Kansas Legislative Research Department September 6, 1977

MINUTES

SPECIAL COMMITTEE ON WAYS AND MEANS - A

August 18, 1977

Morning Session

Chairman Wint Winter convened the Special Committee on Ways and Means - A at 9:00 a.m. In addition to Chairman Winter, the following members of the Committee were in attendance: Senator Billy McCray, Senator Joe Warren, Representative R.E. Arbuthnot, Representative Mike Hayden, Representative Rex Hoy, Representative Mike Glover, Representative Ruth Luzzati, and Representative Irving Niles. Staff members present were: Marlin Rein, Robert Epps, Louis Chabira, Chris Badger, and Norman Furse. Others who were in attendance are listed in Attachment No. I at the end of these minutes.

The Chairman announced that the Committee would consider Proposal No. 65, Community Mental Health and Retardation Facilities, and Proposal No. 66, State SRS Institutions and Programs.

The meeting began with a staff report summarizing data on SRS institutions and community facilities. Included in the data was information on patient terminations, admissions, population, bed capacity, staff/resident ratios, mental health/mental retardation quarterly reports, county mill levy rates, appropriations based on 1977 Senate Bill No. 30, and directories of community mental health centers and developmental disability services and facilities.

At the conclusion of the staff report, Representative Luzzati asked what a patient's average length of stay was at the state's mental health institutions. Mr. Epps of the Kansas Legislative Research Department staff indicated that the average length of stay was approximately 92 to 93 days. Representative Luzzati requested that staff supply to the Committee additional information which would show length of stay by patient group.

Chairman Winter introduced Dr. Robert Harder, Secretary of the Department of Social and Rehabilitation Services (SRS). Dr. Harder directed the Committee's attention to a report prepared by his department which summarizes the five-year plans that relate to operation of the state's mental institutions (see Attachment II). Included in the summary was a status report on mental health planning which Dr. Harder explained in some detail. He noted that future efforts would concentrate on providing evaluative and diagnostic services to persons under 25 years of age. In addition, Topeka State Hospital has eliminated 35 beds in its alcoholism treatment unit and a similar objective is being considered for Larned and Osawatomie State Hospitals. Larned State Hospital is expected to concentrate on treatment of assaultive and aggressive patients by adding 40 beds at the security hospital and 30 beds for the mentally retarded.

Senator Warren asked if the reduced effort in treatment of alcoholism could be attributed to a decline in the number of persons needing treatment. Dr. Harder explained that the reduced effort was more a result of increased local activity in the area of alcoholism treatment. As local centers became more numerous and proficient in the treatment of alcoholism, it has become possible for the state to gradually reduce and perhaps eventually eliminate its efforts in this area. Dr. Harder remarked that the state's financial involvement in the local treatment of alcoholism is relatively new. He noted that prior to FY 1974 no state funds had been devoted to alcoholism treatment, yet the commitment of state funds has exceeded $1 million in five years.

Senator McCray, in questioning the future of Title XX funding, noted what appeared to him to be a paradox in the funding of alcoholism treatments in that additional funds have been made available for the continuation of those programs, but many are being phased out. Dr. Harder responded by saying that new sources of funds are available, such as the recent increase in the liquor gallonage tax and the funding arrangements have undergone modifications because of the phasing out of Title XX funds. Dr. Harder said it would take time for the administrative details of substituting new sources of funding for the old to be worked out.

With respect to the reductions made in some programs in state hospitals, Senator Winter asked if that could be construed as an indication that the hospitals were inefficient in the performance of their tasks. Dr. Harder said he thought it was more a question of what the proper function of the hospitals should be. Senator Winter stated that he felt the state hospitals were already conducting local programs in the sense that they were local for those in need of such services in the area in which the hospitals were located. To replace these programs, he concluded, was the same as replacing one form of local program with another. Dr. Harder said he and his department had not taken a final position on this issue but were treating it as one that should ultimately be resolved by the Legislature.

Senator Warren said he thought it was unusual that operational costs have continued to rise even with a reduction in the number of programs, particularly at the local level. He suggested that responsibility for the operation of certain programs be retained by the state if costs could be kept down by doing so. Dr. Harder responded by saying that a number of local programs were in fact less expensive to operate than they would be if the state administered them but, in any case, patients have a virtually unrestricted choice as to where they may seek treatment and the state is obliged to pay the costs through its established policy of supporting local programs.

Commenting on judicial authority to commit persons in need of treatment to institutions, Representative Glover expressed some reservations about any changes of major consequence in current programs. He noted the importance of maintaining the confidence of judges in the quality of programs in institutions. Dr. Harder made reference to a publication entitled 16 Indices which concerns hospital standards and encouraged those who question whether standards are being maintained in the state's institutions to read it. He observed that Kansas ranks well above the national standard.

In reducing or eliminating several of its programs, Representative Luzzati questioned whether psychiatric trainees in the state's institutions would continue to receive sufficient variety in their training programs. Dr. Harder felt that training programs would actually be enriched by the changes planned and he described some of the opportunities that would still be available. Representative Luzzati suggested that the institutions might experience recruitment problems if programs became too specialized. Dr. Harder stated that the salary level for professional positions is the most critical element in the state's ability to recruit physicians. The veterans' hospitals are highly specialized, he said, but since the salaries there are considered adequate, these hospitals have fewer problems with recruiting quality staff.

Representative Glover suggested the possibility of raising the liquor gallonage tax to cover the loss of Title XX funds. Dr. Harder replied that another increase in the tax was unnecessary and programs would be continued at their present level of operation, although the transition to new funding would not be accomplished without some administrative problems.

Dr. Harder then described the efforts of his department in dealing with the problems of the developmentally disabled. He submitted a status report on "Project Interweave" (see Attachment III) and reviewed portions of it with the Committee.

Senator Warren inquired about the method by which federal funds are distributed. Dr. Harder specified that approximately $500,000 has been made available for aid to the developmentally disabled, of which $200,000 is used for paying state expenses to administer the program while the rest is used to support local programs and is distributed on a grant basis. Senator Warren further inquired how

coordination between state and local programs worked. Dr. Harder said it was accomplished essentially by mutual cooperation and compromise.

In observing the decline in population among the various SRS institutions, Representative Hayden suggested that maybe it was time to consider closing one of the facilities. Dr. Harder responded by saying that although some of the population decline can be attributed to a reduction in the number of certifiable beds, that was a possibility the Committee and the Legislature ought to consider and, further, that the manner in which he presented these statistics on population was intended to demonstrate that this problem needs to be addressed.

Senator Warren asked about the future of Winfield State Hospital. Dr. Harder said there was concern that the institution was destined for closure or reduced operation but that he, in a recent speech before a local audience, attempted to dispel those rumors.

Chairman Winter then introduced Mr. Brent Glazier of the Kansas Association for Retarded Citizens, Inc., the first of several conferees representing mental retardation services. Mr. Glazier made a brief statement to the Committee about the testimony to follow and then introduced Ms. Ethel May Miller of the same association.

Ms. Miller prefaced her remarks by saying she regretted that many of the community groups were viewed as being in competition with each other for state support instead of partners working toward a common goal. She expressed the belief, in response to a comment made earlier, that the mentally retarded have very little "freedom of choice" in the treatment they receive.

