State Treasurer—Continued

equipment, which amounts to $84.000 in the six-month period. The equipment delivery date is slated for May 1970. The Treasurer's Office will run a parallel or dual system in May to test the new equipment. By June or July sufficient data will be gathered to determine the feasibility of an optical scanning system. If such an installation is found to be satisfactory, the Treasurer will lease the equipment from the Department of General Services. Neither the current budget, nor the 1970–71 budget reflects optical scanning leasing costs as this program is regarded as experimental. As a result. the budget of the Treasurer's Office shows the cost of continuing the current process.

It is estimated that if the optical scanning system proves feasible, the Treasurer's Office would realize a revenue gain and budgetary savings of $182,768 a year as follows:

Amounts	*Reason for Revenue Gain or Budgetary Savings*
$32,768	Personnel and equipment costs eliminated and change-over from card stock to flimsey stock.
$150,000	General Fund revenue gain resulting from prompt investment information reports.

This $32.768 budgetary savings is a minimum figure, based upon the assumption that the Treasurer's Office will bear the total rental cost of this equipment. However, the Treasurer will only use this equipment for an average of five hours per day, and if the remaining time (11 hours per day) were used by other agencies such as the State Controller, Franchise Tax Board, or Board of Equalization, then the rental costs would be shared and the additional budgetary savings would be about $94.000 a year, for a total of about $127.000.

We will prepare a supplemental report on the test of this equipment before the Legislature takes final action on this budget.

An estimated $19 million is spent annually by the General Fund on data entry requirements of all EDP systems in the state. If successful, this new equipment could result in substantial budgetary savings throughout the state.

Administration

We recommend approval, on a workload basis, of a new Assistant Treasury Officer III position ($10,860).

This position will provide technical assistance for bond sales, investment and EDP services.

HUMAN RELATIONS AGENCY

The administration of the Human Relations Agency consists of the office of the Secretary for Human Relations and his staff, which is budgeted as a single item (Item 25) and which receives appropriate legislative review and approval.

In addition to the office of agency secretary, agency administrative support also includes special services which consist of staff positions assigned to the office of the secretary but which are funded through contractual arrangements with various departments within the agency.

Human Relations Agency—Continued

A description of such staff services may be found on page 517 of the Governor's 1970–71 Budget.

The budget proposes the expenditure of $211,474 from state and federal funds to support 12.7 positions for special services in the Human Relations Agency in the budget year. The Standards and Rates unit consisting of 9.7 positions is proposed to be funded by $160,670 provided by the Departments of Social Welfare and Health Care Services. The purpose of the Standards and Rate unit is to analyze health care and protective services data for the secretary regarding programs administered by the agency. The Departments of Public Health and Mental Hygiene have allocated a total of $38,000 from their General Fund appropriations to fund two positions to be located in the office of the secretary which will carry out duties as they relate to the coordination of the mental retardation program. The Department of Public Health has an additional contract with the agency to provide $12,804 to fund one position in the secretary's office.

While we do not necessarily question the need for the positions and functions described above, we do question the method used to budget funds for such activities since it aids in circumventing the role of the Legislature in performing a proper review of the executive budget.

The budget item containing the appropriation for the office of the Secretary for Human Relations does not reflect the true size or cost of the total operation of that office.

Indeed, the impression is given that the administration of the Human Relations Agency is being accomplished with a much smaller staff and fiscal support than is actually the case.

We seriously question the method used to budget additional funds and positions for the office of the Secretary for Human Relations. Although the practice of "borrowing" funds and staff allocated to departments within an agency to augment the secretary's staff is not confined to this agency alone, we feel it is important that the Legislature in its review of the Human Relations Agency be aware of all the facts.

Agency administration may well require the addition of staff from time to time to aid the secretary in the performance of his duties. We would recommend, however, that the secretary provide adequate justification for such staff augmentations, and that they be identified in such a fashion that the Legislature be able to assess their true impact on the performance of agency operations.

HEALTH AND WELFARE SUMMARY

The 1970–71 budget proposes total expenditures of $4,286,700,000 in state, federal, county, and special funds to support various health and welfare programs. These expenditures are summarized in Table 1. Individual summaries of programs and expenditures are included in the analysis of each major departmental program.

Human Relations Agency—Continued

Table 1

Health and Welfare Program Costs, by Source, 1970–71
(In Millions)

Program or department	*State funds*	*Federal funds*	*County funds*
Office of Secretary	$0.284	$0.08	$0
Department of Health Care Services	457.0	519.9	217.6
Deparment of Human Resources Development	330.4	631.4	0
Deparment of Mental Hygiene	291.1	0.3	12.0
Department of Public Health	38.4	48.4	1.0
Department of Rehabilitation	6.1	35.9	0
Department of Social Welfare	642.2	793.9	259.8
TOTALS	$1,765.5	$2,030.8	$490.4

GRAND TOTAL ALL FUNDS, $4,286.7

The ever-increasing role of the federal government in the health and welfare area should be noted, because as federal programs and federal funds are increased, state and local expenditures must necessarily rise to meet federal requirements.

DEPARTMENT OF HEALTH CARE SERVICES

Item 112 from the Health Care Deposit Fund **Budget page 521**

Requested 1970–71	$15,111,723
Estimated 1969–70	8,695,650
Actual 1968–69	6,363,473
Requested increase $6,416,073 (73.8 percent)	
Total recommended reduction	$1,630,000 (partial)

SUMMARY OF MAJOR ISSUES AND RECOMMENDATIONS

1. *We recommend a reduction of $1,630,000 from the amount of $4,500,000 proposed for the Medi-Cal Management System Prototype.*
2. *We withhold recommendation on $1,677,027 for increased administrative costs related to proposed adjustments in the Medical Assistance Program.*

The analysis of this item is found in our discussion of Item 272, the California Medical Assistance Program (Medi-Cal).

Human Relations Agency
DEPARTMENT OF HUMAN RESOURCES DEVELOPMENT

Items 113 through 119 and 131 from the General Fund, the Unemployment Compensation Disability Fund, the Department of Employment Contingent Fund, and the Unemployment Trust Fund Budget page 555

Requested 1970–71	$25,061,230
Estimated 1969–70	24,910,464
Actual 1968–69	16,787,767
Requested increase $150,766 (0.6 percent)	
Total recommended reduction	None

GENERAL PROGRAM STATEMENT

The Department of Human Resources Development, created by Chapter 1960, Statutes of 1968, incorporates the former Department of Employment, the Service Center Program, the State Office of Economic Opportunity and the California Commission on Aging. The department became operational as an administrative entity on October 31, 1969.

The department's objectives are to: (1) enable disadvantaged persons to reach and maintain a level of economic sufficiency through job training, placement and related programs (educational, medical, etc.), (2) provide employers with employable persons through regular placement activities in industry and agriculture, and (3) provide for the payment of unemployment and disability insurance benefits to eligible recipients. To fulfill these objectives, the department has been organized in the manner shown in Table 1. The department informs us that further reorganization may occur during the current year.

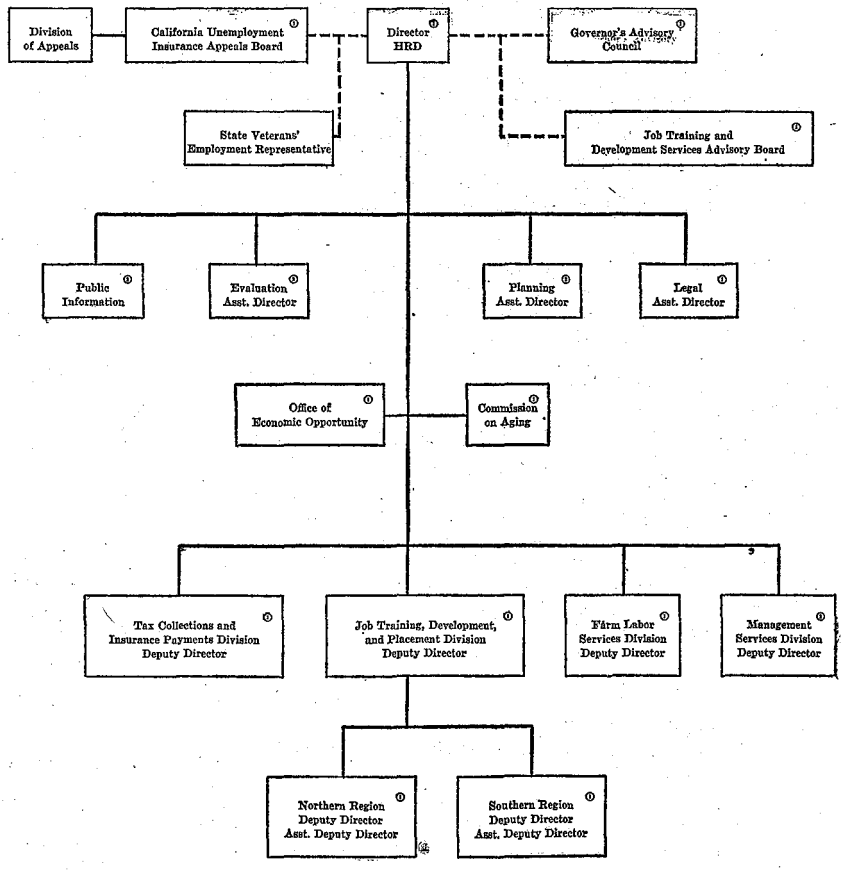
The department's programs are administered through the Job Training, Development and Placement Division, the Tax Collections and Insurance Payments Division, the Farm Labor Services Division, the Management Services Division, the State Office of Economic Opportunity and the California Commission on Aging. The programs will be discussed under the divisions which administer them in the analysis and recommendations which follow.

The department proposes a total expenditure program of $961,751,098, which is an increase of $109,806,943 or 11 percent over its estimated current-year expenditure of $851,944,155. This increase reflects a projected increase in federal unemployment insurance benefits to be paid in 1970–71. The department's programs and funding sources are summarized in Table 2.

Department of Human Resources Development—Continued

Table 1

DEPARTMENT OF HUMAN RESOURCES DEVELOPMENT (PHASE I)



- - - Cooperative or Advisory
——— Line Authority
① Appointed by Governor
⑥ Career Executive Assignment (Civil Service)

Department of Human Resources Development—Continued

Table 2

Programs by Funding Source—Department of Human Resources Development (1970–71)

I. *State Funds*[1]	
General Fund	
Work Incentive Program (WIN) (Item 113)	$5,330,397
Service Center Program (Items 114 and 131)	5,144,916
Commission on Aging (Item 115)	87,455
Office of Economic Opportunity (Item 115)	42,618
Migrant Master Plan (Item 116)	286,725
Title V, Manpower Development and Training Act, matching funds (Murphy amendments)	500,000
	$11,392,111
Unemployment Compensation Disability Fund (Item 119) (administrative costs for Disability Insurance Program)	13,012,260
Department of Employment Contingent Fund (Items 114 and 117)	656,859
Totals (state funds)	$25,061,230
II. *Federal Funds*	
Employment Security Financing Act (Item 118) (audit funds—Reed Act)	$41,100
Unemployment Administration Fund	
1. Grants for administration of Employment Security Program	81,272,618
2. Grants for Service Center Program	5,901,162
Title V, Manpower Development and Training Act	1,500,000
Work Incentive Program (WIN)	21,321,588
Older Americans Act (Commission on Aging)	519,609
Office of Economic Opportunity	318,746
Migrant Master Plan	2,610,647
Service Center Program	3,619,398
Totals (federal funds)	$117,104,868
III. *Unemployment Fund*	
Unemployment Insurance Benefits (derived from employer contributions)	$514,300,000
IV. *Unemployment Compensation Disability Fund*	
Disability Insurance Benefits (derived from employee contributions)	305,285,000
Total Expenditure	$961,751,098

[1] With the exception of the WIN Program, the amounts identified as "state funds" (totaling $25,061,230) may be changed legislatively by amendment of the Budget Bill without precipitating a corresponding change in the level of federal support for the department.

Department of Employment Contingent Fund

The Department of Employment Contingent Fund is composed of (1) penalties paid by employers who have violated provisions of the Unemployment Insurance Code, (2) rental payments made by the department for office facilities which have been financed by the Contingent Fund, and (3) interest earned on deposits in the fund.

This fund is used to cover the costs of the department which the federal Bureau of Employment Security (U.S. Department of Labor) will not allow to be financed with federal funds. These costs include pro rata charges, administrative overhead charges of other agencies and certain direct charges rendered to divisions of the department. The budget requests an appropriation in the amount of $656,859 which is

Department of Human Resources Development—Continued

a decrease of $122,564 or 15.7 percent from the estimated current-year expenditure of $779,423. The reduced expenditure reflects a lower pro rata charge for statewide administrative services.

Reed Act Funds

Under the provisions of the federal Employment Security Financing Act, the department anticipates that it will receive federal funds to conduct an audit of the Unemployment Insurance Program and its job training, development and placement activities. The federal government agreed last year to pay the cost of this audit for a five-year period of which this is the second year. The Department of Finance, which performs the audit, estimates the cost at $41,100 for the budget year.

ANALYSIS AND RECOMMENDATIONS

We recommend approval.

JOB TRAINING, DEVELOPMENT, AND PLACEMENT DIVISION

This division is responsible for the administration of the Job Training and Job Development and Placement Programs, whose objectives

Table 3
Division of Job Training, Development and Placement
Proposed Funding and Staff Allocation
(1970–71)

Proposed Funding Allocation	*Job Training Program*	*Job Development and Placement Program*
General Fund	$10,014,964	$960,349
Employment Contingent Fund	205,033	219,328
Reed Act	11,927	9,490
Federal Funds	42,990,542	22,136,589
Reimbursements	3,482,782	88,002
Totals	$56,705,248	$23,413,758

Proposed Staffing Allocation (Man-years)	*Applicant Recruitment, Evaluation Element*	*Training Element*	*Development Element*	*Placement Element*
Employment Services	621.7	109.7	146.3	950.9
MDTA [1]	--	501.6	--	--
Job Corps	44.6	7.9	--	--
PWEDA [2]	--	--	2.0	--
Work Incentive Program [3] (25% General Fund)	--	685.0	14.3	14.3
Concentrated Employment Program	341.6	33.3	5.2	4.5
Service Center Program [3]	348.0	--	--	--
Employment	--	--	--	581.5
Rehabilitation [3]	159.1	--	--	--
Supportive Services [3]	34.0	--	--	--
JOBS,[4] CAMPS [5]	10.1	10.0	3.4	24.0
Totals	1,559.1	1,337.5	171.2	1,575.2

[1] Manpower Development and Training Act.
[2] Public Works Economic Development Act.
[3] Funded wholly or partially by General Fund.
[4] Job opportunities in the business sector.
[5] Co-operative Area Manpower Planning System.

Department of Human Resources Development—Continued

and methods of operation are discussed later in this analysis as they relate to the field operations of the department. Table 3 shows the proposed budget-year allocation of funds and personnel for the division.

Delivery of Services Required by Statute

As required by Chapter 1460, Statutes of 1968, the department has designated sixteen areas of the state as economically disadvantaged and will allocate approximately 65 percent of its resources to them. The law defines a disadvantaged area as one "composed of contiguous census tracts within urbanized areas, as defined by the 1960 census, wherein 20 percent of the families report annual income less than three thousand dollars ($3,000) according to the 1960 census, or comparable areas which because of technical factors cannot be isolated by census tracts or be isolated as a 'continguous' census tract. Such areas shall have a population of not less than 25,000." In further compliance with the statute, the department has authorized the establishment of 19 Human Resources Development (HRD) Centers in the above areas to augment the eight Service Centers which have existed in those areas for a number of years. All of the HRD Centers are now in operation except the one proposed for Pasadena which has an official opening date of April 1, 1970. We understand that the department intends to designate the present service centers as HRD Centers during the current

Table 4

Economically Disadvantaged Areas (EDA) and Related HRD Centers and Service Centers

(1970–71)

EDA	*Number and Location of Center*
Alameda County	3—East Oakland West Oakland Fruitvale
Bakersfield	1
Fresno	2—East Service Center West Service Center
Long Beach	1
Los Angeles	6—Los Angeles Central Los Angeles Avalon—Florence Compton Pacoima Watts Service Center East Los Angeles Service Center
Pasadena	1
Richmond	1—Richmond Service Center
Sacramento	1
San Bernardino	1
San Diego	1—San Diego Service Center
San Francisco	4—San Francisco Mission District San Francisco Bay View (Hunter's Point) San Francisco Chinatown San Francisco Western Addition Service Center
San Jose	1
Santa Ana	1
Stockton	1
Vallejo	1
Venice-La Playa	1—Venice Service Center
Totals—16	27

Department of Human Resources Development—Continued

year. Table 4 identifies the designated disadvantaged areas and the locations of the new HRD Centers and present Service Centers.

In addition to the centers listed in Table 4, the Division of Job Training, Development and Placement also provides services through the facilities shown in Table 5.

Table 5

Additional Department of Human Resources Development Service Facilities (1970–71)

Type of Office	*Number*
Employment Service	81[1]
Adult Opportunity Centers (ADC)	1
Youth Opportunity Centers (YOC)	15
WIN Program Service Points	41
Skill Centers	3
Richmond Neighborhood House	1
Concentrated Employment Program (CEP)	4
Total	146

[1] Includes offices which perform only the employment service function and those which perform both the employment and unemployment insurance functions (see page 599 of the analysis for information on the Unemployment Insurance Program).

Distribution of Job Agents

The enabling legislation for the Department of Human Resources Development (Chapter 1460, Statutes of 1968) required the State Personnel Board to establish the position of "job agent" who would be responsible for "arranging and coordinating services necessary to motivate, train and place hard-core unemployed persons in jobs." There are currently 140 job agents who are assigned to the HRD and Service Centers on the basis of the number of disadvantaged families residing in each economically disadvantaged area.

Services Provided by HRD Centers

As a means of encouraging people to utilize the new centers, information on the services offered by them is disseminated in the target areas by the Applicant Recruitment and Evaluation Element of the Job Training Program and by the job agents who also perform outreach activities. Community residents employed as aides work through minority organizations, community action agencies, churches, schools, etc., to encourage people in the area to use the centers' services.

New clients at each center are processed by a common intake unit which untilizes the consolidated intake form developed by the former Service Center Program. This form contains all the information (work history, education, health, etc.) needed to diagnose the individuals' problems. This unit also identifies the client's needs and ascertains his eligibility for the available services. State law requires the department's training resources to be allocated to persons on the following priority basis: (1) unemployed heads of households, (2) underemployed heads of households, (3) other unemployed and underemployed persons, and (4) other persons. Veterans are to be accorded priority pursuant to existing federal law.

The function of the job agent, after interviewing the client and reviewing his intake form, is to develop a training and employment

Department of Human Resources Development—Continued

plan which meets the client's needs. In developing such a plan, the job agent may draw from programs administered by the Training Element of the Job Training Program (such as those authorized under the Manpower Development and Training Act, Work Incentive Program, Neighborhood Youth Corps, Job Corps, etc.), or he may utilize programs administered by other departments such as the Adult Education Program under the Department of Education or the Apprenticeship Training Program under the Department of Industrial Relations. The plan developed for the individual client may also include supportive services (medical, welfare, etc.) which he or his family may need to enable him to complete successfully his employability plan.

Each job agent is assigned a number of clients and is responsible for their progress until their original employment plans have been "successfully completed." The law states that: "The training and employment plan for each eligible person assigned to a job agent shall be considered successfully completed when the goal specified in the eligible person's plan has been achieved or after 18 months of continuous employment."

The objective of the Job Development Element of the Job Development and Placement Program is to develop job openings for both the occupationally qualified worker and for those who are becoming qualified through the training programs mentioned above. This activity may entail persuading public and private employers to restructure entry-level positions to accommodate newly trained personnel.

The final step of the program, actual job placement, is provided by the Job Placement Element of the Job Development and Placement Program. The objectives of this element are to: (1) assist employers in meeting their manpower needs, (2) assist jobseekers in finding jobs that would utilize their highest skills, and (3) place trainees in jobs.

Manpower Development Fund Incomplete

Chapter 1960, Statutes of 1968, which established the Manpower Development Fund, specifies that it is to be administered by the Department of Human Resources Development and that 75 percent of the moneys therein (except Work Incentive Program funds) be utilized in the 16 designated economically disadvantaged areas of the state. The law further specifies that funds allocated from the sources shown in Table 6 shall be deposited in the Manpower Development Fund.

Fund expenditures shown in parentheses in Table 6 have not been deposited in the Manpower Development Fund as required by state law. Thus, although the moneys allocated pursuant to the federal Economic Opportunity Act and Title III of the Social Security Act are included in the department's budget totals, they will not be allocated in a manner consistent with the 75 percent requirement governing the Manpower Development Fund. The federal funds allocated to the Department of Education for the purpose of eliminating illiteracy will be administered directly by that department rather than by the Department of Human Resources Development.

Department of Human Resources Development—Continued

Table 6

Manpower Development Fund (1970–71)

Source of funds

	Amount
Work Incentive Program (WIN)[1]	
State share (20 percent)	$5,330,397
Federal share (80 percent)	21,321,588
Economic Opportunity Act	(361,364)
Adult Basic Education (Section 18601, Educ. Code)	(16,343,006)
Service Center Program	4,569,250
Vocational Rehabilitation Act[2]	(—)
Manpower Development and Training Act (MDTA)	
Title II funds (Unemployment Administration Fund)	7,165,231
Title IV funds (Murphy Amendments)	
State share (25 percent)[3]	500,000
Federal share (75 percent)	1,500,000
Allowances	18,000,000
Unemployment Administration Fund	
Title III, Social Security Act	(10,000,000)
Total	$58,386,466

[1] These funds are to be used statewide without specific regard for the designated economically disadvantaged areas (EDA).

[2] Section 11006.5 of the Unemployment Insurance Code provides that these funds shall be deposited in the fund "only upon recommendation of, and in the amount determined by, the Secretary of the Human Relations Agency . . ." The Secretary has determined that inclusion of these moneys in the fund would endanger federal funding arrangements with the Department of Rehabilitation.

[3] Original appropriation of $1 million made in 1969–70 and balance carried into budget year although original $500,000 in current year has not yet been obligated.

Work Incentive Program (WIN)

The 1967 amendments to the federal Social Security Act established the Work Incentive Program (WIN) and required each state to implement the provisions of the act by June, 1968. California complied with this requirement, and began accepting enrollees in September, 1968. The program has thus been fully operational in California for approximately 15 months.

The WIN Program's stated objective is to remove persons from the welfare rolls by providing them with education, training, work experience and other services (medical, child care, etc.) as required to resolve individual problems that have prevented entry into the work force. Eligible recipients of this program are members of households receiving assistance under the Aid to Families with Dependent Children Program (AFDC) who are over the age of 16 and not enrolled in school. Within these broad guidelines, recipients are referred to the Department of Human Resources Development by local welfare agencies in 27 selected counties, each of which has over 1,100 active AFDC cases.

Specifically excluded from the program are persons who are (1) ill, incapacitated, or elderly, (2) too far away from a project to make participation practical, (3) full-time students, and (4) persons whose presence at home is required because of the illness or incapacity of some member of the household.

Federal funds for the program are allocated to the U.S. Department of Health, Education, and Welfare (HEW), but the primary responsibility for administration of the program at the federal level is vested in the Department of Labor. This division of authority between the

Department of Human Resources Development—Continued

two federal departments has produced administrative uncertainty in state and local agencies because each federal department issues directives and regulations to its delegate agencies in the WIN Program. Illustrative of this conflict is the fact that the U.S. Department of Labor has published a WIN Handbook containing program regulations and procedures to be followed by the Department of Human Resources Development, and the other participating agencies, but the state and local departments of social welfare have not fully implemented its provisions. We understand that the Department of Health, Education, and Welfare also intends to publish an administrative handbook on WIN for use by the state and local departments of social welfare.

WIN Funding

As shown in Table 6, the program costs of the department's WIN Program are shared by the federal government and the state under an 80 percent (federal)—20 percent (state) matching formula. The WIN budget for the 1970–71 fiscal year is $26,651,985. Of this amount, $21,321,588 (80 percent) is furnished by the federal government and $5,330,397 (20 percent) by the state. Additional WIN Program costs (covering such items as transportation and medical expenses of WIN enrollees) are administered by the counties under the following sharing formula: 75 percent federal, 16⅔ percent state (Department of Social Welfare) and 8⅓ percent local.

Federal funds are allocated to the states by the Secretary of Labor on the basis of the number of program units (slots) assigned to each state. The number of slots assigned is based on the number of residents who have attained age 16 and are receiving assistance from the Aid to Families with Dependent Children Program. Each "slot" enables the state to retain an individual in the program for a period of one year. If an individual completes the program (becomes employed) in less than a year, the state may accept another enrollee to utilize the time remaining in that slot. The Secretary assigns a dollar value to the slots which is equal to the cost of training an individual in an existing Department of Labor program (vis., MDTA) in the state. The state's funding allocation is equal to the number of slots multiplied by the department's estimate of training costs. Based on these factors and available federal moneys, California was assigned 16,800 slots for the 1969–70 fiscal year having a dollar value of $21,325,000. California's target group of AFDC recipients numbers approximately 84,000.

WIN Participants

Aid to Families with Dependent Children recipients are selected and referred to the WIN Program by local welfare departments. Once enrolled in the WIN Program, they are classified into one of three categories.

Under category I, the department seeks to place the individual in an existing job for which he is qualified. If the individual is placed in a job with a salary which is insufficient to meet his needs, he may receive a supplemental welfare grant computed under a formula which considers his wages and financial needs.

Department of Human Resources Development—Continued

Under category II, a person not readily employable will be referred to existing federal or state training programs such as the Neighborhood Youth Corps, New Careers, or those authorized by the Manpower Development and Training Act (MDTA). If none of these programs has an open training slot, the individual may be placed in a WIN-sponsored program of vocational training, or he may be given a work experience assignment. Under each of these alternatives, the client continues to receive his regular welfare grant from the county, plus training expenses and an incentive payment of $30 per month from the WIN Program.

Individuals who cannot be placed in either category I or II may be placed in category III which to date, has been implemented only in San Luis Obispo County. An individual in this category is placed in a special work project arranged by the department in cooperation with public and private agencies and is guaranteed a total income equal to his welfare grant plus 20 percent of his earnings. If this amount is not realized, he will be eligible for a supplemental welfare grant from the county in which he resides. The cases of individuals in category III will be reviewed every six months to assure that regular employment will be secured as soon as possible.

An effort is made by the Job Placement Element to place the individual in a job after he has completed the training program assigned to him. The WIN Program performs a follow-up three to six months later to ascertain the employment status of the individual. This follow-up is important as a method of measuring the success of the program.

