HUMAN RELATIONS AGENCY
Sacramento, California
Contact: Spencer Williams

FOR RELEASE 1:30 P.M.
JULY 2, 1969

Spencer Williams, secretary of the State Human Relations Agency, today directed the formulation of a master plan to encourage the maximum development of the mentally retarded.

Williams announced the action at a meeting of a Senate committee considering a report concerning the hospitalization of the mentally retarded which was made at his request.

The Secretary urged the committee to back administration efforts to "provide an integrated, modern, effective system of care for California's retarded."

Development of the master plan was the Number 1 recommendation on an action program submitted by the Human Relations Agency Task Force on Mental Retardation services.

"While this plan is being formulated we shall proceed to implement the other three major points submitted to me for action by the task force so far as the Legislature will permit," Williams said.

He said the state would expand its regional diagnostic and counceling center network to provide residential and other services as close to home as possible, consistent with quality care. "We will encourage innovation in provision of residential care, but always with the best interest of the individual uppermost," Williams said. He said the centers would also provide a single point of entry into the system of mentally retarded care to help each parent learn what his child needs and to secure the necessary resources.

Some major recommendations directed to the department of mental hygiene will be implemented at once, but others will require further study and legislative approval.

Williams pointed out that substantial progress in the care of the mentally retarded has already been made. He cited new legislation that went into effect yesterday as providing some increases in service. He noted that other legislation, particularly AB 225 supported by the administration, to bring all mental retardation services together is pending.

Williams said the number of regional centers authorized was increased from two to six last year and that the administration is supporting an additional increase this year.

He said that the number of filled treatment positions in state hospitals for the mentally retarded was increased by 500 persons in the past two years even though there was a slight reduction in the hospital population. He said 200 more positions are requested in the budget for this year.

Williams also called attention to increased efforts by the Department of Rehabilitation, the expansion of development centers for handicapped minors and the upsurge in community placement of the retarded from the state hospitals by the Department of Social Welfare.

The 72-page report and its 26 recommendations were made by a three-man task force headed by the associate dean of the University of California's College of Medicine at Irvine, Dr. Thomas Nelson. Nine top consultants from throughout the nation and scores of experts participated in the study which extended from July 1968 to June this year.

Williams expressed his appreciation to the task force, the consultants and others that assisted them for the report and assured them that all of their recommendations will be given full consideration by the administration.

"The task force recommendations will probably raise controversy, objections by some, and a few will distort and exploit the report, inflaming rather than illuminating this emotional subject," Williams said. "Opinions as to what, when and how much should be done do vary among different groups, parents, employee, professional and citizen organizations."

The task force, consultants, and experts had something to say about the types of facilities needed, the types of employees who should provide the services, the research programs, the types of programs such as medical, rehabilitation, education, and others, and the types of treatment that should be provided certain categories of patients.

There was no hesitation by the Department of Mental Hygiene to recommend basic acceptance of the report. The Department's Director, James V. Lowry, M.D., has always worked for elimination of the "control and custody" principle which the task force states is a predominant policy of the state hospital programs, although the team said there were "noteworthy exceptions to this policy".

The Department has been establishing the groundwork to provide hospitalization only for those mentally retarded requiring it. The last fiscal year, ending Monday, saw the first drop in seven years in the number of mentally retarded patients. The Department of Social Welfare in cooperation of the Department of Mental Hygiene willcontinue to seek placements for patients not requiring hospitalization.

The recommendations seek to attain the task force's objective: "To assess present systems of services and recommend needed organizational and program adjustments as well as guidelines for further program development."

The members of the task force are Thomas L. Nelson, M.D., Associate Dean, California College of Medicine, University of California, Irvine, Chairman; Richard Koch, M.D., Director, Child Development Division, University of Southern California School of Medicine, Los Angeles; Irving Philips, M.D., Associate Clinical Professor of Psychiatry, University of California Medical Center, San Francisco.

The recommendations follow.

For Action by Secretary, Human Relations Agency

1. The Secretary of the Human Relations Agency should develop a master plan for achieving the goals set forth in the document referred to earlier in this report, "The Undeveloped Resource, A Plan for the Mentally Retarded in California." This document expressed a philosophical approach which dictates that the general goals of programs for the mentally retarded are to allow for maximum growth, development, and fulfillment for each individual who is mentally handicapped. The master plan should be updated annually in keeping with changing needs and newer trends of care.

2. A single point of entry should be established in each community, whether it be a Regional Center contract agency, a local public health department, or a Short-Doyle program, to help parents define the specific needs of their child and reach the appropriate service resource.

3. An effort should be made immediately to implement regionalization of care so as to provide residential services for mentally retarded individuals at all levels from community to state care and as close as possible to the individual's home consistent with quality care.

4. Experimental and innovative models of community residential care should be encouraged through expansion of present programs for placements from state hospitals into family homes, hostels, cooperative living projects, nurseries, and schools.

For Action by the Director of Mental Hygiene

5. The Departments of Mental Hygiene and Social Welfare should jointly (a) determine the nature and extent of the placement, funding, and staff resources required to effect movement of residents out of the state hospitals who no longer require state operated residential services, (b) mobilize such resources, and (c) expedite placement of the residents.

6. For those persons who require state residential care, services should be organized consistent with broad program goals and sufficient budgetary support to achieve the maximum developmental potential of each resident.

7. DMH residential services for the mentally retarded at any one facility should include no more than 500 residents in a Medical Program for the Multiply Handicapped (Type I), no more than 150 in a Developmental Program (Type II), and no more than 150 in a Rehabilitation Program (Type III).

8. A type and level of staffing should be developed for mental retardation programs that would permit individual and small group programming in keeping with recommendation No. 7, above.

9. The director of each MR service in a state institution should develop a program for individual residents or groups of residents so that all care and treatment personnel may know at any moment in a resident's institutional stay (a) what stage of development he is in, (b) where he is going, and (c) what is to be anticipated in his eventual development. The program should always be in a state of flux with no ceiling placed on individual potential.

10. There should be greater exchange of resources between state hospital and community; the hospitals should purchase high quality community services where available and state hospitals should develop easily accomplished procedures for short term admissions from the community.

11. Hospital projects that have proven their worth experimentally, whether supported by federal funds or state research funds, should be continued as part of the ongoing hospital operations budget. Efforts should be made to translate the results of such projects into programs throughout the hospital system wherever appropriate and with sufficient funding.

12. Educational services in DMH facilities should be provided in accordance with standards of the California Department of Education for Special Education programs in public schools.

For Action by Secretary, Human Relations Agency

13. Active support should be given toward obtaining substantial increases in salaries.

For Action by the Director of Mental Hygiene

14. DMH Headquarters should be reorganized, placing the Director and the two Chief Deputy Directors within the Office of Director.

15. The functions of the Division of Hospitals and Division of Local Programs should be consolidated and redistributed between a Division of Mental Retardation Services and a Division of Mental Health Services.

16. Services to the mentally retarded in state institutions should be headed by a Program Director responsible to the Deputy Director, Mental Retardation Services. There should be three broad program classifications: (a) Medical, (b) Developmental, and (c) Rehabilitation, each headed by a Program Chief responsible to the Program Director.

17. Development of MR programs in facilities on the grounds of MI hospitals is supported as a temporary expediency and only under certain conditions and guidelines: (a) written plan approved by Deputy Director, MR Services, (b) implementation of plan before admission of residents, (c) transfers by small increments, starting with Rehabilitation Programs, and (d) linkage of MR/MI facility to a parent MR facility.

18. DeWitt State Hospital should be phased out as a facility for the mentally retarded.

19. Parental consent for placement out of state institutions into community facilities should be retained as a normal requirement, with an appeal procedure developed to sources outside of the facility for adjudication of differences between staff and the responsible relative. A consumer representative (not a relative) should participate in the adjudication process.

Personnel Utilization and Development (page 51)

20. Basic care personnel in Medical Programs for the Multiply Handicapped (Type I) should be licensed vocational nurses (LVN) and registered nurses (RN).

21. Basic care personnel in Developmental Programs (Type II) should be child development aides and child development specialists.

22. Basic care personnel in Rehabilitation Programs (Type III) should be psychiatric technicians.

23. Promotion, retention, and merit salary increases for physicians in MR programs should be based primarily on a critical annual review of performance as demonstrated in a clinical setting for the mentally retarded, irrespective of specialty background of the physicians.

24. Basic residency programs for physicians should be continued for psychiatric programs and extended to pediatrics, emphasizing mental retardation and related handicapping conditions.

25. More opportunity should be given all basic care personnel for upward mobility into various management and professional classes in order to fill manpower needs.

26. Basic training for the various basic care personnel should occur in junior colleges with DMH providing stipends and field practice settings.

news from the
CALIFORNIA STATE EMPLOYEES' ASSOCIATION

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FOR RELEASE TO AM's OF
January 19, 1972

The California State Employees' Association today charged that thousands of mental patients have been released from state hospitals without adequate protection or treatment.

In a special study titled, "Where Have All the Patients Gone?" CSEA urged the legislature to halt plans to close Mendocino, Metropolitan, Patton and Stockton State Hospitals.

CSEA also asked a complete legislative review of community mental health programs financed by state funds under the Lanterman-Petris-Short Act of 1969.

"CSEA finds evidence that the tragic consequences of this act have been to take thousands of mentally ill patients out of state hospitals and scatter them among counties unequipped to provide adequate care," said Walter W. Taylor, CSEA's general manager.

"LPS also has made it difficult to treat mentally disturbed persons--even in a state hospital--for a significant period of time," Taylor said.

"In far too many cases, these patients end up in transient hotels, small board and care homes or in prison. Their illnesses are not being treated.

"County and private facilities just are not equipped to handle the flood of patients being released by the state," said Taylor.

Taylor also said that "costs under LPS have skyrocketed."

Between fiscal 1965-66 and 1970-71; expenditures at 1971 dollar

--more--

value for services to the mentally ill have increased by more than $28 million, the CSEA study reports.

There will be a net increase of $9.7 million in the cost of state-financed mental health care during fiscal 1972-73 under the governor's proposed budget, despite plans to close 2 hospitals this year and 2 more within 36 months, states the CSEA study.

"We charge," said Taylor, "that the state has distorted the humanitarian aims of Lanterman-Petris-Short and used that law as an excuse to act without adequate planning, without education of either the community or the patient, and without provisions for alternative care."

"Complicating the problem is the crazy quilt pattern of state and county licensing laws which permit an estimated 32,000 former mental patients to live in unlicensed board and care homes alongside the geriatric patient," Taylor said.

"Obviously, CSEA has more than a passing interest in what happens to our mental hospitals. Thousands of our members are employed there. Their jobs are in danger, along with the health of their patients," said Taylor.

"But it should be understood that the very members and non-members of CSEA who urged the Association to undertake this study are also professional treatment personnel who share a deep concern for the welfare of the men and women they treat.

"Our report only scratches the surface of problems relating to community mental health programs.

"We hope that by calling this situation to the public's attention we will open a dialogue leading to a more objective and orderly approach to treatment of California's mentally ill," said Taylor.

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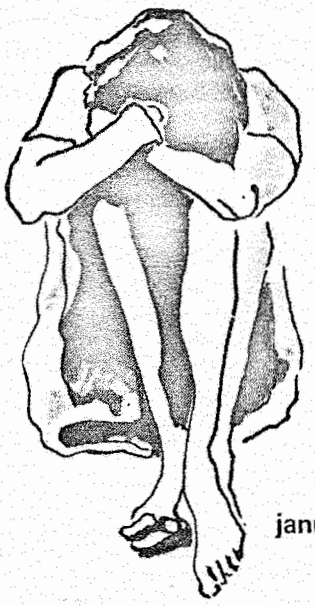
where have all the patients gone?

a CSEA report on the crisis in mental health care in california



january 1972

introduction

In 1969 there were 9 state hospitals caring for approximately 15,700 mentally ill citizens of California.

Today, in 1972, only 6 state hospitals are treating mentally ill patients, and their number has shrunk to 7,200.

Tomorrow—by the end of 1973—it appears 2 more hospitals will close and approximately 2,000 more patients will be released to community-level care.

What has happened to the 8,500 patients released since 1969?

Are they cured, and back with their families living happy, healthy lives?

If not, are they under professional care, and what is the level of that care?

And what of new patients, people who experience a mental breakdown which requires institutionalization and treatment? How and where are they being cared for?

These are some of the questions which this paper attempts to answer.

The California State Employees' Association represents approximately 16,000 employees of the state Department of Mental Hygiene, including doctors, nurses, technicians and therapists.

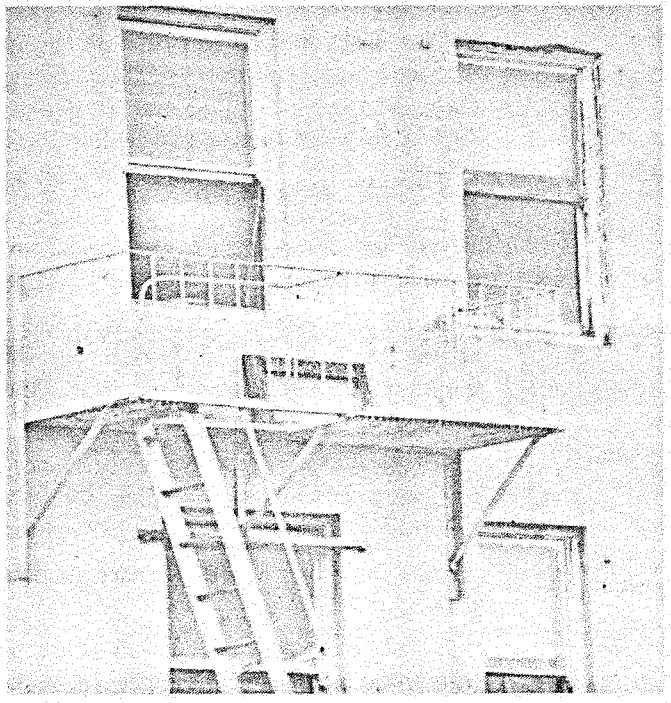
They are concerned over the state of publicly financed mental health care in California. They are afraid they know what has happened to most of those 8,500 patients.

