement rate for group homes and residential programs throughout the State, despite the fact that various regions and cities have different costs of living. This fact, exacerbated by the State's failure to provide cost-of-living increases for such programs, has led to the loss of over 100 residential treatment and group home beds in S.F. during the past three years. <u>Residential treatment and group home administrators cannot afford to run programs in S.F.because the cost of living is higher than</u>

the State reimbursement rate.

In most cases children in out-of-home placement are expected to reunify with their families upon graduation from these programs, but the closing of S.F.-based group homes has necessitated placing children in counties with a lower cost of living, making visitation and family participation in their child's treatment both costly and difficult if not impossible for many families.

The current state of S.F.'s children's mental health system is unconscionable both morally and fiscally. Children are deteriorating to the point that they require increasingly more acute levels of service than they required when they entered the system. This is a gross disservice to our children, their families and to those untrained personnel charged with their care.

This is all the more true in light of the fact that the "new" five year plan unveiled by S.F. children's mental health system administrators in May 1987 merely restates the recommendations for closing service gaps, unanimously endorsed by the Mayor's Mental Health Task Force in January 1985. None of the 1985 recommendations have been implemented. With this new five year plan the 1985 Task Force goals have been merely postponed for seven years.

Additionally, although the new five-year plan accurately identifies needed services, of the four goals outlined in the plan two are stated merely as needs, with no indication as to how those needs will be met, one of the resources is being developed through the leadership of those outside the children's mental health system and one (which will yield only five more mental health beds) is in the planning stages.

Like most professional human services, psychiatric services are expensive and labor-intensive. S.F. mental health officials estimate that it will take an infusion of several million dollars to subsidize the full continuum of mental health services needed by S.F.'s children and youth (not to mention its mentally ill adults.) But, the past three to five years have shown that "more money" cannot be the only solution pursued by mental health system administrators.

Those charged with the responsibility of meeting the mental health needs of our children and youth must take a critical look at their structures, planning efforts and service delivery systems; to develop more creative, more cost-effective and less reactive solutions to the very urgent crises in children's mental health. Further, Department of Public Health administrators must rebalance the present system-- from the current over-reliance on emergency shelter, secure detention, and acute psychiatric care to an increase in the availability of prevention and early intervention resources.

Mr. Lempinen's series describes S.F.'s failure to respond effectively to the needs of its current legions of mentally ill adults

yet, through the numerous, critical gaps and inadequacies in our mental health services for children and youth, we are spawning S.F.'s mentally ill adults of tomorrow.

Respectfully Submitted,

Laura Grandin, Ph.D.

Laura Grandin, Ph.D., Chairperson*

Mayor's Advisory Council on Children, Youth and Families

* Author, "Children's Mental Health in San Francisco: An Overview of the System, with Recommendations for Closing Service Gaps." Mayor's Mental Health Task Force Report.

TESTIMONY OF JANICE KRAMER

7/13/87

Senator Marks, and everybody, my dears, blessings on us all. Only come on, PLEASE! The deck was stacked! It's over time to grow beyond recycling bandaids! The real truth si that Mama Earth is a school/training planet. We're in The Finals before the new semester. And I offer quantum leaps of how mind/emotions/spirit/body/wisdom/humor worketh, free of by donation. These are called, among other titles - Spiritual *ds The Cosmic Breakthrough, soon to be a prototype for the whole planet. Please, enough is enough! Please, let me help more deeply!

Light Trails, Me

JOSEPH MC INERNEY
231 8th Avenue
San Francisco, California 94118

Senator Milton Marks, Chairman,
Senate Subcommittee on the
Rights of the Disabled
1036 State Building
350 McAllister Street
San Francisco, CA 94102

Dear Senator Marks:

As per your request, here is a somewhat broader perspective of the issues and points raised in my presentation before your committee last Monday.

The point should not be overlooked that this committee responsibility lies not so moch in the budgetary restraints placed upon the local community mental health services by the present administration in Sacramento, but in protecting the civil rights of those same clients who are affected by the customs and policies perpetrated upon them by the powers that be in City Hall, and those in policy making functions in administration, and those who carry out such policies in the various mental health facilities affiliated therewith.

That the San Francisco Community Mental Health Services is an unethical organization, composed of unethical, unscruptous, arrogant, incompetent, irrational, and paranoid therapists and administrators, past and present, is a foregone conclusion, witness the many civil actions and claims which have been brought against them, which have failed to restrain their malicious manner and behavior and demeanor toward the civil rights of their clients. Stronger action is needed, such as investigation by the State Attorney

General and the Board of Medical Quality Assurance, to curb their bellicose belligerence.

I would like the Senator to know that this organization is using its facilities as a training ground for unlicensed psychology students from various educational facilities, that they are failing to disclose this fact to the clients of their facilities in their consent to treatment forms, constituting fraud and deceit on such clients violating the principles of informed consent to treatment. Moreover these so-called therapists they employ have the arrogant effrontery to write anything they well please in their so-called medical records, or scandal sheets which they could more properly be called. I have read some of the most blasphemous nonsense written by these the-rapists, which can only be considered to be the babblings of a paranoid schizophrenic. That the paranoid idealogy of psychiatry should carry it to extremes is not surprising, witness the case of the actress, Frances Farmer, , railroaded into a mental institution, like so many thousands before and after her and experimented upon with mind altering drugs, and finally lobotimized when they couldn't break her (their) spirit.

By the acts and conduct of the San Francisco Community Mental Services, it can be presumed they they wish to eliminate or manifestly erode and corrode the the intent of the Legislature in upholding and enhansing the civil rights of their clients, and re-establish the old State hospitalization system. Certainly their failure to observe the law as it now exists suggests an evil motive to oppress those who in their view, do not quite fit into the system of things as they would have it. God help this country if the courts and those entrusted with upholding the law of this country

are unwilling and/or unable to do so against the likes of the San Francisco Community Mental Health Services, and those who administer it and its policies.

This organization and its lackeys go on rambling about the so-called"mentally ill" and their own though processes, sometimes incoherently that a layman or uninformed individual or organization wouldn't know what whats really behind it. In their definition of the term "mentally ill" as they construe and apply it, no one would escape having it applied to them, including they themselves.

There is presently in the San Francisco Superior Court, a class action suit against the San Francisco Community Mental Health Services because of the actions of its former director, Alan Leavitt, in publicly labeling the entire clients of this organization as "mentally ill" in the San Francisco Examiner.

As I pointed out in the formal hearing the California Welfare and Institutions Code Section 5331 states that "No person may be presumed to be incompetent (mentally ill, insane) because he or she has been evaluated or treated for mental disorder or chronic alcoholism, regardless of whether such evaluation or treatment was voluntarily or involuntarily received. -------".Here in the paranoid idealogy of the San Francisco Community Mental Health Services and its administrators, one has only to be an unfortunate client of such a facility to be presummed to be "mentally ill" (along with the facility itself). The danger from such paranoid thinking is the greatest threat to the civil liberties of this country since World War II. This is the same kind of thinking which led psychiatry in Germany to assist the Nazi government in exterminating their so-called "mentally ill"Doubtless if America had lost

the war these same individuals would be doing the same.

