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This Commonwealth's Commitment

"We have a choice: to plow new ground or let the weeds grow." Jonathan Westover

The Commission is deeply indebted to the following organizations for their generous contributions in making possible the publication of this report:

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The public service of the Museum of Modern Art and the two Richmond firms made it possible for the Commission to provide sufficient copies of its final report, in such a striking format, to interested individuals and groups throughout the Commonwealth.

This Commonwealth's Commitment

A study of mental, indigent and geriatric patients and the services and surroundings provided them by the Commonwealth of Virginia, with specific and general recommendations for improving their conditions for today and their hope for tomorrow

COMMONWEALTH OF VIRGINIA
COMMISSION ON MENTAL, INDIGENT AND GERIATRIC CARE

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To: THE GOVERNOR OF VIRGINIA
AND THE MEMBERS OF
THE GENERAL ASSEMBLY OF VIRGINIA

Gentlemen:

It is a pleasure to present to you the Report of the Commission on Mental, Indigent and Geriatric Patients, in compliance with Chapter 587 of the Acts of the 1968 General Assembly.

This report provides a blueprint for the future, keyed to Virginia's needs and resources, to give hope for the mentally ill and dignity to the aged.

In it are the first steps that must be taken in the coming biennium. It is addressed not only to your Excellency and the General Assembly but also to the people of Virginia in the confidence that, aware of the need, they will meet the challenge.

The Commission expresses its appreciation to the hundreds of individuals and organizations contributing invaluable advice and energy to our work and to the many local authorities who helped make the Commission's six public hearings so productive.

Respectfully submitted,

Omer L. Hirst
Chairman

THIS COMMONWEALTH'S COMMITMENT

In 1773, the first public mental hospital in the Western Hemisphere was opened in Williamsburg, Virginia and for many years thereafter, this Commonwealth was a leader in the field of care for the mentally ill. We are no longer in that position today.

In the decade of the 50's, Virginia was challenged with the problem of improving its highway system. That challenge was met. In the decade of the 60's, Virginia was challenged with the problem of improving its educational system. That challenge was met. Today we are challenged with the problems of the mentally ill and the aged. When will this challenge be met? Will the 70's be a new decade of decision? Will the full resources of this Commonwealth be marshalled to meet this need? Or will the cries of shame and suffering go unheeded? The choice rests with the people of Virginia!

This Report of the Commission on Mental, Indigent and Geriatric Patients, consists of eleven broad recommendations and subsequent sections of facts and figures substantiating the individual recommendations.

This study deals with the two very broad fields of mental health and the care of aged and indigent patients needing institutional care. These fields are closely interrelated because past policies have overloaded State hospitals with geriatric patients and have not encouraged alternative facilities for them. Six recommendations deal with the mental health system, three with geriatric and indigent patients and the last two cover both fields.

The recommendations for geriatric and indigent patients are not to be considered of a lesser importance or urgency for being listed second. Old age is the fate of almost all of us. Poverty-stricken, enfeebled, disoriented, childish old age is such a painful fate for us to contemplate that people have a tendency to turn away, to refuse to see its miseries. By using State hospitals as repositories for the aged, local communities have saved themselves not only money but the trouble of caring. It is time for our localities to assist in providing care for their old people in a humane and dignified way near home and relatives and friends. It is time to free the State hospitals to devote their resources to those patients young and old who need specialized psychiatric supervision.

With respect to the six recommendations on mental health, it should be pointed out that overriding the specific recommendations, and evolving from them, is a concept which the Commission is convinced is of paramount importance to any consideration of the Commission's Report. The essential ingredient in the improvement of Virginia's mental health services is the realization—and implementation—of a totally new direction and attitude. This concept has been eminently successful in many other states.

The concept, simply stated, is that the individual mental health programs must be seen as comprising a total package, rather than competing for priorities. The ultimate objective of this Report is to improve not only Virginia's mental hospitals and mental hygiene clinics and mental health centers, but to improve Virginia's *mental health services* and its services to the State's elder citizens who are not mentally ill, but nonetheless ill and in need of institutional care. To do so requires imagination, coordination and bold leadership; it requires appropriations; it requires a new direction. Some 250 years ago, Jonathan Westover wrote, "With land and with life, we have a choice—to plow new ground or let the weeds grow." Today, we no longer have that choice; we have let the weeds grow far too tall . . . and the hedgerows of inertia have hidden the horizons of initiative. We *must* plow new ground!

The Commission has tried to do so in this Report. It has reviewed the problems and the potential of the State hospitals; it has collected the facts and considered the futures of the community mental health centers; it has studied the services rendered our senior citizens; it has viewed with alarm—but not in panic—the increasingly difficult task of recruiting and retaining adequate manpower; but the primary concern has not been the pieces, but the package. At the risk of repetition, this Commission is convinced that the successful improvement of mental health services to both the mentally ill

and the less fortunate of Virginia's citizenry requires a total commitment to the concept of a coordinated system of care focused on the patient rather than the agency or institution.

This conviction is based not merely upon feelings, but upon facts and figures collected and discussed during the course of the following activities:

(1) Site visits to Lynchburg Training School, Eastern State Hospital, Western State Hospital, Southwestern State Hospital, Central State Hospital, and the Northern Institute of Mental Health;

(2) Monthly meetings of the Commission and special meetings of the three subcommittees;

(3) Discussions with agency heads and other professional representatives of the mental health services systems in the State;

(4) Collection of statistical and other relevant information from professional mental health literature and in meetings with experts in the field;

(5) Participation in public hearings in Richmond, Danville, Hampton, Arlington, Roanoke and Abingdon; and

(6) Consultation with the Commission's staff and the Division of State Planning and Community Affairs.

From these varied sources has come the inescapable conclusion that the task before us is both difficult and long. This Commission's Report provides a blueprint upon which we can build for the future—and it is designed so that the first steps can be taken today. But a blueprint is not a building. To bring these plans to actuality will require money—money to raise salaries, money to train manpower, money for buildings. To bring these plans to actuality will also require the determination of the citizens of Virginia to settle for nothing less than a total commitment to excellence. This commitment must be *actively* conveyed to the members of the General Assembly so that necessary appropriations may be made!

We believe the people and the Assembly will accept our challenge. We understand and they understand that a successful battle for life and health will cost money. No gimmick or magic reorganization chart will produce mental health and dignity for the elderly. The answer lies in new ideas, new programs and cold, hard cash. This must become the Commonwealth's commitment.

THE RECOMMENDATIONS

The Commission strongly urges the implementation of the following recommendations as the most viable approach to the solution of Virginia's mounting problems in the fields of mental, indigent and geriatric patient care. The eleven broad recommendations were compiled from the detailed reports submitted by the subcommittees on services to mental patients, services to geriatric patients and manpower and training. Each of the recommendations is presented in greater detail in subsequent sections of this Report, and substantiating data is contained in the appendices to the Report.

The recommendations are not necessarily listed in order of their importance. There are certain items of *immediate* need which are presented in the fourth section of this Report. However, the Commission again emphasizes that they must be considered as a whole, rather than as individual alternatives, if the total concept of mental, indigent and geriatric patient services is to be realized.

Toward that end, the Commission recommends:

I. Strengthening The State Hospital System.

That the State hospital system be strengthened through the following means:

A. Defining the responsibilities of the State hospital system more clearly, with program planning to provide care for the mentally ill in the most appropriate way, place and time in the course of illness.

B. Strengthening *services* through (1) improved staffing, (2) general service planning and development and (3) reorganization of specialized services to meet specific needs of special classes of patients.

C. Construction of new, *smaller hospitals* in major and growing population centers for the purposes of (1) providing a therapeutic patient environment, (2) bringing services closer to the patients and (3) enabling recruitment of professional and other staff from areas where they are more readily available. This program would be in lieu of the construction of any new or replacement beds at the four existing hospitals and enable them to gradually discontinue the use of substandard buildings.

D. Strengthening *community involvement* in the State hospital program.

II. Community Mental Health Services.

That the development of *community mental health services* be integrated into existing and planned hospital services by means of:

A. Facilitating continuity of care between State and community services through the future development of regional program administration on the basis of evolving need for service coordination as local programs develop and hospital services become a phase of *total* care.

B. Establishing a system of *local diagnostic screening services* for the purpose of avoiding inappropriate or unnecessary referrals to State hospitals.

C. Gradually developing alternative care plans in the community for hospitalized patients who could function adequately in settings other than a State hospital and would benefit from *community placement.*

D. Developing *community mental health centers* with federal construction and staffing grants to match State and local funds, to the extent that such facilities can be adequately staffed and supported.

E. Continuing support of existing mental hygiene clinics and extension of this program to new areas.

III. Psychiatric Institutes.

That psychiatric institutes be established in connection with the medical schools for the purposes of (1) training mental health personnel on doctoral, masters and undergraduate levels; (2) conducting basic and applied mental health research; (3) developing new patterns of manpower utilization; (4) providing leadership in developing new curricula for on-the-job training programs and teaching in such programs; and (5) providing patient care with responsibility to serve a specified geographic area, within the framework of their total objectives.

IV. Development of Manpower.

That the effort of strengthening a total State mental health service system be integrated into a manpower development program involving:

A. An Assistant Commissioner for manpower, training and recruitment to serve as coordinator between the Department of Mental Hygiene and Hospitals, the State hospitals, the medical schools, the mental health clinics and the community mental health centers. He would also establish continuing training programs for all mental health personnel, using available public health and educational facilities as well as mental health institutes.

B. A complete review and revision of personnel policies, so that higher pay scales may be established with broader discretion in setting salaries, and expanding fringe benefits, toward the goal of meeting national salary averages in all categories, just as was done on behalf of higher education.

C. Establish a training program for clinical psychologists and an effective program for training graduate psychiatric nurses, in addition to promoting on-the-job training in all State facilities in coordination with the development of new patterns of staff utilization.

D. Providing adequate stipends for mental health training on all levels, with the expectation that the recipients of such stipends accept employment in public mental health service in Virginia for the same number of years as the stipend is received or repay the stipend if they prefer.

E. Promoting the development of a State-wide community college program for the training of mental health workers, in coordination with the creation of job openings for such workers in State hospitals and community agencies. In addition, much closer coordination should be established between the Department of Mental Hygiene and Hospitals and high school guidance counselors throughout the State in an attempt to attract high school graduates into the Department's training programs.

F. Designing career ladders enabling advancement in the mental health field on the basis of quality of services performed and participation in on-the-job training programs as well as academic background.

G. Considering the local supply of manpower in planning locations of new mental health facilities.

V. Strengthen Central Office Staff.

That the staff in the *Central Office* of the Department of Mental Hygiene and Hospitals be expanded to include more professional personnel of outstanding capabilities and expertise in defined areas for the purpose of providing State-wide leadership in coordinated program planning and development.

VI. Change of Department Name.

That the name of the Department of Mental Hygiene and Hospitals be changed to the *Department of Mental Health,* in order to more clearly reflect the concept of a total mental health system.

VII. Construction Grants for Long-Term Care Facilities.

That *State grants* be provided localities for the construction of public and non-profit nursing homes with priorities for grants based upon community need.

VIII. Geriatric Centers for the Mentally Ill.

That special geriatric centers for patients needing psychiatric care be established at each of the four major State hospital sites and at Piedmont and Catawba.

IX. Geriatric Pilot Projects.

That the State institute pilot projects involving comprehensive geriatric services to selected target areas. These projects would include:

A. A pilot project for supervised community placement of elderly patients currently in State hospitals.

B. A pilot project for pre-admission screening of geriatric patients referred to the courts for State hospital commitment.

C. Home service to elderly citizens in the target area.

D. Transportation.

X. Full Use of Federal Funds.

That maximum use be made of all applicable federal funding programs for the purpose of strengthening services to the mental, indigent and geriatric patients.

XI. Continuing the Study.

That a Commission on Mental, Indigent and Geriatric Patients be authorized, appointed, staffed and adequately funded for another biennium for the purpose of following up on these recommendations and expanding sustained interest in mental, indigent and geriatric services on the part of the general public and its elected representatives.

THE REASONS

Having set forth its eleven broad recommendations, the Commission feels it will be both desirable and helpful to the reader to follow a parallel format in outlining the reasons for each individual recommendation. Again, the fact that the reasons are broken into eleven separate presentations in no way lessens the Commission's conviction that the solution to Virginia's problems in mental, indigent and geriatric patient care lies in *a total commitment to a total concept.* The individual parts are presented in the following pages . . . but when considered as a total package, the whole is greater than the sum of its parts.

