




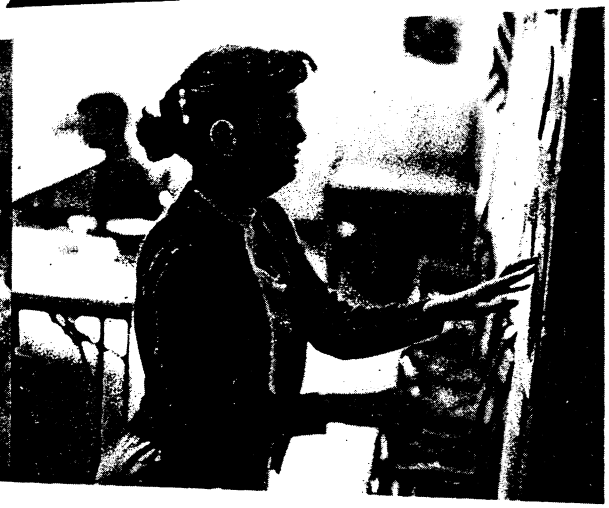

HOPE
for Virginia's voiceless citizens





HOPE FOR VIRGINIA'S VOICELESS CITIZENS

A REPORT TO THE GOVERNOR AND THE 1972 SESSION OF THE GENERAL ASSEMBLY FROM THE COMMISSION ON MENTAL, INDIGENT AND GERIATRIC PATIENTS

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Director, Department of Welfare and Institutions

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Chief, Gerontology Planning, Division of Planning and Community Affairs

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Commissioner of Health

Woodrow W. Wilkerson, D.Ed.
Superintendent of Public Instruction

To: THE HONORABLE LINWOOD HOLTON, GOVERNOR OF THE COMMONWEALTH OF VIRGINIA
AND
THE GENERAL ASSEMBLY OF VIRGINIA

It is with deep concern, yet at last with solid hope, that I present to you the Report of the Commission on Mental, Indigent and Geriatric Patients as directed by the 1970 Session of the General Assembly.

Your Commission speaks for Virginians who are voiceless in their own behalf, utterly dependent on what we, their fellow citizens, can do for them.

Since your Commission made its 1970 Report on the needs of patients in Virginia's mental hospitals, including many indigent geriatric cases, we have studied intensively the needs of Virginia's retarded children and its emotionally disturbed youngsters.

For a long time, all those people had one handicap in common—a public attitude which they were voiceless to change. Too many of us had the mistaken idea that retardation and mental illness were hopeless. We found the whole subject distasteful, even frightening. We turned away. That is why public neglect condemns so many of those in our mental hospitals and institutions for the retarded to long, silent misery erupting occasionally into public scandal.

Since 1968 the Commonwealth has made a major effort to repair past neglect. The job cannot be done in a year or two. But now, at last, we can have a realistic hope that Virginia will fulfill its commitment.

I believe we can all feel a deep stirring and upturn in the tide of public opinion. It gives us hope that we shall have more money to work with, year after year. It gives us hope for relieving the crippling shortage of professionals of all kinds through establishment of Psychiatric Institutes which have been authorized since 1944. Above all, it gives hope for a coordinated system of care under which all State and community services can work together without duplication or competition to get the most from every available dollar.

Unless we accomplish the goals set before us in this Report, we shall roll up year after year a crushing burden of costly institutionalized cases far greater than we need to carry.

Unless we accomplish those goals we will be heedlessly cruel to these voiceless fellow citizens whose limitations do not limit their capacity to feel and to suffer.

Let us act now, and go on acting, to keep today's new hope growing and give it substance.

Respectfully submitted,

Chairman

November 15, 1971

MAJOR RECOMMENDATIONS

The Commission on Mental, Indigent and Geriatric Patients urged in 1970 that the Commonwealth make a commitment of "new ideas, new programs and cold, hard cash" for help to the mentally ill and dignity for the aged who are ill. The Commission has been gratified by the attention given to these needs by the 1970 General Assembly and Governor Holton and by the improvements in care which such attention has brought about.

However, so much remains to be done in these fields and in the new areas of study, mental retardation and emotionally disturbed children and youth, that the Commission hopes it can convey its feeling of urgency. Among the many claims for public attention and the tax dollar, we push these needs forward to help Virginians who cannot speak for themselves because of their handicaps. We chose three of our 15 major recommendations for highest priority, not because they are new, which they are not, but because they are so long overdue:

1. *The Psychiatric Institutes,* which were our highest priority in 1969, are again our highest priority in 1971 because they are the key to meeting the State's critical shortage of mental health professionals.

2. Greatly increased funds for *community services* for the mentally retarded and mentally ill because this is the key to reducing the population of the State institutions.

3. Residential facilities under the Department of Mental Hygiene and Hospitals for those emotionally disturbed adolescents for whom there is now no appropriate place of treatment because they have been so long neglected.

