A Model for California

COMMUNITY MENTAL HEALTH PROGRAMS

Mental Health Association in California

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This book is dedicated to all those who are touched by mental illness: consumers, families and friends, mental health professionals and administrators, politicians, volunteers and advocates; all decision-makers who affect the lives of the mentally disabled.

May we all begin to work more closely to provide appropriate, humane and loving mental health care and treatment for Californians in need.

ACKNOWLEDGEMENTS

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Areta Crowell, Ph.D., gave tirelessly of her energy and talents in editing the sequential drafts of this Model. The facilitator especially appreciates her personal warmth and enthusiastic support during the difficult times.

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Barbara N. Burke

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Mental Health Association of California

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BACKGROUND

In Spring 1979, the California Assembly Permanent Subcomittee on Mental Health and Development Disabilities held a hearing on "What Mental Health in California Would Look Like in Five Years." At this first meeting of the Subcommittee chaired by Assemblyman Thomas H. Bates, it became clear that a comprehensive, systematic mental health program for California citizens was not yet in place, and could not be anticipated to be in place within five years.

Chairman Bates and the Subcommittee unanimously voted to ask a coalition of mental health providers and consumers to develop a consensus among themselves and their constituencies about appropriate mental health care in California. The Mental Health Association in California, a volunteer advocacy group for the mentally ill and for mental health, was asked to facilitate the group, which came to be called the Legislative Work Group.

Chairman Bates helped identify providers and consumers, as well as interested lay persons, to work together to develop a proposal for presentation to the Subcommittee. The Subcommittee, at the Spring 1979 meeting, recalled that important mental health legislation had been initiated by the Subcommittee in the past, and felt that — given the lack of appropriate mental health care and services — it would be desirable to again put forth omnibus legislation. The results of the Legislative Work Group's efforts would be a major contribution to such legislation.

Participation in the Legislative Work Group has been demanding in talent, energy and time commitment. Many participants volunteered their time and paid their own expenses. Those contributing and participating in the process include:

Facilitators

Present: Barbara Burke, Mental Health Association in California

Past: Peter DuBois, Mental Health Association in California

Participants

The following persons have at some time participated in meetings of the Work Group. They are shown with their affiliation during participation.

Joan Amundson, Consultant, Assembly Permanent Subcommittee on Mental Health and Developmental Disabilities
*Marcia Buck, Organization of Mental Health Advisory Boards
*Lila Berman, Citizens Advisory Council
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*Ed Bernath, Organization of State Hospital Chairpersons
*Lois Lowdon, State Department of Mental Health
Randy Feltman, M.S.W., Children's Committee of Conference of Local Mental Health Directors

Many others contributed invaluable written and verbal input and suggestions.

CREATING A LIVING DOCUMENT

The Mental Health Legislative Work Group, in attempting to develop meaningful mental health care for all citizens in California, set several criteria for its work:

- The Model shall be developed and "owned" by the joint efforts of consumers and providers and no one group should dominate the endeavor.
- A consensus must be reached on all decisions for the group to effect its goal.
- It should develop a "model" of mental health care, which would include minimum standards of service functions.
- It should focus on the public service system (Short-Doyle) portion of mental health care only at this stage, omitting fee-for-service Medi-Cal for psychiatric care.

The group determined basic needs for care, which were evolved into quantitative standards. It studied and developed categories of care, resulting in the Model for California Community Mental Health Programs. The group reviewed the responsibilities of the Short-Doyle programs to assure the availability of mental health services for each county's residents and to serve those who cannot provide service for themselves. In practice, the population with the greatest needs becomes the Short-Doyle (public) responsibility, which highlights the need to prevent the development of severe and chronic disabilities. Persons served in the public system generally represent the severely mentally disordered — those who suffer from psychosis and affective disorders and those who often are not considered "good" patients because of aggressive acting out behavior, nonverbal styles, low socioeconomic status and/or poor prognosis. They are often patients no one else wants to serve; Short-Doyle is the treatment resource of last resort. The experience of the participants, knowledge of the special needs of the population to be served, state of the art experience reflected in the literature, and relevant data from other State and local programs entered into the deliberations of the group.

Phase II

The California Model is expected to change somewhat as a result of further statewide experience using it for planning and program development. Such flexibility is appropriate for a previously untested model and should not detract from its credibility and usefulness.

After the first phase of the Model was completed in January 1980, and widely distributed, a number of questions and concerns were raised which have led to this Phase II document. The fundamental agreements have not changed, but the participants in the process believe it more fully meets the requests of users of the Model for increased clarity in the presentation as well as responding to previously unanswered questions.

It is anticipated that the Model will be a living document, flexible and adaptable to facilitate the efforts to meet the needs of the mentally ill in California, their families, friends and neighbors, as well as to provide preventive services to all citizens of California. As research reveals new information about effective treatment approaches, the Model should be changed accordingly.

Future work will address the integration of other resources and funding systems for the delivery of mental health services in California since Phase II addresses only the services provided by the public, Short-Doyle system. More data than are presently available on the nature and extent of other service systems are necessary to carry out this intent.

The Model is predicated upon the following assumptions, but does not itself address these issues.

1. There must be strong, capable leadership to manage the resources.
2. There must be continuous monitoring of the quality of care and program implementation. Systems for such evaluative and corrective actions are not included in the Model, but it is assumed they would be operational as an independent force working to assure an efficient and effective community mental health program.

The quantitative resources of the Model cannot guarantee a satisfactory mental health program, but, conversely, good leadership cannot provide an effective program with considerably fewer resources than are needed.

The Model should thus help to eliminate the general tendency to confound resource shortage problems with leadership and administrative problems.

PURPOSE

It is the purpose of the Model to serve as the framework for the development and financing of a comprehensive community mental health program in California so that individual and community needs can be met.

Long-Range Planning

It is recommended that the Model be used for long-range planning and budgeting. Comparison of the distribution of existing programs against the Model standards easily identifies those areas where a program has the greatest discrepancies between the actual and the Model. This analysis can help to assure that important functions of a community mental health program are not overlooked or kept too small and can be used to assure development of a balanced system.

This Model, if applied as a service system, eliminates the need for categorical funding as specific protection for any of the elements described in the Model. The existing County service patterns are so disparate that statewide selection of one or another function for funding priority may penalize some County efforts to develop a comprehensive, balanced system. The Model can be used by the State administrative authority and by local planners to bring about the necessary balance of functions through locally prioritized program development without categorical funding or legislative mandate.

Coordination of Planning

Inclusion of the Model program as the framework of the State Three-Year Plan for Mental Health can facilitate the statewde coordination of State and County functions, and ultimately help to increase the comparability of local programs. It can provide the basis for accurate and meaningful aggregation of local data to provide a statewide program description. It can also increase the ability of state and local planners to identify priorities for program development in order to maximize the coordination of Federal, State and local funding.

The Model also provides the necessary common terminology to facilitate coordination of the various levels of health planners, including County Short-Doyle authorities, local Health Systems Agencies, and State health planning and mental health authorities. Much confusion occurs when health planners must make judgments on the need for one type of 24-hour care and treatment (e.g., acute hospital services) — without adequate recognition as to how the availability of a continuum of care affects the need for acute services. The Model should greatly facilitate coordination of mental health and related planning efforts.

Limitations of Phase II: Only Short-Doyle System Planning

It is not the purpose of the Model at this phase of development to serve as the all-inclusive statement of need for mental health programs. That is ultimately the responsibility of the State and local health planning agencies. Fee-for-service Medi-Cal, Veteran's Administration and other private sector services are not administered by the same mental health authorities as the Short-Doyle program (see p. 42). In the next phase of development we intend to discuss incorporation of those resources into the Model. Based on reasonable epidemiological data, full implementation of the Model, together with the continuation of existing fee-for-service Medi-Cal and other private practice non-Short-Doyle resources, are necessary to meet the needs of the residents of California. In the interim, specification of the level of Short-Doyle responsibility should assist in the further technical development of mental health planning.

Public and Private Planning

The Model recognizes the valuable role of private providers in serving the mental health needs of public patients. The place where the respective roles of public and private providers in a county are considered together is in the formulation of the annual Short-Doyle Plan. As public and private sectors join together in the drafting of the County Plan, this process helps ensure that the allocation of resources for public patients will be properly balanced between public and private providers.

PHILOSOPHY

Comprehensive, Balanced, Appropriate System

The basis for the Model is a comprehensive mental health system, a balanced system of mental health services appropriately available to all Californians. The functions of the system emphasize the consumer's right to receive services in the least restrictive level of care and setting, and availability of services to all citizens, both clients and non-clients, for prevention of mental illness as well as treatment for the mentally ill. Special efforts must be made to reach underserved portions of the population through outreach and other means. For example, the mental health needs of minorities have generally not been adequately addressed or met. Accordingly, it is necessary to identify those program areas with special relevance to the mental health needs of minorities and to provide guidelines for the development and delivery of services to such populations.

The Model defines a comprehensive, balanced mental health system as one including levels of care which are not only singularly available to clients who require specific treatment, but are linked to one another in a network to provide the most appropriate level or type of service for each client. A client appropriately would move through these services as determined by diagnosis and assessment; however, some clients may remain indefinitely at a certain level of care according to individual needs. Linkage between the elements of the system is essential to assure appropriate service delivery.

Emphasis on Community Adaptation

It is the basic philosophy of the Legislative Work Group that mental health services, including preventive services, be provided in a manner culturally, linguistically, and age-appropriate and specific to the nature of the community and the needs of clients. These services are to be provided in the most humane manner, as close to a normal home environment as possible, when possible in a community-based setting, without sacrificing client safety or care.

The Model emphasizes the range of service functions which should be available to meet the needs of community residents; it is not to be interpreted as a rigid, facility-based design, although it does show the relationship of various facilities and programs to the necessary service functions, i.e., the range of administrative arrangements that can provide the variety of functions in cost effective ways.

Attention to the physiological issues of mental illness must be considered in diagnosis and assessment. Individual needs should be met with attention to the types and levels of disability and the individual's own choice about treatment approaches.

Least Restrictive in Attitude and Environment

It is a fundamental right of patients to be served in the least restrictive setting that can effectively meet their needs. A balanced system addresses "least restrictive" in terms of both attitude to clients and an environment which can help to create a non-rigid system. These services would be culturally, linguistically and age relevant in a continuum from acute intensive inpatient treatment through various non-hospital residential programs to outpatient and community support. The elements would include psychotherapy, medications, other outpatient services, case management and rehabilitation. There would be emphasis on the priorities of appropriate levels of medication, on the practical skills and rehabilitation necessary to attain independent function, the importance of normal residential settings, the assumption of ability rather than disability, and positive expectations of client performance. The system would include smaller facilities, client involvement in decisionmaking, and immersion of the client in the community in normative settings. It must be noted that the Legislative Work Group is definite in its posture that the State hospitals' resources must remain available until appropriate alternatives are in place in communities.

Alternatives to Hospitalization

The Model puts forth a full system of alternatives to institutional settings which have as a focus the rehabilitation of clients in the mental health system. These alternatives should have specific linkages with one another, and with the general treatment and social services system as a whole. These linkages would not be limited to the mental health system, but would include community resources utilized by the general population. They provide, at every level, alternatives to institutional settings. The linkages in the continuum will allow clients to move within the system to the most appropriate level of service. They allow for direct referral of clients, without requiring the client to pass through the entire system to reach the most appropriate level.

Most emotionally disturbed persons are likely to recover more effectively and rapidly in appropriate local treatment programs than in distant facilities. Therefore, it is essential to provide for maximum liberty consistent with the protection of the client and the community and appropriate care. It is recognized

that State or regional hospitals have an identifiable role in complementing and supplementing the community mental health system.

Quality of Care Essential

Underlying the philosophy of the Model is the need for assurance of quality care in all services and linkages in the system: there must be a high degree of quality. This important assurance must thread through the fabric of the Model — indeed, hold it together. This assurance of quality would appropriately be monitored by the State Department of Mental Health.

Optimal care for mentally ill persons requires comprehensive attention to biological, social and psychological needs. This balanced attention must be a primary consideration at all phases of a person's care. It must be recognized that this care is created by caring, well-trained human beings. Therefore, this Model affirms that major consideration at all phases of planning must be the training, recruitment, retention, and support of high caliber staff. Recognition must be given to the unique skills of the various mental health professionals and to the need for maintaining an optimal blend of those skills throughout the assessment and treatment process. Employment of professional staff in any or all positions, regardless of discipline, is consistent with this emphasis.

Medications are a necessary and important part of the treatment program for many patients; however, they should not be used as a substitute for other appropriate treatment services.

There is urgent community concern to assure adequate treatment of the difficult, often violent, persons who are admitted involuntarily. Such patients currently constitute a large proportion of public hospital admissions in California; the resources needed to handle these patients as well as other acutely ill persons are counted in the Model standard for 24-hour acute intensive care. However, that resource will not be sufficient if other parts of the system are not in place to provide for timely movement out of an intensive level of care. The result will be unnecessarily and inappropriately long stays. Thus, the full range of treatment alternatives in the Model is necessary and sufficient to treat the full range of public mental health responsibility.