I. Strengthen the State Hospital System.

Contrary to the forecasts of some and the hopes of others, the Commission is convinced that there is no realistic substitute for the State hospital system within the foreseeable future. It is totally unrealistic to anticipate the introduction of sufficient community mental health services to begin to meet the total needs of our individual localities anytime soon. The State hospital currently offers the only mental health services available to much of this Commonwealth—and, especially in the rural areas, will continue to do so for the foreseeable future. The reasons for this are many but the conclusion is inescapable: *the State hospital system must be strengthened as the first step in improving Virginia's mental health services.*

The Commission's studies reveal that a sizeable proportion of mental patients have chronic and disabling problems that require constant or repeated hospitalization which cannot be handled in community facilities in the near future. In addition, the number of chronic patients can be expected to increase with the increase in general population, particularly in the elderly group. It should also be pointed out that there are seriously mentally ill patients who do not respond fully to any type of psychiatric or related treatment. Such persons are appropriately housed in State hospitals as the most feasible means of providing them with adequate food and shelter and a protective living environment under the supervision of a trained staff.

These factors can be expected to at least balance the anticipated decrease in hospitalization rates due to the decreasing length of stay of the acute patient group and the expected decrease in the number of inappropriate referrals to the State hospital system. However, it is the Commission's position that the only thing worse than the unnecessary hospitalization of an individual would be the denial of State hospital services to one in need of them.

Patient Movement

A downward trend in the ratio of hospitalized patients to the general population is well established nationally and in Virginia, although Virginia's rate of decrease is slower than the national average. However, with a general population increase of 25 percent forecast over the next ten years in Virginia, one would expect that the anticipated decrease in hospital resident rates will be at least balanced by the anticipated population increase. (This projected increase is particularly marked in the older age group: a 42.6% increase in the elderly population is projected between 1965 and 1980.)

Also, the decrease in resident patient rates has been accompanied by a steady increase in admission rates. To balance this increase, there has been a parallel increase in discharges, indicating an increasing turnover rate among patients with acute, relatively short episodes of mental disturbance.

While at first glance, it might appear that the statistical implications indicate a continuance of the current high level of hospitalization, a more realistic appraisal must include the potential impact of constantly improving treatment methods and medication. Assuming that every new avenue of treatment is explored, it seems reasonable to anticipate—and even to forecast—an eventual decline, not only in the percentage of those hospitalized (in relation to the total population), but in the actual number of patients.

Staffing Problems

At the present time, the staffing of State hospitals is the most severe problem in the mental health field in Virginia

and in the nation. A wide range of recommendations for meeting the mental health manpower demands are detailed in the section on Manpower Development, but the crisis nature of the problem in Virginia is graphically illustrated by the following facts:

A. In the spring of 1969, there were 505 unfilled positions at the State institutions, out of a total of 7,012 authorized positions. It should be noted that the authorized positions of any State agency take into account the fiscal problems as well as the anticipated availability of personnel. As a result, the number of *authorized* positions is inevitably lower than the number of positions *needed* to do the job effectively.

B. Of these vacancies, the distribution between employee categories was as follows:
   1. There were 38 vacancies for physicians, out of 165 authorized positions.
   2. There were 111 vacancies for nurses, out of 507 authorized positions.
   3. There were 232 vacancies for attendants, out of 4,218 authorized positions.
   4. There were 124 vacancies among other groups, including psychologists and social workers, out of 2,122 authorized positions.

C. A personnel survey conducted in the fall of 1968 showed that:
   1. Fourteen out of fifteen psychiatrists in training (and 45 out of 70 other physicians) were foreign-trained.
   2. There were only sixteen full-time board-certified or board-eligible psychiatrists in the State hospitals then serving an average number of 15,280 patients.
   3. There were only ten social workers employed in the four major State hospitals.
   4. The personnel turnover rate in our State mental hospitals is 26.8% in one year.

If the State hospital system is to be strengthened, the recommendations contained in the Manpower Development section of this Report must be implemented at the earliest possible date.

Treatment and Activity Programs

It is the Commission's view that an effort is made to treat hospitalized patients with kindness and to give dedicated service to them. However, the lack of patient activity and involvement is evident and contributes to the regressive process threatening hospital patients. The following needs are evident:

A. Comprehensive initial diagnosis and evaluation which can lead to intelligent treatment and management.

B. Sufficient personnel to carry out all of the types of treatment. With intensive individual psychotherapy possible for only a limited number of cases, both professional and non-professional personnel must be more effectively and imaginatively utilized.

C. The pervasive practice of continuous television viewing and idleness among large groups of patients for days and weeks and even years must be replaced with meaningful activities involving work, hobbies, physical exercise, recreation and social interaction.

D. *All* patients must be actively involved in group and individual treatment if they are to reach their highest potential and have a chance to reconstruct their lives.

The above approaches can be implemented by non-professional staff, provided there is a sufficient number of able professionals with leadership ability to design and implement programs and on-the-job training. Such professionals should include not only physicians, nurses, psychologists and social workers, but also industrial therapists, rehabilitation counselors, occupational and recreational therapists, teachers and other trained personnel. With the involvement of attendants, social work aides and trained volunteers in these

programs, it should prove possible to substantially improve the quality of life in our institutions and more meaningfully prepare patients for return to the community.

Unitization

The Commission finds a great deal of merit in the concept that patients in each of the existing State hospitals be grouped on a geographic basis. By dividing our present giant facilities into geographically homogeneous units, it would be possible to improve the personalization of treatment programs, to reduce the emotional impact of the actual hospitalization and to somewhat smooth the transition from community to hospital and back again by maintaining some semblance of a community of interests within the hospital itself. While the change obviously requires considerable thought and planning, this concept merits full consideration.

Services to Special Groups

The Commission recognizes that services to children are an essential part of the total mental health services, but is not prepared to make specific recommendations in this area, pending the report of the VALC Committee on Emotionally Disturbed Children.

While *geriatric patients* certainly comprise a special group within our State hospitals, the Commission's recommendations in this area are outlined in the sections of this Report dealing with the total geriatrics question.

All services to the criminally insane should be concentrated at a single location so that a specialized program under expert leadership can be developed.

Physical Facilities

The Commission recommends the construction of smaller hospitals in metropolitan areas in lieu of the construction of any additional or replacement beds at existing State hospitals. The Commission fully recognizes that the Department of Mental Hygiene and Hospitals is planning for the construction of 2,302 beds over the next ten years at the four State hospital sites. This involves replacement of 1,700 beds and construction of 602 new beds. However, we feel strongly that the Commission's proposal as an alternative to building on present sites offers the following advantages:

A. It would bring services closer to where patients are and facilitate their movement into and out of the hospital.
B. It would make possible a gradual decrease in size of present institutions, with the phasing out of substandard buildings, giving more space for needed patient activities.
C. It would facilitate recruitment of personnel that are difficult to attract to present rural hospital locations.
D. It would enable closer ties with communities served by the hospital.
E. It would enable the hospital to gradually take increased responsibility for total mental health services in its geographic area, which at present constitutes the only real hope for services to surrounding rural areas that have no professional personnel to render such services.
F. The combination of the above factors would substantially improve not only the quantity of services, but also the quality of treatment rendered to patients.

Construction Proposal

With an average rate of overcrowding of 420 patients, there is no doubt that some hospital construction must take place unless we choose to perpetuate our present overcrowded and substandard facilities. Furthermore, the demolition of some old buildings is urgent, since they represent a potential threat to the health and welfare of patients, as well as intolerable working conditions for staff.

Rather than perpetuate—or even accelerate—the giant, semi-remote State hospital as presently constituted, the Commission recommends the construction of small metropolitan area hospitals in the areas of Charlottesville, Richmond, Norfolk, Roanoke, Danville and expansion of the facilities in Northern Virginia. Varying in size from 100 to 700 beds,

these new facilities would replace any proposed construction at existing State hospitals. Each hospital in the system would treat the whole spectrum of patients from its geographic area with a possible exception of specialized groups such as children or the acutely physically ill. More specific data concerning patient loads, service areas, etc., is presented for each proposed hospital in Appendix B to this Report.

Community Involvement

It is the firm conviction of the Commission that increased community involvement in the State hospital system is essential to the strengthening of the system. We must bridge the moat of misunderstanding which too often surrounds psychiatry itself, not to mention the State hospitals. Toward that end, we offer the following recommendations:

A. Appointment of a Professional Advisory Board, which would include representatives of the two medical schools in the Commonwealth, the Virginia Neuropsychiatric Society, the State Medical Society, the Virginia Association for General Practitioners, the State Psychological Association, the State Association of Social Workers, the State Nurses Association and the State Bar Association.

This would provide the Governor and the State Hospital Board with an additional source of qualified professional advice on the questions of new treatment developments, training and recruiting personnel, etc. It would be appointed by, and report directly to, the Governor.

B. Appointment of an advisory board to each State hospital. Such boards should include, but not be limited to, representatives of local mental health boards. It would be essential that such boards be kept fully informed of the State hospital program serving their area so that local programs may be developed in relation to the existing program, with clear identification of coordination needs.

C. Increased involvement of such civic groups as the Virginia Association for Mental Health, so that such groups may provide effective leadership in public education and rally the public support needed for any substantial progress in Virginia's mental health services.

D. Increased involvement of professional organizations (physicians, nurses, social workers, etc.) that presently appear to be somewhat alienated from the public mental health services system.

E. The extension of State hospital services to areas that have no mental health programs and are unable to develop full-time local staff. This could be done through mobile clinics in coordination with the aftercare program and the mental health coordinators program outlined later in this Report.

II. Community Mental Health Services

One of the major problems encountered in the area of *community mental health services* has been the lack of continuity of patient care between the State hospital system and the various community services. With limited staff and funding, most community services focus primarily upon the short term, acute patients with the best chance of recovery. The others either end up in the State hospital or are lost in the "No Man's Land" between the two facilities. The key to continuity of care between State and local facilities is a significant reorganization of the State mental health system.

Regionalization

An increasing number of states are introducing systems with assistant commissioners responsible for both hospital and community psychiatry in the several regions of the states. Regionalization would provide continuity of care for the patient, optimum use of professionals, sensitivity to local and individual needs and greater citizen involvement. The Commission is convinced that there are great benefits in the regional administrative team approach even though problems obviously exist. It offers an opportunity for expanded leadership within the State mental health system which would be reflected in upgraded performances by the entire Departmental staff and in improved care for the patients.

Local Coordinators

One way to gradually develop regional ties would be

through the use of local mental health program coordinators assigned to the State's twenty-two planning districts. The responsibility of these administrators would be to coordinate services, collect information for program development and assume leadership roles in such development. As services expand and become more complex, the need for regional administration would naturally follow. Until that time, however, the local coordinators would report to the Director of Community Services in the Central Office. A counterpart in each State hospital would be employed, so that a continuous line of communication would be established between hospital, community and central administration.

Community Screening Services

It is strongly recommended that the present referral system to State hospitals be reviewed and revised. Rather than detail possible alternative plans—several of which have been studied by the Commission—suffice it to say that the present system simply doesn't work satisfactorily.

It is the Commission's contention that proper cooperation between, and coordination of, the State hospital system, general hospitals, private physicians, mental health coordinators and aftercare nurses, all bringing together available community resources to assist patients and families, would assist patients in the crises preceding and following hospitalization in State institutions. Hopefully, it may even eliminate the need for some admissions to State hospitals. Toward this end, it is recommended that a community screening program be considered, with the initial focus on screening *in the community* for diagnostic purposes and referral to the proper services. It would be the job of the mental health coordinator and a local physician to deliver the service. If the State would guarantee payment for indigent patients, it is felt that at least two beds in every general hospital could be made available for emergency uses. Only the provision for adequate facilities in the communities can end the antiquated and inhumane practice of jailing mental patients.

Community Placement

Community placement of elderly and chronic patients has been tried in a number of states. Experience has shown that the success of the program depends upon adequate remuneration to foster and boarding homes, careful preparation of the patient and the home, and sufficient staff for follow-up.

Community Mental Health Centers

Comprehensive community mental health center legislation was enacted in Virginia in 1968 to further supplement a 1963 federal law.

While there is no way of knowing how many communities will implement the program, the Department tentatively plans for the construction of two community mental health centers, similar to the Riverside hospital facility in Newport News, each biennium. As centers develop, they should be encouraged to provide substantial diagnostic, short term in-patient, out-patient, aftercare and rehabilitative services to former State hospital patients and to persons vulnerable to hospitalization. The Commission supports State grants for construction and staffing of the centers to match federal and local funds.

Mental Health Clinics

There are presently 32 mental hygiene clinics affiliated with the State system in Virginia. The Commission supports the continued funding of these clinics, with local participation, for the purpose of providing the following services:

A. Early and preventive treatment focused on strengthening the family unit.
B. Identifying, referring and giving follow-up services to patients in need of more intensive psychiatric care.
C. Providing consultative services to schools, courts and welfare departments.
D. Providing local leadership in program development, health education, consultation, agency coordination, etc.

It is of prime importance that efforts be made for clinic services to reach families who may need this service but are

not educated or conditioned to seek such service. Closer working relationships between clinics and schools, juvenile courts, welfare departments, etc., should be established and maintained so that child and family problems can be identified and treated as early as possible.