The WIN staff has expressed concern over the volume of federal forms required to administer the program. Although form revisions have occurred since the beginning of the program, the staff feels that the time necessary to complete these forms could be spent in activities more advantageous to their clients. Since the program has only been operating in California for approximately 15 months, a comprehensive evaluation is not possible at this time. Such an evaluation will be more meaningful after enrollees currently in training programs become employed and the required follow-up has been made to determine their subsequent employment status.

Needed Administrative Improvements in the WIN Program

During our interim review of the WIN Program, we encountered the following problem areas which are susceptible to correction at the state and local level:

(1) *Communications Gap With WIN Enrollees.* A welfare recipient's (Aid to Families with Dependent Children recipient) initial exposure to the WIN Program usually occurs when he/she receives a letter from the Department of Human Resources Development (HRD) informing him of his selection for the program and the date and time of his enrollment interview. The WIN personnel state that county social welfare workers often fail to notify their clients that they are being referred to a different and mandatory program or give them any details as to: (a) the purposes of the WIN Program, (b) how the recipients might benefit from it, and (c) the consequences that are authorized

Department of Human Resources Development—Continued

under law should the recipient refuse to participate in the program. In some cases, the social workers do not properly brief their clients because their own knowledge of the program is too limited. As a result, recipients generally are reluctant to enter the program and suspicious of its objectives at the time of their enrollment.

(2) *Inefficient Screening of WIN Referrals.* An additional problem occurs in the selection of welfare recipients for referral to HRD for enrollment. Approximately one out of every five persons referred to WIN is rejected by HRD and his file is returned to the county welfare department because he did not meet program eligibility requirements. These inappropriate referrals create a costly administrative problem as well as an inconvenience to the client and are indicative of the confusion concerning the WIN Program's policy guidelines.

(3) *Day-Care Facilities Inadequate.* The federal guidelines for the WIN Program issued by the U.S. Department of Labor require the participating county welfare departments to furnish day-care services to AFDC mothers who are enrolled in WIN. These services can be provided by local day-care and children's centers, preschool and Head Start programs, licensed and unlicensed family day-care homes, and homemaker and babysitting services in the recipient's home. Frequently, however, these services are not readily available to AFDC mothers and many of them have dropped from the program for this reason. A recent study on day-care problems by the Assembly Committee on Education has confirmed the inadequacy of present facilities to cope with the number of eligible children.

(4) *Lack of Coordination Among State and Local Agencies.* Responsibility for the administration of the WIN Program is delegated to the Department of Human Resources Development by federal law. This responsibility, however, is shared with the state Departments of Education and Social Welfare—the Department of Education providing basic and vocational education services and the Department of Social Welfare providing initial referral and ancillary services (medical, transportation costs, etc.). The problem of coordination between the Departments of HRD and Social Welfare is illustrated by the following quotation taken from the minutes of the October meeting of the WIN policy committee, which committee is composed of representatives from each department: "It was noted for the record that the premature release of these regulations was without the agreement of Welfare. It was stated by Employment (sic) that the division notice in question was released without Social Welfare's agreement because Employment felt it necessary to establish the program as rapidly as possible."

This lack of coordination and communication is more prevalent between the state departments and the county welfare agencies. The Department of HRD is empowered to issue regulations directly to its local WIN offices while the Department of Social Welfare must coordinate procedures with the 27 participating county welfare departments. Conflict thus occurs when the local WIN staff proceeds ac-

cording to its instructions before similar instructions are received by the county welfare personnel.

Disagreements between WIN field offices and county welfare departments have arisen concerning reimbursements of enrollee child-care and transportation expenses which are paid by the county departments. County personnel state that some of these expenses are excessive and have refused to pay the enrollee. Even when such claims are deemed valid by the county welfare departments, there has often been a six-week delay in the issuance of the reimbursements which has caused an economic hardship on the enrollee.

WIN Program enrollees receive their basic welfare grants plus reimbursements for child-care and transportation expenses and an additional standard monthly allowance of $25 per month from the local welfare agency. Such financial assistance should cease after one completes the program, but in several instances recipients have continued to receive these payments after they became employed because the local WIN office did not advise the local welfare personnel of the change in the client's status.

A further example of poor communications occurred in Santa Clara County when the state increased the county's WIN slots from 544 to 1,200 for the current year. According to Santa Clara welfare personnel, neither the State Department of Social Welfare nor county officials knew of this increase in time to change the local allocation for the program. As a result, the county budgeted for a 20 percent increase in slots but received an increase of more than 100 percent.

(5) *Possible Job Development Problems.* The jobs for which enrollees are being trained are basically entry level classifications such as nurses aide, janitor, groundskeeper, mechanic, etc. The WIN staff state that it attempts to provide training for an individual based on his preferences, abilities, and the requirements of the labor market. However, competition for such entry level jobs is great and if the job market is tight, the WIN Program may be performing a disservice to the enrollee and to the state by creating trained unemployables.

TAX COLLECTIONS AND INSURANCE PAYMENTS DIVISION

The Tax Collections and Insurance Payments Program, which is administered by this division, seeks to lessen the economic hardships of the involuntarily unemployed through two distinct forms of income stabilization, one of which provides benefits in the case of unemployment (unemployment insurance) while the other provides assistance in the event of illness (unemployment compensation disability insurance).

As shown in Table 2, projected benefits for unemployment insurance and disability and hospital benefits total $819,585,000 for the 1970–71 fiscal year. Unemployment insurance benefits are estimated to represent $514,300,000 of that amount and disability and hospital benefits the remaining $305,285,000. The estimated expenditure for unemployment benefits is based on projected rates of unemployment while that

Department of Human Resources Development—Continued

of disability and hospital benefit payments is based on the department's claims experience in relation to the total number of persons covered by disability insurance.

Unemployment insurance benefits are funded by employer contributions which are determined by applying a percentage formula (specified in the Unemployment Insurance Code) to the employer's payroll. The disability and hospital benefits are funded primarily by percentage assessments on employees' wages.

Disability Insurance Administration Costs

The budget proposes an appropriation of $13,012,260 from the Unemployment Compensation Disability Fund for the direct and indirect support (pro rata charges for services provided by other divisions in the department) of the administrative costs of the Disability Insurance Program. This is an increase of $288,879 or 2.2 percent over the estimated expenditure of $12,723,381 during the current year. The department proposes no additional personnel for the budget year and states that the above increase reflects the added cost of merit salary increases and related benefits for existing tsaff.

FARM LABOR SERVICES DIVISION

The Farm Labor Services Division administers the Farm Labor Services Program and the Migrant Services Program. The Farm Labor Service provide agricultural placement services through 45 permanent farm labor offices and additional seasonal mobile employment units for outreach contacts with workers.

Migrant Services Program

The Migrant Services Program administers the Migrant Master Plan which was authorized by Chapter 1576, Statutes of 1965. The program's objectives are to provide the following services and facilities for migrant farmworkers and their families:

(1) "Temporary", seasonal, flash peak, family-style housing with companion water and sewage services. The adopted unit is constructed of plywood and includes a floor, toilet and shower, washbasin, water heater, sink, stove and room dividers.

(2) Compensatory and remedial education for children and adults.

(3) Supervised day-care and food for children between the ages of two to five years is provided six days a week, 10 hours a day to allow parents to work in the fields.

(4) Full sanitary facilities and drinking water at each camp with centrally located showers and laundries, washers and dryers, in addition to toilets in each of the plywood units.

(5) Health clinics which are administered by the Farm Workers Health Service of the State Department of Public Health.

Table 7 shows the number and locations of migrant centers that are funded through the Migrant Master Plan.

Department of Human Resources Development—Continued

Table 7

Farm Labor Centers—Calendar Year 1969

Center location (county)	No. of units	Families served	Persons served	Dates open	Day care ADA
Watsonville (Santa Cruz)	100	107	598	6/6–10/31	36
Hollister (San Benito)	75	105	618	6/23–10/31	33
Gridley (Butte)	100	133	677	5/19–11/28	61
Yuba City (Sutter)	94	181	901	5/19–10/31	31
Madison (Yolo)	100	112	629	6/9–10/3	19
Davis (Yolo)	50	85	404	5/26–10/17	20
Dixon (Solono)	100	145	730	5/19–10/31	51
Williams (Kern)[1]	100	--	--	----	--
Harney Lane (San Joaquin)	96	276	1412	5/16–11/14	40
Mathews No. 2 (San Joaquin)	96	181	969	5/9–10/15	37
Mathews No. 3 (San Joaquin)	96	148	732	5/15–11/14	49
Empire (Stanislaus)	85	121	601	5/15–10/31	53
Patterson (Stanislaus)	55	86	450	5/17–11/14	56
Westley (Stanislaus)	100	131	653	5/15–11/14	56
Ballico (Stanislaus)	50	70	363	6/2–10/17	19
Merced (Merced)	60	69	448	6/9–10/3	19
Los Banos (Merced)	90	114	652	6/16–10/17	20
Livingston (Merced)	50	87	483	6/2–10/24	16
Planada (Merced)	50	79	471	5/23–10/29	21
Parlier (Fresno)	125	138	723	6/9–10/17	42
Raisin City (Fresno)	75	95	630	6/16–10/30	24
Indio (Riverside)	80	155	658	11/17 ----	--

[1] Units authorized and under construction.

In our Analysis of the 1969 Budget Bill, we noted that approximately 300 of the Migrant Program's "plydome" units (constructed of polymethane and paper) were no longer usable and that they would not be replaced due to the lack of federal construction funds. The program has since received a construction grant in the current year totaling $1,779,460 which will provide for the replacement of 284 "plydome" units with plywood units and the construction of 280 new plywood units during the current year. The department anticipates that $1,088,000 in federal funds will be available to construct 320 new plywood units during the budget year.

All of the program's housing units are being constructed by the Housing Fabrication and Vocational Training Element. This element, which was organized in cooperation with the federal Office of Economic Opportunity, the Rohr Corporation of San Diego, and representatives of labor, provides vocational training and work experience to agricultural workers while supplying the program with housing units. The element began production in August 1968 and proposes an expenditure of $370,921 in federal funds during the budget year. Its housing units have a unit cost of $1,650 delivered on site, which is comparable to the cost of units built by private industry. This element had placed 53 of its trainees in private employment as of December 31, 1969, and has approximately 40 trainees currently enrolled in its construction project.

Department of Human Resources Development—Continued

Migrant Services Program Funding and Administrative Responsibility

The direct administration and supervision of the migrant camps is provided by county housing authorities and/or health departments under contract with the Migrant Services Program. The state's responsibilities are to provide: (1) assistance in program development, (2) supervision in program operation, (3) program evaluation, and (4) consultive services.

For support of this program, the budget proposes a General Fund appropriation of $286,725, of which $189,225 (supplemented by approximately $78,000 in local rental moneys) will be used to maintain the camps in the off season and the remaining $97,500 (supplemented by another $78,000 in local rental moneys) will be allocated to the day-care program. Since the federal Office of Economic Opportunity no longer funds migrant day-care services, the 1970–71 day-care program will again be supplemented by federal funds channeled through the State Departments of Social Welfare and Education. The Migrant Program estimates it will receive approximately $2,610,647 in federal funds for a total proposed expenditure level of $2,897,372, which is a decrease of $668,409 or 18.7 percent from the estimated current year expenditure of $3,565,781. This decrease reflects a reduction in the amount of housing construction funds allocated to the program by the federal government.

OFFICE OF ECONOMIC OPPORTUNITY

The Office of Economic Opportunity, which was established administratively in the Governor's office in 1964, was transferred to the department in November 1968. Its purposes are (1) to provide technical assistance services to local antipoverty agencies, and (2) to advise the Governor with regard to his veto power over proposed local antipoverty projects financed by Title I, Part B, and Title II of the federal Economic Opportunity Act, as amended.

The program proposes a General Fund appropriation of $42,618, which is an increase of $106 over the estimated current year expenditure of $42,512. The program estimates federal funding in the amount of $318,746, which will produce a total budget year expenditure of $361,364.

Organizational Confusion

In the course of last year's budget hearings on the State Office of Economic Opportunity, a question was raised as to the appropriateness of the allocation of personnel between the technical assistance and review and coordination functions of the office. As reported in the agency's 1969–70 program budget, 5.9 positions were proposed for the technical assistance program. This program assists community action agencies by (1) developing and maintaining a resource profile, (2) coordinating state, local and federal resources, (3) developing programs, and (4) providing technical expertise for program activities. In contrast, 14.9 positions were proposed for the review and coordination program, the objective of which as stated in the 1969–70 program

Department of Human Resources Development—Continued

budget is to "impose a discipline, through the review process, upon community action agency programming in order to assure that programs selected by the Governor have sufficient quality to deserve the opportunity for funding." Stated somewhat differently, the functions of this unit are: (1) to evaluate the programs of community action agencies at the time they apply for grants and (2) to evaluate the effectiveness of existing programs which seek renewal of their funding grants. Based on its evaluation, the program makes recommendations to the Governor as to the advisability of approving the agency's funding request.

This staff organization was initially explained in the office's October 1968, activity report to the administrator of the Human Relations Agency as follows: "The system for implementing the new processing procedure at State Office of Economic Opportunity appears to be working smoothly. Basically the new system places responsibility for review and coordination of all Office of Economic Opportunity programs in the state in the hands of six field representatives serving community action agencies in southern California, central California, northern California, and coastal areas . . . .

"The Review and Coordination representatives, in turn, refer inquiries and requests concerning technical assistance to the new staff of Technical Assistance specialists in State OEO. It is hoped that the new streamlined procedure (separating State OEO field representatives into two teams—a grant review team and a specialist team) will simplify and expedite the work flow of State OEO."

The director of the State Office of Economic Opportunity stated in his testimony on the budget last year that the agency was not, in fact, organized in the above manner and that each community action representative in the agency is a generalist who supplies all services (review, coordination and technical assistance) to a community action agency.

In an effort to determine the actual allocation of personnel to each of these functions, the Assembly Ways and Means Subcommittee requested the agency to submit a report to our office and to the Legislature prior to January 1, 1970. The report contains a detailed accounting of the allocation of staff time between the technical assistance, review, and coordination functions for the period January through November, 1969. According to the report, the Community Action Representatives allocated 3,556 hours (31.7 percent of their total hours) to program *review,* 5,407 hours (48.2 percent) to *coordination* services and 2,244.5 hours (20.1) to *technical assistance* services.

CALIFORNIA COMMISSION ON AGING

The California Commission on Aging was established in 1956 as the Citizen's Advisory Commission on Aging to advise the Governor on the needs of California's senior citizens. The commission's role was expanded in 1965 by Section 18357 of the Welfare and Institutions Code, which authorized the commission to act as the administrative agency to implement the provisions of Title III (Community Grants) of the federal Older Americans Act of 1965, as amended. The commission is

Department of Human Resources Development—Continued

composed of eight members appointed by and serving at the pleasure of the Governor, two members of the Senate appointed by the Committee on Rules, and two members of the Assembly appointed by the Speaker.

The commission's proposed expenditure of $607,064 is a decrease of $18,720 or 2.9 percent from the estimated current-year expenditure of $625,784. The requested expenditure is composed of $87,455 from the General Fund and $519,609 in federal funds. Table 8 shows the program's staff and funding sources for the years indicated.

Table 8
Staff and Funding of the Commission on Aging
(1966–71)

Fiscal year	*Staff*	*State*	*Federal*	*Total*
1966–67	9.1	$92,457	$532,904	$625,361
1967–68	11.5	120,333	548,503	668,736
1968–69	11.5	102,095	891,153	993,248
1969–70 (Estimated)	11.9	106,175	519,609	625,784
1970–71 (Proposed)	11	87,455	519,609	607,064

The proposed General Fund appropriation is $18,720 or 2.9 percent below the estimated current-year expenditure of $106,175. Federal funding is projected at the same level as in the current year but this is subject to revision because Congress has not passed the appropriations bill for the Older Americans Act. The federal monies appropriated will be allocated to the states in proportion to their population over 65 years of age. On this basis, California received approximately 4.99 percent of the funds appropriated for 1969–70.

The Administration on Aging within the U.S. Department of Health, Education and Welfare has determined that each state may utilize $75,000 of its total allocation for the costs of administrating its program. The proposed budget would provide the commission with an administrative expenditure in the amount of $162,455 (compared to $181,175 in the current year) and funds for Older Americans Act projects in the amount of $444,609, which is the same as the current level.

The commission currently provides technical services to 70 local Older Americans Act projects and anticipates no additional projects in the budget year. These projects consist of local committees on aging, senior citizen clubs and senior citizen centers initiated by a local public entity or voluntary agency for the purpose of utilizing the experience and skills of senior citizens for community betterment. All project proposals are submitted to the staff of the commission who determine that (1) the project provides a service not already provided in the community, (2) the proposal conforms to federal law, (3) the sponsors of the proposal are capable of conducting the program, and (4) funds are available for the program's support. Based on the above factors, the staff makes a recommendation to the commission which approves or disapproves the project proposal. If the project is approved, it is funded as shown in Table 9.

Department of Human Resources Development—Continued

Table 9

Support for Older Americans Projects

Period covered	*Federal share*	*Local share*
First year	75%	25%
Second year	60%	40%
Third year	50%	50%
Over three years	0%	100%

As indicated in Table 9, the local sponsor is expected to provide total support for a project at the end of the third year. The policy of the commission is to refuse funding for any project which is not to be continued beyond its third year.

Department of Mental Hygiene

SUMMARY

Proposed total program expenditures 1970–71 (all funds)	$333,424,108
Estimated total program expenditures 1969–70 (all funds)	325,797,414
Increase (2.3 percent)	7,626,694

GENERAL PROGRAM STATEMENT

For the 1970–71 fiscal year, proposed expenditures for support of the Department of Mental Hygiene total $333,424,108, to be financed by General Fund appropriations, federal grants and reimbursements. Table 1 summarizes these proposed expenditures by activity and source of funds. The table indicates that the support of mental hygiene activities will exceed that estimated to be expended during the current fiscal year by $7.6 million.

The department administers the following programs:

1. Prevention of mental illness and mental retardation.
2. Diagnosis of mental illness and mental retardation.
3. Care and treatment of persons suffering from mental illness and mental retardation.
4. Research into the causes underlying mental illness and mental retardation.
5. Training to assure sufficient manpower to implement the department's programs.
6. Assistance to communities providing local psychiatric (Short-Doyle) services in 54 counties.

The programs are implemented by state and county facilities for the mentally ill including nine state hospitals, 52 community Short-Doyle programs, four state hospitals for the mentally retarded, two neuropsychiatric institutes, and departmental administration.

Table 1

Department of Mental Hygiene
Summary of Activities, 1970–71 and Change from 1969–70

Activity	Budget Bill item number	1970–71 General Fund	1970–71 Federal funds	1970–71 Reimbursements	1970–71 Total	Change from 1969–70 Amount	Change from 1969–70 Percent
Facilities for the Mentally Ill							
(1) State hospitals for the mentally ill	123, 273	$121,337,137 (Mentally retarded, $17,216,145; mentally ill, $104,120,992)	--	$1,032,300	$122,369,437	—$11,796,826	—8.8%
					(75,936,000)*	(+22,011,000)	(+40.8%)
(2) Local assistance Short-Doyle	273	75,936,000	--	30,580,058	106,516,058	+12,396,559	+13.2%
State hospitals for the mentally retarded	124	65,746,390	--	90,270	65,836,660	—405,454	—0.6%
Neuropsychiatric institutes	122	13,129,059	--	--	13,129,059	—635,833	—4.6%
Departmental administration	120	6,995,982	--	1,959,330	8,955,312	—1,068,301	—10.7%
Research and training	121	7,998,973	300,000	--	8,298,973	+6,552,452	+375.2%
Special project activities		--	--	8,318,609	8,318,609	+2,584,097	+45.1%
TOTAL		$291,143,541	$300,000	$41,980,567	$333,424,108	+$7,626,694	+2.3%

* The state contribution of $75,936,000 to the local assistance Short-Doyle program is 40.8 percent more than was expended during the current fiscal year.

Department of Mental Hygiene
DEPARTMENTAL ADMINISTRATION

Item 120 from the General Fund Budget page 608

Requested 1970–71	$6,995,982
Estimated 1969–70	6,969,688
Actual 1968–69	6,070,618
Requested increase $26,294 (0.4 percent)	
Total recommended reduction	$378,927
Withholding recommendation pending further study	252,071

SUMMARY OF MAJOR ISSUES AND RECOMMENDATIONS

GENERAL PROGRAM STATEMENT

Departmental administration formulates and administers policy for the Department of Mental Hygiene. It is charged with the responsibility of coordinating, supervising, and evaluating state and local programs within legislative intent and consistent with a high level of medical and business practice. Departmental administration is composed of the following units, each of which is responsible for a specific departmental function:

1. Executive—This unit includes the Office of the Director, Public Information, and various advisory boards and committees.

2. Medical Programs—This unit includes the Office of Medical Programs, Program Planning, Program Review, Division of Hospitals, Division of Local Programs, and Division of Research and Training.

Departmental Administration—Continued

3. Administrative Management—This unit includes the Office of Administrative Management, Data Processing, Management Analysis, Personnel Services, Legal Services, and Administrative Services.

ANALYSIS AND RECOMMENDATIONS

The budget proposes total support for departmental administration in the amount of $8,955,312. This includes an appropriation of $6,995,982 from the General Fund, and $1,959,330 in reimbursements. The proposed total support is a decrease of $1,068,301, or 13.5 percent, below that which is estimated to be expended during the current year. This decrease is largely atttributable to shifting the funding of certain activities to "special activities" under Item 121, Research and Training.

Departmental administration is proposing to transfer 10 positions to the Division of Research and Training, abolish 17.1 positions, and add 82.5 positions for a net increase of 55.4 positions.

Bureau of Program Audits

We recommend approval.

The budget proposes six new positions to implement a permanent, on-going fiscal and performance audit of community Short-Doyle programs. These positions consist of one supervising auditor, four general auditors and one stenographer to provide clerical support. The establishment of such an audit during 1970–71 will facilitate the later implementaion of the local cost reporting system mandated by the Lanterman-Petris-Short Act. In addition, it will provide management information necessary to assure the continued coordination of the community mental health system.

Medical Assistance Program

We recommend approval.

Forty-six positions are proposed to bring the mental retardation programs at the hospitals for the mentally ill into conformance with federal Medi-Cal standards. These positions are reimbursed by contract with the Department of Health Care Services. The positions consist of 23 registered nurses, 4.5 psychiatric social workers, 5 teachers, 3 social workers and 6.5 clerical. The federal Department of Health, Education and Welfare (HEW) has notified all states that if the staffing standards are not met there will be a loss of federal funds.

Bureau of Biostatistics

We recommend approval as budgeted.

The department is proposing the establishment of 2.5 clerical positions in the Bureau of Biostatistics to undertake implementation of S.B. 250 (Chapter 1119, Statutes of 1969). This act requires the Department of Mental Hygiene to maintain records necessary to identify persons who are subject to the provisions of the Welfare and Institutions Code relating to mental patients possessing firearms.

Departmental Administration—Continued

COMMUNITY MENTAL HEALTH COST REPORTING SYSTEM

We recommend the Department of Mental Hygiene and the consultant selected for Phase B, continue to define evaluation criteria for mental health program effectiveness during Phase B of the Local Program Cost Reporting/Data Collection System Development. We further recommend that any findings as a result of this effort be incorporated in the system design.

The Department of Mental Hygiene, as a result of the Community Mental Health Services Law, Chapter 1667, Statutes of 1968, is charged with the responsibility of implementing a Cost Reporting/Data Collection System by December 31, 1971. The law, in essence, provides for the establishment of an intergovernmental system of mental health programs and requires the Department of Mental Hygiene to develop a cost reporting system for local programs which will:

1. Guarantee that charges made for services to mentally disordered persons or persons affected with chronic alcoholism under a county Short-Doyle Plan shall not exceed the actual cost thereof in accordance with standard accounting practices;
2. Establish uniform methods for determination of the individual patient's ability to pay;
3. Provide uniform collection procedures;
4. Supply management information relating to the costs of patient care and treatment, specifically the costs of program priorities detailed by types of services defined by law;
5. Permit analysis and comparison of local facilities within a common frame of reference;
6. Provide cost/effectiveness analysis to be used in determining local program economic feasibility;
7. Apply to all facilities, but be designed to be flexible and adaptable so that each facility can tailor the system to that facility's unique activities and needs; and
8. Provide management control.

Cost System Plan

The department developed plans for the design of a cost reporting/data collection system in two phases. Phase A was to consist of a short-term preliminary design survey for the identification of problem areas and to set the scope for the main project (Phase B). Phase B was to consist of the actual detail design and implementation of the Cost Reporting/Data Collection System. The Legislature appropriated $360,000 ($50,000 for Phase A, and $310,000 for Phase B) during the 1968 session but stipulated that a report of the findings and recommendations of Phase A be made to the Joint Legislative Budget Committee and the Department of Finance prior to the release of funds for Phase B.

Late in the 1968–69 budget year, the department requested proposals for the conduct of Phase A of the cost system from a number of management consultant firms. In its request for proposal, the department

Departmental Administration—Continued

stated the objectives of Phase A to be: (1) a survey to establish the management information requirements of community facilities and state agencies, (2) to document the data collection problems involved in costing community mental health services, and (3) to set the scope for the ensuing design and implemenation of the cost reporting/data collection system.

Contractor Services

A private consulting firm was awarded a contract in September 1969 to begin the preliminary design survey. Completion of Phase A was required within 16 weeks of its start, and was to be conducted by a team made up of consultant and departmental staff. The survey was to include a detailed review of procedures, facilities, requirements and data collection problems in five counties: San Diego, Los Angeles, Santa Clara, Alameda and Shasta. These counties were selected primarily because they represented a cross section of programs, size and complexity.

In addition to the functional requirements outlined above, the consultant was also required to recommend state staffing, develop a time schedule and provide the basic elements of a request for proposal for Phase B design and implementation.

Report of Phase A

Phase A work was completed by the consulting firm and the department in December 1969 and a report of findings and recommendations was submitted to the Joint Legislative Budget Committee on January 19, 1970. The report describes the project team's survey of state and local systems, their problems and requirements, and recommends a conceptual systems design which will fulfill the cost reporting/data collection requirements of the Community Mental Health Services Law.

The report recommends a modular approach to the implementation of a cost reporting/data collection system, with each module able to operate independently of the others. The recommended system includes the following modules:

(1) Policy and Procedural Module—A major recommendation of the report relates to the necessity of making basic policy and procedural decisions. The report recommends that the Department of Mental Hygiene develop an administrative manual for both county and departmental personnel use which will uniformly define the classification of services, calculation of rates for services, eligibility criteria, ability-to-pay criteria, collection procedures, contracting practices, and rules for data submission requirements. Findings indicate that these procedures are not uniformly developed throughout local and state facilities, and before an automated system of budgeting, claims and evaluation can be undertaken, policy decisions must be made regarding standard procedures.