Screening for the presence of concomitant and contributory medical illness should be part of the workup for every patient being admitted to Short-Doyle treatment settings. This screening should include a medical history, physical examination, and laboratory procedures as appropriate. If a comprehensive medical examination has been done within six months, then a review of such examination should be documented in the patient's Short-Doyle record. Other medical treatment costs should be paid for out of appropriate health care sources rather than Short-Doyle mental health funds.

Continued evaluation of the mental health system, and this Model, must take place. The Model should flex to meet the changing needs and mores of communities. Additionally, accountability of programs provided pursuant to the Model to the client and the public is essential.

We should ensure that all segments of the community have been involved in the planning, development, provision, monitoring and evaluation of mental health programs affecting their community. Quality of care standards must assure the cultural relevance of services to the population to be served.

Community Participation in Program Planning and Delivery

Community residents should be heavily involved in the planning and oversight of local mental health programs. Volunteers should also be involved in service delivery wherever possible, especially in community support programs. Such community involvement not only assures local accountability that services will be responsive to unique community populations and needs, but it helps to strengthen the normalization of mentally ill persons into the community/social structures.

INTRODUCTION TO THE MODEL

The California Model is proposed in order to establish both the essential functions of a community mental health program and the relative amounts of services necessary to accomplish the objectives of community mental health programs as established in the Lanterman-Petris-Short and Short-Doyle Acts. Recognizing that there is a need for preventive services and acute intervention, nevertheless the needs of the chronically mentally disabled have been given prime consideration in the development of the Model.

It has been developed to assure that a comprehensive, uniform range of mental health services shall be available through the Short-Doyle system to residents of all counties. It is recommended that there be a standard minimum level of service in each of the "Model" service categories to assure equity and a balanced service system. Implementation of the "Model" system is contingent upon the level of State support for the complete range of service categories; since this is conceptualized as an interlocking system, failure to develop one aspect of the system would impair the overall functioning of the system.

The Model defines a comprehensive, balanced, locally administered service system which emphasizes availability of the most effective services combined with the least restrictive settings. It has been developed with awareness of the strengths and deficiencies of current systems, of the fiscal constraints within the public service sector, and the knowledge that further critical decisions must be made regarding the administration of programs. These issues are discussed in "implementation." Briefly, whatever the administrative arrangement, the standards assume control of the resources by the local Director of Mental Health so that they may be organized most efficiently to achieve the program objectives.

Unique program design and staffing considerations are required to meet the mental health needs of the elderly, children and youth, racial and ethnic minorities, physically handicapped and criminal offenders. Programs and treatment modalities should be planned and implemented to ensure an accessible, equitable, and appropriate response to the unique life experiences of minority residents. It is expected that the resource levels provided according to this Model will enable counties to implement specific program requirements appropriate to each group. Current Short-Doyle utilization patterns for certain of these groups are very "unbalanced," reflecting inadequacies of the existing system; these should change as the system improves. For example, overutilization (largely involuntary) of acute inpatient and State hospitals by some ethnic persons of color is considered to be the result of inadequate outreach and prevention programs and perceived irrelevance of *customary* outpatient and day treatment services. The absence of the effective community alternatives is believed to increase the use of the most restrictive treatment settings, a result contrary to the philosophical foundation of the entire community mental health movement. It is recommended that proportionately more resources should be directed to Community Outreach Services (Consultation, Education, Information, Community Organization and Outreach) in predominantly minority communities.

The special program balance required by youth and geriatric residents has been added to the Model to clarify the recommended distribution of Model services to these age groups. Local adjustments should be made to correspond to the actual age distribution in each County; the figures given are based on statewide averages.

Local planning must be held accountable to design staff and locate the program elements within the total resources available to raise the effectiveness of services to these special groups and to increase the availability, appropriateness, and acceptability of services to all community residents.

Relationship to Needs Indices

The prescription of necessary amounts of services are given for an average population base of 100,000. The Model is designed to meet the needs of the average number of Short-Doyle eligible persons in an "average" 100,000 population. Adjustments must be made at the local level to take into account the relative poverty of each specific planning area population, the availability of other resources, and the impact of unique age and ethnic distribution on the various levels of services needed.

Most efforts to quantify need are based on indirect demographic indicators of the relative socioeconomic status of populations of different areas. More direct epidemiological methods may provide an estimate of the numbers of persons who are in need, and generally identify the severity of need. Neither approach to need assessment, however, specifies the types of services nor the amounts that should be available. The Model provides the specificity regarding types and amount of services needed in a complementary way to classical needs assessment approaches.

Special Rural Considerations in Application of the Model

The principles of this Model can be achieved even when population centers are small or widely dispersed. Access to the full range of Model service functions is needed by all California residents.

There are, however, certain special considerations which must be kept in mind in applying the Model to sparsely populated areas. For example, in such areas, more than one category of service may be provided by the same staff depending on the particular needs of the individual clients to be served at that particular time. Such functions as outpatient services, consultation, education and case management would typically be provided by the same staff, in a single, unified program. It is, therefore, imperative that these programs not be restricted or excluded from funding solely because their service delivery system is generic and multi-functional. It is also important to recognize that the quantitative level of the Model functions may fluctuate in small programs and further that it may be possible to provide comparable functions in a smaller number of settings than is specified in the Model. Thus, flexibility is assumed in applying the Model to rural areas. In addition, services to mental health clients may often be provided in close collaboration with other local agencies and professionals, making it difficult under such circumstances to distinguish a mental health service from a child protective service or a school counseling service. Crisis and transitional residential care may be provided in a portion of an appropriate residential care facility with outside staff providing separate and additional services as indicated by the needs of the clients. Acute, intensive care might be provided in several of the regular beds in a local general hospital with augmented psychiatric nursing care for the more disturbed patients provided by means of an on-call roster of nurses and aides. Community physicians would assume more than the usual level of responsibility for the care and treatment of such inpatients, with back-up consultation from a psychiatrist. This close collaboration of services in no way suggests that sparsely populated areas need fewer staff equivalents than persons with similar needs residing elsewhere.

Such factors as long distances to be traveled, fluctuating utilization rates and the need for special, outside technical assistance can result in higher than usual overhead or administrative costs in sparsely populated areas. For example, mental health services may be required to fund a transportation capability where no public transportation exists and where distances would be a deterrent to patients obtaining services. There is also an absolute minimum number of administrative staff required to support any program. If fewer administrative staff are provided, the program will not be viable. Flexibility must thus be available in applying these quantitative standards to sparsely populated areas.

It also must be kept in mind that at some point a given category of service cannot be feasibly implemented because the population to be served is so small as to result in an unacceptably low utilization. However, such thresholds of feasibility can only be determined by each local area based on its unique needs and resources. When the feasibility for a category of service is found to be low, regional services should be developed by inter-County agreements, under local control and designed to serve a natural catchment area. An example might be programs for those few patients who present such significant management problems as to require care in a special regional facility.

Special Minority Considerations in Application of the Model

There are, also, unique considerations when applying the Model to minority populations. Treatment services for these populations must combine education, crisis intervention, outreach, and various therapeutic approaches.

The emphasis must be on this combined treatment approach, not on fragmented services that consist of only preventive or educational methods and if these fail, admitting the individual to an inpatient unit on an involuntary basis.

It must be clearly stated that there is a large segment of the population who — for age, cultural, linguistic, or personal reasons — cannot utilize the traditional mental health services delivery system. It is the responsibility of a comprehensive system to provide the community/treatment services necessary for these populations. These services must be relevant and useful within the individual's belief system. It is not realistic to expect an emotionally distressed person to change his/her belief system to become eligible for mental health services. Professional backup in the form of staff training, consultation, and case supervision would allow a broad range of human care agencies to handle increasingly more complex mental health situations, thereby referring fewer cases into the Short-Doyle Mental Health treatment system. This is much more advantageous to the individual, as it minimizes the disruption of normal productivity by utilizing existing familial and community support systems to maximum benefit.

Given this basic support system, even extremely small numbers of clients within a given community could be appropriately served. The goal is to provide quality mental health services to as many of the population as possible. Hiring bilingual, bicultural professionals does not diminish services to the dominant culture; it simply enhances the spectrum of

services to an additional and important segment of the population.

Forensic Mental Health

A separate category of Forensic Mental Health services to persons who are or have been under justice system jurisdiction is appended to the overall Model. The service needs of this target group fall within the spectrum of services described in the Model. However, due to the unique nature of the target population and the need for ongoing credible interaction with the justice system, programs are often specifically designed. Some programs may be operated within a secure environment, either inside or outside a detention facility. The categories of service and basic standards are summarized separately under the heading of Services to the Justice System, Forensic Mental Health (Adult) and Services for Mentally Disordered Wards and Dependents of the Juvenile Court.

STANDARDS FOR SERVICES: THE PROPOSED MODEL

It is recommended that counties assure their clients have access to the following mental health services. For each service, a population-based standard is expressed in terms of a minimum level of service per 100,000 population. Separate tables showing the recommended distribution of services for children and geriatrics appear on pages 31 and 32.

Service Function	Standard Service Level Per 100,000 Population
1. Twenty-Four Hour Acute, Intensive Care	15 beds
2. Short-Term Crisis Residential Care	10 beds
3. Twenty-Four Hour Transitional Residential Care	20 beds
4. Long-Term Rehabilitative Care	40 beds
5. Out-of-Home Placement	
a) Supervised Out-of-Home Placement	60 beds
b) Semi-Independent Living	15 beds
6. Emergency Services, Crisis Intervention, Screening, Evaluation and Disposition	a) 24-Hour Emergency Evaluation Treatment and Holding Services (for approx. 1,000 persons annually).
	b) 1 Crisis Intervention Program (7 da/wk, late afternoon-evening shift, 2 FTE [Full-time equivalent personnel] staff)
	c) Mobile Crisis Service: 150 visits/yr.
7. Acute Day Treatment	— One acute Day Treatment program of 9 staff to deliver 7,000 units of service
8. Outpatient Services	— One Outpatient Clinic of 20 staff to deliver 16,250 units of service
9. Case Management	— 8.6 FTE professional staff plus support staff and tracking system
10. Community Support Services	13 FTE staff
a) Day Rehabilitation	9 FTE
b) Socialization	2 FTE
c) Services to Semi-Independent Living Programs	1 FTE
d) Respite Care	1 FTE
e) Companion (Volunteer) Program	
11. Community Outreach Services (Consultation, Education Information, Community Organization and Community Client Contact)	6 FTE staff
12. Mental Health Advocacy	.5 to 1.0 FTE staff
13. Services to the Justice System—Adult and Juvenile	

The goal in the development of 24-hour care services in categories 1 - 5 is the creation of a continuum of care that allows for treatment in the least restrictive, most effective setting appropriate to each client. In each of the categories, the intent is to provide a range of settings in order to develop specific services geared to individual needs. Therefore, 24-hour services are envisioned in settings ranging from general hospitals for those psychiatric patients requiring medical care and support, as well as medical patients requiring psychiatric services, to residential alternatives to institutions such as semi-independent living programs. The various levels of care, from acute to out-of-home placement, are assigned minimum bed levels in a ratio designed to encourage the development of transitional services. All patients entering a 24-hour setting should have had a recent medical history, physical, and appropriate medical evaluation, with results in the mental health record.

In sparsely populated areas the necessary range of intensity levels and type of services could be provided in multi-functional settings, with shared staff, thus reducing the expected number of 24-hour program settings but not minimizing the variety of functions to be provided.

The proposed standards for 24-hour care services (categories 1 - 5) include a total of 160 beds of all varieties for the Short-Doyle-eligible persons in each 100,000 general population. Prior to the development of Short-Doyle, there were approximately 37,000 mentally ill persons in State hospitals. At that time the population of California was 16,000,000. Disregarding the beds in local hospitals that were at that time occupied by the mentally ill, the State hospital utilization corresponded to 231 beds per 100,000, thus the standards continue the national trends away from institutional-based, 24-hour care.

1. **Twenty-Four Hour, Acute, Intensive Care**

   Persons to Be Served

   This level of care is appropriate for patients who are severely and acutely mentally disordered, both voluntary and involuntary, often with associated medical problems.

   Patients who are characterized by marked impairments, i.e., violent, suicidal, may require restraints, typically require medication and need intensive treatment. For planning purposes, the need for acute care is determined by the severity of the dysfunction, regardless of the length of treatment time required. Only persons who are extremely impaired should be treated in these expensive, high-demand resources. If the impairment is less serious, other levels of care would be adequate and appropriate. Likewise, persons should generally move from these into less intensive settings as quickly as possible.

   This category of care must meet Title 9 inpatient staffing standards, and may be provided in both hospital and non-hospital settings. Because some of the patients to be treated are non-ambulatory, have organic disorders, medical complications or have been physically damaged (e.g., trauma from accidents, etc.) some services *must* be hospital-based. Some patients with severe functional mental disorders may also require hospital settings: e.g., intravenous feeding for catatonic or severely depressed patients. So long as the treatment program provides effective, medically supervised, acute, intensive mental health care, however, such care can be provided in settings other than general or free-standing hospitals. These non-hospital settings include a "skilled nursing facility" (SNF) with appropriately augmented staff, or a "psychiatric health facility" (PHF).