The Commission recommends that mental health clinics be continued in those areas which have a community mental center only as an adjunct to that center. The separate clinics can serve a vital function in those areas not yet ready for, or unable to support a community mental health center.

Related Public Health Services

The present network of public health personnel and facilities throughout the State should play a key role in providing the framework for the rapid expansion of community services for the aged and mentally ill. There are more than 2,000 professional public health workers distributed throughout all local areas of this State and a considerable number of new as well as older health centers. Cooperation and coordination with the present public health system would take advantage of the excellent rapport that now exists with many families in all areas. Comprehensive medical service operations, to include mental health services, offer a great economy of the limited resources.

III. Psychiatric Institutes

The only way for Virginia to secure qualified, well-trained professionals in the numbers needed is to train them within the State. Even if the Commonwealth had a superlative salary structure and a leading professional program, it is doubtful that it could attract professionals in sufficient numbers from training programs outside Virginia. Professionals tend to locate for their careers in areas not far removed from where they took their professional training. At the present time, Virginia trains a grossly inadequate number of mental health personnel. The two medical school departments of psychiatry turn out a maximum of eleven psychiatrists per year. A few more are trained in programs at two of the State mental hospitals. The numbers are not adequate for either the demands of the State hospital system or the private sector.

Compounding the difficulties, there is no program for training clinical psychologists in Virginia. Nor is there an effective program for advanced training in psychiatric nursing in the State. The Graduate School of Social Work at Virginia Commonwealth University does not train sufficient social workers to meet the needs in other areas and psychiatry as well.

In short, any improvement in Virginia's mental health care must be based upon a substantial increase in the capacity for basic training of mental health professionals. As a matter of top priority, the recommended Psychiatric Institutes, funded through the Department of Mental Hygiene and Hospitals, should be completed at the earliest possible date at Richmond and Charlottesville as the most feasible means of strengthening professional and subprofessional training programs in all mental health disciplines.

Special funding should be made available to develop programs in clinical psychology at several universities. Graduate programs in psychiatric nursing should be supported at *both* medical schools and the existing Graduate School of Social Work at Virginia Commonwealth University should be strengthened.

The Department of Mental Hygiene and Hospitals has plans for the construction of a psychiatric institute at the Medical Sciences Division of V.C.U. during the next biennium and one at the University of Virginia Medical School during the following biennium. One of these institutes, therefore, is at least two years from completion and the other more than four years. Some training of mental health professionals must begin now, however, if any significant progress in programs is to be made within the next few years. The Commission, therefore, recommends that sufficient appropriations be made to the Departments of Psychiatry at the two medical schools in the State in order to enable them to develop adequate training programs, to develop a staff for the institutes, and to develop a more meaningful liaison with the State mental health system. These developments will assure the maximum use of the psychiatric institutes im-

mediately after construction is completed and will prevent a lag in the development of badly needed professional staff personnel.

That such a long range program can be successful has been amply demonstrated in North Carolina. In 1952, when the University of North Carolina Department of Psychiatry was established, extra funds were made available to it by the Department of Mental Hygiene, with the goal of upgrading the state mental health system. In 1952, when this plan began, there were only three board-certified psychiatrists in the state mental health system. In 1968, when this Commission heard testimony from the North Carolina Commissioner of Mental Health, Dr. Eugene Hargrove, there were 85 board-certified physicians in the North Carolina mental health system, most of whom were psychiatrists. *Over 70% of them had been trained in North Carolina.*

IV. Development of Manpower

The question of *manpower and training* in the Department of Mental Hygiene and Hospitals in the Commonwealth of Virginia gives cause for major alarm! As a group, the mentally ill and geriatric patients of this State, unless they can afford to pay for it privately, are *not* getting the level of care that is potentially available in the 1960's.

The need for additional personnel is critical at all levels, but particularly in the professionally trained categories. It should be pointed out here that money alone is not the solution . . . but an interstate comparison of professional salaries reveals that Virginia lags substantially behind national salary levels in the various job categories. For professional personnel, two factors are of overwhelming—and equal—importance: adequate salaries *and* productive working conditions. To insure the latter, the Commission recommends the employment of an *Assistant Commissioner for Manpower and Training,* who would serve as a coordinator between the Department and its several institutions, the medical schools, the clinics, and the mental health centers. He would provide leadership in recruiting professionals into the State mental health system and also establish continuing training programs for all mental health personnel in the system.

To effectively cope with current manpower problems calls for a complete review and revision of personnel policies and budgetary practices on the State as well as the Department level.

The Commission believes that State hospital superintendents are hampered by the rigidities of the State personnel system and the lack of individual discretion in rearrangement of budget line items. However, greater initiative must be exerted by and demanded of all key personnel if such discretion is to prove beneficial.

While salary scales must be competitive with other state hospital systems and include appropriate fringe benefits, unless the reimbursement is phenomenal it is not, of itself, sufficient to attract professional personnel. In short, both a challenge for the present and opportunities for the future must be offered. New and exciting programs, opportunities to participate in training—all are essential to successful recruitment. It is absolutely essential that the salary structure be made competitive with the national average and with surrounding states, but in addition the professional climate has to be improved. Effective professional leaders can mobilize and train sub-professionals and volunteers to deliver an enormous amount of effective mental health care. This sort of program requires exceptionally able leaders, however, and in order to recruit them it is necessary to pay them a competitive salary. In addition to generally upgrading the salary structure, we strongly urge that the upper limits for professionals be raised, much increasing the spread of salary range over its present limits.

Even if the State achieves an adequate salary structure, one can anticipate recruiting and retaining first-rate personnel only if the system is a professionally rewarding, stimulating place in which to work. To develop such a system requires a number of things. Professional personnel should have the opportunity for—and be encouraged in—further professional development. That is, it should be expected that within the time they are working and for which they are being paid,

it is appropriate that they should devote time to study and research. Professional meetings at each of the institutions should be encouraged and financing provided so that distinguished outside consultants can be brought in at regular intervals. This is particularly true of Southwestern State Hospital which is geographically remote from other medical centers. Encouragement and support of attendance at national meetings should be the rule, rather than the exception. When institutes are established, means should be made available for professional personnel to spend varying periods of time in residence at the institutes in Richmond or Charlottesville. Moreover, leaders in the system should be offered academic appointments and true relationships with the educational institutions. This is a powerful drawing card in recruiting ambitious people of high calibre. Both formal and in-service training programs should be established in each of the institutions and residency programs should be implemented as soon as sufficient staff is available. There is nothing which does as much for the morale and high level of patient care in a medical institution as an ongoing program of training at all levels.

The case of hospital attendants may be used to illustrate the severe problem of non-professional staffing. Over half of all the established positions are in this group. The beginning salary for attendants is $3,744—an income which is near the poverty level in this country! Moreover, the expectation of never making more than $5,880 can scarcely be expected to attract either the quality or the quantity of personnel required. At present, there are a fairly sizeable number of attendants who have worked in their positions for many years and, because of their dedication, will continue to work in the system. However, it becomes increasingly difficult and soon may be impossible to recruit new young people with any ability for these positions. The hospital attendant is a key person in the total treatment situation. He is the one who is in closest daily contact with the patients, carries out much of the treatment as well as having the responsibility to call in professional personnel when the patient's condition so dictates. In most instances, it is difficult or impossible to provide ongoing, on-the-job training for these people.

In general, the present attendants are dedicated, humane and hard working. However, their skills and approaches are about 20 to 30 years out of date. Because of the lack of vigorous modern treatment programs and intensive training programs, however, many have attitudes of hopelessness toward mental illness. This is in direct contrast to the new possibilities and potential that modern techniques and new drugs can produce in an adequately staffed hospital. The whole system works against the type of active, optimistic, social environment which is possible in good mental hospitals.

If we are to attract and retain competent non-professionals, the same practices that are applicable to professional recruitment must be followed. Salaries and fringe benefits must be sufficient to compete in the labor market and enable the staff member to live well above the poverty level. In addition, training, both on the job and off the job, must be expanded and made not only more available, but more exciting. Finally, a career ladder must be established whereby the staff member can broaden the scope of his job and his responsibilities—and be paid accordingly. Starting at the bottom of the ladder should not necessitate a person staying at the bottom of the ladder.

Through the introduction of career ladders into the system, not only can present staff members grow in their jobs but recruitment possibilities expand considerably. In addition, such a step would enable close ties with the community college system in the State as a source of mental health technicians. These sub-professionals or para-professionals can assume increasing amounts of responsibility for mental health care in our institutions, provided proper training and supervision are available. Through cooperation with the community college system, the former can be provided. Nor should the potential recruitments in the high schools be overlooked. Through a program of cooperation with high school guidance counselors, careers in the mental health field can be presented to—and made attractive to—emerging high school seniors who may well be fully equipped for some of the necessary tasks in the general mental health care field.

Finally, the Commission strongly urges the consideration of manpower supply in locating new mental health facilities. Aside from the obvious conclusion that the isolation of State mental institutions which has developed in the past should be done away with, a positive consideration of the available manpower should be a factor in determining new locations. Further, the proper liaison between local citizens, political governing bodies and members of the State hospital system would go a long way toward a greater understanding on the part of the public of the functions of the State mental institution. Proper leadership could encourage the use of State hospital facilities by other segments of the community. Playing fields can be made available to little leagues and other youth activities. Auditoria, gymnasia and other facilities can be made available to the general public. Joint concerts, which both patients and public can attend, can further reduce the barriers between them. As for the impact of such moves on recruiting, it obviously relieves the onus of seeming to be a different sort of person if one works in the previous isolation of a mental hospital.

V. Strengthen Central Office Staff

It is the Commission's view that the employment of highly trained professionals in strategic leadership positions is the most efficient and economical approach to the strengthening of Statewide program planning and development. This is also the most realistic approach under the present conditions of acute shortages of professional personnel. The need for leadership in program development is critical. To alleviate this situation, the Commission recommends the creation of seven new Central Office positions.

These seven positions would be at the Assistant Commissioner level and would be titled either "Director" or "Assistant Commissioner." In addition to the *Director of Manpower and Training,* whose duties were outlined in the preceding section of this report (and whose establishment the Commission strongly recommends), the most urgent need is for a *Director of Geriatric Services.* This person's responsibilities would include providing leadership in program development at the proposed geriatric centers in the State hospital system, in cooperation with the directors of those individual centers. He would also work with the appropriate State departments (Health, Welfare, etc.) for the development of a comprehensive approach to geriatric services in the State.

A *Director of Mental Retardation* should be appointed to provide full time direction to the development of services to those persons confined to the State hospital system in our training schools for the retarded.

A *Director of Children's Services* should be employed to give special guidance in services to children. It would also be his responsibility to explore all avenues of the prevention, care and treatment of emotional disturbances and drug abuse both directly by the State hospitals and clinics and through better coordination with the Departments of Welfare and Institutions and Education.

A *Director of Research and Programming,* responsible for long range planning, is required if we are to keep pace with the constant changes in the field of mental health care. Not only would such an individual provide leadership in the State system, which would stimulate actual research activities at our various institutions, but such position would give further evidence to professionals that Virginia is indeeed committed to the care of its mentally ill and would serve as a positive factor in recruiting efforts.

A *Director of Community Services* is needed to give the Central Office a constant contact with the communities which it serves—or should be serving. In addition to serving as the Central Office member to whom the local mental health coordinators would report, this Assistant Commissioner would provide a single source of advice and information for localities seeking guidance on the means of establishing clinics or mental health centers. He would suggest resources, priorities, guidelines, etc., which would enable the localities to avoid known pitfalls in their initial efforts.

A *Director of Mental Health Program Grants,* with expertise in federal and foundation funding and grants, could

well earn his keep in the first year or two. Annually, untold amounts of money go begging because the availability is unknown or the requirements are not made clear or the matching funds are not forthcoming. A wide range of local services and a vast array of special projects within the State hospital system might well be made possible through such grantsmanship.

It is also stressed that the above proposed positions be established with realistic salary scales so that qualified professional personnel in the fields of medicine, psychology and sociology can be recruited on a competitive basis. Furthermore, this leadership group should be provided with adequate staff and other support so that their talents can be most effectively utilized.

VI. Change of Department Name

"The Department of Mental Hygiene and Hospitals" is both antiquated and awkward as a label for the State agency charged with the responsibility of caring for Virginia's mentally ill. It is far too restrictive a title if we are to introduce bold leadership, imagination, and new directions on behalf of Virginia's mentally ill. With this in view, the Commission recommends that the necessary legislation be prepared, introduced and passed changing the name of this agency to the *Department of Mental Health.*

VII. Construction Grants for Long-Term Care Facilities

The Commission recommends that the State provide grants to localities for the construction of non-profit and public nursing homes, with priorities established on community needs.