(2) Budget Module—It is anticipated that budgeting will begin at the service-within-facility level of the local programs. Direct and indirect patient care within the facility and indirect nonpatient service will be combined with planned units of care, staffing hours, service

Departmental Administration—Continued

priorities and anticipated income. Budget data from the state hospitals and headquarters units would be added at the state level to produce a budget document for submission to the control agencies and the Legislature and provide a performance guide for the state department, counties and facilities. Extensive use of automated methods are anticipated for this module.

(3) Claims Processing Module—This module will include the collection of evaluation statistics as well as actual claims data. Automated methods will be used to collect service costs by service within facilities, including service rates, number of units, amount, number of patients and staff hours by type. In addition, aggregate patient statistics will be collected for statistical analysis of caseloads and demographic characteristics.

(4) Evaluation Module—A key element in any meaningful management information system is the development of data regarding the results or effectiveness of programs. It is proposed that the system collect descriptive data and statistics on patient activity but does not require positive patient identification. The proposed system, like the state hospital system, does not collect information about individual treatment procedures. Findings of the study indicate that there is a strong resistance by county officials to submit reports which identify individual patients receiving treatment. The reason indicated for this resistance is that patient data specifically identified may be considered confidential in nature and the institution may be subject to a law suit.

The report indicates that the detailed system design and implementation should begin immediately so that the December 31, 1971, deadline can be met. According to the schedule recommended by the consultant, design would be complete by September 1970, programming and testing by August 1971, and installation or modifications of hardware complete by the December 1971 deadline. A program of field training, management analysis and other supporting functions would be carried on in conjunction with the system design and implementation.

The Phase A report does not specify the cost of full implementation. However, the consultant has estimated contract fees for Phase B to be $360,000. The department has been authorized to expend $300,000 for contractor fees and $10,000 for keypunching during the 1969–70 fiscal year, and intends to put Phase B out to competitive bid.

We are concerned that the system design recommended by the consultant in the Phase A report does not sufficiently consider the problem of mental health program effectiveness (we have expressed a similar concern with respect to the State Hospital Cost Reporting System). We recognize, however, the complex nature of the problem and the difficulty in determining precise definitions of evaluation criteria.

Equipment and Operating Expense

We recommend deletion of $191,376 for computer equipment and $55,515 for related supplies and operating expenses for a savings of $246,891.

The budget proposed to support EDP services for the Department of Mental Hygiene requests $246,891 for additional equipment and sup-

Departmental Administration—Continued

plies to support the Local Program Cost Reporting/Data Collection System. The procurement of more EDP equipment is not warranted at this time.

The Phase A report indicates that the primary use of computer hardware and peripheral equipment will occur during the 1971–72 budget year. It is anticipated that a total of 660 hours, or less than one month of available computer time will be required during the next budget year. We recommend that this requirement be met with existing equipment during nonpeak periods or with computer facilities in another state agency.

Personnel

We withhold recommendation regarding personnel requirements pending analysis of a report which specifies all associated costs for installing the Local Program Cost Reporting/Data Gathering System submitted January 29, 1970.

The positions affected by this recommendation consist of (1) 20 positions located in the Bureau of Data Processing; specifically one operations research analyst, two associate DP systems analysts, one supervisor EDP, five programmers, five computer operators, and six keypunch operators; (2) three positions located in the Bureau of Management Analysis; specifically, one cost systems manager and two associate management analysts; (3) five positions in the Bureau of Patient's Accounts; specifically, one Medicare procedures specialist, two patient's estates and accounts specialists, and two clerk-typists.

A second report, dated January 29, 1970, was submitted to both the Joint Legislative Budget Committee and the Department of Finance in conformance with the provisions of the Supplementary Report of the Committee on Conference adopted by the 1969 Legislature. This second report proposes equipment and personnel needs for Phase B of the local cost reporting system.

The Phase A report outlines (in man-months) the personnel requirements for Consultant, Management Systems, Biostatistics, Patient Accounts and EDP systems and programming personnel. However, the department has established some positions administratively during the current fiscal year and other positions have been assigned to the Phase A study. We have been unable to reconcile the current status of personnel resources with the requirements for Phase B. We expect however, to reconcile all associated costs, including personnel, in the report required by the 1969 Committee on Conference, and will make a final recommendation at the time the department budget is considered by the fiscal committees.

STATE HOSPITAL COST REPORTING SYSTEM

We recommend that the department discontinue its development of a management reporting system based upon the existing design of the state hospital cost reporting system and recommend the deletion of $99,012 requested for video terminals and related expenses in the state hospitals for this purpose.

Departmental Administration—Continued

We further recommend that departmental management determine its requirements for data as it pertains to program or treatment cost effectiveness, and prepare a plan for the development of a system which would fulfill these requirements, utilizing present data processing capability.

Since 1964, the Department of Mental Hygiene has expressed the desire to develop a management information system. However, due to the lack of definitive informational needs, budgetary constraints, and the concern of the administration over the fragmented approach to statewide EDP, the department was unable to obtain funds for the implementation of such a system. On July 1, 1966, federal Medicare legislation required that state mental health programs establish the actual cost of care rendered Medicare recipients within the institutions so that federal reimbursement could be made on a more accurate basis. Since the Department of Mental Hygiene at that time billed inpatient hospital services on a per capita cost basis, i.e., total program costs divided by average patient population, it became necessary to develop a cost accounting system which would meet the federal requirements for reimbursements.

Increased Revenues to the State

The federal medicare legislation provided that payments for accrual costs of mental health treatment would be made to the states retroactive to July 1, 1966, although the deadline for accurate cost reporting was January 1, 1968. This meant that the department: (1) had 18 months in which to design and implement a cost accounting system and (2) would collect approximately $1,480,000 in additional net revenues from the federal government for the period in which the cost accounting system development occurred. It was also estimated that as a result of more accurate cost accounting systems, the state could expect during the fiscal year 1968–69 to average net revenues of $200,000 per month as a result of federal reimbursements and third party billings. The Department of General Services, by request of the Department of Mental Hygiene, conducted an independent study which substantiated departmental estimates.

Development of an Automated Cost Reporting System

In April of 1967, with the approval of the Department of Finance, a request for proposal to design and implement a state hospital cost reporting system was submitted to 19 consulting firms. By mid May 1967, the contract was awarded and the project began its design phase. Early in the design stage, it was learned that certain assumptions made by the consultant in the original proposal to identify costs by typology, or the type of treatment actually received by the patient during his stay in the mental hospitals, had to be adjusted to a cost-center concept, or categories of treatment at the ward level. The basic difference in the approaches is that the typology concept identifies treatment rendered individual patients, whereas the cost-center approach identifies broad categories of treatment as it relates to the staffing ratios for care at the ward level. Although both approaches apparently satisfied the

Departmental Administration—Continued

medicare requirements, it was determined, based on the initial fact-gathering conducted by the project team, that the cost-center approach should be implemented since this concept related more closely to actual management practice in the hospitals.

Design and implementation of the cost-reporting system proceeded with a cost-center approach and the system became operational in April 1968—four months past the medicare deadline. The primary reason for the delay was the major changes in medicare regulations made at the federal level which necessitated significant changes in the computer programs. After some initial start-up problems, the system became operational on a current basis in the spring of 1969. However, because of the lack of time for adequate system testing and documentation due largely to the pressure created by the January 1, 1968 deadline, the system's major programming logic was not able to handle all of the system's requirements and some re-programming was necessary. This was completed in October 1969 and the system is now current and fully operational.

The objectives of the system are to: (1) satify the requirements of medicare, (2) establish actual costs of patient care, (3) bill patients and third party payors equitably, and (4) provide management information to headquarter and hospital management. The system does indeed, satisfy the requirements of medicare billing, and provides patients and third-party payers with charges more closely related to actual costs. However, in our judgment there is some doubt that the system effectively establishes the actual cost of patient treatment or provides meaningful management information to headquarters and hospital administrators.

It is apparent that because the state hospital cost reporting system was designed around the requirements of federal medicare legislation, it does not fully meet the requirements of a meaningful managment information system in the Department of Mental Hygiene. We believe that the development of such a system is mandatory and should be designed with management needs expressly outlined.

Cost Center Approach

Although dentistry, X-rays, laboratory and other ancillary services are accurately recorded for each patient account, the actual treatment rendered a patient is not specifically identified by the cost reporting system. The system design provides for the establishment of cost centers, or broad categories of treatment programs, usually expressed as a ward type. "Intensive psychiatric care" and "Acute geriatric" are examples of cost centers, and as such identify a general level of treatment for all the patients treated within these cost centers. However, the system does not provide for the identification and recording, except on the patient's medical chart, of the specific method of treatment rendered the individual patient within the cost center. Table 1 is an example of a typical report produced by the state hospital cost reporting system.

Table 1
Direct Ward Nursing Costs
Hospital Summary

Cost Ctr.	Description	Div.	This month: Average number of patients	This month: Labor cost	This month: Cost per patient day	Year to date: Average number of patients	Year to date: Labor cost	Year to date: Cost per patient day
71	Medical	1	40.0	$16,373	$13.19	41.0	$95,942	$12.70
72	Surgical	1	35.0	20,370	18.77	37.9	110,882	15.89
76	Inten. nursing	1	.0	00	.00	33.4	28,755	4.66
78	Acute geriatric	1	264.8	62,327	7.59	265.5	414,927	8.49
			339.8 †	99,070	9.40	377.8 †	650,506	9.35
85	Gen. mental rtd.	2	399.0	80,381	6.49	426.5	486,543	6.19
			399.0 †	80,381	6.49	426.5 †	486,543	6.19
61	Inten. psy. care	3	119.0	23,562	6.38	32.8	45,532	7.52
63	Combine psy.	3	116.4	24,308	6.73	256.4	281,949	5.97
			235.4 †	47,870	6.55	289.2 †	327,481	6.15
61	Inten. psy. care	4	2.5	00	.00	62.1	105,302	9.20
77	Acute disturb.	4	137.2	51,145	12.02	37.5	97,978	14.19
81	Alcoholic	4	93.8	27,072	9.30	115.2	157,677	7.43
			233.5 †	78,217	10.79	214.8 †	360,957	9.12
63	Combine psy.	5	305.9	52,101	5.49	366.2	349,754	5.18
81	Alcoholic	5	.0	00	.00	35.9	41,898	6.32
			305.9 †	52,101	5.49	402.1 †	391,652	5.29
61	Inten. psy. care	6	93.2	16,879	5.83	25.7	34,421	7.27
62	Cont. psy. care	6	134.5	13,168	3.15	67.7	52,011	4.16
63	Combine psy.	6	98.2	20,098	6.59	257.5	221,861	4.68
76	Inten. nursing	6	123.1	19,417	5.08	81.2	71,878	4.80
			449.0 †	69,562	4.99	432.1 †	380,172	4.78
	Hospital total		1962.6 †	$427,202	$7.01	2142.5 †	$2,597,311	$6.58

Departmental Administration—Continued

Management Reports

The report depicted in Table 1 represents cost data. We agree that these cost data may cause an administrator to examine the reasons for the cost differences between cost-center types and differences between cost-centers of the same type in different facilities. However, the data do not provide the administrator any information as to whether the treatment rendered patients during the periods of time indicated had any effect on their mental health.

Our contention is not that the cost reporting system does not provide valuable information but that it does not provide information regarding program effectiveness. Efforts by the department to make data such as that shown in Table 1 a meaningful tool to line supervisors and administrators at the hospital level is impractical. The reports generated by the system contain data which are difficult for hospital personnel to analyze and compare, particularly those reports which display data regarding similar cost centers among the 14 state hospitals. Hospital personnel have no means to investigate the difference in cost between their own cost center and that of another hospital, since the system does not provide procedures for communication between hospital counterparts. Further, the system does not provide alternatives for corrective action at the hospital level when differences in costs are identified.

More properly, the data produced by the state cost reporting system should be analyzed by headquarters personnel for the purpose of improving administrative efficiency. The system identifies costs by which fundamental comparisons can be made between operating units. The system does not provide management with insight into whether the basic purpose of the department is being served. For program decisions, cost data must be considered within a context of program accomplishments, otherwise it can be relative only to administrative decisions.

It is for these reasons that we recommend deletion of $99,012 requested for video terminals and related expenses in the state hospitals and that departmental management determine its requirements for data as it pertains to program or treatment cost effectiveness, and prepare a plan for the development of a system which will fulfill these requirements, utilizing the present data processing capability. During the design of this system, we recommend the department consider the information needs of the agency and the Legislature and urge the inclusion of the system in an overall Human Relations Agency ADP center.

We do not anticipate that implementation of these recommendations should require the department to secure consultant services. We believe that development of such a system can be undertaken within current departmental budgetary constraints.

OFFICE OF PLANNING

We recommend the abolishment of the Office of Planning for a General Fund savings of $33,024.

The stated function of the Office of Planning is to provide assistance to the director of the department with regard to his responsibility for the long-range planning activities of the department. The office was first established as a General Fund support program in 1965–66. Pre-

Departmental Administration—Continued

viously, the federal government had provided full support for the planning activities undertaken by the department.

In 1966, the Office of Planning undertook preparation of a report specifying the optimal organization of mental health services in various regions throughout the state. By December 1968 three studies had been completed and published: "Mental Health Services in the Upper San Joaquin Valley," "Mental Health Services in the Sacramento Valley and Northeastern California" and "Services for the Mentally Retarded in the Mid San Joaquin Valley." At that time, the department indicated that two additional studies would soon be published: "Mental Health Services in the North Coast Region of California," and "Mental Health Services in the South San Joaquin Valley." In addition, it indicated that it was in the process of undertaking a study of the San Francisco and San Diego regions. Publication of these studies was expected in June 1969. At present (February 1970), however, only "Mental Health Services in the North Coast Region of California" has been completed and published. Publication of the south San Joaquin Valley, San Francisco and San Diego studies is yet to occur. It is our understanding that additional studies necessary to complete examination of the mental health service needs of the entire state is not yet significantly underway, and, indeed, may be discontinued.

The Office of Planning has not been adequately discharging its responsibilities. During the five years since its establishment, it has not formulated a usable plan which can be employed to direct the department's long-range efforts. We believe that long-range planning must be undertaken. However, we can only conclude that such planning cannot occur within the Department of Mental Hygiene.

We believe that it is appropriate to point out that our views are shared by the members of the task force appointed in 1968 by the Secretary of the Human Relations Agency to undertake an examination of the present provision of services to the mentally retarded in California. In its report, submitted to the secretary June 23, 1969, the task force noted: "As part of its responsibility, the task force was requested to review the system of organization and management within the Department of Mental Hygiene both at headquarters and at the state hospitals. The single most important observation made by the task force regarding the management of mental retardation services was the lack of overall planning direction and goals. This management deficiency permeated the entire system from the headquarters level through the medical directors of the various state hospitals, the ward physicians, down to the psychiatric technician level."

Administratively it may well have been a mistake to expect such planning to occur within the Department of Mental Hygiene. The preparation of long-range plans necessarily is directed towards the resolution of large, complex problems which are of a concern beyond this one department. Consequently, long-range planning requires interdepartmental cooperation and an interdepartmental perspective.

We are recommending, therefore, that the Office of Planning, Department of Mental Hygiene, be abolished and its functions be absorbed

Departmental Administration—Continued

into the Comprehensive Health Planning Unit located in the Department of Public Health.

The Comprehensive Health Planning Unit is the unit in state government charged with the responsibility of formulating long-range comprehensive health plans for the state—plans involving the jurisdictional responsibilities of all health agencies. It was established in 1967 to implement the provisions of PL 89-749 which is the federal Comprehensive Health Planning Act. This transfer should not preclude the Department of Mental Hygiene from undertaking operational planning for internal purposes. Such planning has in the past and at the present continues to be undertaken by separate bureaus and agencies within the department. The transfer of the long-range planning activities of the Department of Mental Hygiene to the Comprehensive Health Planning Unit simply recognizes that the Department of Mental Hygiene should not be exempt from the provisions of PL 89-749 and implementing state legislation which encourages and supports the spirit of PL 89-749.

Department of Mental Hygiene
RESEARCH AND TRAINING

Item 121 from the General Fund **Budget pages 602 and 607**

Requested 1970–71	$7,998,973
Estimated 1969–70	1,432,626
Actual 1968–69	1,233,822
Requested increase—None	
Total recommended reduction	None

GENERAL PROGRAM STATEMENT

The Department of Mental Hygiene actively encourages research into the causes underlying mental illness and mental retardation, and, in addition, develops and implements training programs to alleviate the acute and chronic shortage of trained and technical help in the field of mental health. The Division of Research and Training is responsible for coordinating and administering the research and training activities of the department.

Research is conducted at the two neuropsychiatric institutes and 10 of the 14 state hospitals by permanent research staffs. Research projects funded by the state are reviewed by a 12-member advisory group of scientists. Departmental research has assisted in the development of effective active-treatment programs at the state hospitals and underlies much of the shift away from custodial care. For fiscal year 1970–71, the department proposes to abolish 1.2 positions and add 9.2 new positions for a net increase of 8 research positions.

Training programs have been established at each of the 13 hospitals, the two neuropsychiatric institutes, the two centers for training in

Research and Training—Continued

community psychiatry, many of the local Short-Doyle programs, and in various colleges and universities within the state.

The discharge of the training responsibilities assigned to the department has been difficult due to a policy which (1) has permitted the dispersion of the administrative function pertaining to training activities, and (2) has required the budgeting of training resources to individual facilities. The budget proposes for the first time that during 1970–71 the administrative and budgeting functions relating to the department's training programs be centralized in a Bureau of Training located within the Division of Research and Training. To this end, the budget indicates a transfer of 363 authorized positions from various other bureaus and divisions within the department primarily the Neuropsychiatric institutes and the hospitals, to the newly created Bureau of Training.

ANALYSIS AND RECOMMENDATIONS

We recommend approval.

The amount proposed in this item provides support for both research and training activities. Of the $7,998,973 total, $1,162,160 is proposed for support of the department's research activities, which is an increase of $270,466 or 18.9 percent, above that estimated to be expended for research during the current fiscal year. An additional $300,000 is to be provided by the federal government to bear the cost of overhead expenses related to research activities funded by the state. The special research project activities of the department are supported by $8,318,609 in reimbursements from the federal government, the University of California and other state agencies.

The balance of the appropriation provides support for the training activities of the department in the amount of $6,836,813, which is $1,500,000 or 22 percent less than that estimated to be expended during the current fiscal year.

Department of Mental Hygiene
NEUROPSYCHIATRIC INSTITUTES

Item 122 from the General Fund **Budget page 601**

Requested 1970–71	$13,129,059
Estimated 1969–70	13,740,052
Actual 1968–69	10,407,762
Requested decrease $610,993 (4.4 percent)	
Total recommended reduction	None

GENERAL PROGRAM STATEMENT

The Department of Mental Hygiene administers two neuropsychiatric institutes. These are Langley Porter, located in San Francisco, and the Neuropsychiatric Institute, located on the campus of the University of California at Los Angeles Medical School. These two institutes are

Neuropsychiatric Institutes—Continued

charged with the responsibility of administering three major departmental programs:

(1) Research into the causes underlying mental illness and mental retardation.

(2) Training to assure sufficient manpower to implement the department's programs. Training is provided in psychiatry, psychology, social work, mental health nursing, and nursing in related mental health fields.

(3) Hospital and clinical services to the extent that they provide the necessary framework for quality research and training.

ANALYSIS AND RECOMMENDATIONS

We recommend approval.

The Department of Mental Hygiene is requesting $13,129,059 in General Fund support for the two neuropsychiatric institutes. This is a decrease of $610,993 or 4.4 percent less than that which is estimated to be expended during the current year.

The budget proposes transferring 101 authorized positions to the Bureau of Training and the addition of 25 new positions consisting of 2 clerical positions, 2 research technician positions, and 21 additional positions for the newly established mental retardation unit at the Neuropsychiatric Institute at U.C.L.A.

Department of Mental Hygiene
SERVICES TO THE MENTALLY ILL

Items 123 and 273 from the General Fund **Budget page 588**

Requested 1970–71	$197,273,137
Estimated 1969–70	187,044,963
Actual 1968–69	154,548,899
Requested increase $10,228,174 (5.5 percent)	
Total recommended reduction	$600,000

SUMMARY OF MAJOR ISSUES AND RECOMMENDATIONS

1. We recommend that the Legislature direct the Department of Mental Hygiene to begin the immediate phase out of all treatment services at Mendocino State Hospital, scheduling complete deactivation for June 30, 1971.

2. We recommend that an appropriate organization study the long-term needs for the mentally retarded in the north Central Valley and northeastern California area.

3. We recommend that the remaining 3,647 beds which will be surplus in the system June 30, 1971, be eliminated through the consolidation of individual hospitals via development of an ongoing program of facility demolition and/or sale.

Services to the Mentally Ill—Continued

We recommend that $500,000 of the $1.1 million estimated to be saved during fiscal year 1970–71 through phaseout of Mendocino State Hospital be used to fund implementation of the recommended ongoing program of demolition and/or sale.

4. We recommend that an additional $500,000 from the first year savings be transferred to Item 132 to support an increase of Community Services Division (CSD) workers to improve the followup services rendered to patients discharged from state and county mental health programs.

5. We recommend that the Standards and Rates Unit of the Human Relations Agency undertake an examination of the rates paid all community caretaker agencies providing care to the mentally ill and mentally retarded. Such a study should be directed toward the determination of the adequate level of rates for the various levels of necessary community care to insure the efficient movement of patients from the state hospitals to the community and their retention therein.

GENERAL PROGRAM STATEMENT

The Department of Mental Hygiene administers nine state hospitals for the mentally ill and, in addition, provides financial assistance to counties furnishing Short-Doyle services.

ANALYSIS AND RECOMMENDATIONS

The budget proposes a total General Fund expenditure of $197,273,137 in two items for support of services to the mentally ill, including support for state hospitals and local programs. The items are as follows:

Item 123, for support of judicially committed patients, mentally retarded patients, patients committed pursuant to the Penal Code in the hospitals for the mentally ill and those mentally ill patients whose county of residence is not participating in a local mental health program as provided in Division 5 of the Welfare and Institutions Code, Department of Mental Hygiene	$24,656,265
Item 273, for assistance to local agencies in the establishment and operation of mental health services in accordance with Division 5 of the Welfare and Institutions Code	$172,616,872

Within the total of $197,273,137, the Department of Mental Hygiene proposes $121,337,137 for support of the state hospitals for the mentally ill. This includes $17,216,145 for support of services to the mentally retarded at the hospitals for the mentally ill and $104,120,992 for support of services to the mentally ill. In addition, the department proposes $75,936,000 as part of $172,616,872 appropriated in Item 273 for state assistance to locally administered Short-Doyle programs. The General Fund support for services to the mentally ill is supplemented by an additional $31,612,358 in reimbursements.

Services to the Mentally Ill—Continued
Proposed Position Changes

We recommend approval.

On January 1, 1970, the nursing staff assigned to the hospitals for the mentally ill attained 100 percent of the standards prescribed by the California Commission on Staffing Standards. The Department of Mental Hygiene anticipates a continuing decrease in the number of mentally ill patients resident at the hospitals for the mentally ill. Consequently, the budget assumes that full conformance to the standards can be maintained through 1970–71 while at the same time 1,009.8 ward-area nursing positions can be eliminated by June 30, 1971.

The budget also proposes the elimination of 121.8 additional administrative, treatment, and support positions on the basis of the projected decline in patient workload. A total of 236 additional positions are scheduled to be transferred to other departmental programs as follows: 28 positions to the hospitals for the mentally retarded and 208 positions to the Bureau of Training.

A total 15.5 care and welfare non-nursing positions are being added to permit continuation of the 1969–70 authorized level of care for various programs. These positions include eight physician and surgeon positions, 1.5 staff psychologist positions and six psychiatric social worker positions. In addition 19.9 positions have been requested on the basis of increased workload, four of which are reimbursable on contract with the Department of Corrections.

A total of 140 nursing positions are budgeted for existing mental retardation units at the hospitals for the mentally ill. This augmentation will permit the attainment of 92.5 percent of the standard prescribed for these units. In addition 36 positions are budgeted to support continued implementation of the Napa mental retardation unit.

The net change in the number of authorized positions is a reduction of 1,156.2.

STATE HOSPITAL OVERHEAD COSTS

The development of a network of viable community mental health programs throughout the State of California has decisively altered the role of the nine hospitals for the mentally ill administered by the department. Traditionally, the state hospital system has been the largest public repository of mental health services. Currently, however, the state hospitals are functioning largely in the capacity of a backup resource for the community based Short-Doyle programs. The most visible manifestation of this change of role is the dramatic decline of the number of mentally ill patients residents at the nine state hospitals. Since 1959, the number of patients at the hospitals for the mentally ill has decreased 64 percent, from 37,489 (June 30, 1959) to 13,365 (December 4, 1969); nor does the department anticipate a cessation of hospital depopulation in the near future.

This depopulation has resulted in a very substantial increase in the number of surplus beds at the hospitals for the mentally ill. Using the October 1969 rated bed capacity as our base for computing vacancy we have prepared a table which delineates the actual and estimated

Services to the Mentally Ill—Continued

number of surplus beds on specified dates from October 23, 1969 to June 30, 1971.

The capital outlay budget indicates that for the current and budget years 2,782 beds and 2,442 beds respectively will be "deactivated" in various hospitals for the mentally ill. The budget outlines a schedule of specific buildings and wards which are to be deactivated. These beds are in addition to the 1,539 beds being eliminated by the closure of Modesto State Hospital. However, we have received no information as to how deactivation is to be accomplished or if in fact any savings will result.

We have used the department rated bed capacity of October 1969 with the exception of the elimination of 2,047 beds due to closure of Modesto State Hospital and the conversion of MI beds to MR beds at Agnews and Napa State Hospitals.

Table 1

Surplus Beds at the Hospitals for the Mentally Ill (Based upon the October 1969 rated bed capacity)

Date	*Rated bed capacity*		*Population*	*Surplus beds*
10/23/69	19,406		13,731	5,675
12/04/69	19,406		13,365	6,041
6/30/70 (Est.)	19,406		12,383	7,023
7/01/70 (Est.)	17,597	(closure of Modesto, conversion of beds, Napa)	12,383	5,214
6/30/71 (Est.)	17,359	(conversion of beds, Napa and Agnews)	10,969	6,390

Based upon data derived from the department's cost reporting system, we have estimated that the total annual overhead cost per bed at the hospitals for the mentally ill is approximately $2,500. The 6,390 unoccupied beds (June 30, 1971) at the hospitals for the mentally ill, therefore, represent an overhead expenditure of $15,975,000 for which no direct output can be attributed.

Table 2 computes the total annual equivalent overhead expenditure for unoccupied beds at the hospitals for the mentally ill for each of the dates specified.