   Description of Services

   These services are to provide immediate, round-the-clock, intensive crisis care and treatment with clear medical direction and orientation, including comprehensive medical examination at the time of admission.

   The standard is for 15 beds per 100,000. The balance of different types of acute care settings to be used may require adjustment according to local needs; most significantly, high incidence of PCP* use would require relatively more hospital-based beds per 100,000. The standard of 15 would include all acute care regardless of age and setting. Where State hospitals provide acute care, they may be counted as "existing resources" for comparison with the standard, but it is the premise of the Model that the acute care would generally be provided in local services settings.

   *Toxic psychoses due to PCP generally require hospital-based mental health treatment.

2. **Short-Term Crisis Residential Care**

   Persons to Be Served

   This level of care is appropriate for acute, usually transient disorders, involving cooperative voluntary patients not needing continuous medical supervision. It is generally appropriate for persons undergoing severe situational disturbance or stress reaction marked by temporary impairment and inability to function.

   Description of Services

   Generally, 5 - 10 beds per 100,000 will meet the need for this level. The services would be provided in community care facilities or other residential

settings, but *not* in acute hospitals, skilled nursing or intermediate care facilities. Stays will be brief, usually not longer than two weeks. Clients may not require medication and the facilities are typically non-locked.

This program would generally be provided in one phase of the Community Residential Treatment System (CRTS-AB3052). It could also be provided through acute treatment in a family care setting with sufficient resources for supervision and intervention (e.g., Southwest Denver paradigm).

3. **Twenty-Four Hour Transitional Residential Care**

Persons to Be Served

Two groups of patients are to be served in this level: (1) Patients who have been treated at an acute stage of illness, but who have not yet returned to their prior level of functioning; and (2) patients who have been chronically dependent and/or institutionalized and who need assistance to return to independent living settings.

Patients will generally have had a recent hospitalization, but present no immediate control problems. They are generally persons with basic problems of impulse control, life organization and inappropriate behavior. A wide spectrum of diagnostic categories would be found, including thought disorders, borderline conditions, affective disorders and those organic conditions with a good prognosis. Some persons experiencing situational disturbances could be included, but generally for much briefer stays than the median for this modality. Conservatees could be included, though generally clients would be voluntary.

This would generally be the most appropriate category of 24-hour care for children and adolescents. Children and youth appropriate for this level of care would include those with serious impairment in personality development and with behavioral disturbances sufficiently severe to require temporary placement away from the home environment.

Description of Services

These are appropriately staffed social rehabilitation programs not tied to Title 9 staffing; they are intended to provide an interim step, now largely absent from the system, to assist clients after an acute stage of illness who have not yet returned to their prior level of functioning or to assist persons who have been chronically dependent and institutionalized into independent living. The intent is to restore the client to a normalized lifestyle. It is, therefore, desirable that these programs be provided in small residential settings to the maximum extent feasible. Such an environment enhances the efforts to help the client make a transition to normal life.

Support and 24-hour supervision must be an integral part of the program as well as active involvement in growth services in order to assist clients with impaired functional abilities to move from acute care to less protective and more independent functioning. Without the support of the program, clients would be at risk of returning to the hospital. There is a broad range of community services which should be provided in conjunction with the residential service, though generally not on the same site. The adjunctive services include day treatment, vocational and prevocational training and rehabilitation, and outpatient (e.g., verbalization, remotivation). Facility staffing will be heavy in evenings and on weekends; during the daytime, most clients should be involved in adjunctive programs. Staff must be skilled in providing guidance and encouragement to use other community services.

This generally should be the most frequently used category of 24-hour care for children and adolescents. Approximately 20 beds per 100,000 population are needed at this level, of which half would be for children and adolescents. The program will emphasize helping the youngster to develop appropriate social responses, to internalize controls, and to improve school performance and interpersonal skills. Staff will provide role modeling. Transitional care can occur in appropriately augmented facilities such as specialized ("treatment") foster homes, group homes and intermediate term residential treatment facilities. Utilization of community resources should be an integral part of the program. Young people in this program will attend special schools.

4. **Long-Term Rehabilitative Care**

Persons to Be Served

This level of care will serve those persons who have traditionally been relegated to State hospitals or maintenance settings because of behavior which has been unacceptable or unmanageable. They generally are severely and persistently (as contrasted with recurrently) disabled with multiple problems, and cannot tolerate more intensive treatment programs. Many of these are older and nonambulatory; in addition, there may be young adults and adolescents included.

Description of Services

Persons in these programs require medical services, supervision and closely structured rehabilitation programs to improve their basic functioning. A major focus will be remotivational care and social training within a protective setting. It is estimated

that an average of 18 months - 3 years may be required to achieve the improved level of functioning, although some may require care for an indefinite period. Staffing is heavily weighted toward occupational and rehabilitational therapies. Medical care is generally supplied by community physicians (funded either by Short-Doyle or fee-for-service Medi-Cal) and is not included in the facility staffing pattern. The service pattern will entail in-house programming 12 to 16 hours/day, 7 days/wk. in addition to 24-hour care and supervision. The long-term residential treatment center category of the Community Residential Treatment System applies to this level of care. Skilled Nursing Facilities with a Special Treatment Program or Intermediate Care Facilities with appropriate augmentation and special rehabilitation program focus, may correspond to this service category. Most long-term rehabilitative care should be provided in non-institutional facilities of less than 30 beds. The standard calls for 40 beds per 100,000 in programs of this type.

5. **Out-of-Home Placement**

A) Supervised Out-of-Home Placement

Persons to Be Served

This level of care is for clients requiring minimal (less than 24-hour), long-term supervision. Residents should be provided access to the full range of supportive and treatment services, including outpatient care and social rehabilitation, as outlined in their continuing care plan. Most clients who are chronically disabled and are eligible for SSI and Medi-Cal, will require long-term maintenance at this level. Appropriate maintenance and subsistence support is required for persons who would be unable to function in the community without this level of care. Persons who will not accept more intensive treatment options will also be included in these programs.

Description of Services

These services are offered in board and care type residencies which provide for basic personal needs, e.g., food and shelter are provided and any medication regimen is monitored by the board and care staff. Small board/care homes should be homelike and provide the support which would be found in a family setting. Larger homes can include some recreational services. There should be two levels of care available in board/care homes: the basic level is what is included in this component of the Model and these costs are entirely covered by the SSI allowance. The costs of the higher level of care should be included in the community support segment of the Model —board/care and the community support service system must be closely linked. The necessary supportive and treatment services for these persons are included in other parts of the Model (case management, outpatient, etc.). No Short-Doyle costs are shown for this function but these resources should be proportionately available in communities throughout the State.

The standard is 60 beds per 100,000, which is considerably lower than current utilization, with the anticipation that transitional, rehabilitative, and semi-independent living resources will have a significant impact on the ultimate service pattern.

B) Semi-Independent Living

Persons to Be Served

Persons served in this level of care do not require 24-hour support and supervision. They demonstrate acceptable social behavior but require additional assistance to develop skills which will allow them to become self-sustaining in independent living situations. They can typically take care of their physical needs.

Appropriate semi-independent living programs should also be available for youth with emancipation needs. These are youth who are able to move to a program which requires a lower level of care but who have no viable supportive resource available within their own homes. The focus of this type of out-of-home placement program is upon socialization and preparation for independent living.

Description of Services

This is a structured, supervised program to provide the most normal community alternative for persons not able to live independently. The structure is provided by other than live-in support staff, and focuses on day-to-day problems of living in that setting. Individuals may use this program as a transition to independent living or may remain indefinitely in order to avoid the need for more intensive settings. It is estimated that 15 persons per 100,000 would be in these settings at any time; 3-4 apartments would be required for the program. Additional satellite apartments will be needed as clients move through the program and attain more independent status.

Necessary support and treatment services are provided by the "outpatient" and "community support" components of the Model. Residential costs are borne by the clients, usually through their SSI.

6. **Emergency Services, Crisis Intervention, Screening, Evaluation, and Disposition**

These are the primary intake resources for services for the acutely ill, voluntary or involuntary. They may be brought in by police or paramedics, private ambulances, family/friends or neighbors, or walk in or call in alone. There are various ways to assure availability of 24-hour crisis resolution and pre-admission screening. Some capability for mobile emergency evaluation and crisis services should also be provided, especially in sparsely populated areas or rural settings.

A) **Emergency Services Evaluation and Treatment**

Persons to Be Served

Patients served by this service would be exhibiting acute psychiatric symptomatology. Patients may be suicidal or potentially violent; they may be in panic states, behaving bizarrely, confused, hallucinating, or otherwise so disturbed as not to be able to care for their own physical needs. Patients exhibiting psychotic behavior due to acute drug intoxication would also be evaluated here.

Description of Services

This service provides 24-hour, 7-day-a-week emergency evaluation and treatment. A preliminary diagnosis would be made and some form of treatment initiated, usually medication and crisis intervention. This service would provide a capability for a 24-hour holding service. After initial diagnosis and treatment, patients would often be referred to a 24-hour (acute) care facility, but these programs can effectively divert persons from inpatient services who would, without it, be routinely admitted to acute inpatient programs. Diverted patients would generally be referred to day treatment, outpatient services or returned to the community. In rural areas, these programs may be provided in the emergency area of a general hospital through on-call mental health services.

B) **Crisis Intervention: Walk-in and Call-in Services**

Persons to Be Served

This program would serve anyone in the general community with a psychiatric concern or emergency, needing information about services or referral, needing advice about how to deal with someone else in a psychiatric emergency, etc.

Description of Services

This program would provide walk-in service, at least five days per week from 8 a.m. to 5 p.m., or in an afternoon-evening shift, call-in services and be available 24 hours, seven days per week. This service would provide information and referral to all other components of the mental health system. In addition to classic (verbal) crisis intervention, other interventions might be provided.

C) **Mobile Crisis Service**

Persons to Be Served

This service is designed as a crisis intervention for persons experiencing an acute episode who are not appropriate for, or do not choose to participate in, hospital or other facility-based 24-hour emergency services. The service is for those who would benefit most from a treatment intervention in their usual living environment. The intervention may last as long as 48 hours, or be as short as a few hours.

Description of Services

The service provides 24-hour, 7-days-a-week mobile crisis capability to go to the home environment of a person in crisis and work intensively to resolve the situation without utilizing other emergency settings or 24-hour programs. Services would include, but not be limited to, crisis intervention, family work when appropriate, development of specific treatment plan, referral to other appropriate resources, and coordination of resources on a short-term basis. The service would be designed to maximize utilization of the home environment to achieve stabilization. It would

be staffed on a part-time "on-call" basis by staff in outpatient or other emergency services.

Standards

Per 100,000 Pop.	Est. # Patients Annually
A. Emergency Services Program	1000
B. 2.0 FTE, 10 units/da 8-5 pm./7 da.	1820
C. 150 visits/yr × 4 hr/visit × 2 professionals × $25/hr = $30,000	250

7. **Acute Day Treatment**

Persons to Be Served

This program should serve as an alternative to hospitalization for those who need a psychiatrically directed multi-disciplinary treatment program. The patients suitable for such a program have serious mental disorders reflected in a current or recent history of destructive behavior to self or others and/or are those who are unable to function in normal roles due to the severity of their handicap and who need help to mobilize themselves to acquire the rights and benefits needed for the ongoing reconstruction of their lives. Distress and anxiety immobilize these clients so they cannot even begin to gain control over their own basic living needs.

Description of Services

This is an intensive treatment function which would be used by persons living in their own homes or in transitional residential services, or other residential care settings. In order to function as a substitute for hospitalization by persons living in their homes or board and care homes, there must be a strong support system available to the individual.

This program must be staffed according to Title 9 regulations which include half-time physician supervision of the treatment program for all clientele.

This level of program is very appropriate for those children and youth who are unable to function satisfactorily throughout the entire day in their homes and also are frequently unable to conform their behavior well enough to attend regular school classes. The program should include an on-site educational component with teachers who have knowledge and experience in dealing with emotionally disturbed children or youth.

In sparsely populated areas, this function would probably not be provided in a separately identified program. It might be included with crisis residential services or with community support services. The mix of acute 24-hour care, crisis, residential and day treatment will depend on local circumstances; these are particularly interdependent services.

Standard:

One Acute Day Treatment program per 100,000 (9 full-time equivalent staff including clerical) should be able to provide services to 30-40 persons at any time. This corresponds to the estimates of the persons in short-term crisis residential and transitional residential service programs who would be using the program.

8. **Outpatient Services**

Persons to Be Served

These are services for persons who require crisis intervention or sustained therapeutic intervention in accordance with a treatment plan, with goals and objectives arrived at in collaboration with the client. Clients will include persons with acute or moderate disruption of their mental functioning. They need professional assessment of the nature of their problems. Treatment plans will focus on individual growth and development, maintenance of functioning, resolution of serious family strife or gross problems in normal role functioning which interfere with the ability of the individual to carry on vocational, educational, or other daily responsibilities. Clients may require assistance in formulating the beneficial use of leisure time activities to combat isolation, loneliness, and to reverse regressive tendencies which have led to depression, isolation, etc. Some patients treated in this setting are so seriously disturbed that, without family or other social support, they might well require 24-hour care.