As for new patients, what is happening to them is known first-hand by CSEA's members who work in the 6 remaining state mental hospitals. And they are upset.

A radical change in the state's system of caring for the mentally ill occurred in 1969 when the Lanterman-Petris-Short Act of 1967 went into effect.

Only now is the full impact of that change begining to be felt.

It will be felt even more keenly in the months and years ahead unless someone applies the brakes.



CSEA researcher Richard Funderburg examines trash cans and sink on landing of hotel used by mental patients discharged from state hospitals. At left, hotel exterior. Hospital security officer estimated 50 percent of those staying at the hotel the day these photos were taken were former patients.

the lanterman-petris-short act

What has become known as the Lanterman-Petris–Short Act was passed in the fading hours of the legislature's 1967 session.

It combines with the Short-Doyle Act of 1957 to form the California Mental Health Act.

As conceived by its architects, this revolutionary new system for handling the mentally ill was designed mainly to:

- protect the patient from institutionalization without his consent.
- remove the stigma of mental illness by holding all records confidential to the hospital.
- promote community-level care of the mentally disordered, aided by 90-10 state financing–with county government paying 10 percent of the cost.

CSEA finds evidence that the tragic consequences of this act have been to:

- take thousands of mentally ill patients out of state hospitals and scatter them among 58 different counties, there to be absorbed by as many different community mental health programs.

In far too many cases these patients end up in transient hotels or small board and care homes in run-down neighborhoods where they receive no treatment for their illness;

- decrease the number of days a state hospital may hold a mentally ill individual.
- skyrocket the cost of mental health care.

Before LPS, patients were admitted to state mental hospitals on a voluntary basis and kept as long as either the patient or his physician felt was needed.

Patients also were committed involuntarily, through the courts, at the request of family or law enforcement agencies, the length of their stay determined by doctors' judgment.

Under LPS, state hospital authorities can hold patients for only 72 hours, unless they want to stay longer or unless 2 attending physicians sign a paper certifying the person is a danger to others or to himself, whereupon he is committed for 14 days for intensive treatment.

After that 14 days, whether or not the patient has

improved, he must be released unless he has physically assualted another person, in which case he may be kept for 90 days.

The Short-Doyle Act of 1957 designated the county as the local unit of government to provide mental health services and mandated that each county with a population of 100,000 or more had to provide mental health services. The act also provided that the state would fund 75 percent (now 90 percent) of the community program and the county would provide the remaining funds.

The Lanterman-Petris-Short Act was aimed at the mentally disordered, chronic alcoholic, and user of narcotics and dangerous drugs. Incorporating findings expressed in the 1961 report of the Federal Joint Commission on Mental Illness and Health, LPS: (1) held counties responsible for providing community treatment facilities, (2) minamized court procedures, and (3) gave the mentally ill person the right to refuse involuntary treatment unless he was a grave danger to himself or others.

The act protected the civil rights of patients, mandating the right to a hearing before the Superior Court on a writ of habeas corpus, the right to personal property, the right to see visitors, the right to use the telephones, to wear one's own clothing, and the right to refuse shock treatments or labotomy.

In affect, the LPS Act provided a bill of rights for the mentally ill.

It also made it increasingly difficult to treat mentally disturbed persons for a significant period of time.

a case in point: santa clara county

Santa Clara County is a progressive, sprawling populous community south of San Franciso Bay.

Its residents have an active mental health association, community programs aimed at improving mental health care, and a small but modern psychiatric facility—Valley Medical Center.

There are approximately 1,000 board and care homes in the San Jose area (San Jose is the county seat of Santa Clara County) housing geriatric patients and ex-mental patients.

When the Department of Mental Hygiene began early release of hundreds of mental patients from Agnews State Hospital in San Jose, the community awoke to find their local mental health facilities seriously and dangerously overcrowded.

San Jose's Council for Community Action Planning (C-CAP) studied the situation and adopted a report on the crisis on Nov. 27, 1971.

That report was highly critical of the administration of the Lanterman-Petris-Short Act.

Quoting:

"What the outcome of Short-Doyle and Lanterman-Petris-Short might have been is now difficult to say, for its provisions have been distorted in practice and misrepresented in policy determinations.

"The primary distortion is the present state administration's use of LPS philosophy as a rationale for acting without plan, without prior notice and without concern, to remove from the state hospital context, and to preclude from entrance to such facilities, hundreds of ill persons *without provisions for alternative care."* (Emphasis theirs)

Before Sept. 15, 1971 the usual patient caseload a month at Valley Medical Center was 60. Since, the C-CAP report states, the caseload has risen to 176 average a month.

"The physical plant cannot absorb any more patients," the report states.

"In addition, there is little privacy for patients. Because of lack of sufficient space, intake, counseling, examination, treatment—all take place in the midst of hectic, public environment.

"The staff and program of Valley Medical Center was reputed as one of the best in the state before the increase in caseload produced a factory-like atmosphere where the press of patients, the uncontrollable noise level and the lack of space destroyed the capability of an innovative service to deliver meaningful patient care," the report states.

What of the impact on board and care homes in Santa Clara County?

C-CAP's report found that a large caseload in greater need of assistance, such as will be caused by closure of Agnews State Hospital's facilities for the mentally ill, "would defeat recent movements aimed at improved availability of services for the already discharged."

Investigators for C-CAP reported many ex-mental patients found the board and care home experience "refreshingly positive."

"These facilities," said the report, "provide a sheltered environment, a minimal degree of supervision and assistance with transportation, medication, hygiene, etc., to their residents.

Having found that many board and care homes were pleasant, well-run environments, C-CAP investigators were forced to report also that "many are negative places, at best, in which to reside."

The report states that the "freedom from restraint which has fostered uniqueness and responsiveness to the residents...has another face—a picture of unregulated license which provides little protection to residents and leaves to the discretion of the board-and-care operator all conditions and often all decisions regarding the interests of the resident."

"Persons too sick to be placed in board and care homes are already in evidence."

C-CAP researchers reported: "there is no licensing and no means to enforce standards.

- "board and care clients do not have adequate counseling, therapy and rehabilitative services at the present time."
- "because of a lack of staffing standards, residences are often ill-staffed for the provision of the appropriate level of supervision."
- "some persons too sick to be placed in board and care facilities are already in evidence. The dumping of clients in need of specialized and closely supervised environments, in homes geared to the client in need of merely a sheltered home-away-from-home, has already created havoc in a few homes and neighborhoods."
- "for the misplaced patient, the denial of needed specialized service is unjustifiable and retards or negates attempts at rehabilitation."

C-CAP researchers concluded that for the Department of Mental Hygiene to release acute mental patients from Agnews State Hospital and attempt to locate them in board and care homes "would be the destruction of the board and care homes which now provide housing and sheltered care for 1,000 persons."

Another community organization to study the effects of closing Agnews was Chapter 23 of the California State Employees' Association, most of whose members work at the hospital.

They commissioned a $3,500 study of "The Impact of California's Mental Health Act on Mental Health Care in Santa Clara County."

A San Jose research firm undertook the study and reached many of the same conclusions as did the Council on Community Action Planning.

Dr. John Rieger III, M.D., a consultant employed by the San Jose research firm, reported:

"Of 12 facilities (board and care homes) visited, one-third rated superior, one-third rated flatly inadequate and the remaining third doing a passable job of warehousing mentally ill human beings.

"Location of board and care homes, in San Jose as in other large metropolitan centers, are mainly in deteriorating neighborhoods.

(1) the patients who live in them are too poor to afford residence in more expensive areas of the city, and

(2) deteriorating neighborhoods frequently possess large, once-elegant houses appropriate for the purpose."

What will happen to psychiatric care facilities in Norwalk?

The research firm found the average age of such dwellings in San Jose to be 51 years.

Santa Clara County is fairly typical of metropolitan-suburban California.

Problems which come to Santa Clara County will, in all likelihood, visit other similar communities in the state.

What will happen to psychiatric care facilities in Norwalk (Los Angeles County) if Metropolitan State Hospital closes its doors and dumps its mentally ill patients on the doorsteps of hospitals and boarding homes in southern California?

what has happened to the patients?

Few persons would dispute the desirability and value of community-based mental health services.

But CSEA does challenge the wisdom of dismantling the existing state hospital system.

We charge:

• Facilities, personnel and programs are inadequate in most counties.

• The Department of Mental Hygiene has failed to plan adequately for the future use of state hospital facilities. State hospital programs and community facilities are not mutually exclusive.

Modesto State Hospital was closed in 1970 and turned over to Stanislaus County to be used for educational purposes.

DeWitt State Hospital at Auburn will close its doors finally late in May of this year, and Agnews State Hospital near San Jose will close its books on the mentally ill before the end of 1972.

Stockton State Hospital already has closed one wing devoted to care of the mentally ill.

CSEA has learned that DMH plans to close Metropolitan State Hospital and Mendocino State Hospital sometime between June 30, 1972, and June 30, 1973.

This information is contained in a memo signed by Dr. O. L. Gericke, medical director at Patton State Hospital, of which CSEA has obtained a copy.

He concludes this memo, dated 11/16/71:

"Other hospitals for the mentally ill, such as Patton and Stockton, have uncertain futures with the closing date being possible from 24 to 36 months from now."

Few new county facilities have been built for the care of mentally ill since LPS went into effect.

Most counties in California have a "community mental health program," as called for under the LPS Act, in name only.

An administrator in a county office oversees transfers of mental health patients and deals them out to psychiatric wings at county hospitals and to private psychiatric care facilities, which charge the county (and the state) for this service.

Others are found to be eligible for "Aid to the Totally Disabled" (ATD) with 50 percent federal funding, and can be placed in board and care homes.

As of September 1, 1971, more than 8,100 mentally ill patients have been placed on ATD by the community services division of the Department of Social Welfare.

"...they are worried about the cost of keeping them in the hospital."

This method of handling mental patients has become so popular with the state administration that next year the community services division will be moved lock, stock and typewriters to the Department of Mental Hygiene, adding $21 million a year to the DMH budget for 1972-73.

A Napa State Hospital surgeon blames excessive reliance on ATD, in lieu of proper psychiatric-medical care, for the low percentage of success with patients under the present program.

"Less than 10 percent of all patients admitted to state hospitals are returned to the community as productive citizens," he stated.

"County mental health administrators order patients released long before they are ready because they are worried about the cost of keeping them in the hospital. It is cheaper to put them on ATD and place them in a home at the expense of welfare. The procedure is dictated by economics, not psychiatric-medical judgment."

Most counties have out-patient psychiatric facilities, but because of the voluntary nature of mental health care under LPS, many released patients never show up.

State and county welfare workers share the responsibility for placing patients released from state hospitals, but cannot force them to use their ADT checks for any particular purpose.

Many of his former patients end up in transient hotels paying $12 to $15 a week for a single room.

Confused, disoriented and often sedated upon their release, many of these patients go off on their own and end up in transient hotels paying $12 to $15 a week for a single room.

This information comes to CSEA from a physician-surgeon at one of the state's hospitals, who asked that his name not be used. He told CSEA investigators that many of his former patients have ended up in transient hotels where their money disappears.

They have no one to turn to and become police problems, he said.

The sheriff of a northern California county told CSEA investigators that since LPS, 2 of the transient hotels in his town have become homes for many ex-state hospital patients.

One day early in January 1972 a state hospital security officer estimated to CSEA investigators that 50 percent of the occupants of one of the hotels were former state mental patients living on ATD.

Since 1966, more than 11,000 state mental patients age 65 and over have been admitted to nursing homes.

More than 16,000 younger patients have been placed in the several types of boarding homes whose owners make a living by housing such patients.

A typical board and care home accommodates up to 6 patients and is located in a poor, deteriorated section of town.

Board and care homes are not psychiatric facilities. Mental patients are commingled with senile patients.

Undoubtedly many such homes are operated by kind and considerate owners who carefully see to the needs of their tenants.

But supervision of patients is minimal and the owner need have no training in the care of such persons.

The only license needed to operate a 6-bed board and care home in any county in California is a $10 business license.

Some counties don't even insist on that, and state law makes no provision for licensing board and care homes of 6 beds or less.

In Los Angeles County, the mental health subcommittee of the county's Comprehensive Health Planning Association reported in November of 1970 in a paper on consumer protection:

"Superficial examination of the present system reveals conditions in our residential care facilities which (1) undermine attempts to rehabilitate (mental patients)...allows far too many proprietors of residential care facilities to exploit those in their care in favor of profit making, and (3) allow most of these facilities to operate without licensing and surveillance by proper authorities.

"those who benefit are not the interested recipients ...but the proprietors of the residential care facilities."

"It should also be pointed out that while much of the financial support for residential care comes from the state, those who benefit are not the intended recipients (the client) but the proprietors of the residential care facilities."