Table 2

Overhead Expenditures for Unoccupied Beds, Hospitals for the Mentally Ill at Various Dates

Date	*Surplus beds*	*Annual expenditure rate*
10/23/69	5,675	$14,187,500
12/04/69	6,041	15,102,500
6/30/70	7,023	17,557,500
7/01/70	5,214	13,035,000
6/30/71	6,390	15,975,000

A portion of these expended overhead dollars for unoccupied beds can be justified on the basis of (1) the need to maintain a 5-percent bed vacancy (which we believe to be appropriate for large, long-term psychiatric hospitals) for purposes of managing unexpected emergen-

Services to the Mentally Ill—Continued

cies and making adequate provision for the remodeling and conversion of beds, and (2) the fact that certain of the overhead costs included in the total overhead cost of maintaining a hospital bed are attributable to activities which are basically unrelated to hospital capacity (e.g., research). However, to fund the remaining overhead cost of supporting unoccupied beds appears to be an unproductive use of state dollars.

Reduction of bed capacity may be undertaken in three different ways: (1) closure of hospitals, (2) consolidation of individual hospitals in conjunction with an ongoing program to demolish or sell outright vacated square footage and (3) conversion of patient-occupied wards to other usage. Full realizable savings requires closure of hospitals. A partial, but drastically reduced savings may be realized through consolidation of individual hospitals in conjunction with an ongoing program to demolish or sell outright vacated buildings. Negligible, if any, savings can be realized through conversion of patient-occupied wards to other usage.

Table 3 compares potential savings to be realized through implementation of each of these methods to effect reduction in the number of surplus beds which are estimated will be in existence June 30, 1971. Computation of the dollar figures included in Table 3 is based upon the estimated savings resulting from closure of Modesto State Hospital and data derived from the department's cost reporting system. The number of surplus beds used as a base in Table 3 is the June 30, 1971 figure used in Table 2 minus 550 beds to provide for the necessary 5-percent vacancy factor.

Table 3

Comparison of Potential Savings to Be Realized Through Implementation of Various Methods of Bed Reduction

Method of reduction	*Number of surplus beds to be reduced by June 30, 1971 (based upon October 1969 rated bed capacity)*	*Saving per bed*	*Total potential savings*
Closure of hospitals	5,840	$2,250 (based upon closure of Modesto State Hospital)	$13,140,000
Consolidation of hospitals via demolition and/or sale of surplus capacity	5,840	$425	$2,482,000
Conversion of bed capacity to other usage	5,840	Negligible	Negligible

Based upon our analysis of methods to reduce surplus bed capacity and our computation of potential savings to be realized thereby, we are making the following recommendations which we believe will assure the state of the fullest possible saving of General Fund dollars consistent with the provision of a high level of medical and psychiatric care.

Services to the Mentally Ill—Continued
Mendocino State Hospital

We recommend that the Legislature direct the Department of Mental Hygiene to begin the immediate phaseout of all treatment services at Mendocino State Hospital, scheduling complete deactivation for June 30, 1971.

Currently, Mendocino, Agnews and Napa State Hospitals provide psychiatric, alcoholic and drug-abuse services to residents of the north coast region of California (Mendocino, Colusa, Del Norte, Glenn, Humboldt, Lake, Shasta, Siskiyou, Sonoma, Tehama, and Trinity Counties), the north San Francisco Bay region (Napa, Alameda-Oakland and north, Contra Costa, Marin, San Francisco and Solano Counties) and the south San Francisco Bay region (Alameda—south of Oakland, Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz). In the past years, the demand for mental health programs of the counties which compose the north coast, and the north and south San Francisco Bay regions required the services of three state hospitals for the mentally ill. More recently, however, the demand of these counties has diminished to a point at which the services of only two state hospitals are neeeded.

Specifically, we estimate that by the end of the 1969–70 fiscal year there will be 2,209 excess beds (October 1969 rated bed capacity minus 270 M.I. beds converted to M.R. beds) at the three hospitals: 343 at Mendocino, 615 at Napa and 1.215 at Agnews. Our estimates for the end of the 1970–71 fiscal year indicate that there will be 2,654 excess beds (October 1969 rated bed capacity minus 508 M.I. beds converted to M.R. beds) at the three hospitals: 516 at Mendocino, 840 at Napa and 1,298 at Agnews. Table 4 indicates the excess bed capacity at Mendocino, Napa and Agnews State Hospitals for June 30, 1969, June 30, 1970 and June 30, 1971.

Table 4
Excess Bed Capacity at Mendocino, Napa, and Agnews State Hospitals

	June 30, 1969	*June 30, 1970*	*June 30, 1971*
Agnews			
Population	1,416	1,204	1,025
Bed Capacity	2,455	2,455	2,323
EXCESS	1,009	1,251	1,298
Napa			
Population	2,707	2,152	1,821
Bed capacity	3,037	2,767	2,661
EXCESS	332	615	840
Mendocino			
Population	1,268	1,168	995
Bed capacity	1,511	1,511	1,511
EXCESS	243	343	516
TOTAL EXCESS	1,584	2,209	2,654

It is clear that by the end of the 1970–71 fiscal year, Napa and Agnews State Hospitals will easily be able to absorb the entire Mendocino patient workload which the department estimates will be 995.

The termination of state-provided mental health services at Mendocino State Hospital is further justified by the fact that the distance

Services to the Mentally Ill—Continued

by automobile to Mendocino State Hospital from all but four of the north coast and north San Francisco Bay counties—Del Norte, Humboldt, Mendocino and Lake—is greater than it is to Napa State Hospital. Table 5 compares the distance traveled by automobile to Napa and Mendocino State Hospitals from all of the counties which comprise the north coast and north San Francisco Bay region.

Table 5

Distance by Automobile From the North Coast and North San Francisco Bay Counties to Napa and Mendocino State Hospitals

County	*(Miles to) Napa State Hospital*	*(Miles to) Mendocino State Hospital*
Mendocino [1]	100	0
Lake [1]	93	38
Humboldt [1]	279	179
Del Norte [1]	373	273
San Francisco [2]	71	144
Marin [2]	37	105
Siskiyou	303	309
Trinity	250	256
Shasta	197	203
Tehama	163	169
Glenn	116	122
Colusa	99	105
Sonoma	42	65
Alameda	54	144
Contra Costa	44	144
Napa	0	100
Solano	25	123

[1] Only these counties are closer to Mendocino State Hospital than to Napa State Hospital.
[2] Mendocino State Hospital provides alcoholic and drug-abuse services to residents of San Francisco and Marin Counties; Napa State Hospital, although providing drug-abuse and alcoholic services to residents of Alameda, Contra Costa, Napa and Solano Counties, provides only general psychiatric services to residents of San Francisco and Marin Counties.

Bed capacity at Napa State Hospital sufficient to permit the absorption of the entire estimated June 30, 1971 Mendocino State Hospital patient workload can be secured by assigning all Alameda patients to Agnews State Hospital rather than to Napa State Hospital. Not only will such a reassignment permit Napa State Hospital to absorb the entire Mendocino State Hospital patient workload, it will, in addition, terminate the dubious departmental regulation requiring the residents of the northern and southern halves of Alameda County to secure provision of mental health services from two different hospitals. Alameda County is approximately eight miles closer to Agnews State Hospital than it is to Napa State Hospital.

We estimate that the assignment to Agnews State Hospital of all Alameda patients will free an additional 350 to 400 beds at Napa. Table 6 indicates what we estimate will be the June 30, 1971 patient and excess bed distribution among the three hospitals resulting from implementation of our recommendation. It should be noted that even with the closure of Mendocino Hospital there would still be an excess bed capacity of 1,143 in the North Coast and the North and South San Francisco Bay area.

Services to the Mentally Ill—Continued

Table 6

Estimated Patient Workload and Excess Bed Distribution, Napa, Agnews, and Mendocino State Hospitals June 30, 1971

Hospital	*Population*	*Capacity*	*Excess*
Napa	2,466	2,661	195
Agnews	1,375	2,323	948
Mendocino	0	0	0
TOTAL	3,841	4,984	1,143

The most visible manifestation of the overlap and duplication of services which characterizes the state administered mental health system for the North Coast and the North and South San Francisco Bay Counties is the bifurcated provision of mental health services to residents of San Francisco and Marin Counties. At present, residents of San Francisco and Marin Counties secure provision of mental health services from not one hospital, but two. Regular state hospital psychiatric services are provided by Napa State Hospital, located 71 miles from San Francisco County and 37 miles from Marin County, while alcoholic and drug abuse services are provided by Mendocino State Hospital, located 144 miles from San Francisco County and 105 miles from Marin County.

There is much evidence to suggest that the continued referral of San Francisco and Marin County residents to Mendocino State Hospital is required merely to justify the continued existence of that hospital. Table 7 compares the number of admissions from San Francisco and Marin Counties to Mendocino State Hospital with the number of admissions from all other counties to Mendocino State Hospital:

Table 7

Comparison of San Francisco and Marin Admissions to Mendocino State Hospital with Admissions to Mendocino State Hospital from All Other Counties

(1969) Month	*Total admissions*	*San Francisco admissions*	*Marin admissions*	*San Francisco and Marin admissions combined*	*Other county admissions*
July	360	180 (50.0%)	19 (5.3%)	199 (55.3%)	160 (44.7%)
August	495	297 (60.0%)	17 (3.4%)	314 (63.4%)	181 (36.6%)
September	486	290 (59.7%)	21 (4.3%)	311 (64.0%)	175 (36.0%)
October	667	434 (65.1%)	19 (2.8%)	453 (67.9%)	214 (32.1%)
November	600	355 (59.2%)	27 (4.5%)	382 (63.7%)	218 (36.3%)

A sufficient number of excess beds are currently (October 31, 1969) available at Napa State Hospital to obviate the need for recourse to Mendocino. Table 8 compares the number of San Francisco and Marin County patients resident at Mendocino State Hospital with the number of excess beds at Napa State Hospital, October 31, 1969, June 30, 1970 (est.), June 30, 1971 (est.).

The transfer to Napa State Hospital of the special Mendocino State Hospital alcoholic and drug-abuse programs for residents of San Francisco and Marin Counties will not require the establishment at Napa State Hospital of altogether new and untried programs. The Department of Mental Hygiene has already authorized and established at Napa State Hospital special alcoholic and drug-abuse programs for

Services to the Mentally Ill—Continued

Table 8

Comparison of the Number of San Francisco and Marin Patients at Mendocino State Hospital With the Number of Excess Beds at Napa State Hospital

Date	San Francisco and Marin County patients, Mendocino State Hospital	Excess beds Napa State Hospital
October 31, 1969 [1]	552 (actual)	763
June 30, 1970	550 (est.)	615
June 30, 1971	444 (est.)	840

[1] This date is the only date subsequent to July 1, 1969 for which the department can provide an actual county breakdown of the resident population at Mendocino State Hospital.

residents of the counties which presently are included in the Napa State Hospital service area. The provision at Napa State Hospital of alcoholic and drug-abuse services to residents of San Francisco and Marin Counties will, therefore, only require the expansion of already established and proven programs.

We believe that the continued operation of Mendocino State Hospital as a state responsibility will inevitably produce wasteful overlap and duplication of services, resulting in unnecessary and unproductive overhead expenditures. Absorption of the Mendocino State Hospital program by Napa and Agnews State Hospitals will help to alleviate this misuse of state dollars. We estimate that the General Fund dollars saved through implementation of this recommendation will be approximately $1.1 million during fiscal year 1970–71 and approximately $3.5 million annually thereafter.

DeWitt State Hospital

DeWitt State Hospital, like Modesto State Hospital, which is currently being deactivated by the department, was built by the Army during World War II and was acquired by the Department of Mental Hygiene in 1947 to relieve the acute overcrowding which then prevailed throughout the state hospital system. DeWitt, like Modesto, consists of long, narrow, one-story barracks-type buildings. Floors, interior walls, partitions, doors and window frames are constructed of wood and dry wall boards and, although the hospital is protected by an automatic sprinkler system, the danger of fire remains a source of serious concern to the staff. Of the 39 ward buildings, 28 are approximately 300 feet long by 30 feet wide. The remaining 11 are approximately 150 feet long by 30 feet wide. These buildings are constructed parallel to one another five columns, connected by closed corridors, the total length of which extends for more than a mile.

The present demand of the counties served by DeWitt State Hospital is small and has been declining as illustrated in Table 9.

Page 585 of the budget shows the mentally ill population declining from an actual population on June 30, 1969, of 644 to an estimated June 30, 1971, population of 300. It is our understanding that the department plans to phase out and deactive DeWitt after July 1, 1971.

If such deactivation occurs the number of excess beds at Stockton State Hospital on June 30, 1971, estimated to be 326, should be sufficient to permit the transfer to Stockton of all northeastern California

Services to the Mentally Ill—Continued

Table 9

Admissions of Mentally Ill to DeWitt State Hospital by County for July, August, and September 1969

County	*July*	*August*	*September*
Butte	2	4	2
El Dorado	6	4	1
Lassen	2	3	2
Modoc	0	0	0
Nevada	5	17	14
Placer	40	21	27
Plumas	0	1	0
Sacramento	48	39	29
Sierra	0	0	0
Sutter	7	5	8
Yolo	4	10	8
Yuba	5	7	6
Totals	119	111	97

patients resident at DeWitt on June 30, 1971. Based upon the experience gained through closure of Modesto State Hospital, many of the patients currently resident at DeWitt will be placed in community facilities.

We estimate that the ultimate phaseout of all treatment services for the mentally ill at DeWitt will generate a first-year savings of approximately $500,000 and an annual full-year savings of approximately $1.5 million.

Mental Retardation Services at DeWitt State Hospital

DeWitt State Hospital provides services not only to persons afflicted by mental illness, but to approximately 780 persons suffering from mental retardation as well. While there is excess bed capacity at the hospitals for the mentally ill to permit the transfer of the mentally ill patients now resident at DeWitt State Hospital to other state hospitals for the mentally ill, there is at present no excess bed capacity at the hospitals for the mentally retarded to permit a similar transfer of the mentally retarded patients currently resident at DeWitt to other hospitals for the mentally retarded. There are currently (December 4, 1969) 1,419 more patients at the hospitals for the mentally retarded than rated bed capacity sanctions.

However, the Department of Mental Hygiene estimates that a continued decline of the number of patients resident at the hospitals for the mentally retarded in conjunction with a specified increase in rated bed capacity will result in an excess of 610 beds at the hospitals for the mentally retarded by June 30, 1971. Table 10 depicts the development of excess bed capacity at the hospitals for the mentally retarded, June 30, 1969, to June 30, 1971.

If the department plans the ultimate phaseout of DeWitt, careful consideration should be given to the placement of the mentally retarded patients.

We recommend that an appropriate organization such as the California Medical Association or the California Council for Retarded Children study the long-term needs for the mentally retarded of the

Services to the Mentally Ill—Continued

Table 10

Development of Excess Bed Capacity at the Hospitals for the Mentally Retarded, June 30, 1969, to June 30, 1971

Date	Population	Rated bed capacity		Excess beds
June 30, 1969	12,582	10,523		—2,059
June 30, 1970	11,421 [1]	10,793	(270 beds added at the Napa MR unit)	—628
June 30, 1971	10,421 [1]	11,031	(132 beds and 106 beds added at the Agnews and Napa MR units respectively)	+610

[1] The major portion of this decline reflects efforts undertaken by the Community Services Division of the Department of Social Welfare to place a total of 2,800 patients from the hospitals for the mentally retarded during the two-year period extending from June 30, 1969, to June 30, 1971.

north central valley and northeastern California area. With the development of a statewide system of mental retardation regional diagnostic centers, many mentally retarded who heretofore have been admitted into the state hospitals are currently being placed in community facilities. However, the state hospitals are continuing to treat the severely retarded, multiply handicapped who are considered inappropriate for community placement. Such study should consider the construction of a new hospital at the present DeWitt site or the use of the Weimar Tuberculosis Center as a treatment facility for the provision of mental retardation services.

The phaseout of all services for mentally ill patients at DeWitt State Hospital would give recognition to the fact that the justification which originally prompted its acquisition no longer exists. The termination of the DeWitt mental retardation program will accord recognition to and secure implementation of a major recommendation contained in an *Action Program for the Mentally Retarded in California,* a report submitted June 23, 1969, to the Secretary of the Human Relations Agency by a task force appointed by the secretary for the purpose of assessing the present provision of services to the mentally retarded of California and making recommendations for "needed organizational and program adjustments." That major recommendation is as follows: "We strongly urge that DeWitt State Hospital be phased out as a facility for the mentally retarded."

The termination of the Mendocino program for the mentally ill will result in the elimination of 1,511 of the 5,840 beds for the mentally ill which will be surplus June 30, 1971. We estimate that this will generate an annual full-year savings of approximately $3.4 million. The ultimate phaseout of DeWitt State Hospital would generate an additional annual full-year savings of $3.1 million.

We recommend that the remaining 3,647 beds be eliminated through the reduction of bed capacity at individual hospitals via development of an ongoing program of demolition and/or sale. The eventual full-year savings resulting from implementation of this recommendation will be approximately $1.5 million.

We recommend that $500,000 of the $1.1 million estimated to be saved during fiscal year 1970–71 through phaseout of Mendocino State

Services to the Mentally Ill—Continued

Hospital be used to fund implementation of the recommended ongoing program of demolition and/or sale.

Table 11 summarizes the 1970–71 savings and the eventual full-year savings to be secured through implementation of our recommendations regarding overhead expenditures for unoccupied beds:

Table 11
Savings to Be Secured by Implementation of Recommendations Regarding Surplus Bed Overhead

Beds	*Method of reduction*	*1970–71 savings*	*Full-year savings*
(1) 1,511 beds, Mendocino State Hospital	Closure	+$1.1 million	$3.4 million
(2) 1,381 beds, De Witt State Hospital (682 M.I. beds and 714 M.R. beds)	Closure	0	$3.1 million
(3) 3,647 beds at remaining hospitals	Demolition or sale	0	$1.5 million
Initial cost of demolition		500,000	
TOTAL SAVINGS		$600,000	$8 million

We recommend further that an additional $500,000 from the first-year savings be transferred to Item 132 to support an increase of 37 CSD workers to improve the followup services rendered to patients discharged from state and county mental health programs.

COMMUNITY MENTAL HEALTH PROGRAMS

We recommend that the Standards and Rates Unit of the Human Relations Agency undertake an examination of the rates paid all community caretaker agencies providing care to the mentally ill and mentally retarded. Such a study should be directed toward the determination of the adequate level of rates for the various levels of necessary care to insure the efficient movement and retention of patients from the state hospitals to the community.

History

Prior to 1957, mental health services were provided to citizens of California primarily through the operation of 10 state hospitals. However, in 1957 the California State Legislature approved the Community Mental Health Services (Short-Doyle) Act which provided for the establishment of community-based mental health service, the costs to be shared equally by the state and the counties. The rapid expansion of community-based mental health services is shown in Table 12.

In 1963, the Legislature provided further stimulation for expansion of community-based health services by revising the 50 percent state/50 percent county Short-Doyle sharing formula to a 75 percent state/25 percent county basis for new or expanded programs.

The Lanterman-Petris-Short Act (Chapter 1667, Statutes of 1967), together with its funding procedure (Chapter 989, Statutes of 1968), became effective July 1, 1969, and has encouraged further expansion of community-based Short-Doyle services. This legislation altered the

Services to the Mentally Ill—Continued

Table 12

Expansion of Short-Doyle Services, 1962–63 to 1968–69—By Admissions

Year	*24-Hour hospitalization*	*Partial hospitalization*	*Outpatient services*
1962–63	9,763	548	22,848
1963–64	22,562	941	32,869
1964–65	37,224	961	49,355
1965–66	39,681	1,480	71,050
1966–67	41,601	1,672	81,294
1967–68	42,349	2,902	93,824
1968–69	41,264	10,518	104,836

commitment process for the mentally ill and provided greater integration of state hospital and Short-Doyle programs. In addition, it readjusted the reimbursement formula for Short-Doyle programs to a 90 percent state/10 percent county cost-sharing basis.

Federal Legislation

The transfer of mental health services from state hospitals to community settings has been stimulated by federal legislation as well as state legislation. The federal Community Mental Health Centers Construction Act of 1963 authorizes the allocation of federal funds to participating states to help support the construction of facilities for the provision of community-based mental health services. This act specifically provides for the development of a mental health services delivery system which will provide alternatives for care to mentally ill patients at state hospitals. It is the intention of the Community Mental Health Centers Act to encourage the treatment of mentally ill persons as close to home as possible, in a manner which minimizes the disruption of family, friend and work relationships.

In 1965, further federal legislation was enacted which amended the Community Mental Health Centers Construction Act to provide for federal grants to help support the initial staffing of community mental health centers. The stated intention of the amendments of 1965 is the provision of assistance for the establishment and initial operation of community mental health centers which provide all or part of a comprehensive community mental health program.

In addition to the Community Mental Health Centers Construction Act the federal government has enacted other legislation which, although not addressing itself explicitly to the problem of mental illness, has stimulated the development of community based mental health programs. The most important of such legislation is the Social Security Amendments of 1965, Titles 18 and 19. Under Title 18 (Medicare), which provides hospital insurance for persons 65 and over, limited coverage is provided for the cost of hospitalizing elderly mentally ill patients in community general hospitals. There is also coverage for nursing care and home health care visits. For treatment in a state mental hospital, there is a limit of 190 days of coverage during the lifetime of a patient.

Under Title 19 (Medi-Cal), federal matching of state funds is permitted for the provision of medical care to mentally ill patients of all ages in community general hospitals or as outpatients in community

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mental health programs who are linked to categorical public assistance programs. However, Title 19 reimbursements do not extend to a patient in a state mental hospital unless that patient is 65 years or older. The budget anticipates a revenue of approximately $22.5 million in federal funds as a result of Titles 18 and 19 coverage of patients in the state mental hospitals. Most of the federal income will result from Medi-Cal coverage for mentally retarded patients.

Professional Opinion

Carefully considered professional opinion underlies the state and federal legislation encouraging the transfer of mental health programs from state hospitals to community settings. Various mental health professionals affirm that two factors play a crucial role in assuring the successful recovery of a person afflicted by mental illness: (1) the maintenance of the patient's relationships with family, friends and colleagues, and (2) the continuity of treatment services rendered to him. Both of these factors are most easily incorporated into a treatment program established at the local level.

Community Treatment of the Chronic and Severely Mentally Ill

Chronic patients, formerly thought to be amenable to treatment only at state hospitals, are currently being treated within community settings.

A demonstration project undertaken at Mendocino State Hospital illustrates the feasibility of shifting the care of the chronic mentally ill from state hospitals to community settings. A total of 309 "hard-to-place" chronic patients were randomly selected to be processed through a carefully devised hospital preleave program. These patients were deteriorated, unmotivated, lacking in community ties, indigent and dependent upon institutional care. In adition, they were relatively uncommunicative and unconcerned regarding dress, manners, and hygiene. Of these 291 patients (94 percent) completed the program and were subsequently placed, and of these only 18 were returned to the hospital as "failures." Thus, the total program success was 88 percent. Similar programs have been developed and implemented at other hospitals throughout the state. These programs attest to the declining need for recourse to long-term hospitalization for treatment of even the chronic and severely mentally ill.

State hospitalization will still be required in the future for treatment of very difficult patients and dangerous psychotics. However, state hospitals are no longer the only or even the primary treatment resource for persons suffering from mental illness. As a result, a continuing decline of the number of mentally ill patients resident at the state hospitals is anticipated.

A Typical Community Mental Health Program

Community mental health programs vary extensively within the state. However, a common theme underlies each. Essentially, a community mental health program incorporates two basic elements which function at three distinct levels. The two elements are: (1) Short-Doyle

Services to the Mentally Ill—Continued

services consisting primarily of local in-hospital services, out-patient services and, occasionally, partial hospitalization services; and (2) a base of community support consisting of an array of out-of-hospital living facilities which provide suitable "homes" for persons suffering from varying degrees of mental illness. This second element is usually organized by staff of the Community Services Division (CSD) of the State Department of Social Welfare, the local welfare department, the State Department of Public Health, and other concerned local public and private agencies.

Three Levels of a Community Program

The first level of function is a crisis level. At this level, the Short-Doyle element provides intensive in-hospital psychiatric services. The purpose of the intensive in-hospital psychiatric services provided by the Short-Doyle element at this level is to return the person being treated to the community as quickly as possible. Failing this, he is transferred to a long-term psychiatric program established usually at a state hospital.

At the second level of functioning, the Short-Doyle element is less predominant but still crucial. At this level, Short-Doyle out-patient services or partial hospitalization services are rendered. The person being treated is not removed from his out-of-hospital living facility, but relies heavily upon the Short-Doyle services.

At the third level of functioning, the Short-Doyle element provides no services and the community support element is completely predominant. The out-of-hospital facility (e.g., a boarding home, family care home, skilled nursing home, etc.) provides the necessary support to maintain the equilibrium of the mentally ill person. Usually, staff of the Community Services Division, the local welfare department, and other local agencies are available to provide regular support (e.g., counseling, consultation) for both the mentally ill person and the caretaker responsible for the "home" in which the mentally ill person has been placed. At all times, the Short-Doyle element is ready to provide services if required.

Normally, persons released from state hospital in-patient programs into a community mental health program are released into the third level of functioning. Their condition is usually sufficiently stabilized so as not to require provision of any of the Short-Doyle services. Typically, the out-of-hospital living facility into which the discharged patients are placed are located by CSD workers. The placement facilities into which CSD workers place hospital patients are usually licensed by one of the following departments: The Department of Public Health, the Department of Social Welfare, the Department of Mental Hygiene, and county social welfare departments. The CSD workers attempt to fit the placements to the needs of the patients and in addition, often with the assistance of public health nurses, attempt to assure the maintenance of standards of care at the facilities into which former state hospital patients are placed. In all instances, mental health services provided by community Short-Doyle programs are available to the patients when required.

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Department of Mental Hygiene Hospital Programs

The following discussion of major state hospital treatment programs is intended to illustrate the relationship between community mental health programs and the state hospitals. In addition, it provides a base of information which will allow identification of (1) the fiscal and treatment benefits which will accrue through development of a harmonious relationship between community and state hospital programs, and (2) the existence of certain inefficiencies which are currently hindering full development of such a relationship.

Since 1959 the number of mentally ill patients resident at state hospitals for the mentally ill has declined 64.5 percent, from 37,489 (June 30, 1959) to 13,303 (January 29, 1970). Table 13 illustrates this trend.

Table 13

Decline in the Number of Patients Resident at the State Hospitals for the Mentally Ill

Year (Last Wednesday of fiscal year)	*In-patient population*	*Decrease from previous year*	*Percent decrease from previous year*
June 1959	36,795	--	--
June 1960	36,084	711	1.9%
June 1961	35,310	774	2.1%
June 1962	34,919	391	1.1%
June 1963	34,087	832	2.4%
June 1964	31,831	2,256	6.6%
June 1965	29,271	2,560	8.0%
June 1966	25,710	3,561	12.2%
June 1967	21,380	4,330	16.8%
June 1968	18,326	3,054	14.3%
June 1969	15,771	2,555	13.9%
January 29, 1970	13,303	2,468 (7 mos.)	15.6% (7 mos.)
June 1970 (est.)	12,383	3,388	21.5%

Clearly, the depopulation of the state hospitals does not indicate that mental illness is any less prevalent today than it was 10 years ago. It indicates only that a new system of delivering mental health services has evolved.