Description of Services

Short-Doyle mental health outpatient services should be accessible and responsive to the needs of the identified community target groups of all ages and ethnic, cultural, and sexual minority groups as well as the physically disabled outpatient programs include the following services:

A) **Brief individual psychotherapy** — adult and child: Diagnostic assessment and testing; brief individual psychotherapy to resolve situational or temporary problems.

B) **Longer term individual psychotherapy** for adults and children to successfully resolve crises and return to higher levels of functioning.

C) **Maintenance therapy:** Designed to support chronically mentally ill persons to maintain level of functioning. This will include time for interagency linkages and indirect treatment contacts.

D) **Information/assistance and referral:** Non-emergency triage service to the general public.

E) **Group therapy:** Adult/child-directed and focused, verbal/non-verbal therapeutic techniques designed to result in resolution or lessening of problems and/or behavior change.

F) **Couple/family/collateral/significant other therapies:** Designed on short-term and long-term basis to utilize the support system that the patient is involved with to assist in creating system and individual change.

G) **Medication therapy:** Prescription of appropriate psychotropic drugs, following the therapeutic response to and identification of side effects associated with the prescribed medication.

H) **Group activity therapy:** Occupational, recreational, and similar activities designed for persons in acute or extended phases of psychosis to facilitate interpersonal contacts in a non-traditional therapeutic activity. Such activities are usually combined with other therapeutic modalities.

I) **Outreach services:** Assessment and treatment for individuals or groups in a natural setting, including staff support to semi-independent living and satellite housing units.

Standard

The level of services needed would require 1 clinic per 100,000 population, with average staff of 20 FTE.

The staff should include a mix of psychiatrists, psychologists, and social workers according to Title 9 regulations as well as therapists with other training and skills. The staff skills, capacities, and characteristics of each clinic should be tailored to the needs of the population being served and should be adjusted to provide quality mental health treatment for client groups such as children and youth, older adults, chronically ill clients, racial and ethnic minorities, and the physically disabled.

9. **Case Management**

Persons to Be Served

Clients who should be served by a case management program include the following: all clients who have been admitted to local acute or State psychiatric hospitals two or more times within the past year; clients whose mental or emotional conditions have been diagnosed as chronic or who have had a continuous serious mental disorder for the previous five years; or any person who as a result of any evaluation has been determined to be incapable of appropriately utilizing available mental health resources or who has experienced gross interference with his or her ability to live independently in the community.

Description of Services

This function is intended to assure continuity of care within the system. It is a process of identification, assessment of need, planning, coordination, tracking and monitoring of continuing needs in the most efficient and effective way possible. The case manager must assess comprehensive needs of the clients, including housing and social services, and assure that services are developed by appropriate responsible agencies.

The comprehensive case management system shall be a distinct and identifiable function within the mental health system of each jurisdiction responsible to the local Mental Health Director, or the Director's designee, capable of assuming full responsibility for the assigned tasks and target population and with sufficient vested authority within the system to intervene efficiently and effectively on behalf of individuals in need.

It is essential that a patient who is receiving case management services is encouraged to be active in treatment planning. Another key factor in successful case management is the ongoing involvement of all members of the treatment team. Effective case management requires close coordination and communication among members of the treatment team. Major planning decisions and changes in a client's treatment plan should be made with the involvement of the client, his or her family, and the entire treatment team.

Standard

8.6 case managers + 2.6 support staff + operating expenses + tracking system.

This standard is derived as follows: There are approximately 400 long-term clients per 100,000 population who need case management services; there should be a caseload of 50 clients per staff member (8 FTE would be minimum for 400 clients but vacation and sick time require additional staff); support staff are added at 1.3 ratio. Patient tracking may be part-time staff in a small county or computer-based in a large county.

10. **Community Support Services**

Persons to Be Served

Clients served by Day Rehabilitation and Socialization Services would be the chronically mentally ill, with generally a long history of repeated hospitalizations and social withdrawal. These persons would generally have few skills of living or vocational skills and exhibit only marginal adjustment to living in the general community. These clients also have few or no community or familial support systems. They would typically be receiving continuing care services, and would deteriorate rapidly if left without a day rehabilitation program. Elderly persons would need to receive services appropriately modified according to reasonable expectations for their lifestyle.

Description of Services

These programs are designed to provide a range of therapeutic and rehabilitative services to persons in various settings including their own home or residential programs. They are less intensive than acute day treatment programs. The intent is to prevent recidivism and to maximize independent living. Treatment and rehabilitation services should be integrated as much as possible to meet client needs.

A) **Day Rehabilitation Services**

Provides counseling and social rehabilitation services for clients living in facilities with little or no treatment component. Ideally, this program should not be hospital-based, and be provided on an outpatient basis. When necessary, especially in sparsely populated areas without public transportation systems, patient transportation must be provided.

This program would have a functional orientation with pre-vocational and vocational services (rather than a "talk-therapy" approach). A pre-vocational service would focus on attitudinal, motivational, emotional and physical impediments to functioning. There is an emphasis on skill seeking and skill enhancement which would point toward vocational goals. These services should be available for those who live at residential facilities and those who live at home. The goal would be to maximally involve the client in meaningful and productive work. Some work experience would be permanently "sheltered" for those who have reached their level of vocational growth as well as being part of a continuum of care for those who can progress through the service toward independent functioning.

B) **Socialization Services**

These services are intended to develop the skills of normal social functioning in persons who are withdrawn and isolated. They will provide for socialization activities during the day, evening, and holidays. Parties, games, dancing, cooking as well as some amount of social group work, are appropriate services. The orientation would be toward the elderly and those living in board and care homes or semi-supervised housing. Activities should be gauged for multiple age groups and culturally appropriate. The standard is set to encourage the use of volunteers to enrich the program. Transportation often must be provided, especially in sparsely populated areas and for elderly or chronically disabled clients.

C) **Services for Semi-Independent Living Programs**

Staff will be required to provide structure and supervision for persons living in apartments or other housing without live-in staff. Assistance will be provided to assure the residents can handle shopping, food preparation and maintenance responsibilities as well as the problems of group living. One staff person is required for each 3-4 apartments (15 beds); it is anticipated most clients will move fairly quickly to totally independent living situations, but some may stay indefinitely, thus adding to the needed services.

D) **Respite Care**

This service provides relief for primary caregivers of persons who require 24-hour care and supervision because of psychiatric disability. The respite service would provide temporary coverage and supervision to enable family members or board/care administrators to leave the home for short or moderately extended periods of time. Respite personnel would assure the uninterrupted continuation of services provided for clients, both in the home and in the greater community. The purpose of respite

care is to prevent the necessity of removing the client from his/her home setting in order to continue to receive required levels of care.

E) **Companion (Volunteer) Program**

A volunteer-based companion program designed to encourage the development of relationships with residents of community care facilities with the goal of motivating and assisting residents to make a successful transition to independent living. The service would primarily be provided by volunteers, including students, who are supervised and coordinated by trained personnel, generally staff of the day rehabilitation or socialization programs. Services provided would include recreation, one-to-one companionship, advocacy, and assistance in developing the knowledge and use of community resources, including housing, vocational services. This service would also provide follow-up for persons who make the transition to independent living settings. This program could be based in the day rehabilitation or socialization program where staffing must include someone with special skill and experience working with volunteers in order to carry out these concepts.

Standards

A) **Day Rehabilitation Services**
9 FTE x 1.3 = 10.4 total staffing (including clerical support)

B) **Socialization Services**
2 FTE x 1.3 = 2.6 total staffing

C) **Services to Semi-Independent Living Programs**
1 FTE x 1.3 = 1.3 total staffing

D) **Respite Care**
1 FTE

E) **Companion (Volunteer) Program**
Included in A and B above

Total Community Support = 13 FTE + clerical support

11. **Community Outreach Services (Consultation, Education, Information, Community Organization and Community Client Contact)**

Community Outreach Services are an integral part of the spectrum of mental health services and must be carefully coordinated with the overall program administration. They enable the mental health system to reach the community-at-large, and provide a proactive way for the system to address the needs of those who do not or will not utilize traditional mental health services, especially populations at risk. An outreach approach also maximizes the effect of limited resources in sparsely populated areas.

The purposes of these services are (1) to enhance the mental health of the general population, (2) to prevent the onset of mental health problems in individuals and communities, (3) to assist those persons experiencing stress who are not reached by traditional mental health treatment services to obtain a more adaptive level of functioning, (4) strengthening individual's and communities' skills and abilities to cope with stressful life situations *before* the onset of such events, and (5) enhancing and/or expanding agencies' or organizations' mental health knowledge and skills in relation to the community-at-large, special population groups, or particular clients.

Particular emphasis should be given to addressing the needs of underserved populations such as children and youth, ethnic minorities, elders and residents of sparsely populated areas. Staffing patterns should include cultural, linguistic, and other special expertise as determined by target group(s). Staff should become aware of and sensitive to the unique life experiences and cultures of many minority clients which are related to lifestyles developed from the clients' experiences in living outside the dominant society. Clients' attitudes toward the mental health program and its staff may include distrust and inhibitions to self-disclosure. Such attitudes are likely to have a profound impact upon the development of rapport and to adversely affect therapeutic relationships. Appropriate responses will require sustained attention to the manner in which services are planned and provided.

Community Outreach Services should be organized with special attention to those public and private agencies which traditionally provide services to underserved minorities, poverty-level populations, elders, residents of sparsely populated areas, and those systems which serve children and youth — e.g., Child Protective Services Division of the Welfare Department, Probation Department (including Juvenile Halls), the schools, and Public Health. Since educational methods are often more easily integrated into existing belief systems, they can serve as the "entry" into the future provision of mental health services to fearful and suspicious communities. Care should be given to improving ways in which local communities can minimize those disruptive stresses which interfere with normal functioning. Information efforts can be used to reduce the stigma of mental illness so those who have been mentally disordered may have a better opportunity to

establish themselves in the mainstream of life.

Community Outreach Services are classified as Mental Health Promotion or Community Client Services, differentiating those activities directed toward promotion and primary prevention efforts from those activities directed toward assisting an individual or family who has a mental health problem or is at risk but who is not reached by the traditional treatment system.

The following functions should be provided in a mix appropriate to the planning area. About 50% of the total should be devoted to the needs of children and youth, both those at risk and those already dysfunctional.

A) **Mental Health Consultation**

The provision of culturally and linguistically appropriate technical assistance by a mental health professional to increase the mental health skills and improve the capabilities of allied caregivers or their agencies.

B) **Mental Health Education (includes education about mental health, mental illness, and for mental health)**

A learning process which imparts principles of sound personal and community health to other professionals, individuals or groups and/or the general public. The goals are to expand knowledge and skills, and to change behavior and emotional response by changing perceptions, attitudes and motivation and by teaching new personal and interpersonal skills.

C) **Mental Health Information**

Programs concerned with providing information about mental health services to the general community and/or particular target populations. Efforts to reduce the stigma of mental disorder are necessary to accomplish the Model goals of maximum normalization of lifestyle for who have been mentally disordered. The goal of these services is a community that is aware of its mental health resources, and of the factors that call for mental health intervention, and is comfortable in utilizing these services.

D) **Community Organization**

Working in collaboration with others, the staff member helps identify community mental health needs and objectives, locates appropriate resources, and initiates problem-solving action. The goals are development or modification of mental health, social, and other community systems to maximize mental health benefits in the community.

E) **Outreach for Prevention (Community Client Contact)**

Activities directed toward strengthening an individual's coping skills and abilities during a stressful life situation through short-term intervention. This intervention is used primarily for those who are at risk, and who, because of cultural, linguistic, or personal barriers, are not reached by the traditional treatment system. Clients are not designated as "patients," do not receive a diagnosis, and usually are not assessed for ability to pay. They often are seen in the home or in other settings where they feel more comfortable, or are reached through a telephone counseling line. They may be linked with ongoing treatment when appropriate after an initial relationship with the outreach staff member is developed.

Goals are provision of culturally and linguistically appropriate short-term mental health services to populations at risk and, when appropriate, linking with treatment services; and the prevention of more serious and costly mental health problems by early identification and timely crisis resolution.

Standard

A) 6 FTE (including para-professionals) per 100,000.

B) The staffing pattern must include cultural, linguistic, and other special expertise as determined by the area's population and target group(s). Staff must be trained in the methods used for Community Outreach Services.