In "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom Bruce J. Ennisa Staff Attorney New York Civil Liberties Union and Mental Health Law Project, and Thomas R. Litwack an Assistant Professor of Psychology with the John Jay COLlege of Criminal Justice, the City University of New York lay bare the crackpot philisophy and psychiatry with the SF CMHS subscribes to. I quote from this articlefrom volume 62 "----there is no evidence warranting the assumption that psychiatrists can accurately determin who is 'dangerous'; -- there is little or no evidence that psychiatrists are more expert in making the predictions relevant to civil commitment than laymen-- 'expert' judgments made by psychiatrists are not sufficiently reliable and valid to justify nonjudicial hospitalization based on such judgments; -- the constitutional right rights of individuals are seriously prejudiced by the admissibility of psychiatric terminology, diagnoses, and predictions, especially those of 'dangerous' behavior; and therefore -- courts should limit testimony by psychiatrists to descriptive statements and should exclude psychiatric diagnoses, judgments, and predictions" California Law Review at page 696. Here the SF CMHS routinely diagnoses their clients as "paranoid" or "paranoid schizophrenic" regardless of what an objective diagnosis would have been if they had bothered to be objective. And these are the same people who lock up other people on such indiscriminate diagnoses and propse to build a hospital to lock up even more based on their unethical, irrational, paranoid idealogy.

As for reasons why psychiatric judgments are unreliable and invalid; "---psychiatrists are prone to diagnose mental illness and

1 to perceive symptoms in ambiguous behavior because they are trained
2 in medical school that it is safer to suspect illness and br wrong
3 than to reject illness and be wrong" page 720. (In other words
4 not innocent until proven guilty, but guilty until proven innocent)
5 Such is the mixed up and unstable rationmal ofv psychiatry.

6 "The factor which may influence diagnosis is the clinician's
7 own personality, value system, self-image, personal preferences,
8 and attitudes----" (page 726)

9 The real catch and the enlightening aspect of this article as
10 far as it relates to the true facts behind psychiatry and most of
11 those who practice it can be summed up on page 727:"---psychia-
12 trists' observations and perceptions of their patients tend to re-
13 flect their own personality structures and problems". In other words
14 the very mental illness that they perceive' exists in the mind of
15 their clients, in reality exists in their own minds.

16 The real and substantial basis for the argument advanced here is
17 the well known case of Tarasoff v. Regents of University of Cali-
18 fornia 17 C.3d 425,; 131 Cal.Rptr. 14, 551 P.2d 334 defendant
19 psychiatrist asserted on (on page 437) "---therapists cannot ac-
20 curately predict whether or not a patient will resort to violence.
21 In support of this argument amicus representing the American Psy-
22 chiatric Association and other professional societies cites numerous
23 articles which indicate that therapists, in the present state of
24 the art, are unable reliably to predict violent acts; their
25 forecasts, amicus claims, tend consistently to overpredict
26 violence, and indeed are more often wrong than right Since predic-
27 tions of violence are often erroneous, amicus concludes, the courts
28 should not render rulings that predicate the liability of therapists

upon the validity of such predictions"

In other words as far as it can be applied to the situation at hand, as long as there is no question of the liability of any therapist with regard to a civil liability for damages in an analguous situation, the validity of their predictions of violence should go unquestioned. Such an argument cannot hold up in this case. The SF CMHS are locking up people based on such presumptions that they know what they are talking about, when it is the manifest paranoia of their paranoid idealogy which is the real culprit.

As I did in the proceeding I call for an investigation of the SF CMHS by the State Attorney General's office. I will bw be in contact with you about my other relevations of this enterprise and its employees.

July 17, 1987

JOSEPH MC INERNEY

SPECIAL REPORT

Crisis in Care for S.F.'s Mentally Sick

By Edward W. Lempinen

San Francisco's mental health system for the poor is teetering on the brink of collapse and is now threatened by cutbacks in several important services.

A Chronicle investigation has found that city officials could be forced to suspend some services for the mentally ill temporarily this month to pay an unbudgeted $1.5 million bill for sending too many patients to the Napa State Hospital.

First of three parts

That is only one problem confronting a system that annually provides services to more than 20,000 indigent people suffering everything from mild depression to chronic schizophrenia.

Throughout this decade, the system has lurched from crisis to crisis, plagued by inefficiency. Tens of millions of dollars have been spent on the most expensive programs, but now services are overcrowded with clients who are suffering more and more severe mental illness.

Administrators, called on to impose order on the chaos, worry that their task will be impossible — both in the short term and in coming years.

"My hope is that we survive through June," said Reiko True, chief of the city's Division of Mental Health Programs.

To solve the immediate problem, administrators are pulling patients out of the Napa asylum. They also are negotiating with the state to cut the bill.

The $1.5 million owed Napa — which True hopes the state will reduce — "would have gone for keeping programs afloat, keeping them more fully staffed" with doctors, counselors and

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Grim Outlook for S.F. Poor Who Are Mentally Sick

From Page 1

others, she said.

In addition, True warned, if the worst comes to pass, some services will have to be cut to balance the current $54 million mental health budget that runs through June 30.

"People may have to be turned away if we have to suspend certain services," she said. "I think that really would be drastic and disastrous."

But more cuts to vital services could be in store after July 1, observers say.

True said that the city Health Commission has ordered her to eliminate 10 to 12 of the city's 104 psychiatric hospital beds. One report indicated that the cut could help "throw the system into crisis" by forcing more people to compete for scarce services.

Also, the Tenderloin Self-Help Center, an acclaimed new program credited with helping troubled people stay out of the hospital, is slashing round-the-clock counseling services because the state and city are withdrawing their support, the center's officials say. The program has served more than 2,000 people since August.

"We're about to be overwhelmed," said Dr. Tom Peters, associate director of the city Department of Public Health. "In some services, we're already overwhelmed."

"It's scary," said Sergeant Forrest Fulton, head of the San Francisco Police Department's Psychiatric Liaison Unit. "If this system doesn't work, people die."

BY CHRIS STEWART/THE CHRONICLE

Richard G., a patient at Napa State Hospital, sat in the fenced-in courtyard of his ward on the hospital grounds

losing about 45 spaces at Napa, as it trims back to its allotment of 248.

Increased service at some neighborhood rehabilitation programs and at high-security nursing homes have not made up for the losses.

Care today is "worse than mediocre," said Peters, at the health department. "The social and personal consequences are more poignant and more pathetic than 'mediocre.'"

Many observers say that an increased severity of mental illness — resulting from years of insufficient and ineffective treatment in city programs — is the prime force creating more demand for services.

Poverty and Drugs

Conditions are aggravated by dire poverty and drug abuse.

More than 70 percent of the clients in the city's public mental health system had incomes of $8,400 or less in 1986. Some estimate that a third to half of the adult patients have conditions aggravated by drug and alcohol abuse.

In effect, the waiting list stretches from the hospitals and the emergency rooms onto the street and into jail.

Roughly one in five prisoners booked at the Hall of Justice gets psychiatric treatment, ranging from counseling to hospitalization, said Christine M. West, director of Jail Psychiatric Services.

She said that two or three times a week someone who is not sick enough to qualify for care elsewhere is brought into an already overcrowded jail on a "mercy booking" — a trumped-up charge that gets a troubled person off the street and into a shelter that provides food and health care.