Within the hospitals administered by the Department of Mental Hygiene there are 12 major identifiable treatment programs for the mentally ill and the mentally retarded.

1. Psychiatric Children

This program provides intensive care to patients under 18 years of age. The nursing staff ratio assigned the program is higher than that of any of the other programs provided at the state hospitals.

2. Psychiatric Adolescents

Patients assigned to this program range in age from 15 to 18. The program is designed to provide intensive care and is, therefore, assigned a high nursing staff ratio.

3. Intensive Psychiatric Care

Patients assigned to this program are provided intensive psychiatric services for a relatively short period of time (generally 60 to 90 days or less). It is expected that patients assigned to this program will respond quickly to treatment and return to the community rapidly. Un-

Services to the Mentally Ill—Continued

responsive patients are generally transferred to continuing psychiatric care programs. Staffing is generally high.

4. Combined Psychiatric Care

This program provides services to both intensive care and long-term patients. Generally, it is found in hospitals administered by physicians who believe it to be detrimental to separate intensive care and long-term patients. Staffing is generally moderate.

5. Continuing Psychiatric Care

Patients assigned to this program are generally unresponsive patients who are expected to remain in the hospital for a considerable period of time. Patients assigned to this program are usually referred from intensive psychiatric care programs. Staffing is generally low.

6. Geriatric

Patients assigned to this program are over 65 and consequently require a higher nursing staff ratio to treat the generally deteriorated psysical condition associated with old age.

7. Infirm Geriatric

Patients assigned to this program are extremely disabled aged patients who require a high ratio of nursing staff.

8. Alcoholic

Patients assigned to this program are persons whose psychiatric and physical condition is primarily associated with the use of alcohol. Staffing is generally low.

9. Intensive Treatment, Mentally Retarded Children

Children assigned to this program are generally 10 years old or younger, severely mentally retarded, but ambulatory and quite active physically. The nursing staff ratio designated for this program is generally high.

10. General Mental Retardation

Patients assigned to this program vary considerably in degree of mental retardation. Generally, these patients are ambulatory and do not require a high nursing staff ratio.

11. Intensive Treatment—Mentally Retarded

Patients assigned to this program are generally nonambulatory and severely retarded.

12. Infirm—Mentally Retarded

Patients assigned to this ward suffer from severe physical handicaps and severe mental retardation. The nursing staff ratio designated for this program is generally high.

CHILDREN AND ADOLESCENT PROGRAMS: FURTHER STUDY

Currently the children and adolescent programs at the state hospitals and in the communities are of particular concern to mental health professionals. A concerted effort to reduce the incidence of mental illness among citizens of California logically requires that the development of this incapacitating disease be diagnosed and treated in its earliest stages. The longer the disease remains undiagnosed and untreated the less likelihood there is of achieving a complete recovery.

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Therefore, it is most appropriate to single out children and adolescent programs for special study.

The number of patients under 18 years of age resident at the state hospitals for the mentally ill has steadily increased during the last 10 years. In June 1960, there were 461 patients under the age of 18 at the hospitals for the mentally ill. In June of 1969, the number of children and adolescents at the hospitals for the mentally ill had increased to 818, an increase of 77.4 percent. During the same period, the number of mentally ill patients, ages 18 to 64, decreased 50.4 percent and the number of mentally ill patients 65 years and older decreased 75 percent. Table 14 compares the trends of these three age groups:

Table 14

In-Patient Population * for the Hospitals for the Mentally Ill
Fiscal Years 1960–1969

Fiscal year ending June 30	*Total number of patients* *	*Age*			
		0–17	*18–64*	*65 +*	*Unknown*
1960	36,556	461	24,627	11,437	31
1961	36,048	524	24,106	11,393	25
1962	35,743	586	24,013	10,984	160
1963	34,955	645	23,335	10,826	149
1964	32,622	724	22,290	9,558	50
1965	30,193	751	20,990	8,352	100
1966	26,567	734	18,878	6,877	78
1967	21,966	720	16,190	4,998	58
1968	18,831	717	14,199	3,897	18
1969	16,116	818	12,404	2,862	32
		up 77.4%	down 50.4%	down 75%	

* Including patients absent on leave less than eight days.

Children's Programs, State Hospitals

The Department of Mental Hygiene has established at Napa and Camarillo State Hospitals separately budgeted programs for the provision of psychiatric services to mentally ill children.

The Napa State Hospital Children's Program

This program provides psychiatric services for children ranging in age from five to 16 and is designed to serve residents of the northern 49 counties of California. It is limited to a maximum of 167 patients. Approximately 60 percent of the children currently being treated are psychotic with diagnoses of schizophrenia and brain damage. The remainder suffer from character disorders. Approximately 13 percent of the total number of children served by the program are nonverbal and 15 percent are incontinent.

The staff assigned to the program consists of one assistant superintendent, nine staff psychiatrists, six staff psychologists, 11 teachers, one occupational therapist, one recreation therapist, 11 psychiatric social workers, and 130 nursing personnel.

The Camarillo State Hospital Children's Program

This program provides psychiatric services for children ranging in age from four to 16 and is designed to serve residents of the nine southern California counties. The program is limited to a maximum of 170

Services to the Mentally Ill—Continued

patients. Approximately 70 percent of the children served by this program are psychotic, with diagnoses of autism and childhood schizophrenia. The remaining 30 percent suffer from character disorders. Over one-half of the children in the program are nonverbal and approximately 20 percent are incontinent. The staff assigned to the program consists of one assistant superintendent, five staff psychiatrists, five staff psychologists, five psychiatric social workers, seven elementary education teachers, one recreation therapist, one music therapist, and 117 nursing personnel.

There are no children's programs established at the other eight hospitals for the mentally ill. Children under 15 admitted to these hospitals are admitted for short stays only. If further treatment requiring the provision of state hospital services is required, the patient is transferred to either Camarillo or Napa State Hospitals.

Table 15 identifies by hospital the number of patients under 15 resident at the hospitals for the mentally ill as of November 30, 1969.

Table 15

Number of Patients Under 15 Resident at the Hospitals for the Mentally Ill, November 30, 1969

Hospital	*Number of patients*	
Agnews	0	
Atascadero	0	
Camarillo	171	
DeWitt	0	
Mendocino	14	(admitted to adolescent program)
Metropolitan	0	
Modesto	0	
Napa	100	
Patton	1	(under four years of age)
Stockton	0	
Total	272	

Adolescent Programs, State Hospitals

Separate adolescent programs have been established at two of the state hospitals for the mentally ill, Napa and Camarillo.

Napa State Hospital

The program at Napa was authorized by the Legislature in 1966 and established in January 1967. It is limited to a maximum of 25 patients and is designed to provide day-care services only. The patients admitted to the program reside in selected adult wards. The staff assigned to the program consists of one senior psychiatrist, one staff psychologist, one psychiatric social worker, two recreation therapists, and two teachers.

Camarillo State Hospital

The Lewis R. Nash Adolescent Center was established in 1966 and is designed to provide 24-hour services to a maximum of 172 patients. Approximately 40 percent of the patients are psychotic; the remaining 60 percent suffer from severe character disorders. The staff assigned to the program consists of four senior psychiatrists, three staff psychologists, four psychiatric social workers, five elementary education

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teachers, five secondary education teachers, two recreation therapists, and 85 nursing personnel.

Adolescent programs have been established at DeWitt and Mendocino State Hospitals. However, these programs have not been funded separately and specific information regarding patient composition and staffing is not available.

Adolescent patients admitted to Agnews, Atascadero, Metropolitan, Patton and Stockton State Hospitals are assigned to adult wards. Table 16 identifies by hospital the number of adolescent patients (15 to 17 years of age) at the hospitals for the mentally ill, November 30, 1969.

Table 16
Number of Adolescent Patients at the Hospitals for the Mentally Ill, November 30, 1969

Hospitals	*Number of patients*	
Agnews	30	
Atascadero	6	
Camarillo	135	
DeWitt	15	
Mendocino	51	(many of whom have been admitted to the Mendocino drug program)
Metropolitan	34	
Modesto	3	
Napa	87	
Patton	33	
Stockton	5	
Total	399	

Cost of Children's and Adolescents' Programs

The uniform billing rates established by the Department of Mental Hygiene for the children's and adolescents' programs are higher than are the billing rates of any of the other programs administered by the department. Table 17 compares the billing rate for children's and adolescents' programs with those of various other hospital programs. All costs are included.

Table 17
Cost Comparison of Children's and Adolescents' Programs With Other State Hospital Programs

Program	*Average monthly cost*	*Percent comparsion with the Psychiatric Children's Program*
Psychiatric children	$1,056.00	--
Psychiatric adolescent	970.50	92%
Acute geriatric	700.50	66%
Intensive psychiatric	684.00	65%
Acute disturbed	664.50	63%
Intensive nursing geriatric	591.00	56%
Continuing psychiatric	580.50	55%
Combined psychiatric	567.00	54%
Alcoholic	534.00	51%

The high cost of children and adolescent programs is largely attributable to the high nursing staff ratio assigned to these programs. The staffing standards for the children's and adolescents' programs are richer than those of all other programs within the state hospital system.

Services to the Mentally Ill—Continued

Table 18 compares the actual on-duty shift ratios of children's programs with various other programs at the hospitals for the mentally ill. The ratios included in this table have been compiled from ward visits.

Table 18

Nursing Staff Ratios for Various Programs at Selected Hospitals for the Mentally Ill, A.M. Shifts

Program	*Ratio Staff: Patients*	*Hospital*	*Unit*	*Date*
(1) Children	1:3.7	Napa	M-3	9-10-69
(2) Children	1:4.6	Napa	M-4	9-10-69
(3) Children	1:4.5	Napa	M-5	9-10-69
(4) Children	1:5.4	Camarillo	565	10-8-69
(5) Combined Psychiatric	1:24.5	Camarillo	116	10-8-69
(6) Intensive Psychiatric	1:11	Mendocino	302	10-16-69
(7) Intensive Psychiatric	1:8	Mendocino	327	10-16-69
(8) Geriatric	1:21	Mendocino	123	10-16-69
(9) Acute Disturbed	1:10.6	Mendocino	326	10-16-69
(10) Combined Psychiatric	1:16.6	Metropolitan	405	9-23-69
(11) Geriatric	1:9.3	Metropolitan	417	9-23-69
(12) Combined Psychiatric	1:26	Metropolitan	389	9-23-69
(13) Geriatric	1:16.5	Camarillo	679	10-8-69
(14) Intensive Psychiatric	1:11.3	Napa	201	9-8-69
(15) Alcoholic	1:12.5	Napa	208	9-8-69
(16) Alcoholic	1:24	Napa	263	9-8-69
(17) Intensive Psychiatric	1:9.3	Metropolitan	208	9-23-69
(18) Combined Psychiatric	1:13	Stockton	362	9-25-69
(19) Combined Psychiatric	1:16	Stockton	137	9-25-69

Table 19 compares the cost of maintaining patients in various state hospital programs to the cost of maintaining those patients in community facilities when they are ready to leave the hospital. It does not compare total program costs, but only those program costs which are easily identifiable and which can be priced with a degree of accuracy.

The program costs incorporated into Table 19 are:

1. Direct care—including only ward nursing personnel at the state hospitals and at similar facilities in the community, foster parents in family-care homes, and supervisorial staff in boarding homes, board and care homes, and other out-of-hospital living facilities.
2. Overhead costs directly related to support of the patient in the facility—including only (a) depreciation on improvements made to the facility, (b) maintenance of the facility, (c) maintenance of grounds, (d) utilities, (e) laundry, (f) housekeeping, and (g) feeding.

Not included are physician or professional services provided in the hospital or the local programs. These would be services provided by psychologists, rehabilitation therapists, tutors, social workers, division-assigned nursing staff, etc. Due to the difference in treatment settings, a meaningful cost comparison cannot be made.

Table 19 is intended to show the added cost of retaining a patient in a state hospital when it has been decided that the patient is capable of returning to the community. As an example, the cost of care for a child in the Napa State Hospital's Psychiatric Children's program, ex-

Services to the Mentally Ill—Continued

clusive of physician or professional services, is $813 per month. When the child is ready to leave the hospital for placement in a family-care home under the supervision of the Community Services Division the cost is $160 per month, a difference of $653 per month. The dollar figures in Table 19 show how much more costly hospital support is than community support when such community support is more appropriate.

Of special note is the savings that can result by the transfer of mentally retarded patients from hospitals into community facilities. A study conducted in late 1968 by the Western Interstate Commission on Higher Education (WICHE) indicated that approximately 4,000 mentally retarded patients were suitable for transfer to community facilities. At that time the Department of Mental Hygiene estimated that lack of parental consent prohibited the transfer of approximately one-half of the patients.

During the current fiscal year the Community Services Division and the Department of Mental Hygiene have been making a concerted effort to place additional mentally retarded patients in community facilities as a result of legislative action authorizing the transfer of $1.2 million from the Department of Mental Hygiene budget to the Community Services Division budget.

There are still hundreds of mentally retarded patients inappropriately hospitalized in state hospitals. To this point our analysis indicates that the community mental health movement is not only justifiable from a treatment standpoint, but, in addition, it is also justifiable from a fiscal standpoint. We note that the Department of Mental Hygiene has done much to encourage this movement. As early as 1962, it prepared a *LONG RANGE PLAN* which called for the transfer of primacy from state hospitals to community based mental health programs. Specifically, it stated that the primary position of mental health services should be established at the local level with state hospitals functioning primarily in the capacity of a backup resource.

However, the community mental health movement has not developed in a completely organized and purposeful manner. Conflicts, bottlenecks, duplication of services and fragmentation have arisen. The Lanterman-Petris-Short Act and the revised Short-Doyle Act, both recently enacted and implemented are resolving many of these problems. Nevertheless, some problems remain and the following analysis and recommendations pertain to them.

COMMUNITY PLACEMENT FOR THE MENTALLY HANDICAPPED

A major objective within the total California mental health program is the prompt release from state hospitals of patients who are capable of living in community facilities. Lacking family, friends and resources, many patients would have to remain in the hospitals if special efforts were not made to find a place for them in the community. The Community Services Division (CSD) of the State Department of Social Welfare provides placement and social services with a staff of 843 located in 41 offices throughout the state. The core of the staff of the Community Services Division consists of psychiatric social workers,

Table 19

Added Cost to the State Due to Continued Retention of Patients in State Hospitals When Community Programs Are Appropriate

Community Programs

— *Level of care* —

DMH Hospital Programs	*Moderate*	*Intermediate*		*Extensive*			
		Intermediate care and supervision		*CSD—private institutions*			
	Group I boarding homes minimum to moderate care and supervision $162/mo.	*Group II boarding homes $187/mo.*	*CSD family care home $160/mo.*	*MR F-type $180/mo. average*	*MR N-type $270/mo. average*	*MR R&S-type $292/mo. average*	*Skilled nursing convalescent hospitals $420/mo.*
Psychiatric children (Napa State Hospital) $813/mo.	----	----	+$653/mo.	----	----	----	----
Psychiatric adolescent (Camarillo State Hospital) $647/mo.	----	----	+$487/mo.	----	----	----	----
Intensive psychiatric care (Agnews State Hospital) $409/mo.	+$247/mo.	+$222/mo.	+$249/mo.	----	----	----	----
Combined psychiatric care (Metropolitan State Hospital) $325/mo.	+$163/mo.	+$138/mo.	+$165/mo.	----	----	----	----
Continuing psychiatric care (Mendocino State Hospital) $353/mo.	+$191/mo.	+$166/mo.	+$193/mo.	----	----	----	----
Geriatric—M.I. (Mendocino State Hospital) $332/mo.	+$170/mo.	+$145/mo.	+$172/mo.	----	----	----	----

Infirm geriatric (Agnews State Hospital) $668/mo.	----	$481/mo. (partially ambulatory)	----	----	----	----	$248/mo.
Alcoholic (Napa State Hospital) $304/mo.	+$142/mo.	+$117/mo.	+$144/mo.	----	----	----	----
Intensive treatment—M.R. children (Sonoma State Hospital) $432/mo.	----	----	+$272/mo.	+$252/mo.	+$162/mo.	+$140/mo.	----
Intensive treatment—M.R. (Fairview State Hospital) $381/mo.	----	----	----	+$201/mo.	----	+$89/mo.	----
Infirm—M.R. (Fairview State Hospital) $433/mo.	----	----	----	----	----	+$141/mo.	+$13/mo.
General M.R. (Sonoma State Hospital) $339/mo.	----	+$152/mo.	+$179/mo.	+$159/mo.	----	+$47/mo.	----

Services to the Mentally Ill—Continued

who evaluate placement plans for patients and find community resources that will permit satisfactory convalescence for the released patient.

Community Services Division psychiatric social workers are required to find suitable resources, help operators and providers of care to understand the special needs of persons served by the program, prepare persons for the experience of new living situations and provide sustained counseling to participants in the living arrangements. Facilities used by CSD and other agencies are as follows:

Board and Care Facilities

These are non medical family type homes for six or less persons licensed by the county welfare departments under the supervision of the State Department of Social Welfare. There are two groups, or types, of board and care facilities with the following differing level of care:

Group I—Minimum Care and Supervision

A person living in this type of facility needs a protective environment but limited personal service. He may be able to go out by himself, take care of his own room and assume responsibility for his own medications. However, he may need some assistance taking medication because of forgetfulness, pood eyesight or shakiness.

Group II—Extensive Personal Care and Supervision

A resident is generally in need of a combination of such services as help with dressing and personal hygiene, extra care because of incontinence, or help with eating. Personal supervision away from home is necessary due to feebleness and extra care may be necessary because the person may be non-ambulatory.

Family Care Home—Extensive Personal Care and Supervision

These are homes certified by the Community Services Division and are intended solely for the admission of not more than six mentally ill or emotionally disordered patients or six mentally retarded patients. The residents are provided with a program of services and protective supervision equal to or exceeding Group II care described above.

Private Institutions—Extensive Personal Care and Supervision (Mentally Retarded)

Family Home (License designation "F"). This is a facility intended solely for the admission of not more than six mentally retarded patients who are provided with a program of services and protective supervision in a home setting. The difference between this type of home and the family care home is that this type of home is licensed by the State Department of Mental Hygiene—not CSD.

Nursery (License designation "N"). This is a facility intended primarily for the admission of non-ambulatory mentally retarded patients who are provided nursing services primarly in crib accommodations. CSD uses this type of private institution more than any other private institution.

Services to the Mentally Ill—Continued

Resident Family (License designation "R"). This is an institution of seven bed capacity or more, intended solely for the admission of mentally retarded persons who require supervision and who are provided with an organized program of services.

Resident School (License designation "S"). This is a facility intended primarily for the admission, care and treatment of educable and trainable mentally retarded patients. The facility provides an educational program on the premises as one of its services.

Table 20 presents the current maximum payments provided the institutions described above.

Lack of Coordinated Plan for Patients

The Community Services Division has been developing a network of procedures and agreements, linking itself with county mental health, county public social services, state hospitals, and related agencies to assist in the implementation of the Lanterman-Petris-Short Act. The degree and nature of involvement of the division varies between the division and various local agencies depending upon the services provided by the local agencies.

We have observed that there is a lack of an overall coordinated plan of organization regarding fiscal, psychiatric, social, educational and recreational needs of the mentally ill in the community.

The mental health system is fragmented in its approach to the provision of essential services to mentally ill persons. There is some duplication of effort and a general inability to focus the combined efforts of the various agencies on the problem. There is a lack of overall statistical information which may be a product of this fragmentation. The various county and state agencies spend a good deal of time referring the client from one agency to another in order to obtain needed funds and rehabilitative and social services.

In addition, operators of facilities not only have to deal with the various social agencies concerned with the client but must also face local zoning ordinances, fire codes and community attitudes which are adverse to the treatment of mentally ill and mentally retarded persons. In addition, there are numerous agencies involved in licensing facilities used for placement of mentally handicapped individuals: State Departments of Mental Hygiene and Social Welfare, local county welfare, public health and various other agencies.

There is a need to clarify the functions and responsibilities of the various agencies dealing with mentally handicapped individuals. No one agency is providing the supervision and followup needed. Even where there are written agreements between the various agencies such as CSD and local welfare and mental health clinics, there is still confusion as to what patients the various agencies are to serve. In addition, there is confusion about how the patients are to get to such services. Supervision and followup are necessary for at least six months after the patient has acted out or been placed in the community in order to assure that the patient remains stable.

Another result of the fragmented mental health system is the lack of control and supervision of mentally ill individuals living in the com-

Table 20

Current Monthly Welfare Payments for Recipients in Nonmedical Out-of-Home Care Facilities

Need items	*Group I boarding homes minimum to moderate care and supervision*	*Intermediate care and supervision*		*CSD—Private extensive care institutions*		
		Group II boarding homes	*CSD family care home*	*F-type*	*N-type*	*R & S-type*
A. Board, room, personal care and supervision	$162	$187	$160	$180 (Average)	$270 (Average)	$292 (Average)
Components of maxima 1) Shelter and utilities 2) Food 3) Personal care and supervision, including minimum basic services normally required for licensing.						
B. Personal and incidental needs (Personal expenses, transportation, recreation, etc.)	37	23	None [1]	None	None	None
C. Clothing, dry cleaning, extra laundry, shoe repair and other similar needs not normally provided by the facility	15	15	None [1]	None	None	None
D. TOTALS	214 (AB-ATD-OAS rates)	225 (AB-ATD-OAS rates)	160	180	270	292

[1] Certain other special funds for family care patients who are on leave of absence are currently provided in the budget for the Department of Mental Hygiene. These include tranquilizing drugs, medical supplies, clothing and $10 personal expense money for persons from state hospitals.

Services to the Mentally Ill—Continued

munity. A number of chronically ill patients, particularly in the large metropolitan areas, are creating problems in the community because the communities lack any effective machinery to deal with them.

Many of the persons currently being released from state institutions have been stabilized in the hospital with drugs and extensive therapy. These items are not always readily available in the communities. In cities such as San Francisco and Los Angeles, chronically ill persons are very often without friends or relatives. These persons often live in hotels where they frequently "act out." This often happens when the patient for one reason or another does not take his medication and degenerates into an uncontrollable condition. Without such medication these persons are not rational enough to live in the community. Many times hotel owners, in order to relieve themselves of a problem, will ask the person acting out to move on rather than calling the police or medical authorities. As a result, these mentally ill individuals end up moving from hotel to hotel until they are eventually jailed or hospitalized again.

Readmissions

A gradual rise in admissions to state hospitals for the mentally ill has occurred over the past six years. This increase is largely attributable to an increase in readmissions. Table 21 depicts the increase in the rate of readmissions to the hospitals for the mentally ill, fiscal years 1963–64 to 1968–69.

TABLE 21

Increase in Rate of Readmissions to Hospitals for the Mentally Ill, Fiscal Years 1963–64 to 1968–69

Year	*Total admissions*	*Readmissions*	*Rate of readmissions*
1963–64	26,764	9,991	37.3%
1964–65	27,231	10,744	39.5%
1965–66	26,800	11,344	42.3%
1966–67	28,834	12,746	44.2%
1967–68	31,481	15,144	48.1%
1968–69	35,739	17,843	49.9%

Readmissions have increased largely because of the increased number of discharges from state hospitals and, hence, the increased number of patients "at risk" in the community. A high rate of readmissions reflects a "failure" on the part of both the persons readmitted to the hospital and the mental health system itself.

A series of visits undertaken by staff of this office to state hospitals, Short-Doyle clinics, local welfare agencies, Community Services Division offices and other concerned agencies throughout the state indicate that the high rate of readmissions to state hospitals is the result of insufficient supervision and support of patients discharged from the hospitals. A successful readjustment to community living after hospitalization requires the former patient to utilize many of the very resources (e.g., initiative, judgment) which have been crippled by his illness. The treatment staff of the hospital from which the patient has been discharged attempts to prepare the patient as much as possible

Services to the Mentally Ill—Continued

for a successful readjustment. However, the supervision and support of community followup agencies are very often indispensable.

The steady increase in the rate of readmissions to state hospitals for the mentally ill from 1963 to the present indicates that the provision of adequate followup services for persons discharged from state hospitals is not a newly developed insufficiency, but, rather, one of long standing.

Staff of the CSD have asserted that currently as few as 20 percent of the patients being discharged from state hospitals are provided followup services. In short, many of the patients released from the state hospitals are not able to make contact with the community agencies responsible for assuring the successful readjustment of former hospital patients to community living. All too often the trained expertise of CSD and Short-Doyle personnel is not brought to bear. Eventually, many of these patients do not again become visible to mental health professionals until they deteriorate to the extent that their abnormal behavior is brought to the attention of such "crisis" agents as the police.

It is clear that to return hospital patients to the community without assuring the adequate provision of followup services constitutes a disservice to the patient, a disservice to the residents of the community into which the patient is placed, and a drain on the fiscal resources of both local and state agencies.

Lack of Facilities

There is a lack of facilities for mentally handicapped individuals in the community.

One of the most important phases of treatment of any mentally handicapped individual is that which takes place outside the hospital. Thus, out-of-hospital facilities are necessary to prevent hospitalization and to provide adequate after care upon discharge. Persons leaving mental hospitals very often need an extra step in the transition from institutional life to leading an independent existence in the community.

In addition to halfway houses or intermediate care facilities, several communities indicated a need for sheltered workshops to provide employment to mentally handicapped individuals who do not have the potential for complete self-support.

There is a need to develop additional family care facilities in order to meet additional demands for placement of persons presently in state mental institutions. Problems occur which make it difficult to develop all of the various facilities which are necessary, such as the attitude of individuals in the community near the location in which the facility is to be located. These individuals very often object to the facilities being placed near them and will oppose the operator in his attempt to obtain a zoning variance, fire clearance or business license.

Inequity of Rates Paid and Funding Problems

As can be seen in Table 9, rates paid for family care are much lower than other homes and institutions used primarily for the placement of the mentally handicapped. It is becoming increasingly difficult to

Services to the Mentally Ill—Continued

develop family care homes at the present rate paid to the home operator. Family care rates are not competitive with licensed Group I board and care homes even though the services required of the operator are considerably more extensive. (The total monthly amount provided for Group I residents including personal and incidental needs is $214. But for the CSD family care home, the amount is $160.) Because of these differences, it will be more and more difficult to develop family care homes, and, in addition, it will be difficult to prevent present family care operators from becoming unlicensed board and care home operators. This will eventually result in reduced placements of mentally handicapped individuals in family care facilities. The problem of community placement for children and adolescents is already becoming acute.

