

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



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



January 10, 2020

TABLE OF CONTENTS

<u>CHAPTER</u>	<u>PAGE</u>
I. EXECUTIVE SUMMARY	1
II. INTRODUCTION AND BACKGROUND	3
III. UPDATES ON 2017 SAFETY NET PLAN INITIATIVES	10
IV. DEVELOPMENT OF THE UPDATED PLAN: STAKEHOLDER INVOLVEMENT	13
V. RECENT INITIATIVES AND MODELS OF CARE TO MEET THE NEEDS OF INDIVIDUALS LIVING IN THE COMMUNITY	16
VI. NEW GOVERNOR'S BUDGET PROPOSALS FOR THE SAFETY NET	21
VII. CONCLUSION	23
VIII. ATTACHMENTS	24
<i>ATTACHMENT 1</i>	25
<i>ATTACHMENT 2</i>	26
<i>ATTACHMENT 3</i>	27

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I. EXECUTIVE SUMMARY

In May 2017, the Department of Developmental Services (DDS or Department) submitted to the Legislature a safety net¹ plan pursuant to Welfare & Institutions Code Section 4474.15(a), which required a plan describing “how the department will provide access to crisis services after the closure of a developmental center (DC) and how the state will maintain its role in providing residential services to those whom private sector vendors cannot or will not serve.”² This updated version of the safety net plan is submitted in compliance with Senate Bill (SB) 81 (Chapter 28, Statutes of 2019, § 6), adding Welfare and Institutions (W&I) Code Section 4474.16, providing:

On or before January 10, 2020, and in conjunction with the Governor’s proposed 2020–21 budget, the State Department of Developmental Services shall submit to the Legislature an updated version of the safety net plan that was originally submitted pursuant to subdivision (a) of Section 4474.15. The updated plan shall be developed in consultation with stakeholders and shall evaluate the progress made to create a safety net, identify the further areas the stakeholder community suggests evaluating, and recommendations from the stakeholder community, and shall consider new models of care for individuals whom private sector vendors cannot or will not serve.

This safety net plan update serves three overall purposes: 1) To provide status updates on service options developed and initiatives undertaken pursuant to the May 2017 safety net plan; and 2) to provide an overview of additional safety net activities and service options initiated since the prior plan; and 3) present proposals for future activities and initiatives. Section II consists of background information on the developmental disabilities services system. Section III provides updates on new service options developed or expanded under the May 2017 safety net plan. Section IV describes stakeholder input and recommendations received since issuance of the May 2017 plan, which has helped inform development of this updated plan. Section V describes recent initiatives and models of care to support individuals who need safety net services and supports to

¹ There is no formal or precise definition of what is meant by the broad concept of the safety net. In July 2017, the Department’s Developmental Services Task Force developed the following working definition:

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.

² *Plan for Crisis and Other Safety Net Services in the California Developmental Services System* (May 13, 2017), https://www.dds.ca.gov/wp-content/uploads/2019/02/Budget_PlanForCrisis_20190215.pdf

successfully remain in and transition to the most integrated settings and to be included as participating members of their communities. Finally, Section VI describes new Governor's budget proposals related to the safety net.

The Department remains committed to strengthening the safety net providing a range of services and supports for individuals with co-occurring and complex behavioral, mental health, or medical needs transitioning to or living in a community setting. The Department will monitor the safety net plan throughout implementation, and will continue to engage with consumers, family members, regional centers, professionals, advocates, and other stakeholders to identify strategies or potential models of services and supports and evaluate the effectiveness of existing models.

II. INTRODUCTION AND BACKGROUND

A. The Lanterman Developmental Disabilities Services Act

The Lanterman Developmental Disabilities Services Act (W&I Code § 4500 et seq.; Lanterman Act) is the foundation of California’s service system for people with developmental disabilities. The Lanterman Act had its origins in 1966, when funds were appropriated to establish two pilot regional centers, one in northern California and one in southern California. During their initial year of operation, the two regional centers served 559 persons. The success of the pilot led to the establishment of a statewide regional center system through enactment, in 1969, of the Lanterman Mental Retardation Act. In 1973, it was renamed the Lanterman Developmental Disabilities Services Act and expanded from serving only individuals with intellectual disabilities to also include individuals with autism, cerebral palsy, epilepsy, and other conditions similar to intellectual disabilities or having similar treatment needs. In Fiscal Year (FY) 2019-20, California’s 21 regional centers will serve an estimated 350,000 individuals.

Prior to the Lanterman Act, publicly funded community services were limited and the primary alternatives to family care—i.e., the “safety net”—were large, state-operated institutions. In 1964, there were over 13,000 people with developmental disabilities residing in four state hospitals (renamed developmental centers in 1985), and another 3,000 on waiting lists.

With enactment of the Lanterman Act, the State of California accepted “a responsibility for persons with developmental disabilities and an obligation to them which it must discharge.” (W&I Code § 4501.) Section 4501 further provides that:

An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream of community life. To the maximum extent feasible, services and supports should be available throughout the state to prevent the dislocation of persons with developmental disabilities from their home communities.

