

**California Health and Human Services Agency
Department of Developmental Services**



**PLAN FOR CRISIS AND
OTHER SAFETY NET SERVICES
IN THE CALIFORNIA
DEVELOPMENTAL SERVICES SYSTEM**



May 13, 2017

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I.

EXECUTIVE SUMMARY

The Department of Developmental Services (DDS or Department) submits this plan in compliance with Welfare and Institutions (W&I) Code section 4474.15(a), which states:

The State Department of Developmental Services shall include an update to the Legislature in the 2017–18 May Revision regarding how the department will provide access to crisis services after the closure of a developmental center and how the state will maintain its role in providing residential services to those whom private sector vendors cannot or will not serve. As part of this plan, the department shall assess the option of expanding the community state staff program authorized in Section 4474.2 to allow the department’s employees to serve as regional crisis management teams that provide assessment, consultation, and resolution for persons with developmental disabilities in crisis in the community.

This update provides background information on the developmental disabilities services system, details stakeholder input and guidance received on the need for a safety net of services to support individuals who have developmental disabilities and are eligible for regional center services under the Lanterman Developmental Disabilities Services Act (Lanterman Act, W&I Code section 4500 et seq.), and identifies new service options to broaden the continuum of service options to support individuals with the most challenging service needs.

The 2017-18 May Revision includes a Safety Net Plan of \$21.2 million (\$7.5 million in new one-time General Fund, and \$13.7 million from existing funds) to:

- Establish two state-operated mobile acute crisis teams. These teams will be available 24-hours a day, seven days a week to provide in-home crisis services and mental health treatment for stabilization to help maintain an individual in their existing residence.
- Develop intensive wrap-around services for persons with co-occurring developmental disabilities and mental health needs. These services will allow individuals to successfully transition out of placement in highly restrictive settings such as Institutions for Mental Disease (IMDs) and acute crisis services, into appropriate community settings. Availability of these services will also help prevent admissions into these highly restrictive settings.

- Plan for the relocation and expansion of the current state-operated acute crisis services by:
 - Refurbishing two existing homes on Fairview Developmental Center's (DC) Mark Lane, through an amendment of the existing ground lease. Once complete, one home will be used to relocate the current five-bed Southern STAR (Stabilization, Training, Assistance and Reintegration) services, and the other home will allow an expansion for up to five individuals.
 - Develop 2 four- or five-bed homes in Fiscal Year (FY) 2017-18 and 1 four- or five-bed home in FY 2018-19 in Northern California to relocate Sonoma DC STAR services and expand the capacity by 8 to 10 beds.
- Increase options to serve individuals with the highest needs:
 - Develop 4 vendor-operated four-bed homes in FY 2017-18 to provide step-down services for dual diagnosed individuals now served in IMDs or other emergency facilities.
 - Develop 3 vendor-operated four-bed homes in FY 2017-18 and 1 four-bed home in FY 2018-19 in the Porterville area to provide step-down services for the Porterville Secure Treatment Program (STP).
 - Develop intensive wrap-around services for individuals transitioning out of STP, through a contract with a private organization.

The Department will explore policy avenues to support an individual with a developmental disability who is receiving regional center services, is in acute crisis, and is in need of an immediate short-term crisis placement in instances when, and for such time as, a court order might not be available.

The Department remains committed to strengthening the safety net of services that provides a range of services to safely meet the needs of individuals transitioning from a DC into a community setting and consumers in the community. The Department will monitor the safety net plan throughout implementation and service delivery to evaluate its effectiveness.

PLAN FOR CRISIS AND OTHER SAFETY NET SERVICES
IN THE CALIFORNIA DEVELOPMENTAL SERVICES SYSTEM

Safety Net Plan Concept	May Revise Request	Existing Funds	Funding	2017-18 Estimated Cost
1. Establish two state-operated mobile acute crisis teams.	\$1.9 million		General Fund	\$1.9 million
2. Develop intensive wrap-around services for persons with co-occurring developmental disabilities and mental health needs.		\$3.0 million	RC POS	\$3.0 million
3. Plan for the relocation and expansion of the current state-operated acute crisis services, known as STAR homes. <ul style="list-style-type: none"> • Renovate two existing homes on Fairview Developmental Center's Mark Lane. • Develop 2 four- or five-bed homes in Fiscal Year (FY) 2017-18 and 1 four- or five-bed home in FY 2018-19 in Northern California to relocate Sonoma STAR services and expand crisis capacity in Northern California. 	\$2.6 million	\$1.3 million \$0.4 million	Harbor Village Account General Fund and CPP Start-Up	\$1.3 million \$3.0 million
4. Increase options to serve individuals with the most challenging service needs. <ul style="list-style-type: none"> • Develop 4 vendor-operated four-bed homes in FY 2017-18 to provide step-down services for dual diagnosed individuals transitioning from IMDs or other emergency settings. • Develop 2 vendor-operated four-bed homes in FY 2017-18 and 1 four-bed home in FY 2018-19 to provide step-down services for the Porterville Secure Treatment Program (STP). • Develop intensive wrap-around services for transitioning out of STP. 	\$3.0 million	\$6.0 million \$3.0 million	CPP Start-Up CPP Start-Up General Fund	\$6.0 million \$3.0 million \$3.0 million
Total	\$7.5 million	\$13.7 million		\$21.2 million

II.

INTRODUCTION AND BACKGROUND

This chapter provides background and pertinent information that has helped formulate the issues surrounding a safety net of services to support individuals who have developmental disabilities and are eligible for regional center services under the Lanterman Act.

The beginning of the California Developmental Center (DC) system dates back to the 1850s, and provided the first residential alternative available to families of individuals with intellectual and developmental disabilities who were unable to be cared for at home. In the 1960s, changes began that led to creation of community alternatives under the Lanterman Act, both in-home services and supports so that more individuals could be cared for at home, as well as facilities that provided community residential options. As the community system developed and the underlying philosophy of community integration gained prevalence in law and court cases, dependence on the DC system and other institutional settings declined. Ultimately, effective July 1, 2012, California placed a moratorium on admissions to state-operated DCs except in very limited circumstances (Assembly Bill 1472, Chapter 25, Statutes of 2012), accelerating the decline in the DC population and the closure of the DCs. The Department submitted to the Legislature on October 1, 2015, a plan to close the Sonoma DC by December 31, 2018. Subsequently on April 1, 2016, the Department released closure plans for the Fairview DC and the General Treatment Area at the Porterville DC by December 31, 2021. The STP at Porterville and the Canyon Springs Community Facility (CF) will remain open. DDS is now at a critical point in history, transforming to community-based, integrated services for all but a limited number of individuals, as defined in statute and based on need.

STAKEHOLDER GUIDANCE

In May 2013, the Secretary of the California Health and Human Services Agency (CHHS), Diana S. Dooley, announced that she was establishing the “Task Force on the Future of Developmental Centers” (DC Task Force). She appointed a broad cross-section of members representing consumers, family members, regional centers, consumer advocates, community service providers, organized labor and the Legislature, with support provided by DDS. The primary purpose of the DC Task Force was to address the service needs of all DC residents and provide for the delivery of cost-effective, integrated, quality services for this population in the future.