The funding base supporting the placement of children and adolescents from state hospitals is considerably more restricted than the funding base supporting the placement of adult patients. Specifically, the two major public assistance programs upon which the total hospital placement program primarily relies, ATD (Aid to the Needy Disabled) and OAS (Old Age Secruity), are restricted to the placement of adult patients (18 and over). The remaining public assistance programs, AB (Aid to the Blind) and AFDC (Aid to Families with Dependent Children), apply to very few of the children and adolescents in the state hospitals for the mentally ill. Hospital social workers estimate that only 5 to 10 percent of the children at the state hospitals are eligible to secure AFDC funding for support of community placement.

The Community Services Division of the State Department of Social Welfare recognizes the limited support rendered by the public assistance programs in securing community placement for readjusted children and adolescent patients. As a result, it has established a "family care budget" to enhance the funding base for these types of placements. The budget consists of General Fund dollars only and is restricted to the support of placements into carefully recruited "family care homes."

The funding difficulties hindering the development of a truly effective placement program for children and adolescents are threefold: (1) The major funding base for placement of children and adolescents from state hospitals, the "family care budget," consists of General Fund dollars appropriated through the budget act. Funds for the public assistance programs which support the placement of adult patients into the community are secured through the public assistance grant structure and are supplemented by county and federal dollars. Budgetary limitations imposed upon the funding of children and adolescent placement programs are far more stringent than are the limitations affecting the funding of similar adult placement programs. (2) The rate ($160 per month) paid to caretakers of family care homes is approximately $20 a month less than the average ATD funded rate paid to operators of unlicensed board and care facilities, the major community placement for adult patients. The CSD personnel and hospital social

Services to the Mentally Ill—Continued

workers who were interviewed stressed that this fact has greatly hampered an effective expansion of the family care program. Specifically, the rate differential paid to operators of unlicensed board and care facilities has encouraged family home caretakers to abandon the family care placement program (the primary resource for placement of children and adolescents) in favor of the unlicensed board and care program which is the major program for placement of adult patients. (3) The types of patients currently on referral to CSD for placement in family care homes are considerably more handicapped than past referrals. Consequently, family home caretakers have indicated an increasing preference for placement of older, more docile adult patients.

Unlicensed Facilities

There are numerous nonlicensed board and care homes located throughout California. Many of the persons in these unlicensed homes are ex-mental-hospital patients or persons with severe emotional problems. The unlicensed homes need only apply for a business license ($10 fee yearly) and a food handler's card through the county health department. There are no legal restrictions on those who apply for such licenses except that the physical plant of the unlicensed homes must meet county fire department regulations in regard to emergency exits from the second story, electrical wiring, etc., and be located in an area zoned for board and room services.

The operators of the homes have varied qualifications. However, they may give good care if they have intensive and frequent counseling with knowledgeable social workers. This was the case in the various homes visited which are used by CSD and county welfare staff. However, the only controls on abuse of patients is visual observation, which can be the result of a routine home visit, a complaint of an individual, or the attitude of the owner. In the past, CSD and county welfare staff could and did remove patients from homes with inadequate standards. Since July 1, 1969, mentally ill persons leaving state hospitals are released without supervision. Because of the lack of authority, neither CSD nor county social workers are able to remove patients as they did in the past. Mentally retarded persons will be the responsibility of regional diagnostic centers effective July 1, 1971.

Lack of Funds

We found that there was a lack of funds for mentally handicapped persons for transportation to the various service agencies and clinics as well as for incidental expenses such as babysitting.

Welfare funds are provided, but only to the extent of meeting basic food, clothing and shelter needs and not the ancillary needs of handicapped individuals. Services are not available to a person who is not able to get to the clinic because of the lack of transportation or child care. In order to reach these individuals, welfare budgets should be more flexible in transportation allowance and other incidental expenses, as is the case in recipient training programs.

One other problem relating to funding is resulting from the presently excessive time required to process applications from mentally handi-

Services to the Mentally Ill—Continued

capped individuals for ATD. This long processing time is resulting in a loss of federal funds at the expense of state CSD funds. This occurs when a non-ATD state hospital patient being placed by CSD staff must initiate his ATD application at the time of, or shortly after, placement. Starting the ATD application in this manner requires that the application be processed through the regular ATD application process which sometimes takes from three to six months. Special handling of ATD applications are made when ATD is applied for by persons still in the state hospital. This procedure could be applied to those people leaving the hospital and applying for ATD thus making better utilization of available federal funds.

Department of Mental Hygiene
HOSPITALS FOR THE MENTALLY RETARDED

Item 124 Budget page 596

Requested 1970–71	$65,746,390
Estimated 1969–70	66,151,844
Actual 1968–69	59,086,665
Requested decrease $495,454 (0.6 percent)	
Total recommended reduction	None

GENERAL PROGRAM STATEMENT

The Department of Mental Hygiene administers four hospitals which have been established exclusively for the care and treatment of the mentally retarded: Fairview, Pacific, Porterville and Sonoma State Hospitals. In addition, separate units at five hospitals for the mentally ill have been set aside for the care and treatment of mentally retarded patients. These units are located at DeWitt, Patton, Agnews, Camarillo and Napa State Hospitals. Funds totaling $17,216,145 are provided in Item 123, Hospitals for the Mentally Ill, to support the special mental retardation units at the hospitals for the mentally ill.

ANALYSIS AND RECOMMENDATIONS

We recommend approval.

The budget proposes an appropriation from the General Fund of $65,746,390 for support of hospitals for the mentally retarded. The total program expenditures are estimated to be $65,836,660, which includes the proposed appropriation and $90,270 in reimbursements. This is a decrease of $405,454 or 0.6 percent less than that which is estimated to be expended during the current fiscal year.

The department is requesting the transfer of 28 authorized positions from the hospitals for the mentally ill to the hospitals for the mentally retarded. These positions include five personnel clerks, two dentists, two dental assistants, and 19 rehabilitation therapists. The department is also requesting the transfer of 46 positions to the newly created

Hospitals for the Mentally Retarded—Continued

Bureau of Training. The total change in authorized positions for the hospitals for the mentally retarded is minus 18.

The staffing standards for nursing positions assigned to the hospitals for the mentally retarded have not yet been attained as in the hospitals for the mentally ill. However, the nursing staff ratio has significantly improved. Staffing at the hospitals for the mentally retarded was at 80 percent of the standard on June 30, 1969. At that time, a program designed to attain 100 percent of staffing standards over a five-year period was implemented. By June 30, 1970, it is projected that staffing will be at 86.2 percent of the standards prescribed by the California Commission on Staffing Standards. The budget contains a proposal in Item 123 for the addition of 140 new nursing positions which should allow for the attainment of 92.5 percent of the standard by June 30, 1971.

An analysis of services provided to the mentally retarded is included in our analysis of items 123 and 273.

DEPARTMENT OF PUBLIC HEALTH

Item 125 from the General Fund **Budget page 614**

Requested 1970–71	$11,250,936
Estimated 1969–70	12,243,086
Actual 1968–69	12,312,217
Requested decrease $992,150 (8.1 percent)	
Total recommended reduction	$28,993

SUMMARY OF MAJOR ISSUES AND RECOMMENDATIONS

1. We recommend the enactment of legislation to repeal Article 4 (commencing with Section 350) of the Health and Safety Code, so that the statutes accurately reflect the decision to terminate support for the Division of Dental Health.
2. We recommend an augmentation to the General Fund appropriation in the amount of $29,450 to restore funds for the nursing education scholarship program.
3. We recommend a General Fund reduction of $58,443 in support for the Bureau of Public Health Social Work based on inadequate claiming of federal funds.
4. We recommend the department limit expenditures for departmentally staffed special projects to $2,659,752 unless otherwise provided by the Budget Act.
5. We recommend that the Comprehensive Health Planning Unit absorb the functions of the Office of Planning of the Department of Mental Hygiene.

GENERAL PROGRAM STATEMENT

The Department of Public Health has the responsibility of working with local health departments in the prevention of disease and the pro-

Department of Public Health—Continued

vision of a healthful environment for the people of California. To meet this responsibility the department maintains three major programs:

(1) Environmental Health and Consumer Protection Program
(2) Preventive Medical Program
(3) Community Health Services and Resources Program

To administer these programs effectively, the department also maintains a Management and Planning Program, and a Comprehensive Health Planning unit which relates the department's activities to the total state health effort.

Federally funded special projects administered by the department, although included as integral parts of the various programs, are analyzed as a single item in order to aid the Legislature in assessing the impact of these activities on the department.

The department proposes a total support and subvention expenditure of $89,748,781 in state, federal, and private funds in 1970–71. This is a net decrease of $2,018,771, or 2.2 percent, below the $91,767,552 estimated to be expended in the current year. A breakdown of these expenditures is shown in Table 1.

Table 1

Public Health Expenditures

Departmental Support	*1969–70*	*1970–71*		*Change from 1969–70*	
General Fund	$12,243,086	$11,250,936	—	$922,150	(—8.1%)
Federal Funds	5,534,691	4,714,394	—	820,297	(—14.8%)
Motor Vehicle Fund	64,795	54,800	—	9,995	(—15.4%)
Health Facility Construction Loan Insurance Fund	94,754 *	115,577 *	+	20,823	(+22.0%)
Special Projects					
Federal Funds	7,887,103	8,639,469	+	752,366	(+9.5%)
Private Funds	106,432	78,200	—	28,232	(—26.5%)
Subtotals Support	$25,930,861	$24,853,376	—	$1,077,485	(—4.2%)
Reimbursements	2,597,387	2,946,265	+	348,878	(+13.4%)
Net Totals, Support	$28,528,248	$27,799,641	—	$728,607	(—2.6%)
Regional Dialysis Centers	311,195	260,248	—	50,947	(—16.4%)
Hyaline Membrane Study	200,000	190,182	—	9,818	(—4.9%)
Public Health Subventions					
General Fund	28,549,926	26,468,409	—	2,081,517	(—7.3%)
Federal Funds	34,178,183	35,030,301	+	852,118	(+2.5%)
TOTAL EXPENDITURES	$91,767,552	$89,748,781	—	$2,018,771	(—2.2%)
Recapitulation					
General Fund	$41,304,207	$38,169,775	—	$3,134,432	(—7.6%)
Motor Vehicle Fund	64,795	54,800	—	9,995	(—15.4%)
Health Facility Construction Loan Insurance Fund	94,754 *	115,577 *	+	20,823	(+22.0%)
Federal Funds	47,599,977	48,384,164	+	784,187	(+1.6%)
Private Funds	106,432	78,200	—	28,232	(—26.5%)
Reimbursements	2,597,387	2,946,265	+	348,878	(+13.4%)

* Represents Loan from General Fund

Department of Public Health—Continued

ANALYSIS AND RECOMMENDATIONS

The Department of Public Health proposes a total support expenditure of $27,799,641. This includes a General Fund appropriation of $11,250,936, additional support of $16,378,328 from federal and private funds and reimbursements, $54,800 from the Motor Vehicle Fund, and $115,577 from the Health Facility Construction Loan Insurance Fund. The General Fund appropriation is 8.1 percent below that estimated to be expended during the current year.

The budget indicates that 56 percent of the department's support is proposed to come from the federal government. As we have done in the past, we again caution against an excessive reliance on funds which are subject to modification or withdrawal as federal financial conditions dictate.

The budget proposes a total of 1,305.4 authorized positions to carry out departmental activities. This is a net decrease of 7.3 positions from the 1,312.7 authorized for the current year. No new General Fund positions are proposed for addition in the budget year.

Environmental Health and Consumer Protection Program

The Environmental Health and Consumer Protection Program is composed of the following elements: Food and Drug, Radiological Health, Water Sanitation, Vector Control and Solid Waste Management, Occupational Health and Environmental Epidemiology, Air Sanitation, and related laboratory services.

The objectives of this program are to insure a healthful environment and to maintain the quality and safety of those consumer goods which directly affect health.

Food and Drug Element

The only major changes in this program as proposed by the budget concern the Food and Drug Element. The budget proposes the continuation of support for one food and drug inspector II and one food and drug inspector III which were administratively added in the current year to implement the provisions of Chapter 1241, Statutes of 1969. This legislation concerns the licensing of manufacturers of processed pet foods, and is intended to be self-supporting through the collection of license fees.

We recommend continuation of these positions.

Preventive Medical Program

The Preventive Medical Program is composed of the following elements: Adult Health and Chronic Diseases, Infectious Disease Control, Crippled Children Services, Dental Health Services, Maternal and Child Health, High-risk Group Services, Mental Retardation Services, Malnutrition Control, Alcoholism Control, and related laboratory services.

The objectives of this program are to establish, expand and improve essential personal health services and programs, to identify specific acute and chronic diseases as major causes of illness and death, and to establish and maintain appropriate studies and epidemiologic investigations of the cause and prevention of such diseases.

Department of Public Health—Continued

Infectious Disease Control Element

As a result of Chapter 975, Statutes of 1969, relating to the importation of wild animals, the department administratively added one public health veterinarian in the current year and proposes to continue this position in the budget year. This position is intended to be self-supporting through the collection of fees authorized by the legislation.

We recommend continuation of this position.

Dental Health Element

We recommend the enactment of legislation to repeal Article 4 (commencing with Section 350) of the Health and Safety Code in order that the statutes accurately reflect the decision to terminate support for the Division of Dental Health.

The budget proposes the termination of federal and General Fund support for the Division of Dental Health. The division was established by Chapter 710, Statutes of 1949, and is charged with the administration of ". . . all functions of the department relating to dentistry . . ." The division, however, is prohibited from compelling dental examinations or services and is not permitted to regulate the practice of anyone licensed under the Dental Practice Act or who is engaged in the private practice of dentistry.

In actual operation, the division has acted primarily in a promotional capacity, encouraging agencies and organizations to adopt measures and programs for the prevention of dental disease and for the extension and improvement of dental health services.

From fiscal year 1959–60, when 7.5 man-years were utilized for its activities, the staff of the division has been steadily reduced through a succession of legislative and administrative reductions until the current year, which provides for only 1.2 man-years of service.

We are in agreement with the budget proposal to terminate support for the Division of Dental Health, feeling that the department has ample authority under Section 205(d) of the Health and Safety Code to provide for any activities concerning dental health which might be undertaken in the future.

It seems apparent that the most important program which the division could have carried out would have been to use the information available to it to increase the use of anti-decay techniques in California. This it did not do effectively and aggressively, although the dental groups are strongly in support of such measures and have stressed the major health benefits and welfare cost savings it could provide.

This cut, however, would not impair the ability of the department to take positive steps to apply existing knowledge of the beneficial results which can be achieved by fluoride uses. We believe that an aggressive program is urgently needed.

In order that the statutes accurately reflect the decision to terminate the activities of the division we recommend that legislation be enacted which repeals Article 4 (commencing with Section 350) of the Health and Safety Code.

Department of Public Health—Continued

Maternal and Child Health Element

The Maternal and Child Health (MCH) element depends on federal funds for over 75 percent of the continued support of its activities. As a qualification for the state to continue receiving the federal MCH subsidy, a Family Planning Unit was administratively added to this element during the current year. The budget proposes to continue the positions of public health medical officer III, maternal health nursing consultant, health program advisor I, associate public health statistician, stenographer I, and 0.5 man-years of temporary help which comprise the unit, and are totally funded by the federal government.

We recommend continuation of these positions together with related operating expense.

High-Risk Group Services

Chapter 1380, Statutes of 1969, required the department to establish and maintain a program of health services for American Indians in California. The legislation appropriated $32,117 from the General Fund to support the program in the current fiscal year. Accordingly, the department administratively added the positions of research assistant III, health program advisor III, and clerk typist II to direct the program. The budget proposes to continue these positions in the 1970–71 fiscal year at a General Fund expenditure of $38,355.

We recommend continuation of these positions.

Community Health Services and Resources Program

The Community Health Services and Resources Program is composed of the following elements: State Plan and Local Assistance for Local Public Health Services, Contract County Services, Nursing, Public Health Social Work, Health Education, Health Facilities Licensing and Certification, Health Facilities Planning and Construction, and related laboratory services.

The primary objective of this program is to identify the public health needs of specific communities in the state and to mobilize all available resources to meet those needs.

Nursing Element

We recommend an augmentation to the General Fund in the amount of $29,450 to restore funds for the nursing education scholarship program.

The budget proposes the termination of General Fund support for the nursing education scholarship program administered by the department under the provisions of Sections 380–389 of the Health and Safety Code (the Nursing Education Scholarship Act of 1964). This act authorized the department to grant a minimum of 10 scholarships annually to qualified registered nurses for the purpose of helping to alleviate the shortage of registered nurses in the state. The program requires those persons accepting scholarships to assume an employment obligation in California in teaching, or supervision in a clinical nursing area for a period of not less than one year. Scholarships are granted in the amount of between $200 to $250 per month.

Department of Public Health—Continued

Since 1964, a total of 69 registered nurses have been or are now being assisted under the scholarship program to continue their education in nursing so that they can qualify as teachers or in related supervisory positions in nursing services that provide clinical teaching facilities for student nurses.

The demand for qualified registered nurses in California still exceeds the available supply. The Health Manpower Council of California in a 1968 survey of 194 hospitals estimated a statewide vacancy rate of 6.9 percent for registered nurses. The State Personnel Board estimates a vacancy rate of 24.5 percent for RNs in state employment, resulting in the necessity to hire at fourth and fifth step salaries to acquire needed personnel. In addition, new nursing schools need faculty, home health agencies need master's degree prepared staff to meet licensing qualifications, and the extension of laboratory facilities requires that supervisory personnel have adequate preparation.

As more and more Californians are brought into the mainstream of health care services through the Medi-Cal and other public programs, the shortage of registered nurses as well as other health personnel will surely be reflected through increased costs to those programs and ultimately to those taxpayers who must pay for such programs.

Although the nursing education scholarship program is but one means of reducing the shortage of registered nurses, we are convinced that the expenditure of $29,450 from the General Fund will eventually be more than offset as a savings in the Medi-Cal and Lanterman-Petris-Short programs alone.

The rising cost of health care is of concern to everyone. Increasing the available supply of qualified registered nurses will help to slow these rising costs. It is for these reasons that we recommend that Item 125 be augmented in the amount of $29,450 from the General Fund to provide for the continuation of the nursing education scholarship program administered by the Department of Public Health.

Public Health Social Work Element

We recommend a General Fund reduction of $58,443 in support for the Bureau of Public Health Social Work on the basis that an amount equal to this reduction can be supplemented by federal funds if proper claiming is utilized.

The stated objectives of the Public Health Social Work Element are to reduce or eliminate the economic, psychological, and communications problems faced by the poor and disadvantaged in finding and using health services and to increase health manpower through the development of new health careers among the disadvantaged.

These objectives are also stated as part of the overall objectives of the Departments of Health Care Services, Social Welfare, and Human Resources Development. We are not prepared at this time to state that the objectives of this element duplicate or are in conflict with the objectives of other departments. We observe, however, that without exception, the similar objectives of these departments are accomplished with substantial support from the federal government, while the Public

Department of Public Health—Continued

Health Social Work Element and its objectives, are funded almost entirely from the General Fund.

The budget states that four of the six positions in the Bureau of Public Health Social Work are assigned to duties in other elements within the department. Two of these positions act as full-time consultants to the Bureau of Health Facilities Licensing and Certification. The duties of these consultants are to work with hospitals, nursing homes, home health agencies, and extended care facilities to resolve problems and enhance social health services in facilities licensed by the state.

While such duties may be essential to the proper licensing and certification of facilities, we seriously question the continued use of General Fund supported positions when federal funds from Titles XVIII and XIX of the Social Security Act are available for such purposes, and are in fact utilized to fund a large part of the Health Facilities Licensing and Certification Element. It appears that proper claiming procedures, if utilized by the department, could result in an increased amount of federal support for the two positions assigned to licensing and certification duties.

Another stated function of the Bureau of Public Health Social Work is to increase health manpower by identifying the need for, and the training of "new health careerists", recruited mainly from low income groups. The positions in the bureau which perform these duties are supported from the General Fund. Again, it appears that the department has overlooked the possibility of utilizing available federal funds to carry out this function. The Federal Manpower Development and Training Act of 1962, together with subsequent amendments, already supports similar activities in California, primarily through the Department of Human Resources Development. Furthermore, Chapter 1068, Statutes of 1969 (AB 1240) created within the Department of Human Resources Development an Office of Manpower Utilization which has as its mission the development of entry level jobs in state and local government in the human services field. We have been informed that this activity will be funded almost entirely by federal funds. We fail to see the need for the Department of Public Health to engage in similar activities without a concerted effort to obtain federal funding.

It appears evident that the department, through its Public Health Social Work Element, engages in activities for which available federal funds exist, but which the department has not claimed, therefore imposing excess burdens on the General Fund.

We therefore recommend that the General Fund support for the Bureau of Public Health Social Work be reduced by $58,443, and that the department obtain federal support for the activities carried out by that bureau.

Health Facilities Licensing and Certification

Under the provisions of Title XVIII of the Federal Social Security Act, the Department of Public Health is charged with the responsibility for performing certain certification and consultation services to

Department of Public Health—Continued

assist health facilities to qualify as providers of services under the federal Medicare program.

The 1967–68 amendments to the Social Security Act provide for additional types of health care services providers, greater review of such provider operations, and more frequent consultations and inspections to insure strict compliance with the intent of the act.

These amendments became effective July 1, 1969, and as a result the department administratively added the following eight positions in the current year and proposes to continue them in the budget year:

1 Occupational therapy consultant, Bureau of Health Facilities Licensing and Certification
1 Pharmaceutical program coordinator, Bureau of Health Facilities Licensing and Certification
2 Associate public health statisticians, Bureau of Statistical Services, for assignment to Laboratory Field Services
1 Statistical clerk, Bureau of Statistical Services, for assignment to Laboratory Field Services
2 Clerk-typists II, Laboratory Field Services
1 Clerk-typist II, Bureau of Health Facilities Licensing and Certification

These positions are funded entirely by federal funds and are justified on a workload basis.

We recommend continuation of these positions.

Health Facilities Planning and Construction Element

This element provides assistance and consultation to health facilities, health planning agencies, and architects on the need for facilities and services, construction requirements, and master plan preparation. It also reviews construction projects and inspects such projects to insure compliance with approved plans and to recommend reimbursement for work completed.

Chapter 970, Statutes of 1969, enacted the California Health Facility Construction Loan Insurance Law which provides for state-guaranteed mortgage loans for the construction or modernization of certain health facilities. To implement this legislation, the department administratively added nine positions during the current year and proposes to continue these positions in the budget year. Five of these positions are located in the Bureau of Health Facilities Planning and Construction and are supported from the Health Facilities Construction Loan Insurance Fund. These positions are as follows:

1 Construction advisor, health facilities
1 Consultant in hospital planning
1 Architectural assistant
2 Clerk-typist II

The four remaining positions added as a result of Chapter 970 are located in the Management and Planning Program and are discussed below in the analysis of that program.

Department of Public Health—Continued

These positions are anticipated to become self-supporting in the future through the collection of mortgage loan fees.

We recommend their continuation.

Management and Planning Program

In order to accomplish the health goals of the administration and the Legislature, and to facilitate the efficient administration of the other departmental programs, the Department of Public Health maintains a Management and Planning Program which provides staff services to the director and program personnel.

This program is composed of the following elements: Administration, Vital Statistics Registration, Special Services, Data Processing, and Laboratory Services.

Administration

To implement the provisions of the Health Facility Construction Loan Insurance Act (Chapter 970, Statutes of 1969), described above, the department administraively added the following four positions:

1 Mortgage loan specialist, Bureau of Program and Budgeting Services
1 Accounting officer II, Bureau of Fiscal and Accounting Services
2 Clerk-typist II, one in Bureau of Program and Budgeting Services, and one in Bureau of Fiscal and Accounting Services

These positions are proposed to be continued in the budget year and are anticipated to become self-supporting through the collection of mortgage loan fees.

We recommend their continuation.

The Bureau of Fiscal and Accounting Services added one clerk-typist II position administratively during the current year and is proposing its continuation. It is also proposing the addition of another clerk-typist II in the budget year. These positions are supported entirely by federal funds and are justified due to increased workload in the processing of vendor's claims for the Crippled Children Services Program.

We recommend continuation and approval of these positions respectively.

Vital Statistics Registration Element

Since 1965, the State Department of Public Health has been charged with gathering and making available statistical information relating to divorce in California. Based partly on this information, the Legislature enacted Chapter 1608, Statutes of 1969, which became effective January 1, 1970. This law radically revises California's procedures in providing for the dissolution of marriages. Chapter 1608 also lays upon the department more complex statistical procedures in the dissolution of marriage reporting program.

To aid in the implementation of this legislation the department has administratively added the following positions during the current year:

1 Health program advisor II, Bureau of Vital Statistics Registration
1 Health program advisor I, Bureau of Vital Statistics Registration

Department of Public Health—Continued

1 Clerk-typist II, Bureau of Vital Statistics Registration
1 Clerk-typist I, Bureau of Vital Statistics Registration

The budget proposes to continue these positions in the budget year. They are justified on a workload basis and costs will be partially offset through the collection of fees imposed upon persons filing for a dissolution of marriage.

We recommend their continuation.

Data Processing Element

In a report "Short Range Master Plan for the Utilization of Electronic Data Processing in the State of California," dated December 30, 1968, the Office of Management Services identified the need to study the EDP requirements of state agencies in the San Francisco Bay Area with a view to consolidating services. A working committee of bay area data processing managers, chaired by a member of the Office of Management Services staff, was formed to complete the initial planning for a Bay Area Data Processing Service Center. The working committee's report "San Francisco Bay Area Interim EDP Plan," dated June 13, 1969 was submitted to the state EDP Policy Committee and was approved with certain amendments at the committee's June 1969 meeting.

The plan originally called for the establishment of a service center operated by an area advisory committee. However, the Director of the Office of Management Services, with the Department of Public Health concurring, recommended to the EDP Policy Committee that operational authority be given to the Department of Public Health since management by a committee was impractical. The Office of Management Services further recommended that a Bay Area Data Processing Advisory Committee, made up of the directors and chief executive officers of the participating bay area departments, be appointed to serve as a policy and coordinating body.

Participation in the DP Center

The agencies originally included in the plan for a Bay Area Data Processing Service Center were:

1. Department of Public Health
2. Department of Industrial Relations
3. Public Utilities Commission
4. Bay Area Transportation Study Commission
5. Department of Insurance

During the fall of 1969, the Department of Health Care Services was added to the list of participating agencies because, although the agency is located in Sacramento, it receives a large part of its data processing services from the Department of Public Health.

Of the participating departments, only the Department of Industrial Relations and the Department of Public Health have their own computer capability. The other agencies contract for EDP services from other state agencies or outside service bureaus and the Department of Insurance receives no EDP services at all.