B. Reduced Reliance on Developmental Centers (DCs) and Other Institutional Living Arrangements, and Non-integrated Services

Since the enactment of the pioneering Lanterman Act, the trend, both in California and nationally, has been a steady decline in the dependence on institutionally based care and treatment and an increase in community-based services and supports for

individuals with developmental disabilities. Several laws and court cases have played a significant role in providing the impetus for this trend, including the following:

- *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384 – The California Supreme court held that the Lanterman Act created an “entitlement” to services enabling each person with developmental disabilities to live a more independent and productive life in the community.
- Americans with Disabilities Act (ADA), 42 U.S.C. § 12100 et seq. – Landmark 1990 civil rights legislation prohibiting discrimination based on disability, including in the provision of government programs and services.
- *Coffelt v. Department of Developmental Services* (1990) – Class action lawsuit alleging unnecessary institutionalization of DC residents who had been determined by their planning teams to be capable of living in the community, but who remained institutionalized only because there were not enough community resources to meet their needs, in violation of the Lanterman Act entitlement. The 1993 settlement resulted in more than 2,000 DC residents moving to the community over five years, and numerous system reforms including dedicated funding for the development of community resources.
- *Olmstead v. L.C.* (1999) 527 U.S. 581 – The U.S. Supreme Court held that unnecessary institutionalization of people with disabilities who can live in the community constitutes unlawful discrimination based on disability under the ADA.
- Assembly Bill (AB) 1472 (Chapter 25, Statutes of 2012) – 2012-13 budget trailer bill legislation that, among other things, placed a moratorium on DC admissions, with only limited exceptions for individuals involved with the criminal justice system or in acute crisis. AB 1472 required comprehensive assessments of all DC residents to determine the community resources necessary to meet their needs; limited admissions of individuals with developmental disabilities to Institutions for Mental Disease (IMDs) and other restrictive settings, including out-of-state placements; and authorized the use of secured perimeters with delayed egress in licensed homes to enable individuals who would otherwise be at risk of institutionalization to remain in the community.
- Self-Determination Program – In 2013, the Legislature authorized the statewide Self-Determination Program (SB 468, Emmerson, Chapter 683, Statutes of 2013). Self-determination provides individuals with developmental disabilities greater autonomy and flexibility in selecting, controlling, and directing services and supports to achieve their desired goals. Self-determination has been linked to positive outcomes, including more autonomous functioning and enhanced quality of life, which better enable individuals with developmental disabilities to live and work in their communities. These positive outcomes, in turn, can be expected to

reduce the incidence of acute crises and the need to access institutional care and other safety net services.

- Home and Community-Based Services (HCBS) Programs – In 2014, the federal Centers for Medicare and Medicaid Services (CMS) published final regulations affecting specified programs and services funded through Medicaid (including Section 1915i waiver programs). The regulations recognize that many individuals at risk of being placed in medical facilities can be cared for in their homes and communities. In addition, it set higher standards for HCBS settings in which it is permissible for states to pay for services using federal financial participation under Medicaid. California must comply with the HCBS settings criteria by March 2022.
- Developmental Center Closures – Pursuant to the 2015 May Revision to the Governor’s Budget, the Department submitted to the Legislature closure plans for the then-three remaining DCs—Sonoma DC, Fairview DC, and the Porterville DC General Treatment Area (GTA). The closure plan for Sonoma DC was submitted on October 1, 2015 with the goal of closure by the end of 2018. The plan for closing both Fairview DC and Porterville DC GTA was submitted on April 1, 2016, with the goal of closing both facilities by 2021. Sonoma DC closed in December 2018, and Fairview DC and the Porterville DC GTA are expected to have the last person move in January 2020.
- Community Resource Development Plan (CRDP) – The Department’s Community Placement Plan (CPP) was developed to provide funding to enhance the capacity of the community service delivery system to support individuals moving into the community from more restrictive, institutional settings and for individuals at risk of institutionalization. As reliance on DCs and other restrictive institutional settings has declined, and in recognition of evolving community service system needs and priorities, the 2017-18 developmental services budget trailer bill (AB 107, Chapter 18, Statutes of 2017) amended Section 4418.25 of the Welfare and Institutions Code to authorize the Department—when it determines sufficient CPP funding has been appropriated and reserved for a fiscal year for purposes of meeting the needs of individuals transitioning from the DCs—to allocate the remaining CPP funds to RCs for purposes of community resource development to address services and supports needs of consumers living in the community through a new CRDP.
- AB 2083 (Cooley, Chapter 815, Statutes of 2018) – was enacted to develop a coordinated, timely, and trauma-informed system-of-care approach for foster children and youth, including individuals with developmental disabilities, who have experienced severe trauma by addressing systemic barriers to the traditional provision of interagency services. (See Section V.D., *infra*.)

Safety net services are a continuum of services and supports serving individuals with complex medical, behavioral, and mental health conditions from an early age through

adulthood, through stages of behavioral and mental health crises, and phases of supports and placements. Safety net services also include preventive services and stabilization supports for consumers at risk of or experiencing acute crises, and transition and support services for individuals moving from highly restrictive settings, such as DCs, IMDs or the Secure Treatment Program (STP) at Porterville DC. The continuum of safety net services is represented in **Figure 1**, below.

The safety net system is person-centered, trauma-informed, and intended to avoid or step down from highly restrictive placements and interventions. With the closure of state-operated DCs, the evolving safety net system ensures individuals with co-occurring behavioral, mental health, and medical needs are identified in childhood and adolescence and the range of safety net supports are in place throughout the individual's lifespan. The safety net system recognizes that consumers with co-occurring behavioral and mental health conditions often receive supports with multiple agencies, including mental health, special education, psychiatric, and mobile crisis services. Individuals with co-occurring behavioral and mental health needs can often be supported in family homes, with fewer psychiatric hospitalizations, if intensive supports are identified early, provided in the home, and linked with multiple agencies.³