After indicating that she felt there was no significant overlapping in state and local programs, Ms. Miller reviewed the efforts at both levels -- primarily in the areas of medical service, crisis care, pre-school and child development, vocational rehabilitation, and research -- pointing out the differences between state and local programs. She indicated that state programs were advantaged by greater flexibility in staff scheduling, more adequate medical and nursing service, and better physical facilities. Local programs had the advantage of prompt and direct assistance, more variety in programming, and greater parental participation because of their physical proximity to the location in which the programs are administered.

Ms. Miller also noted several similarities in the efforts to provide assistance in the areas of mental health and mental retardation. State assistance in both areas, for example, is based on the same statutory authority; they are administered by the same state agency; non-state funding support for both is approximately equal; both have approximately the same number of licensed community centers; and operating expenditures are comparable. In the course of her remarks, which included statistics on the current birth rate of the mentally retarded, Ms. Miller distributed to members of the Committee a summary of her association's comparisons between state and local programs. (See Attachment IV.)

In concluding her remarks, Ms. Miller recommended that 1977 Senate Bill No. 30 be changed to convert the state aid formula so that community-based facilities would receive no less than 50 percent of adjusted income. In her opinion, such a change would give due recognition to the fact that local efforts to support local progams includes such funding sources as private donations. Moreover, she contended that it also serves as protection against dependency on federal and state support.

Chairman Winter introduced Ms. Joan Strickler of Kansas Advocacy and Protective Services for the Developmentally Disabled. She felt that some of the problems facing local programs for the developmentally disabled occurred as a result of too rapid development of such local programs in replacing state programs that were being phased out before the local ones had become fully operational. She also identified as a problem what seemed to her to have been an undue burden on local program support by making the matching requirement of Title XX funds a local match instead of a state one. She felt that local programs are only "surviving" at the present time on a rather meager subsistence of state and federal funds. In concluding, Ms. Strickler reaffirmed her support for community-based programs which, she noted, have been endorsed by three U.S. presidents.

The Committee recessed until 1:30 p.m.

Afternoon Session

Chairman Winter reconvened the meeting at 1:30 p.m.

Mr. Bob Smith, representing the Kansas Association of Rehabilitation Facilities (KARF), appeared before the Committee. With him to present accompanying testimony were Mr. Don Schreiner and Mr. Abe Hussein. Mr. Smith passed out written testimony. A summary of that testimony is as follows. (That handout is attached.)

In 1973 Kansas made an effort to move people from state institutions to the community. The services involved are based upon three basic principles:

1. That developmental disabilities services should be provided in most normalizing and least restrictive environment;
2. That such services should be accredited as soon as possible by national accreditation agencies; and
3. That services should be provided for the severely mentally handicapped and the severely developmentally disabled.

Page 2 of the handout, No. 3, provides a definition of developmentally disabled.

The handout goes on to maintain that a lack of planning and inadequate funding could cause the return of more than 300 Kansans to state-operated institutions for the mentally retarded.

The remainder of the testimony centered on some of the services provided on the local level, and some of the obstacles to the expansion of these services. It then went on to propose specific recommendations. The services discussed include children's services, residential services, and adult work/training services.

The report recommends the Legislature mandate measures and procedures to ensure commitment to a community-based comprehensive service system and to designate and empower a developmental disability planning authority. The goals of the proposed agency are outlined in the attached supplement. The testimony asked for supplemental funds to be available in FY 1978.

The report also recommended the use of Title XIX funds for certain residential facilities, shifting certain foster care services from Title XX to Title IV-A, having state funds assume administrative and indirect costs, setting aside Title XX funds for services for mentally retarded and disabled children, and having the state pay the match required for Title XX.

Mr. Schreiner and Mr. Hussein also provided brief, related testimonies.

Senator Warren asked Mr. Smith where the proposed developmental disability planning authority would fit in the system. Mr. Smith responded by saying that placement and responsibility of the planning authority would have to be worked out.

Mrs. Suzanne Woods from the Kansas Developmental Disabilities Council appeared before the Committee on behalf of the Council. Her one-page statement is attached, together with a table showing the computed population of the developmentally disabled by age group, type of disability, number served, and number projected to be served.

Representative Luzzati asked Mrs. Woods what process was used to administer the grants from federal funds. Bob Epps replied that the federal funds are appropriated through the state budget process with the Developmental Disabilities Council making the actual grant awards to qualified applicants.

Representative Arbuthnot asked what proportion of the funds were spent on administrative costs. Secretary Harder said that approximately one-half of the money was used to administer the program.

The Committee then switched to a discussion of community mental health services. Mr. Robert Blake, representing the Association of Directors of Community Mental Health Centers of Kansas, provided a handout and gave introductory remarks, stating his belief that there is a need for a shift in financial resources to accompany the movement of patients from the state hospitals to the community mental health and mental retardation centers.

Chairman Winter objected to the comparison of funding levels for community mental health centers and state mental hospitals. Mr. Blake responded that he simply wanted to point out the disproportion in funding. Chairman Winter directed Mr. Blake to proceed with his testimony.

Mr. Blake continued, comparing the number of patient admissions, cost per admission, and percent of patients treated. He went on to discuss prevention programs by the community mental health centers and the social advantages of community-based programs. His written testimony and corresponding graph sheet are attached.

Chairman Winter opened the floor to questions.

Representative Hayden asked Mr. Blake for his personal opinion of the projected closing of the adult outpatient program at Topeka State Hospital. Mr. Blake said that the closing represents a shifting of programs to meet a particular crisis and that it is a local problem, not a state-wide problem.

Chairman Winter asked Mr. Blake to answer the same question in his "official" capacity. Mr. Blake said that the closing might cause a great burden on Shawnee County because of the sheer number of patients. He said that Topeka has a unique problem because there is a large influx of people to use treatment facilities at the Veterans Administration Hospital or Topeka State Hospital, and that many of those people tend to continue to use the outpatient program after their release from the two hospitals (i.e. Topeka has a disproportionate number of mental patients).

Ms. Marian Vernon, representing the Mental Health Association in Kansas, passed out a one-page handout and read her request that the Committee authorize an in-depth study of the funding for the community mental health centers and out-of-state institutions so that Kansas can provide the best mental health services for the least dollars.

Chairman Winter said he felt that there would be no problem in the Committee granting her request.

Mr. Ben Farney, Chairman of the Kansas Citizens' Committee on Alcohol Abuse, addressed the Committee. Mr. Farney criticized the fact that Title XX funding for community mental health alcohol treatment programs has been reduced. He stated that community mental health programs are an integral part of the total alcohol treatment program and said he felt there was a need to assist and encourage mental health programs to expand services.

Secretary Harder responded to the criticism by saying that while it was true that Title XX funds had been reduced, other sources of funds are now available to fund such programs.

Mr. Farney addressed the proposal in the summary of the five-year plan to reduce the number of beds for alcoholism treatment at the Osawatomie State Hospital. Mr. Farney maintained that the proposed bed reduction had never been discussed publicly, despite a recent Citizens' Committee on Alcohol Abuse meeting in Wichita which specifically addressed the possibility of bed reductions in state hospitals. Secretary Harder responded by saying that one cannot discuss adequately the possibility of closing one hospital unit without discussing all three. Secretary Harder stated that all three must be discussed to make specific recommendations on programs.