As Virginia's aged population continues to grow, homes that offer appropriate care and economical rates will be increasingly in demand. Public agencies must be able to purchase care for the needy at a reasonable cost. The private individual or family with a moderate income cannot pay an increasingly high monthly rate for a long period of time.

Recognition should be given to private enterprise which for the past twenty years has taken a major role in building and operating long-term care homes. However, several areas of the State continue to be without adequate facilities. Apparently the limited economy of those areas have not been attractive to the proprietary operator. There is an obvious lack of facilities to provide long-term care for the low-income aged group. Although only about nine percent of the total aged population require long-term care, this is still a significant number of costly institutional beds. Although the precise number of geriatric beds required in the State is subject to varying estimates by varying experts, it is generally conceded that a large number of new beds are needed now and for the future. A conservative estimate of the total need for beds in nursing homes and homes for the aged places the number at 29,524. With some 3,500 of the existing 19,000 beds located in State hospitals, the communities are short approximately 10,000 beds at present!

The differences between localities in the percentage of bed needs met are presented in detail in Appendix D to this Report. For illustrative purposes, however, we might point out that medical service area 32 (Wytheville) has 88% of the geriatric beds it actually needs, while medical service areas 37 and 38 (Lebanon and Grundy) have absolutely *none!* There is not a single geriatric bed in the two areas!

The Commissioners of Welfare and Institutions, Mental Hygiene and Hospitals, and Health have recommended an appropriation of $5 million for the construction of some 1,200 beds in six community non-profit or local regional public geriatric facilities over the next biennium. Local sources and Hill-Burton funds would be added to this appropriation to meet the estimated construction cost.

The Commission fully supports the Commissioners' recommendation, provided:

1. That priority be granted to areas of greatest unmet need, with no ongoing construction.
2. That the grant vary with the community's ability to participate in the financing of construction. The

matching formula could well be the same as the one used in local public health service programs, which allow for up to 80% State and federal participation in construction costs.

The construction grant program would be under the administration of the Department of Health, in connection with the Hill-Burton program. In view of the considerable private construction now underway, it is recommended that a State-wide system of public nursing homes not be initiated at this time, and that the Commonwealth does not expand its nursing home operations except where it is absolutely needed. At the present time, there are about 2,000 elderly citizens in the four major State hospitals that could probably receive a better priority elsewhere and at the same time, relieve the State hospitals of a major effort that could be redirected towards their basic missions. In view of the current state of growth of nursing homes, it is impossible to determine whether or not there will be a continuing State-wide need for public nursing homes on a county or regional scale. However, the Commission feels that there is ample and urgent need for further detailed study of the problem, in view of the new Medicaid program providing for skilled and intermediate nursing care to welfare patients which began on July 1, 1969, and which will be extended to medically indigent persons on January 1, 1970. Many elderly State hospital patients will also be covered by this program. In principle, the Medicaid program administered by the Department of Health will cover indigent patient nursing care in proprietary, public and non-profit facilities, with the Welfare Department continuing to make payment for residential care provided welfare clients in public or private facilities. Thus, it would seem possible for indigent elderly persons to receive the care they need without establishing "discrete facilities for poor people"—which is simply a modern euphemism for poor houses!

VIII. Geriatric Centers for the Mentally Ill

There are approximately 3,500 elderly patients in State hospitals in Virginia. The average cost for their care in geriatric wards was $6.94 per patient day during the quarter ending March 31, 1969. The range in cost in the geriatric wards was from $5.27 to $7.28 per patient day. A sizeable proportion of elderly patients require more intensive medical care, costing an average of $20.24 per patient day, with a range from $12.56 to $31.68. However, the number of geriatric patient days in the medical-surgical centers constitutes such a small part of total services to geriatric patients that the average cost for geriatric care per patient day would not exceed $8.00. Unfortunately, the State only appropriates $6.70 per patient per day to the State hospitals, regardless of age. Someone, somewhere, is getting left out! As the most effective means of preventing this inequitable drain on the State hospital system's already limited resources, the Commission recommends the establishment of a geriatric center for the mentally ill at each of the four major State hospitals and at Catawba and Piedmont.

These centers would provide all levels of patient care as follows:

1. Residential care to encourage independence and self-help.
2. Custodial nursing care.
3. Intensive nursing care with physical rehabilitation services.
4. Acute and sub-acute hospital care.

All of these patients should have:

a. Recreational and social activities to meet their special needs.
b. Psychiatric care focused on the therapeutic environmental approach involving staff specially trained to be helpful in relation to the psychiatric problems of the elderly.

In order to assure the rightful priority of the special needs of geriatric patients, the geriatric centers should be budgeted and administered separately from the rest of the hospital units, although remaining under the direction of the Department of Mental Hygiene and Hospitals. Local

direction would come from the Director of Geriatric Services employed at each of the centers and reporting to the Director of Geriatric Services in the Central Office, as proposed in the preceding section of this Report.

The Commission has considered the possibility of transferring the geriatric program to either the Health Department or the Welfare Department. However, the proposed centers are definitely intended for geriatric patients in need of psychiatric care. This group, according to our study, constitutes almost half of the present geriatric State hospital group.

In providing State hospital geriatric services, the Commission considered the alternative of utilizing one of the existing State hospitals for geriatrics only. Such a program would offer the advantage of providing a facility focused solely on the needs of the geriatric patient and freeing the other State hospitals from an overload of geriatric patients. However, the disadvantages of such a program far outweighed any advantages. The Commission found that such a single-unit program would remove the patient even further from his home community; would present severe staffing problems, inasmuch as geriatric wards tend to be more depressing and less attractive than general wards; would still be inadequate, inasmuch as none of the current hospitals is really equipped for such long-range geriatric needs; and would prove wasteful in terms of proper utilization of current medical-surgical units. A single geriatric hospital would require far more elaborate medical-surgical facilities than any presently in operation.

The Commission, therefore recommends the geriatric center approach as a means of fully utilizing existing facilities and at the same time providing a new focus on geriatric care in State hospitals. The establishment of such programs as recommended would involve an increase in professional and other staff and would upgrade existing facilities. The increased cost should be met by allowing Medicare payments to be used for services to *geriatric patients*. If an increase in the hospital's income is used as a rationalization for a parallel decrease in State appropriations, there will be no hope of improving geriatric services.

IX. Geriatric Pilot Project

It is recommended that the State undertake two pilot projects in community services to the elderly focusing on both the urban and rural aspects of the problem. These projects may well pave the way to new approaches in geriatric care. The projects should be administered by the Commission on the Aging, which would choose the locations to coordinate with their planned or ongoing activities. The possibility of using matching funds under the federal Older Americans Act should be explored. The emphasis of the projects should be on evaluating the effectiveness and cost of a comprehensive approach to the geriatric problem.

One aspect of the pilot projects would involve community placement of State hospital geriatric patients. Two special studies of patient care needs conducted for the Commission at Eastern and Western State Hospitals showed that almost half of the geriatric patients could be cared for in nursing homes, homes for the aged or in private homes. The Commission feels that these patients are not appropriately in State mental hospitals but feels even more strongly that attempts to discharge them must be paralleled by the development of alternative systems of care.

Another part of the pilot projects would be a program of screening patients in the community before admission to the State hospitals. The Commission's special studies showed that about 20% of the geriatric admissions are inappropriately referred to State hospitals for terminal care (dying soon after admission) and another 13% were found not to need such hospitalization within a short time after admission. The focus of the program would be on appropriate placement rather than the simpler process of screening out inappropriate State hospital referrals. A physician-social worker team would be the prime service providers, with the local general hospital serving as a back-up facility providing staff and equipment essential to determining rehabilitation potential and providing

intensive treatment.

Home services in the community and related programs such as friendly visitors, "meals on wheels," day-care programs, public health nursing services and assistance from home health aides, have been reviewed by the Commission. As an adjunct to family efforts, such programs can be of great help in providing at least a semblance of normal social relationships. In order to explore the potential of such programs as means of avoiding or postponing institutionalization, it is recommended that they be introduced on a pilot basis in conjunction with the proposed programs on pre-admission screening and patient placement. In this manner, community programs would have to relate to the needs of actual or potential State hospital patients.

Experience has shown that a transportation program is essential if community services are to reach the elderly people who most need such services. It is the Commission's recommendation that the pilot programs also consider methods of providing suitable transportation for elderly persons and prepare a realistic analysis of the cost involved.

X. Full Use of Federal Funds

In considering the means of strengthening the State hospital system, the potential of Medicare and the new Medicaid program must be considered. All elderly people in State hospitals who would be eligible for public assistance if they were not hospitalized are now eligible for Medicaid. Furthermore, patients falling below a certain income level and categorically related to welfare patients, will also be eligible on January 1, 1970. Medicaid covers total cost for service, 65% of which comes from federal sources. Were we to increase services in physical therapy, nursing care, psychiatric treatment and other areas of need, the expansion of these services would also be covered. Thus it is entirely realistic to say that geriatric patients in State hospitals can be provided upgraded services without additional cost and that the present level of State investment for present services can be supplemented by the addition of a federal Medicaid contribution amounting to several millions of dollars annually. This offers a tangible means for improved services, *provided* the legislature does not decrease its appropriation in direct proportion to the increase in income from federal sources.

In addition to the potential Medicare and Medicaid support, federal grants are available for a multitude of construction and service programs. The present federal appropriation per biennium is $2 million for construction of community health centers in Virginia to match local and State funds on a dollar for dollar basis. The federal appropriation for staffing these centers is open-ended. With proper guidance from the Director of Community Services, localities will be in a position to qualify for such grants far more efficiently than they are presently able to do.

The Vocational Rehabilitation Act provides federal funds for rehabilitation services to mentally ill persons on a matching basis of four federal dollars for every State dollar. The 1970 federal appropriation of $16 million for Virginia calls for $4 million in State funds. The actual State appropriation for 1970 is $2 million, which means that one-half of the available federal funds will go unclaimed. There appears to be untapped federal resources of considerable magnitude that could be effectively used for the rehabilitation of mentally ill persons, if only the State would make direct and adequate appropriations to the Department of Vocational Rehabilitation to enable the Department to meet federal requirements.

Under the federal Public Health Service Act, federal funds totaling $219,000 for the current fiscal year were allocated to Virginia for mental health services. In the past, the major part of this allocation has gone to the continuing clinic program. The Commission recommends that these funds be freed for pilot projects, such as the ones recommended on behalf of geriatrics in an earlier section of this Report. With the present budgeting and allocation system, it is exceedingly difficult to initiate new programs. Any viable service system must have a little room for maneuver. It is not realistic to expect creativity and innovation in a system that is financially frozen for two years at a time.

The above comments mention only a few of an almost

unlimited number of federal grant programs that are administered by many federal agencies, which have the potential of bringing financial assistance to the administration of Virginia's services to her mental, indigent and geriatric patients. The establishment of a Director of Mental Health Grants, as previously recommended, is vital to the exploitation of all of these services.

XI. Continuing Study

The facts, figures and feelings unearthed in the course of this Commission's study clearly indicate the need for a sustained public and legislative interest in the critical area of Virginia's services to, and treatment of, mental, indigent and geriatric patients. It is not possible to conduct a truly comprehensive study of total service needs and alternative approaches within the limitations of the present Commission's funds and staff. It is, therefore, the strong recommendation of the Commission that another Commission on Mental, Indigent and Geriatric Patients be authorized, appointed, staffed and adequately funded for the next biennium to continue the studies and follow up the findings that have been made.

THE FIRST STEPS

The Commission was charged with the responsibility of suggesting an order of priorities for General Assembly appropriations for mental, indigent and geriatric patients. While the Commission has emphasized the need to move forward in all recommended areas, not everything can be done at once. Financial resources are limited. More detailed planning needs to be done by the Departments concerned on some items. There are simply not enough professionally qualified and sub-professionally trained people to do the job as it should be done. The items below can and should be provided for this biennium. It is the Commission's belief that they will both bring visible progress and also form the first steps of a coherent program to solve the long-range problems.

Manpower

1. *Increasing salaries for Department of Mental Hygiene and Hospitals personnel.* The major key to obtaining and retaining sufficient numbers of qualified mental health personnel, both professionals and others, is competitive salaries. The Commission advocates salary increases sufficient to bring Virginia up to the salary level of surrounding states. Figures presented to them call for an increase of $4.58 million per year and will provide an average salary increase of approximately 18%. Such an increase will probably not bring us up to the national average.

2. *Establishing psychiatric institutes in connection with the medical schools.* Psychiatric institutes should be established at each medical school in the State for the purposes of training mental health personnel, conducting basic and applied mental health research, and developing new patterns of manpower utilization.

The Commission supports the Department of Mental Hygiene and Hospital's plans for the construction of such an institute at M.C.V. during the next biennium at a cost of $4.79 million and planning money of $290,000 for one at the University of Virginia.