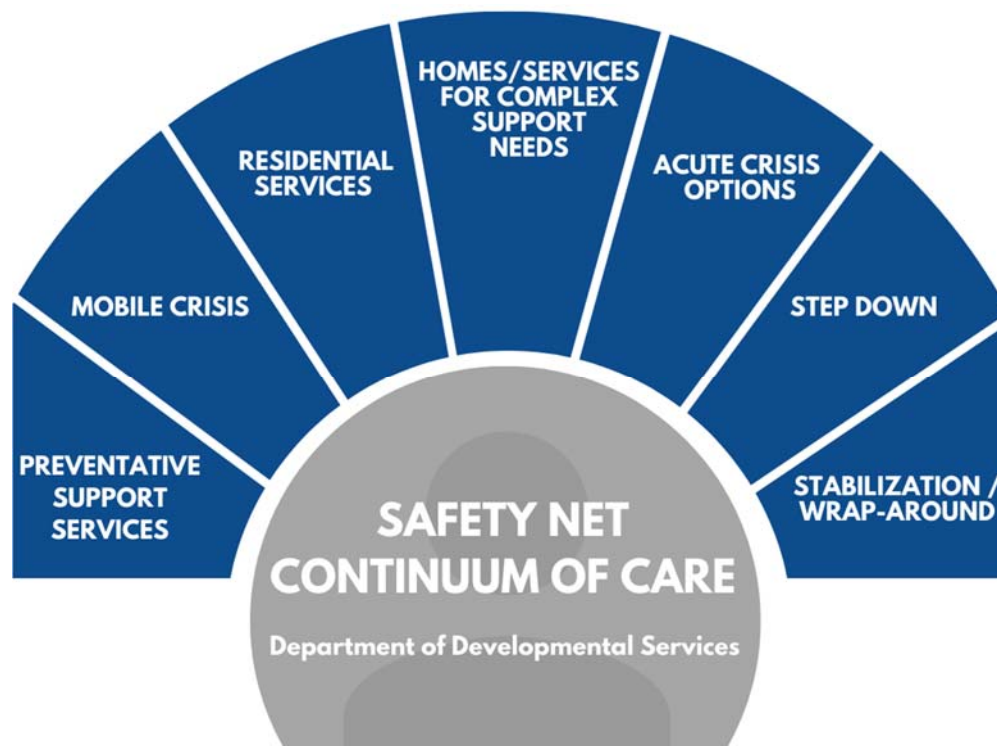


Figure 1

³ Kalb, L., Beasley, J, Caoili, A. & Klein, A., *Improvement in mental health outcomes and caregiver service experiences associated with the START program*, American Journal on Intellectual and Developmental Disabilities: January 2019, Vol. 124, No 1, pp. 25-34.

With the recent closures of state-operated institutions and the corresponding development and enhancement of safety net and other community-based services and supports, the role of the state in the provision of direct services has steadily declined. That role is now essentially limited to supporting individuals experiencing acute crises and those involved in the criminal justice system.

While enhancements continue to be made, through person-centered practices the service delivery system for individuals with developmental disabilities is now closer than ever to achieving the intent and vision of the Lanterman Act, including that “[a]n array of community-based services and supports ... be established that is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life, and to support their integration into the mainstream life of the community.” (W&I Code § 4501.)

C. Demographic Trends in the Developmental Disabilities Services System

The RC system, like the State, has undergone demographic changes over the last decade. (See **Attachment 1**.) For example, from FY 2008-09 to FY 2018-19:

- The number of individuals age 60 and older nearly doubled, and the number under age 22 years increased by more than 85,000. However, the share of regional center consumers who were under age 22 remained unchanged at approximately 65 percent.
- Relatively few consumers report more than one race/ethnicity; however, the group of those who do is growing faster than any other racial/ethnic group.
- Individuals who identify as Asian and Hispanic/Latino increased by more than half over this period.
- While English remains the most commonly spoken language (79% of all consumers), Spanish is the second most commonly spoken language. An additional 27,553 Spanish-speakers were added over the period.

Much of the recent growth in RC caseload comes from diverse ethnic and language communities that have historically faced challenges understanding and accessing generic and RC service options. Some communities may not use safety net services at similar rates or settings as White English-speaking consumers. For many, cultural traditions may focus on families providing care. Increasing access to and utilization of safety net services by those communities are priorities for the Department and the RCs. Cultural and linguistic competence is a major consideration in developing and evaluating the effectiveness of safety net services. In collaboration with the Department, RCs solicit community input and gather data related to purchase of service authorization, utilization, and expenditures to identify where significant differences occur and barriers to equitable

access to services and supports. This information is used to develop recommendations and plans to reduce existing disparities and to track progress in meeting established improvement targets.⁴

The changing mix of the population—including the increase in the number of individuals diagnosed with autism and the growth of the adult population—contributes to the anticipated need for safety net services. (See **Attachment 2.**) Among the trends in population characteristics from FY 2008-09 through FY 2018-19 are the following:

- The number of individuals age 22 and over diagnosed with intellectual disability grew substantially over this period. Intellectual disability remains the system's largest diagnostic category by far, comprising 42 percent of all consumers.
- The number of individuals diagnosed with autism more than doubled from FY 2008-09 through FY 2018-19. RCs now serve approximately 52,000 more individuals under age 22 with autism than in FY 2008-09, and eighty percent of RC consumers with autism are under age 22. However, the rate of growth was higher over this period for individuals age 22 and older.
- 5th Category (individuals with conditions similar to intellectual disability or having similar treatment needs) remains the smallest diagnostic group. However, growth was substantial over this period, at more than 37 percent.

The Department and RCs use several databases to track service utilization, including the Client Master File (CMF) and the Client Development Evaluation Report (CDER). **Attachment 3** lists some of the available safety net-related data.

Stakeholders have identified the need to develop and improve access to centralized, descriptive, and crisis-related data to identify gaps in the community service system and evaluate outcomes. Stakeholders have identified and made recommendations concerning additional types of information that would be helpful in identifying the continuing needs of the safety net system and assessing outcomes, including data on:

- Individuals living at home who have had several and/or extended emergency room visits or incidents involving a police response;
- Individuals who become at risk of disruption in or loss of their living arrangement prior to, or at some point after, receiving crisis services;
- Individuals with a dual diagnosis of a developmental disability and a mental health disorder;

⁴ See, e.g., Disparities Funds Program, <https://www.dds.ca.gov/rc/disparities/disparity-funds-program>.