A Department of Social Welfare official estimated for CSEA that there are 32,000 mentally ill patients housed in unlicensed board and care facilities in California.

As of November 30, 1971, there were 108 licensed long-term facilities for treatment of the chronic mental patient scattered across the state. Their beds total 9,416.

What other private or public (non-state) facilities are available to the mental patient discharged from a state hospital?

- psychiatric hospitals for the acutely ill, licensed by DMH. As of July 1, 1971, there were 32 with 2,594 beds.
- general hospitals, either private or public, with wards for the acute mentally ill, licensed by the Department of Public Health. The latest available figures date to December 30, 1970, which showed there were 47, with 1,204 beds.
- county hospitals with wards for the mentally ill. As of January 1972, there were 31, with 1,239 beds.

In 1972-73 the Department of Mental Hygiene is expected to close state hospitals with 3,267 beds and discharge an estimated 1,900 doctors, nurses, technicians and therapists trained in the care of psychiatric patients.

Two CSEA members, both psychiatric technicians at Mendocino State Hospital, recently visited several convalescent facilities to see how former patients were being cared for in the community setting.

They found one patient, a woman, tied in a chair with a webb strap which was pulled tight and cutting into her bust. The patient was blind, and while at Mendocino had been provided with special clothing made for her because she could not dress herself. A good supply of these dresses was sent to her after her release. The technicians found her in old clothing not belonging to her.

Another patient in another facility came up to the technicians and cried, pleading to be taken back to Mendocino. "They never even talk to us here," she said.

At still another facility the technicians found a former Mendocino patient who they recalled as a constant walker, up early each morning on her own. "She would take another patient by the hand and walk her," one of the technicians recalled.

But at the local care facility, they discovered her still in bed at 10:30 a.m. "She appeared to be sedated heavily. Her gown and bedding were soiled with food, possibly from breakfast. When we inquired as to why she was in bed, one of the staff implied that the aide probably hadn't got around to getting her up yet."

A fourth patient, who the technicians remembered as ambulatory, was found tied in a chair with a black eye and a discolored, swollen elbow, allegedly from a fall.

"She begged to come back with us," one of the technicians reported. The patient died a short time after the visit, they told CSEA investigators.

deaths

Where have all the patients gone?

Some of them died, of course.

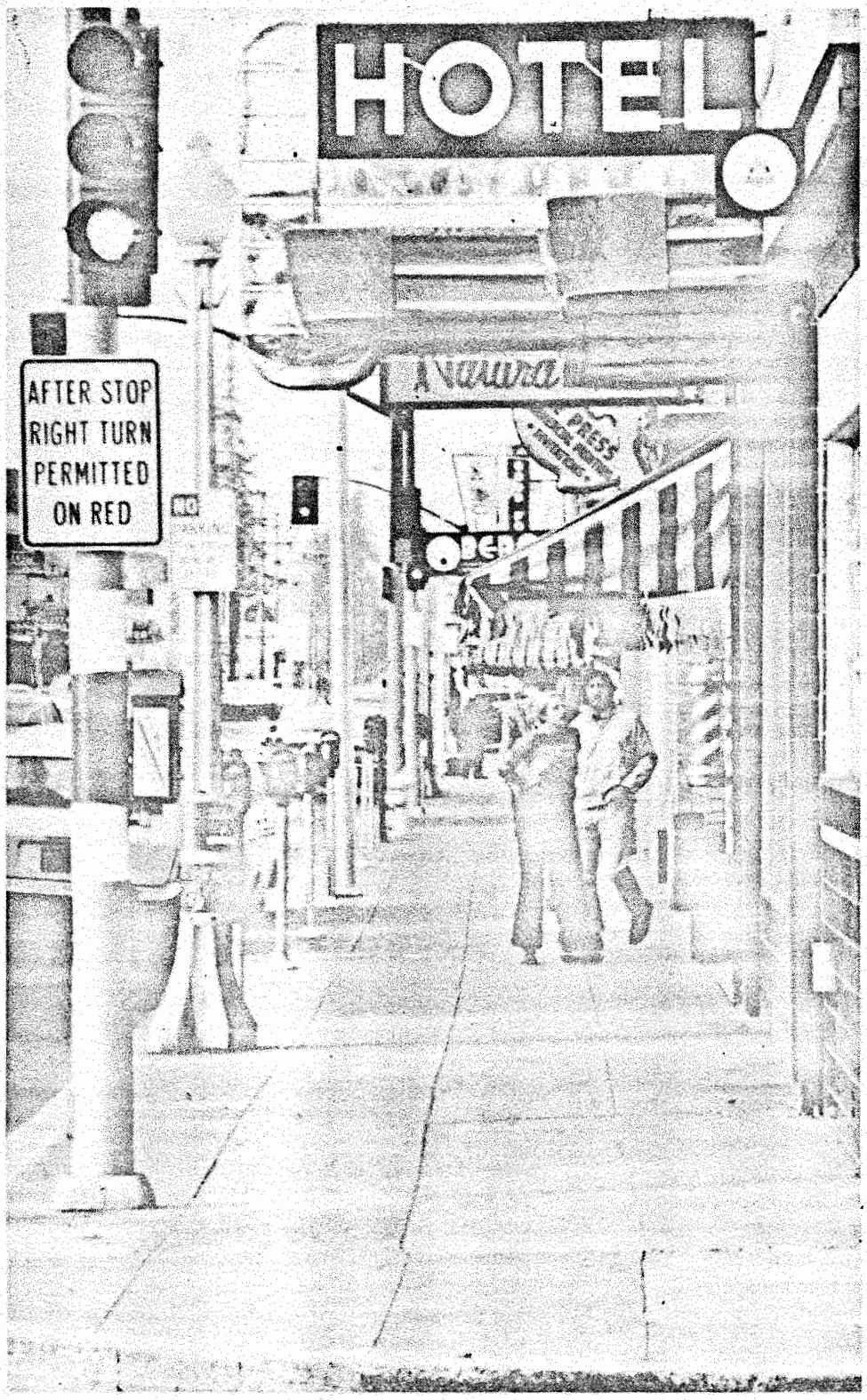
Among transferred patients, the death rate appears to be from 5-10 percent higher than among patients who remained where they were.

A study of the effect of transfers on the mortality rate of mental patients is being conducted at the Langley-Porter Neuropsychiatric Institute in San Francisco.

Called the "Modesto Relocation Project," the report is scheduled for release at the end of this coming June.

It shows an 18.2 percent mortality rate among patients transferred when Modesto State Hospital closed 2 years ago. The death rate among Modesto patients averaged 10.5 percent in the 4 years preceding closure of the hospital.

Among a control group of 100 patients at Stockton State Hospital, the death rate was 5 percent.



Street scene near one hotel assertedly occupied by former patients discharged from state mental hospital under the Lanterman-Petris-Short Act.

cost

State officials have claimed the closing of state hospitals and shifting care to the local level is saving tax dollars.

In isolated areas of treatment this may be true.

However, in terms of total state expenditures, savings of tax dollars has not materialized.

Between fiscal 1965-66 and 1970-71, expenditures at 1971 dollar value for services to the mentally ill in all programs increased by more than $28 million.

Total expenditures for services to the mentally ill reached a high of $292,513,477 in the 1970-71 fiscal year.

In the current fiscal year, the Department of Mental Hygiene has budgeted $104.1 million to pay its 90 percent share of the cost of community mental health programs.

Next year it proposes to spend $123.3 million for community mental health care, an increase of $19.2 million.

In the same time period, the department's budget for care of the mentally ill in state hospitals will shrink from $107.1 million to $97.6 million, a drop of $9.5 million.

This means a net increase of $9.7 million in the cost of state-financed mental health care during fiscal 1972-73.

Even these figures do not show the real growth in the total program cost of maintaining mentally ill patients at the community level. Other significant costs which are not easily identifiable and therefore cannot be priced with a degree of accuracy include:

- counties' share of local programs.
- cost of services shifted from the Department of Mental Hygiene to other departments (Social Welfare, Rehabilitation, and Public Health).
- Medicare and Medi-Cal contributions.
- dentistry, physical therapy, and other professional services provided locally by charitable organizations.

Most county budgets for mental health have increased under LPS. For example, in 1968-69, Los Angeles County's budget for treatment for the mentally ill was $16,245,786. In the 1969-70 fiscal year, estimates were $22,925,790 and during the current fiscal year, county mental health officials requested $36,864,304 and received $35,409,953 to finance their community mental health programs.

In Santa Clara County, the budget in fiscal 1969-70 for Health and Sanitation was $10,345,483 and during this fiscal year the budget increased to $13,065,646. Napa County's entire mental health budget in 1965 was $80,000. Today the county has a budget of $1,100,000.

The above figures in themselves do not show the staggering costs related to the community concepts of treating the mentally ill. Various hidden factors are seldom identified as costs for treating the mentally ill. For example, the increased costs to local law enforcement, to our court system and especially the increased cost of welfare as thousands of mentally ill patients are made eligible for Aid to the Totally Disabled with 50 percent federal funding.

The problem of multiplicity of services within counties is a serious one. The County of Los Angeles for instance operates 37 different facilities for the diagnosis and treatment of mental illness, alcoholism, drug addiction, and emotional disturbances of childhood.

In some treatment areas, costs are possible to measure as evidenced by recent cost accounting figures released by the Department of Mental Hygiene.

However, in the important area of continuing psychiatric care, the comparison shows that it costs more to contract out the psychiatric care of patients than it does to treat them in state hospitals.

In 1970 the average basic cost for continuing psychiatric care in state mental hospitals was $34.35 a day. Varying widely, costs for similar care in county facilities range from $39 a day at Monterey County Hospital to $125.57 a day at Los Angeles County-USC Medical Center.

In between these 2 extremes are:

$70 a day at Sacramento County Medical Center
$76 a day at San Francisco General Hospital
$47 a day at Kern County General Hospital
$68 a day at Santa Barbara General Hospital
$62 a day at Orange County Medical Center
$68 a day at Stanford University Hospital

While the total cost picture is admittedly sketchy, cases which find their way to county boards of supervisors and other local authorities often contain evidence that local costs are excessive.

According to current figures in Sacramento County, it costs $120 a day for an average 8 to 10 days to hospitalize a mentally ill patient—an increase of 70 percent over the February 1970 figures released by the Department of Mental Hygiene. Outpatient care in Sacramento County costs an average $36 an hour.

Although the county has no current waiting list, they could still use more money. The county, because of lack of funds, is not able to do as much consultation as they would like to do.

"I cannot afford it and I doubt that our taxpayers can."

One citizen whose wife has been chronically ill for over 12 years and has been hospitalized 6 times writes:

> "Sacramento County facilities under the Short-Doyle-Petris system do not provide the clinical approach and are the most expensive I have experienced. I cannot afford it, and I doubt that our taxpayers can, either. I had to fight to get my wife released from Sacramento County facilities after she was there 10 days at a cost of $1,448. My wife is now at Stockton State Hospital."

A new cost-reporting data collection system has recently been approved and is expected to permit analysis and comparison of costs in local facilities within a common frame of reference. Until such time as reports become available, relative cost/effectiveness analysis of programs will continue to be imcomplete.

mental illness and crime

CSEA charges that the number of mentally ill persons wandering the streets of California has increased alarmingly.

Since Lanterman-Petris-Short went into effect, some law enforcement agencies have experienced a marked and abrupt increase in the number of incidents involving former mental patients.

This flood of incidents has been so great that several police agencies have stopped keeping track of the number of persons they pick up who are wandering around acting in a peculiar manner. These include Los Angeles, Santa Clara, Napa and Mendocino counties.

The problem in Los Angeles County has become so acute that a special division of the sheriff's office has been formed to handle cases of mental illness.

Napa County Sheriff Earl Randol told CSEA investigators that economic crime, such as shop-lifting, is his biggest problem with former mental patients.

Napa State Hospital, next to the City of Napa, has housed the mentally ill since 1875.

The Napa Police Department told CSEA investigators they handled 12 cases involving mentally ill patients in 1958, a typical year before LPS.

In 1970 the number jumped to 328. Last year that department too stopped keeping data on mentally ill suspects.

Prior to 1969, Napa police handled an average of 10 suicide attempts a year by mental patients. In 1970 the number soared to 51.

The Napa Police Department was in the habit of keeping track of pedestrians "not in control of themselves." Before 1969 the highest number of such incidents reported in any one year was 15, in 1966.

In the last 6 months of 1969—right after LPS went into effect, 27 such incidents were reported in the City of Napa. In 1970 the figure leaped to 74.

In November of 1969, alarmed at the increase in crime by the mentally ill, the Hon. Goscoe W. Farley, president of the California Conference of Judges, appointed an 11-member committee of judges to study the effect of the Lanterman-Petris-Short Act.

They reported back 2 months later. Among their many findings:

- Commitments of the criminally insane to jail or prison terms increased dramatically during the first six months of the act. Compared to the same period a year earlier (1968), the increases were 298 percent in Los Angeles County, 66 percent in Alameda County, 60 percent in San Francisco County, and 50 percent in San Diego County.
- "Under LPS since July 1, 1969...the mentally disordered defendant remains in jail without medical treatment and is criminally prosecuted.

• "Because LPS does not involuntarily treat a mentally disordered person...unless he is a danger to himself or others, or is gravely disabled, the individual often decompensates and finds himself in a criminal court.

• "Because he is not receiving medical treatment, he often further deteriorates to where he is unable to stand trial."