The DC Task Force considered the special service needs of the residents and the services provided at the DCs, analyzed the services and supports that were available in the community, and identified what additional services and supports may be needed in the community. The work of the DC Task Force culminated in six recommendations as

presented on January 13, 2014, in the “Plan for the Future of Developmental Centers in California.”¹

There was a general understanding among the members of the DC Task Force that the future of the DCs was changing and that additional DCs would be closing, although some of the members were opposed to DC closures. With the additional closure of DCs and future reliance on community services, discussions focused on the need for a safety net of services, including what kind of service alternative would be available when a community service provider is unable or unwilling to care for an individual because of potential safety and liability issues. This service alternative was sometimes described as a “placement of last resort” or as a “can’t say no” option. Many members advocated that the State has a role in providing the placement of last resort.

The context for the safety net discussion often centered around individuals with the most challenging behaviors and support needs, and services to respond to and support a person in crisis in his or her current residence, or otherwise provide immediate crisis stabilization services in another appropriate setting. Additionally, a need for transitional services was identified to support the person’s return to his or her home or other community reintegration alternative, including development of a new model of care that would provide a higher level of behavioral support and a long-term residential option.

By the nature of the deliberations, the DC Task Force concentrated on those served in the DCs and what community services they needed, although a wide range of community issues, somewhat outside the scope and purpose of the DC Task Force did arise. The DC Task Force called for another task force to address the larger community system. In July 2014, Secretary Dooley reconvened the DC Task Force and formed the Developmental Services Task Force (DS Task Force) with five additional members with expertise specific to community-based services.

The scope of the DS Task Force work is broader than that of the DC Task Force, covering essentially all aspects of the community system. During its initial meetings, various areas of focus were identified and then organized by subject areas. Pertinent to this report, safety net issues were combined with other community services issues under the title “Community Supports and Safety Net Services.”

Analyses and discussions on the topic of Community Supports and Safety Net Services occurred in three workgroup sessions held on May 17, July 27 and September 28, 2016. The work was presented to the DS Task Force on February 15, 2017, and finalized in the Community Supports and Safety Net Services Summary, Attachment 1. “Safety net” was generally defined by the task force as:

Timely access to essential services and supports necessary for persons with developmental disabilities to maintain health and safety and to address medical, psychiatric, behavioral, residential, staffing, equipment, or other needs, when other

¹ Available online at <http://www.chhs.ca.gov/DSTaskForce/PlanfortheFutureofDevelopmentalCenters.pdf>

services and supports fail, are interrupted, are not available, or additional services and supports are necessary for an urgent or medical need. May or may not require a change in placement.

In essence, the DS Task Force envisioned a robust system of services and supports that is accessible and timely, and maintains the health and safety of persons with developmental disabilities, particularly when other services and supports fail or are no longer sufficient to sustain a person's health and safety. Such a system is consistent with the Lanterman Act, captured as Guiding Principles from the October 8, 2014, DS Task Force Meeting Summary, and provided here as Attachment 2.

In addition to the Guiding Principles, the safety net concept has many aspects and characteristics, as discussed by the DS Task Force, and shared by stakeholders, including: flexibility; enhanced services and options to meet individual needs, from youth to seniors; quality assurance; trusted and trained staff; availability of services throughout the state; prevention of behavior escalation; utilizing the least restrictive interventions; cross-education with other systems, including law enforcement and first responders; and supporting people in their homes as a priority. The Task Force also identified a need for greater residential options and stability for individuals with significant service needs; more crisis facilities throughout the state; more start-up funds for safety net services; more state oversight of safety net services; a residential setting that cannot refuse to serve someone; more managed care and medical, dental, psychiatric, and behavioral services; and more intensive supports for individuals in transition from one setting to another.

Like the DC Task Force, the DS Task Force carefully considered the need for enhanced services and supports for individuals in crisis, and ways to prevent a crisis from occurring. Crisis prevention included developing models of support to prevent an individual from becoming involved in the criminal justice system or needing a more restrictive level of care. In addition to adherence to the Guiding Principles and the general service needs noted above, specific recommendations included:

1. Creation of a funding source similar to the Community Placement Plan (CPP) to start up new services for individuals currently being served in the community and develop safety net services;
2. Development of crisis services throughout the state, including more mobile crisis teams for timely intervention and more attention to medication management;
3. Increased options for DC staff to support consumers in the community;
4. Development of secure housing options to prevent more restrictive placements, including options for registered sex offenders;
5. Creation of mechanisms to help people return to their former home after a crisis, including comprehensive assessments and long-term transition planning;

6. Increased communication throughout the system about the benefits of Supported Living Services and the Self-Determination Program;
7. Increased options for therapeutic day programs;
8. Reduced caseloads for regional center case managers for individuals who are in crisis; and,
9. Providing a placement of last resort.

DDS recently sought broader input to the safety net observations and recommendations from the Task Force. In January and February 2017, DDS organized and facilitated three Safety Net Stakeholder meetings in Napa, Fresno and Costa Mesa, CA. Participants in these meetings included representatives from the developmental services system, similar to and overlapping with the membership of the DC and DS Task Forces, and included experts from universities, practitioners in the fields of psychiatry and behavioral health, and other interested state agencies. Meetings were structured to receive input on: the definition of the safety net services for persons with significant behavioral needs and/or significant mental health needs; services for the forensic population at the STP at Porterville DC; and ways to safely transition and support individuals moving from developmental centers to the community. The meetings proved beneficial to increasing the understanding of the developmental services system, the challenges facing the system, and the complexities involved in addressing many of the safety net issues. The draft summary of the meetings was released for public comment on March 17, 2017, and is titled, "2017 Safety Net Stakeholder Meetings: Common Themes by Topics." The final document is provided as Attachment 3.

The input from the statewide safety net forums, including subsequent stakeholder input, is thoroughly described in Attachment 3. Below are summary statements from those meetings pertinent to this report:

1. Greater service capacity and treatment models are recommended, including essential services (medical, dental, mental health, medication management, etc.), crisis services, residential options including affordable housing, emergency placement options, services for children and adolescents, and other specialized supports. This includes treatment for both the mental health needs and the developmental disability when an individual has a dual diagnosis.
2. Increased coordination and local collaboration between agencies involved in our service system, particularly to break down barriers among agencies, access mental health, medical and crisis services, and providing training and communication with first responders, law enforcement, the criminal justice system and others.

3. A comprehensive transition process is needed in the community to provide continuity of treatment and supports, focus on the individual, and provide pre- and post-transition wrap-around supports, monitoring and case management, similar to the transition planning process for individuals moving out of a DC.
4. Mobile crisis services are recommended throughout the state and in some geographic locations in particular.

The Department appreciates each opportunity to evaluate system issues and to plan for improvements. These efforts have informed this report.

As described in the “Plan for the Future of Developmental Centers in California” from the work of the DC Task Force, the characteristics and diagnoses of the DC residents and their associated needs are not unique to the DCs, and individuals with similar needs are already being served in the community. With a moratorium on DC admissions since 2012 and continuing transitions out of DCs, regional centers identify appropriate services for a growing population of individuals with more challenging and intensive needs. With the statutory use of CPP funding potentially changing as proposed in the 2017 Governor’s Budget (see Attachment 4 for the proposed trailer bill language), the focus shifts to providing the services that are needed to appropriately serve and support the most challenging populations in our system, whether or not the individual previously resided in a DC.