- Individuals with an intellectual or other developmental disability who are likely to develop early onset Alzheimer's disease;
- Individuals involved with the criminal justice system; and
- Other individuals whose indicators of a developing crisis are not captured by system databases.

The Safety Net Workgroup of the Department's Developmental Services Task Force will continue to discuss these data needs and recommendations, including determining information and data that may currently be available through RCs, and identifying additional types of data that should be further explored.

III.

UPDATES ON 2017 SAFETY NET PLAN INITIATIVES

Since the release of the May 2017 safety net plan the Department has developed and implemented, or is in the process of developing, numerous projects providing acute crisis and other safety net services. What follows is a status update on these projects as of December 2019.

A. Stabilization, Training, Assistance and Reintegration (STAR) Program

The state-operated STAR homes provide individuals experiencing an acute crisis with person-centered support and crisis stabilization on a time-limited basis to enable them to successfully return home or transition to more appropriate, less restrictive living settings. Services are provided based on an individualized Needs and Services Plan (NSP), which is developed through a team approach using person-centered practices supporting the individual's positive control and self-determination. Depending on the supports identified in the NSP, services may include health care, education, work training, employment, self-help training, leisure activities, behavior management, and socialization skills development.

North STAR: One home opened in April 2019 in the North Bay Regional Center (NBRC) geographic area, a second home is opening in Winter 2019-20, and a third home is in process. The three homes will have a combined capacity to serve 14 individuals. Regional Center of the East Bay (RCEB) is facilitating the development of the homes. Two of the homes are licensed Community Crisis Homes (CCHs) for up to five adults. The third home will be licensed as an Enhanced Behavioral Supports Home (EBSH) or a CCH serving up to four children and adolescents, with a projected service date of Summer 2020.

South STAR: Two CCHs, each serving up to five adults, are being developed, with a projected service date of Summer 2020.

Canyon Springs – Desert STAR (temporary): Since September 28, 2018, pursuant to SB 175 (McGuire, Chapter 884, Statutes of 2018), DDS has authority to accept court admissions of individuals experiencing an acute crisis to a separate and distinct unit of the state-operated Canyon Springs Community Facility, operating as a STAR unit to serve up to 10 individuals. These judicial admissions may be made until June 30, 2021.

Central STAR: CVRC is facilitating the development of one CCH for five adults and one CCH or EBSH for four children and adolescents with projected service dates of Fall 2020. Pending development of the home for children and adolescents, two temporary acute crisis residences—one for five adolescents and one for five adults—are to be

located on the grounds of Porterville DC. (The residence for adolescents opened in December 2019.)

B. STAR Crisis Assessment Stabilization Team (CAST)

CASTs are state-operated mobile crisis services, housed at the North and South STAR, providing partnerships, assessments, training and support to individuals continuing to experience crises after RCs have exhausted all other available crisis services in their catchment areas and who are at risk of having to move from their own or family home or from an out-of-home placement to a more restrictive setting.

CAST began accepting referrals in January 2018. North CAST is currently serving NBRC, Alta California Regional Center (ACRC), and RCEB. South CAST is serving Inland Regional Center (IRC), Regional Center of Orange County (RCOC), San Diego Regional Center (SDRC), and San Gabriel/Pomona Regional Center (SGPRC). Each CAST has the capacity to manage up to ten individuals at a time. As of early December 2019, there were 86 CAST referrals. A third CAST, to be housed at the Central STAR, is expected to provide services in the early spring of 2020.

C. Porterville DC Secure Treatment Program (STP) Step-Down Homes

CVRC is developing three step-down homes, with delayed egress, to support individuals transitioning to the community from the Porterville DC STP who need intensive supports and services prior to transitioning to more permanent housing. These homes, which will be operated by Liberty Healthcare, include one four-person CCH, projected to begin providing services in Winter 2019-20, and two four-person CCHs with projected service dates of Summer 2020. Pre-transition activities are a key element of this service.

D. Porterville DC STP Intensive Individualized Transition Support Services

Intensive individualized transition support services are provided statewide to individuals moving from the Porterville DC STP. These services include pre-transition risk assessment, assistance with in-depth planning utilizing person-centered practices, environmental assessments of the community home, and consultation and/or direct services before, during and after transition to the community for intensive forensic, behavioral, and psychiatric support.

Liberty Healthcare began providing these services in November 2018. As of early December 2019, Liberty had 16 active cases, with an additional 15 completed risk assessments and three new referrals.

E. Institutions for Mental Disease (IMD) Step-Down Homes

IMDs are highly restrictive psychiatric facilities that do not typically provide person-centered services for individuals with developmental disabilities and co-occurring psychiatric disabilities. For this reason, current law places defined restrictions and time limitations on the purchase of IMD residential services by RCs. (E.g., W&I Code § 4648(a)(9)(C).) DDS holds monthly calls with RCs to discuss the status of transition planning for individuals residing in IMDs.

IMD step-down homes support individuals transitioning into the community from IMDs who need intensive supports and services prior to transitioning to a more permanent living arrangement. These homes are licensed and certified as CCHs, providing services for up to four individuals. One home has been providing services in the ACRC area since May 2019. Three additional homes—one in the FNRC area and two in the SGPRC area—have projected service dates in Winter 2019-20.

F. IMD Intensive Individualized Transition Services

IMD intensive individualized transition services are provided to support individuals before, during, and after transition from an IMD into a community home, or individuals at risk of being placed in an IMD. Services include: Pre-transition risk assessment, assistance with individualized planning using person-centered practices, environmental assessments of the community home, and consultation to residential providers for intensive behavioral and psychiatric supports.