Mr. Farney went on to state that alcoholism can be treated successfully at local units and that he would recommend contracting with private alcoholism treatment facilities to administer the local programs, but said that such contracts for services required planning is not existent in the present program. He stated that there is currently much instability in the planning for programming.

Mr. Farney said that $263,000 of federal funds for the purpose of decriminalization of alcoholism would be available to provide conversion from criminal to medical treatment. The money is available for the next six years. The Department of Social and Rehabilitation Services, however, is waiting for an Attorney General's Opinion on the issue of Kansas compliance with the Federal Uniform Alcoholism and Intoxification Treatment Act. That opinion must accompany the grant application.

Mr. Farney said that there was currently no program for the expenditures of the liquor gallonage tax.

Chairman Winter asked for questions. There were none, which completed the regular agenda.

The Committee then moved into a discussion on the current status of the Osteopathic Aid Bill passed by the 1977 Legislative Session.

Dr. Joe McFarland, Academic Officer of the Board of Regents, and Dr. John Conard, Executive Secretary of the Board, appeared before the Committee.

Chairman Winter requested that Dr. McFarland bring the Committee up-to-date on the status of the bill. Dr. McFarland reviewed his last meeting with the Committee and said that the Board had tried to implement the Committee recommendation but that the Kansas City School of Osteopathic Medicine would not comply with the previous verbal agreement. Dr. McFarland stated that at this point there is no consensus on how to implement the bill.

Representative Hoy declared that the intent of the Committee was to buy ten slots above the current level. Representative Glover said that it was not possible to buy ten additional slots this year because of the school's interpretation of purchase of slots and the fact that 15 Kansans were admitted during the regular admissions process.

Representative Hayden stated the purpose of the bill was to increase the number of physicians in Kansas and that there was no need to underwrite the expenses of people already admitted to the school. He suggested that the Board proceed to implement the bill, notwithstanding the fact that only 15 students were admitted and that the 1978 Legislature could re-evaluate the program based on admissions for next fall.

Representative Glover asked how many Kansans were currently enrolled in the school. Dr. McFarland replied that there were 26 seniors from Kansas and 15 freshmen. Representative Hoy asked how many of the seniors are planning to return to Kansas. Dr. McFarland said that he did not know.

Chairman Winter asked Representative Hayden which part of the plan he wanted to proceed with. Representative Hayden stated that the Committee should proceed with both; that the Committee should send up a trial balloon and evaluate the results. After the results are evaluated, the Committee would wither abandon the program or aggressively expand it.

Representative Luzzati made the point that the money had been appropriated but that none had been expended to date. Representative Hayden said that the money was for the purpose of buying slots above the current enrollment. Chairman Winter stated that buying slots caused no obligation for the students to return to Kansas and that there is no point in paying $90,000 to get ten students into the freshman class when the Committee already has 15.

Representative Luzzati read the motion passed at the previous Committee meeting. Chairman Winter asked why the Committee's direction could not be carried out. Dr. McFarland indicated that the president of the school, Dr. Breman, refused to meet with him. Chairman Winter asked why Dr. Breman's position had changed.

Mr. Jim Maag stated that there had been a meeting recently between Dr. Breman, the Governor, Terry Whelan, and him. Ms. Whelan said that in the previous day's meeting with the Governor, a compromise had been reached which would result in the state paying the differences of $5,750 tuition and the cost of tuition at the University of Kansas Medical Center. The school, in turn, would reduce the tuition to such students to $1,150.

Mr. Maag said that the school has nothing to gain at the $1,150 level and that Dr. Breman would probably not guarantee ten slots at that price.

Mr. Rein pointed out that the bill is a student aid bill to get graduates to practice in Kansas and not like the purchase of slots for dental school students.

Representative Hoy asked where the Committee got the information to write the bill. Representative Hayden responded that the information had come from the school officials, but that the school has reneged on its part of the agreement.

Chairman Winter commented on the break in the good faith agreement and said that the Committee was not willing to change the intent of the law. Senator McCray asked if the motion made at the previous Committee meeting was not beyond the authority of the Committee.

Ms. Whelan testified that Dr. Cole had met with Dr. McFarland and said that the original agreement sounded good but that such agreement had not been approved by President Breman. Senator Warren asked how much each student pays. Ms. Whelan replied that it cost each student $5,750.

Representative Glover expressed his belief that the motion made at the previous Committee meeting was meaningless.

Chairman Winter asked Dr. Conard what action he suggested the Committee take. Dr. Conard replied that his intent was to inform the Committee that the bill had not been implemented at the present time but that he would be willing to go ahead with Dr. Breman's proposal if the Committee so directs.

Chairman Winter stated that it was the responsibility of the Governor and appropriate administrators to implement the law and that it was not the function of the Committee. Representative Glover said the previous meeting's motion could not be binding.

Chairman Winter said he believed the meeting should be adjourned. Representative Hayden said that the motion from the July Committee meeting was impossible to implement and moved to reconsider the motion. Representative Glover seconded the motion to rescind. Chairman Winter adjourned the meeting. The next meeting was set for September 8-9, 1977. September 8 will be devoted to testimony on Proposal No. 70 - Energy and September 9 will be for a review of the status of Title XX funds.

Prepared by Louis Chabira and Chris Badger

Approved by the Committee on:

10-10-77
(Date)

ATTACHMENT I

OTHERS IN ATTENDANCE

Name	Representing
Robert Blake	Association of Kansas Mental Health Centers Directors
Marion Vernon	Mental Health Association in Kansas
G.H. Miller	Topeka Association for Retarded Citizens
Brent Glazier	Kansas Association for Retarded Citizens
B. Sabol	Department of Social and Rehabilitation Services
Lauren Harrod	Department of Social and Rehabilitation Services
Hal Boyts	Johnson County Mental Health Center
Steve Solomon	Wyandotte Mental Health Center
Bernice Tapima	Shawnee Community Mental Health Corporation
Ruth C. Dickinson	State Planning and Research
Ed Stacey	Developmental Services of Northwest Kansas
Jim Bean	Tri-Valley Development Center, Inc., Humboldt
Dr. Robert Harder	Secretary, Department of Social and Rehabilitation Services
Jim Blume	Developmental Services of Northwest Kansas, Atwood
James H. Hays	Division of the Budget
Suzanne Woods	State Developmental Disabilities Council
Lyle Koerpen	Institute of Logopedics
Joan Stricklin	Kansas Advisory and Protective Services for the Developmentally Disabled
Benjamin F. Farney	KCCAAA
Ibrahim Hussein	Kansas Association of Rehabilitation Facilities
Bob Smith	Developmental Services of Northwest Kansas
Don Schreiner	Mid-Kansas Developmental Services, Newton
Jim Budde	Kansas University, Affiliated Family, Lawrence
Joe Keppy	Cerebral Palsy Research Foundation
Gene Headkick	United Cerebral Palsy of Kansas
Maurice Cummings	Reno Occupational Center
Joan E. Wasellowski	Kansas Association of Rehabilitation, Inc.