Another important aspect is to determine the necessary and appropriate role for the State in providing residential or other services for these challenging populations.

FOCUS OF THE REPORT

DDS’ goal, working closely with the regional centers and other system partners, is to continue to develop the system of services along with the necessary capacity to support all individuals in the least restrictive and most appropriate environment, consistent with the principles and vision of the Lanterman Act. The work of stakeholders supports several common themes and goals that provide important guidance. The Department now must define a targeted and feasible path toward community service improvements that addresses the safety net. This report presents a framework for California’s developmental services safety net plan and safety-net-related proposals contained in the proposed budget for implementation in FY 2017-18, which include, the plans and commitments of DDS to pursue issues and recommendations further, as well as to remain on a continuous path of system improvement. DDS will review the safety net plan throughout implementation and service delivery to evaluate its effectiveness.

III. CRISIS SERVICES

The most critical safety net issue in the developmental services system is to develop the appropriate resources and services to support individuals with the most significant behavioral and mental health challenges. Recent progress has been made toward developing new models of care, such as the acute crisis services at Fairview and Sonoma DCs and new residential models of care (Enhanced Behavioral Supports Homes [EBSH] and Community Crisis Homes [CCH]). However, DDS has identified other areas that support individuals with the most significant behavioral and mental health needs.

DDS's goal is to continue to develop the system of services to support individuals in the least restrictive environment and, concurrently provide appropriate treatment and structured planning to transition individuals out of more restrictive settings. Additionally, appropriate services will help to support and maintain individuals in their home, with alternative safety net services available that are responsive to urgent circumstances if an individual is displaced.

ACUTE CRISIS SERVICES

Beginning in 2012 and expanded in 2015, DDS has operated acute crisis services at Sonoma and Fairview DCs with a capacity of five residents each, referred to respectively as Northern and Southern STAR residences. An individual may be admitted to a STAR residence if he or she meets the W&I Code section 4418.7(d)(1) definition of "acute crisis," as determined by a court:

(d)(1) For purposes of this section, an "acute crisis" means a situation in which the consumer meets the criteria of Section 6500 and, as a result of the consumer's behavior, all of the following are met:

(A) There is imminent risk for substantial harm to self or others.

(B) The service and support needs of the consumer cannot be met in the community, including with supplemental services as set forth in subparagraph (E) of paragraph (9) of subdivision (a) of Section 4648 and emergency and crisis intervention services as set forth in paragraph (10) of subdivision (a) of Section 4648.

(C) Due to serious and potentially life-threatening conditions, the consumer requires a more restrictive environment for crisis stabilization.

Individuals served in the STAR residences are court-ordered for involuntary treatment, are provided mental health treatment for stabilization, and receive the services and

supports to prepare them for transition to a less restrictive environment within 13 months. Since the inception of the acute crisis services, the STAR residences have generally operated at full capacity with a referral list for future admission. Individuals who cannot be admitted to a STAR residence are typically admitted to a psychiatric facility, such as an Institution for Mental Disease (IMD).

Significant input was received from the various stakeholder forums indicating support of the STAR services as an appropriate service option for DDS to provide.

After the closure of Sonoma and Fairview DCs, the current STAR residences will no longer be supported by the DC infrastructure. Therefore, as part of the 2017 May Revision, DDS proposes the following continuation and expansion of STAR services:

- a. The 2017 May Revision proposes to refurbish two existing residences on Mark Lane, to replace the existing Southern STAR home at Fairview DC and expand capacity by another four to five beds. The 2017 May Revision includes trailer bill language (Attachment 5) to amend the Harbor Village ground lease authority (Government Code section 14670.35) to allow DDS to renovate two existing homes on Mark Lane. To this end, the State would retain a parcel of DC property contiguous to Harbor Village and modify the existing Harbor Village ground lease. The long-term maintenance and management of all homes on Mark Lane will utilize working capital funds set aside for the operation of Harbor Village. DDS proposes to continue operating the current Southern STAR residence at Fairview DC until these two new homes become operational. Both homes will be operated by the state.
- b. For ongoing crisis services to replace Northern STAR by another four to five beds, the 2017 May Revision includes \$2.6 million in one-time funds and \$0.4 million in existing CPP FY 2017-18 funds to develop 2 four- or five-bed STAR homes in the community (licensed as Community Crisis Homes, Intermediate Care Facilities for the Developmentally Disabled, or as appropriate). One additional four- or five-bed STAR home in the community will be developed in FY 2018-19 with CPP funding. DDS will partner with a regional center to build the homes using the buy-it-once model. DDS will staff and operate these acute crisis homes.
- c. DDS proposes to establish two mobile acute crisis teams with staff attached to the current STAR programs at Sonoma and Fairview DCs. These teams would provide in-home crisis services and mental health treatment for stabilization, and provide services and supports to help maintain individuals in their existing residence. These services will be available for deployment 24-hours a day, 7 days a week. Within 10 days of the deployment of the state mobile crisis team, an interdisciplinary team meeting will be scheduled to assess service supports. The mobile acute crisis team support will continue until, as identified through the Individual Program Plan, ongoing service support alternatives are identified. The 2017 May Revision includes 14.5 positions and \$1.9 million in one-time funding

for both teams in FY 2017-18. Starting in FY 2018-19, DDS will bill RCs for these mobile acute crisis services. DDS will re-assess staffing needs for mobile acute crisis teams after the first year of operation.

REDUCING RELIANCE ON RESTRICTIVE SETTINGS

With the moratorium on admissions to DCs, individuals with the most complex and challenging needs may be admitted for involuntary psychiatric treatment pursuant to the Lanterman-Petris-Short Act (LPS Act) (W&I Code section 5000 et seq.), to a locked or unlocked mental health facility such as an IMD. Such options may provide an immediate and necessary time-limited alternative for urgent circumstances where the safety of the person and/or others is immediate and is the primary concern. However, these options cannot meet all of their service needs nor effectively support their transition to a suitable living option. The Department will address this issue with three primary strategies: 1) Develop greater capacity for specialized residential services; 2) Increase transition options for persons in Porterville's STP and 3) Establish an option for intensive transitional and preventative support services that can be tailored to an individual's needs.

a. Specialized Residential Options for Persons with Developmental and Mental Health Needs

At any given time there are approximately 200 individuals who have a developmental disability and are a danger to themselves or others as a result of a mental disorder, including adolescents, and who are at risk of institutionalization or incarceration. Some have been referred to a state-operated STAR home, but were not admitted because their service needs conflicted with, or could not be safely served with the current STAR residents. This population requires intense psychiatric supports, often in a secure setting, to provide protection and stabilization through the crisis, as well as intensive services and treatment to help them transition to appropriate community settings. Approximately 100 of these individuals are currently served in large institutions for people with mental disorders, such as IMDs, and other facilities that are not designed to support an individual with a developmental disability and are ineligible for federal financial participation. Others are receiving involuntary psychiatric treatment pursuant to the LPS Act. While these resources often keep people safe, they often lack the capacity to support the individual's transition to a less restrictive setting.

Using the CPP process and approximately \$6.0 million in existing CPP FY 2017-18 funds, DDS proposes to develop four regional community homes, two in the North and two in the South, as a step-down from IMDs, STAR residences, or other highly restrictive settings, and as prevention from entering more restrictive settings. The homes would include intensive psychiatric supports to address mental health needs as well as intensive services and treatment to address developmental needs and prepare individuals for transition to a less restrictive setting, utilizing the concept of intensive transitional and preventative support services as described in c. 1 below.