• "Many cases involve a mental disorder that is chronic, where the person is unable to provide food, clothing or shelter. After a short-term hospitalization and heavy medication, they go into a period of remission (abatement of symptoms)...as soon as the person is out of the treatment facility and off medication he goes into a period of exacerbation where he cannot provide his food, clothing and shelter."

• "The urgency of the problem is clearly demonstrated by the cases where the criminal defendants are found to be legally sane and competent to stand trial although they are found to be mentally disordered. The result is they are returned to the criminal court to remain in jail, without treatment, for criminal prosecution."

• "Many individuals certified for 14-day intensive treatment (in state hospitals) do not fit the definition of gravely disabled, nor do they fit the strict requirements (for) 90-day treatment.

• "Many individuals have to be discharged into the community while still in need of psychiatric treatment..."

As a consequence the judges' committee recommended extending the period of involuntary treatment to 30 days, instead of 14.

So far the Department of Mental Hygiene has ignored the judges' recommendations.

Judge Harry Petris of the Los Angeles Superior Court was chairman of the judges' committee.

Interviewed in Los Angeles recently, he told CSEA:

"Developments in the first 6 months under Lanterman-Petris-Short have become even more pronounced today."

Two years ago that committee recommended that the legislature:

• authorize municipal, superior and federal court judges to suspend criminal proceedings and obtain involuntary medical treatment for mentally disordered individuals.

• provide for involuntary treatment of mentally disordered persons who do not fit into the classification "dangerous to self or others, or gravely disabled."

• prohibit release back to the community of patients who are a "menance to the health and safety of others."

So far, both the legislature and the Department of Mental Hygiene have ignored the judges' recommendations.

"Defective and dangerous to the persons most directly involved."

In 1968 Judge Albert H. Mundt of the Sacramento Superior Court published a critical analysis of the Lanterman-Petris-Short Act.

In this document he said the statute is, in his opinion, "defective and dangerous not only to the persons most directly involved, the mentally ill and the alcoholic, but to all of the people of the State of California."

He was particularly critical of a provision which prevents detention of a suspected mentally ill person until that person violates a court order.

"It (the new law) provides for a court-ordered evaluation of a person who is, as a result of mental disorder, a danger to others, or to himself, or gravely disabled, who has refused or failed to accept evaluation voluntarily.

"The order obtained after the filing of a petition is served on the person by a peace officer, a counselor in mental health, or a court appointed official.

"The person, after the service of the notice, is permitted to remain in his home, or any other place of his choosing, prior to the time of evaluation, without the exercise of any control whatever.

"It is only when he fails to appear for evaluation after having been so notified, that he may be taken into custody and placed in the facility for treatment and evaluation for a period not to exceed 72 hours."

The old law allowed the court to order detention pending evaluation, after finding the person dangerous to himself and others.

Mundt (who is retired now) wrote:

"The mentally ill person is not always responsible for his conduct and may be very dangerous. The fact that it is necessary to get an order for evaluation is in and of itself indicative of stress and an emotional condition, because of which he does not cooperate...

"He often is aware that an evaluation might result in his detention for a substantial period of time. A notice to appear for such evaluation...is very likely to throw that person into a state of panic, or anger, or other frenzied conduct that might result in serious harm to him or to others.

"It is ironic," Mundt notes, "that under (LPS) a peace officer may arrest and detain an alleged mentally ill person while...a Superior Court Judge is required to wait until a person fails to appear for evaluation before he is permitted to order the exercise of that power..."

Judge Mundt wrote it is "difficult to conceive why the legislature seized upon 14 days as the period during which all mentally ill people requiring care have recovered to the point where they no longer need that care.

"Certainly we are...aware that the chronic mentally ill who require treatment over long periods, frequently lack the judgment, because of their illness, to understand and appreciate the fact that they do need treatment.

"We...find these people resisting treatment. Many of them are ill to the point where they need to be closely confined, under constant surveillance.

"Heavy sedation has been and still is being utilized to control their conduct.

"It seems to me that those who have pressed so hard for this (law)...somehow conceive that if you ignore these realities and say there is no mentally ill, that such sick people will disappear or the illness will go away, when such, of course, is not the fact."

And sure enough, Judge Mundt was right.

"Such sick people" have not disappeared nor gone away.

They have been released from state hospitals.

They are living in 6-bed board and care facilities, in county hospitals, in long-term treatment homes and in transient hotels.

They are in jail. The judges' report tells us that, and so do police department records.

But how many are in state prisons CSEA has been unable to learn because the LPS Act keeps secret all state mental health records.

The facts, however, suggest that there may be a correlation between the effect of LPS on mental health care in California and the recent violence in California prisons.

At least it would be well for the state legislature to investigate this possibility.

alan post said it in 1970

Legislative Analyst A. Alan Post, in his 1970 analysis of the state spending program, stung operation of the Lanterman-Petris-Short Act with a series of criticisms:

• "Another result of the fragmented mental health system is the lack of control and supervision of mentally ill individuals living in the community."

• "A number of chronically ill patients, particularly in metropolitan areas, are creating problems because the community lacks any effective machinery to deal with them.

"In Los Angeles and San Francisco chronically ill persons are often without friends or relatives. These persons often live in hotels where they frequently 'act-out.' Many 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.

o "As a result these mentally ill individuals end up moving from hotel to hotel until they are eventually jailed or hospitalized again."

• "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 re-admissions to state hospitals is the result of insufficient supervision and support of patients discharged from the hospitals."

• "It is clear that to return hospital patients to the community without assuring the adequate provision of follow-up 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.

• "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 mental patients to community living...

"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' agencies as the police."

• "There are numerous unlicensed 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.

"In the past (the Community Services Division of DMH) 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."

csea recommends

CSEA investigators and researchers spent 4 months and 700 man-hours compiling this report on the crisis that faces publicly-financed care of the mentally ill in California.

We have attempted to answer the question asked at the beginning: "Where have all the patients gone?"

In all too many cases they have ended up in prison, in transient hotels and in unlicensed board and care homes.

More will make the same hopeless trip unless the administration and legislature act to stop the closure of state mental hospitals and take another look at how we are caring for our mentally ill.

Therefore, CSEA makes the following recommendations:

- The legislature should order an evaluation of the effectiveness of state-financed mental health care at the community level to include an analysis of:

  —quality, availability, cost and social impact of local programs as they have evolved under the Short-Doyle and Lanterman-Petris-Short laws.

  —merit and feasibility of developing cooperative programs between state mental hospitals and community facilities.

  —development of a master plan for providing mental health services to insure overall coordination of fiscal, psychiatric, social, educational and recreational needs of the mentally ill.

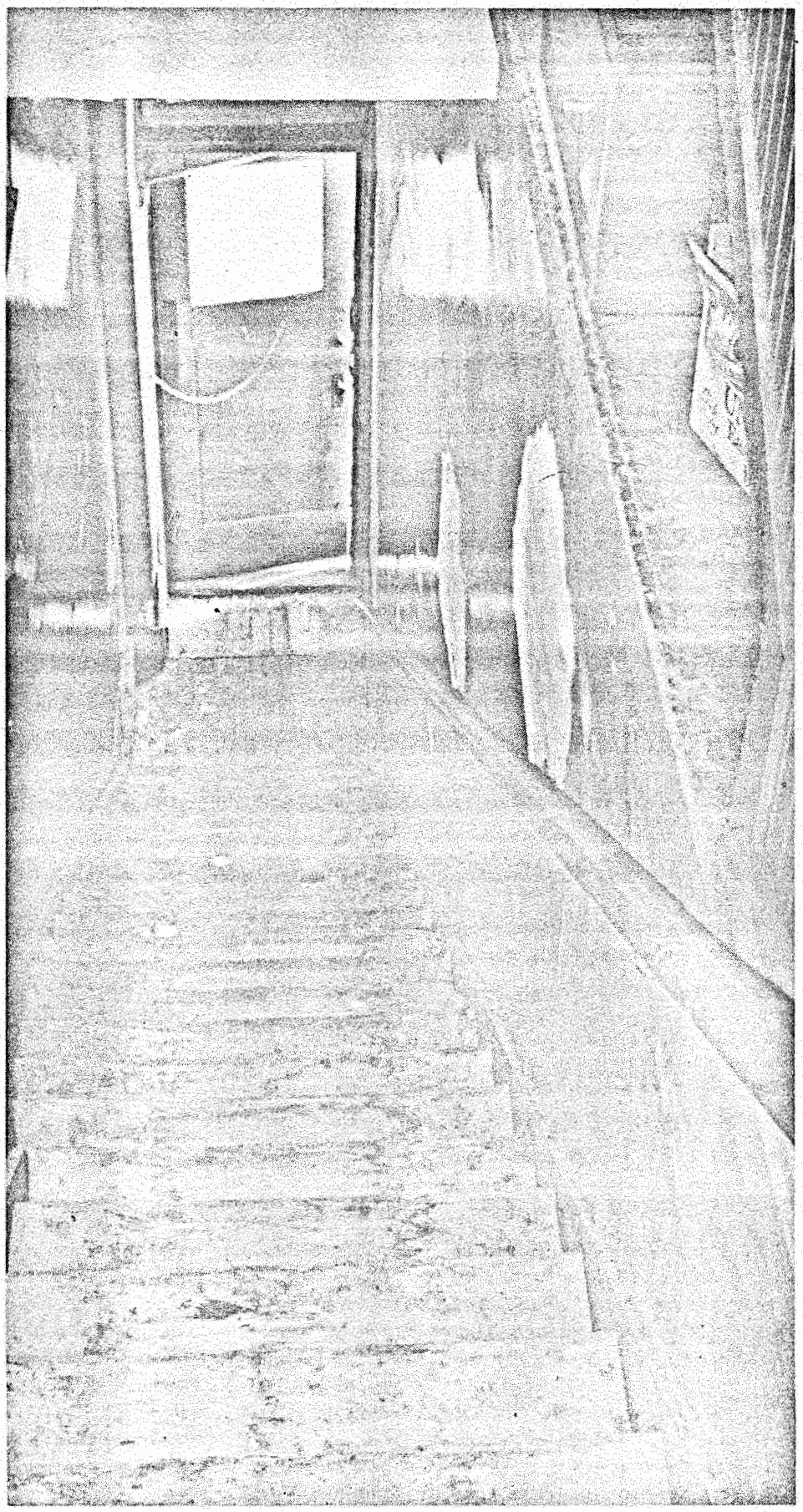
  —development of a uniform treatment program to include establishment of minimum criteria for community-level mental health care programs, avoiding 58 fragmented programs administered by 58 counties, but taking into consideration the need for flexibility and adaptability.

  —clarification of the functions and responsibilities of the various agencies dealing with the mentally ill to avoid leaving mentally ill individuals living in the community without supervision and control.

- The Department of Mental Hygiene should hold its plans to close Mendocino, Metropolitan, Patton and Stockton State hospitals in abeyance until the legislature completes its study and makes recommendations.

- The legislature should pass emergency legislation repealing AB 2648 of 1971, which orders counties to use all existing county and private facilities before admitting patients to state hospitals.

- The state should assume full responsibility for the quality of publicly financed mental health care in California.



Light slants through stairway door in transient hotel frequented by mental patients discharged from state hospitals.

State of California Department of Mental Hygiene

Memorandum

To : James M. Hall
Secretary
Human Relations Agency

Date : March 16, 1972

File No.:

From : Office of the Director

Subject: Plan for State Hospital Closures During Fiscal Year 1972-73

The Legislature has requested a timetable for the closing of state hospitals during the 1972-73 budget year. The budget indicates that closure of two hospitals may be required during the coming year. The latest report on use of state facilities affirms this proposed estimate insofar as one hospital is concerned. It is not possible to report a decision now on a second hospital: geographical considerations, fluctuations in patient referrals, and further inquiries to local program directors require more time before such a decision is made.

Accordingly, the Department of Mental Hygiene plans to close Mendocino State Hospital by September 1, 1972. Attachments indicate the rapidly decreasing use of this hospital by community programs.

The number of patients in the state-operated hospitals for the mentally disordered continues to decline. Shorter hospital stays and provision of alternate methods of treatment in the community eliminate the need for many referrals to state hospitals. County governments have indicated they can provide service to their citizens. All of these factors contribute to the decline in state hospital bed requirements.

Admissions to Mendocino State Hospital will not be necessary after May 1.

Patients at this hospital who can be more suitably treated or cared for in community programs or facilities will be placed in the community. Local program directors and relatives or guardians will be consulted.

Patients at Mendocino, who in the judgment of community mental health directors continue to require state hospital treatment and care, will be placed in a state hospital having a program suitable to their needs.

In general, programs at Mendocino State Hospital will be transferred intact together with the current staff to support them to the degree such staff will move to the hospitals that are listed in the attachments to this report and at the times specified.

Treatment personnel and support persons not moving with programs will exercise the normal civil service rights to transfer, demotion and/or layoff. The Department's plan for transfers and training is an attachment.

The equipment in Mendocino will be redistributed in accordance with state laws and current rules and regulations.

Property will be turned over to the Department of General Services for disposition in accordance with law.