Through ACRC and SGPRC, Merakey is the statewide provider of IMD intensive individualized transition services. Merakey began providing these services in October 2018. In Northern California, as of early December 2019, Merakey had 11 active cases, most of whom have transitioned to the community and are receiving wrap-around supports. In Southern California, Merakey had 13 active cases, most of whom have likewise transitioned to the community and are receiving wrap-around supports.

IV. DEVELOPMENT OF THE UPDATED PLAN: STAKEHOLDER INVOLVEMENT

Stakeholder discussions on safety net services have continued since issuance of the May 2017 safety net plan, involving families, local providers, clinicians, advocates, and RCs. Recent discussions have broadened to examine services and supports to meet the needs of all community members, at all levels of need.

The Department's Developmental Services Task Force—which includes broad representation by consumers, family members, advocates, RCs, service providers, clinicians, and legislative staff—has engaged in frequent discussions of the safety net. These stakeholder discussions will continue within the Task Force and the Task Force's recently expanded Safety Net Workgroup, which held its first meeting on December 12, 2019.

Initial input from stakeholders, including the Safety Net Workgroup, supports several common themes and goals that guide new plans and initiatives for the safety net and models of care, including:

- Providing a continuum of services across the lifespan;
- Utilizing person-centered practices in identifying individualized services and supports;
- Addressing the early point of entry into crisis services and preventive/pre-crisis interventions;
- Meeting the needs of a changing population (e.g., non-DC residents with complex needs, growing caseload of younger individuals and adults with Autism Spectrum Disorder);
- Ensuring culturally competent services and supports for an increasingly diverse population;
- Building the expertise and capacity of generic services professionals and emergency responders; and
- Applying the principles of trauma-informed care in the provision of safety net services.

Summary of recommendations obtained from stakeholder meetings:

Increase community capacity

- Prioritize crisis services in the allocation of community resource development funding.
- Increase capacity for long-term residential placements, with educational components, and short-term stabilization placements for youth and adults with co-occurring needs.
- Develop crisis and stabilization services and supports for children and adolescents with developmental disabilities, including a focus on children who are dependents or wards of the court.
- Identify individuals at risk for crisis; offer preventive or early-crisis intervention supports and services to reduce potential trauma and break the cycle of crisis and reliance on highly restrictive interventions or residential placements.

Work with community partners

- Identify opportunities for training of mental health clinicians, health care professionals, direct support professionals, first responders, etc. on developmental disabilities and co-occurring conditions and/or challenging behaviors.
- Explore opportunities to encourage and support professional educational curricula for medical, nursing, mental health, behavioral, and other professional disciplines that include the development of expertise, and career paths, focusing on providing services to individuals with developmental disabilities.
- Increase collaboration and communication among community partners (including RCs, county mental health, special education, clinicians, service providers, local law enforcement, etc.) to build capacity, share resources, and improve access to services.
- Provide training for first responders.
- Share information on best practices, including stories from other states, on what is working well.

Improve access to services

- Work with generic service providers (e.g., transportation, medical/dental, mental health) to enhance competencies that enable them to better serve individuals with developmental disabilities.

- Enhance cultural competencies and linguistic diversity among providers and professionals providing services and supports to consumers and families.
- Increase coordinated outreach and trainings to families and caregivers, particularly from underserved racial/ethnic, language, geographical (e.g., rural), and disability (e.g., deaf and hard of hearing) communities, on accessing services and supports, and navigating the system.

The Department's goal, in collaboration with the RCs and stakeholders, is to continue to evaluate and develop a continuum of safety net services and increase capacity to support individuals with developmental disabilities in the most integrated setting, consistent with the principles and vision of the Lanterman Act.

V. RECENT INITIATIVES AND MODELS OF CARE TO MEET THE NEEDS OF INDIVIDUALS LIVING IN THE COMMUNITY

The Department is developing safety net services that are fluid and dynamic, with access points meeting the needs of consumers and families regardless of their required level of intervention. This dynamic continuum begins with preventive interventions and specialized wrap-around services and supports by providing consumers, families, professionals and direct support staff the tools, skills, and interventions needed to quickly and effectively prevent, identify, and deescalate crises.

By developing a framework for the crisis prevention and intervention continuum and expanding its capacity, consumers and those providing them with support will be able to access and move through the continuum in a fluid manner, receiving tailored, appropriate levels of intervention and support regardless of their entry point. DDS, in collaboration with stakeholders, is continuing to identify and address gaps in the community safety net system of services and supports.

Since issuance of the 2017 safety net plan, safety net services and supports have been a priority for the utilization of CPP/CRDP funds. New and proposed safety net initiatives include the following:

A. Community Crisis Homes for Children

The 2014-15 developmental services budget trailer bill, SB 856 (Chapter 30, Statutes of 2014), authorized the Department, utilizing CPP funds, to establish and certify CCHs, licensed as adult residential facilities by the Department of Social Services. (W&I Code §§ 4698-4698.1) RCs, families, and community stakeholders identified a continuing need in the safety net, however: Community crisis homes for children and adolescents. SB 81, the 2019-20 developmental services budget trailer bill, addressed this need by amending the CCH statute to additionally authorize the certification of CCHs licensed as group homes, to serve children and adolescents.⁵ These homes will provide residential options for children and adolescents with developmental disabilities whose living arrangements are disrupted due to an acute crisis. This includes situations in which, due to the severity of a child's crisis or family situation, the child cannot remain in the

⁵ SB 81 also requires the Department, no later than March 1, 2020, to develop guidelines regarding the use of restraint or containment in CCHs, which must be maintained in the facility program plan and plan of operations. (W&I Code § 4698(d)(1).) As required by this provision, in developing the guidelines, the Department will consult with appropriate professionals regarding the use of restraint or containment in CCHs and the state's protection and advocacy agency (Disability Rights California) regarding appropriate safeguards for the protection of clients' rights.

family home until stabilization has been achieved. These homes will provide an alternative for individuals who have been admitted to, or are at risk of admission to highly restrictive settings, including state-operated acute crisis facilities, general acute hospitals, psychiatric hospitals, IMDs, or out-of-state placements. CCHs provide a short-term option to enable children and adolescents to achieve stability and to prepare them to return to their family home or other community living arrangement.