3. *Training of professional mental health personnel prior to the establishment of psychiatric institutes.* The two psychiatric institutes will play a key role in the training of adequate professional personnel. However, according to present plans, it will be more than two years before the first is functioning and more than four years before construction on the other could be completed. Therefore, it is recommended that $250,000 per year be appropriated to each of the departments of psychiatry at the University of Virginia Medical School and M.C.V. during the next biennium, for a total of $1 million, to extend their present training function and to develop better liaison with the State hospital system.

4. *Providing adequate stipends for mental health training.* An adequate number of qualified staff personnel is an absolute requirement to any effective mental health program. At the present time, there is an acute shortage of such

personnel, to include psychiatrists, clinical psychologists, psychiatric nurses, social workers, therapists, licensed practical nurses and psychiatric aides in the Commonwealth. The Commission feels that the State should appropriate $300,000 for the biennium in order to encourage employees and other qualified citizens of the Commonwealth to train in these areas and to provide adequate manpower resources for public mental health services.

Geriatrics

1. *Providing State grants to localities for the construction of long-term care facilities.* This idea came to the Commission as the unanimous recommendation of its ex-officio members, Drs. Davis and Shanholtz and Messrs. Brown and Fox. They propose that the State appropriate $5 million in the next biennium, to be supplemented by local funds and federal Hill-Burton funds, for the construction of 1,000 to 1,200 beds in six community geriatric centers.

The Commission fully supports this proposal since it is obviously the only way to promote construction of needed facilities for our elderly citizens in areas where none or very little exist.

2. *Providing State support for pilot projects involving community services to elderly citizens.* It is recommended that the State support two pilot geriatric programs that may well pave the way for new approaches in geriatric care. These projects will coordinate all services in the community that are available to older people there, and develop other services such as homemaker and health aid, senior center, income maintenance, housing, meals-on-wheels and transportation. These programs have a great potential to avoid or postpone institutionalization of a large segment of our older citizens.

The Commission on the Aging, which should administer these projects, has completed necessary plans and feels that they would require about $285,000 per year each. However, a considerable amount of this money could come from the federal government under the Older Americans Act and more could be financed by the localities. State money of $500,000 should be sufficient for both projects for the biennium.

Delivery of Mental Health Services

1. *Developing community mental health centers.* The Commission supports the appropriation of (1) $1.5 million in the next biennium which will permit the construction of two community mental health centers, with an equal amount coming from local funds and $2 million federal funds and (2) $2.74 million for the operation and maintenance of community services to match local and federal money.

These mental health centers will provide a continuity of patient care between the State hospital system by providing substantial diagnostic, short-term in-patient, outpatient, aftercare and rehabilitative services.

2. *Establishing seven directors for various services in the Department of Mental Hygiene and Hospitals.* The employment of highly trained professionals in strategic leaderships positions is the most efficient and economical approach to strengthening the State-wide program and development. The Commission supports the establishment of seven positions at the Assistant Commissioner level in the Department of Mental Hygiene and Hospitals.

Director of Manpower and Training
Director of Geriatric Services
Director of Mental Retardation
Director of Children's Service
Director of Research and Programming
Director of Community Services
Director of Mental Health Program Grants

Corresponding to the establishment of the position of Director of Geriatric Services should be the employment of a director for each of six geriatric centers in the State.

Fifty thousand dollars per year will be necessary for each of the seven directors and their necessary staff and forty thousand dollars per year for each of the six geriatric directors. This will require $1.18 million for the biennium.

3. *Construction of mental hospitals near centers of population.* With an average rate of overcrowding in our State hospitals of 420 patients per hospital and a general population increase of 25% forecast over the next ten years, there is no doubt that some hospital construction will have to take place. Rather than building at the giant, semi-remote State hospital as presently constituted, the Commission recommends the construction of small metropolitan area hospitals in the areas of Charlottesville, Richmond, Norfolk, Roanoke, Danville and expansion in Northern Virginia, varying in size from 100 to 700 beds. These new facilities would replace any proposed construction at existing State hospitals.

The amount of $450,000 is requested for the next biennium in order to complete plans for the construction of two of these smaller hospitals in the following biennium as a beginning of this plan.

4. *Continuing support of the existing mental hygiene clinics and expansion of this program.* At present there are 32 mental health clinics in Virginia which are funded with both State and local money. The Commission recommends the construction and expansion of this program as a means of providing vital services (early and preventative treatment; identifying, referring and follow-up services; and consultative services to schools, courts and welfare agencies) in those areas not yet ready for, or unable to support, community mental health centers.

In the current biennium budget, $2.78 million is appropriated for this activity and an increase to $4.17 million is being requested in the next biennium which will provide for an additional five clinics. Therefore, an additional $1.39 million is needed.

5. *Regionalization of the Department of Mental Hygiene and Hospitals.* The Commission recommends the eventual creation of a system with Assistant Commissioners responsible for both hospital and community psychiatry in the several regions of the Commonwealth. A single system of mental health care will foster a continuity of care for the patient, optimum use of professionals, sensitivity to local and individual needs and greater citizen involvement. Many other states have developed such a system with great success.

Since it is unreasonable to expect much relief from the acute shortage of top professionals in the immediate future, it does not seem practical that this system can be implemented within the next biennium. However, $40,000 is requested for the next biennium for planning purposes.

Continuing The Study

Continuing the Commission on Mental, Indigent and Geriatric Patients. The facts, figures and feelings treated in the course of this study clearly indicate the need for a sustained public and legislative interest in the critical area of Virginia's services to, and treatment of, her mental, indigent and geriatric patients.

It is not possible to conduct a truly comprehensive study of total service needs and alternative approaches within the limitations of the present Commission's staff and funds. It is strongly recommended that a similar Commission be authorized for at least two more years and funded with $50,000 so that it can be adequately staffed.

RESUME OF COSTS

In any review of proposed costs and necessary appropriations, one little known fiscal fact which should be highlighted at this time is the amount of *income* produced by the Department of Mental Hygiene & Hospitals. While it has traditionally been the responsibility of the State to care for the mentally ill, the patients themselves and their families have individually and collectively borne much of the expense. In fact, patient reimbursements to the Department of Mental Hygiene & Hospitals currently account for 17% of the total state general fund expenditures on mental health.

The expanded use of such programs as Medicaid, Medicare and private insurance plans is expected to increase this reimbursement to more than 25% of the total cost of our mental hospitals. In fact, short-term, intensive treatment facilities can even approach a self-sustaining level through widespread use of such insurance programs. As an example, the Northern Virginia Institute of Mental Health is already operating on a near break-even basis, with patient fees providing about 80% of the operating costs for its 80 beds.

The following is a recapitulation of the estimated cost of the items which must be accomplished during the 1970-1971 biennium:

Increasing salaries	$ 9,160,000
Establishing psychiatric institutes	5,080,000
Immediate training of professionals	1,000,000
Stipends for mental health training	300,000
Construction grants for long-term facilities	5,000,000
Pilot project for home services to geriatrics	500,000
Community mental health centers	4,240,000
Directors for various services	1,180,000
Construction of small hospitals	450,000
Mental hygiene clinics	1,390,000
Regionalization of the Department	40,000
Continuing the Study	50,000
	$ 28,390,000

The Commission feels that the appropriation requested herein should be considered as a total package for the minimum that must be done in the next two years in developing a comprehensive and effective program for our mentally ill and older citizens in the Commonwealth of Virginia. However, if for budgetary reasons, the entire amount requested cannot be met, we feel that the first priority should be given to salary increases and those other measures that deal with the training, recruitment and retention of sufficient mental health personnel in all categories and at all levels.

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The ex officio members of the Commission, Dr. Hiram W. Davis, Commissioner of Mental Hygiene and Hospitals; Dr. Mack I. Shanholtz, Commissioner of Health; Mr. Otis L. Brown, Director, Department of Welfare and Institutions; Mr. Julian P. Fox, Jr., Chairman of the Commission on the Aging and Mr. William L. Painter, former Chairman of the Commission of the Aging, who gave us the benefit of their advice at the many meetings of the Commission.

The staffs of these Departments who provided much of the factual information upon which the Report is based.

The Honorable Alan A. Diamonstein, Member, House of Delegates; Mr. C. Arthur Fowler, former President, Virginia Nursing Home Association; Mr. Robert L. Gordon, Administrator, Richmond Nursing Home; Mr. Robert D. Ham, Director, Virginia Bureau of Medical and Nursing Facilities Services; Mr. Julian Hamlin, Regional Director, U. S. Department of Health, Education and Welfare; Mr. Henry Y. Hawthorne, Administrator, Patrick Henry Hospital; Mr. Walter Imwald, Administrator, Virginia Home; Dr. James B. Kenley, Director, Virginia Division of Medical and Hospital Services; Mr. Herbert G. Ross, Director of Public Welfare, City of Richmond; Mr. Don W. Russell, Commissioner, Vocational Rehabilitation; and Mr. Willard Warrick, Administrator, Lake Taylor Hospital, all of whom provided helpful information and advice.

Mr. T. Edward Temple, Director of the Division of State Planning and Community Affairs, for assigning staff to the Commission.

Mrs. Margareta Miller, who served as staff, for her invaluable work in conducting special studies of geriatric patients, in gathering information from the voluminous professional literature, in writing reports for the subcommittee and especially for her spirit of deep personal concern for the patients as individuals which pervaded all she did.

Mr. John A. Banks, Jr., of the Division of Statutory Research and Drafting, who attentively and efficiently handled administrative matters for the Commission.

The Honorable Mary Marshall, who joined the Commission at its meetings and in its deliberations.

Mrs. Anne P. Hirst, who attended many meetings and contributed so much to the success of the Commission by her enthusiasm and interest.

These distinguished out-of-State authorities who briefed the Commission at day-long conferences:
Dr. Alvin I. Goldfarb, private psychiatrist and leading authority on geriatrics, New York City;
Dr. Milton Greenblatt, Commissioner, Mental Health and Mental Retardation, Massachusetts;
Dr. Eugene Hargrove, Commissioner of Mental Health, North Carolina;
Dr. Alfred C. Kraft, Director, Medical Services and Facilities, Department of Public Welfare, Pennsylvania;
Dr. Harold L. McPheeters, Associate Director of Medical Health, Southern Regional Education Board and former Commissioner of Mental Health, Kentucky; and
Dr. Israel Zwerling, Director, Bronx State Hospital and Professor of Psychiatry, Albert Einstein College of Medicine, New York City.

The more than eighty interested persons who so ably shared their knowledge by testimony at the public hearings and by their letters and memoranda.

The Commission wishes to pay special tribute to the Mental Health Study Commission of 1956 and to the hundreds of Virginians who contributed to its work. Their report has been fundamental to recent improvements in mental health care in Virginia and to this study.

APPENDIX A
History of the Commission

A general concern among the citizens of the Commonwealth and Members of the General Assembly for the care and treatment of the mentally ill and the elderly citizens of Virginia began to grow during the latter part of the nineteen sixties. As a result, both Houses of the General Assembly, at its 1968 Regular Session, unanimously enacted House Bill No. 423, which created the present Commission.

Chapter 587

An Act to establish a Commission on Mental Indigent and Geriatric Patients for the purpose of a study and report; and to appropriate funds.

[H 423]

Approved April 4, 1968

Be it enacted by the General Assembly of Virginia:

1. § 1. There is hereby created a Commission to conduct a study of the care of the mentally ill in Virginia in the institutions and clinics administered by the State Hospital Board and by the State Department of Health, in comprehensive mental health centers receiving State aid, and in general and psychiatric hospitals and of geriatric patients in State hospitals, for the purpose of advising the General Assembly on the best use of available resources of money and personnel. It shall be known as the Commission on Mental Indigent and Geriatric Patients.

§ 2. The Commission shall give specific attention to:

(a) The desirability, methods and costs of decentralizing the State hospital system into locally or regionally controlled comprehensive community mental health centers and into institutions under the administration of the State Hospital Board.

(b) The particular problem of the patients over the age of sixty-five years and the desirability and feasibility of finding or creating alternative facilities for them such as public or private nursing homes or outpatient facilities for those aged who might thereby be kept with their families.

(c) Whether the position of Geriatrics Program Director should be established in the Department of Mental Hygiene and Hospitals.

(d) The effect the development of community mental health services can be expected to have on the number and type of patients in the State hospital system.

(e) The advisability of stronger State support in developing and financing community mental health services in the smaller cities and rural areas.

(f) Measures required to assure accreditation of Virginia State mental hospitals.

(g) The most appropriate long range use of the four existing State mental hospitals in terms of ultimate size and kinds of patients.

(h) The fullest possible use of resources other than those of the Department of Mental Hygiene and Hospitals, including the use of psychiatric beds in general hospitals.

(i) The development of training programs for personnel in the mental health care field at a Psychiatric Institute, in existing institutions of higher learning, in hospitals and in clinics.