STATE OF KANSAS

ROBERT F. BENNETT, *Governor*

Attachment II

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

State Office Building

TOPEKA, KANSAS 66612

ROBERT C. HARDER, *Secretary*

February 22, 1977

Division of Vocational Rehabilitation

Division of Social Services

Division of Mental Health and Retardation

Division of Children and Youth

Division of Administrative Services

Alcohol and Drug Abuse Section

State Office Economic Opportunity

SUMMARY OF FIVE YEAR PLANS

State Hospitals

In the last ten years the average resident population in Kansas' three state hospitals has declined by 1,238 patients, or more than 50%. This decline continues today at the rate of 5.6%, or about 100 patients a year. The state hospitals served 5,665 inpatients and 2,258 outpatients during FY 1976, with an average resident population of 1,253 patients for the year. Over the last five years inpatient figures remained steady, outpatient figures declined. The hospitals admitted 3,952 people in FY 1976, 55% of these admissions were voluntary, 45% were not. Admissions have shown a marked annual increase over the last five years, but began to level off in FY 1975 and 1976. The rate of voluntary to involuntary admissions shows no decided trend, and it is yet too early to tell how Senate Bill 26 will affect these figures. A patients' average length of stay in the hospital has been cut in half since 1970. While average length of stay rose slightly in 1976, the trend continues to be toward shorter time spent in the hospital. Of those patients admitted in FY 1976, more than 70% stayed less than sixty days.

The state hospitals will become increasingly specialized as Kansas develops a comprehensive mental health service system. The comprehensive system idea means that each hospital will begin to emphasize its own unique program and services. Immediate plans call for Topeka State Hospital to concentrate on services to people under 25,

with special emphasis on evaluation and diagnosis. The hospital will add adolescent evaluation and diagnostic beds assuming these duties from the Youth Center at Atchison. The hospital will also add a new youth rehabilitation unit like those at Larned and Osawatomie, and will at the same time eliminate beds in the adult and alcoholism programs.

Larned State Hospital will continue its emphasis on security services for the assaultive or aggressive patient. The hospital will renovate two units, one of 30 beds the other of 40, to accomodate the backlog of mentally disordered offenders and aggressive mentally retarded who are a difficult problem for the rest of the SRS system. Larned will also eliminate beds from its medical, surgical, and alcoholism units. Osawatomie State Hospital will also eliminate beds from its alcoholism unit.

The state hospitals will continue to concentrate on short-term crisis intervention hospitalization for the seriously ill patient who requires a structured inpatient environment. Over the next three years the state hospitals will reduce their bed capacity by about 575 beds as their average resident population declines. They will also continue to move people as quickly as possible back to their home communities. The mental health delivery system will increasingly emphasize the growing network of community mental health centers. These centers provide individual, day-to-day support and counseling when and where it is needed without unnecessarily disrupting the individual's work or family life. Thus, the state hospitals will become resource institutions to which the community mental health centers may turn for specialized services and treatment.

SUMMARY TABLE FOR THE STATE HOSPITALS

January [illegible], 1977

SERVICE	PATIENT & BED CENSUS TYPE	LARNED STATE HOSPITAL	OSAWATOMIE STATE HOSPITAL	RAINBOW FACILITY	TOPEKA STATE HOSPITAL	ALL INSTITUTIONS	GAP	PROPOSED
Adult Services	Beds	153	217	20	235	625	None	Reduce Adult Beds at TSH by 35.
	Average	151 99%	181 83%	19 95%	173 74%	524 84%		
	High	162 106%	200 92%	30 150%	196 83%	588 94%		
	Low	132 86%	143 66%	12 60%	145 62%	432 69%		
Adolescent Services	Beds	46	108	10	103	267	See Summary Points.	Increase TSH by 35 Adolescent/Youth Beds.
	Average	38 83%	60 56%	7 70%	65 63%	170 64%		
	High	45 98%	82 76%	10 100%	87 85%	224 84%		
	Low	19 41%	41 38%	4 40%	40 39%	104 39%		
Children's Services	Beds	19	N/A	20	28	67	Evaluation Program for Pre-Adolescents.	Transfer to TSH Evaluation Procedures formerly done at YCAA.
	Average	15 79%		16 80%	22 79%	53 79%		
	High	18 95%		19 95%	25 89%	62 93%		
	Low	3 16%		13 65%	15 54%	31 46%		
Alcoholism (Substance Abuse) Services	Beds	35	71	10	38	154	Too many Alcoholic Beds.	FY-78 - TSH Reduce from 38 to 26 Beds. OSH Reduce by 10 Beds. LSH Reduce by 10 Beds.
	Average	24 69%	39 55%	9 90%	24 63%	96 62%		
	High	40 114%	54 76%	15 150%	31 82%	140 91%		
	Low	10 29%	19 27%	4 40%	14 37%	47 31%		
Medical/Surgical Services	Beds	60	52	N/A	19	131	Too many Medical Surgical Beds.	TSH - No Change. LSH - Reduce by 10 Beds. OSH - No Change.
	Average	42 70%	41 79%		11 58%	94 72%		
	High	50 83%	47 90%		16 84%	113 86%		
	Low	34 57%	38 73%		5 26%	77 59%		
Senior Citizen Services	Beds	N/A	36	N/A	N/A	36		
	Average		30 83%			30 83%		
	High		34 94%			34 94%		
	Low		26 72%			26 72%		
Security Services	Beds	121	N/A	N/A	20	141	More Security Beds Needed.	Increase LSH Security Capacity by two Wards, one 40-Bed Unit, one 30-Bed Unit.
	Average	99 82%			15 75%	114 81%		
	High	115 95%			18 90%	133 94%		
	Low	94 78%			9 45%	103 73%		
Youth Rehabilitation	Beds	30	61	N/A	N/A	91	More Beds Needed.	Establish a YRC at YCAA for 30 Beds. Establish a new 30-Bed Unit at TSH for Youth.
	Average	25 83%	26 43%			57 63%		
	High	31 103%	45 74%			70 77%		
	Low	7 23%	11 18%			18 20%		
Rehabilitation Unit	Beds	30	N/A	N/A	N/A	30		
	Average	14 47%				14 47%		
	High	20 67%				20 67%		
	Low	6 20%				6 20%		

N/A: Not Applicable

STATE OF KANSAS

ROBERT F. BENNETT, *Governor*

Attachment II

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February 22, 1977

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PROJE INTERWEAVE QUAN IED OBJECTIVES Attachment III

Goal and Objectives	Present Status	Implementer	Proposed Fund Source	Ti le
bGoal #1 - Develop and ordinate evaluation and se management services and sure that all D. D. persons ve an I.P.P.	Ongoing process			1982
Objective #1 - To assist in recruitment and employment of professionals to engage in diagnosis and evaluation.	The institutions already provide an array of professional skills. There is some community involvement but this effort needs to be expanded.	Three community D.D. centers and four state institutions	Local, state and federal funds	1982
Objective #2 - Expand information and referral by expanding staff in area offices and by contracting with private D. D. agencies.	Project FIND helped to locate and refer 1,006 DD children across the state in FY 1977.	Dept. of SRS	Local, state and federal funds	1979
Objective #3 - To establish statewide information and referral services through computerization.	A computer referral system is under development and should be operating by July 1, 1978.	SRS and Dept. of Education, and Dept. of Health	Federal SRS and education funds	1979
Objective #4 - To upgrade the statewide screening program for D. D.	EPSDT screened more than 14,000 children last year including many DD's.	SRS, Dept. of Education, and Dept. of Health	Federal SRS and education funds	1977
Objective #5 - To work with the Board of Regents to make maximum use of closed circuit TV and telenet.	Depends on proposed funding for the Public Broadcasting System in Kansas.	Board of Regents and SRS	Federal and state funds	1980
bGoal #2 - Develop comprensive education and aining programs.	These programs have been undertaken at all four institutions. There are also numerous community programs.			