A transition structure similar to STAR residences would authorize step-down services for up to 13 months.

DDS will also earmark existing CPP funds and establish as a continued priority in the CPP Guidelines for FY 2017-18 the development of housing options to move individuals out of mental health facilities and into small homes with services that support both their mental health and developmental needs.

b. Transition Options for Persons in Porterville's STP

Historically, the demand for secure treatment at Porterville DC has exceeded the facility's capacity. Each year, more people are court-ordered to Porterville than there are individuals who transition from that program to community settings or return to the criminal court system for adjudication after restoration of competency. For individuals who cannot achieve competency, they may be recommitted to the STP under W&I Code section 6500 as a danger to self or others, and stay for many years without an appropriate community option. With a statutory cap of 211 people that can be served in the STP and a critical need to admit individuals timely from the criminal justice system, additional options are needed to manage the STP population and safely support transitions to the community. DDS, in partnership with the regional centers, is conducting comprehensive community readiness assessments of current W&I Code section 6500 commitments at Porterville DC.

Residential options and services are needed that specifically target STP consumers who can successfully transition to community resources in a way that continues to protect public safety while promoting the development of skills that will support consumers' integration in the community. DDS proposes to develop two, four-bed homes in the Porterville area using the CPP process and \$3.0 million in existing CPP FY 2017-18 funds, to serve individuals who are committed to the STP. One additional four-bed home will be developed in FY 2018-19 with CPP funding.

The homes would likely be licensed as Enhanced Behavioral Supports Homes with Delayed Egress and a Secured Perimeter, and include appropriate treatment and transition services at all stages. Intensive transitional and preventative services and supports are proposed as described in c. 2 below, to provide intensive supports for successful transitions.

c. Intensive Transitional and Preventative Support Services

For individuals with the most challenging behaviors, including individuals with a dual diagnosis of a mental disorder and a developmental disability, and/or individuals involved in the criminal justice system, service needs are generally more complex. Intensive transitional support will increase the ability for the consumer to establish long-term success.

DDS proposes to develop intensive, person-specific services to address the needs of individuals who have challenging behaviors and are the most difficult to serve. This proposal will target three particular areas: 1) individuals with forensic needs, 2) individuals with a mental disorder and a developmental disability, and 3) individuals with severe aggressive behaviors. In FY 2017-18, these services will be focused on successfully supporting and transitioning individuals into less restrictive environments. Transition and treatment services may include, but are not limited to: psychiatric supports for individuals with dual diagnoses, forensic services, medical/clinical services, pharmaceutical/medication management to provide continuity, and proper administration and careful adjustment of medications, as needed.

1. Intensive Transitional and Preventative Support Services: DDS proposes \$3.0 million in existing POS funding be used to support individuals with both a mental illness and developmental disability transitioning out of, and preventing their placement into highly restrictive settings such as IMDs and acute crisis services. DDS will convene key regional centers to develop a service option that delivers intensive wrap-around services for individuals currently being served in, or at risk of admission to, an IMD setting.
2. Intensive Transitional Services for Porterville STP Residents: DDS proposes \$3.0 million in one-time funding to support focused efforts on transitioning individuals with forensic issues, committed under W&I Code section 6500 to the Porterville STP. DDS proposes to contract for expert services from a private organization to provide risk assessments and evaluations, advise planning teams on needed services, develop model services to support the safety, security and treatment of the most difficult individuals during the transition process, train and support service providers, and successfully maintain individuals in their community placements. Intensive transition services will be needed for one to two years for each individual moving from the STP. Ongoing funding will be provided through CPP placement funding.

IV. THE STATE'S ROLE IN PROVIDING RESIDENTIAL SERVICES

W&I Code section 4474.15(a) requires DDS to include an update regarding “how the state will maintain its role in providing residential services to those whom private sector vendors cannot or will not serve.”

As indicated in Chapter II, the work of the DC Task Force focused, in part, on the need for a safety net of services, so that when a community service provider is unable or unwilling to care for an individual because of potential safety and liability issues, there would always be a service alternative. This service alternative was sometimes described as a “placement of last resort” or as a “can’t say no” option. Many members advocated that the State has an appropriate and ongoing role in providing the placement of last resort.

THE STATE'S CURRENT ROLE

As part of its scope of responsibility, the DC Task Force considered the appropriate role of the State in delivering services for the three primary categories of DC residents: those with enduring and complex medical needs; those involved with the criminal justice system; and those with significant behavioral support needs. Throughout deliberations, the members remained cognizant that funding is limited and, given fiscal realities, it is important to effectively use State funds and maximize federal funds for both short- and long-term costs associated with the delivery of services. Eligibility for federal funding becomes an important consideration when proposing residential services in large or restrictive settings, or in settings associated with a DC. Specific to the State operating residential services, the DC Task Force made the following recommendations:

1. The State should continue to operate the Porterville STP as a preferable option to incarceration, a locked psychiatric facility or placement out-of-state. Secure treatment was viewed as primarily a responsibility of the State.
2. The State should continue to operate the Canyon Springs CF as a re-entry program for consumers leaving the Porterville STP.
3. The State should operate some transition facilities, like the program at Canyon Springs CF, only smaller (15 beds or fewer).
4. The State should operate acute crisis facilities of 15 beds or fewer, like the Fairview DC STAR, at least in the Northern and Southern parts of the State.
5. The State should provide DC staff to assist with the transition of individuals with challenging behaviors.

Following release of the DC Task Force recommendations, as part of the 2014 May Revision, DDS responded that it would continue to operate the Porterville STP and the Canyon Springs CF. The Department now provides acute crisis services at both Fairview and Sonoma DCs.

As discussed above, the 2017 May Revision additionally provides the following state-operated resources:

- Development of five acute crisis (STAR) homes (four in FY 2017-18, one in FY 2018-19) for the continuation and expansion of existing state-operated acute crisis services after DC closures.
- Establishment of two state-operated mobile acute crisis teams to provide immediate support in existing residential settings for individuals in crisis that might otherwise be admitted to IMDs or become involved with law enforcement.
- Contract funding for intensive transitional support for individuals currently in STP to successfully transition to community resources in a way that continues to protect public safety while promoting the development of skills that will support consumers' integration in the community.

PLACEMENT OF LAST RESORT

The general perception among stakeholders is that only the State can fill the role of providing a placement of last resort, or a residential alternative that cannot refuse to care for an individual. However, in limited circumstances, DDS has denied admission of an individual to a DC.

With a moratorium on DC admissions, except for individuals ordered by the courts to the Porterville STP or for acute crisis services, regional centers are currently identifying services for all individuals in the community.

Under the Lanterman Act, individuals should be served in the least restrictive environment appropriate for their needs. To reach this goal, a continuum of services is needed to serve every individual regardless of level or complexity of need. Through the CPP, DDS and regional centers are working to achieve greater capacity and specialized services throughout California, and to create the means to prevent admission to, or transition individuals out of restrictive placements. Chapter III describes the Department's proposals included in the 2017 May Revision for these purposes. Also in direct response to DC Task Force recommendations, and working with stakeholders through the regulatory process, DDS has promulgated regulations for EBSHs and proposed emergency regulations effective March 20, 2017, for CCHs. These licensing options will be a significant addition to the continuum of community residential and support services.