J. M. Stubblebine, M. D.
Director of Mental Hygiene

Attachments:

1. County Referrals to State Hospitals
2. Patient Movement Plan
3. Personnel Plan
4. Episode Costs - State Hospital and Community Programs
5. Fiscal Impact Statement

MENDOCINO STATE HOSPITAL USE BY COUNTY

	1966-67		July 1971 - February 1972	
	Admissions	Inpatient Days	Admissions	Inpatient Days
Colusa	19	2,477	0	244
Mendocino	363	57,313	480	26,172
Del Norte	19	3,212	4	1,196
Shasta	97	20,196	2	2,119
Humboldt	168	31,660	54	9,695
Siskiyou	22	5,184	21	3,138
San Francisco	1,306	173,291	103	29,020
Marin	277	15,280	24	7,700
Sonoma	515	60,007	51	11,317
Alameda	177	35,121	5	7,072
Lake	80	8,104	117	5,831
Tehama	30	3,625	10	808
Trinity	8	2,326	1	272
Glenn	18	3,306	0	0
Other Counties	336	157,788	388	64,806
Totals	3,435	578,890	1,260	169,370

NUMBER OF PATIENTS

MENDOCINO STATE HOSPITAL

Fiscal Year Ending June 30		Fiscal Year Ending June 30	
1950	2,716	1961	2,261
1951	2,711	1962	2,302
1952	2,607	1963	2,264
1953	2,635	1964	2,061
1954	2,490	1965	1,815
1955	2,378	1966	1,715
1956	2,305	1967	1,590
1957	2,237	1968	1,538
1958	2,456	1969	1,308
1959	2,421	1970	1,115
1960	2,330	1971	821
		March 1, 1972	560
		June 30, 1972 (Est.)	150

Attachment 2: Patient Movement Plan (Mendocino)

Admissions from all counties will be closed by May 1, 1972.

Transfers

Date	Program	Present Population	Probable Number for Transfer	Transfer to
May 1	(Penal Code)	74	74	Napa
May 1	(Southern Counties)	55	55	Camarillo
May 15	Medical-Surgical	31	5-10	Napa
May 15	Special Projects (MR)	45	45	Stockton
June 1	General Psychiatric	133	100-110	Stockton
June 15	Geropsychiatric	60	30-40	Stockton
June 15	Alcohol	40	5-10	Napa
July 1	Adolescent	83	20-40	Stockton
July 1	Drug	24	5-10	Napa
July 15	Acute Psychiatric	12	0	-

The hospital will be closed on September 1, 1972.

Rated Bed Capacity & Present Number of Patients

Napa

Rated Bed Capacity	2,105
Patients	1,738
Difference	367

Stockton

Rated Bed Capacity	1,055
Patients	782
Difference	273

Total No. of Patients to be Transferred to Stockton: 195 - 235
Total No. of Patients to be Transferred to Napa: 89 - 104

Attachment 3: Personnel Plan

The Department is able to offer positions to all ward level nursing services personnel. If the employee is willing to transfer, he has 30 days in which to move and all moving expenses will be paid; as well, a per diem allowance for up to 30 days is permitted during relocation. In the case of working couples, every effort is made to transfer spouses in class to the same location and the dates of transfer are coordinated.

Where a position in his own class is not available, an employee under certain circumstances may demote in lieu of layoff. Employees with over ten years of satisfactory State service who are displaced in this fashion may be granted a "red circle rate"; that is, they may retain their former salary rates for specified periods depending upon number of years of service.

Where employees cannot be placed in an area of their choice and must terminate their State service, they are placed on priority reemployment lists which are good for five years.

Through DMH and State Personnel Board programs, employees are placed in other departments, such as the Department of Corrections, where their skills can best be used.

Various training programs for employees are sponsored by DMH in anticipation of shrinking job opportunities in DMH: Training course to prepare for community employment; training of Psychiatric Technicians to become Registered Nurses; one and two year curriculums in work with the mentally retarded and with mentally ill children; demonstration projects where they can show transferability of skills to other settings.

State employees separated by layoff or inability to transfer to another location upon hospital closure are now eligible for unemployment insurance.

Attachment 4: Episode Costs - State Hospital and Community Programs

MENDOCINO SERVICE AREA COUNTIES

INPATIENTS COST PER EPISODE *
1971

	Total State Hospital Episodes	State Hospital Cost Per Episode	Total Community Episodes	Community Cost Per Episode
Del Norte	17	$3,989.29	38	$387.05
Humboldt	174	$ 176.39	590	$118.11
Siskiyou	93	$2,180.81	303	$361.96
Mendocino	943	$1,654.46	NO LOCAL INPATIENTS	
Marin	851	$1,663.26	759	$252.33
Tehama	45	$2,500.36	174	$611.09
Sonoma	929	$2,328.66	1,718	$182.67
Alameda	5,695	$1,526.50	2,213	$934.31
Lake	193	$1,421.23	NO LOCAL INPATIENTS	
Trinity	12	$2,565.50	2	$310.50

*These are costs at which each hospital patient from each county is referred to and not necessarily Mendocino. However, the comparisons are about the same no matter which hospital is used.

ATTACHMENT 5: FISCAL IMPACT STATEMENT

Closure of Mendocino State Hospital by September 1, 1972 will result in a savings of 275.3 positions and $1,860,000 in annual expenditures.

HUMAN RELATIONS AGENCY
Sacramento, California
Contact: Alex Cunningham
(916) 445-0198

HRA #72-4

IMMEDIATE RELEASE
March 23, 1972

Dr. J. M. Stubblebine, Director of the State Department of Mental Hygiene, today announced that Mendocino State Hospital will be closed by September 1, 1972. He said the closure is the result of the successful implementation of the Lanterman-Petris-Short Act.

"Never in the history of California have such successful medical and social programs been available to Californians who are mentally ill," Stubblebine said. "Because of the increased effectiveness of the treatment being provided by community mental health programs, fewer Californians need to be cared for in state hospitals.

"Community mental health directors are referring fewer patients to state hospitals. The operation of numerous state hospitals for the mentally disordered is fast becoming unnecessary."

There are now 9,100 patients in the state hospitals for the mentally ill (see attached chart). There were 10,876 at the start of the fiscal year. In 1966, there were 26,567 patients. The average length of stay in state hospitals has declined steadily from 223/in days 1960 to 75 today. The average stay for first admissions is 14.7 days.

Mendocino State Hospital now has only 541 patients, down from 821 on July 1, 1971, the start of the fiscal year. The hospital has the capacity to care for 900 patients and has handled in excess of 2,700 prior to 1967 when Governor Reagan adopted new space standards recommended by the American Psychiatric Association.

New admissions to the hospital will be halted May 1. Between now and the final closure date, approximately 215 patients will be transferred to Stockton State Hospital and about 100 to the Napa state facility. Other patients will be able to return to their homes or communities by the time Mendocino is closed.

Stubblebine said community mental health programs have been especially successful since the Lanterman-Petris-Short Act was approved in 1969. The legislation, introduced by Assembly Frank Lanterman (R-La Canada) and Senators Nicholas Petris (D-Oakland) and Alan Short (D-Stockton), requires that community mental health programs be established, that counties be reimbursed by the state for 90 percent of the costs of their community programs, and prohibits commitment of a Californian unless he is a present danger to himself or others.

Community programs will have more than $25 million in additional money available from state, federal, and local funds, and fees and insurance revenues during the 1972-73 fiscal year. Over $250 million will be spent during the same period for the care and treatment of patients who are mentally ill, compared with $151 million in 1966-67. More than $170 million will go to community programs in the coming fiscal year compared to $35 million in 1966-67. The remainder will provide treatment for patients referred by the communities to state hospitals.

Governor Reagan said he was extremely pleased with the success the Department of Mental Hygiene has had in implementing the Lanterman-Petris-Short Act.

"Dr. Stubblebine and his staff are to be congratulated for the work they have done on behalf of the mentally ill," the Governor said. "There is no question that California is the nation's leader in providing care and treatment for its citizens stricken with mental illness. The department's implementation of the LPS Act is mainly responsible for this success."

James M. Hall, Secretary of California's Human Relations Agency, whose eight departments include the Department of Mental Hygiene, said: "California's mental health record is outstanding. The measurement is not in numbers or dollars, but rather in the quality of care and treatment of patients. Our citizens have benefitted by having mental health programs available that allow them to remain close to home and lead near-normal lives.

"Dr. Stubblebine and the entire Department of Mental Hygiene understand the needs of mentally disordered patients. They have held the patients' interests paramount and have provided excellent and positive care and treatment. My appreciation is shared with the families and friends of patients who have their loved ones home again."

With the closing of Mendocino, three hospitals for the mentally ill will have been closed this year--DeWitt, Agnews, and Mendocino.

There are currently 607 employees at Mendocino. All ward nursing personnel will be offered positions at other hospitals. (310) Some non-ward treatment employees will have to transfer to other state agencies. Openings exist in several state departments, including the Department of Corrections.

310 Nursing (includes janitors!) Dept of F
100 Non-nursing (but treatment) prob. P
200 Support (Cooks, Gardiners) other Depts

Mendocino was opened in 1893. For many years it was the state's "security" hospital, where patients were referred from the courts after trial on criminal charges or because they were too mentally disordered to stand trial. The "security" unit was moved to Atascadero in 1954. Mendocino has served North Coast and Bay Area counties since that time as an open hospital.

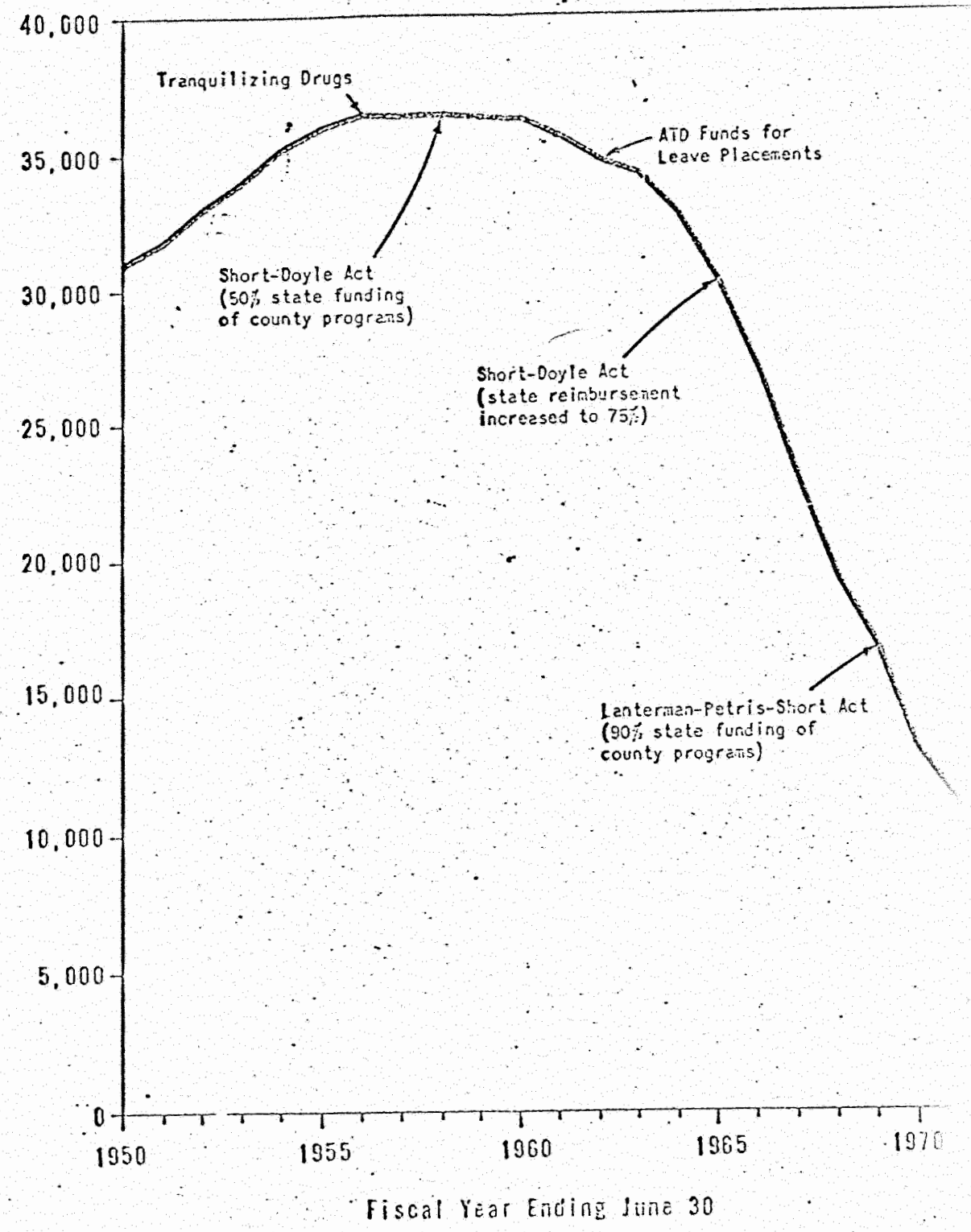
All of the counties affected by the closing have in-patient mental health programs, except Mendocino and Lake Counties. Funds will be made available to the two counties to establish programs. These counties also have the option to contract with other community programs or refer patients to Napa State Hospital.

# # # #

Attached is a chart showing the long term trends in State hospital utilization.

LONG-TERM TRENDS IN STATE HOSPITAL UTILIZATION

Average Daily Population of Mentally Disordered
1950-1972



April 10, 1972

#34

Department of Mental Hygiene
Office of Information
744 P Street, Room 724
Sacramento, California 95814
Telephone: (916) 445-6921

MEMORANDUM FOR THE PRESS

In late February the Department of Mental Hygiene was apprised that medical records of patients at Atascadero State Hospital may have been altered for purposes at that time unknown.