PROJECT INTERWEAVE

QUANTIFIED OBJECTIVES

Goal and Objectives	Present Status	Implementer	Proposed Fund Source	Timetable
SubGoal #2 (continued)				
Objective #1 - Insure that all school-age D.D. in institutions are enrolled in public education classes.	On target. Date: September 1, 1978. Significant progress by September 1, 1977.			1978
Special Education enrollment (as of 6-1-77)	TSH 147 LSH 74 OSH 65 RU 60 PSH 242 KNI 282 WSH 100 YCAA 65 YCAB 85 YCAT 165	SRS and Dept. of Education	Federal education funds and state education and SRS and local education funds	1979
Objective #2 - That MH & RS assist in development of training and educational curriculums for preschool and adult staff.	SRS has agreed to a Special Training grant with K.U. The Division of MH and RS has a staff coordinator and two other contracts for training.	Div. of MH & RS	State and federal vocational education funds	1977
Objective #3 - MH & RS will develop and upgrade licensing standards and encourage all agencies to meet national accreditation standards.	A department wide team has been established to carry out this objective.	Div. of MH & RS	Local, state and federal funds	1982
Objective #4 - Establish and/or expand preschools	SRS has 62 child care centers now serving 671 DD children.	Dept. of SRS	D. D. funds, local, state and other federal funds	1982
Objective #5 - Establish and/or expand adult day training facilities.	Implementation of this objective is still rather limited. Two training facilities were opened in FY 1977.	Dept. of SRS	D. D. funds, local, state and other federal funds	1982

PROJEC INTERWEAVE QUANT IED OBJECTIVES

Goal and Objectives	Present Status	Implementer	Proposed Fund Source	Tim le
Goal #2 (continued)				
bjective #6 - SRS work ith federal and state gencies to assure sub-ontract work for D. D. enters and increased ublic job possibilities.	No action.	SRS	State	1980
Goal #3 - To have available ide variety of living angement programs for ldren and adults in each ion.	There are 991 resident facilities serving adults across the state: 79 of these with 747 beds serve adult DD clientele exclusively.			
bjective #1 - MH & RS meet ll standards in provision f institutional services ased on individual goals nd objectives.	On target.	Each institution	State and federal ICF/MR	1977
bjective #2 - SRS develop olicy of reviewing quality f treatment and care in ursing homes.	Four ICF/MR's were incorporated in FY 1977. The Department expects to add 300 additional beds in FY 1978.	SRS	Federal and state	1977
bjective #3 - Services be stablished for emotionally isturbed aggressive D.D.	Accomplished. These beds have been added at LSH effective 7-1-77.	Div. MH & RS	State and federal ICF/MR	1978
bjective #4 - SRS expand omemaker and chore services for families of D.D. children and semi-independent adults.	$2 million has been budgeted for home-maker chore services in FY 1978. More than 1500 disabled including DD clients were served in FY 1977.	Div. of Social Services of SRS	Federal and state	1978

OJECT INTERWEAVE QUANTIFIED OBJECTIVES

Goal and Objectives	Present Status	Implementer	Proposed Fund Source	Timetab
SubGoal #3 (continued)				
Objective #5 - SRS assist in development of 11 specialized living arrangements for D. D. children.	SRS now has 538 foster families and 4 facilities with a bed capacity of 249 which can serve the DD child.	SRS	Federal, state and local sources	1979
Objective #6 - SRS assist in development of 11 specialized living arrangements for D. D. adults.	See Subgoal #3.	SRS	Federal, state and local sources	1979
Objective #7 - SRS continue to assist agencies in removing architectural barriers.	SRS continues to offer on-going technical assistance.	SRS	Federal voc. rehab. funds and local funds	1982
Objective #8 - Reduce inpatient populations in each of the four institutions. PSH KNI WSH NSH	6-30-77 / By 1982 252 / 200 430 / 400 524 / 450 200 / 175 1406 / 1225	Div. MH & RS, each institution	None required	1982
Objective #9 - MH & RS plan for development of specialized programs for multi-handicapped child and/or adult.	Increasing numbers of multiply handicapped are being served at KNI and WSH.	Div. MH & RS	State and federal	1982
Objective #10 - SRS expands capabilities through development of special s[illegible]l service personnel in f[illegible]r homes and adoptive homes.	Special social service personnel is still an objective for the future. The department continues its on-going recruitment of foster and adoptive homes for the DD child.	Div. of Social Services of SRS	State and federal	1982