12. **Mental Health Advocacy**

These are services to assist mentally disordered persons by helping them to help themselves to secure or upgrade services to which they are entitled and to protect and extend their rights. The advocate is, above all things, the personal representative of the client. The ability to function adequately, or within a range designated as normal, in a community setting is a major goal of the mental health system for its clients, thus it is a high priority to assist mentally disordered persons to regain or to maintain the management of their lives as concomitant to mental health. For these persons it is imperative that every effort be employed to enlist linguistic assistance when necessary from the community to assure they can understand the advocacy message. Advocacy has high priority as a cost-effective tool to further the overall goals of preventing chronicity and placing mentally disordered persons in the most non-restrictive settings. Many of the objectives of

advocacy programs are shared by the treatment system; each has a different role in accomplishing the objectives. For instance, while both the therapist and the advocate are helping the client to function independently, the therapist focuses on the intrapersonal factors and the advocate focuses on the system-related problems that interfere with the ability of clients to take control of their own destiny.

The following types of advocacy are encouraged, with the performance objectives shown as appropriate:

A) **Program or system advocacy:** Intervention on behalf of a group or category of mentally disordered persons by an approved advocate, in either a non-judicial or a judicial forum.

The performance objectives are:

To ensure that a list of all rights contained in the Title 9 Administrative Welfare and Institution Codes are posted in all facilities.

To ensure that all incoming clients are appropriately notified, verbally and in writing, in a language the patient understands, of their rights, and the client record is so noted.

To investigate complaints and to ensure that a clear written and published manner of registering a complaint is available to all clients and in a language that the client understands.

To collect data on denial of rights and provide summary written reports as appropriate and/or required to local and State bodies.

To participate in the planning, monitoring, and evaluating processes for mental health services at a local level and to represent the client's point of view in these processes.

To assist in training all mental health system personnel in the rights of patients and the relationship between self-determination and advocacy. Such training should stimulate mental health systems personnel to respect and enhance the dignity, self-worth and self-determination of all clients.

B) **Individual advocacy:** Intervention on behalf of an individual client by an approved advocate as the personal representative of that client.

The performance objectives are:

To assist the individual mental health system client or patient by supplying the tools required to exercise control over his or her destiny.

To investigate complaints by mental patients in licensed health, or community care facilities.

To collect data on the number and nature of complaints received and on complaints substantiated.

To monitor compliance with patient rights, laws and regulations.

To act as a personal advocate for clients who are unable themselves to register a formal complaint.

To assist the client in obtaining maximum sustenance from the array of community services available by helping the client to create culturally and linguistically appropriate personal community support networks.

To act as an agent for the client only and wherever possible in response to the client's direction.

C) **Internal advocacy:** Intervention by an advocate working within the same system which provides services to the client.

D) **External advocacy:** Intervention by an advocate working outside the agency which provides services to the client.

Internal advocacy requires access to client records and considerable dexterity in distinguishing between the wishes and requirements of the client represented and the wishes and requirements of the the service provider. If this can be accomplished successfully, substantial strengths accumulate to the internal advocate position: familiarity with the specific agency framework, personnel, and policies plus ease of access to the client. External advocacy is generally essential when the client or the program requires legal representation by lawyers in or out of courts of law, or when internal advocacy is constrained.

Standard

Not less than .5 per 100,000.

Counties with small populations would be encouraged to share resources to develop independent advocacy services on a regional basis.

13. **Services to the Justice System - Adult and Juvenile**

Adults and juveniles under the jurisdiction of the justice system are a special population whose mental health needs must be addressed.

A) Mentally disordered persons who are picked up by the police may be evaluated and transferred to the appropriate mental health treatment setting if they meet the requirements of Section 4011.6 or 4011.8 of the Penal Code.

B) Those who are charged with crimes and are mentally disordered and present both a danger to the society at large and a security risk require very special attention.

C) Adults under the jurisdiction of the justice system due to the commission of a crime not related to a mental disorder may have concurrent psychiatric conditions and, thus, should have services from the mental health system.

D) Juveniles who are wards of the Juvenile Court and who have committed a crime that would be considered a crime had it been committed by an adult are held in a juvenile detention facility or kept on probation. There are also wards who are status offenders whose behavior is generally unacceptable to society for children, but whose behavior would not be considered criminal were they adults. At the present time these children are seldom incarcerated in a juvenile institution. Both groups of Juvenile Court wards require considerable services in the probation and mental health systems.

E) Dependents of the Juvenile Court are children who have been abused and/or neglected and present very special problems. They are generally under the care of a public social services agency and a very large percentage of them demonstrate emotional and behavioral problems which are a direct result of their life experiences to date. The availability of mental health intervention for these children is essential if we are to prevent extensive mental disorders and other tragedy for these children in the future.

Both adults and children involved with the justice system require special services, some because incarceration prohibits access to community services; some due to the special needs presented by these individuals. Some of these unique needs are brought about by the individual's use of crime or violence to express emotional problems.

The types of programs required are parallel to the total range of services presented above, 24-hour through community outreach services.

Where minority persons represent a significant number of the persons under the jurisdiction of the justice system, mental health staffing should be proportionately adjusted.

Standards for services to the justice system are presented on pages 34 and 35.

Examples of Activities and Methods in Delivery of Community Outreach Services

	Mental Health Promotion			Community Client Services	
	Community at Large	**Special Pop. Groups**	**Agencies & Orgs.**	**Individuals & Families**	**Agencies & Orgs.**
Consultation		Consultation with a group of law enforcement officers on how to handle their own stress. Consultation with a school around staff relationship problems.	Consultation with a group of law enforcement officers on understanding the dynamics of domestic violence. Consultation with a community agency to help them set up a program to address the problems of child abuse. Consultation with a school to help develop a mental health education program for students.		Case consultation with an agency which serves runaway adolescents. Case consultation with school personnel. Case consultation with juvenile probation officers.
Education	Media campaigns to promote mental health concepts such as coping with stress, mental health needs of the aging, etc. Workshops/seminars on such topics as parenting skills, coping with losing a job, etc. Drama presentations on mental health concepts.	Workshop/seminar on the emotional stress of being a new parent. Facilitating a self-help group for those who have recently become widows and widowers.	Training board & care home operators to develop programs for their residents. Training group home staff on signs of suicidal intent in adolescents.	See Community Client Contact below.	
Information	Brochure or slide presentation on mental health services available. Telephone information & referral on mental health services. Participation in health fairs.	Presentation on mental health services available to a group of nurses who make referrals on their jobs. Presentation to Medical Society on services available for chronic patients ready for release from inpatient treatment.	Dissemination of information to agencies/organizations on mental health services available. Presentation to a coalition of social service providers on new community residential treatment programs being developed.	Specific referral information to a person needing treatment services.	Specific referral information for an agency which needs to link one of its clients with treatment services.
Community Organization	Organizing the general community to support development of board & care homes.	Helping a Pacific Asian group develop funding resources for setting up mental health counseling services.	Participating with other human service agencies to develop services for victims of domestic violence. Serving on a board of an agency to provide policy input related to mental health.		Participating with staff from various agencies around the needs of a specific client.
Community Client Contact				Time-limited crisis intervention with an individual or family who just arrived in this country. Short-term counseling with a senior who is not willing to come into a clinic for mental health services. A suicide intervention contact on a telephone counseling line.	

STANDARDS FOR SERVICES: SUMMARIES OF LEVELS OF SERVICE

24-Hour Care Services Summary

Level of Service	Who's Served	Service Characteristics	Duration of Service	Where Provided	Minimum # Beds 100,000 Pop.
1) 24-Hr. Acute Intensive Care	Patients who are severely & acutely mentally disordered both voluntary and involuntary—marked by extreme impairments, intensive treatment required	Immediate, intensive round-the-clock, medically supervised treatment. Intended to restore a prior level of functioning	• Up to 30 days • Often less than 10 days	• Gen'l Hospital • PHF's • Augmented SNF's • Freestanding Psych. hosp.	15 in gen'l or psych. hosp. & non-hospital Local needs determine the balance between hosp. & non-hospital Based on 85% occupancy
2) Short-Term Crisis Residential Care	Clients who are undergoing acute situational crisis or severe stress reaction	Active social rehabilitation model intended to promote rapid restoration to prior level of functioning. Medic may not be required, facility typically not locked. Usually also use day Rx program off site.	10 days - two weeks	• Crisis house of CRTS • Specialized family care setting (e.g., S.W. Denver)	10 Beds
3) 24-Hour Transitional Care	Clients with impaired ability to cope due to severe emotional disturbances or mental disorder. Most appropriate 24-hr setting for children and youth.	Programs intended to assist clients to move to less protective care or more independent functioning after an episode of acute care. Examples: Adolescent group homes, Adult halfway houses. Treatment svcs. are generally provided off-site.	3 - 12 months, 6 months average	• Transitional residential care of CRTS • Psychiatric health facilities	10 Adult Transitional 10 Child & Adolescent Based on 90% occup.
4) Long-Term Rehabilitative Care	Clients who are severely and persistently disabled & may be difficult to manage, due to serious mental disorders	Closely supervised and structured in-facility rehabilitation prog. intended to improve basic functioning. Emphasis on occup./rehabilitation therapy. In-house programming 12-16 hr/da; 7 da/wk	18 - 36 mos. av: 1 yr +	• SNF's with special treatment program • Long-Term Res. Treatment prog. of CRTS • Augmented ICF	40 Beds Based on 95% occup.
5) Out-of-Home Placement	Clients who are chronically disabled due to mental disorder	Provides for clients' basic needs & gen'l supervision. Includes respite care beds. Rehab. and treatment provided through outpatient and community services.	6 mos. +	In "normal" residential surroundings Bd/Care Homes Group Homes SSI/SSA	60 Supervised Out-of-Home 15 Semi-Independent Living

Nonresidential Services Summary

Level of Service	Who's Served	Service Characteristics	Program/facilities Required	# Persons Served Annually
6) Emergency Service & Evaluation	a) Eval, Treatment & Holding: Exhibiting acute symptoms; potentially violent/suicidal; Includes drug induced psychosis.	Primary intake services for acutely ill persons voluntary or involuntary. 7/day/week; 24 hours/day; Diagnosis and medication; 24 hour holding capability.	a) 1 Emergency Unit	1,000 persons/yr 1,000 U/S
	b) Crisis Intervention: Any emergency or crisis in living.	5 day/week, walk-in 24 hour, 7 day/week call in; information and referral	b) 2 FTE's	1,820 persons/yr 1,820 U/S
	c) Mobile Crisis Service: as above	7 day, 24-hr field response	c) included in other programs	150 persons/yr.
7) Acute Day Treatment	• Severely disordered • Unable to function in normal roles • Residence may be in 24-hr care program or own home	Substitute for hospitalization; Intensive and multi-disciplinary; Title 9 regulatory staffing: Half-time physician required; 3-6 months treatment	1 Acute Day Program 9 FTE staff (incl. clerical)	160 persons/yr (30-40 at any given time.)
8) Outpatient Services	• Crisis or sustained therapeutic intervention • Moderate to severe disturbance • Should be accessible to all persons in target community.	Assessment and testing; full spectrum of typical outpatient services including medication; should be tailored to meet special needs of population being served, including children, minorities	1 Clinic 20 FTE (average)	2,000 persons/yr 16,250 U/S
9) Case Management	• Diagnosed as chronic • Continuous mental disorder: 5 yrs • 2 or more hospital admissions in prior year	Effecting continuity of care - identification, planning, monitoring; assurance of all necessary services; distinct & identifiable function.	8.6 Case Mgrs. + 2.6 support staff + oper. expenses + tracking system	400 persons/yr 4,800 U/S av. caseload: 50
10) Community Support Services	• Chronically ill; • Repeated hospitalizations; • Having few living/vocational skills; little familial support; socially isolated, withdrawn	a) Day Rehavilitation: Counseling/social rehabilitation, functional vocational & pre-vocational skill emphasis. b) Socialization Services: skills of daily living, development of social skills & support network. c) Semi-Independent Living Program: Assistance in independent daily living. Volunteers encouraged. d) Respite Care - permit maintenance in community by relief to caregivers.	a) 9 FTE 13 FTE + Cler. b) 2 FTE c) 1 FTE d) 1 FTE	600 persons/yr

System Support and Unique Services Summary

Level of Service	Who's Served	Service Characteristics	Program/Facilities Required
11) Community Outreach Services: Consultation, Education Information, Community Organization, & Outreach, Community Client Contact	The general public and high risk groups, particularly: • Children/Youth • Cultural/Linguistic & other minorities	Cultural and linguistic appropriateness is essential in all these services Consultation: technical assistance to increase capabilities of caregivers and related agencies Education: to communities about mental health, mental illness, and for mental health. Information: about mental health & services to general & target communities. Efforts to reduce stigma of mental illness necessary to accomplish Model goals Community Organization: to secure public participation and support for mental health action Community/Client Contact: aimed at alleviating problems of high risk group by taking services to the community.	6 FTE's (including paraprofessionals) with appropriate cultural/language expertise 6,000 "contact" hrs/yr
12) Mental Health Advocacy	Mentally disordered persons/clients.	Assure client/staff understanding of rights; Investigate complaints; Intervene for individual clients or groups of clients; collect data on rights violations; Provide summary reports to local and state bodies.	Standard of 0.5 FTE/ 100,000
13) Services to the Justice System	Adults and juveniles under the jurisdiction of the Justice System	A full range of services, parallel to those outlined above, tailored to the local justice system	See Report on the Model for full details