Admission to a state-operated residential facility necessitates constitutional due process protections and therefore requires time for court proceedings and ultimately a court order for admission. The need for immediate crisis services when a person can no longer remain in his or her home or current placement has been identified as a safety net issue in the various stakeholder forums. Although the state-operated acute crisis services, known as STAR residences, and the additional service options proposed in this plan fill an important role in the continuum of services, they may not solve the need for an immediate placement option when an individual is in crisis. The Department will explore policy avenues to support an individual with a developmental disability who is receiving regional center services, is in acute crisis, and is in need of an immediate short-term crisis placement in instances when, and for such time as, a court order might not be available.

DDS will continue to evaluate services, including the statewide need for acute crisis services, the success of EBSH and CCH models of care, as well as other service options developed as a result of the 2017-18 proposals. Realizing community integration and developing community capacity to provide less restrictive living options are a priority. With these proposals, state-sponsored residential and support services will remain a part of the continuum of service options to support individuals with the most challenging service needs.

V. ATTACHMENTS

1. Community Supports and Safety Net Services Summary (DS Task Force)
2. Guiding Principles (DS Task Force)
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Attachment 1

DS Task Force Community Supports and Safety Net Services Summary

DS Task Force General Definition of a Safety Net:

Timely access to essential services and supports necessary for persons with developmental disabilities to maintain health and safety and to address medical, psychiatric, behavioral, residential, staffing, equipment, or other needs, when other services and supports fail, are interrupted, are not available, or additional services and supports are necessary for an urgent or medical need. May or may not require a change in placement.

Definition of a Crisis:

A situation that without the presence of services would result in a severe negative impact to that person's life

General Principles:

- A range of supports is necessary for a "safety net" system, if a piece is missing, it impacts the whole system
- The focus should be on person-centered planning
- Safety net involves many components- an enhanced medical system, including medical, dental, behavioral health, equipment repair, medication tracking, day program, and employment
- The safety net system should be flexible
- Services must be developed to support consumers who are involved or at risk of becoming involved with the criminal justice or civil commitment systems
- Trusted, trained staff are key
- Services should align with new federal rules
- Ensure services are available throughout the state
- For crisis services there must be immediacy
- Utilize least restrictive interventions

- Focus not only on the point when someone enters a crisis, but also the point before they enter into crisis
- The priority should be creating stability and keeping people in their homes
- There should be a place where people can be stabilized and then transitioned back when it is safe for the community and the person
- There should be mechanisms to help people return to their former home after a crisis if they want to return to that home
- Prevention is important to keep someone from escalating into the criminal justice system
- Look at the original, organic diagnosis, in addition to what is immediately presented for intervention techniques
- With consumers who have been traumatized or abused, look at compliance, prevention measures and behavior factors
- Ensure training in trauma informed care
- We need to develop an array of living options for those in Institutions for Mental Disease (IMD) due to a crisis so they can return to the community
- There needs to be a reeducation of systems involved in crisis care, including stakeholders outside of the DD/IDD system, such as the police
- Self-determination should be examined as a component
- There should be a safety net that supports individuals of all ages, from youth to seniors
- There needs to be state oversight to ensure the delivery of quality services

Three Areas of Focus and Policy Recommendations

Pre-Crisis Service Recommendations

- There should be a model of funding similar to CPP that allows for startup, support and innovation for those currently being served in the community.
- Staffing and training should be evaluated for specialized facilities and supports, as well as the needs of complex consumers

- There should be more robust “wrap-around” services, such as medical, dental, psychiatric management, medication management, and durable medical equipment
- There should be a focus on person-centered planning and evaluation of supports
- Utilize state staff transferring into the community
- There should be a focus on cultural competencies and language barriers
- Improved transportation
- Increased therapeutic day program options
- Development of secure housing to prevent more restrictive placements
- There needs to be better communication across the system about crisis services and supported living
- The goal should be to keep people in their homes

Crisis Services Gaps

- There should be faster placement and more flexible schedules for return back to the community
- There should be comprehensive assessments of people in crisis, which include thinking long term about the individual needs
- Ensure crisis programs correctly medicate
- Develop more mobile, timely crisis teams
- Increased crisis setting capacity, potentially state-operated
- Develop resources for families to call if an individual is having a crisis
- Reduction in caseload for a period of time for individuals who are in crisis
- There should be training available for first responders for our consumers in crisis

Gaps in Fundamental Services

- Develop more managed care

- Need to have flexibility in timelines in movement
- Need to develop long-term, community based, residential options for individuals with significant service needs
- Need to develop community-based models that support the service needs of individuals involved or are at risk of becoming involved in the criminal justice system
- Need to develop long-term community options for Registered Sex Offenders
- Try to prevent bouncing around from home to home; makes the individual look undesirable and providers do not want to take that individual – safety concerns and psych issues
- Have complex crisis settings throughout the state so individuals are not traveling long distances during a crisis
- Ensure a “no reject” setting
- There needs to be more state oversight of safety net services
- There should be a transition rate for service provider staff to allow them to help individuals transition through multiple settings
- There should be start-up funds for the community to help develop safety net services, similar to CCP
- There should be more coordination with police and first responders
- There should be an examination of the median rate

Recommendations for DDS:

- The department should evaluate where there are service gaps in crisis and “wrap-around” services throughout the state
- The department should evaluate opportunities for increased training and coordination
- The department should evaluate its current oversight and work with stakeholders on refining and enhancing this oversight to ensure a quality statewide safety net
- DDS should incorporate these principles and recommendations into their legislative report on safety net services

Attachment 2

**EXCERPT FROM THE OCTOBER 8, 2014
DEVELOPMENTAL SERVICES TASK FORCE MEETING SUMMARY**

Guiding Principles

The Task Force expressed strong interest in capturing the principles that should be fundamentally included in every subject area and used as a goal or guide when considering changes to the community system. Also, it was recognized that some topics, such as the 2014 Centers for Medicare and Medicaid Services (CMS) regulations on Home and Community Based Services (HCBS), will necessarily have an impact on each area. Specifically, the overarching principles and topics for consideration under each subject area are:

1. The Lanterman Developmental Disabilities Services Act guarantees regional center services for the life of the consumer, thereby creating an entitlement program in California.
2. The core component of the service delivery system is a comprehensive person-centered Individual Program Plan (IPP), also referred to as a whole person or authentic IPP, which is carefully crafted and enables choice.
3. Consumers must be empowered to make choices and receive the services and supports they need to lead more independent and productive lives in the least restrictive environment appropriate for the individual. Consumers must be at the center of any problem analysis or solution, with the objective of providing services that people want. Emphasis should be placed on consumer choice, self-determination and consumer-directed services.
4. Ensuring consumer health and safety is critical, which includes protecting individuals from harm and abuse, and providing appropriate crisis intervention and response.
5. Services must be culturally and linguistically appropriate and responsive to the consumer and his or her family.
6. Any model of care or service must receive sufficient and stable funding to be successful in accomplishing its goal and be sustainable. The adequacy of resources is an issue that permeates all aspects of the service system.
7. The tenets of community integration and access reflected in the 2014 CMS regulations for HCBS must be incorporated throughout the service system, including but not limited to consumer choice; consumer independence; consumer rights to privacy, dignity and freedom from coercion and restraint; opportunities

for integrated employment; and settings that meet consumer-specific provisions based on these principles.