Department of Public Health—Continued

Center Accomplishments

During the current fiscal year, the Bay Area Data Processing Advisory Committee has: (1) elected as chairman, the Director of the Department of Public Health; (2) appointed a service center manager, the EDP manager for the Department of Public Health; (3) considered alternatives for equipment consolidation among the participating departments; (4) outlined provisional milestones in the development of BADPSC; (5) established the organizational characteristics of the service center and its relationship to the participating departments; and (6) prepared a budget of $1,465,796 for fiscal year 1970–71 which is reflected in the participating departments' budget requests. The Public Health share of the BADPSC budget is $771,113. In addition, the service center manager has initiated steps to determine the precise program and operational needs of the participating departments, and, through the EDP staff at the Department of Public Health, has conducted an analysis of the alternative equipment capabilities available within existing EDP resources in the bay area.

Effect of Statewide Long Range Master Plan

In September 1969, the Office of Management Services prepared a draft Long Range EDP Master Plan. This report recommended the Bay Area Data Processing Service Center be limited to the Department of Public Health and the Department of Industrial Relations with the remaining departments serviced by other state EDP centers or private service bureaus. Because it appears that it will be sometime before this plan, or a revision, is adopted, the Bay Area Data Processing Advisory Committee has proceeded with the implementation of the service center as mandated by the State EDP Policy Committee.

Service Center Activities During the Budget Year

During the next fiscal year, the Departmnet of Industrial Relations will release its IBM computer and convert all programs to the service center. The Public Utilities Commission and Bay Area Transportation Study Commission will continue to obtain most of their data processing service from private service bureaus and other state agencies. However, they will use the Bay Area Service Center to the extent that it is feasible and appropriate. The Department of Insurance will not receive any data processing service in the coming year because funds for this purpose are not available. The Department of Health Care Services is expected to continue its use of the Department of Public Health as its EDP resource until a total data processing system is developed for the Medi-Cal program.

The success of the Bay Area Data Processing Service Center depends largely on the utilization of the center by the participating agencies. As the number of applications performed at the service center increases, the unit cost per application is expected to decrease. It is possible that with enough participation, the Department of Public Health can support a computer system which could provide time-shared services over a wide geographic area. In this way, the diverse needs of the participating agencies can be met in a very economical, effective and direct man-

Department of Public Health—Continued

ner. We therefore support the development of this service center and urge the participating departments, and other departments in the bay area, to utilize the service center to the maximum extent possible.

Laboratory Services Element

This element operates five centralized backup units for the support of department wide laboratory requirements and also administers and coordinates the work of all laboratories serving departmental programs.

To provide for laboratory services necessary for the implementation of Chapter 975, Statutes of 1969, (importation of wild animals) the department administratively added the positions of assistant microbiologist and laboratory assistant II during the current year. The budget proposes to continue these positions in the budget year. The cost of these positions is borne by the General Fund but is anticipated to be offset through the collection of fees specified in the legislation.

We recommend approval.

Special Projects Program

We recommend that the Legislature direct the Department of Public Health, by including language in the Budget Act, to limit expenditures for departmentally staffed special projects to the budgeted amount of $2,659,752. This limitation should not apply to federal funds which are passed through the department to local agencies, or to additional departmentally staffed special projects which are approved pursuant to the procedures outlined in the Budget Act of 1969.

The budget proposes to continue the special projects program which involves assistance to support health services, training, services and demonstrations, and special investigations.

Totally funded from federal and private grants, the special projects program proposes to expend $8,717,669 in the budget year. This is an increase of $724,134 or 9.1 percent over the $7,993,535 proposed to be expended on this activity in the current year.

Two basic types of special projects are included in the budget proposal. The first or "pass through" type includes $6,057,917 which the department approves and then passes on to local agencies. The responsibility for administration and completion of this type of special project is left to the local agency.

The second type of special project is the departmentally staffed project, which includes projects for training, services and demonstrations, and special investigations. These types of projects are estimated to expend $2,659,752 in the budget year and will require 202.4 positions for their completion.

The number of departmentally staffed special projects has grown substantially in the past five years. In 1969, the Budget Act included language which established appropriate review procedures to which special projects in excess of those shown in the budget were to be subjected. To date, these procedures have helped to establish appropriate priorities for additional projects and we recommend that similar language be included in the Budget Act of 1970.

Department of Public Health—Continued

The budget proposal leaves unresolved the issue of the impact of this activity on other departmental operations. There is also the question of the appropriateness of the location of extensive research programs in the State Department of Public Health rather than the University, where such research is not only traditional but serves to meet instructional needs as well.

The future of federal support for any special project is by no means assured and is available only on a year-to-year basis.

Comprehensive Health Planning

We recommend that the Comprehensive Health Planning Unit absorb the functions of the Office of Planning currently located in the Department of Mental Hygiene.

In 1967, as a result of the provisions of PL 89-749, the Governor designated the State Department of Public Health as the single state agency responsible for comprehensive health planning. In order to meet these responsibilities, the department established the Comprehensive Health Planning Unit. That same year the State Health Planning Council was established by Chapter 1597, Statutes of 1967. The council is advisory to the Administration and the Comprehensive Health Planning Unit acts as staff to the council.

Prior to the current year, the activities and accomplishments of the comprehensive health planning effort in California were formative. Any measurement of results must be tempered by the fact that the administration elected to develop this program under the concept of *process planning*. Process planning differs from *operational planning* in that it is based on the belief that the involvement and participation of groups representing government, providers and consumers provides a sound basis for concensus and support for priorities in allocating California's health resources to the needs of its citizens. Operational planning is decision oriented and is directed to short-term goals.

Results, therefore, are difficult to define, and in many cases appear to have happened in spite of, rather than because of, the comprehensive health planning effort. This has led to a natural frustration, both within the administration and the Legislature.

In an attempt to partially redirect the efforts of the Comprehensive Health Planning Unit and the State Health Planning Council, the Legislature enacted several bills during the current year which, it is hoped, will encourage comprehensive health planning to engage in both process and operational planning.

Among such legislation is Chapter 1550, Statutes of 1969, which revised and expanded the membership of the Health Planning Council. Increased from 13 to 21 members, the council is composed of a majority of consumers of health services. Chapter 1451, Statutes of 1969, prohibits the construction or expansion of hospitals and related health facilities unless such construction or expansion has received the approval of the voluntary areawide health planning agency for the area in which such facility is to be constructed or expanded. Nine such area-

Department of Public Health—Continued

wide agencies presently exist in the state, and were established pursuant to Section 314(b) of PL 89-749, and with the assistance of the Comprehensive Health Planning Unit.

In another action which was designed to further the responsibilities of comprehensive health planning, the Governor's Reorganization Plan No. 1 of 1969, which became effective on September 11, 1969, eliminated the Advisory Hospital Council which had existed since 1947, and transferred its duties to the Health Planning Council. These duties consist primarily of administering the allocation of federal funds for hospital construction under the Hill-Burton and other federal programs, and the administration of the California Hospital Survey and Construction Act. The implications of this transfer were important enough to result in the appointment of three former members of the Advisory Hospital Council to the expanded membership of the Health Planning Council.

The current year, therefore, has been one in which both legislative and administrative efforts have attempted to produce a measurable output from the Comprehensive Health Planning Unit and the Health Planning Council. These efforts are not intended to replace the need for continued comprehensive planning, but to act as a needed adjunct to such planning.

We strongly support the measures which have been taken in the current year to produce meaningful health goals for comprehensive health planning.

The budget proposes to continue the comprehensive health planning activities at a total cost of $1,028,965, of which $67,992 is borne by the General Fund. The remainder is borne by the federal government from funds allocated to the state under the provisions of Public Law 89-749.

In an effort to further redirect comprehensive health planning toward a greater involvement in operational planning, we are recommending that the Comprehensive Health Planning Unit absorb the functions of the Office of Planning currently located in the Department of Mental Hygiene. This transfer does not preclude that department from performing operational planning for internal purposes. It simply recognizes the fact that the Department of Mental Hygiene is not exempt from the provisions of Chapter 1451, Statutes of 1969, which relates to facility planning, construction and expansion and is described above. Such planning should be carried out at one place and the Comprehensive Health Planning Unit appears to be most suitable. The implementation of this recommendation will result in a better and more efficient usage of the state's mental health resources as they relate to health resources as a whole. This recommendation is also in keeping with the spirit of Public Law 89-749, which is titled "The Partnership for Health Program."

Department of Public Health
REGIONAL DIALYSIS CENTERS

Item 126 from the General Fund **Budget page 630**

Requested 1970–71	$260,248
Estimated 1969–70	311,195
Actual 1968–69	302,939
Requested decrease $50,947 (16.4 percent)	
Total recommended reduction	None

GENERAL PROGRAM STATEMENT

Chapter 1988, Statutes of 1965, authorized the Department of Public Health to establish two regional renal dialysis centers for the treatment of persons suffering from chronic uremia (kidney disease).

Located in San Francisco and Los Angeles, the centers are designed to provide dialysis services to approximately 50 persons at each center. The centers also provide training for medical and nursing personnel who will carry out these services in other areas of the state.

The Department of Public Health acts only as a granting agency for state funds which are appropriated for the continuation of these two centers.

ANALYSIS AND RECOMMENDATIONS

We recommend approval.

The department proposes a General Fund appropriation of $260,248 for the support of the two centers in the budget year, which is a decrease of $50,947 or 16.4 percent below that estimated to be expended in the current year. The decrease in General Fund support can be accounted for by an increased amount of third party payments to the program, mainly at the San Francisco center. This decrease in no way affects the present number of persons receiving services at the two centers, or the quality of those services.

Department of Public Health
HYALINE MEMBRANE

Item 127 from the General Fund **Budget page 637**

Requested 1970–71	$190,182
Estimated 1969–70	200,000
Actual 1968–69	200,000
Requested decrease $9,818 (4.9 percent)	
Total recommended reduction	None

GENERAL PROGRAM STATEMENT

Chapter 1426, Statutes of 1968, authorized the Department of Public Health to conduct a three-year pilot study for the diagnosis and treat-

Hyaline Membrane—Continued

ment of children suffering from hyaline membrane. The authorizing legislation requires that cost data for providing care to children suffering from this condition be developed, and that an annual report be submitted to the Legislature.

The purpose of this study is to determine the feasibility of treating hyaline membrane under the Crippled Children Services Program.

ANALYSIS AND RECOMMENDATIONS

We recommend approval.

The budget proposes a net General Fund appropriation of $190,182 to support the third and final phase of the hyaline membrane pilot study. This is a decrease of $9,818 from the $200,000 estimated to be expended in the current year.

Department of Public Health

CALIFORNIA HEALTH FACILITY CONSTRUCTION LOAN INSURANCE FUND

Item 128 from the General Fund **Budget page 614**

Requested 1970–71	$115,577
Estimated 1969–70	94,754
Requested increase $20,823 (22.0 percent)	
Total recommended reduction	None

GENERAL PROGRAM STATEMENT

Chapter 970, Statutes of 1969, enacted the California Health Facility Construction Loan Insurance Law, which established in the Department of Public Health a program of self-liquidating state insured, guaranteed loans for the construction of public and nonprofit hospital facilities. The purpose of the program is to encourage the flow of private capital into the health facility construction field.

Since loans made under the provisions of this program are guaranteed and insured by the state, the legislation authorized the collection of fees from those persons who apply for, and/or receive state guaranteed and insured loans. The Health Facility Construction Loan Insurance Fund was created as a revolving fund into which all revenues from such fees shall be deposited, such revenues to be used to finance the program.

ANALYSIS AND RECOMMENDATIONS

We recommend approval.

Chapter 970, Statutes of 1969, appropriated $94,754 from the General Fund to be deposited into the Health Facilities Construction Loan Insurance Fund to be used as "seed money" to cover the administrative costs of the program until such time as this amount could be repaid, with interest, to the General Fund from fees collected pursuant to law.

California Health Facility Construction Loan Insurance Fund—Continued

The budget proposes another loan from the General Fund to the Health Facilities Construction Loan Insurance Fund in the amount of $115,577. This amount will support nine positions in the department which have been added to implement the program. This General Fund loan must also be repaid with interest.

It is anticipated that in the budget year enough will be collected from fees to enable the Health Facilities Construction Loan Insurance Fund to begin to repay its debt to the General Fund. In the meantime, however, continued General Fund support is necessary to allow the program to function.

DEPARTMENT OF PUBLIC HEALTH

Item 129 from the Motor Vehicle Fund **Budget page 614**

Requested 1970–71	$54,800
Estimated 1969–70	64,795
Actual 1968–69	–0–
Requested decrease $9,995 (15.4 percent)	
Total recommended reduction	None

GENERAL PROGRAM STATEMENT

The Department of Public Health in charged with the responsibility of determining the medical effects of air pollution. To support this activity the department maintains three professional positions and one clerical position who coordinate their work closely with the Air Resources Board. Because this activity is directly related to air pollution it is supported from the Motor Vehicle Fund.

ANALYSIS AND RECOMMENDATIONS

We recommend approval.

The budget proposes an appropriation of $54,800 from the Motor Vehicle Fund to support four positions in the budget year. This is a decrease of $9,995 from the $64,795 proposed to be expended in the current year.

DEPARTMENT OF REHABILITATION

Item 130 from the General Fund **Budget page 682**

Requested 1970–71	$5,974,465
Estimated 1969–70	6,748,650
Actual 1968–69	8,753,477
Requested decrease $774,185 (11.5 percent)	
Total recommended reduction	None

Department of Rehabilitation—Continued

SUMMARY OF MAJOR ISSUES AND RECOMMENDATIONS

1. We withhold recommendation on the proposal to develop additional contracts with public and private agencies because we question the overall efficiency of the proposal, as well as the department's potential for obtaining the necessary agreements.

2. We recommend that the department implement to the fullest extent possible the intent of Chapter 1369, Statutes of 1968. In addition, an amendment to Chapter 1369 may be needed to authorize welfare recipients to remain in county welfare department caseloads while receiving, under contract, vocational rehabilitation services from the Department of Rehabilitation.

GENERAL PROGRAM STATEMENT

The State Department of Rehabilitation is primarily responsible for assisting and encouraging handicapped individuals to prepare for and engage in gainful employment to the extent of their capabilities. Secondary objectives of the department are to increase the handicapped individual's social and economic well-being. The department's general program areas relate to (1) vocational rehabilitation of the disabled, (2) development of community resources, (3) disability determination, (4) departmental administration and (5) the service center program which is discussed in Item 131. The department operates under the authority of the Federal Vocational Rehabilitation Act and various sections of the Welfare and Institutions Code.

ANALYSIS AND RECOMMENDATIONS

For the 1970–71 fiscal year the budget proposes a total program requirement, after reimbursements, of $43,214,383, of which $35,871,905, or 83 percent, is from federal funds, $5,974,465 or 14 percent is from the General Fund and $1,368,013 or 3 percent is from the Industries for the Blind Manufacturing Fund. The total proposed expenditure is $220,612 less than that estimated to be expended during the current year. The General Fund appropriation is $774,185, or 11.5 percent, less than that estimated to be expended during the current year.

The proposed support from the General Fund for 1970–71 of $5,974,465 does not include a separate appropriation to the Department of Rehabilitation of $747,042. This represents the rehabilitation element in the Service Center Program and is reported upon in our analysis of that program, Item 131.

The total number of man-years budgeted to carry out all programs relating to this budget item are as shown in Table I (state service center positions are excluded):

Table 1

Number of Man-Years, Department of Rehabilitation

Fiscal year	*Total*	*Change from prior year*
1967–68 (actual)	1,736.3	
1968–69 (actual)	1,737.5	+ 1.2
1969–70 (estimated)	1,900.8	+163.3
1970–71 (proposed)	1,898.8	— 2.0

Department of Rehabilitation—Continued

The 1970–71 decrease is to take place in the sensory disorders element of the vocational rehabilitation of the disabled program.

Vocational Rehabilitation of the Disabled Program

The purpose of this program is to provide vocational rehabilitation services to help disabled persons overcome their physical or mental handicaps and secure employment. Vocational rehabilitation has been defined as the restoration of disabled persons to the fullest physical, mental, vocational and economic usefulness of which they are capable.

Vocational rehabilitation services are broad in scope and include:

(1) Medical diagnosis to determine the nature and extent of the disability and the need for medical, surgical or psychiatric treatment.
(2) Counseling and guidance to help discover a suitable employment objective.
(3) Physical restoration to remove or reduce the employment handicap.
(4) Academic and vocational training to prepare the client for employment compatible with his physical and mental ability. In addition, sheltered workshops are used to provide training and work experience for severely disabled persons.
(5) Job placement in keeping with the clients' physical condition and vocational ability. This includes providing equipment to help them establish their own businesses and includes followup adjustment services.

Basic Vocational Rehabilitation Element

Basic vocational rehabilitation services are provided to disabled people at or near working age, whose disability is a vocational handicap in that it interferes with obtaining or keeping employment. Services are provided primarily through a statewide system of local offices. Vocational rehabilitation counselors are located in each field office and have the responsibility to (1) establish an effective working relationship with handicapped clients, (2) help clients decide on a plan that will overcome their handicaps, (3) arrange for the necessary services such as training and medical treatment, (4) systematically review the plan during its course, (5) help clients secure employment following completion of employment preparation, and (6) follow up to make sure that services and placements are suitable. Counselors are assisted by vocational psychologists who give and interpret psychological tests for individual clients and by medical consultants who make decisions concerning medical information in the cases.

Within the basic vocational rehabilitation process the department expects to return to employment 15,000 disabled people during the 1970–71 fiscal year. The total expenditures for this element are expected to increase from $35,801,914 in 1969–70 to $35,987,685 in 1970–71. Table 2 contains basic accomplishment data in this area.

Department of Rehabilitation—Continued

Table 2

Basic Vocational Rehabilitation Process Accomplishments and Cost

Fiscal year	Disabled persons removed from welfare	Total clients returned to employment	Total expenditures	Cost per rehabilitation
1967–68 (actual)	3,322	10,389	$26,355,489	$2,537
1968–69 (actual)	3,605	14,450	29,745,353	2,059
1969–70 (estimated)	3,750	15,000	35,801,914	2,387
1970–71 (proposed)	4,000	15,000	35,987,685	2,571

Page 683 of the department's program budget indicates that it will cost an average of $2,571 for each person rehabilitated in 1970–71, and that 15,000 clients will be rehabilitated at a total expense of $35,987,685. On the basis of an average cost of $2,571 per person rehabilitated and the availability of $35,987,685 it would appear that 14,000 persons will be rehabilitated rather than the 15,000 indicated in the budget. Assuming the accuracy of the estimated cost per rehabilitated person the department will return 1,000 less disabled persons to employment than will be returned during the current fiscal year.

The department plans to develop additional contracts with public and private agencies utilizing $631,659 of the other agencies' funds as the source of required state matching of available federal funds. Individual agreements will reflect program emphasis dependent upon the needs and circumstances of the local public or private agencies involved in the cooperative effort. At the time of this analysis the department was unable to explain which public and private agencies would be involved and to what extent. The department did indicate that it was actively seeking contractual agreements and would be able to give a progress report on its efforts at the time of the legislative hearings on the budget. The net result of these contracts may be a shift in program emphasis relating to the type of clients served.

We withhold recommendation on this proposal because we question the overall efficiency of such a possible redirection of effort and question that adequate agreements to match federal requirements will be possible.

The purpose of the change is apparently to save state funds, a laudable goal. Under the federal Rehabilitation Act, California is required to spend in each fiscal year as much on basic rehabilitation as it did in 1968–69 if it is to receive federal matching money. The $631,659 to be put up by local agencies will enable the state to meet the federal maintenance of effort requirement related to this item. Nothing in the program budget indicates that this shift will improve the department's ability to achieve its objectives, only that it will save state funds.

Any overall change in program emphasis will result in a reduction in the number of persons enrolled in rehabilitation programs in 1970–71. Caseloads from the new agencies will take time to develop whereas there is no delay in maintaining full caseloads in the current system. Since it takes about 20 months for a disabled person to complete the services he needs to become employed, full impact of the rehabilitation

Department of Rehabilitation—Continued

achieved by the new cooperative programs will not be realized until late 1972 at best. On the other hand, if this $631,659 and the matching federal money were put into the present ongoing system many rehabilitations would probably occur six months to one year earlier. In addition, rehabilitations may also decrease if more difficult clients are served as a result of the new agreements.

At the time of this analysis the department was finding it difficult to complete agreements with local agencies because of federal regulations. According to the department, federal regulations state that no money can revert back to the local organization whose funds have been utilized as the source of state matching for available federal funds. This is apparently to prevent states from using already existing private rehabilitation programs to meet their maintenance of effort requirement.

Should it become necessary for the state to provide the $631,659 in question we recommend the entire amount be used to rehabilitate welfare and potential welfare recipients. This is the most profitable group to work with from a tax savings point of view and the money spent will be more than offset in savings at a later date.

We recommend that the department implement to the fullest extent possible the intent of Chapter 1369, Statutes of 1968. In addition, an amendment to Chapter 1369 may be needed to authorize welfare recipients to remain in county welfare department caseloads while receiving, under contract, vocational rehabilitation services from the Department of Rehabilitation.

On page 685 of the program budget, the department explains why it could not implement Chapter 1369. Chapter 1369 requires that the Departments of Social Welfare and Rehabilitation enter into agreements to provide rehabilitation services to welfare and potential welfare recipents. These agreements are to provide for the most effective use of federal funds. The chapter also requires that savings made available as a result of these agreements shall be used exclusively to provide vocational rehabilitation to welfare or potential welfare recipients. Public assistance recipents under these agreements are to transfer to the Department of Rehabilitation and receive their grant as a supplemental expense allowance while undergoing rehabilitation training. As the department points out, federal regulations require that all rehabilitation clients be paid the same training expense allowance from the department.

Table 3

Percent of Governmental Participation in Major Welfare Training Programs

Training Program	*Total*	*Federal*	*State*	*County*
Vocational Rehabilitation—Department of Rehabilitation	100	80	20	0
Work Incentive Programs (WIN)—Department of Human Resources Development	100	80	20	0
Educational Training Services Programs (ETP)—County Welfare Departments	100	75	--	25

Department of Rehabilitation—Continued

As can be seen from Table 3 the two programs with the most federal participation are WIN in the Department of Human Resources Development and Vocational Rehabilitation in the Department of Rehabilitation. WIN training slots are full. See page 595 of this analysis for discussion of the WIN program.

Rather than abandon the implementation of Chapter 1369 we recommend that the Department of Rehabilitation explore the possibility of contracting with counties having Educational Training Services Programs (ETP). Such contracts could provide better utilization of federal and county funds. See page 684 of this analysis for discussion of ETP programs. An amendment to Chapter 1369 may be needed to authorize welfare recipients to remain in county welfare department caseloads while receiving, under contract, vocational rehabilitation services from the Department of Rehabilitation. On an overall basis every welfare recipient enrolled by the department increases the federal share of the cost of training welfare recipients.

Prevocational Rehabilitation Element

Persons in this program element are provided services to prepare them to take advantage of the vocational rehabilitation services described above under the basic vocational rehabilitation process. Visually impaired clients receive training in independent travel, physical conditioning, braille, typing, activities of daily living, home economics, shop, and business methods. Severely mentally retarded clients, most of whom do not have vocational potential, receive help in a sheltered workshop arrangement administered by the Department of Rehabilitation.

Based on previous experience within the prevocational rehabilitation services element we expect 1,060 clients to graduate to the basic vocational rehabilitation process in 1970–71. Table 4 contains basic accomplishment data in this area.

Table 4

Prevocational Rehabilitation Services and Costs

Fiscal year	*Persons served*	*Estimated transfers to basic rehabilitation*	*Total expenditure*
1967–68	1,642	946	$974,854
1968–69	1,732	998	975,699
1969–70	1,800	1,037	1,207,747
1970–71	1,840	1,060	1,203,341

DEVELOPMENT OF COMMUNITY RESOURCES PROGRAM

This program is designed to encourage the development and improvement of rehabilitation resources, particularly in rehabilitation facilities and workshops. Through the program the department provides a wide range of advisory services to private organizations interested in workshops for the disabled. Consultation is provided in production engineering, cost accounting, sales promotion, marketing, etc.

Under this program the department also provides consultation and review of requests for (1) project development grants, (2) grants to

Department of Rehabilitation—Continued

establish or improve facilities, (3) training service grants, and (4) research and demonstration project grants. Federal funds are available for these activities and the department is responsible for a review of requests prior to receipt of federal funds.

For the 1970–71 fiscal year the cost of this program is budgeted at $868,032 as compared with an estimated cost of $1,012,411 for the 1969–70 fiscal year.

Although needed facilities continue to be unavailable in various areas in California, the funding of this program has been reduced. This program is in competition with basic rehabilitation funds and is considered by the department lower in priority than the basic rehabilitation program. Unless additional General Funds are made available to the department this program will remain inadequately funded to meet local needs identified by the department.

THE DISABILITY DETERMINATION PROGRAM

In 1956, the Congress amended the Social Security Act to allow disabled injured workers to receive disability insurance payments. Under the law, payments can be made if the worker is unable to perform substantial gainful activity because of a physical or mental disability. The federal government contracts with the state vocational rehabilitation agencies to make the disability determinations. Each disabled applicant is also considered for vocational rehabilitation referral. The support of the Disability Determination Program is financed entirely from federal funds.

Disability determination counselors work with medical consultants in this program through offices located in Oakland and Los Angeles. The counselors are responsible for evaluating the work factors in the disability determinations and the medical consultants for the medical factors. It is the counselor's job to decide which of these applicants should be referred for consideration of vocational rehabilitation. The great majority of applicants for disability insurance are older, severely disabled persons.

For the 1970–71 fiscal year the cost of this program is budgeted at $6,480,264 as compared to an estimated cost of $6,400,373 for the 1969–70 fiscal year. During the budget year 108,000 disability determination applications will be processed and 12,000 persons will be referred for vocational rehabilitation.

DEPARTMENTAL ADMINISTRATION PROGRAM

The purpose of this activity is to provide executive direction, planning, policy determination and office services for operation of all department programs. Organizational units include the Executive Office, Management Services, and Field Support Services. The budget proposes an expenditure of $2,581,383, most of which is distributed to other programs, for the 1970–71 fiscal year. This is $9,608 above the amount estimated to be expended during the current fiscal year.

Department of Rehabilitation
SERVICE CENTER PROGRAM

Item 131 from the General Fund Budget page 695

Requested 1970–71	$747,042
Appropriated 1969–70	816,556
Appropriated 1968–69	863,426
Requested decrease $69,514 (percent)	
Total recommended reduction	None

ANALYSIS AND RECOMMENDATIONS

This item is analyzed under the Department of Human Resources Development (Item 113).

SOCIAL WELFARE

GENERAL SUMMARY

Social Welfare has as its objectives providing money for food, clothing, and housing; certification for medical care and food stamps; and rendering social services to dependent persons so that they may become more self-sufficient and independent. In actual fact, the latter objective is so poorly served as to be inconsequential; witness the rapid and constant rise in welfare dependency in California. Proposed 1970–71 social welfare requirements in California, from all funds, total $2,138,389,277. This is an increase of $306,951,479, or 16.8 percent over the estimated expenditures for 1969–70. The $2,138,389,277 is broken down by source of funds in Table 1.