Summary of Standards per 100,000 Population

Program Function	Program/Facilities Required	Estimated # Persons Served Annually (a)	Estimated Annual Units of Service	Estimated Cost per Unit of Service (b)	Adjusted Gross Cost (b)
1) 24-Hour Acute, Intensive Care	15 Beds	310	4,654		$ 714,500
(a) Hospital			days	$232	
(b) Non-Hospital				125	
2) Short-Term Crisis Residential	10 Beds	220	3,102	95	294,700
3) 24-Hour Transitional	20 Beds	40	6,570	75	492,750
4) Long-Term Rehabilitative Care	40 Beds	40	13,870	32	443,840
5) Out-of-Home Placement			(Program costs		
(a) Supervised Out-of-Home Placement	60 Beds	60	included in Comm. Support & other		
(b) Semi-Independent Living	15 Beds	30	Categories)		
				24-Hour Care Services Sub-Total	**$1,945,790**
6) Emergency Services					
A. Eval. Trtmt. & Holding	Emerg. Unit	1,000	1,000	$ 175	$ 175,000
B. Crisis Intervention	2 F.T.E. (c)	1,820	1,820	25	48,750
C. Mobile Crisis	On-call	150	150 visits	200	30,000
7) Acute Day Treatment	9 F.T.E.(c)	160	7,000	50	350,000
8) Outpatient	20 F.T.E.(c)	2,000	16,250	50	812,500
9) Case Management	8.6 F.T.E.(c)	400	4,800	75	357,500
10) Community Support	13 F.T.E.(c)	600	n.a. (d)	n.a.	528,750
11) Community Outreach Services	6 F.T.E.(c)	n.a.	6,000 hrs.	50	292,500
12) M. H. Advocacy	.5-1 F.T.E.(c)	n.a.	n.a.	n.a.	18,750
13) Services to Justice System	n.a.	520	n.a.	n.a.	485,010
				Grand Total per 100,000 population (e)	**$5,044,550**

a) Persons will receive services in several programs, therefore this column will not yield unduplicated client count.
b) At 1979 rates. Administration costs are not included.
c) All full-time equivalents (FTE) refer to professional staff only.
d) n.a.= not applicable.
e) Total excluding Services to Justice System = $4,559,540. Non-24 Hour subtotal, exclude Justice System = $2,613,750.

Summary of Standards for Children and Youth Services*

Portions of the total model standard should be availabe for children and youth, but not necessarily in proportion to their proportion of the total population. The following assumptions governed the recommended allocation of resources.

1. Young Children should very rarely be hospitalized, and then only briefly for intensive evaluation and treatment planning. Most of the time, mentally disturbed youth should be treated in settings approximating as closely as possible a normal home setting. Those who are most seriously disturbed would be appropriately treated in transitional settings; most others would be in supervised out-of-home placement (specialized foster care and group homes). Altogether only 17% of the total 24-hour program capacity would be needed for children.

2. Community Outreach Services are of particular importance in assuring that the needs of high risk young people are identified and responded to appropriately.

3. The average 100,000 population would include approximately 25% children and youth.

Program Function	Total Model Standard	Children & Youth Standard	C/Y % of Total	Comments
1. 24-hr. Acute, Intensive Care	15 Beds	1.5 Beds	10%	This function may be developed on a regional basis.
2. Short-Term Crisis Residential	10 Beds	3 Beds	30%	Specialized, trained foster homes can provide this service. Need not be regional.
3. 24-Hr. Transitional	20 Beds	10 Beds	50%	Appropriate for many severly disturbed c/y, with necessary adjunctive service.
4. Long-Term Rehabilitative Care	40 Beds	4 Beds	10%	Many will be in foster homes but not part of mental health system; the capacity of such settings is not included here.
5. Out-of-Home Placement				
a) Out-of-Home Placement	60 Beds	6 beds	10%	
b) Semi-Indep. Living	15 Beds	3 beds	20%	For emancipated youth.
6. Emergency/Crisis	2 FTE +Emergency Unit	0.5 FTE	25% of Crisis Intervention	Use of emergency services varies considerably according to localities.
7. Acute Day Treatment	9 FTE	1 FTE	10%	
8. Outpatient Services	20 FTE	5 FTE	25%	C/Y would use these proportionately to their % of population.
9. Case Management	8 FTE	2 FTE	25%	C/Y would use these proportionately to their % of population.
10. Community Support	13 FTE	2 FTE	25 % of day rehab. services	C/Y use about 25% of Day Rehabilitation services but not socialization.
11. Community Outreach Services	6 FTE	3 FTE	50%	These programs are essential to meet the needs of C/Y.
12. Mental Health Advocacy				No separate standard is included although it is important that advocates include attention to all C/Y programs within their domain.
13. Services for Mentally Disordered Wards and Dependents of the Juvenile Court				Separately described; there may be considerable variation in the level of services needed for this category, according to differing local judicial practices.
Total Cost of Model C/Y Programs: $1,229,510 (including #13)				
Total C/Y Program as % of Total Model Cost: 25%				

***Current figues do not reflect potential impact of Social Services Redesign.**

Summary of Standards for Geriatric Services*

Most studies show the incidence of mental disorder among the elderly exceeds that for the general adult population. Nevertheless, the elderly tend not to seek mental health services and special considerations should guide the development of services to meet their needs. The following assumptions governed the recommended allocation of the total resources.

1. Inadequate diagnosis and treatment of elderly mentally disordered patients have resulted in inferior care for many.

2. Specially trained personnel should be available to provide assessment, diagnosis and treatment planning on a mobile basis to the elderly in their own homes or in health care institutions.

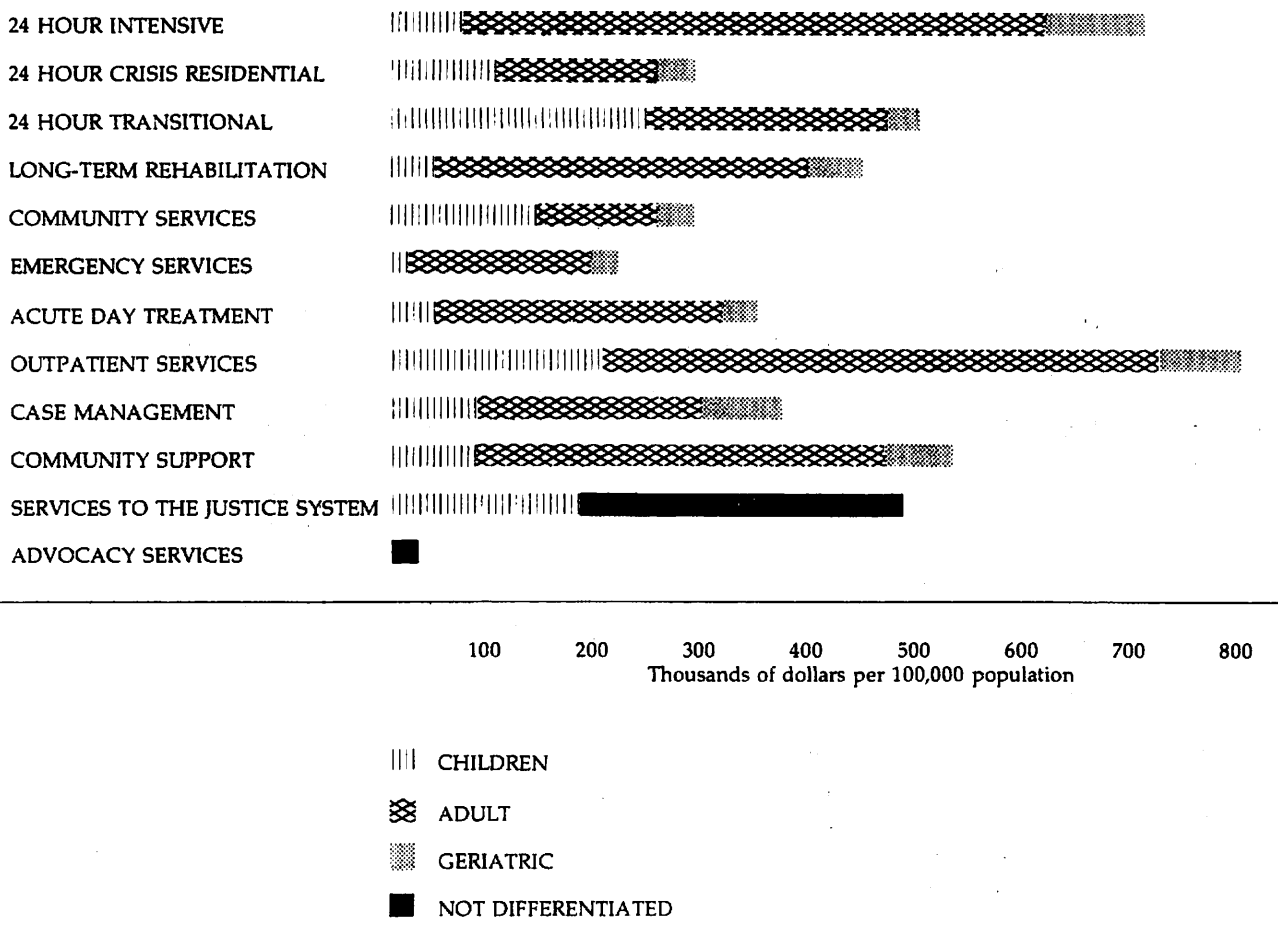
3. The mobile geriatric team would provide consultation and training in all 24-hour and day care settings serving the elderly to assure the development of appropriate treatment programs. The team would provide case management as well as program consultation and liaison between services.

4. The average 100,000 population would include approximately 10% (10,000) persons over age 65.

Program Function	Total Model Standard	Geriatric Standard	Ger. % of Total	Comments
1. 24-Hour Acute Intensive Care	15 Beds	2 Beds	13%	Need not be located in a hospital. In sparsely populated areas, these should be included in adult acute care services; in urban areas, specialized psychogeriatric programs could be developed in appropriately augmented health care settings. (e.g. General Hospital, SNF).
2. Short-Term Crisis Residential Care	10 Beds	1 Bed	10%	The elderly may require longer stay than adult clients.
3. 24-Hr. Transitional	20 Beds	1 Bed	5%	Facilities should not exclude elderly clients who meet other admission criteria.
4. Long-Term Rehab. Care	40 Beds	4 Beds	10%	May need to be regionalized in order to provide the necessary special programs.
5. Out-of-Home Placement				Should be specially designated to assure availability to the elderly, not necessarily age-segregated facilities.
a) Supervised	60 Beds	6 Beds	10%	
b) Semi-Independent Living	15 Beds	1.5 Beds	10%	
6. Emergency Services	24-Hr. availability	Mobile Team 3.5 FTE/100,000 .5 FTE for each additional 100,000	10% of units	Multidisciplinary team should be available for combined emergency screening, outpatient and case mgmt. functions.
7. Acute Day Treatment	9 FTE 10,400 U/S	Included in Std.	10% of units	Programs should be designed to be able to include geriatric patients.
8. Outpatient	20 FTE 16,250 U/S	1 FTE	5% of units	Specially trained person should be included in staffing pattern and work closely with mobile team.
9. Case Management	8.6 FTE 400 caseload (pt. of mobile team)	.6 FTE caseload: 30-40 short-term & 30-40 long-term		Elderly clients would require additional services, especially those living alone and at risk of institutionalization.
10. Community Support	13 FTE	Included in Mobile geriatric Team		Special geriatric consultant would help to assure regular programs meet needs of geriatric clients.
a) Day Rehabilitation				
b) Socialization				
c) Svc. for Semi-Indep. Living				
11. Community Outreach Services	6 FTE	Included in Mobile geriatric Team	n.a.	Full staffing of mobile team would enhance linkages of mental health and other community programs for the elderly.
12. Advocacy	.5 to 1.0 FTE	No separate Standard	Not age-specific	Regional efforts may be desirable to provide non-age specific advocacy functions adequately.

N.B.: Mobile team is drawn from the elderly populations' share of emergency, outpatient, case management and community services staffing.
*Based on the Position Paper of the Geriatric Committee of the Conference of Local Mental Health Directors. For fuller exposition, please refer to that Paper.