(j) The most efficient use of staff through development of accurate job descriptions and adequate salary levels.

(k) Full use of available funds, including Medicare, Medicaid and all other federal funds and private foundation grants.

(l) The advisability and feasibility of constructing a system of public regional nursing home facilities throughout the State.

§ 3. The Commission shall consist of fifteen members to be appointed by the Governor from the State at large. The Governor shall also appoint the chairman. In addition, the Director of the Department of Welfare and Institutions, the State Health Commissioner and the Commissioner of Mental Hygiene and Hospitals shall be ex officio members of the Commission. The members of the Commission shall receive no compensation for their services but shall be reimbursed for expenses incurred by them in performing the work of the Commission.

§ 4. The Commission may employ agents, employees or consultants and may rent such office space, equipment and facilities as may be necessary to carry out the purposes of this act. All departments and agencies of the State are directed to assist the Commission in its studies.

§ 5. The Commission shall conclude its study and report its recommendations to the Governor and the General Assembly not later than November fifteen, nineteen hundred sixty-nine.

2. There is hereby appropriated from the general fund of the State treasury the sum of ten thousand dollars to carry out the purposes of this act.

The Governor appointed Senator Omer L. Hirst of Fairfax, Chairman of the Commission and the following members: Delegate Charles W. Gunn, Jr., Lexington; Delegate Richard M. Bagley, Hampton; Dr. David R. Hawkins, Charlottesville; Mrs. Jessie H. Key, Stuart; Dr. Henry Lederer, Richmond; Delegate Dorothy S. McDiarmid, Vienna; Mrs. Pierre S. Palmer, Burke; Mr. Thomas N. Parker, Jr., Richmond; Colonel James W. Roberts, Norfolk; Senator James C. Turk, Radford; Mr. Fitz Turner, Richmond; Mr. Edward B. White, Jr., Richmond; Judge Pressley B. White, Virginia Beach; and Mrs. Helen Hardy Wright, Harrisonburg.

Mr. Otis L. Brown, Director, Department of Welfare and Institutions: Dr. Hiram W. Davis, Commissioner, Mental Hygiene and Hospitals; Dr. Mack I. Shanholtz, Commissioner, Department of Health; and Mr. William L. Painter (later succeeded by Mr. Julian P. Fox, Jr.) Chairman, Commission on the Aging, served as ex officio members.

Mr. Gunn was elected as Vice-Chairman. The Commission was divided into three subcommittees: Indigent and Geriatric Patients, chaired by Mrs. McDiarmid; Mental Patients, chaired by Mr. Gunn; and Staff and Training, chaired by Dr. Hawkins.

The Division of Statutory Research and Drafting, represented by Mr. John A. Banks, Jr., provided counsel and staff assistance.

The Division of State Planning and Community Affairs conducted several studies, under the direction of Mrs. Margareta Miller. These studies were very extensive and comprehensive. The data gathered by Mrs. Miller and her staff, and the analysis thereof, provided the principal basis for many of the recommendations made in this report.

The full Commission conducted at least one meeting each month from June 1968 until present, and the subcommittees have been equally active. Field trips of the full Commission and subcommittees included visits to all five State hospitals; Powhatan Nursing Home, Falls Church; Patrick Henry Hospital, Newport News; Lake Taylor Hospital, Norfolk; and the Richmond Nursing Home.

Many representatives of State and local governments briefed the Commission. Lengthy conferences were held with the following distinguished out-of-State authorities on the subjects of the care and treatment for the mentally ill and the elderly and State mental health organizations and operations:

Dr. Alvin I. Goldfarb, private psychiatrist and leading authority on geriatrics, New York.

Dr. Milton Greenblatt, Commissioner, Mental Health and Mental Retardation, Massachusetts.

Dr. Eugene Hargrove, Commissioner, Mental Health, North Carolina.

Dr. Alfred C. Kraft, Director, Medical Services and Facilities, Department of Public Welfare, Pennsylvania.

Dr. Harold L. McPheeters, Associate Director of Mental Health, Southern Regional Education Board and Former Commissioner of Mental Health, Kentucky.

Dr. Israel Zwerling, Director, Bronx State Hospital and Professor of Psychiatry, Albert Einstein College of Medicine, New York.

Public Hearings were conducted in Richmond, Abingdon, Roanoke, Arlington, Hampton and Danville. Seventy persons addressed the Commission at these hearings, and many others sent in statements for consideration and incorporation into the record.

APPENDIX B
Small Hospital Plan

The Commission recommends the construction of smaller hospitals in metropolitan areas in lieu of the construction of any additional or replacement beds at existing State hospitals. Each hospital in the system would treat the whole spectrum of patients from its geographic area with a possible exception of specialized groups such as children or the acutely physically ill.

The locations below appeared to the Commission to provide State hospital service where most people of Virginia are and will increasingly be in the years to come. The numbers of beds are merely suggestions based on limited study of the home areas of patients now in the hospitals. More thorough study is necessary to determine exact numbers and the phasing of the construction program.

a. Charlottesville—a 100 bed unit as an integral part of the proposed Psychiatric Institute for Research and Training at the University of Virginia School of Medicine.

b. Richmond—a 100 bed unit as an integral part of the Psychiatric Institute for Research and Training previously authorized at Virginia Commonwealth University's Medical College of Virginia.

Note: The psychiatric institutes would have the responsibility for providing patient care to a specified area, within the framework of their teaching mission.

c. Norfolk area—a 700 bed unit to serve the urban part of planning district 20 (see attached map) which is presently sending some 1,000 patients to Central State Hospital, with the provision that geriatric patients in need of specialized geriatric services be referred to the proposed geriatric center at Central State Hospital or to other community facilities as their needs require.

d. Roanoke area—a 500 bed unit to serve planning district 5, which is presently sending 510 patients to State hospitals, and possibly planning district 11. It is recommended that geriatric patients from district 5 not in need of intensive psychiatric care continue to be sent to Catawba or geriatric centers at Western State and Southwestern State Hospitals, for the purpose of maximal utilization of existing medical-surgical facilities and other specialized services. The Commission understands that existing facilities at the new site in Staunton are being and can be further used as geriatric facilities. However, the addition of a 100 bed unit for ambulatory geriatrics capable of self-care would contribute considerably to the geriatric program at Western State Hospital. Thus, only 100 of the 1,000 geriatric beds requested at Western State Hospital would be needed if the proposed facilities at Roanoke and Northern Virginia were to assume a patient load of 500 each. In addition to service responsibility to planning district 5, the Roanoke facility would be well suited for a pilot project on mobile clinics serving the surrounding rural areas.

e. Northern Virginia area—a 500 bed unit serving planning district 8, which is presently sending 737 patients to Staunton. This service would be complemented by the services of the Northern Virginia Institute with its 120 beds.

f. Danville—a 500 bed facility to be phased in after the Roanoke facility is well established. It would serve planning district 12, which is now sending 595 patients to Central State Hospital. The addition of 700 beds in Norfolk and 500 beds in Danville would significantly reduce the size of Central State Hospital. In view of this, the building program at Central State proposed by the Department of Mental Hygiene & Hospitals should be limited to service facilities. Central State would then evolve as a multi-purpose facility providing forensic psychiatric services, geriatric services, mental retardation services and general psychiatric services to a more limited geographic area.

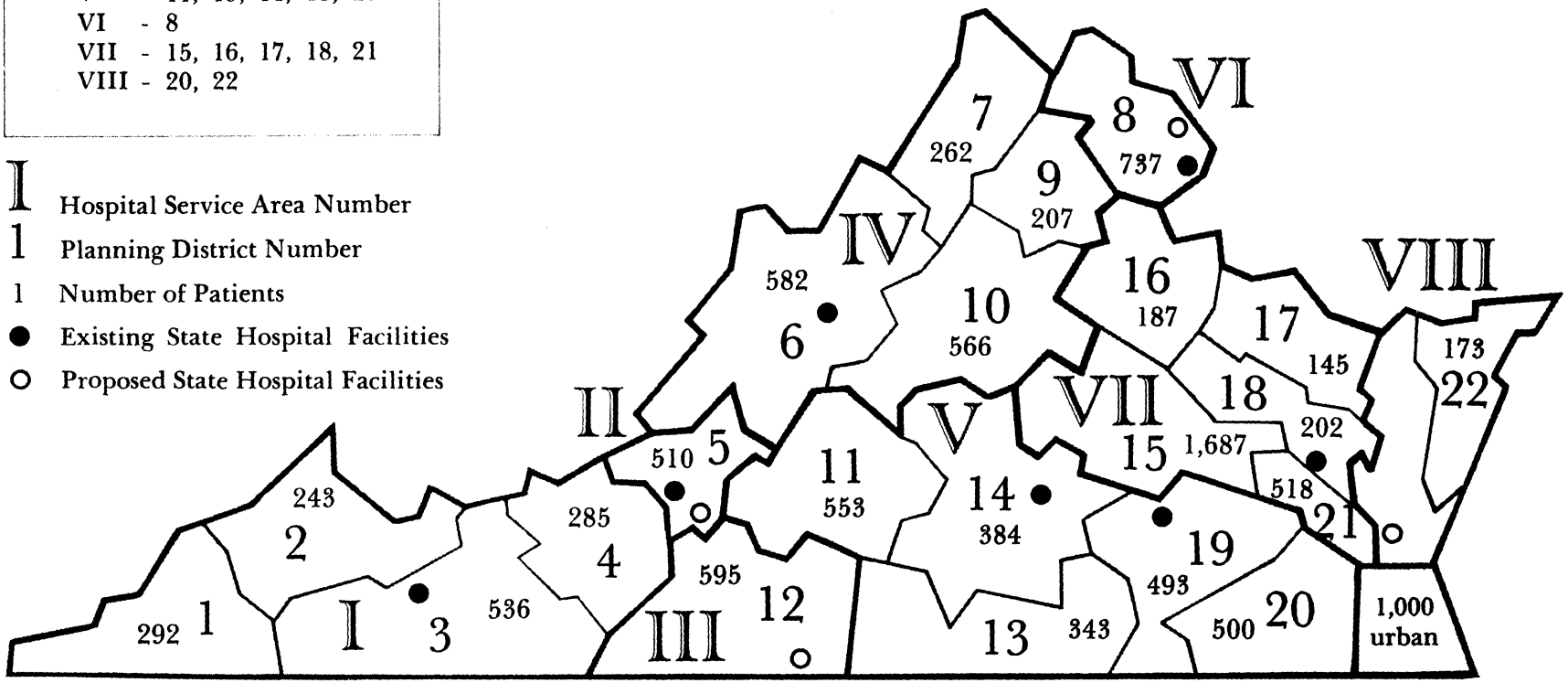
ENCLOSURE TO APPENDIX B

Existing and Proposed State Hospital Facilities on Basis of Resident Patients in State Hospitals by Planning District (except facilities for retarded) as of June 25, 1969

Proposed Hospital Service Areas Planning Districts

I - 1, 2, 3, 4
II - 5
III - 12
IV - 6, 7, 9, 10
V - 11, 13, 14, 19, 20
VI - 8
VII - 15, 16, 17, 18, 21
VIII - 20, 22

I Hospital Service Area Number
1 Planning District Number
1 Number of Patients
● Existing State Hospital Facilities
○ Proposed State Hospital Facilities



APPENDIX C

Comparison of Professional Salary Scales of Virginia and Two Nearby Southern States

The data below were obtained by the Commission in September, 1969 by direct communication with the Commissioners of Mental Health of two nearby Southern States. The figures indicate that Virginia pays significantly less to physicians except for the entrance salary of Staff Physician I. In the higher reaches of the Department, salaries are as much as one-third lower in Virginia. Although entrance salaries for psychologists and social workers are competitive, less career progress is possible than in the other states.

The comparisons may not be precise for all positions because designations for certain positions are somewhat different from state to state.

There are other factors of importance that do not show in the salary comparisons. Fringe benefits are one. In another instance, one of these states reports; "Doctors may be recruited anywhere within the pay grade salary range for which they are qualified, subject to the approval of the State Commissioner of Mental Health". Flexibility is less in Virginia. It should also be pointed out that in some states there are substantially more provisions for support of travel to professional meetings and availability of specific relief of time from other duties to engage in research or other forms of professional development.