Evidence of a Problem

In dozens of reports and interviews, mental health workers and experts said the system already is not working.

The results:

■ People who are desperately ill and poor roam every neighborhood in the city. An estimated 33 percent of the 6,000 to 8,000 homeless people in the city are mentally ill. Some are hungry, unkempt and hallucinating. Others are violent. People with moderate psychiatric problems often cannot get attention without a weeks-long wait.

■ Police said they received 18,600 calls involving psychiatric concerns in 1984, and they estimate that the number will be twice as high this year.

■ The psychiatric team for the county jail — which nearly doubled in size in four years — reports a 74 percent increase in the amount of service given to prisoners between 1982 and 1986.

■ The city's public psychiatric emergency rooms at San Francisco General Hospital and privately owned Mount Zion Hospital are sometimes so crowded that patients must wait there for days. Both have been accused of illegal crowding.

■ Huge budget increases have been spent on providing hospital beds at a cost of $400 a day and on other premium services, while prevention and rehabilitation services costing $20 to $180 a day have been neglected.

■ San Francisco is committing people for involuntary treatment at a rate greater than that of any county of comparabe size in the state. Often, those patients are forced to take anti-psychotic drugs that can have debilitating side effects.

■ Other services — whether in psychiatric hospital wards or neighborhood halfway houses — are so crowded that two people are waiting for every bed that becomes available.

Change for the Worse

"There are not the kind of services that will take care of people until they're better, or until they improve," said Dianne Wolfe, a psychiatric nurse who works with the police. She said the situation has deteriorated in the past five to 10 years.

"They're getting more and more acute every day," said Dennis Conkin, a supervisor for the threatened Tenderloin Self Help Center. "I see results of the city's failure all the time — the guy who's masturbating in public or digging in garbage cans, or people who are picking at themselves."

The public mental health system is so overburdened that only the most seriously troubled people get close attention, and they are often rushed through rehabilitation and discharged to make room for someone else.

Some say that San Francisco's public mental health system is encouraging mental illness as much as it is helping to treat it.

BY STEVE RINGMAN/THE CHRONICLE

Police officer Lynn Torres, psychiatric nurse Dianne Wolfe and police Sergeant Forrest Fulton returned from evaluating disturbed people

THE STRAIN ON S.F.'S MENTAL HEALTH SYSTEM

San Francisco Population
1982 700,200
1986 741,600
Increase of 5.9%
Source: State Department of Finances estimates

People Using the City's Public Mental Health System
1982 17,650
1986 19,971
Increase of 13.2%
Source: County Mental Health Services

San Francisco Active Caseload Of Mentally Ill
1985 11,356
1986 15,793
Increase of 39.1%
Source: Community Mental Health Services

"There's a generation of patients who have largely been lost," said Dr. John Hopkin, head of psychiatry at San Francisco General Hospital and the University of California at San Francisco. "That's a great tragedy."

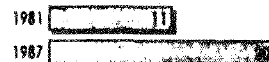
The crisis had its genesis in the 1960s policy of deinstitutionalization, which turned more than 30,000 people out of California's bleak asylums.

They were supposed to go back to their families and their communities, where housing and rehabilitation programs would nurture them in a way that an institution never could.

JAIL BURDEN

How San Francisco's Jail Psychiatric Services has grown:

Staff



Budget

Source: San Francisco Jail Psychiatric Services

There would be hospitals for those who were suffering acute psychiatric crises, as well as lodges, halfway houses and independent-living assistance to help ease them back into the community. An array of counseling services would help prevent acute problems in others. There would be asylums, too, for the small number of severely debilitated people who could not hope to live in the community.

Not Enough Money

However, the state and federal governments never provided the funds for such a full range of services.

As programs and housing for the mentally ill have eroded, demand has risen. Between mid-1982 and mid-1986, the number of children and adults, including senior citizens, using county mental health services rose 13.2 percent, from about 17,700 to almost 20,000.

During that time, the city population increased by just 6 percent, and many of the new residents were Latinos or Asians who had fled war or genocide.

Some say San Francisco is a magnet for the mentally ill because it is so tolerant. Police say that other towns and cities sometimes give their patients "Greyhound therapy" — a one-way bus ticket to San Francisco.

City statistics show that as demand rose through the 1980s, services slowly diminished.

The city had as many a 1,300 beds in private board-and-care homes in the mid-1970s but now has only about 750.

Twenty-six out of about 130 spaces for the severely ill in psychiatric hospital wards have been cut from the city's services in the past two years, and now the city also is

She estimated that 60 percent of those who pass through the jail's segregated 22-bed area for mentally troubled prisoners get their primary psychiatric care at the jail.

Before these prisoners are released, psychiatric staffers try to make appointments with counselors, doctors or clinics. But success is mixed.

"If they get out of jail on Tuesday, and they have an appointment 2½ weeks away, that's a lot of time to get lost in the shuffle," West said. Often, they end up back in jail.

Patients who suffer a severe crisis often are taken to a psychiatric emergency room, and from there to San Francisco General. Ideally, doctors say, the hospital would stabilize them in a few days, perhaps a week, then send them to less expensive programs for less intensive care.

But state investigators earlier this year found that the average stay there is 26 days — at about $400 a day.

"I've seen people come out of a crisis, get it together and then lose it again because they had to stay so long," said Juan Cruz, a county patients' rights advocate.

Once they are moved, "some people end up in the wrong place," Cruz said. "It's like, wherever there's an opening, that's where they go."

Widespread Mistakes

Such inappropriate treatment is widespread throughout the mental health system, state and local officials say. Some patients end up in institutions when they need drug therapy or help in coping with such daily needs as food and shelter.

In one case, a woman with serious drug problems and depression was held for nearly three weeks in a ward at San Francisco General with patients who were severely disturbed and heavily sedated.

It was her second visit to the hospital. She had first been admitted when she was almost paralyzed by depression. But she won her release. After five days of liberty, she went to the Psychiatric Emergency Services clinic at the hospital and asked for more help.

The clinic staff, chronically overwhelmed, referred her to a different crisis center, which referred her to an outpatient clinic.

That night, in desperation, she attempted to give herself an abortion.

The physical injuries were minor, and she was hospitalized again. In an interview at the hospital, she said she received little counseling and virtually none related to her

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Mental Health Hospitals Still Unacceptably Crowded in S.F.

Nowhere is the crowding of the city's public mental health system more obvious than in the psychiatric emergency rooms at Mount Zion Hospital or San Francisco General Hospital.

Both take people who are suicidal, profoundly depressed or in the midst of a furious psychotic episode. They must hold the patients until a bed at a hospital or another program opens up.

Both are clean, well-lit places. Both are notoriously crowded.

Last year, San Francisco General's community advisory board found "deplorable and incredible" conditions in the Psychiatric Emergency Services clinic at San Francisco General.

Board members "found 13 clients sleeping over in PES, five of whom were on thin mats on the floor," according to a letter from the board to county health officials and Mayor Dianne Feinstein. Some had been there two days.

Such conditions, the board wrote, "clearly violate state licensing regulations and are therefore illegal."