Summary of California Model Standards of Children, Youth, Adults, and Geriatric Services



Services to Justice System
Forensic Mental Health (Adult)
(excluding judicially committed persons)

Basic Standards and Costs per 100,000 Population

A. Service In Jail	Programs/ Facilities Required	Estimated # Persons Served Annually	Duration	Estimated Annual Units of Service	Estimated Cost Per Unit of Service	Adj. Gross Cost	Comments
1. Emergency Evaluation & Triage (in-(including 4011.6 P.C.)							To triage all inmates entering jail to refer inmate for further screening to identify mental disorders; give crisis intervention until referral for outpt. under A-2.
a) Female	Emergency Evaluation	364	1 visit	364	$ 75	$ 27,300	
b. Male	Emergency Evaluation	1,274	1 visit	1,274	75	95,550	
2. Outpatient							To provide Court, and self or Sheriff referred evaluation; brief treatment; diversion out of criminal justice, avoid hospitalization & reduce deterioration of mentally ill in jail.
a) Female	Crisis Intervention and Treatment	35	5 visits	175	$ 40	$ 7,000	
b) Male		65	5 visits	325	40	13,000	
		100					
B. Service in Community							
1. 24-hr Acute Intensive Care-Hospital (4011.6/8 P.C.)	1.5 Bed	36	14 days	504	$ 200	$ 100,800	To provide evaluation & short-term tx. to inmates meeting inpt. criteria and to those with security risk which would have to be treated in a secured facility (inside or outside of jail).
2. 24-hr Transitional Care (4011.8 P.C.) †	1 Bed	7	45-90 days	420	$ 50	$ 21,000	Pt. under dual jurisdiction of criminal justice & mental health systems requiring less intensive (more intermediate Rx) remaining under dual jurisdiction.
3. Long Term Rehabilitative Care †	7 Beds	2	120 days	240	$110	$ 26,400	Pts. are referred primarily from the services described above to receive long term soc. & reh. services toward non-recidival & independent functioning in community.
4. Case Management		67	6-12 months (12 visits)	804	$ 40	$ 32,160	Tracking, linkage, monitoring, precare & aftercare of patient either still under dual jurisdiction or release therefrom.
		TOTAL COST PER 100,000 POPULATION (1979 BASE):				**$323,210**	

Only for persons under the *dual jurisdiction* of the Court and Mental Health Systems.
† One third of Service Category B-1, ⅔ of B-2 and ½ of B-3 should be in a secured facility.

Services for Mentally Disordered Wards and Dependents of Juvenile Court

Category of Services		Est. Annual No. of Patients	Duration	Cost Per Unit	Subtotal Cost	Total Cost
Emergency Evaluation and Triage	Wards	156	1 visit	$ 75	11,700	
	Dependents	62	1 visit	75	4,650	$16,350
24-Hour Acute Intensive Care	Wards	.8	30 days	250	6,000	
	Dependents	.3	30 days	250	2,250	8,250
24-Hour Transitional Care	Wards	.75	275 days	110	22,687	
	Dependents	.75	275 days	110	22,687	45,375
Long-Term Rehabilitation	Wards	.5	375 days	30*	5,625	
	Dependents	.5	375 days	30*	5,625	11,250
Day Treatment	Wards	.25	375 days	50	4,687	
	Dependents	.25	375 days	50	4,687	9,375
Outpatient & Case Mgmt.	Wards & Dependents	100	20 units	50	100,000	100,000
						Total Cost per 100,000 population: $190,600
						Services to Justice Systems (Adult and Youth) Combined Total: $485,010

*Treatment Costs Only

METHODOLOGY FOR DEVELOPMENT OF THE MODEL

This Model is based on expert judgment regarding the necessary components for a sound community mental health program. It avoids both the extremes of accepting what is judged to be unacceptably low levels of care and of overstating need in a fantasy "wish list" approach.

Resource standards are generally established by the following methods; for each the applicability of the method to the California Model is briefly described.

A. **Comparative Standards:** Data are presented below which show that the proposed standards are within the range of existing resource patterns in other states and catchment areas, but this model emphasizes the use of residential programs, with community support and outpatient services, to maximize normal lifestyle and minimize restraints for persons served by the system. This emphasis is consistent with the prevailing community mental health value systems and ideology in California.

B. **Historical Standards:** Resource standards based on past performance do not adequately project the impact of changing standards of practice in the field. They should not be used to set a new standard but should be used to guide the projection of resources needed on a year-by-year basis to reach the "standard" level.

C. **Normative Standards:** This method was selected by the Legislative Work Group because it best facilitates a changing program emphasis. The experts who rated the necessary standards were persons responsible for planning, organization and delivery of public and private mental health programs throughout California.

The usual specific techniques of needs assessment such as community-based information gathering, services-utilization analysis and use of social indicators as predictors of need have all been considered to the extent possible and appropriate in arriving at the recommended standards and levels.

Unfortunately, the data base necessary to scientifically establish such a model is not as extensive as we would wish. There are few, if any, places where an adequate community mental health system can be said to provide services to a similarly delimited target group and which incorporate the desired non-institutional approach which maximizes normal lifestyle, quality of life for clients and minimal restrictions. Without a measurable "test" situation to apply to other areas, the usual method used to gauge what "ought" to be is the judgment of experts.

It should be emphasized that the standards apply only to that sector of the population which is served by the Community Mental Health system. The current standards should not in any way be construed as applicable to the entire population of a county or of the State. The percentage of the population which obtains its care outside of publicly funded programs varies from county to county.

Emphasis was given to the experience of those counties where there is judged to be a "successful" program which met the criteria of an efficient, but non-stressed system, with general community acceptance of the available services.

The specialized requirements of prevention, minorities, sparsely populated areas, children's and geriatric services have been addressed by separate committees and their reports have been incorporated in the total Model. At this time, no quantitative changes in the proposed total standard are required to incorporate those specific target groups. The Model categories are mutually compatible with these reports.

The most controversial aspects of the proposed service levels involve 1) reduction of current acute inpatient service patterns in many programs 2) general increase in overall budget.

1. Evidence from a number of counties shows they are able to adequately serve crisis stabilization, acute treatment, transitional treatment and long-term rehabilitative needs within the total 24-hour resource standards of the Model. Counties with higher levels of acute 24-hour utilization are generally marked by the absence of transitional and long-term rehabilitative programs. They also tend to have high rates of involuntary hospitalization.

   A manual on State Mental Health Planning, published in 1977 by the National Institute of Mental Health, cites a range of 20-375 psychiatric beds per 100,000 population in current plans; 50-100 beds per 100,000 are most frequently chosen. The proposed model calls for a total of 55 beds in what would correspond to a range of *licensed health* facilities including general hospitals, free-standing psychiatric hospitals, psychiatric health facilities and skilled nursing facilities. This is clearly within the range of current planning practice. (Not all *need* be provided in licensed health facilities, many of

the Long-Term Rehabilitative should be in less institutional settings.)

Short-Term Crisis Residential Care, Transitional* Out-of-Home Placement and Semi-Independent Living standards call for another 105 beds in non-licensed or community-care licensed programs.

The usual criticism of the Hill-Burton approach to planning for resources is that one cannot plan for inpatient resources in a vacuum: utilization is most heavily influenced by the availability, accessibility and acceptability of other resources. Such problems are very evident when the available resources in California are examined in comparison with the Model: there are marked shortfalls in other than acute hospital 24-hour resources.

Total California service patterns, including public and private sectors, have been:

A) **Licensed capacity**

Acute hospital beds in general hospital and free-standing psychiatric hospitals:	32/100,000
Acute State hospital beds:	31/100,000
Total =	63/100,000

(This excludes VA beds; also note that State hospital beds do not all provide acute care though they have been so licensed. It also includes all public and private facilities.)

*Transitional services would preferably be in community-care licensed facilities, but could be in health facilities.

B) **Utilization** (from OSHPD, State Plan for Health, Chapter IX)

"Acute" beds total public and private	24/100,000
Long term: (excluding supervised out-of-home placements, semi-independent living)	
Total =	56/100,000

"Acute" defined by stay in SH less than 30 days and other local acute hospitalizations. (This is probably an over estimate of true need in acute care.) Short-Doyle and State hospital acute bed utilization (Approx): 6/100,000

C) **Other States' Utilization** (from A Manual for State Mental Health Planning)

a) **Maryland** Short-term psychiatric beds: 00/100,000

b) **Virginia** Current use: 150/100,000 - all types
Proposed standards: 90/100,000

c) **West Virginia** Long-term beds, standards: 100/100,000
Other alternative beds: 100/100,000
Halfway house beds: 10/100,000

d) **S.W. Denver** Acute care beds, hospitals: 1/100,000

It is clear that the California proposal is not at either extreme for 24-hour services, although it is projected that recent patterns of acute hospital care can be reduced if other transitional and rehabilitative services are established.

2. It has been known for years that there are needs beyond the immediate crises served by some form of 24-hour and emergency intervention. No one in the field has been satisfied with the level of rehabilitation and independence achieved by persons who were once hospitalized; no one has been satisfied with large numbers in board and care or skilled nursing facilities without support and treatment services. The community problems created by the large number of persons who have been deinstitutionalized will not disappear with further reduction in 24-hour services; in fact, as the criteria for admission to hospitals are tightened further, the need for community support and systems which prevent hospitalization will be even more marked. Thus, it should not be surprising that there is evidence of a need to expand services.

   If no community service programs had been implemented, and State hospital services were provided at the same level as their peak in 1957, the total program cost in 1979 dollars would be approximately $1.3 billion with *no adjustment for population growth*. Even discounting the maximum level to account for the impact of psychotropic medication, and calculation based on the usage of 1963-64, the State hospital equivalent cost would be $1.1 billion. Yet no one would judge that the old State hospital system was an adequately effective system of mental health care.

Beyond the equivalent services to chronically and severely disturbed persons, shifted from State hospitals to the range of community services, the Model includes a large amount of services which ameliorate stress and crises, community interventions, support to schools and other social institutions, etc. These are now recognized as necessary elements of a community mental health program which extends the program support to all sectors of the community-at-large. This Model provides for the dependent client population formerly treated only in State hospitals in a more effective and acceptable way and also provides for a range of community services within the comparable costs of what the State hospitals would have required. This is clearly an indication of the real cost-effectiveness of this proposed model program.

Relationship of the Model to the Fee-For-Service Medi-Cal System

Integration of the administration of fee-for-service Medi-Cal (FFS M-C) with the Short-Doyle system should be considered after the model Short-Doyle system has been developed and implemented. These resources are specifically not included in the standard levels at this time, for the reasons which follow, although in theory both systems should be serving the same community needs, thus both should eventually be included in assessing resources and unmet needs. FFS M-C is not included now because:

1. There is great variability between counties in the availability of fee-for-service providers.
2. There is now no mechanism or structure to manage FFS M-C so that the resources could be integrated into a closed-end appropriation system such as Short-Doyle. Until such mechanisms are provided legislatively, there can be no meaningful way to include the FFS Medi-Cal as contributing to the provision of "standard" services for a community. If under control of the local mental health Director, FFS Medi-Cal resources could be integrated into the Model standards. The extent to which the standard levels would have to be adjusted should be determined at that time.
3. There is evidence that FFS M-C currently often serves a different population, with different characteristics and needs, than the Short-Doyle system. Pressures of insufficient resources have forced the Short-Doyle system to reduce services to less severely disabled persons, to reduce inpatient lengths of stay, and to curtail personal growth-oriented programs. Further, Short-Doyle Medi-Cal now provides some services not available through the FFS M-C system, such as day treatment. Uniformity of "benefits" provided by the Model system is a fundamental concept.

IMPLEMENTATION RECOMMENDATIONS

1. **Administration of the Model Program**

   The system should be a high-quality, decentralized, service delivery system under local administration pursuant to the ongoing administrative provisions of the Short-Doyle Act. Accordingly, the State should ultimately divest itself of direct service administration, although it is anticipated that some State service capacity will be necessary for a small population of Penal Code offenders who require intensive security, and possibly for other specialized, difficult groups of clients. It is essential, however, that the comprehensive range of locally administered programs be developed before State hospitals are further reduced. The continued reduced availability of programs in State hospitals, without compensatory local programs ready to operate, is having a markedly negative effect on many local communities.

2. **Roles of State and Counties in Implementing the Model Program**

   The State Department of Mental Health responsibilities in the Short-Doyle system should be:

   a. Setting of statewide policy and standards;

   b. Allocation of funds;

   c. Monitoring of compliance of programs with statewide standards;

   d. Information gathering and exchange;

   e. Coordinating regional planning among counties for some services;

   f. Planning for and ensuring an adequate level of manpower development and training;

   g. Liaison with other State and Federal agencies; and

   h. Statewide planning, working toward a unified plan for Short-Doyle and C.M.H.C.s and assuring compatibility with O.S.H.P.D. and Title XIX plans.

   In order to minimize the State's conflicts with its regulatory role, it is recommended that wherever feasible the State divest itself of direct service responsibilities. However, to assure stable, quality care it is further recommended that before any particular change is made the feasibility of providing any State services under alternative auspices should be clearly established and tested. The counties' responsibilities in the Short-Doyle system should be:

   a. Planning services;

   b. Developing services;

   c. Delivering services;

   d. Identifying services best provided regionally and working with other local mental health authorities to implement regional programs;

   e. Coordinating with other health and human services systems;

   f. Evaluating services; and

   g. Providing local management/administrative services and educational/training services.

   A statement of legislative intent should note that counties are the primary service delivery resources in the system, and that they may provide services through contracts or directly. As stated in existing legislation, there should be a commitment to contract for services when available and of equal quality. The systemwide goal of decentralized, localized service delivery authority should be reemphasized.

   The County Short-Doyle Plan should remain the vehicle whereby the County develops the strategy for implementation of the Model. The County is expected to plan service location, staffing, and target group considerations within the Model standards to assure appropriate accessibility, availability, acceptability and quality of the services provided.