Four CCHs for children and adolescents with co-occurring mental health conditions will be developed through ACRC, RCEB, Valley Mountain Regional Center (VMRC), and SDRC. The 2019-20 budget included funding for the development of three of these facilities. In addition, two of the CCHs for children and adolescents were approved through CPP/CRDP proposals for SDRC and VMRC. The first of these CCHs is expected to begin providing services by March 2021.

Two additional CCHs for children and adolescents with co-occurring mental health conditions focused specifically on meeting the needs of youth in foster care will be developed through RCEB and SDRC. These two homes will provide a comprehensive model of care that includes person-centered, trauma-informed residential services, mental health and medical care, and educational services. Individualized services and supports will be provided through collaboration among service system partners, including the county child welfare agency, county mental health, the local education agency, and the regional center.

Working with the Department of Social Services, DDS is in the process of gathering stakeholder input and developing regulations governing CCHs for children and adolescents. The regulations will be issued, initially as emergency regulations, in early 2020.

B. Systemic, Therapeutic, Assessment, Resources & Treatment (START) Services

The START (Systemic, Therapeutic, Assessment, Resources, and Treatment) model is a comprehensive approach to the provision of crisis prevention and intervention services to people with developmental disabilities and co-occurring mental and behavioral health conditions. First established in 1988, START is designed as a lifespan service with the goal of improving diagnosis and treatment, supporting effective services, creating service linkages, promoting health and wellness for both the consumer and the caregiver, and decreasing the need for emergency services.

START provides person and family-centered, trauma-informed, multi-disciplinary, positive lifespan support for individuals ages six years and older. The model is evidence-based and utilizes a national database to provide feedback to stakeholders and to assess the effectiveness and efficiency of START services. The START model

places heavy emphasis on cultural and linguistic competency in all its approaches, practices and tools.

The Center for START Services provides training to local START teams, access to whole-person assessment tools, community education (training to community partners, and monthly local practice groups), technical and clinical support, data collection and management, and comprehensive and independent evaluation of the system of care.⁶ Local START teams are comprised of START coordinators, therapeutic coaches, team leads, a director, clinical director, and medical director. The local teams (coordinated by a contracted entity selected by the RC) provide 24-hour case coordination to improve supports and service outcomes. The teams also provide family, staff, and provider support and education through onsite or in-home therapeutic coaching. The teams conduct whole-person assessments and develop cross-system linkages (connecting developmental services providers, crisis teams, mental health providers, first responders, hospital staff, etc.).

Two California RCs—San Andreas Regional Center (SARC) and SDRC—began implementing START services for 99 individuals in December 2019.

C. Specialized Caseload Ratio for Consumers with Complex Needs

Family stakeholders have stressed the need for enhanced service coordination for families and consumers in crisis (or pending crisis) to: provide timely response to crises and post-crisis follow-up; serve as a knowledge base and liaison to other systems; hold more timely and frequent meetings; and expedite access to needed services. In response, and through the 2019-20 budget, SB 81 provides for a specialized RC service coordinator-to-consumer average ratio of 1 to 25 for all consumers with complex needs. For this purpose, a consumer with complex needs means an individual who is:

- 1) Receiving RC-funded mobile crisis services or has received those services within the past six months;
- 2) Receiving state-operated crisis assessment stabilization team services, or has received those services within the past six months;
- 3) Placed in a community crisis home;
- 4) Placed in an acute crisis home operated by the Department;
- 5) Placed in a locked psychiatric setting or a locked psychiatric setting in the past six months;
- 6) Placed in an IMD;

⁶ The Center for START Services website can be found at: <https://www.centerforstartservices.org/>.

- 7) Placed out of state as a result of appropriate services being unavailable within the state;
- 8) Placed in a county jail and eligible for diversion, or found incompetent to stand trial; or,
- 9) A person the Department has determined cannot be safely served in a DC.

The 1 to 25 ratio is authorized for up to 12 months after the consumer is no longer receiving the services described in (1) or (2), after the consumer is no longer placed in a facility described in (3) through (8), or after the Department has made the determination in (9), above. The regional center director is authorized to grant a one-time extension of these time limits of up to six months based on a new and complete comprehensive assessment of the consumer's needs. (W&I Code § 4640.6(c)(4).)

D. Children and Youth in the Child Welfare System: AB 2083 Implementation

Approximately 4,700 children and youth in the child welfare system receive services and supports from the RC system. AB 2083, enacted in 2018, requires each county to develop and implement a Memorandum of Understanding (MOU) outlining the roles and responsibilities of the various local entities serving children and youth in foster care who have experienced severe trauma. It is intended that system partners create a service plan defining how they will work together as an administrative team, as defined in the MOU, with collaborative authority over the interrelated child welfare, juvenile justice, education, developmental, and mental health children's services. The MOU will support the structure and processes of each partner agency and provide a framework to guide the operations, activities, decisions, and direction of each of the partner agency employees when planning with children, youth and families.

Additionally, AB 2083 calls for the Secretary of the California Health and Human Services Agency (CHHS) to establish a Joint Interagency Resolution Team with representatives from designated departments, including DDS, to provide guidance, support, and technical assistance to counties regarding trauma-informed care to foster children and youth served by multiple agencies. The identified mission of the Joint Interagency State Resolution Team is to: 1) Promote collaboration and communication across systems to meet the needs of children, youth and families; 2) support timely access to trauma-informed services for children and youth; and, 3) resolve technical assistance requests by counties and partner agencies, as requested, to meet the needs of children and youth.