8. There must be fiscal accountability, transparency and fiscal responsibility in the service system, including maximizing the use of federal funding.
9. An appropriate framework for monitoring and quality assurance should be built into services.
10. Technology should be utilized.
11. Developmental center resources (land, staff and buildings) should be leveraged or made available to benefit consumers in the community.
12. Flexibility should be incorporated into the system to address choice and special circumstances, such as allowing Health and Safety exemptions.

ATTACHMENT 3

2017 Safety Net Stakeholder Meetings: Common Themes By Topic (as of 3/31/17)

In January and February 2017, the Department of Developmental Services (Department) held three stakeholder meetings throughout the state to discuss safety net services for consumers with challenging service needs. The meetings occurred in Napa, Fresno, and Costa Mesa, and participants included consumers, family members, advocates, service providers, clinical staff, housing representatives, regional center staff, and staff from various state agencies. This document contains a consolidated summary of common themes, categorized by topics, provided by stakeholders in attendance at each regional meeting.

What does “safety net” mean?

- Timely and flexible access to essential services (medical, dental, mental health, etc.).
- Comprehensive, coordinated continuation of supports between multidisciplinary agencies.
- Utilization of a person and family centered approach.
- Availability of an array of service options (crisis supports, employment, in-home services, residential, psychiatric, etc.).
- Trained and qualified professionals and providers.
- Identifying ways to create stability and keep people safe and in their home communities, starting at an early age and throughout their lifetime.

What are systems and services that work?

- The Lanterman Act and the regional center system (referral process, service coordination, liaisons).
- Person centered planning, centered on the individual with developmental disabilities.
- Individualized supports (supported living services, employment, respite, etc.).
- Preventive interventions and strategies.
- Mobile crisis services.
- Local level collaboration between multiple agencies.
- Well trained provider staff.
- Residential and crisis models/services (North and South STAR, Adult Residential Facilities for Persons with Special Health Care Needs [ARFPSHN], supported living services, small settings, community homes).

What are the gaps in the safety net?

Issues/gaps

- Availability of qualified, competent professionals, including direct care professionals.
- Regulatory and/or state processes are too cumbersome, outdated, and/or lengthy (Health and Safety Waiver process, Licensing, coordination with the mental health system, funding and rates).
- Funding and rates issues

- Transition and treatment gaps (continuation of care).
- Timeliness, availability, and coordination of services.
- Barrier of coordination of services between agencies.
- Inconsistency of training for community agencies and provider staff.
- Availability of affordable housing.
- Need a place that “cannot say no,” or a “placement of last resort.”
- Lack of supports for, and community awareness of, individuals with developmental disabilities and mental health needs.
- Capacity issues throughout the system (crisis beds, mobile services, short-term crisis options, emergency placements).
- Inadequate treatment models and appropriate services for children and adolescents, especially those with dual diagnoses (including social and emotional supports and education options).

Priority suggestions/recommendations.

- Increase training (first responders, criminal justice system, community partners, direct service providers, family members, medical/dental providers).
- Increase access to and availability of services (mental health, medical, crisis, housing, employment, transportation, and social recreational).
- Streamline and create flexibility within system-wide processes (Health and Safety Waiver process, cross-vendorization, sharing of resources, licensing, oversight).
- Increase communication and collaboration between multiple systems of care (RCs, mental health, other departments).
- Promote continuity of care for individuals.
- Explore options for “placements of last resort,” including potentially retaining the North and South STAR crisis homes.
- Identify or increase funding specific to safety net services.

Services for persons with significant behavioral and mental health needs

What works?

- Trained, consistent, skilled, experienced, trusted and competent provider staff.
- Person centered approach.
- Involvement of community partners.
- Individualized services and supports (behavioral, crisis, supported living, telemedicine).
- Availability of meaningful and engaging activities (e.g. work, exercise, etc.).
- Acute crisis residential facilities (STAR home model).
- Residential services/small settings (secured perimeter and delayed egress homes, mental health rehabilitation centers, and home-like settings).
- Circle of supports (relationships with family members and peers).
- Cross training.
- Wraparound and transition services.
- Training for provider staff and first responders.
- Medication management.

- Regional center collaboration with agencies (mental health, schools, first responders, law enforcement, medical staff, community).
- Behavior supports and interventions.

Issues/gaps

- Need for more community awareness (language and cultural barriers too).
- Treatment focuses on mental health needs and not the developmental disability (not a whole person approach, need for appropriate treatment for dually diagnosed individuals).
- Lack of trained and experienced service providers and professionals (behavioral consultants, psychiatrists, medical).
- Funding and rates are not flexible.
- Need for immediate mental health supports without access delays.
- Need to educate first responders on the needs of individuals with developmental disabilities.
- Language and cultural barriers, including communication barriers for individuals who have non-standard ways of communicating.
- Limited statewide resources for crisis supports.
- “Not in My Back Yard” (NIMBY) concerns.
- Geographical and transportation challenges.
- Greater access to mobile crisis teams
- Availability of employment opportunities for consumers.
- Need for more residential service options (more available stable, affordable housing).
- Continuity of care and transition of services.
- Pharmacological oversight/coordination
- Lack of experienced mental health professionals.
- Court hearings/referrals are slow to schedule.

Priority suggestions/recommendations.

- Increase availability of professionals (psychiatrists, behaviorists, and mental health professionals).
- Implement support and training for all levels of direct service provider staff, identify how best to develop future staff.
- Monitor and evaluate models and best practices; measure outcomes, replicate successful models
- Develop a model for medication review/management.
- Ensure person centered planning approach for all services, including assessments (and encourage development of a circle of support).
- Enhance development of appropriate homes and resources (location, stability, affordable, crisis homes, short-term options, step down options, potential day programs with delayed egress, one-stop locations, dental services).
- Improve access to mental health services, including coordination between agencies.
- Early transition planning.

- Support positive, enriching opportunities/activities (competitive integrated employment, social recreational activities, exercise).
- Increase collaboration and coordination of services.
- Increased training for provider staff and first responders.
- Develop services specific to the needs of the individuals with behaviors (day program and employment).
- When available, use the Self-Determination program to increase choice and availability of services and supports
- Training in trauma informed care, stress management and recognition of abuse and how to prevent it.

Alternative and transition options for the forensic population

Recommendations for supports or services necessary to provide appropriate, safe and sustainable transitions.

- Implement wraparound supports pre- and post-transition.
- Ongoing education and treatment for individuals, including children and adolescents (drug, alcohol, competency, life skills, anti-bullying, community awareness, consumer rights training).
- Emphasize discharge planning process, with specialized supports in place (delayed egress, 1:1 staff ratios, inpatient and outpatient services, preventative supports, meaningful engagement activities). Build community partnerships; enhance inter-agency collaboration (justice systems and other professionals).
- Enhanced training for service provider staff and community members.
- Implement ongoing monitoring and case management during transitions (have an appropriate transition plan).

Other considerations.

- Continuity of supports and services that are meaningful and individualized (behavior plans, job and training opportunities, drug treatment).
- Include and encourage meaningful relationships with family members and peers (circle of supports) during transition and treatment planning.
- Provide ongoing training for the criminal justice system and first responders.
- Ensure that individuals are prepared for transitions.
- Develop placement options in the community, including competency training and other forensic services
- Explore a forensic conditional release program specific to individuals with developmental disabilities.