3. **Relationships of the Community Residential Treatment System (CRTS) to the Proposed Model**

   The CRTS programs are included within the Model program elements. They are explicitly called forth in the appropriate categories and included as a vital and important part of this comprehensive community mental health program. Where the Model program includes the CRTS programs (e.g., Short-term Crisis Residential, Transitional and Long-term Rehabilitation) it is recommended that the program review procedures established by AB 3052 be used, with the proviso that each County would receive its share of resources for each standard category. In practice, this would mean double review of those portions of the County Plan which refer to the CRTS-linked categories of the Model; i.e., the regular Departmental review plus the CRTS Advisory Committee review.

4. **Assuring the Comprehensive Range of Services**

The Short-Doyle system has thus far not mandated any particular set of programs nor amounts of programs to be provided. Equitable availability and accessibility to all State residents requires that standards be adopted and programs funded accordingly. It is proposed that after a phase-in period (the length of which is necessarily contingent upon the expression of legislative intent to develop the Model program) counties would be limited to the standard budget amounts required for each program category. Variance from the basic standard for each service category should be allowed to cover local planning considerations so long as the total remained the same and there is an acceptable rationale for the variance.

Deviation in the direction of less restrictive 24-hour services, within the framework of the Model, would also be permitted if appropriately justified by local needs, population characteristics and other available resources.

The accompanying table shows the statewide status of implementation of the Model and highlights the major deficiency in acute non-hospital, transitional and community support services.

A particular planning problem is posed by those services which a County is operating in excess of the standard level. Counties in which this situation exists should be required to address clearly the steps they will take to reduce excess programs as they plan to implement the Model. In some counties, there is an excess of acute or long-term care beds but a corresponding absence of non-hospital alternatives. Duplicate funding will be required during sufficient time to permit development of the missing or insufficient system elements — the necessary duplicate funding time would vary according to the type of programs which are to be developed. Counties would be expected to move toward the Model program levels in a system-oriented way which would incorporate all program elements each year. They should not be permitted to develop any one category in isolation; rather there should be gradual increments in all "shortage" categories until the standard level is reached; similarly, there should be gradual complementary reduction in the "surplus" categories. It should, however, be noted that facility acquisition and other system considerations could make it cost-ineffective to require such shifts. Where this is the case, the County should be permitted to justify its continuation of existing services.

5. **Anticipated Time and Resources Required to Implement the Model**

The accompanying tables summarize the potential State general fund requirements to implement the model. New net State funds would be $242,000,000 (in 1979 dollars) when adjustments are made for the reductions in certain categories that would be required. In overall State budget terms, this is a small fraction of the total State resources. The investment of these funds would, however, yield a rich reward in sound community mental health programming.

The most difficult planning task inherent in implementation is the development of residential programs, which is proving to be increasingly difficult due to factors such as spiraling housing costs, lengthy procedures to obtain certificate of need, licensing and zoning approvals, etc. It has become evident that a potential provider must have guaranteed ongoing funding in order to invest in the heavy startup costs for these programs. A special reserve fund is recommended to facilitate the development of the Model program. The reserve would cover the necessary "duplication" funding and would be needed only during the planned phase-in period.

A 5-year phase-in is recommended; most counties would have no trouble meeting the standard levels in all categories within that time, but some of the larger ones may find that a difficult target date. Each year of the phase-in period must include at least a proportionate increase in resources: 1/3 to 1/4 of the needed increase is necessary to achieve a completely balanced system at the end of 5 years. A larger increase in the early years would be necessary if all the residential programs were to be established in time to meet the 5-year target. It is recommended that the deficit in 24-hour program categories ($187 million) be made up in 4 years (at $46.8 million per year) and the deficit in non-24-hour categories ($187 million) be made up in 3 years (at $62 million per year). Thus, the first year would require commitment of $111 million, but a major part of the funds (about $50 million-$60 million) should be placed in a "reserve" account since program startup would take most of the year and the programs would not be fully operational until into the second year. Any augmentation less than $111 million essentially delays the time period for full implementation of the Model.

Even in favorable economic circumstances it would take a major financial commitment to implement this program. In the present circumstances, the prospects of making progress may be very limited, but it is still very important that there be a clear statement of policy objectives against which priorities can be assessed. This is one significant function the Model serves now.

Short-Doyle
Comparison of Adjusted Gross Cost and State General Funds for Standard with Existing and Additional State General Fund Needs
Fiscal Year 1979-80

	STANDARD[1]					
	Adjusted Gross Cost	Percent State General Fund[2]	State General Fund	Estimated Existing State General Fund	Add'l State General Fund to Meet Standard	Total State General Fund Needs
I. Intramural	$404,655,138	82.4	$297,211,248	$200,777,170	$ 96,434,078	$402,860,938
A. Acute 24-Hour Hospital	65,660,640	72.7	47,735,285	90,496,971	(42,761,686)[5]	90,496,971
B. Acute 24-Hour Non-Hospital	97,295,250	84.7	82,409,077	8,923,145	73,485,932	82,409,077
C. Transitional 24-Hour Care	140,478,000	82.9	116,456,262	24,062,554	92,393,708	116,456,262
D. Long-Term Rehabilitative Care	101,221,248	50.0	50,610,624	77,294,500	(26,683,876)[6]	113,498,622
II. Out-of-Home Placement and Semi-Independent Living	85,405,442[3]	26.2	22,376,226[4]	989,574	21,386,652	22,376,226
III. Outpatient/Day Treatment	260,835,611	85	223,000,000	116,880,000	73,790,832	190,670,832
IV. Extramural Community Support	176,074,422	100	176,000,000	59,628,600	98,838,380	158,466,980
V. Extramural Community Services	42,760,875	100	43,000,000	33,120,000	5,364,788	38,484,788
VI. Training/Manpower Development	17,104,350	100	17,000,000	5,045,600	9,493,098	14,538,698
Total	**$986,835,838**		**$778,000,000**	**$416,440,944**	**$362,000,000**	**$827,389,462**

[1] Excludes state and local judicial commitment programs.
[2] Excludes fee for service Medi-Cal.
[3] Includes $15/day Life Support.
[4] Includes only $5/day Special Treatment Program.
[5] Funding of $42,761,686 in state general funds required to maintain the current program.
[6] Additional funding of $36,204,128 required to meet units of service standard, and funding of $26,683,876 in state general funds required to maintain the current program.

Estimate of Added Funds Needed Statewide to Implement the Model: Duplicate, Transition Funds $120m, New State General Funds $362m.

Note: These categories are combined in slightly different ways than the basic model to permit comparison with available program data.

State of California Department of Mental Health, Analysis and Information Section, October 4, 1979, Rev. October 18, 1979

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Chart continued from previous page

Estimated Persons[1] for each level of Need per 100,000 Population	Fee for Service MediCal Services	Short-Doyle Services According to the California Model	Private Sector Services	Persons Not Served or Served Elsewhere	Past Service[4] Experience
LOW NEED: TOTAL = 27,500 persons/100,000					
	Not reported in psychiatric svcs., probably a large part of general medical care. Kaiser & other studies show that mental health svcs. may reduce "high medical users" level of general medical treatment.	Community Services: 6,000 hours/100,000 It is assumed these svcs. are provided in ways which can affect large numbers of community residents. The Model standard may need to be increased when better estimates are available of the other svcs. which can address this need.	No estimate is possible at this time.	Cost effective interventions are often provided outside the mental health system: e.g., • pastoral counseling • marriage, family counseling • community education (e.g., stress seminars, parenting courses, etc.) A large portion of this group (60% or more) are treated in the general medical system.	No available data

[1]Estimates of the number of persons needing services by level of need are derived from the Warheit factors applied to total population. Correspondingly estimates of services needed are provided according to the number of persons to be served, not costs or units of service.

[2]The share of services looks very different when units of service are compared. For example in 1977, FFS M/C accounted for 23% of days and 35% of discharges, private sector accounted for 47% of days and 20% of discharges, and Short-Doyle was 31% of days and 46% of discharges. Looking only at acute hospital care, the pattern presented is: 18% of persons served by FFS M/C, 37% by Short-Doyle, and 45% by private sector.

[3]Current use pattern of Short-Doyle + State Hospital = 377/100,000 receive hospital services. Projected hospital use of 310/100,000 represents reduction of 18%.

[4]Description of actual utilization and service patterns are derived from the *California State Health Plan, 1980-1985* and 1979 FFS MediCal summary data (California Department of Health, 01/06/81).

General Note: The application of this generalized service pattern should be revised for each target area to reflect the specific age, sex, and ethnic composition of the area when factors are available for all segments of the population. Likewise, there may be changes in the private sector share of the total according to changes which may develop in insurance coverage, HMO enrollment, changing FFS M/C regulations, etc. Local variations in the availability of private providers would have to be considered in applying this generalized pattern to any specific area.

AC:jm
3 6/81

Estimated Total Need for Mental Health Services and Generalized Pattern of Service Provision

The Role of Fee-for-Service MediCal, Private Sector Care and Short-Doyle According to the California Model[1]

Estimated Persons[1] for each level of Need per 100,000 Population	Fee for Service MediCal Services	Short-Doyle Services According to the California Model	Private Sector Services	Persons Not Served or Served Elsewhere	Past Service[4] Experience
HIGH NEED: TOTAL = 2,400 persons/100,000					
a) Acute Care[2]	Acute hospital: 155 persons/100,000 (average of 1977 and 1979 M/C utilization rates, 183 and 127 respectively)	24-hr. Acute, Intensive:[3] 310 persons/100,000. Short Term Crisis: 220 persons/100,000. Emerg. Holding (50%) 500 persons/100,000	Acute hospital: 157-375 persons/100,000 (if reduced av. length of stay to Statewide av., private sector could serve more than twice present # patients; p. 475)	Intensive Care Svcs. to Justice System clients would fall in the High Need Group: 145 persons/100,000 VA = 66/100,000 Not Served = 240	1977 data: (p. 465, State Health Plan) 783/100,000 received hospital care: 131 - State Hospital 66 - VA 183 - FFS M/C 246 - Short-Doyle 157 - Private (Est. from p. 475/465) In addition, 156/100,000 received "partial hosp. care" 149/100,000 received "extended care" 53/100,000 received non-hosp. resid. serv.
b) Extended Care	SNF's: 29/100,000 (1977 util.; p. 465 of State Health Plan)	Acute Day Treatment: 160 persons/100,000 Transitional Care: 40 persons/100,000 Long-Term Rehab: 40 persons/100,000 Out-of-Home Plcmnt: 90 persons/100,000 Community Support & Case Mgmt. Svcs. are also directed to these persons.			
Subtotal = 2,370	184 8%	1,360[3] 57%	375 16%	451 19%	1,141
MODERATE NEED: TOTAL = 9,800 persons/100,000					
	Outpatient/Clinic Services 1,338 persons/100,000 (Based on MediCal svcs. from psychiatrists, psychologists, clncs, & hosp. outpatients. Persons seen in hosp. deducted from the user total since these are counted in high need group. Net users = 221, 792 (State total.)	Outpatient Services 2,000/100,000 Emergency Svcs. (50%) 500 persons/100,000. Crisis Intervention 1,820 persons/100,000	Private Practice Services: 2,040 persons/100,000 (Total licensed providers = 7,431, or 34 per 100,000; p. 495) Estimate based on 60 persons per provider	2,058. Includes those who refuse treatment, find it inaccessible or unacceptable, those who do not recognize their need for svcs., and those who are treated in the general medical system	1977 data: State Health Plan. 3,856/100,000 received outpatient services. 2,007 - Short-Doyle 921 - FFS M/C 927 - Private Practice
Subtotal = 9,756	1,338 14%	4,320 44% Includes duplicate count within these services as well as duplication of those referred to private sector, therefore, there is residual unmet need according to these estimates.	2,040 21%	2,058 21% (See page 463, State Health Plan)	

Chart continued on next page

Projection of Resources Development
Statewide Total
All Target Groups
Fiscal Year 1981-82

Service Program Type	Present Program Level		Target
	Cost	Number of Beds	Number of Beds
ACUTE STATE HOSPITAL (24 HOUR)	$ 97,912,110	2,476.42	1,176.53
ACUTE LOCAL HOSPITAL (24 HOUR)	101,232,774	1,343.35	1,295.54
ACUTE LOCAL NON-HOSPITAL (24 HOUR)	14,710,498	539.32	2,903.66
NON-ACUTE (24 HOUR)	60,686,418	2,648.10	10,593.88
	Cost	**Units**	**Units**
EMERGENCY SERVICES	$ 35,303,989	344,834.00	571,349.00
OUT-PATIENT	128,185,102	2,245,728.00	3,501,268.00
PARTIAL DAY	62,423,836	1,254,134.00	4,172,447.00
	Cost	**Caseload**	**Caseload**
CASE MANAGEMENT	$ 24,712,309	30,693.00	79,128.00
	Cost	**Full Time Equivalent**	**Full Time Equivalent**
PREVENTION CONSULTATION AND EDUCATION	$ 34,283,282	917.06	1,757.60

Source: California Department of Mental Health, Statistics and Data Retrieval Section 1/82.