In addition to the collaborative efforts with CHHS and state partners in the execution of the deliverables required by AB 2083, DDS is working closely with RC partners and community stakeholders in assessing and documenting current capacities and barriers to local service provisions for children and youth in foster care who have experienced severe trauma.

In partnership with RCs, DDS is working to identify opportunities to increase service and placement options and expand preventive and outreach opportunities for the professionals and families serving and supporting children and youth with developmental disabilities in the foster care system. Through ongoing engagement with RCs via technical assistance meetings, workshops and collaboration calls, and identifying data collection opportunities, DDS is better able to make informed, data driven, coordinated decisions to address the barriers and gaps in service and placement options experienced by these children and youth, their families, and the professionals coordinating and providing services.

VI. NEW GOVERNOR'S BUDGET PROPOSALS FOR THE SAFETY NET

A. Enhanced Caseload Ratios for Children Ages Three and Four

Issue: Often, navigating the service delivery system for families with young children can be difficult, particularly for those moving from Early Start to Lanterman Act services, or entering into the RC system. Families may need services from multiple entities (e.g., RCs, Medi-Cal or private health insurance, education). The complexity of multiple systems creates challenges for families in navigating and accessing needed supports.

Proposal: The Governor's proposed budget for FY 2020-21 includes ongoing \$16.5 million (\$11.2 million General Fund) to establish a 1 to 45 service coordinator to consumer caseload ratio to better assist families in accessing needed services and supports. Benefits include earlier RC service utilization and connection with other service delivery systems, which can prevent or reduce the need for long-term services. This is particularly true for communities of color or other underserved populations. Thus, this proposal is consistent with the Governor's initiative on improving early childhood development and will assist in mitigating inequity and service access issues.

B. Expansion of START

Issue: As discussed in Section V.B., *supra*, the START model is a comprehensive approach to the provision of crisis prevention and intervention services to people with developmental disabilities and co-occurring mental and behavioral health conditions.

Proposal: The Governor's proposed budget for FY 2020-21 includes one-time funding of \$4.5 million (\$2.6 million General Fund) to expand START to four additional RCs.

C. Enhanced Behavioral Supports Homes (EBSHs) with Secured Perimeters

Issue: EBSHs provide services and supports in a homelike setting to adults and children with developmental disabilities who need intensive services and supports due to challenging behaviors that cannot be managed in a community setting without the availability of such services and supports and who are at risk of institutionalization or out-of-state placement, or who are transitioning to the community from a developmental center, other state-operated residential facility, IMD, or out-of-state placement. (W&I Code § 4684.81.) In 2012, AB 1472 authorized licensed homes using delayed egress devices of the time delay type to install and utilize secured perimeters. (Health & Safety Code § 1531.15.) Placement in an EBSH with delayed egress devices and a secured perimeter requires an IPP team determination that the person lacks hazard awareness

and impulse control and requires the level of supervision afforded by a facility equipped with secured perimeters to avoid admission to, or continued placement in, a more restrictive setting.

EBSHs with delayed egress devices and secured perimeters enable many individuals placed in the STP at Porterville DC—particularly individuals who have been civilly committed pursuant to Welfare & Institutions Code Section 6500 et seq.—to transition to a less restrictive residential setting in the community. However, the community currently does not have capacity to provide such placements for the number of STP residents who could successfully make such a transition.

There are individuals charged with crimes who have been judicially determined to be incompetent to stand trial and are waiting in county jails for placement in the STP for competency training but are unable to receive these services because the STP is currently limited by statute to house no more than 211 individuals. An increase in the number of EBSH homes with delayed egress devices and secured perimeters will enable many current STP residents to more timely transition to less restrictive settings, and thereby reduce wait times for individuals in county jails to be admitted to the STP.

Proposal: The Governor’s proposed budget for 2020-21 includes \$7.5 million (General Fund) to develop five additional EBSHs with delayed egress devices and secured perimeters, which will support up to 20 individuals from the STP.

D. Temporary Expansion of the Porterville DC STP Population Limit

Issue/Proposal: As a further measure to address the number of individuals with developmental disabilities waiting in county jails for admission to the Porterville DC STP—and pending the development of additional community resources to facilitate the transition of STP residents to the community—the Department is proposing to temporarily increase the statutory population cap applicable to the STP by 20 individuals. As those community resources (e.g., EBSHs with secured perimeters) are developed, the STP population cap would be reduced back to the current level.

VII. CONCLUSION

The Department continues to engage with stakeholders in assessing the crisis and safety net needs of the individuals served by regional centers who are living in the community or who are transitioning from restrictive settings. The Developmental Services Task Force and Safety Net Workgroup will continue to discuss current trends, needs, and potential service strategies for individuals receiving regional center services, particularly children and adolescents who have developmental disabilities and co-occurring psychiatric diagnoses. In support of these efforts, the Department continues working with regional centers to expand the inventory of crisis services and develop additional resources to strengthen services in their local communities. Finally, the Department will continue to keep the community and the Legislature informed of these efforts and the progress being made, including through regularly scheduled legislative staff briefings and its Developmental Services Task Force Internet web page (<https://www.dds.ca.gov/initiatives/ds-task-force>).