An investigative committee was appointed immediately to determine if the allegations were true. The committee has found many of the allegations to be true. It is an unacceptable situation and will be remedied. A copy of the committee's findings are attached. But with no recommendation as yet.

The Department is currently developing new programs, procedures and considering personnel changes. These will be made public as quickly as possible, but not before next Friday. At that time the investigating committee will be in Sacramento to consider the program and procedure suggestions and to make recommendations based on their findings. Because the meeting consistently will be involved with personnel matters, it will be a closed meeting. However, the recommendations will be made public as quickly as approved by the committee and adopted by the Department.

The investigation into the problems at Atascadero were initiated by Dr. J. M. Stubblebine, Director of the Department of Mental Hygiene, as promptly as they were called to his attention.

The Attorney General is being informed this morning of the findings.

Atascadero patients (all males) are:

1. Persons referred by the courts who are too sick to stand trial. These persons are referred back to the court upon certification of competency.

2. Persons found not guilty of a crime because of insanity and sent to Atascadero for treatment and observation. When treatment is completed, these persons are referred back to the court for its disposition.

3. Persons convicted of a crime who are mentally disordered sex offenders and who are hospitalized for treatment. When treatment is completed, these persons are referred back to the court for its disposition.

4. A small group of patients who are too mentally disordered and dangerous to patients and personnel at other open state hospital grounds.

There are about 2,400 mentally disordered offenders in hospitals for the mentally ill, of which 1,300 are at Atascadero. About half of the 2,400 were involved in sex offenses. The remainder are not dangerous and have been assigned to other hospitals. The Department has found that the records of these patients have not been tampered with.

The following statement is that of Dr. J. M. Stubblebine:

I have been concerned about the treatment for and opportunities offered to the mentally disordered offender for a very long period of time. I am concerned about those in prison, on the streets, or in hospitals. They are men, women and youngsters.

Since I became Director of the Department last July, a considerable amount of time and thought has gone into developing suggestions toward not only solving a critical public problem but at the same time, aiding the offender to recover his health and return to society as a productive citizen.

I did not know of these tragic occurrences at Atascadero until recently. I am not yet sure how grave and depriving they have been to any particular person. The degree and consistency of the activity, as found by the special committee, is abhorrent.

The Department has requested funds from the California Council on Criminal Justice to establish an elite "blue ribbon" committee to investigate, take testimony, weigh facts and make recommendations to overhaul the entire structure of the law as it relates to the mentally disordered offender. I am hopeful of approval.

In the meantime, this Department will act quickly and effectively to make sure that Atascadero procedures and programs are changed and monitored. These will be in effect by May 1, or sooner. The altering of medical records has, of course, ceased. Personnel changes as are necessary will be made, and I wish to make the first announcement today.

I have offered the position of Clinical Director at Atascadero State Hospital to Dr. Michael Serber who was with me today. He is going to consider it and will let us know as quickly as possible.

Members of the committee are: John L. Moody, M.D., Northern California Psychiatric Society; Norman Graff, M.D., California Medical Association; Dr. Abe Linn, Napa State Hospital; Dr. Jerry Kayne, Patton State Hospital; Dr. Harold W. Nolen, Agnews State Hospital.

# # # #

April 7, 1972

Project #11

Review of Professional Practices at Atascadero State Hospital

I. Charge:

A. To determine the validity of a number of charges alleging that treatment and administrative practices at Atascadero State Hospital failed to meet professional, legal and ethical standards.

B. To recommend remedial action in any instance where the charges were found to be valid. Specifically, the charges to be investigated alleged that court decisions were given preference to medical standards in determining treatment program, medical records were being altered, and medical care was not being provided to all those patients whose physical conditions warranted additional attention.

II. Recommendations: (to be developed)

III. Findings:

In looking into the charges, the task force findings fell into five major areas including: Organization, Court Influence on Treatment Programs, Medical Records, Medical Care and Additional Observations. Although the examination of such items as medical records, statements of policy and operating procedures, administrative directives, as well as interviews with staff resulted in a number of specific findings pertaining to specific cases, only the general conclusions are presented in this report.

A. Organization: Atascadero State Hospital has not implemented the program organization used in the other state hospitals. The treatment program is divided into five Sections which serve specific geographic catchment areas. In addition to these five programs there is a Med/Surg. Section which serves the entire hospital population and a Service Section which

which houses the coordinators of such services as Professional Education, Research, Nursing, Psychology, etc. All of these Sections report directly to the Associate Medical Director. With this organization the formal chain of command from the top level down is designed as follows:

1. Hospital Medical Director;
2. Associate Medical Director;
3. Section Chief (Staffing Psychiatrist);
4. Ward Physician or Program Coordinator.

The major problems that seem to exist at Atascadero in conjunction with this organization are as follows:

1. Although the formal organization would indicate that all unit personnel are responsible to report to the Ward Physician or Program Coordinator, in reality, this organization is frequently bypassed and staff report to the Section Chiefs or Service Coordinators.
2. There is a lack of open two-way communication between the Section Chiefs and the Ward Physicians or Program Coordinators.
3. The organization of all clinical personnel including both physicians and members of other disciplines is unclear in terms of lines of communication, lines of authority and individual responsibilities.
4. Appropriate committees, although identified in the formal organization, are ineffectively utilized. This was particularly true of the Credentials Committee which failed to carry out its assigned functions of:
   a. Delineation of privileges to be extended to the members of the active medical staff beyond those assignments made by the Section Chiefs, Associate Medical Director and Medical Director.

b. Investigation of any breach of ethics that may be reported involving members of the active staff.

c. Investigation of the credentials of newly appointed staff members.

5. The Medical Records Librarian's position of a consultant-advisor with limited knowledge of the mechanics of the hospital's daily routine recording procedures inhibited her effectiveness in carrying out the full range of quality control procedures included in her responsibility.

B. Court influence upon treatment program design.

Atascadero State Hospital's diagnostic and treatment procedures may be traced by a series of "staffings" which serve as decision points during the patient's course in the hospital. When a patient first arrives at the hospital he is examined by the Ward Physician and an evaluation of his physical and mental status is completed within 72 hours after the examination. At this time a tentative diagnosis is entered in the patient's record. Within five weeks after admission the Ward Team members jointly evaluate the patient and submit their findings through the use of a multidisciplinary staffing form to the Section Chief. The Section Chief then reviews the findings and, after a brief discussion with the Ward Team and brief interview with the patient, confirms or revises the tentative diagnosis and treatment plan. Periodically, the Ward Team reviews the patient's progress through his treatment program. Finally, when the Ward Team feels that the patient has gained maximum benefit from his hospitalization the staffing process is repeated to determine final disposition of the case.

In reviewing this decision making process the task force concluded that the treatment program is heavily influenced by the judicial system. This influence is noticeable to the point that court decisions are

given preference to medical standards in treatment program determination. The key points leading to his conclusion are as follows:

1. The major determinants for treatment programs for each individual patient are:
   a. The type of commitment.
   b. The crime or alleged crime of the patient.
   c. The probable sentence the patient would have received if convicted and sent to Corrections for a definite period of time.
   d. The patient's ability to respond to treatment as manifested by his confession of guilt.
2. Arbitrary amounts of time in residence are required of patients according to their type of commitment or offense rather than their progress in the treatment program. Review of the "staffing checklist" as well as statements made during the interviews revealed that:
   a. Minimum time limits were required for specific types of commitments and offenses.
   b. Minimum periods of time in residence without ataractic medication were categorically required of some patients as a condition for their return to court in spite of an acknowledgement by some staff that this was inappropriate for many patients.
3. The primary treatment modality used at Atascadero is group therapy on the basis that it seems to be the best means of forcing the patient to acknowledge his guilt. Through peer pressure the patient "learns to be a patient" and submits to the power of the therapist. Individual therapy is minimized as a low-yield, uneconomical treatment modality.

4. The attitude of the Senior Medical Staff (Section Chiefs) established a dictatorial atmosphere which:

   a. Emphasized physical and legal constraints over psychiatric care.

   b. Emphasized the necessity of caution in releasing patients so that the hospital and its staff would not receive adverse publicity due to patient "failures" upon return to the community.

   c. Appeared preoccupied with acting in the function of "judge and jury" rather than providing appropriate psychiatric evaluation and consultation.

   d. Regarded court decisions which disagreed with hospital recommendations as "losses" on a win-lose basis.

5. In the interest of avoiding criticism from the courts, both written statements as well as unwritten policies emphasized the need for consistency of clinical opinions. Because of this, conflict which arises from disagreements between staff is generally repressed rather than dealt with openly and creatively. Examples of this repression appeared in:

   a. Statements made in interviews that it was unwritten policy that opinions entered on the multidisciplinary staffing forms must be in agreement with each other and consistent with other notes in the records.

   b. Statements in the staffing checklist which emphasized the need for consistent notes particularly in cases being returned to court with negative recommendations.

   c. Statements made in interviews that all disagreements were worked out in team meetings prior to the entry of clinical opinions in the medical records.

   d. Record review which revealed a remarkable degree of uniformity in the majority of cases.

C. Medical Records.

The process of making an entry into a medical record at Atascadero State Hospital begins with the professional staff member's initial note either being dictated on tape or written in long hand on a "C-Note" form. The original note is sent to the Section Clerk for transcription while the carbon is maintained on the ward (a carbon of the dictated note is returned to the ward after initial transcription). The Section Clerk then files the initial note in a temporary file until enough entries have been made to complete a type-written page. Once the entries have been typed into the medical record the original notes are destroyed and a carbon copy of the page is sent to the ward to replace the several entries in the ward chart. When the notes are entered in the medical record they are submitted to the authors for their signature. At the desire of the Section Chief, at any point in this process he may review the entries in the medical record and take one of the following actions:

1. Approve the note;
2. Request the author to change the note;
3. Request the author to delete the note;
4. Delete the note without the author's consent;
5. Enter a counter note in the chart.

Upon his own initiation, the author of a note may also make changes in his note at any point during this process. One exception to this practice is the entries in the continuous nursing notes in the ward charts. In consultation with the Medical Record Librarian, nursing service has followed the practice of lining out any notes which are in error rather than deleting the notes. In conjunction with the accusations regarding the practice of changing notes the major findings are:

1. The medical records are altered by removal, omission or replacement of staff notes containing clinical opinions.
   a. This practice was particularly prevalent in Section E during a recent period of several weeks when all notes were reviewed by the Section Chief resulting in the elimination of "conflicting or contradictory" entries. According to information received in the interviews this same practice was commonly used in the other Sections at the discretion of the Section Chiefs.
   b. Changes made in the notes either by the authors or by the Section Chiefs have been both editorial and substantive.
   c. Both the Medical Record Librarian and the Chief Clerk disclaimed knowledge of these practices resulting in alteration of the records but, agreed that such practices would be inconsistent with acceptable standards of medical records practice.
2. Entries by professional staff into the medical records are restricted in order to conform to other opinions, particularly those of the Section Chiefs.
   a. Evidence obtained through interviews and review of the medical records verified that entries made by the professional staff in cited cases were restricted when they failed to conform to ward team recommendations or Section Chief evaluations. This was found primarily in Section E and was not always a uniform practice throughout the other Sections.
   b. Although there was evidence where divergent opinions were entered in the medical records, it was noted that most of the records revealed a considerable degree of uniformity of opinions and recommendations.
   d. Staff interviewed cited the team meetings as useful in settling disagreements. While such meetings may account for positive

agreement resulting in uniformity of opinion they may also be a subtle means of exerting pressure to eliminate all divergence of opinion prior to making any notations in the charts.

D. Medical care.

Although it had been alleged that the hospital administration had arbitrarily restricted or limited medical investigation, care and follow-up of clinical somatic problems, there was no evidence to validate this charge.

1. There was no evidence of any deliberate or wanton denial of diagnostic and therapeutic care of patients.
2. There was evidence in a small minority of cases of questionable judgment in terms of appropriate treatment procedure.
3. There was evidence of lack of communication between one ward physician and the Med/Surg. Section Chief which may have resulted in a lack of appropriate referrals for additional diagnostic laboratory procedures.

E. Additional observations.

1. The medical staff, particularly the Section Chiefs, exhibited inadequacies and deficiencies in accepting and practicing newer concepts in psychiatric care and administration. Specifically they appeared:
   a. Unable to communicate effectively with and provide appropriate guidance to their subordinate staff;
   b. Lacking the technical competence necessary to function in their positions;
   c. Lacking confidence in their own professional ability particularly in relationship to testifying in court;
   d. Unable to make creative use of conflict or divergence of opinion.
2. In some records reviewed it appeared that the hospital is not following departmental policy regarding the use of seclusion and restraints.

There were instances of patients remaining in seclusion for periods as long as 14 days with no 24-hour reviews recorded in the notes.

IV. Methodology

A. A Task Force was formed to investigate the charges which included representatives from Psychiatric practice both within the Department of Mental Hygiene as well as from relevant professional organizations.

B. The Task Force was provided with background information regarding the charges and also oriented to Atascadero State Hospital's unique function of serving the mentally ill offender. Included in the background material were relevant statements of policy and procedures abstracted from both the Department and the Hospital manuals, records, etc., as well as relevant material from the various legal codes pertaining to Atascadero.

C. A site visit was conducted by the Task Force which included:

1. Orientation to the hospital and its administrative practices by the Medical Director and Hospital Administrator.

2. Interviews with staff including both those directly involved in the charges as well as others randomly selected from the Hospital staff roster.