Under the supervision of the Secretary for Human Relations the State Department of Social Welfare, through the 58 counties in California, will provide cash assistance to a monthly average of 1,875,170 welfare recipients in 1970–71. Other persons in need but not eligible for these programs are provided assistance under county general relief programs.

In addition, the State Department of Social Welfare provides other special services, classified as follows: demonstration and pilot programs in public assistance, child development and protection programs, the adoption program, public protection programs (licensing of boarding homes and institutions), public welfare manpower program (staff recruitment and training), and administrative improvement programs. These programs are primarily administered through the various counties under the supervision of the State Department of Social Welfare.

Additional amounts will also be spent to provide health and welfare support and assistance for Californians through the Departments of Health Care Services, Public Health, Mental Hygiene, Rehabilitation, Corrections, Youth Authority, and through federal and local poverty prevention programs. The upward trend in welfare to needy persons in California is anticipated to continue in the 1970–71 fiscal year as

Table 1

Total 1970–71 Social Welfare Expenditure Including Administrative Cost by Budget Item and Source of Funds

Item	*Program*	*Total*	*Federal*	*General Fund*	*County*
132	State Operations	$30,897,348	$10,645,526	$20,251,822	--
279	Public Assistance	1,598,663,500	746,462,400	599,846,200	$252,354,900
--	Federal Aid Programs	4,266,939	4,266,939	--	--
280	Out-of-Home Care	93,396,400	45,547,000	40,820,700	7,028,700
281	Unmet Shelter Needs	3,814,482	1,907,241	1,500,000	407,241
282	Local Administration of Public Assistance	370,185,000	245,944,000	1,168,381	123,072,619
283	Special Social Services	37,165,608	27,492,020	9,673,588	--
	Total	$2,138,389,277	$1,082,265,126	$673,260,691	$382,863,460

Table 2

Public Assistance by Source of Funds—Estimated Expenditures, 1970–71

Programs	*Total*	*Federal*	*General Fund*	*County*
Aid to the Blind	$22,702,600	$10,858,400	$8,948,600	$2,895,600
Aid to Needy Disabled	239,836,500	114,369,400	107,543,200	17,923,900
Aid to Families with Dependent Children	957,705,400	432,639,700	320,648,000	204,417,700
Old Age Security	378,419,000	188,594,900	162,706,400	27,117,700
Total	$1,598,663,500	$746,462,400	$599,846,200	$252,354,900

General Summary—Continued

indicated in Table 3, which shows the number of welfare and Medi-Cal recipients in California in relation to the civilian population.

Table 3

California Population and Number of Welfare and Medi-Cal Recipients

Fiscal year	Monthly average civilian population	Percentage increase from prior year	Monthly average recipients	Percentage increase from prior year	Recipients as percent of civilian population
1960–61	15,865,000	--	601,952	--	3.8
1961–62	16,342,000	3.0	638,626	6.1	3.9
1962–63	16,909,000	3.4	743,168	16.4	4.4
1963–64	17,473,000	3.3	831,626	11.9	4.8
1964–65	17,970,000	2.8	944,524	13.6	5.3
1965–66	18,367,000	2.2	1,141,863	20.9	6.2
1966–67	18,710,000	1.9	1,298,194	13.7	6.9
1967–68	19,037,500	1.8	1,475,662	13.7	7.8
1968–69	19,329,000	1.5	1,643,600	11.4	8.5
1969–70 (est.)	19,636,000	1.6	1,856,900	13.0	9.5
1970–71 (est.)	19,966,000	1.7	2,119,600	14.1	10.6

LOCAL ADMINISTRATION OF PUBLIC ASSISTANCE

In administering the public assistance programs, county welfare departments incur costs under two major categories: (1) Those attributable to departmental management and supporting staff services and (2) those attributed to services provided to people. Table 4 shows the overall expenditures for local administration of public assistance for the past, current and budget year by source of funds.

Table 4

Local Administration of Public Assistance by Fiscal Year and Source of Funds

Fiscal year	Total	Federal	State	County
1968–69	$259,698,246	$176,931,000	$354,654	$82,412,592
1969–70 (est.)	325,448,000	219,367,000	1,168,381	104,912,619
1970–71 (est.)	370,185,000	245,944,000	1,168,381	123,072,619

Welfare Administration

We recommend that the state adopt a system of direct state administration of all categorical aid welfare programs, county general relief programs, certification of food stamps, and Medi-Cal.

Need for State Administration

California has traditionally administered the welfare function through a state-county system. The State Department of Social Welfare is responsible for supervising the administration of the categorical aid programs and social service programs. The counties are directly responsible for determining eligibility, paying assistance, providing services, and reporting to the state.

We believe that this system has developed into a huge, complex organism which devotes excessive amounts of its resources to relatively unproductive functions through which the state and county each attempts to preserve its own identity and to overcome almost unsolvable administrative problems among and between its semiautonomous parts.

General Summary—Continued

The net result of this dual system and the continuing problems it produces is that welfare laws are not uniformly applied throughout the state, that it is impossible to locate and assess responsibility for program failure, and that the cost of program administration is substantially more than it needs to be. In addition, the burden placed on the local property taxpayer to help finance the welfare programs has become excessive in most counties and inequitable between counties with low tax bases and counties with high tax bases.

The most expensive single function performed by the state department is its relatively fruitless effort to write and interpret rules, regulations and explanatory material for 58 semiautonomous county welfare departments. The county welfare departments in turn expend much time and effort attempting to comply and at the same time preserve their local autonomy and to respond to local demands which are frequently incompatible with state requirements.

In the end, we do not have uniform application of welfare laws in all jurisdictions. The efforts of social workers are diverted to endless problems of communication and interpretation, and no real progress is made toward the basic objective of the system, which is the elimination of dependency of welfare recipients to the greatest practical extent. In fact, Table 3 indicates clearly that we are steadily losing ground.

The argument most commonly advanced for the retention of the present system at the local administrative level is that local authorities, being closer to the people, can judge need more accurately and therefore prevent the undue enlargement of caseloads. This argument may have been valid when California was rural in character and when relief was a direct financial responsibility of local resources. However, these conditions no longer prevail in California, and the growth of caseloads and cost, which is evident in recent years, contradicts the argument. Today, eligibility and grant levels are prescribed by statewide standards and any significant deviation or difference resulting from local attitudes violates the intention of the law. It is far more likely that realistic welfare programs can develop under a system of state administration more amenable to direct legislative control on a statewide basis than from the present unwieldy, chaotic structure which is engrossed in the problems of self-preservation and autonomy at the expense of making progress towards welfare's basic objectives.

Last year we estimated that if the state could approach the administrative cost per recipient that prevailed in Michigan and Illinois, California could save approximately $95 million per year in federal and county funds. Due to various factors, including higher costs, we do not anticipate a saving of this magnitude. However, we do believe a saving on the order of $50 million could reasonably be expected after implementation of state administration.

Although the difficulties identified below could be remedied to some degree in the present system, any progress would be limited and extremely difficult to accomplish because of the many separate governmental units now involved. The chances for developing a modern public

General Summary—Continued

welfare program geared to the needs of welfare recipients and taxpayers will be greatly enhanced if California will change to a state administered welfare program.

1. Improved fiscal support and cost sharing.

One of the most serious problems in the present welfare system arises from the use of the property tax to support welfare. Large expenditures on behalf of welfare recipients result in unusually heavy property tax burdens in those counties with low tax bases and high concentrations of recipients. This is part of the reason why general relief is so heavy a burden in spite of its limited standards in these counties.

Under our state administration proposal, the state would take over the entire local cost of the welfare program. The tax burden would thus be spread over the wider base of the state's entire citizenry. In addition, it would make a major contribution to the goal of property tax relief.

2. More appropriate delegation of authority, responsibility and accountability.

An organization, particularly for administration of a program as large and important as public welfare, must be structured in such a way that responsibility for its success or failures can be clearly placed. The present structure in California lends itself only too well to "buck-passing" between various county and state officials. In a system of state administration the Legislature and the Governor would be fully responsible and accountable to the people.

California's county welfare directors under the present system have two masters: their board of supervisors and the State Director of Social Welfare. County supervisors employ and fire welfare directors. They set salaries, vacations and sick leave policies, county general relief policies, and they set the philosophical tone for the implementation of welfare programs.

The State Director of Social Welfare, through state regulations, interprets state laws and federal regulations and tells the county welfare directors what they must do and what they must not do. The individual county welfare director, therefore, frequently finds himself doing something at state direction which is contrary to the desires and philosophies of those who have the power to remove him from office. This dual supervision would not be present under state administration.

3. Equity and uniformity within the welfare programs.

The differences in philosophy and methods of operation in California's counties clearly result in unequal treatment of welfare recipients. The goal of assuring equal treatment under the law is even more important in public welfare because welfare gives or withholds that which is essential to people in need. Equal and uniform treatment would be greatly enhanced in a state-administered system.

The welfare recipient who moves across a county line finds it necessary to get acquainted with a new caseworker, to learn the new agency's

General Summary—Continued

policies, and probably to experience an actual change in the amount of assistance received.

When a recipient transfers from one county to another there is also considerable administrative cost involved for the second county welfare staff to develop the many new control documents and records and to do a new workup on the case. Based on Sacramento County "transfer-in" statistics, applied statewide, we estimate that there are currently over 2,000 monthly transfers from one county to another.

Under a state-administered system, less rigid district lines could be maintained, grants would be determined in the same way and in the same amount (depending upon the cost of living in the areas moved into), and there would be no reason why a short move across a county line would need to interfere with casework. If the move is such that it would not be economical for the current worker to keep the case, the complete case records and controlling documents could be transferred to the new location, thereby avoiding the present wasteful procedure of starting a new record in the new county of residence.

A state-administered organization would be much more likely to function as a single system in carrying out programs defined and established by the Legislature for meeting the needs of the citizens in every part of the state.

4. Greater administrative efficiency.

The State Department of Social Welfare and the federal government have a large number of auditors for extensive auditing of the various county documents. If welfare payments and employee payrolls, as well as other disbursements of funds, were actually made by the state, these extensive auditing activities could be greatly simplified. Also, since under our proposed state-administered system no local funds would be expended, the complicated allocation procedures necessary to establish reimbursements to local government could be eliminated.

Even greater savings could come in payment, bookkeeping, management analysis, and statistical reporting activities. In a state-administered system these activities could be expedited by central machine operations and management analysis support. It would be necessary to maintain in the local offices on-the-spot funds to meeet emergency needs but all other disbursements for personnel and assistance grants could be made and recorded centrally. As it is now, these expenditures, including over one million mothly checks to recipients, are made by various administrative units and departments within the 58 counties using various methods and procedures and at various stages of automation.

State administration could materially reduce paperwork by substantially reducing the number of forms and accounting documents required. Counties often develop additional forms which require slightly different information from the state forms. Some counties have developed over 500 county forms which are used in addition to the state required forms.

General Summary—Continued

One of the important advantages of the present California system is, of course, the geographical accessability of its public assistance services. Each county has a welfare department, and careful thought must be given to this factor in planning any new organization. However, accessability to welfare offices in the current system is sometimes wasteful and confusing because of the historical decision that located a given county boundary. In some metropolitan areas such as East Palo Alto, there are two or more welfare offices in the same geographical area operated by different county welfare departments. One county will locate an office in a poverty area to serve its county residents while other welfare applicants and recipients who live across the county boundary but in the same poverty area must go considerable distance to the county seat of their county.

State offices under state administration can be located where they are needed and where they are accessible. In this way, optimum efficiency can be more easily achieved.

DEPARTMENT OF SOCIAL WELFARE

Item 132 from the General Fund **Budget page 696**

Requested 1970–71	$20,251,822
Estimated 1969–70	17,314,274
Actual 1968–69	14,778,915
Requested increase $2,937,548 (17.0 percent)	
Total recommended increase	$500,000

SUMMARY OF MAJOR ISSUES AND RECOMMENDATIONS — *Analysis page*

1. *We recommend a General Fund transfer from Items 123 and 273 to this item of $500,000 to provide followup service to the mentally ill.* — 684

GENERAL PROGRAM STATEMENT

The State Department of Social Welfare coordinates and integrates a statewide social welfare program. The department also is required to provide fair hearings to welfare applicants and specific reports to the federal government. The department pursues its objectives through a series of programs and functions. These include Public Assistance Categorical Aid and Special Social Service programs which are grouped into five broad categories as follows:

1. Support and Maintenance programs
2. Human Resources Conservation programs
3. Public Protection programs
4. Community and Local Agency Resources Improvement and Support programs.
5. Systemwide Planning, Management and Supporting Functions.

In terms of man-years, total positions for state operation of the department for the past, current and budget years are shown in Table 1.

Department of Social Welfare—Continued

Table 1

Total Man-Years, Department of Social Welfare

Fiscal year	*Total*	*Change from prior year*
1968–69	1,545.4	+71.1
1969–70	1,780.9	+235.5
1970–71	1,734.2	—46.7

The department also has 94.5 authorized positions which do not appear in this item. These positions are discussed under Item 283 of this analysis (Special Social Services programs).

ANALYSIS AND RECOMMENDATIONS

The appropriation in this item indicates an increase of $2,937,548 over that estimated to be expended during the current fiscal year. The increase is misleading because the proposed appropriation includes $1,960,844 which is shown as a reimbursement from the Department of Mental Hygiene for the 1969–70 fiscal year. The state operations actually are proposed to increase 5.6 percent rather than the 17.0 percent previously indicated.

The executive agency of state government administering the welfare programs is the State Department of Social Welfare, which is headed by a director and chief deputy director, appointed by the Governor. The director is responsible for setting policy, adopting standards that define the purposes and responsibilities of state welfare operations, administering welfare programs, and rendering decisions on public assistance appeals cases.

A seven-member State Social Welfare Board, appointed by and serving at the pleasure of the Governor, functions as an advisory body to the department and is also responsible for broad study in the welfare field.

SUPPORT AND MAINTENANCE PROGRAMS

The Support and Maintenance programs are designed to enable people to subsist at a level compatible with an established minimum standard of health and decency. Aid payments are provided through public assistance programs for adults and for children and their families and by certifying eligibility for Medi-Cal benefits and for federal food stamps.

The state operational cost of the supporting elements of the program are carried in this item of the budget. Aid payments are made through Aid to Families with Dependent Children, Aid to the Needy Disabled, Old Age Security, and Aid to the Blind programs. These categorical aid programs may be supplemented by county general relief programs which are separate and in addition to the programs mentioned above.

HUMAN RESOURCES CONSERVATION PROGRAMS

The Human Resources Conservation programs are designed to strengthen and preserve family life, improve the capabilities of individuals to realize their full potentials for productive, independent living, increase their earning capacity and protect those who cannot effectively protect themselves.

Department of Social Welfare—Continued

The Human Resources Conservation programs consist of the following. For the purposes of this analysis we have discussed only the Self-Support and Protective Services for the Mentally Handicapped programs listed below. These are the two programs about which we have pertinent comments.

1. The Self-Support program.
2. The Child Protection program.
3. The Adoption program.
4. The Adult Protection and Self-Care program.
5. The Protective Services for the Mentally Handicapped program.
6. The Family and Child Development program.

Self-Help Program—Recipient Training

The self-support programs are concerned with planning, motivating and preparing the recipient for job training and placement and includes sheltered employment for disabled persons and day-care services.

Work Incentive Program

The Work Incentive program (WIN) is designed to restore appropriate AFDC recipients to regular employment through counseling training and job placement, or to provide employment on special work projects to improve the communities in which they live. Currently the program is operated in the 27 counties having the larger AFDC caseloads and will be extended to other counties as federal funds become available. County welfare department responsibilities are: (1) refer all AFDC recipients who are trainable or employable to the State Department of Human Resources; (2) provide social services to the families of those enrolled in the program as needed; (3) provide for child care when needed and provide training or work-related expenses in addition to the normal public assistance grant. The State Department of Human Resources Development (HRD) staff is responsible for the assigning of accepted recipients to counseling, tutoring, orientation training, work experience training, or special work projects and for the eventual placement of the recipients in employment. While HRD staff works with the WIN enrollee in the various aspects of the WIN program, county social work staff assists the enrollee's family with any social problems the family may have. In addition the county staff assists with training-related problems of transportation and child care.

The WIN program represented a substantial change in administrative handling of the rehabilitating, training and placement of welfare recipients for employment. County welfare department training programs were abandoned under the rules of the State Department of Social Welfare in many counties on July 1, 1968, in order to participate in the WIN program which was required as a result of the 1967 Social Security amendments.

It is difficult to evaluate the effectiveness of the WIN program because it has only been in actual operation about one year. In addition, many of the problems that are present would occur in any program which has so many agencies and people involved. However, we have

Department of Social Welfare—Continued

identified some of the problems which make it difficult for the WIN program to achieve its objectives. These appear on page 595 of this analysis.

Educational Training Program

The Educational Training Program (ETP) is designed to supplement and complement the WIN program by providing self-support services in areas of the state not covered by WIN or where WIN cannot serve all appropriate recipients. It is administered by county welfare departments that elect to do so in accordance with a county plan of services which assures no duplication of effort. Upon completion of training under ETP, participants are referred to the Department of Human Resources Development for job placement. As the capacity of WIN increases, the activities carried under this program will decrease proportionately. However, there will remain between 10,000 and 20,000 AFDC recipients who will not be eligible for WIN because they are nonfederal AFDC recipients.

Many county welfare departments including Los Angeles abandoned their local training programs under the assumption that the WIN program would fill the training needs of recipients in their counties. Because of the lack of training slots and other restrictions, WIN does not accommodate all welfare recipients in a useful work training, job readiness, or placement program.

Although there is proper concern for this group of welfare recipients, counties are not providing adequate funds to train recipients. The cost sharing for the support of ETP is 75 percent federal and 25 percent county. In the WIN program the sharing is 75 percent federal, 16½ percent state and 7½ percent county. Because of the budgetary restrictions that most counties are faced with, it is doubtful they will budget additional funds for ETP. However, counties do have the basic responsibility for recipient training of persons not eligible for the WIN program.

Protective Services for the Mentally Handicapped

We recommend a General Fund transfer of $500,000 from Items 123 and 273 to this item to provide followup services to the mentally ill.

The Community Services Division (CSD) of the State Department of Social Welfare provides the following services with a staff of 843 located in 41 offices throughout the state:

1. Crisis prevention and intervention.

   In this activity, psychiatric social workers counsel mentally ill and mentally retarded persons and families during crises. Social workers refer such persons to medical, psychiatric, or other local facilities, and collaborate with other agencies to plan alternatives to psychiatric hospital admission and to prevent unnecessary hospital admissions and readmissions.

2. Release planning for mental hospital patients.

   In this activity social workers serve hospitalized patients and their families in the community. They develop and utilize alter-

nate care resources in the community and plan prerelease with hospital staff, patients, families and community.

3. Psychiatric social work services to former mental hospital patients.

In this activity social workers provide individual, group and family counseling and casework services. They refer patients to various agencies in the community for medical, psychiatric and financial services as needed, and education, rehabilitation, recreation and volunteer services. In addition, they develop community placement resources and provide aftercare social work services to patients and families.

A major objective of the California mental health program is prompt release of patients in state hospitals who are capable of living in community facilities. Lacking family, friends and resources, many of the patients would have to remain in the hospitals if special efforts were not made to find places for them in the community. Much of the necessary planning and placement activity must be done by the division's psychiatric social workers. The social worker evaluates placement plans for patients and finds community resources that will permit the released patient satisfactory convalescence.

A growing number of mental hospital patients require careful prerelease planning for special placement in out-of-home care. A variety of placement resources are being recruited to serve these special needs.

The family care program uses the services of families with adequate homes, income and personal resources who are willing to take patients into their homes as members of the family. These families are reimbursed at the rate of $160 per month per patient and have the benefit of the continuing counsel of the psychiatric social worker. In December 1969, there were nearly 4,500 mentally retarded and mentally ill patients living in family care homes.

A rapidly growing part of the Protective Services for the Mentally Handicapped program is out-of-home placement in a variety of other community resources. These include licensed board and care facilities for older persons, small residential hotels and other nonlicensed living facilities for other adults and young adults, licensed nursing homes for adults, and private institutions for mentally retarded infants and children.

Community Services Division psychiatric social workers are required to find suitable resources, help operators and providers of care to understand the special needs of persons served by the program, prepare persons for the experience of new living situations and provide sustained counseling to the participants in the living arrangements.

The division has been developing a network of procedures and agreements, linking itself with county mental health, county public social services, state hospitals, and related agencies to assist in the implementation of the new mental health law. The degree and nature of involvement of the division with various local agencies varies depending upon the services provided by the local agencies.

Department of Social Welfare—Continued

In our analysis of the current mental health program on page 641 of this analysis, we identify several problems which effect the Protective Services for the Mentally Handicapped program. One of these problems directly relates to action taken by the department to reduce staff and funds for the care of mentally ill persons. Specifically, the department, because of an anticipated reduction in mentally ill on-leave patients and the high vacancy rate in the Community Services Division, reduced the budgeted positions for the care of the mentally ill by 36.5 positions.

As we indicate in our analysis of the mental health program there is a lack of supervision and care of mentally ill individuals living in the community. A number of chronically ill patients, particularly in the large metropolitan areas, are creating problems in the community because the community lacks any effective machinery to deal with the patient. These persons, who are sometimes dangerous, remain in the community despite their exhibiting very disturbed behavior immediately prior and immediately after momentary observations by peace officers or local mental health clinic personnel.

Under the old mental health programs many of the patients leaving the state hospitals were classified as on-leave patients and were supervised directly by CSD. Under the Lanterman Petris Short Act, patients will be discharged directly to the community and will only come under CSD care indirectly. Because CSD caseloads are already full, only a very limited number of the mentally ill will be admitted to the CSD program. Because most local mental health clinics are not staffed to provide the followup social services needed we recommend the transfer of $500,000 from the Department of Mental Hygiene support items to fund 37 additional positions to the CSD staff to provide needed followup.

The number of positions needed is based on the staffing ratios of one psychiatric social worker to 58 mentally ill patients. The 37 positions would consist of 27 psychiatric social workers, five first line supervisors and five typist-clerks. Additional clerical and supervisory support would come from present CSD staff.

Due to the present lack of available staff CSD has almost stopped accepting new mentally ill patients. If the division accepted the additional mentally ill persons who are currently being referred to it, the 1970–71 monthly average mentally ill caseload would be 3,790 cases compared to the current average of 2,530. The 1970–71 budget provides enough staff at the 1–58 ratio to care for a caseload of 900 mentally ill patients. However, due to the severe needs of the communities the division has currently accepted 2,530. Thus, for 1970–71, 56 additional psychiatric social workers would be needed to provide meaningful service and care for the caseload of 3,790 patients.

We recommend that only 27 of the 56 additional psychiatric social workers, plus supervisory and clerical staff be authorized for the 1970–71 fiscal year. A total of 29 case aide positions were authorized in the current budget to take over work presently being performed by psychiatric social workers without a corresponding adjustment in the 1–58

Department of Social Welfare—Continued

caseload yardstick. As of December 1969, all of the 29 aides have been employed and should be fully trained by June 1970. These aides are to provide support for social workers as well as providing such subprofessional tasks as transporting individuals to and from shopping and community or professional appointments. The aides also are to supervise small groups of mentally handicapped persons during recreational outings or assist in the supervision of large groups at such outings. The case aide positions should be considered in the staffing standards. The General Fund cost for the 37 positions would be $88,482 which would be matched by $265,446 in federal funds.

The remainder of the $500,000 General Fund money that would be transferred to this item as result of the anticipated closure of DeWitt and Mendocino State Hospitals could be used to purchase transportation, childcare, workshops and special training and education programs for the mentally ill. In the state hospitals these items are either not needed or are currently provided. Table 2 indicates the increases recommended and source of funds.

Table 2

Summary of Recommended Changes in the Protective Services for the Mentally Handicapped Program

	General Fund	*Federal fund*	*Total*
Net increase of 27 psychiatric social workers	$68,202	$204,606	$272,808
Increase of five supervising psychiatric social workers	13,905	41,715	55,620
Increase of five clerk-typists I	6,375	19,125	25,500
Operating cost and purchase of community services	411,518	545,500	957,018
	$500,000	$810,946	$1,310,946

Public Protection Program

The objective of this program is to maintain standards for children's agencies and facilities, facilities for aged persons and life-care contracts. These objectives are met through licensing and inspection programs under the provision of Sections 16000–16318, Welfare and Institutions Code. The department reviews, counsels and licenses facilities for the reception and care of the aged and for the reception and care of children, both directly and through delegation to local agencies. The department also issues certificates of authorization for certain institutions for the aged to enter into life-care contracts with aged persons.

Community and Local Resources Improvement and Support Programs

Community and Local Agency Resources Improvement and Support programs are designed to help local agencies and communities develop the resources required to meet the needs of disadvantaged people and to help coordinate community efforts to deal with the problems faced by these people. These specific programs include: Community, Planning and Development; Public Welfare Manpower program and Demonstration Projects program.

Department of Social Welfare—Continued

Systemwide Planning, Management and Supporting Functions

This program includes centralized activities and services regarding planning, direction, administration and audit control. In addition, this program includes general administrative staff, the Research and Statistics Bureau, the Electronic Data Processing Bureau and other departmental support staff.

Fiscal Affairs

The object of this function is to assure that the funds available for the department's programs are expended in accordance with state and federal law.

A recent study by the Department of Finance indicates that the department audits are released on an average of 20 months after the completion of the audits. The same study also shows that about 42 percent of the audit time is spent in supervision and general administration, and only 58 percent is actually devoted to field auditing.

The Controller believes his office could perform these audits more efficiently by reducing the reporting lag time and increasing the field audit time. We propose to explore the merits of transferring this audit function to the Controller's office and still retain federal funding and report to the Legislature.

Human Relations Agency

DEPARTMENT OF INDUSTRIAL RELATIONS

Item 133 from the General Fund **Budget page 750**

Requested 1970–71	$20,768,273
Estimated 1969–70	23,592,038
Actual 1968–69	21,822,406
Requested decrease $2,823,765 (11.9 percent)	
Total recommended reduction	$7,100,000

SUMMARY OF MAJOR ISSUES AND RECOMMENDATIONS

We recommend the following changes in the department's organization and operating procedures. Most of the recommendations are contained in the report of the Commission on California State Government and Economy in its 1969 study of the department. (Analysis page 696.)

1. "The commission recommends a study of the role of the state in apprenticeship programs. As an alternative proposal, we recommend the abolishment of the Division of Apprenticeship Standards for a General Fund savings of approximately $2,000,000.
2. Consolidate the Divisions of Industrial Welfare and Labor Law Enforcement for a savings of $100,000 annually.