A year later, a midmorning visitor at the clinic found patients still were sleeping on mats in open hallways. And a March state report found that "patients are held sometimes up to three days."

Psychologist Robert Mahon, the clinic director, said in an interview, "Five hours would be a reasonable period of time" to hold most people who come to the clinic.

"If you find they (the patients) are getting agitated, well, you'd be agitated too if you just had to sit there and wait," he said.

At Mount Zion's Community Crisis Services, state inspectors charged in October that the hospital had kept a patient longer than the 24 hours allowed by state law.

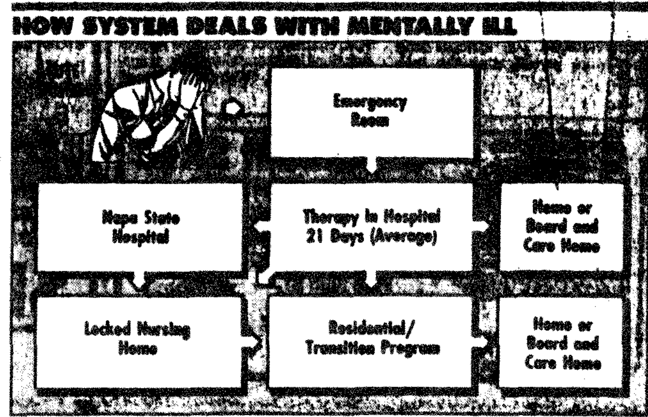
Art Hom, the clinic director, explained that other services in the county were so crowded that there was no other place to send that person.

"I don't want to abandon the rules, but I've got a problem here and nobody's listening to me," Hom said, obviously frustrated.

Because others services are so scarce, he said, "we are forced at times to take unnecessary risks to make room in our clinic by releasing people who could have benefited by acute inpatient hospitalization.

"Every potentially dangerous patient is not given the service he or she needs."

—*Edward Lempinen*



Mental Health Program for Poor in Dire Straits

From Page 6

drug use.

"It's a nightmare," she said. "The groups (group therapy programs) here are geared to teaching people not to spit on the floor. ... They have a grooming group to teach you to keep yourself clean. How is that kind of stuff going to help me?"

She later won a court-ordered release.

Chronic Schizophrenia

Administrators and psychiatrists say it also is difficult to find appropriate care for those who are chronically mentally ill and profoundly troubled.

Tom suffers from chronic schizophrenia, and his medical charts show many suicide attempts and outbursts of violence during the 15 years he has been in city mental health programs and psychiatric hospitals.

Now his face is rigid and contorted — a possibly permanent side effect from the use of prescribed anti-psychotic drugs.

In January, he was hospitalized but fought commitment and was discharged to the streets three weeks later. In March, he was hospitalized after cutting his wrists, and again he was discharged to the streets, with the requirement that he visit an outpatient clinic.

As he checked into a South-of-

RICH SAMPLES
Advisory board chairman

Market hotel, he said, he was "depressed and paranoid."

"If I didn't find satisfaction and love, I was going to commit suicide," Tom explained politely. "It was a suicide pact I made with myself."

He overdosed on alcohol and his anti-psychotic medication. Later, at a movie, he heard one of the characters urging him to return to the hospital. Six days after his release, he was back. Now he is locked in a Bay Area nursing home.

"We live like refugees," he said. "It hasn't been easy going in and out of all these different programs."

Rushed Therapy

Mental health officials say that those who do get into rehabilitation programs are often rushed through to make room for others who are waiting.

"At no point is the patient fully assessed and diagnosed," said Peters. "For many patients, the sense is one of incompleteness, frustration."

Rich Samples, the chairman of a community advisory board and a longtime client in the mental health system, has heard such stories often.

"You need to be in a place long enough to settle down, to relax, to get some things in order," he said. "Sometimes three or four months isn't enough." The average stay in many residential rehabilitation programs is two to three months.

Responding to the crisis, San Francisco health officials have developed detailed plans calling for several hundred new beds in neighborhood-based programs. They have streamlined the administration of mental health programs.

San Francisco General Hospital is expanding its emergency room. County officials hope to build a $26 million high-security "skilled-nursing facility" on the hospital grounds.

But substantial improvement in service is tens of millions of dollars and several years away, most say. They concede that a lack of money — now and perhaps in years to come — probably will result in conditions getting worse.

In their most gloomy moments, San Francisco mental health officials fear they may be in such a deep hole that getting out will be extremely difficult.

"I don't think anybody knows if it can be done," said Hopkin at San Francisco General. "I don't know how long it will go on ... how many more generations of patients will be looking at insufficient rehabilitation programs," he said. "That makes me feel sad when I go to bed at night."

Art Hom, director of Community Crisis Services at Mount Zion Hospital, said the greatest need of the mentally ill is to overcome the public's continued indifference: "The wretched quality of their lives is an affront to civilized society."

TOMORROW: How the system broke down

SPECIAL REPORT

Mental Health Funds Misspent, Critics Say

By Edward W. Lempinen

San Francisco has spent tens of millions of dollars since 1982 on top-dollar care for the indigent mentally ill.

Now, some city officials say it has been a mistake.

Huge budget increases have been spent on hospital service that costs about $400 a day and on other premium services, while prevention and rehabilitation services costing $20 to $180 a day have been neglected.

Today, as many as half the patients in public psychiatric hospital wards do not need to be there, but they must wait for space in less-expensive programs that are just as crowded, or more crowded.

As they languish, millions of dollars are drained away from other indigent patients and from cheaper rehabilitation services.

In dozens of interviews and reports, The Chronicle found during a three-month investigation that services have eroded and people have developed more severe illnesses despite a 56 percent increase — from $34 million to $54 million — in the city's budget for mental health programs since 1982.

Local officials say their system is locked in a permanent state of crisis, bedeviled by inefficiency and constantly pressed to find more money.

Second of three parts

State officials suggest that millions have been squandered by mismanagement.

Dr. Tom Peters, associate director of the city's Department of Public Health, said huge sums

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Rising Costs Threaten S.F. Mental Health System

From Page 1

of money have been needed just to keep the system afloat.

But he conceded that some people see the mental health programs "as a drain into which we have poured millions and millions of dollars. Some would say they've seen no improvement. And some would say that it has gotten worse."

The system that is supposed to provide mental health care to more than 20,000 low-income San Franciscans is a crazy-quilt patchwork, a hodgepodge of services that has developed more by accident than by design, say critics.

"Failure is built into the system," said one mental health worker.

New Services

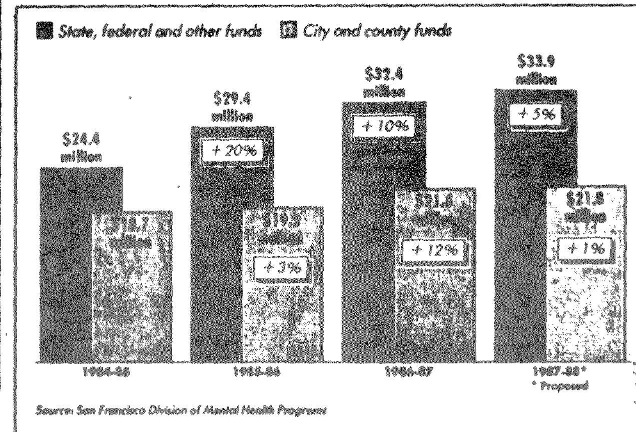
Reiko True, who took over the city's mental health division less than 18 months ago, is working to to open new prevention and rehabilitation services that could relieve pressure on the hospitals, emergency rooms and state asylums.