Title and Level	State A	State B	Virginia
I. Physician			
Staff Physician Physician I (non-specialty)	$14,750–20,590	$15,564–19,812	$15,675–20,500
Physician II (specialty trained)	17,250–24,350	19,812–25,236	18,700–21,400
Physician III (board certified)	18,700–26,560	19,812–25,236	18,700–21,400
Mental Hygiene Clinic Director	20,280–31,750	**	19,600–22,400
Chief of Service	18,700–31,750	22,920–29,220	18,700–21,400
Clinical Director	20,280–34,750	**	19,600–22,400
Assistant Superintendent	**	25,236–32,220	21,400–23,400
Superintendent	**	27,828–35,520	21,400–25,600
Assistant Commissioner	**	30,684–39,168	28,000
Commissioner	**	**	28,500
II. Psychologist			
Psychologist A (A.B. Degree)	5,700	6,708– 8,412	7,032– 7,680
Psychologist B (M.S. no experience)	7,600–10,200	8,028–10,116	8,400–10,992
Psychologist B (Ph.D., no experience)	10,200–13,800	10,608–13,476	9,168–12,000
Psychologist C (M.S. and experience)	8,800–11,850	8,808–11,100	10,512–13,728
Psychologist C (Ph.D. and experience)	10,200–13,800	12,240–15,564	11,472–15,000
Psychologist D	11,825–16,175	12,240–15,564	12,528–16,400
Psychological Services Director	13,680–18,980	15,564–19,812	13,728–17,900
III. Social Worker			
Psychiatric Social Worker	7,600–13,800	6,408–12,840	7,032–13,128
Social Worker Director	10,980–14,940	10,116–16,332	10,512–13,728
IV. Nurses			
Mental Hospital General Duty Nurse	5,700– 8,180	6,120– 7,680	6,720– 8,040
Head Nurse	**	6,708– 8,412	7,344– 8,400
Nurse Supervisor	7,065– 9,485	7,344– 9,216	8,040– 9,600
Nurse Assistant Director	7,600–10,200	8,808–11,100	8,784–10,992
Nurse Director	7,600–14,940	8,808–11,100	8,784–10,992

* The occupation titles and levels may not be identically comparable due to insufficient description of varying titles from state to state.

** Information not given.

APPENDIX D

Survey of Bed Need
Nursing Homes and Homes for the Aged
by Medical Service Areas [1]

No proven or standard measuring device has yet been found to determine the actual need for all institutional facilities such as nursing homes, homes for the aged and related facilities. However, reliable estimates can be made based on state and national studies and experience. There is adequate information to support the theory that about sixteen percent of the total aged population are in need of health care assistance. Of this figure, about seven percent need assistance for independent living, such as home health services and outpatient medical services. The remaining nine percent are in need of a sheltered or institutional environment.

Those needing an institutional environment can further be categorized according to the level of care needed. Need according to levels of care have been grouped into three categories: "skilled nursing care", "intermediate nursing care", and "residential care". National studies indicate that of the total population aged 65 and over, 3.5% need "skilled nursing care", 1.5% need "intermediate nursing care" and 4% need "residential care" facilities. Planning for skilled nursing facilities has been carried on for the past twenty years, both nationally and in Virginia, by the Hill-Burton Agency. The Virginia Hill-Burton Plan presently indicates a 3.1% need for skilled nursing care facilities. Tables presented in this report have utilized the Medical Service Areas of the Hill-Burton Plan for projections of the need for "skilled", "intermediate" and "residential" care.

The Virginia Advisory Hospital Council in its Hill-Burton Plan uses forty (40) Medical Service Areas grouped into ten (10) Medical Service Regions. These areas are the basis for collection, organization and analysis of data on health and medical care facilities and for the allocation of federal Hill-Burton hospital construction grants. The areas have been delineated following analysis of current patient utilization data, taking into consideration population distribution, natural geographic boundaries, trade centers, political boundaries affecting patterns of service, and transportation factors.

		Nursing Facilities	*Residential Facilities*	*Total Facilities*
R–1	Nassawadox			
	Existing Beds	147*	102*	249
	Total Beds Needed	228	195	423
	% Need Met	64.5	52.3	58.9
	Unmet Bed Need	81	93	174
B–2	Norfolk			
	Existing Beds	1,321	222*	1,543
	Total Beds Needed	1,374	1,109	2,483
	% Need Met	96.1	20.0	62.1
	Unmet Bed Need	53	887	940
I–3	Portsmouth			
	Existing Beds	365	69	434
	Total Beds Needed	444	364	808
	% Need Met	82.2	19.0	53.7
	Unmet Bed Need	79	295	374
I–4	Suffolk			
	Existing Beds	65	70	135
	Total Beds Needed	209	176	385
	% Need Met	31.1	39.8	35.1
	Unmet Bed Need	144	106	250
R–5	Franklin			
	Existing Beds	0	7	7
	Total Beds Needed	129	112	241
	% Need Met	0.0	6.3	2.9
	Unmet Bed Need	129	105	234
I–6	Newport News			
	Existing Beds	754*	73	827
	Total Beds Needed	934	756	1,690
	% Need Met	80.7	9.7	48.9
	Unmet Bed Need	180	683	863

		Nursing Facilities	*Residential Facilities*	*Total Facilities*
I–7	Petersburg			
	Existing Beds	270	90	360
	Total Beds Needed	599	488	1,087
	% Need Met	45.1	18.4	33.1
	Unmet Bed Need	329	398	727
R–8	South Hill			
	Existing Beds	0	41	41
	Total Beds Needed	204	172	376
	% Need Met	0.0	23.8	10.9
	Unmet Bed Need	204	131	335
I–9	Farmville			
	Existing Beds	92	129	221
	Total Beds Needed	389	320	709
	% Need Met	23.7	40.3	31.2
	Unmet Bed Need	297	191	488
B–10	Richmond			
	Existing Beds	1,741*	1,252*	2,993
	Total Beds Needed	2,329	1,872	4,201
	% Need Met	74.8	66.9	71.2
	Unmet Bed Need	588	620	1,208
R–11	Warsaw			
	Existing Beds	34	18	52
	Total Beds Needed	199	168	367
	% Need Met	17.1	10.7	14.2
	Unmet Bed Need	165	150	315
I–12	Fredericksburg			
	Existing Beds	248	55	303
	Total Beds Needed	364	300	664
	% Need Met	68.1	18.3	45.6
	Unmet Bed Need	116	245	361
R–13	Warrenton			
	Existing Beds	73	0	73
	Total Beds Needed	119	104	223
	% Need Met	61.3	0.0	32.7
	Unmet Bed Need	46	104	150

		Nursing Facilities	*Residential Facilities*	*Total Facilities*
I–14	Fairfax-Arlington			
	Existing Beds	1,602*	724*	2,326
	Total Beds Needed	1,624	1,308	2,932
	% Need Met	98.6	55.4	79.3
	Unmet Bed Need	22	584	606
R–15	Leesburg			
	Existing Beds	31	0	31
	Total Beds Needed	144	124	268
	% Need Met	21.5	0.0	11.6
	Unmet Bed Need	113	124	237
I–16	Winchester			
	Existing Beds	224	137	361
	Total Beds Needed	294	244	538
	% Need Met	76.2	56.1	67.1
	Unmet Bed Need	70	107	177
R–17	Woodstock			
	Existing Beds	107	32	139
	Total Beds Needed	134	116	250
	% Need Met	80.0	27.6	55.6
	Unmet Bed Need	27	84	111
R–18	Culpeper			
	Existing Beds	13	260*	273
	Total Beds Needed	124	108	232
	% Need Met	10.5	240.7	117.7
	Unmet Bed Need	111	0	0
I–19	Harrisonburg			
	Existing Beds	144*	218*	362
	Total Beds Needed	369	304	673
	% Need Met	39.0	71.7	53.8
	Unmet Bed Need	225	86	311
B–20	Charlottesville			
	Existing Beds	322	140	462
	Total Beds Neeeded	694	564	1,258
	% Need Met	46.4	24.8	36.7
	Unmet Bed Need	372	424	796

		Nursing Facilities	*Residential Facilities*	*Total Facilities*
I–21	Staunton			
	Existing Beds	243	124	367
	Total Beds Needed	414	340	754
	% Need Met	58.7	36.5	48.7
	Unmet Bed Need	171	216	387
R–22	Lexington			
	Existing Beds	50	0	50
	Total Beds Needed	124	108	232
	% Need Met	40.3	0.0	21.6
	Unmet Bed Need	74	108	182
I–23	Lynchburg			
	Existing Beds	575	524*	1,099
	Total Beds Needed	789	640	1,429
	% Need Met	72.9	81.9	76.9
	Unmet Bed Need	214	116	330
R–24	South Boston			
	Existing Beds	92	22	114
	Total Beds Needed	179	152	331
	% Need Met	51.4	14.5	34.4
	Unmet Bed Need	87	130	217
B–25	Danville			
	Existing Beds	259	112	371
	Total Beds Needed	429	352	781
	% Need Met	60.4	31.8	47.5
	Unmet Bed Need	170	240	410
I–26	Martinsville			
	Existing Beds	82	0	82
	Total Beds Needed	254	212	466
	% Need Met	32.3	0.0	17.6
	Unmet Bed Need	172	212	384
B–27	Roanoke			
	Existing Beds	780*	328*	1,108
	Total Beds Needed	1,129	912	2,041
	% Need Met	69.1	36.0	54.3
	Unmet Bed Need	349	584	933

		Nursing Facilities	*Residential Facilities*	*Total Facilities*
I–28	Covington			
	Existing Beds	49	0	49
	Total Beds Needed	164	140	304
	% Need Met	29.9	0.0	16.1
	Unmet Bed Need	115	140	255
R–29	Pearisburg			
	Existing Beds	36	0	36
	Total Beds Needed	59	56	115
	% Need Met	61.0	0.0	31.3
	Unmet Bed Need	23	56	79
R–30	Radford			
	Existing Beds	139	0	139
	Total Beds Needed	169	144	313
	% Need Met	82.2	0.0	44.4
	Unmet Bed Need	30	144	174
R–31	Pulaski			
	Existing Beds	42	56	98
	Total Beds Needed	104	92	196
	% Need Met	40.4	60.9	50.0
	Unmet Bed Need	62	36	98
R–32	Wytheville			
	Existing Beds	97	75	172
	Total Beds Needed	104	92	196
	% Need Met	93.3	81.5	87.8
	Unmet Bed Need	7	17	24
R–33	Galax			
	Existing Beds	17	0	17
	Total Beds Needed	224	188	412
	% Need Met	7.6	0.0	4.1
	Unmet Bed Need	207	188	395
R–34	Marion			
	Existing Beds	103	8	111
	Total Beds Needed	134	116	250
	% Need Met	76.9	6.9	44.4
	Unmet Bed Need	31	108	139

		Nursing Facilities	*Residential Facilities*	*Total Facilities*
R–35	Tazewell			
	Existing Beds	84	0	84
	Total Beds Needed	149	128	277
	% Need Met	56.4	0.0	30.3
	Unmet Bed Need	65	128	193
I–36	Abingdon			
	Existing Beds	275	115	390
	Total Beds Needed	364	300	664
	% Need Met	75.5	38.3	58.7
	Unmet Bed Need	89	185	274
R–37	Lebanon			
	Existing Beds	0	0	0
	Total Beds Needed	99	88	187
	% Need Met	0.0	0.0	0.0
	Unmet Bed Need	99	88	187
R–38	Grundy			
	Existing Beds	0	0	0
	Total Beds Needed	69	64	133
	% Need Met	0.0	0.0	0.0
	Unmet Bed Need	69	64	133
R–39	Norton			
	Existing Beds	50	41	91
	Total Beds Needed	234	196	430
	% Need Met	21.4	20.9	21.2
	Unmet Bed Need	184	155	339
R–40	Pennington Gap			
	Existing Beds	0	16	16
	Total Beds Needed	109	96	205
	% Need Met	0.0	16.7	7.8
	Unmet Bed Need	109	80	189
State Total				
	Existing Beds	10,526	5,060	15,586
	Total Beds Needed	16,204	13,320	29,524
	% Need Met	65.0	38.0	52.8
	Unmet Bed Need	5,678	8,260	13,938

1. Based on survey conducted May, 1969.

• Areas with facilities which serve a national, regional or statewide population.