3. Record review of cases including:

a. Specific cases cited by both the individuals making the charges as well as other staff defending the hospital's position;

b. A sample of cases of patients who had filed writs of habeas corpus;

c. A random sample of discharges over the last six months;

d. A random sample of the current resident population.

D. The findings of the Task Force were summarized and distributed in draft form to the Task Force members for review and comment.

E. A follow-up meeting will be scheduled to review the findings and draft the recommendations.

NEWS RELEASE

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#42

A special commission of judges, a district attorney, and a business executive have concluded that it "is imperative that there be greater liaison between the medical profession and those engaged in the administration of justice in order to attempt to resolve misunderstandings" related to treatment of the mentally disordered offender.

The commission recommended that the "Department of Mental Hygiene and the Judicial Council sponsor a joint committee to review the laws relating to the confinement of the mentally ill who are charged with or convicted of criminal acts and the administration of these laws so that the law and the practices thereunder may reflect both the current state of learning concerning psychiatric problems and modern concepts of due process of law."

The commission was named by Dr. J. M. Stubblebine, Director of the Department of Mental Hygiene, to review a department document of last May in which it was reported that medical procedures at Atascadero State Hospital were expedient in some cases or preferred by medical and legal entities rather than always in the best interests of patients.

The reviewing group found that some practices were true insofar as some procedures involving medical decisions by staff at Atascadero, but the commission said there was no basis in the records they reviewed which indicated judges requested the changes, as had been implied in the original document.

The commission also recommended:

> "Because of questions raised by the material developed in the earlier investigation, there should be further review to determine the extent to which there were any alterations or deletions from any patient's record, and if so, whether it had any appreciable effect on his detention or release.

"The Director of the Department of Mental Hygiene should provide to those staff members responsible for reporting to and appearing in court, through a qualified attorney, seminars and other educational materials concerning the state laws and court procedures governing the custody and release of those committed to the institution."

In it's finding the commission found:

"On the basis of the evidence reviewed, this committee found no specific case where a patient was detained or released because of an alteration or deletion of a record.

"There was no evidence to justify the conclusion that there were illegal or unethical practices among the general staff. In one section of the hospital, it was admittedly the practice of the section chief to remove from the patient record, or omit, or replace, notes made by members of the staff. The section chief characterized those notes as inappropriate, untruthful, contradictory, and conflicting. However, the evidence does not support a finding that this practice occurred in any other sections of the hospital.

"There is no evidence that any judge or public prosecutor requested or suggested that any patient of Atascadero State Hospital ready for release or return to court should be kept in confinement in violation of his constitutional rights. There is no evidence that any judge or public prosecutor requested or authorized or was aware of the alteration of any medical record. There is no evidence of court interference with the treatment program design."

The commission members reviewed the task force report, the transcript of the interviews of Atascadero State Hospital personnel conducted by the task force, and had available for review all written material, including patient records, considered by the task force.

The commission said:

"The complaints giving rise to the original investigation and the evidence produced in that investigation focus the spotlight on the inherent difficulty of combining judicially administered restraint with medically administered treatment. The evidence produced indicates that those charged with the treatment of the mentally ill offender may misunderstand the requirements of the legal system and feel improper pressures because of that misunderstanding. It is equally probable that those engaged in the administration of justice are inappropriately seeking and demanding a certainty in diagnosis and prognosis which the medical profession cannot supply."

The commission consists of:

Mr. Ed Bell on the corporate staff of Beckman Instruments, Inc. and a member of the Board of Directors of the California Association for Mental Health

Superior Court Judge Arthur L. Alarcon of Los Angeles

Justice Richard M. Sims, Jr., First District Court of Appeal, San Francisco

Superior Court Judge Jay R. Ballantyne of Tulare County

Mr. Robert Tait, District Attorney of San Luis Obispo County

September 26, 1972

REPORT OF RECOMMENDATIONS AND CONCLUSIONS OF THE ATASCADERO STATE HOSPITAL REVIEW COMMITTEE

Committee Members:

Mr. Ed Bell, Chairman
Judge Arthur L. Alarcon, Vice-Chairman
Justice Richard M. Sims, Jr.
Judge Jay R. Ballantyne
Mr. Robert Tait

The committee was formed at the request of J. M. Stubblebine, M.D., Director of the State Department of Mental Hygiene, to review the findings set forth in a task force report concerning Atascadero State Hospital, dated May 2, 1972. The purpose of the review is to ascertain if the findings in that report are supported by the evidence considered by the task force which made the report and to make recommendations thereon. The task force report is entitled "Project 11. Review of Professional Practices at Atascadero State Hospital."

The committee members reviewed the task force report, the transcript of the interviews of Atascadero State Hospital personnel conducted by the task force, and had available for review all written material, including patient records, considered by the task force.

The committee met on June 29 and 30, 1972, in San Francisco. The recommendations and conclusions of the Atascadero State Hospital Review Committee are as follows:

A. RECOMMENDATIONS

1. The complaints giving rise to the original investigation and the evidence produced in that investigation focus the spotlight on the inherent difficulty of combining judicially administered restraint with medically administered treatment. The evidence produced indicates that those charged with the treatment of the mentally ill offender may misunderstand the requirements of the legal system and feel improper pressures because of that misunderstanding. It is equally probable that those engaged in the administration of justice are inappropriately seeking and demanding a certainty in diagnosis and prognosis which the medical profession cannot supply. It is imperative that there be greater liaison between the medical profession and those engaged in the administration of justice in order to attempt to resolve those misunderstandings.

   To this end, it is recommended that the Department of Mental Hygiene and the Judicial Council sponsor a joint committee to review the laws relating to the confinement of the mentally ill who are charged with or convicted of criminal acts and the administration of these laws so that the law and the practices thereunder may reflect both the current state of learning concerning psychiatric problems and modern concepts of due process of law.

2. Because of questions raised by the material developed in the earlier investigation, there should be further review to determine the extent to which there were any alterations or deletions from any patient's record, and if so, whether it had any appreciable effect on his detention or release.
3. There is a continuing, ongoing need for research projects. In the future, such projects must be carefully delineated and personnel selected who are able to work compatibly with other hospital personnel.
4. The Director of the Department of Mental Hygiene should provide to those staff members responsible for reporting to and appearing in court, through a qualified attorney, seminars and other educational materials concerning the state laws and court procedures governing the custody and release of those committed to the institution.
5. With reference to the findings D and E of the May 2, 1972 report, it was this committee's observation that they involved methods of medical treatment and individual competence which we were not qualified to evaluate.

B. GENERAL CONCLUSIONS

1. On the basis of the evidence reviewed, this committee found no specific case where a patient was detained or released because of an alteration or deletion of a record.

2. There is no evidence that any judge or public prosecutor requested or suggested that any patient of Atascadero State Hospital ready for release or return to court should be kept in confinement. There is no evidence that any judge or public prosecutor influenced or authorized the alteration of any medical record. There is no evidence of court interference with the treatment program design.

3. There was no evidence to justify the conclusion that there were illegal or unethical practices among the general staff. In one section of the hospital, it was admittedly the practice of the section chief to remove from the patient record, or omit, or replace, notes made by members of the staff. The section chief characterized those notes as inappropriate, untruthful, contradictory, and conflicting. However, the evidence does not support a finding that this practice occurred in any other sections of the hospital.

4. The generalities contained in the findings of the task force report as a whole were not warranted or supported by the limited scope of the investigation undertaken by the task force making that report. It would be unfortunate if these generalities may have reflected upon the staff members and employees of Atascadero State Hospital whose ability and loyalty have never been questioned. The task force

which prepared the May 2 report acted quickly because of complaints which indicated a disruptive situation that appeared to threaten the functioning of at least one section of the hospital. It appears that most of the complaints came from one person who had a sincere disagreement with the person to whom he was administratively responsible with respect to the practices reviewed by the earlier task force.

C. CONCLUSIONS ON EVIDENCIARY SUPPORT ON SPECIFIC FINDINGS MADE IN MAY 2 REPORT

FINDING A; Page 4

The report states:

> "Atascadero State Hospital has not implemented the program organization used in the other hospitals."

This committee has been informed that Atascadero State Hospital was at one time exempt from the program concept conceptualized in PRU Project #57, "A Study of Patient Treatment Program Organization for State Hospitals." We are also advised that in September, 1971, this exemption was withdrawn and the Superintendent of the hospital was instructed to implement that program.

The timing and the full responsibility for implementation for that program is not clear from the record and no opinion is expressed as to what steps should have been taken by

the time of the original review. The findings are correct in that the recommended program was not implemented and they correctly set forth the practice of geographical distribution in effect at the time.

FINDING A, 1 and 2; Page 5

The report states:

"1. Although the formal organization would indicate that all unit personnel are responsible to report to the Ward Physician or Program Coordinator, in reality, this organization is frequently bypassed and staff report to the Section Chiefs or Service Coordinators.

"2. There is a lack of open two-way communication between the Section Chiefs and the Ward Physicians or Program Coordinators."

The record review shows evidence of lack of communication apparently engendered by the lack of chain of command between the research project and the normal functioning of the hospital. The conclusion that the staff frequently bypassed the Ward Physician or Program Coordinator and that there was a general lack of open two-way communication between Section Chiefs and the Ward Physician or Program Coordinator is not sustained by the limited record before us.

FINDING A, 3: Page 5

The report states:

"3. The organization of all clinical personnel including both physicians and members of other disciplines is unclear in terms of lines of communication, lines of authority and individual responsibilities."

We find no support in the record for this finding.

FINDING A, 4a and 4b; Page 5

The report states:

"4. Appropriate committees, although identified in the formal organization, have been ineffectively utilized in some instances. This was particularly true of the Credentials Committee which failed to carry out a number of its assigned functions, e.g.:

a. Investigation of any breach of ethics that may be reported involving members of the active staff.

b. Investigation of the credentials of newly appointed staff members."

No written records were available to establish whether or not the Credentials Committee met and carried out any of its assigned functions. In the absence of any evidence that any breach of ethics was reported to the Committee, it cannot be assumed that it was derelict in failing to conduct an investigation.

It should be noted, in reference to Finding 4b, that the by-laws of the medical staff of Atascadero State Hospital provide:

> "The Credentials Committee shall not be concerned with appointment of physicians to the medical staff since that is the function of the Associate Medical Director, Medical Director, and State Personnel Board."
>
> (By-laws, Page 5, Paragraph 3, Section 2)

FINDING A, 5: Page 5

The report states:

"5. The Medical Records Librarian's position of a consultant advisor with limited knowledge of the mechanics of the hospital's daily routine recording procedures inhibited her effectiveness in carrying out the full range of quality control procedures included in her responsibility."

There is evidence to support the conclusion that there was inadequate centralized supervision of the procedures for recording medical records.

FINDING B; Pages 6 and 7

The report states:

"B. Court influence upon treatment program design.

Atascadero State Hospital's diagnostic and treatment procedures may be traced by a series of 'staffings' which serve as decision points during the patient's course in the hospital. When a patient first arrives at

> the hospital he is examined by the Ward Physician and an evaluation of his physical and mental status is completed within 72 hours after the examination. At this time a tentative diagnosis is entered in the patient's record. Within five weeks after admission the Ward Team members jointly evaluate the patient and submit their findings through the use of a multi-disciplinary staffing form to the Section Chief. The Section Chief then reviews the findings and, after a brief discussion with the Ward Team and brief interview with the patient, confirms or revises the tentative diagnosis and treatment plan. Periodically, the Ward Team reviews the patient's progress through his treatment program. Finally, when the Ward Team feels that the patient has gained maximum benefit from his hospitalization, the staffing process is repeated to determine final disposition of the case."

For reasons set forth below, this Committee considers the title of this finding "Court influence upon treatment program design" unfortunately inappropriate. The report correctly states the general procedure as set forth in the first paragraph under this heading quoted above.

Finding B of the report continues as follows:

> "In reviewing this decision-making process, the Task Force concluded that the treatment program is heavily influenced by the judicial system. This influence is noticeable to the point that court decisions are given preference to medical standards in treatment program determination. The key points leading to this conclusion are as follows:

"1. The major determinants for treatment programs for each individual patient are:

a. The type of commitment.

b. The crime or alleged crime of the patient.

c. The probable sentence the patient would have received if convicted and sent to Corrections for a definite period of time.

d. The patient's ability to respond to treatment as manifested by his confession of guilt."

Analysis of key points under this paragraph reflects the following discrepancies:

There is no evidence of court interference with the treatment program design. There is some evidence that in a few instances medical decisions were improperly influenced by the following factors:

a. To avoid embarrassment in court proceedings because of possible staff disagreement on diagnosis or prognosis.

b. To keep a patient in confinement in certain cases for the minimum time the person would serve if sent to prison to avoid further incarceration.

c. To justify a failure to recommend release from confinement.

d. To avoid criticism because of use of medication to tranquilize a patient returned to court.

e. To prevent criticism if a person were released and subsequently committed a violent crime.

There is no evidence that any prosecutor or judge requested or suggested that any patient ready for release or return to court should be kept in confinement, nor that any prosecutor or judge influenced or authorized the alteration of any medical record.

The record does not support that the "major determinants for the treatment programs" are those set forth in Finding B, 1, a, b, c, and d. It does show that the treatment program has been influenced with reference to a, b, c, and d and that d applies only to Mentally Disordered Sex Offenders.