Her staff has recommended that San Francisco spend at least $22 million in the next six years to expand mental health services — including adding hundreds of new beds for community-based rehabilitation and prevention programs. An additional $26 million reportedly is needed for a 185-bed locked nursing home proposed for the city.

Without that money, staffers said, more seriously troubled men, women and children will have to be put in hospitals. And more will be deprived of care.

BY STEVE RINGMAN/THE CHRONICLE

Steve Fields of the Progress Foundation runs programs for the mentally ill



WHERE S.F. CAN HOUSE ITS MENTALLY ILL

[bed icon] = 10 BEDS *(1987 figures)*

Institutional *Hospital and locked facilities subsidized by Medi-Cal; Napa costs paid by the state*

	Beds	Change in no. of beds since 1980
Hospitals *Cost per day: $392 (avg.)*	104	+25.3%
Napa State Hospital *Cost per day: $211*	246*	—
Locked Nursing Homes *Cost per day: $120 (estimated avg.)*	345	+72.5%

people who are waiting for a bed in a neighborhood program to open up.

Another example: In mid-1985, the state closed El Dorado Guidance Center in San Jose, citing dozens of violations, including rape, prostitution and drug use, on the premises of the locked nursing home.

Thirty of those patients were residents of San Francisco, and they were transferred to Napa State Hospital.

But each county is allocated a limited share of the space in state hospitals, and in early 1986, the state informed San Francisco that it was sending too many patients to the asylum. It warned the city that it must move them or pay $2.3 million to keep them there.

By gradually removing about 45 patients, the city has reduced the bill to $1.5 million. At additional cost, the city is now placing them in locked nursing homes around the Bay Area. It is also pleading with the state to reduce the Napa bill and warning that some services may be suspended unless the state relents.

Looking for the Cause

Tracing the cause of the system's failure requires the unraveling of a stubborn financial mystery. There is no smoking gun, no single villain, no blame that can be easily assigned. Those who guide the system have noble intentions.

What emerges, though, is a picture of a bureaucracy that has drifted from crisis to crisis, unable or unwilling to plan, beset by financial problems that are sometimes beyond control.

Short-term solutions financed on a shoestring have often compounded the long-term problems, creating the need for new solutions that are even more expensive.

The strains first appeared in the 1960s and 1970s as more than 30,000 mentally ill Californians were turned out of state-operated asylums.

Counties were supposed to provide more humane and more effective care locally — in community care that emphasized crisis prevention and rehabilitation.

At the foundation of the plan were the privately operated board-and-care homes. In the mid-1970s, they provided basic food and shelter to about 1,300 people in the city at less than $20 a night per person.

The residents usually paid the rent with Social Security and other public-assistance checks. Some attended city day-care programs, which provide treatment, training or psychiatric care, depending on the client's condition.

Available Beds

By 1980, there were more than 300 beds in halfway houses, lodges and cooperative apartments geared to helping people return to independence. Some were owned by the city, and others were owned by private firms under contract to the city.

Beds at city-run San Francisco General Hospital and other hospitals were available to those in crisis. But under the system, patients were to be stabilized within a few days and then moved to a rehabilitation program.

Observers say now that neither the state nor the federal government provided enough money to do the job. And in the late 1970s, the governments began to withdraw hundreds of millions of dollars from care for California residents — leaving the city to foot the bill.

At the same time, board-and-care homes closed, one after another. Inflation drove up costs, but most residents were not able to afford large rent increases. Owners were getting older, and many retired.

The Lone Star Hotel, a privately owned 46-bed board-and-care home in the Western Addition, closed in August 1985. Dr. Mel Blaustein, president-elect of the San Francisco Psychiatric Society, found that within a year, seven of the Lone Star residents had died, about a half-dozen had disappeared, and at least six had been hospitalized for psychiatric treatment.

Residential *From most intensive to least intensive care*

Type	Beds	Change
For Acute Cases *Cost per day: $178 (avg.)*	24	—
Lodges *Cost per day: $62 (avg.)*	58	+20.8%
Transitional Housing *Cost per day: $68 (avg.)*	120	+25.0%
Co-op Assisted Independent Living *Cost per day: $33 (avg.)*	240	+71.4%
Privately Owned Board and Care *Cost per day: $19 (avg.)*	750	−25.0%

Source: Community Mental Health Services; [illegible] San Francisco Psychiatric Society

* S.F. used up to 290 beds in 1984

Neighborhood Protests

Meanwhile, neighborhoods furiously contested every city attempt to open new community-based rehabilitation programs.

The troubles were aggravated by Reagan administration budget-slashing in the early 1980s that took millions of dollars from housing and food stamp programs and Social Security benefits.

By 1981, the victims started showing up at psychiatric emergency rooms and psychiatric hospitals — sicker, poorer, more often homeless and more likely suffering from a lack of treatment.

In the six years since, there have been four city mental health directors, one major administrative reorganization and one $4 million budget deficit.

Director Alan Leavitt quit in 1984, saying, "Needs have grown far more than our ability to cope with them."

A year later, in a temporary stint as director, Peters described the system as "so shapeless and so fundamentally out of control that it just hemorrhages money."

True said early this year that San Francisco's system was "on the brink of collapse."

Long-Term Planning

Even during the period from mid-1984 to mid-1986 when the system's budget rose from $43 million to $54 million, there was precious little planning for long-term spending, some say.

"This is a human services system that has never done any prospective planning," complained Steve Fields, executive director of Progress Foundation, which operates nine halfway houses, lodges and other residential programs. "We have traditionally made decisions based on the need of the moment."

Where did the money go? To the most intensive, expensive services:

■ Annual financing for the emergency rooms at San Francisco General and Mount Zion Hospital has roughly doubled since 1981, to $2 million and $1.7 million, respectively, according to Community Mental Health Service figures.

■ In the past year alone, San Francisco has increased by about 150 the number of beds it uses in locked nursing homes for adults, and now has 240 such beds.

■ Although the system has pared the total number of psychiatric hospital beds, the 104 now remaining are constantly full. The average patient at San Francisco General stays 26 days, according to state investigators, at a cost to the state and city of about $400 a day.

The city mental health staff reports that 30 percent of those hospitalized do not qualify for Medi-Cal. That forces the city to take an estimated $2.3 million a year from other programs to pay the hospital bill.

■ The number of beds in neighborhood programs has increased since 1981 by about 150 — most of them this year — to about 450. In the same period, about 250 beds were lost in private, low-rent board-and-care homes.

State investigators say much of the new funds went into pay raises for city mental health workers. And, some say, Medi-Cal aid to the poor has contributed to the trend toward expensive treatment because it usually does not subsidize care in community-based programs.

"San Francisco's history in recent years is to solve the problems by putting the money into resolving the immediate crisis," said Dr. Steven Shon, a top clinical adviser and troubleshooter in the state Department of Mental Health. San Francisco officials, he said, "haven't done all the things that could be done."