Safely transitioning and supporting individuals

Pre-transition intervention supports

- Identify and increase access to community resources (medical, dental, public benefits, mental health services, faith based resources, etc.)
- Encourage pre-placement visits and cross training.
- Conduct whole person assessments; use person-centered approach during all planning and help the individual prepare for transitions.

- Review the individual's history; identify needed supports (especially medication lists and history).
- Designate a contact person to assist with coordination of care for the individual during the transition
- Ensure coordination between the developmental center, crisis service, individuals' home, and the medical community.
- Have an appropriate, comprehensive transition plan, including back-up plans.
- Create an electronic record system to capture and share an individual's medical, behavioral, medication, etc. history with current and future providers; this record will follow the individual

Transition supports

- Conduct ongoing assessments post-transition to identify additional needs.
- Include trusted developmental center support staff to assist the individual in the community, to include working in community homes or day programs.
- Use transition teams to follow the individual after placement in the community.
- Ensure that services and supports are appropriately in place (medical, behavioral, employment, etc.)
- Ensure wraparound supports are available when needed, to include if crisis seems imminent.

Community sustainability

- Continue training for staff and family members who will be supporting the individual.
- Ongoing and effective training for providers (train-the-trainer model, share best practices).
- Promote access and relationships with family members.
- Continue mobile crisis services/team.
- Develop opportunities for community integration.
- Develop resources (medical, housing, providers, crisis homes, day programs, transportation).
- Identify funding to support transitions.

Outcomes

- Consumer satisfaction and quality of life (choices, relationships, employment, meaningful engagement, productivity, personal satisfaction, health, community involvement, peer support).
- Stable living environments.
- Measure success beyond one year.
- Monitor outcomes through documentation, meetings, and recording signs of stability.

ATTACHMENT 4

PROPOSED TRAILER BILL LANGUAGE TO EXPAND THE USE OF CPP

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 4.1. DEVELOPMENTAL SERVICES [4400 - 4499]

(Division 4.1 added by Stats. 1977, Ch. 1252)

**PART 1. GENERAL ADMINISTRATION, POWERS AND DUTIES OF THE
DEPARTMENT [4400 - 4437]**

(Part 1 added by Stats. 1977, Ch. 1252)

4418.25.

(a) The department shall establish policies and procedures for the development of an annual community placement plan by regional centers. The community placement plan shall be based upon an individual program plan process, including the process as referred to in subdivision (a) of Section 4418.3, and shall be linked to the development of the annual State Budget. The department's policies shall address statewide priorities, plan requirements, and the statutory roles of regional centers, developmental centers, and regional resource development projects in the process of assessing consumers for community living and in the development of community resources.

(b) (1) To address the need for services and supports for consumers living in the community, and to reduce reliance on developmental centers and mental health facilities, including institutions for mental disease as described in Part 5 (commencing with Section 5900) of Division 5, for which federal funding is not available, and out-of-state placements, the department shall establish a statewide specialized resource service that does all of the following:

(A) Tracks the availability of specialty residential beds and services.

(B) Tracks the availability of specialty clinical services.

(C) Coordinates the need for specialty services and supports in conjunction with regional centers.

(D) Identifies, subject to federal reimbursement, developmental center services and supports that can be made available to consumers residing in the community, when no other community resource has been identified.

(2) By September 1, 2012, regional centers shall provide the department with information about all specialty resources developed with the use of community

placement plan funds and shall make these resources available to other regional centers.

(3) When allocating funding for community placement plans, priority shall be given to the development of needed statewide specialty services and supports, including regional community crisis homes.

(4) If approved by the director, funding may be allocated to facilities that meet the criteria of Sections 1267.75 and 1531.15 of the Health and Safety Code.

(5) The department shall not provide community placement plan funds to develop programs that are ineligible for federal funding participation unless approved by the director.

(c) (1) The community placement plan shall provide for dedicated funding for comprehensive assessments of developmental center residents, for identified costs of moving individuals from developmental centers to the community, ~~and~~ for deflection of individuals from developmental center admission, and for increasing community capacity to provide services and supports to other individuals who live in the community. The plans shall, where appropriate, include budget requests for regional center operations, assessments, resource development, and ongoing placement costs. These budget requests are intended to provide supplemental funding to regional centers. The plan is not intended to limit the department's or regional centers' responsibility to otherwise conduct assessments and individualized program planning, and to provide needed services and supports in the least restrictive, most integrated setting in accord with the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)).

(2) (A) Regional centers shall complete a comprehensive assessment of any consumer residing in a developmental center on July 1, 2012, who meets both of the following criteria:

(i) The consumer is not committed pursuant to Section 1370.1 of the Penal Code.

(ii) The consumer has not had such an assessment in the prior two years.

(B) The assessment shall include input from the regional center, the consumer, and, when appropriate, the consumer's family, legal guardian, conservator, or authorized representative, and shall identify the types of community-based services and supports available to the consumer that would enable the consumer to move to a community setting. Necessary services and supports not currently available in the community setting shall be considered for development pursuant to community placement planning and funding.

(C) Regional centers shall specify in the annual community placement plan how they will complete the required assessment and the timeframe for completing the assessment for each consumer. Initial assessments pursuant to this paragraph for individuals residing in a developmental center on July 1, 2012, shall be completed by December 31, 2015, unless a regional center demonstrates to the department that an extension of time is necessary and the department grants such an extension.

(D) The assessment completed in the prior two years, or the assessment completed pursuant to the requirements of this section, including any updates pursuant to subparagraph (E), shall be provided to both of the following:

(i) The individual program planning team and clients' rights advocate for the regional center in order to assist the planning team in determining the least restrictive environment for the consumer.

(ii) The superior court with jurisdiction over the consumer's placement at the developmental center, including the consumer's attorney of record and other parties known to the regional center. For judicial proceedings pursuant to Article 2 (commencing with Section 6500) of Chapter 2 of Part 2 of Division 6, the comprehensive assessment shall be included in the regional center's written report required by Section 6504.5. For all other proceedings, the regional center shall provide the comprehensive assessment to the court and parties to the case at least 14 days in advance of any regularly scheduled judicial review. This clause shall not apply to consumers committed pursuant to Section 1370.1 of the Penal Code.

(E) The assessments described in subparagraph (D) shall be updated annually as part of the individual program planning process for as long as the consumer resides in the developmental center. To the extent appropriate, the regional center shall also provide relevant information from the statewide specialized resource service. The regional center shall notify the clients' rights advocate for the regional center of the time, date, and location of each individual program plan meeting that includes discussion of the results of the comprehensive assessment and updates to that assessment. The regional center shall provide this notice as soon as practicable following the completion of the comprehensive assessment or update and not less than 30 calendar days prior to the meeting. The clients' rights advocate may participate in the meeting unless the consumer objects on his or her own behalf.

(d) The department shall review, negotiate, and approve regional center community placement plans for feasibility and reasonableness, including recognition of each regional centers' current developmental center population and their corresponding placement level, as well as each regional centers' need to develop new and innovative service models. The department shall hold regional centers accountable for the development and implementation of their approved plans. The regional centers shall report, as required by the department, on the outcomes of their plans. The department shall make aggregate performance data for each regional center available, upon request, as well as data on admissions to, and placements from, each developmental center.