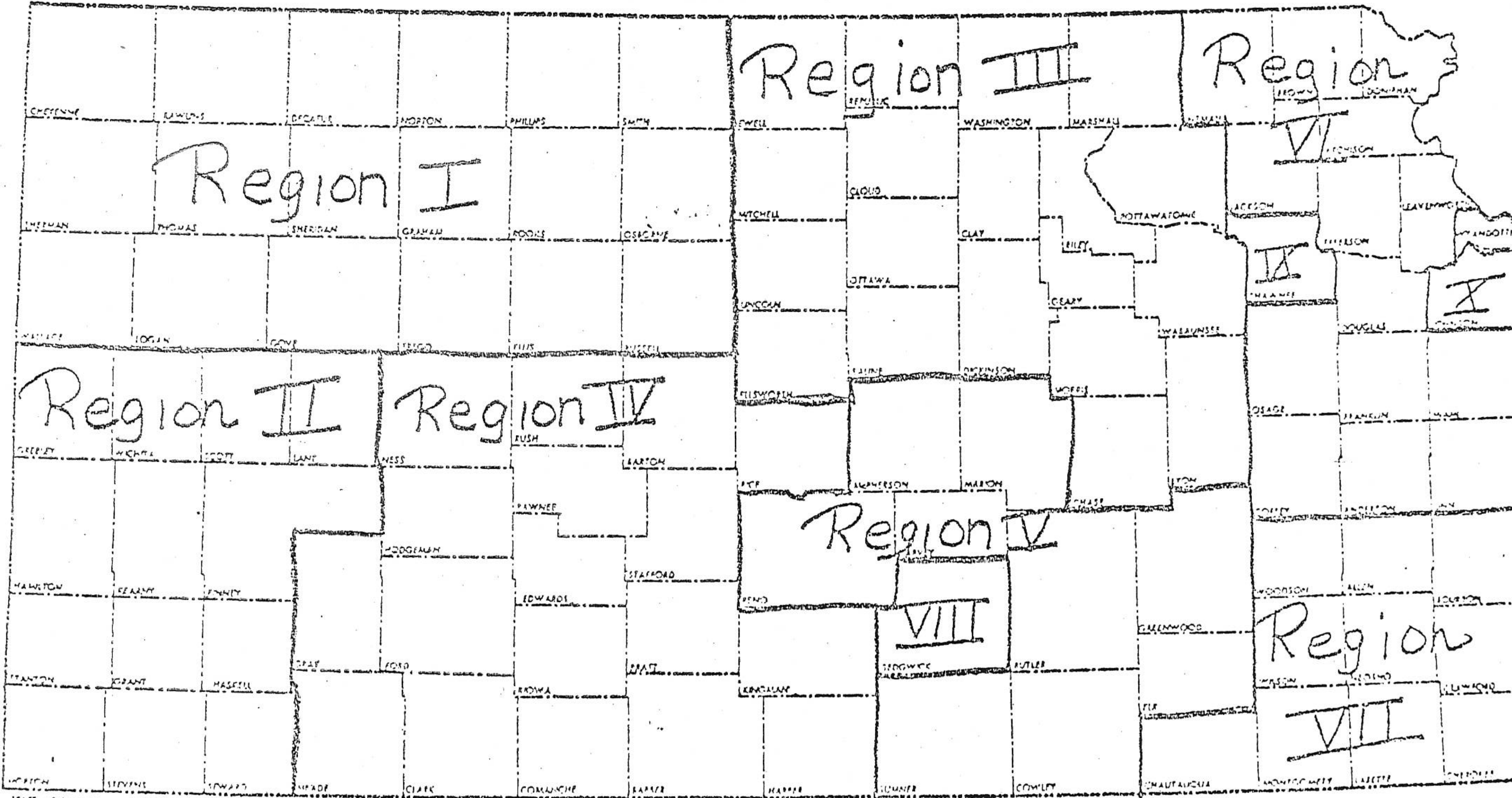
PROJE INTERWEAVE

QUAN IED OBJECTIVES

Goal and Objectives	Present Status	Implementer	Proposed Fund Source	T able
ubGoal #4 - SRS plan, oordinate and provide for upport services to D. D. eople and their families.	On-going.			1982
Objective #1 - Develop interdisciplinary teams for assessment and treatment of emotionally disturbed D. D.	No action.	Community mental health, D. D. community agencies along with all state institutions	Federal, state and lcoal	1980
Objective #2 - MH & RS conduct special training sessions on counseling with D. D. and his family.	The department will be moving to accomplish this objective in FY 1978.	Div. MH & RS	State and federal	1979
Objective #3 - MH & RS actively plan for transportation in rural as well as urban areas.	SRS signed contracts with 13 community agencies in FY 1976 worth $228,530 for transportation services to DD clients.	Dept. of Transportation and Dept. of SRS	Federal transportation funds and state and local funds	1978
Objective #4 - SRS plan for professional reviews to insure time-limited guardianship and conservatorship.	The governor and the department have agreed to the establishment of a Protection and Advocacy agency under a DD grant which will undertake these reviews.	SRS	State	1978
ubGoal # 5 - MH & RS continue o plan with and coordinate elivery of research and raining by Kansas Center on uman Development. Develop nd implement manpower raining model.	The department and the university hold regular on-going liaison meetings.	University of Kansas and Div. of MH & RS	State and federal	1982
SubGoal #6 - MH & RS continue o review and make information available on amounts and	On-going.	Div. of MH & RS	Federal and state	19,

DEVELOPMENTAL DISABILITIES REGIONS

KANSAS



Testimony on Proposal No. 65-66
Special Committee on Ways and Means-A
Senator Wint Winter, Chairman

Hearing August 18th, 1977
Prepared by:
Ethel May Miller, Volunteer
Kansas Assn. for Retarded Citizens
6100 Martway, Mission, Kansas 6620[illegible]

"Review of programming, staff, patient population trends, financing and relationships. . .offering services similar. . .including furthe consideration of the revised state aid formula proposed in S.B. 30." No. 65

"Review of the state SRS institutions to include an examination of the cost. . .an assessment of the relationship of institutional programs to community-based programs. . . .". No. 66

We appreciate having the opportunity of sharing with you several points we feel pertinent to the above studies. In doing so we hope to help clarify what we hope are viewed by you, other legislators, state administrators, and Kansas citizens (taxpayers all) as the mutually supportive roles of Mental Health and Mental Retardation Services, whether they be state institutions or community centers.

If we are recognized as partners rather than competitors, serving along side of, but not subservient to each other, solutions to our current plight may be seen more clearly and it is to that end that we are presenting our testimony in consortium efforts.

REVIEW OF PROGRAMMING AND STAFFING...ASSESSMENT OF RELATIONSHIPS...
RETARDATION

State Institutions and Community Centers for Retarded and Developmentally Disabled citizens offer essentially the same type of programming, with the same ultimate goals, those of enabling the individuals served to develop to higher levels of functioning and independence, preferably in or near the home community.

Admission to either the state institution or community center is not regarded as final, with the continuing goal to move the individual in accord with the fullfillment of the above purpose. The admission regulations of state institutions for retarded indicate how the two services, community and state institutions, are not duplicated or competitive:

> "Article 23. 30-23-3. PERSONS ELIGIBLE FOR ADMISSION TO . . . STATE INSTITUTIONS FOR THE MENTALLY RETARDED. Those mentally retarded persons whose needs are such that they cannot be met physically, emotionally, or financially by the natural, foster, boarding or other substitute family, and for whom appropriate community services are unavailable at the point in time at which admission is sought."

In other words, state institutions, while offering similar program content as those offered in community centers, are established to serve those who need the more structured 24-hour program and/or the medical and nursing services available at the state institutions, plus those from areas of the state where community services are not yet available (and probably won't be unless the funding base is clarified and stabilized.)

The admission regulations make it clear that it is not simply a matter of free choice, nor is it a matter of competition. It is and should be on the basis of individual need and what is, and is not available to meet those needs.

The following may serve to clarify the roles, while indicating areas of specialization in program content, based on needs of population served:

PROGRAM AREAS	STATE INSTITUTIONS	COMMUNITY CENTERS
Medical and Nursing Services	Usually by in-house medical and other clinical staff (except for surgery?)	Usually by contracted consultant service from community or regional resources, public and private.
Diagnosis and Evaluation	In conjunction with above, plus other in-house treatment team and parents if possible.	In conjunction with data from above, plus in-house treatment team and parents.
Crisis Care (Short-term emergency or unplanned absense of parent or guardian)	By in-house staff, available at at least one or two state institutions.	
Respite Care (short term planned absence, for those not requiring nursing care, nor having severe emotional-behavioral problems.)		Becoming available in or through community center services. Still *very* limited.
Counseling and Parent and Public Education	In-house staff	In-house staff and consultants.