Crowded Wards

It is widely believed that the system shaped in the years of turbulence is now ill-equipped to take care of people.

One example: San Francisco General's psychiatric ward has an average 102 percent occupancy, according to one hospital administrator. Its wards are crowded with

Admitting Mistakes

Deep inside a report issued last December, the county mental health staff conceded past mistakes:

"Looking back, a better long-term solution may have been to proportionately increase services at all levels of care rather than putting most available resources into the acute level. In fact, it might have been better to put more resources at the community services level."

It has been an expensive lesson.

Now, though, city officials estimate that it will take millions more to make needed adjustments — to establish the new locked nursing home for the small number of very troubled patients and to provide more community rehabilitation programs for the rest.

But the millions are not available.

In December, the mental health staff asked for $11.5 million in additional city funds, about half to develop community-based programs for more than 500 people. With the city facing reduced revenues in the year beginning July 1, Mayor Feinstein last week proposed an increase of about $1.3 million, almost all of it for institutional care for children and adults.

In the most comprehensive plan ever assembled for San Francisco's public mental health system, True's staff has proposed a six-year effort to supplement both community and institutional programs.

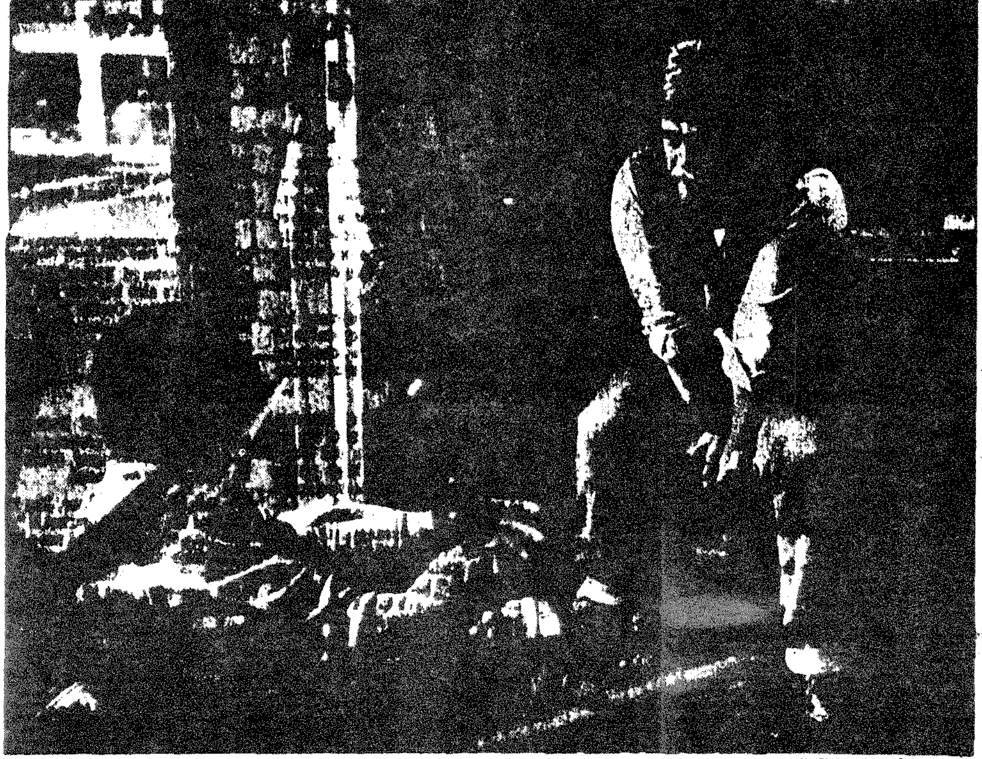
Feinstein has insisted that the city government has already provided substantial new funds and that it cannot — and should not have to — provide much new support. But little seems forthcoming from the state or federal governments.

Peters suggested that the only choice may be to reduce services to some people, concentrating on the group that is the most severely troubled.

True's staff has said the same. But she acknowledged that people with mild or moderate problems — or those just out of the hospital — will be left to get sicker if prevention and rehabilitation programs are not expanded.

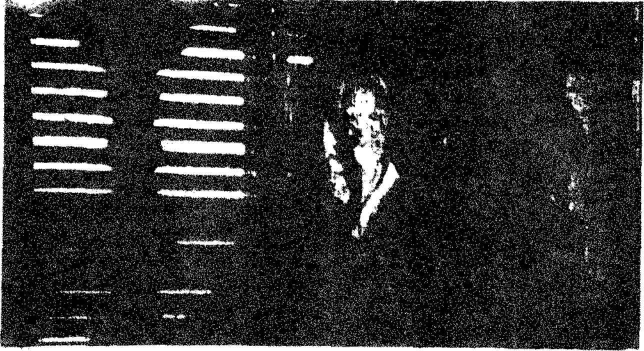
"I feel very sad about it," she said, "but that's the reality."

TOMORROW: Where the system is headed



BY STEVE RINGMAN/THE CHRONICLE

Dennis Conkin, outreach supervisor at the Tenderloin Self-Help Center, talked with another counselor



BY STEVE RINGMAN/THE CHRONICLE

'You have to overcome this patients' rights business,' said William Margolis

BY CHRIS STEWART/THE CHRONICLE

A patient at Napa State Hospital grimaced during a talk with his counselor

Debate Rages Over Locking Up the Mentally Troubled

Last of three parts

By Edward W. Lempinen

San Francisco's beleaguered mental health system is locking up an increasing number of people under questionable circumstances and giving them controversial anti-psychotic drugs, according to state investigators and local experts.

Among comparable urban counties in California, San Francisco has the highest rate of forced commitment, The Chronicle learned in a three-month investigation of the city's mental health system for the poor.

Some police, mental health workers and administrators say that they have had no choice — that mentally ill people are on average more severely ill today than ever before, more often dangerous, and often refuse to seek help.

In a scathing March report, however, the state Department of Mental Health found "no corroborating evidence" that San Francisco patients are more sick than those in other counties.

Instead, it said: "Documentation indicates that involuntary holds are being used excessively and, in some instances, inappropriately. Though state law requires that patients be given the option to (submit voluntarily), if they are able and willing . . . , ample evidence suggests that this is not, in fact, being done."

The trend has prompted a furious response among some civil rights advocates and patients. They say the actions are a harrowing reminder of public mistrust and the fear of mental illness — and a reminder that the days of snakepits and straitjackets, lobotomies and electroshock therapy are not long past.

"They're talking about building bigger and more secure institutions," said one woman, the mother of a mentally troubled adult son, who asked to remain anonymous. "I think that means using more drugs instead of less. We're at a very dangerous point."

Even some of the city's top public health administrators are warning that renewed reliance on institutional care could bankrupt San Francisco's public mental health system.

Already, they say, increased use of locked hospital wards, the state asylum and high-security nursing homes is draining millions of dollars away from programs for prevention and rehabilitation.

"That's just sweeping (the problem) off the street," complained Dennis Conkin, a supervisor at the Tenderloin Self-Help Center. "We're going to be locking them up and giving them shots and hiring more staff to control them. That's not dealing with the problem."