(e) Funds allocated by the department to a regional center for a community placement plan developed under this section shall be controlled through the regional center contract to ensure that the funds are expended for the purposes allocated. Funds allocated for community placement plans that are not used for that purpose may be transferred to Item 4300-003-0001 for expenditure in the state developmental centers if their population exceeds the budgeted level. Any unspent funds shall revert to the General Fund.

(f) Commencing May 1, 2013, and then on April 1, 2014, and on April 1 annually thereafter, the department shall provide to the fiscal and appropriate policy committees of the Legislature, and to the contractor for regional center clients' rights advocacy services under Section 4433, information on efforts to serve consumers with challenging service needs, including, but not limited to, all of the following:

(1) For each regional center, the number of consumers admitted to each developmental center, including the legal basis for the admissions.

(2) For each regional center, the number of consumers described in paragraph (2) of subdivision (a) of Section 7505 who were admitted to Fairview Developmental Center by court order pursuant to Article 2 (commencing with Section 6500) of Chapter 2 of Part 2 of Division 6, and the number and lengths of stay of consumers, including those who have transitioned back to a community living arrangement.

(3) Outcome data related to the assessment process set forth in Section 4418.7, including the number of consumers who received assessments pursuant to Section 4418.7 and the outcomes of the assessments. Each regional center, commencing March 1, 2013, and then on February 1, 2014, and on February 1 annually thereafter, shall provide the department with information on alternative community services and supports provided to those consumers who were able to remain in the community following the assessments, and the unmet service needs that resulted in any consumers being admitted to Fairview Developmental Center.

(4) Progress in the development of needed statewide specialty services and supports, including regional community crisis options, as provided in paragraph (3) of subdivision (b). Each regional center shall provide the department with a report containing the information described in this paragraph commencing March 1, 2013, and then on February 1, 2014, and on February 1 annually thereafter.

(5) Progress in reducing reliance on mental health facilities ineligible for federal Medicaid funding, and out-of-state placements, including information on the utilization of those facilities, which shall include, by regional center, all of the following:

(A) The total number and age range of consumers placed in those facilities.

(B) The number of admissions.

(C) The reasons for admissions by category, including, but not limited to, incompetent-to-stand-trial (IST) commitment, Section 6500 commitment, crisis stabilization, and lack of appropriate community placement.

(D) The lengths of stay of consumers.

(E) The type of facility.

(6) Information on the utilization of facilities serving consumers with challenging service needs that utilize delayed egress devices and secured perimeters, pursuant to Section 1267.75 or 1531.15 of the Health and Safety Code, including the number of admissions, reasons for admissions, and lengths of stay of consumers, including those who have transitioned to less restrictive living arrangements.

(7) If applicable, any recommendations regarding additional rate exceptions or modifications beyond those allowed for under existing law that the department identifies as necessary to meet the needs of consumers with challenging service needs.

(g) Each regional center, commencing March 1, 2013, and then on February 1, 2014, and on February 1 annually thereafter, shall provide information to the department regarding the facilities described in paragraph (6) of subdivision (f), including, but not limited to, the number of admissions, reasons for admissions, and lengths of stay of consumers, including those who have transitioned to less restrictive living arrangements.

(h) Each institution for mental disease that has admitted a regional center consumer in the preceding year shall report on February 1, 2016, and on February 1 annually thereafter, to the contractor for regional center clients' rights advocacy services under Section 4433, all of the following:

(A) The total number and age of consumers placed in that facility.

(B) The number of admissions.

(C) The reasons for admissions by category.

(D) The lengths of stay of consumers.

(E) The funding source.

(Amended by Stats. 2015, Ch. 23, Sec. 4. Effective June 24, 2015.)

ATTACHMENT 5

**PROPOSED TRAILER BILL LANGUAGE TO AMEND THE GROUND LEASE AT
HARBOR VILLAGE**

Government Code 14670.35.

(a) Notwithstanding Section 14670, the Director of General Services, with the consent of the State Department of Developmental Services, may let in the best interests of the state and at a price which will permit the development of affordable housing for persons eligible under this section, to any person, including but not limited to any corporation or partnership, real property not exceeding 60 acres located within the grounds of Fairview State Hospital, for the purpose of developing affordable housing, which may include manufactured housing, for the employees of Fairview State Hospital, and for a period not to exceed 55 years. The lease authorized by this section shall be nonassignable, except it may be assignable, subject to approval by the Department of General Services and the State Department of Developmental Services, to a partnership in which the lessee has an interest of not less than 50 percent or to an individual, corporation or partnership which has a net worth of at least three million dollars (\$3,000,000) and has experience substantially equal to that of the lessee in building, marketing, managing and leasing residences of the type to be built under the lease, and shall be subject to review every five years by the Director of General Services, to assure the state that the original purposes of the lease are being carried out.

In the event of default by the lessee under the terms of the lease, the state shall take all necessary steps to cure the default but in no event shall state general funds, except funds collected pursuant to Section 15863, be expended to operate the property.

The housing developed pursuant to this section shall be available for the employees of Fairview State Hospital and to provide transitional housing for patient-clients of Fairview State Hospital returning to the community; provided that the housing available for transitional housing for patient-clients shall not be in excess of 10 percent of the units developed. In the event that vacancies occur in the units which cannot be filled by either employees of Fairview State Hospital or transitional patient-clients, then the units may be made available to persons who are in need of affordable housing and whose incomes do not exceed 80 percent of the median income for Orange County as that income may be defined from time to time by the United States Department of Housing and Urban Development. Should any vacancies exist in excess of 60 days after lessee has conducted a marketing program in cooperation with the Orange County Housing Authority and approved by the State Department of Developmental Services, and during the 60 days the vacancies were made available to employees, transitional patient-clients and persons whose incomes do not exceed 80 percent of the median income for

Orange County, then, upon approval by the State Department of Developmental Services, the vacant units may be made available to any persons employed in the City of Costa Mesa.

The Legislature finds and declares that the provision of decent and affordable housing for state employees and transitional patients, i.e. clients of state mental hospitals, is a public purpose of great statewide importance.

(b) Effective July 1, 2017, the Director of General Services, with the approval of the State Department of Developmental Services, shall amend the existing lease established pursuant to subsection (a) to include a portion of the Fairview Developmental Center property in the area of Mark Lane, for the purpose of developing additional housing units to serve individuals with developmental disabilities. The amendment shall provide that the additional acreage be subject to the existing lease conditions. The amendment shall require a management agreement between the Lessee and the State Department of Developmental Services be established including terms and conditions determined by the Director of the State Department of Developmental Services to be in the best interests of the state. The management agreement shall allow the State Department of Developmental Services to determine the type of housing units to be developed and whether housing is developed by renovation of existing units or construction of new units suitable for providing services to individuals with developmental disabilities. The management agreement shall also give the State Department of Developmental Services the first right of refusal for all housing established pursuant to this section on the subject acreage.

(c) The housing developed for employees of Fairview State Hospital or transitional patient-clients pursuant to paragraph (a) of this section shall first be available for individuals with developmental disabilities receiving services from a regional center pursuant to Division 4.5 of the Welfare and Institutions Code and then, to individuals in need of affordable housing as described in this section.