APPENDIX E [1]

Homes for the Aged and Nursing Homes With National, Regional or Statewide Usage

1. Elks National Home Inc. — *Serves National Population*
   Bedford
   300 Beds—Homes for the Aged

2. Virginia Baptist Home, Inc. — *Serves Statewide Population*
   Culpeper
   260 Beds—Home for the Aged

3. Sunnyside Presbyterian Home, Inc. — *Serves Statewide Population*
   Harrisonburg
   90 Beds—Home for the Aged
   24 Beds—Nursing Home

4. Virginia Mennonite Home, Inc. — *Serves Statewide Population*
   Harrisonburg
   58 Beds—Home for the Aged
   43 Beds—Nursing Home

5. Odd Fellows Home of Virginia, Inc. — *Serves Statewide Population*
   Lynchburg
   75 Beds—Home for the Aged

6. Asa Snyder Memorial Home — *Serves Statewide Population*
   Richmond
   42 Beds—Home for the Aged

7. Eastern Star Home of Virginia, Inc. — *Serves Statewide Population*
   Richmond
   52 Beds—Home for the Aged

8. Home for Needy Confederate Women, Inc. — *Serves Statewide Population*
   Richmond
   82 Beds—Home for the Aged

9. Masonic Home of Virginia (Adult Div.) — *Serves Statewide Population*
   Richmond
   60 Beds—Home for the Aged
   22 Beds—Nursing Home

10. Protestant Episcopal Church Home, Inc. — *Serves Statewide Population*
    Richmond
    40 Beds—Home for the Aged

11. Goodwin House — *Serves Statewide Population*
    Alexandria
    245 Beds—Home for the Aged
    49 Beds—Nursing Home

12. Virginia Methodist Home for the Aged, Inc. — *Serves Statewide Population*
    Richmond
    260 Beds—Home for the Aged

13. Hermitage Methodist Home of Virginia, Inc. — *Serves Statewide Population*
    Alexandria
    225 Beds—Home for the Aged
    121 Beds—Nursing Home

14. Hermitage on the Eastern Shores — *Serves Statewide Population*
    Onancock
    70 Beds—Home for the Aged
    30 Beds—Nursing Home

15. The Methodist Home in Roanoke — *Serves Statewide Population*
    Roanoke
    100 Beds—Home for the Aged
    22 Beds—Nursing Home

16. Friendship Manor Home for Aged, Inc. — *Serves Statewide Population*
    Roanoke
    92 Beds—Home for the Aged
    38 Beds—Nursing Home

17. Lydia H. Roper Home — *Serves Statewide Population*
    Norfolk
    26 Beds—Home for the Aged

18. Little Sisters of the Poor — *Serves Statewide Population*
    Richmond
    153 Beds—Home for the Aged

19. Bridgewater Home for Aging — *Serves Statewide Population*
    Bridgewater
    39 Beds—Home for the Aged
    38 Beds—Nursing Home

20. The Virginia Home — *Serves Statewide Population*
    Richmond
    106 Beds—Nursing Home

21. Patrick Henry Hospital for the Chronically Ill, Inc. — *Serves Regional Population*
    Newport News
    373 Beds—Nursing Home

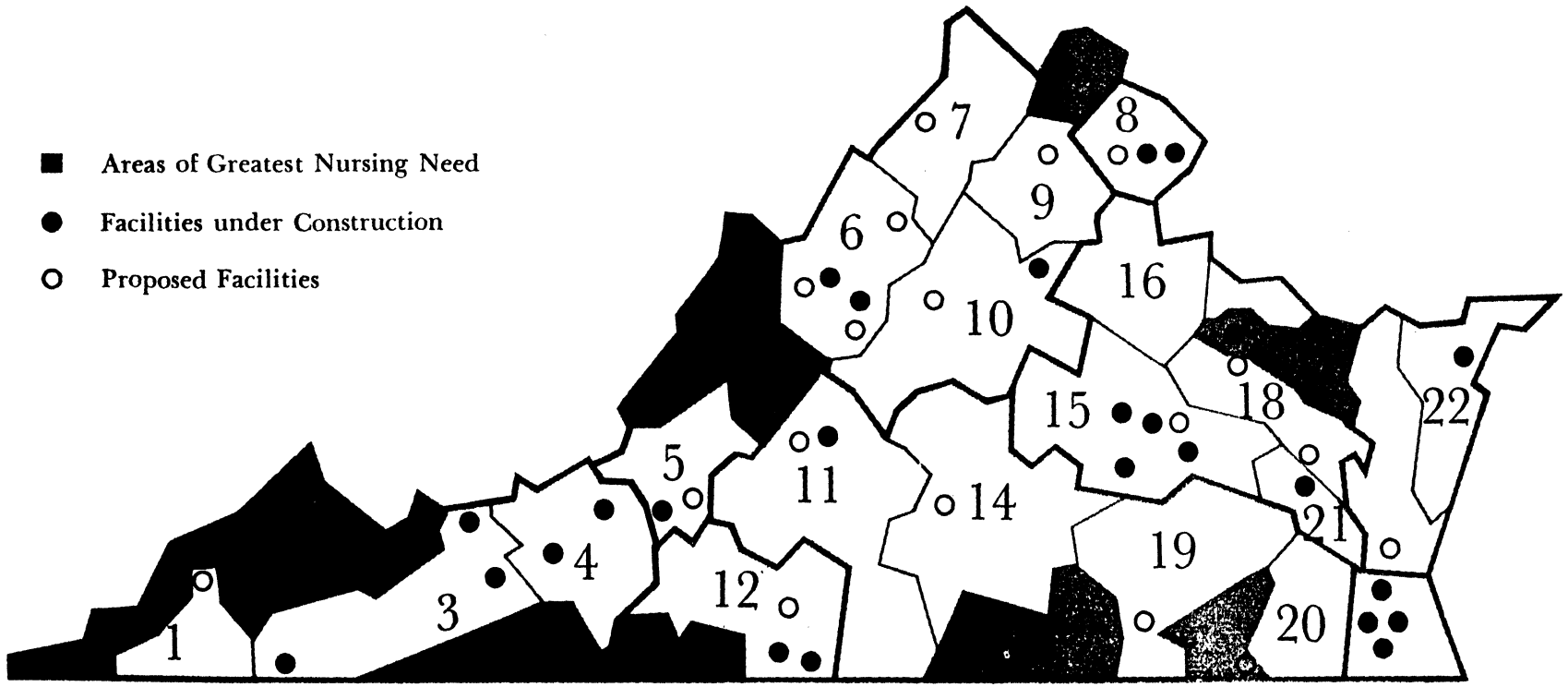
Total National Beds: 300
Total Statewide Beds: 2,462
Total Regional Beds: 373
Total Beds: 3,222

[1] Based on survey conducted May 1969.

APPENDIX F

Geriatric Facilities Under Construction and Proposed July — 1969.

Source: State Health Department's Calculation of percent of bed need met by Medical Service District—as of July 25, 1969.



APPENDIX G

Care Needs of Geriatric Patients in State Hospitals

The Commission undertook a study of the geriatric patients in State mental hospitals in order to determine the nature of their needs and the kinds of facilities and programs best suited to meet these needs.

The study was designed by Mrs. Margaretta Miller of the Division of State Planning and Community Affairs and Dr. Robert S. Miller, Professor of Sociology, College of William and Mary. The data were collected from (1) a 20% sample of resident geriatric patients in Eastern State Hospital, as of April 1969, (2) all geriatric admissions to Western State Hospital between February 1, 1969 and April 30, 1969, and (3) a 50% sample of patients in The Richmond Nursing Home as of April 1969.

Data from Eastern State Hospital were collected under the direction of Dr. Kurt Schmidt, from Western State Hospital under the direction of Dr. William H. Grey and from The Richmond Nursing Home under the direction of Dr. Alan Hecht. All of this data were processed by Mrs. Miller and her staff. The general results are:

There are approximately 3,500 elderly patients in State hospitals in Virginia. The average cost for their care in geriatric wards was $6.94 per patient day during the quarter ending March 31, 1969. The range in cost in the geriatric wards was $5.27 to $7.28 per patient day.

A sizable proportion of elderly patients require more intensive medical care, costing an average of $20.24 per patient day with a range of $12.56 to $31.68. However, the number of geriatric patient days in the medical-surgical centers constitutes such a small part of total services to geriatric patients that the average cost for geriatric care per patient day would not exceed $8.00.

The survey indicated that approximately half of the geriatric patients in State hospitals could be cared for in the community in the following types of settings:

1. 19.8 per cent could be cared for in domiciliary facilities in the community.
2. 20.1 per cent could be cared for in nursing homes.
3. 5.9 per cent could live at home with organized home care.
4. 5.2 per cent could live at home taking care of themselves.

In the survey sample of Eastern State Hospital, representing the total geriatric population in this facility, 57.8 per cent were admitted in old age. The remaining 42.2 per cent were chronic mental patients who had grown old in the hospital. Our elderly State hospital population consists of 35.5 per cent diagnosed psychotic patients. Of the remaining 64.5 per cent, 56 per cent have a diagnosis of chronic brain syndrome with or without psychotic reaction.

As a result of the fact that so many geriatric patients in State hospitals are chronic schizophrenics with a long history of illness and hospitalization, a large portion of these people have very tenuous family ties; *44 per cent have no living children, and 30.9 per cent were never married.* Of the geriatric patients, 33 per cent are widowed.

This group is also quite advanced in age, with fairly even distribution in age groups 65 to 85 (16 per cent were over 85).

There is a high incidence of physical illness at the time of admission, requiring medical attention in 41.4 per cent of the cases at Eastern State and in 40.6 per cent of the geriatric admissions at Western. On the self care index rating (the patient's capability to ambulate, feed, dress, and toilet himself) there were only insignificant differences between the Eastern State sample of the geriatric resident population and the Western State sample of geriatric admissions. For comparative purposes, the corresponding data from the Richmond Nursing Home is presented:

	Resident Geriatric Population Eastern State Hospital	Geriatric Admissions Western State Hospital	Residents Richmond Nursing Home
1. Self-care Capability:			
a. Completely dependent	14.3%	18%	80.2%
b. Severely restricted	29.4	29.5	15.2
c. Moderately restricted	27.4	24.6	4.6
d. Independent	28.9	27.9	None
2. Physical Disability:			
a. Temporary	16.3	18.2	10.2
b. Permanent, mild	30.9	9.1	20.3
c. Permanent, moderate	33.7	42.4	25.4
d. Permanent, severe	14.1	9.1	42.4
e. Undetermined	5.5	21.2	1.7
3. Psychiatric Disability:			
a. Temporary	1.6	9.1	2.5
b. Permanent, mild	34.7	25.0	55.0
c. Permanent, moderate	39.6	45.5	20.0
d. Permanent, severe	19.8	13.6	17.5
e. Undetermined	4.3	6.8	5.0

The above data clearly indicates that the two State hospital samples were very similar in the areas of self-care capability. There was a somewhat higher incidence of permanent moderate physical disability and temporary psychiatric disability in the geriatric admissions (Western State Sample) than in the geriatric resident population (Eastern State Sample). However, more striking than the differences is the marked similarity between the two State hospital groups, the survey involving different patients and evaluators (physicians and nurses in both hospitals and in the Richmond Nursing Home) following the same procedure and definitions for evaluation.

In Western State Hospital 27.7 per cent of geriatric admissions had histories of previous psychiatric hospitalization. The corresponding figure for Eastern State is 56.3 per cent for all resident geriatric patients.

It is also quite clear that the Richmond Nursing Home has a patient load *physically* much sicker and *mentally* less disabled than the geriatric State hospital population.

However, it should be noted that from the survey sample of geriatric admissions at Western State were omitted those patients (19.3 per cent) who died soon after admission. Their inclusion in the sample would have involved contacting their relatives (there was very little information on them in the charts), which could not be done for ethical reasons. The method of handling records after the patient's death made it too time-consuming for the doctors to go back and trace the medical histories of these patients.

Thus, among the geriatric admissions to State hospitals is a sizable group of severely ill patients, who do not show up to a significant degree in the resident population survey due to their short length of stay in the hospital prior to death. However, the practice of inappropriately referring patients for terminal care in State hospitals clearly involves needless stress for the patient and undue strain on the hospital's resources.

A second group of "short-stayers", 13.5 per cent, are discharged or furloughed within a few weeks or months after admission.

The remaining 67.2 per cent of the geriatric admissions have much the same characteristics as the general geriatric State hospital population, consisting of psychotic patients grown old in the hospital as well as geriatric admissions.

In summary, the staff study indicates:

1. That about half of all resident geriatric patients, or 1,750 persons, *could* be placed in the community according to physician's evaluation of their care needs.

2. That about 20 per cent of the geriatric admissions are inappropriately referred to State hospitals for terminal care. This group includes only patients who arrived in the hospital with terminal conditions leading to their death within three months or less.

3. That about 13 per cent of geriatric patients were inappropriately referred to the State hospital in that they were found not to need such care within a short period of evaluation.

Thus, one-third of admissions are clearly inappropriate. This is not to say that these patients did not need care; the study of 268 geriatric case records clearly indicates that practically all geriatric patients referred to State hospitals and their families have gone through profound and traumatic crises prior to the State hospital commitment. More than 40 per cent of these resident geriatric patients and *50 per cent* of the geriatric admissions had a history of community placement and moving around from one living arrangement to another.

In summary, the staff study of social, medical, and psychiatric characteristics of geriatric State hospital patients indicates the following needs:

1. There is a continuing need for the State hospitals to serve mentally ill geriatric patients.

2. Any attempt to discharge elderly geriatric patients from State hospitals must be paralleled by the development of alternative systems of care in the community.

3. The key to avoiding inappropriate referrals to state hospitals lies in the development of a screening system in the community. This system should not primarily be focused on screening out, but on positive long-term planning with patients and families.