FINDING B, 2; Page 7

The report states:

"2. Arbitrary amounts of time in residence are required of patients according to their type of commitment or offense, rather than their progress in the treatment program. Review of the "staffing checklist" as well as statements made during the interviews revealed that:

a. Minimum time limits were generally required for specific types of commitments and offenses.

b. Minimum periods of time in residence without ataractic medication were categorically required of some patients as a condition for their return to court in spite of an acknowledgement by some staff that this was inappropriate for many patients."

The Atascadero "Staffing Checklist" suggests that minimum time limits for specific types of commitments and offenses should be considered. There is evidence to support the finding that minimum periods of time in residence without medication are required before return to court.

FINDING B, 3; Page 7

The report states:

"3. The primary treatment modality used at Atascadero is group therapy. A major reason for employing this treatment, according to the Section Chiefs, is its usefulness in forcing the patient to acknowledge his guilt. This confession is viewed by the Section Chiefs as a pre-requisite to the patient's ability to benefit from further therapy."

The record, including the Atascadero State Hospital Staffing Checklist, which suggests this procedure, supports the finding insofar as verbal persuasion may have been used. However, there is insufficient evidence to indicate that this modality was universally applied to all cases.

FINDING B, 4 and B, 5; Pages 8 and 9

The report states:

"4. The attitude of the Senior Medical Staff (Section Chiefs) established a dictatorial atmosphere which:

a. Emphasized physical and legal constraints over psychiatric care.

b. Emphasized the necessity of caution in releasing patients so that the hospital and its staff would not receive adverse publicity due to patient "failures" upon return to the community.

c. Appeared occupied with acting in the function of "judge and jury" at the expense of providing appropriate psychiatric evaluation and consultation.

d. Regarded court decisions which disagreed with hospital recommendations as "losses" on a win/lose basis.

e. Emphasized potential dangerousness of the patients beyond realistic appraisal.

"5. In the interest of avoiding criticism from the courts, both written statements as well as unwritten policies emphasized the need for consistency of clinical opinions. Because of this, conflict which arises from disagreements between staff is generally repressed rather than dealt with openly and creatively. Examples of this repression appeared in:

a. Satements made in interviews that it was unwritten policy that opinions entered on the multidisciplinary staffing forms must be in agreement with each other and consistent with other notes in the records.

b. Statements in the staffing checklist which emphasized the need for consistent notes particularly in cases being returned to court with negative recommendations.

c. Statements made in interviews that all disagreements were worked out in team meetings prior to the entry of clinical opinions in the medical records. While such meetings may account for positive agreement resulting in uniformity of opinion, they may also be a subtle means of exerting pressure to eliminate all divergence of opinion prior to making any notations in the charts.

d. Record review which revealed a remarkable degree of uniformity in the majority of cases."

The comments set forth above with respect to Findings B, 1, B, 2, and B, 3, apply to Findings B, 4 and B, 5.

FINDING C; Pages 9 through 11

The report states:

"C. Medical Records.

The process of making an entry into a medical record at Atascadero State Hospital begins with the professional staff member's initial note either being dictated on tape or written in longhand on a "C-Note" form. The original note is sent to the Section clerk for transcription while the carbon is maintained on the ward (a carbon of the dictated note is returned to the ward after initial transcription). The Section Clerk then files the initial note in a temporary file until enough entries have been

made to complete a typewritten page. Once the entries have been typed into the medical record, the original notes are destroyed, and a carbon copy of the page is sent to the ward to replace the several entries in the ward chart. When the notes are entered in the medical record they are submitted to the authors for their signature. At the desire of the Section Chief, at any point in this process, he may review the entries in the medical record and take one of the following actions:

1. Approve the note;

2. Request the author to change the note;

3. Request the author to delete the note;

4. Delete the note without the author's consent;

5. Enter a counter note in the chart.

Upon his own initiation, the author of a note may also make changes in his note at any point during this process. One exception to this practice is the entries in the continuous nursing notes in the ward charts. In consultation with the Medical Record Librarian, nursing service has followed the practice of lining out any notes which are in error, rather than deleting the notes. In conjunction with the accusations regarding the practice of changing notes, the major findings are:

1. The medical records are altered by removal, omission, or replacement of staff notes containing clinical opinions.

    a. This practice was particularly prevalent in Section E during a recent period of several weeks when all notes

were reviewed by the Section Chief, resulting in the elimination of "conflicting or contradictory" entires. According to information received in the interviews, this same practice was used in the other Sections at the discretion of the Section Chiefs.

b. Changes made in the notes either by the authors or by the Section Chiefs have been both grammatical and substantive.

c. Both the Medical Record Librarian and the Chief Clerk disclaimed knowledge of these practices resulting in alteration of the records, but agreed that such practices would be inconsistent with acceptable standards of medical records practice.

2. Entries by professional staff into the medical records are restricted in order to conform to other opinions, particularly those of the Section Chiefs.

a. Evidence obtained through interviews and review of the medical records verified that entries made by the professional staff in cited cases were restricted when they failed to conform to ward team recommendations or Section Chief evaluations. This was found primarily in Section E and was not always a uniform practice throughout the other Sections.

b. Although there was evidence where divergent opinions were entered in the medical records, it was noted that most of the records revealed a considerable degree of uniformity of opinions and recommendations.

c. Staff interviewed cited the team meetings as useful in settling disagreements."

It was admittedly the practice in Section E to remove, omit, or replace from the medical records some notes made by the staff. The Section Chief acknowledged that he had removed notes which he characterized as inappropriate, untruthful, contradictory, and conflicting. The interviews recorded also reflected that some other Section Chiefs have also deleted notes from the medical records. Nevertheless, the record fails to support a finding that there was a general removal, omission, or replacement of staff notes, or that there was a general restriction of entries in order to conform to other opinions.

As to the finding that the Medical Record Librarian and Chief Clerk "agreed that such practices would be inconsistent with acceptable standards of medical record practice," we were unable to find any factual support in the record before us for that opinion.

With reference to the factual allegations contained in No. 2 a, b, and c, the record shows that some of the staff cited team meetings as useful, while others felt restricted in the free expression of their professional opinion.

FINDINGS D and E, Pages 11, 12 and 13

The report states:

"D. Medical Care:

Although it had been alleged that the hospital administration had arbitrarily restricted or limited medical investigation, care, and follow-up of clinical somatic problems, there was no evidence to validate this charge.

1. There was no evidence of any deliberate or wanton denial of diagnostic and therapeutic care of patients.

2. There was evidence in a small minority of cases of differing judgment in terms of appropriate treatment procedure.

3. There was evidence of lack of communication between one ward physician and the Med/Surg. Section Chief which may have resulted in a lack of appropriate referrals for additional diagnostic laboratory procedures.

The evidence appears to support the finding in D.

"E. Additional Observations:

1. The medical staff, particularly the Section Chiefs, exhibited inadequacies and deficiencies in accepting and practicing newer concepts in psychiatric care and administration.

Specifically, they appeared:

a. Unable to communicate effectively with and provide appropriate guidance to their subordinate staff;

b. Lacking the technical competence necessary to function in their positions;

c. Lacking confidence in their own professional ability, particularly in relationship to testifying in court;

d. Unable to make creative use of conflict or divergence of opinion.

2. In some records reviewed it appeared that the hospital is not following departmental policy regarding the use of seclusion and restraints. There were instances of patients remaining in seclusion for periods as long as 14 days with no 24-hour reviews recorded in the notes.

3. The major positive impact upon the treatment program seemed to be provided by the nursing staff."

We felt this was medical in nature and outside the scope of our review.

With reference to E, it was this committee's observation that it involved medical treatment and individual competence which we were not qualified to review.

* * *

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

RONALD REAGAN, Governor

DEPARTMENT OF MENTAL HYGIENE

744 P STREET
SACRAMENTO 95814

CC: EM, JET, DL, MKD, ACS, RW, HE, NH, EWT, EJG, RG, CEW, JM, WE, TC, TJ, VO, KFH.

February 18, 1973

Dear Parents and Friends of the Retarded

I want you to know that I share your concern for the good care of the retarded in our State facilities. In the past few days there has been some confusing publicity about the role of the State hospitals. Please be assured that the Health and Welfare Agency and the Department of Mental Hygiene have no plans for mass transfers or sudden closures. Present programs will continue while new goals and services are being planned.

At a press conference this past Thursday, the Department of Mental Hygiene presented a "plan for a plan" emphasizing the orderly and gradual improvement of community-based programs. That statement committed us to local agency involvement in the planning of coordinated services over the next five years. All of this has been spelled out in a recent submission to the Legislature and will be printed in the next issues of the departmental newspapers that you will receive shortly.

Many community and special interest groups will participate in this planning during the next five years. For the retarded persons in the state programs now, only planned changes with family involvement will occur. This administration will continue to meet its financial and legal caretaking responsibilities.

All of us in health administration genuinely hope that these facts will reassure you and encourage you to work with us in giving the very best continuing care to every needy retarded person.

Sincerely,

William Mayer, M.D.

William Mayer, M. D.
Director of Mental Hygiene

MENTAL HYGIENE

GOVERNOR'S REPLY TO A QUESTION CONCERNING THE CLOSING OF HOSPITALS FOR THE MENTALLY AND PHYSICALLY RETARDED--
Young People's Television Program, February 27, 1973

QUESTION: When the state hospitals are closed what's going to happen to all the patients?

ANSWER: Well, here again these are good ones (questions) and I'm glad you're asking because we have some demonstrators here (in Sacramento) right now (February 22). Most of the demonstrators'...presence is based on a total misunderstanding of the facts. They've been fed some propaganda and there's been wild rumors running around that we're going to kick all the patients out of the hospitals. Not true!

Several years ago before I became Governor, a piece of legislation was passed called the Lanterman/Petris/Short bill. This was based on a progressive, modern approach to the treatment of the mentally ill. For generations past, in our whole country, and right here in California, you had these giant so-called state hospitals. Once upon a time they called them asylums. Then everybody got self-conscious so they said, "Let's call them hospitals." But, they were warehouses.

You put the people in there because they were mentally ill and basically they never came out. There was no cure, they simply were stored away for the rest of their lives. The other day a story broke in Illinois of a woman who had been in an Illinois state hospital for 40 years. She never had any mental problem at all. She was physically crippled and when her mother died the rest of her family didn't want to take care of her, so they put her in this institution. Everybody in the institution knew that she was mentally sound and it wasn't until just a short time ago that a legal aid group found out about her case and took it to court. She is now living on a pension in an apartment, happy to be out, with no bitterness about it, but she knew all the time that she was mentally sound.

The approach under this bill in California is for the state to subsidize county mental health care clinics and hospitals that are closer to the patient's home, where it is easier for the family to visit the patient, rather than having to go half way across the state to one of the big state hospitals. But even more, to treat the patients as hospital patients and, if possible, with our new modern drugs, tranquilizers, and so forth to cure them and make them able to live a normal life, and to be a hospital in fact as well as in name.

It (the law) had been passed, as I said, before I came here. But, it hadn't been really fully implemented. There was some mental health care clinics that weren't getting as full a subsidy as they should. The law called for 75 percent and they were getting, in most cases, 50 percent. We are now subsidizing the development of these clinics at 90 percent.

But, no one is being shoved out of a hospital until the county itself says it's ready to take care of him and has the facilities for this care. On this basis, the patients go out and the hospitals are shrinking in population because of this. But, no one is just simply being turned out because we want to close a hospital.

Now when you get down to two hospitals and one's got 700 patients and is built for 3,000, and another one has three or four hundred (patients) and it's built for 3,000--well, pretty soon you close one of those two and you bring these patients over to the nearest hospital. We've been doing this with the mentally ill.

Now we're evolving a plan for the mentally retarded, and this is even more important: To build smaller, more intimate, personalized institutions, near the centers of population and near where the patients come from, to make it easier for their parents to visit them--and this is very important in the mentally retarded cases because they need love and affection.

They're retarded, but this simply means that they're like a little child. No matter how old they get physically, their minds remain at an age that can be from a one year old baby. And these are the most pitiful cases, when they get to be an adult physically, to see someone who is mentally one year's old who is as big as we are and yet who has to have the same care that you give a baby that has to be changed and all this.

But, the more tragic cases are those who reach a level of, say a small child, and they have the same desire for affection and relationship that any small child has. So the whole program is aimed for the patient's sake: getting them into these personalized smaller institutions closer to home and then simply closing out the big hospitals because they're not needed.

In many instances, in the areas near the cities, before the state institution is closed, we offer to local government the institution itself if they can use the facilities for perhaps their own mental health care clinics. And in some cases they do--they start by leasing part of it or taking it over from the state.

But with this plan (mental health) right now, with all the concern that had been drummed up for the parents of patients, particularly in the mentally retarded area, it is tragic that some politicians try to further their own purposes and their own partisan goals by causing this distress to the family and parents of a child who is in one of these retarded homes.

In the first place, no mentally retarded patient will be moved from one hospital to another without the parents' consent. The plan for change to this more localized treatment will be done with planning, and in coordination with the parents and the local communities. It has actually, so far, made California probably the foremost state in the nation, if not in the world, with regard to the care for the mentally ill. We have people coming here from all over the nation and from all over the world to look at our system and our program.

And it makes you a little bitter sometimes, to find this misinformation, this assailing of this program, that is aimed at the best interests of the patient--to hear it assailed as an economy measure. The truth is mental health comes only second to education with regard to state priority. The amount of money we're spending has gone up from less than one hundred million dollars (in 1967) to almost three hundred million dollars I believe. But I know that there has been a tremendous increase in spending for this program to make this transition to this more progressive method of care.

(The above was taken from a direct quote of a question and answer period that the Governor had with high school students.)

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