Refusing Help

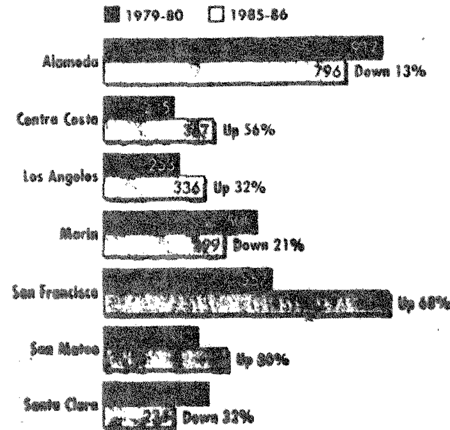
Frustrated and angered by options they find unacceptable or unpleasant, some troubled people have refused to seek help from the city's mental health system for the poor.

According to some mental health workers, they object to long waits for service, strip searches and the unpleasant and sometimes debilitating effects of "chemical restraints."

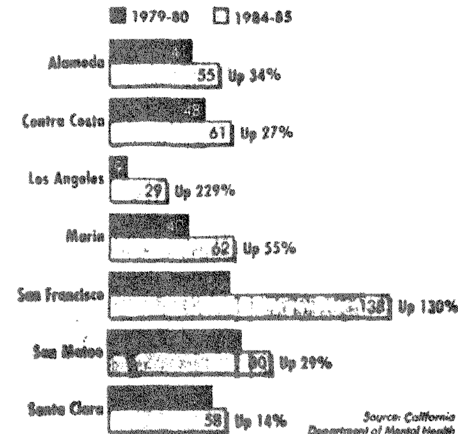
"Medications are being used as a substitute for programs, a substitute for resources," said one client of the mental health system.

PATIENTS COMMITTED AGAINST THEIR WILL

San Francisco and selected counties, rate per 100,000 population committed for 72-hour evaluation and treatment



Rate per 100,000 population committed for one year



Views of Treatment

A quarter-century ago, when California and other states opened their asylums and began releasing thousands of patients, they were moved by a guiding principle: Mental patients can be treated; they can often live independent, comfortable, productive lives, and their treatment should be in the least restrictive possible setting.

Today, however, there is deep division over the treatment of mental illness.

It is reflected in the psychiatric emergency rooms, psychiatric hospitals, state asylums and locked "skilled nursing homes" that are crowded with mentally ill people being held against their will.

On any given day, there are about 700 indigent San Francisco residents in such facilities. The city, meanwhile, is buying more beds in locked nursing homes, planning to build its own nursing home and clamoring for more space at the Napa State Hospital.

According to San Francisco's Community Mental Health Service, the rate of 72-hour commitments increased 42 percent between 1982 and 1986. The actual number of people committed and using county services rose from 4,589 to 6,942, a 52 percent increase.

The rate as of last June 30 was 18 percent higher than that of Alameda County, and almost three times the rate of Los Angeles.

The rate of one-year commitments in San Francisco grew 80 percent between 1984 and 1986, faster by far than any of the state's other counties.

Sicker Patients

One school of psychiatric workers, parents and concerned individuals believes the city has had no choice because patients are dramatically more ill than a decade ago and others' are so severely troubled that no amount of rehabilitation can make them independent.

"Some patients, by all accounts, will need long-term care, maybe even life-long shelter," said Dr. Tom Peters, associate director of the city Department of Public Health.

"We have contributed to that. Some folks who have been victims of undertreatment (in city programs) in the past 10 years — some of them are not going to come back," he said, referring to their slim chance of recovery. "We have to be frank about that."

Measuring the size of this group in need of institutionalization is not easy, but most agree that it is a small fraction of the estimated 20,000 people who get help from city programs every year.

By some counts, the chronically mentally ill number less than 10 percent of the total treated. According to city statistics, about 1,400 patients in the year ended last July 1 — or 7 percent of the total — used about 25 percent of the services provided under the $64 million budget.

Time After Time

Dr. Stephen Goldfinger, director of in-patient psychiatry at San Francisco General, said a group of "less than 80" people in the city are brought into the hospital time after time in severely deteriorated condition, only to win court-ordered releases because they improve so quickly while in the hospital.

"We are doing them no favors to continue to treat them in the community," he said. "The reality is that it's just plain cruel."

The problem, according to some psychiatrists, is that some chronically ill people refuse to admit that they need long-term help and that the law protects those people.

"You have to overcome this patients' rights business," said William Margolis, president of the San Francisco Alliance for the Mentally Ill and father of an adult son diagnosed with schizophrenia.

"Society is going to have to face the fact that some people are never going to be self-supporting."

Margolis' group is part of a nationwide organization that is gaining influence in state legislatures and allies among mainstream psychiatrists. Mayor Dianne Feinstein and others have joined them in demanding changes in the law to make it more easy to commit people for care.

"Law enforcement agencies are helpless in the face of laws which so favor offenders that they make any kind of involuntary commitment nearly impossible," Feinstein wrote earlier this year. "Thus, felonies wait to happen and communities are immobilized."

The Other Side

Such arguments enrage many mental health workers, civil rights advocates and patients.

They concede that some mentally ill people will need long-term care in institutions. But they insist that the lock-'em-up approach is excessive and that it is being used as a substitute for food and housing aid, counseling programs and other help that could keep people out of hospitals and institutions.

Public attitudes, they suggest, have been formed by encounters with the most severely troubled schizophrenics living on the street, by B-grade horror movies and by news accounts of rare but sensational crimes and violence.

Fancher Bennett says she has seen the results of such fear during 15 years as a client of the mental health system — years in which she took a variety of anti-psychotic drugs and was given electroshock treatment. Now adamantly opposed to such practices, she works for the city Patients' Rights Advocacy Services Inc. and is active in the fledgling San Francisco Network of Mental Health Clients.

"The mentally ill are feared," she said. "That's a tradition in society. . . . There's a very hostile environment out there. People think they're very sophisticated and advanced. But they want to lock people up because they're afraid."

Bennett and others say there is no more reason to fear mentally ill people than to fear those considered sane.

"I don't subscribe to the theory that crazy people commit more violent crime," said Christine M. West, director of the city's Jail Psychiatric Services.

Still, West said she notices a trend toward "criminalization of mental illness."

Melissa Daar, executive director of Patients' Rights Advocacy Services, said that only about 20 percent of those legally committed during the second half of 1986 were found "dangerous to others." Three out of five were committed solely because they were found "gravely disabled" — unable to provide themselves with food, clothing and shelter — under state commitment laws.

"I'm afraid you're going to see people get locked up because they don't look pretty," said Conkin, of the Tenderloin Self-Help Clinic. The system has allowed people

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Mental Health Community Divided Over Lock-Up Issue

From Page 4

to deteriorate, he said, and "now they're going to cart off the failures and lock 'em up."

Critical Flaw

The debate — however difficult to resolve — highlights a critical flaw in San Francisco's method of treating the indigent mentally ill.

"Once we've locked them up and tied them down and shot them up with medicines that make them feel bad, they frankly don't want to come to our system anymore," Robert Surber, supervisor of clinical social workers at San Francisco General, recently told the San Francisco Health Commission.