PROGRAM AREAS	STATE INSTITUTIONS	COMMUNITY CENTERS
Individual Program Planning	In-house staff with parents where possible	In-house staff with parents, foster parents, or guardians.
Early Intervention-Infant Stimulation-Home Training	Infants not admitted, except if constant medical care required, then to Pediatric Unit at Winfield State Hospital and Training Center.	One of more rapidly developing program areas of most community centers.
Day Care		Usually included as part of Child Development and Pre-Schoo services. (Before an after school care fo children of working mothers.)
Pre-School and Child Development Program	Pre-school age usually not admitted, except as above. Program offered if such children in residence.	One of major areas o programming offered by community centers.
Special Education Program	Under special education mandate, if such programs are offered within either types of services, they are increasingly staffed and funded under contracted or cooperative arrangemen under public education auspices.	
Work Adjustment, Work Training, and Voc. Rehab. Programs	In-house staff	In-house staff
Sheltered Work and Extended Work Programs	Some offered for those in residence, considered more as training than as actually being employed. In-house staff.	In-house staff, plus extension into regular community settin Major area needing expansion.

PROGRAM AREAS	STATE INSTITUTIONS	COMMUNITY CENTERS
Personnel Training	Both types of services offer in-service training as well as serving as student practicum sites, points of visitation and observation, workshops and institutes, and similar types c personnel training services.	
Research	Grant funded staff	

Both types of services require most of the same type of staff...administrators, office,developmentalists, teachers, therapists, counselors, assistants (or aides), plus building and grounds maintenance

In summary, the major aspects more unique to state institutional program and staff services are:

1. Medical and nursing services.
2. Comprehensive diagnostic and evaluation services.
3. Crisis Care.
4. Twenty four hour shifts.
5. Laundry services.
6. Plant and building and maintenance and housekeeping service on larger scale than communities.

7. Research.

Aspects more unique to community center services are:

1. Early Intervention, Infant Stimulation, Home Training services.
2. Broader scale Work Adjustment, Sheltered Work, and Extended Work programs for adults.
3. Closer partnership of effort with parents and families, due more to proximity than to any basic difference in philosoph

An aspect of the relationships of state institutions for retarded to community centers which we believe needs clarification is that of th term "regional resource".

Reference is often made about state institutions "serving as regiona resource centers." We would like to ask if the state institutions fo retarded are serving as such regional resources and if so, which institution serves in such capacity for which region? What does that institution then actually offer as a regional center to that assign region, any different than they offer statewide?

The state of Kansas has acknowledged the equal validity of both community mental health and retardation services as follows:

1. The enabling legislation for partial state aid for communit mental health and mental retardation facilities is containe within the same statutes.

2. Both are administered under the same Mental Health and Mental Retardation Services of the same state department.

3. Accounts and records are filed quarterly on the same forms, with the same state department.

4. Both are generating near equal amounts of <u>local</u> support.

5. Costs of operation of both are nearly equal.

6. Both include nearly equal numbers of licensed centers.

REVIEW OF POPULATION TRENDS

The following indicates the actual and projected trend in average daily census of our state institutions. To be clarified is whether these figures are for actual 24-hour in-patient residents, or includ out-patients served fewer hours per day or week. (Attachment A.)

State Fiscal Year	Mental Health Institutions	Mental Retardation Institutions
1975	1,351	1,667
1976	1,253	1,515
1977	1,195	1,470
1978	1,297	1,400

Present state data does not have comparable figures of average daily census for community centers, but data available indicates the population trend of numbers served by Community Centers for Retarded as being 3,237 in 1975 to 4,707 in 1976 to projected 5,200 in 1977. These are numbers served usually on a daily basis, weekdays, for from six to eight hours per day each, with 1977 projections made prior to the recent Title XX cutbacks.

State institutions for retarded for the most part serve those ages approximately six or eight up, although with the special education mandate, those of public school-age should be constantly declining. It is probable, however, that for years to come the more severely and profoundly retarded citizens of all ages, plus those with severe emotional-behavioral problems, will continue to need our state institutional services with strong treatment components oriented toward enabling those individuals to develop to higher levels of functioning and independence.

Community Centers for Retarded serve those from infancy to public school age, and those over age 18, thus not duplicating public school services, except in a few areas of the state. With the special education mandate, plus what we trust are the ever improving quality of both special education and vocational rehabilitation services, the admissions or enrollments at community centers reflect a similar trend as state institutions in types of persons served. Community Centers are serving few if any public school age children, except for the more severely or profoundly retarded or multi-handicapped children, and then increasingly by contract with public school funding and staffing.

All services reflect what was forseen in the President's Panel on Mental Retardation Report of 1962: ". . .present experience suggests that requests for admissions of severely retarded are increasing not only in relative proportions,. . .but in absolute numbers. This latter is probably due to the increased survival of such severely retarded individuals due to improved medical care in the community." Today in Kansas we are still urging that social progress keep pace.

Admission to either state institutions or community centers, whether it be in the name of "project re-integration", "de-institutionalization", "normalization", or "least restrictive alternative" or any other popular term, can only be justified when there has been individual planning to determine both the initial suitability of the admission, and follow-along to assure the well-being of the individual is at least as well served in the new setting as in the old.

There is frequently cause for difference of opinion as to what is indeed in the best interest of a disabled person, but there should be no incentive, even incidental or accidental (i.e. shifting the tax burden) for placements which do not have that interest as their first justification!

REVIEW OF FINANCING

Our major concern to present to you is the decline in our state support of Mental Health and Mental Retardation Services in Kansas. Projected is a decrease in such support in the amount of over $5,500,000 for 1977 as was appropriated in 1976. (Attachment B.)

Although the figures are not fully comparable, since figures for state institutions are on the state fiscal year and those for community centers are on a calendar year, they do accurately reflect a trend of reduced state commitment.

While this trend is an obvious shift of the tax burden from state to local and federal, we not only question this maneuver but also wonder about "maintenance of state effort" as one of the requirements for eligibility for full utilization of federal funds, especially Title XIX.

The state's share of the operating costs of state institutions for both mentally ill and mentally retarded is decreasing as follows: (Attachment A.)

State Fiscal Year	M.H. Institutions	M.R. Institutions
1975	79%	76%
1976	80%	75%
1977	62%	58.5%
1978	57%	43%

Current Kansas Statutes Sec. 2, K.S.A. 1976 Supp. 65-4403 authorize that "each mental health center and each facility for the mentally retarded applying for state financial assistance shall receive assistance in an amount not to exceed fifty percent (50%) of the total estimated income of such mental health center or such facility for the mentally retarded." (Underlines ours.)

Instead, funds have been distributed on the basis of 50% of local income, with the pro-rated percent of state support being as follows (Attachment C.)

1. Percent of State Support to Local Income	1975	1976	1977
Mental Health Centers	27%	36%	39%
Mental Retard. Centers	8%	12%	18.5%
2. Percent of State Support to Total Income			
Mental Health Centers	8%	9%	9%
Mental Retard. Centers	2%	4%	4%
3. Percent of State Support to Total Operating Costs			
Mental Health Centers	6%	7%	8%
Mental Retard. Centers	2%	4%	4%

Realizing you will want verification of these summaries through the Legislative Research Department, we do urge that the Interim Study Committee give very careful consideration of these funding distributions.