VIII. ATTACHMENTS

1. Demographic Changes in the Regional Center System, FY 2008-09 to FY 2018-19
2. Growth in Lanterman Consumers by Diagnosis and Age, FY 2008-09 to 2018-19
3. Available Safety Net-Related Data

Attachment 1

**Demographic Changes in the Regional Center System,
FY 2008-09 to FY 2018-19**

Program Metric	FY 2008-09	FY 2017-18	FY 2018-19		Growth, 2008-09 to 2017-18	Growth, 2017-18 to 2018-19
Number of Individuals Served						
On January 1	237,000	326,000	347,000		38%	6%
FY Total Served	298,180	402,194	425,434		35%	6%
By Age Group*						
Birth to 2 Years	62,242	83,263	91,497		34%	10%
3 to 10 Years	68,567	92,997	99,017		36%	6%
11 to 17 Years	41,666	55,870	58,664		34%	5%
18 to 21 Years	21,971	29,204	30,665		33%	5%
22 to 31 Years	36,015	56,612	58,852		57%	4%
32 to 59 Years	58,627	68,049	69,591		16%	2%
60 Years and Above	8,780	16,193	17,148		84%	6%
By Race/Ethnicity*						
African-American	27,497	33,701	34,936		23%	4%
Asian	23,785	35,887	37,711		51%	5%
Hispanic/Latino	105,903	160,487	169,933		52%	6%
Multiple Races/Ethnicities	4,146	11,835	13,231		185%	12%
Other	27,338	39,508	46,482		45%	18%
White	109,511	120,776	123,141		10%	2%
By Primary Language*						
Chinese	2,452	3,712	3,804		51%	2%
English	228,195	303,525	323,228		33%	6%
Spanish	56,936	81,116	84,348		42%	4%
Vietnamese	2,639	3,465	3,556		31%	3%
Other	7,646	10,370	10,498		36%	1%
Number of Consumers Served in Developmental Centers						
	2,330	618	349		-73%	-44%

* Data is for the population served over an entire fiscal year.

Sources: DDS enacted budget; DDS analysis of Client Master File; DDS Fact Book, and Quarterly Client Characteristics Reports as of November 2019.

Attachment 2

**Growth in Lanterman Consumers by Diagnosis and Age,
FY 2008-09 to FY 2018-19**

Diagnosis	FY 2008-09		FY 2018-19		Growth, 2008-09 to 2018-19
	Number	Age Group as Share of Total	Number	Age Group as Share of Total	
Intellectual Disability					
3 to 21 Years	69,665	44.3%	63,040	35.7%	-9.5%
22 Years and Above	87,652	55.7%	113,560	64.3%	29.6%
Total	157,317	100.0%	176,600	100.0%	12.3%
Autism					
3 to 21 Years	44,633	86.0%	96,526	80.5%	116.3%
22 Years and Above	7,257	14.0%	23,453	19.5%	223.2%
Total	51,890	100.0%	119,979	100.0%	131.2%
Epilepsy					
3 to 21 Years	15,879	38.3%	11,165	27.6%	-29.7%
22 Years and Above	25,602	61.7%	29,354	72.4%	14.7%
Total	41,481	100.0%	40,519	100.0%	-2.3%
Cerebral Palsy					
3 to 21 Years	16,521	45.2%	12,649	33.9%	-23.4%
22 Years and Above	20,020	54.8%	24,618	66.1%	23.0%
Total	36,541	100.0%	37,267	100.0%	2.0%
5th Category					
3 to 21 Years	12,514	55.2%	15,101	48.2%	20.7%
22 Years and Above	10,162	44.8%	16,199	51.8%	59.4%
Total	22,776	100.0%	31,300	100.0%	37.4%

Note: Data is for the population age three and older served at any time during the fiscal year. (Few individuals under age three have a diagnosis.) Consumers may have more than one diagnosis.

Attachment 3

Available Safety Net-Related Data
Data Presented at Community Supports & Safety Net Services Meetings

• **Characteristics of Consumers by Residential Setting**

May include gender, age group, race/ethnicity, diagnosis, legal status, "target behaviors"

- Characteristics of Consumers Admitted to STAR Homes
- Characteristics of Consumers Referred but not Admitted to STAR Homes
- Characteristics of Consumers Living in Canyon Springs
- Characteristics of Consumers Living in Porterville DC - Secure Treatment Program (PDC-STP)
- Characteristics of Consumers Residing Out of State
- Characteristics of Consumers Admitted to Community Crisis Homes (CCH)
- Characteristics of Consumers Admitted to Enhanced Behavioral Support Homes (EBSH)
- Characteristics of Consumers Admitted to Enhanced Behavioral Support Homes with Delayed Egress/Secured Perimeter (EBSH with DE/SP)
- Characteristics of Consumers Admitted to Specialized Residential Facilities (SRF) with DE/SP
- Characteristics of Consumers Admitted to Institutes of Mental Disease (IMD)
- Characteristics of Consumers Admitted to Skilled Nursing Facilities (SNF)

• **Number of Consumers in Certain Residential Settings**

- Number of Individuals in Jail, Penal Facilities, and California Youth Authority by Regional Center and Calendar Year
- Involuntary Psychiatric Admissions per Special Incident Reports

• **Number of Consumers with Challenging Needs**

• **History of Consumers' Moves Among Residential Settings**

May include placement prior to admission and upon exit, length of stay, current placement

- Move History of Consumers Admitted to STAR Homes
- Move History of Consumers Referred but not Admitted to STAR Homes
- Move History of Consumers Admitted to Community Crisis Homes
- Move History of Consumers Admitted to Enhanced Behavioral Support Homes (EBSH)
- Move History of Consumers Admitted to Enhanced Behavioral Support Homes w DE/SP (EBSH)
- Move History of Consumers Admitted to Specialized Residential Facilities (SRF) with DE/SP
- Consumers Residing in IMDs by Length of Stay

• **Housing Development Overviews**

- Community Crisis Homes
- Homes with Delayed Egress/Secured Perimeter
- Adult Residential Facilities for Persons with Special Health Care Needs (ARFPSHN)
- Enhanced Behavioral Supports Homes
- New Models in Development and In Use
- Projected Service Dates for New Models of Homes Under Development