Other conditions humiliate and anger those who seek help and those who are forced to get help, observers say.

In its March report, the state found a number of civil rights abuses and other problems in the San Francisco mental health system that may contribute to patients' distress.

Among them were "routine" strip searches in psychiatric hospitals, waits of up to three days in psychiatric emergency rooms, and commitment hearings so "rife with procedural problems" that patients are often held longer than legally allowed.

Difficult Jobs

The city's top mental health administrators are very wary of the trend toward more hospital and institutional care.

They are now proposing a high-security, 185-bed "skilled-nursing facility" at San Francisco General. It will house patients who are so ill that recovery will, at best, take a long time, along with a group of perhaps 20 who are so severely ill that no other institution will take them. The $26 million project, to be financed mostly by a proposed bond issue, is backed by Feinstein.

But the administrators are cautioning that for the vast majority of the mentally ill, even some who are profoundly troubled, institutional care is neither effective nor economical.

"Institutions, unless they're designed awfully creatively, are not the places to send people who are angry and frustrated and lashing out," said Peters. "It's a horribly expensive way to go about our business."

An improvement, he said, would be the use of "creative, community-based solutions that are nowhere near as expensive."

Reiko True, the director of the mental health division in the city Health Department, also backs plans for the locked nursing facility. But she has warned frequently it will not solve the city's overcrowding crisis, and she has pressed for funds to add several hundred beds in low-cost community-based programs.

"What would we do if the law were liberalized, making it easier to put people in the hospital?" she remarked earlier this year. Because money is so tight and hospitals and other institutions are so crowded, she said, "I couldn't comply with it if I wanted to."

Among the creative, inexpensive services advocated by many patients and social workers are expanded services to help the mentally ill meet basic needs.

"If the lack of food and shelter is making people crazy, it behooves the health system to deal with more than symptoms," said Robert V. Tobin, executive director of the Central City Hospitality House for homeless and mentally ill people.

Standards for Independence

To live independently, a person has to be able to go to the grocery store, pay the rent, visit counseling or medical services, buy some clothes and conquer the public-assistance bureaucracy. In an institution, those chores are taken care of by the staff.

"Once they walk out of (a hospital or institution), these (chores) are in eight or 10 different places," said Richard Gilberg, chief of county operations in the state Department of Mental Health. "It's very difficult. If any two or three of those things fall apart, ... your whole life falls apart and you're back in the hospital."

That happens regularly, according to workers and patients throughout the system. But if social workers could be hired to help mentally ill people, they say, then many would be able to stay more comfortably in the community.

Bennett agreed, her voice tense after her own frustrating years in the mental health system.

"Damn it, it's not all their mental illness that causes the problems," she said. "I'm tired of hearing that.

"Just because you're mentally ill doesn't mean you don't want the same things other people have — home, some money. You want control over your life."

BY STEVE RINGMAN/THE CHRONICLE

Tammy Kessler, an outreach counselor for the Tenderloin Self-Help Center, worked the South-of-Market streets

Funds Scarce to Rebuild Mental Health System

By Edward W. Lempinen

Frustrated political and public health officials urged yesterday that San Francisco rebuild its mental health system for the poor, but they warn that little money will be available for the job.

Politicians and health commissioners were unanimous in saying that grave inefficiency and waste are preventing mentally troubled San Francisco residents from getting the help they need.

In the wake of a Chronicle series this week detailing a mental health system on the brink of collapse, the officials called for reduced use of high-cost services at hospitals and other institutions, and more reliance on prevention and rehabilitation programs that serve more people at lower cost.

Call to Overhaul the System

San Francisco Supervisor Wendy Nelder called for an "overhaul" of the system that is supposed to care for more than 20,000 city residents with problems ranging from depression to chronic schizophrenia.

Board of Supervisors President Nancy Walker said she is "fed up" with the problems that have gone unsolved — and with services that have failed to provide enough help for much of the decade.

"You have to make damn sure that you spend every penny wisely and well," she said. "We are not doing that and we have not been doing it."

After a three-month investigation, The Chronicle reported that the city's mental health system is crowded with people who are severely ill, often after years of insufficient and ineffective care in city programs.

Although huge increases have brought the annual budget to more than $54 million for the Division of Mental Health Programs, thousands of people cannot get the help they need.

Where the Money Goes

Much of the new money has been pumped into costly care at hospitals and locked nursing homes. Less expensive care that could help people stay out of $400-a-day hospitals has eroded.

Both Walker and Nelder insisted that city services must be recast so that people can get care before their conditions degenerate into psychotic episodes.

"The bottom line is that if people have got some real serious problems, and you don't provide some help at an early stage, then you find yourself dealing with these intense problems which are horribly expensive," Nelder said.

"It would be cheaper in the long run to provide some kind of intervention at a less crucial period."

The city mental health bureaucracy, under the direction of Reiko True, has been struggling to expand prevention and rehabilitation services in residential programs in the past 18 months.

Inefficiency and waste are preventing many severely ill San Franciscans from getting the help they need

"We know what we want to do," said John Blumlein, a member of the San Francisco Health Commission. "How the hell we're going to do it is another matter. Especially because we don't think we're going to get much additional funding this year."

About $750,000 earmarked by the mayor to expand programs for children who are seriously mentally ill could help to stem problems before they become chronic, he said.

Walker said she will propose that the city "bite some really hard bullets" to provide more money to mental health programs for "at least a year."

That would allow administrators to build prevention and rehabilitation programs, a move that could eventually allow the city to curtail hospital use and save money. Hearings on the proposal could come this month, she said.

Mayor's Budget Limitations

Partly to blame for past problems, Walker said, are "budget limitations placed on that department by the mayor's office."

Mayor Dianne Feinstein was in Japan yesterday, and not available for comment. She has argued consistently that the state must provide more financing.

About $350,000 may come from the state if Governor Deukmejian approves budget plans advanced by the Legislature, said Juli Winesuff, a consultant to the Senate Subcommittee on the Rights of the Disabled.

She said proposals would appropriate $1 million to six counties that are being billed by the state for using too many beds in the state mental hospital system.

San Francisco is being billed about $1.5 million, and would get about $350,000 in relief if Deukmejian approves, Winesuff said.

Because money is so tight, the city may have to cut some services in order to improve others, according to Blumlein and others. That pressure may build as the city is forced to spend millions in coming years for care of those with AIDS, said Dr. Richard Sanchez, another member of the Health Commission.

Blumlein noted that the commission already has ordered True to cut 10 to 12 of the city's 104 psychiatric hospital beds after July 1. More than $1 million in savings would then be used to develop less expensive services to serve more people.

True said last week that the plan may have to be delayed because the alternatives are not yet available.

Sanchez called on True's division "to consolidate (or) eliminate some programs that are duplicated in the private sector."

Deukmejian Blamed

The fault, he said, lies with Deukmejian.

"With the present governor, and the way he is allocating money . . . it's a step we have to take," he said.

Sanchez and others are also hoping that voters this November will approve a bond sale to finance a $26 million, 185-bed locked nursing home on the grounds at San Francisco General.

That center would allow severely mentally ill people who do not need intensive care to be moved more quickly from the hospital, they say. But it would not be ready before 1991.