Further, we urge that your study will result in a clear and definite commitment to the state's legislated responsibility for continued assumption of a dependable share of the tax burden for needed services for those who through no fault of their own, or their parents or families, are disadvantaged and disabled. Further, that your recommendations and action make it quite clear that it is not a matter of "either-or", nor one disability, or type of service, competing fo such state assistance, one against the other; but that in fact a strong state commitment will be restored and maintained in behalf of both, with neither "deserving most", nor being "best". . . all being entitled to an equalized share of continued state maintenance of effort in support of Mental Health and Mental Retardation services in Kansas.

REVISED FORMULA FOR DISTRIBUTION OF STATE AID- S.B. 30

We urge the Interim Study Committee to recommend revision of current statutes, or of S.B. 30 if it is to be considered, in order to establish a dependable, equalized share of state aid at 50% of adjusted actual income.

Under the present formula it has been our experience that most legislators assume the percent to mean a percent of the TOTAL income. Actually, under the distribution under the present statutes, the percent of state, local, and federal share of total income has been as follows: (Computed from figures, Attachment C.)

Mental Health Centers	State	Local (Public & Private)	Federal
1975	6%	22%	72%
1976	8%	23%	69%
1977	9%	24%	67%
Mental Retardation Centers			
1975	2%	28%	70%
1976	4%	36%	60%
1977	4.5%	24.5%	71%

(1977 projected prior to Title XX and Title XIX cutbacks for last half of year.)

Had the percent of state support been equalized at the 50% of total adjusted income such as we are all recommending, the following indicates what that sharing of responsibility between local, state, and federal would have been. (Computed from figures, Attachment D.)

Mental Health Centers	State	Local	Federal
1975	11%	23%	66%
1976	11%	23%	66%
1977	12%	24%	64%
Mental Retardation Centers			
1975	14%	28%	58%
1976	18%	36%	46%
1977	12%	24%	64%

To have obtained the preceeding percentage within the 1977 distribution, an additional $1,756,996. of state aid would have been appropriated for that year. The decrease in state maintenance of effort would have still been some $3,700,000 instead of the some $5,500,000 decrease made between 1976 and 1977. (as shown on Attachment B.)

We urge your recommendation of revising the statutes in such a manner as to establish that stable commitment of support at one half (50%) of total adjusted income, reminding you again that this means one half of local income, since state and federal funds are adjusted out of the total income before state aid is granted.

We believe this to be a reasonable balance! Such a formula would thus protect all from undue dependency on federal funds, and would, at the same time, maintain the major requirement for continuance of local effort, thus also preventing an undue dependency of community centers on state funds.

If we are indeed operating as a partnership of efforts, with the mutual sharing of responsibility, community and state, then authorizing a stable state percentage of commitment which can be counted upon is surely deserved for all concerned.

Attachment A.

STATE MENTAL HEALTH AND MENTAL RETARDATION INSTITUTIONS

THREE MENTAL HEALTH INSTITUTIONS

State Fiscal Year	Average Daily Census	Total Operating Expenses	State Gen. Revenue	Percent of State Support of Costs
1975	1,351	23,731,719	18,776,161	79%
1976	1,253	27,095,090	21,656,107	80%
1977	1,195	29,155,293	18,145,799	62%
1978	1,297	31,645,859	18,336,317	57%

FOUR MENTAL RETARDATION INSTITUTIONS

State Fiscal Year	Average Daily Census	Total Operating Expenses	State Gen. Revenue	Percent of State Support of Costs
1975	1,667	20,446,792	15,618,289	76%
1976	1,515	22,875,275	17,212,083	75%
1977	1,470	24,734,706	14,461,963	58.5%
1978	1,400	26,334,191	11,362,887	43%

Attachments A,B,C,D

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Computed from data from
Institutional Fiscal Section
Division of Administrative Services
State SRS Department, 7/25/77

Attachment A.

Attachment B.

STATE AND COMMUNITY MENTAL HEALTH AND MENTAL RETARDATION INSTITUTIONS AND COMMUNITY CENTERS

1975	Number	Total Oper. Costs	State Funds	Percent of State Support of Costs
State M.H. Institutions	3	23,731,719	18,776,161	79%
State M.R. Institutions	4	20,446,792	15,618,289	76%
Community M.H. Centers	24	15,246,267	924,400	6%
Community M.R. Centers	22	9,292,574	226,995	2%
TOTAL		68,717,352	35,545,845	
1976				
State M.H. Institutions	3	27,095,090	21,656,107	80%
State M.R. Institutions	4	22,875,275	17,212,083	75%
Community M.H. Centers	24	19,292,584	1,402,539	7%
Community M.R. Centers	22	9,798,104	396,502	4%
TOTAL		79,051,053	40,667,231	
1977 - Budgeted				
State M.H. Institutions	3	29,155,293	18,145,799	62%
State M.R. Institutions	4	24,734,706	14,461,963	58.5%
Community M.H. Centers	25	21,439,766	1,718,107	8%
Community M.R. Centers	22	17,159,980	758,965	4%
TOTAL		92,489,745	35,084,834	

Summary above reflects trend. Figures for State Institutions are based on state fiscal year and figures for Community Centers are based on calendar year.

Attachment B.

COMMUNITY MENTAL HEALTH AND MENTAL RETARDATION CENTERS

COMMUNITY MENTAL HEALTH CENTERS

Calendar Year	No. Elig. Centers	Total Income	Total Oper. Expenses	Local Elig. Income	State Support	To Local Elig. Income	PERCENT OF STATE SUPPORT	
							To Total Income	To Total Oper. Cost
1975	24	15,207,693	15,246,267	3,415,218	924,400	27%	6%	6%
1976	24	17,194,373	19,292,534	3,888,638	1,402,539	36%	8%	7%
* 1977	25	18,509,633	21,439,766	4,383,042	1,718,107	39%	9%	8%

COMMUNITY MENTAL RETARDATION CENTERS

Calendar Year	No. Elig. Centers	Total Income	Total Oper. Expenses	Local Elig. Income	State Support	To Local Elig. Income	To Total Income	To Total Oper. Cost
1975	22	9,540,934	9,160,860	2,656,160	226,995	8.5%	2%	2%
1976	22	9,292,574	9,798,104	3,344,523	396,523	12%	4%	4%
* 1977	22	16,795,089	17,159,980	4,085,095	758,965	18.5%	4.5%	4%

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* First half year actual, last half estimated.

Attachment C.

COMMUNITY MENTAL HEALTH AND MENTAL RETARDATION CENTERS
(Distribution Had Full State Funding Been Appropriated)

COMMUNITY MENTAL HEALTH CENTERS

Calendar Year	Total Income	Local Support	State Support	Federal Support
1975	15,207,693	3,415,218	1,707,609	10,084,866
1976	17,194,373	3,888,638	1,944,312	11,361,423
* 1977	18,509,633	4,383,042	2,191,521	11,935,070

COMMUNITY MENTAL RETARDATION CENTERS

Calendar Year	Total Income	Local Support	State Support	Federal Support
1975	9,540,934	2,656,160	1,328,080	5,556,694
1976	9,292,574	3,344,523	1,672,261	4,275,790
* 1977	16,795,089	4,085,095	2,042,547	10,667,447

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* First half year actual, last half estimated.

Attachment D.