Mental Retardation

1. Mentally retarded persons should be helped whenever possible to live in the Community rather than being sent to institutions,

therefore

THE STATE SHOULD PROVIDE SUBSTANTIAL FUNDING FOR GREATLY INCREASED COMMUNITY SERVICES AIMED AT REDUCING INSTITUTIONALIZATION OF THE MENTALLY RETARDED, SUCH AS

(a) PROTECTIVE SERVICES

(b) ACTIVITY CENTERS AND WORKSHOPS

(c) ADULT LIVING CENTERS

2. All children in the Commonwealth are entitled to education and training to develop their fullest potential,

therefore

ALL SCHOOL SYSTEMS SHOULD BE REQUIRED TO PROVIDE PROGRAMS FOR EDUCABLE AND TRAINABLE RETARDED CHILDREN, BUT WHERE LOCALITIES HAVE NOT MADE SUITABLE PROGRAMS AVAILABLE, CHILDREN SHOULD BE GIVEN ADEQUATE TUITION GRANTS.

3. The needs of retarded persons and their families have been badly neglected in Virginia in part because there has been no agency of government focused on the total needs of the retarded through their lifetimes,

therefore

A DEVELOPMENTAL DISABILITY PLANNING AND ADVISORY COUNCIL REPORTING TO THE GOVERNOR SHOULD BE ESTABLISHED BY LAW, WITH AT LEAST ONE-THIRD OF ITS MEMBERS REPRESENTING THE RETARDED AND OTHERWISE DISABLED, AND SHOULD BE BUDGETED FOR A SMALL STAFF.

4. Mental retardation can be prevented and the seriousness of the disability can be reduced,

therefore

THE ACTIVITIES OF THE HEALTH DEPARTMENT IN PRENATAL CARE, WELL-BABY CLINICS AND CONSULTATION AND EVALUATION CLINICS SHOULD BE EXPANDED WITH SPECIAL ATTENTION TO MONITORING AND INTERVENING IN HIGH-RISK SITUATIONS. INOCULATONS FOR MEASLES AND RUBELLA SHOULD BE MANDATORY BEFORE SCHOOL ENTRY.

5. Some retarded persons are living in State institutions under physical conditions that no human being should have to endure. The State has a plan for building regional training centers that can house the retarded in pleasant surroundings and also be consultation and professional training centers for their region,

therefore

OBSOLETE BUILDINGS LIKE EASTVIEW AND WESTVIEW AT PETERSBURG TRAINING CENTER MUST BE REPLACED BY RAPID CONSTRUCTION OF REGIONAL TRAINING CENTERS AND OF APPROPRIATE NEW BUILDINGS AT PETERSBURG AND LYNCHBURG.

Emotionally Disturbed Children and Youth

1. There are hundreds of children and youth with severe behavior disorders whom neither the Department of Mental Hygiene nor the Department of Welfare and Institutions at present have the capability to care for properly,

therefore

THE DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS SHOULD DEVELOP PLANS FOR FACILITIES WHICH WOULD COMBINE A THERAPEUTIC ENVIRONMENT WITH INDIVIDUALIZED EDUCATION AND SEEK FUNDS FOR THEM. DEJARNETTE HOSPITAL COULD BE USED FOR THIS PURPOSE OR REGIONAL CENTERS COULD BE ESTABLISHED WITH LOCAL COOPERATION.

2. Some emotionally disturbed children cannot be kept at home or have no homes but need not be in State institutions because they can be maintained in their local public schools,

therefore

GROUP HOMES AND PROBATION HOMES SHOULD BE DEVELOPED IN EVERY COMMUNITY OR REGION OF VIRGINIA USING FUNDS FROM THE LOCALITIES, THE DEPARTMENT OF WELFARE AND INSTITUTIONS, THE LAW ENFORCEMENT ASSISTANCE ACT AND THE DEPARTMENT OF MENTAL HYGIENE'S CHAPTER 10 BOARDS.

3. Children with behavior problems can be helped best within the regular classroom but many teachers cannot cope with them without special training, ongoing consultation or the added help of a teacher's aide,

therefore

EVERY EFFORT SHOULD BE MADE BY SCHOOL SYSTEMS TO KEEP CHILDREN WITH BEHAVIOR PROBLEMS IN THE REGULAR CLASSROOM BY ASSISTANCE TO THE TEACHER.

4. Nevertheless there are children who are too emotionally disturbed for the regular classroom and these children must be educated,

therefore

FINANCIAL ASSISTANCE TO LOCAL SCHOOL BOARDS FOR SPECIAL CLASSES SHOULD BE INCREASED AND REALISTIC TUITION GRANTS SHOULD BE MADE AVAILABLE TO EMOTIONALLY DISTURBED CHILDREN NOT SERVED BY THE PUBLIC SCHOOLS INCLUDING THOSE OF PRE-SCHOOL AGE WHO NEED THERAPEUTIC PROGRAMS.

5. Many of the children in the juvenile correctional institutions are emotionally disturbed or retarded or both,

therefore

THE DEPARTMENT OF WELFARE AND INSTITUTION'S TRAINING SCHOOLS SHOULD HAVE PROPERLY STAFFED SPECIAL EDUCATION CLASSES. THEY ALSO NEED MORE MENTAL HEALTH CONSULTATION AND BACK-UP SERVICES FROM THE DEPARTMENT OF MENTAL HYGIENE.

Areas of Continued Commission Study

1. The improvement of mental health services, in the community and in institutions, is limited by the critical shortage of trained mental health professionals of all kinds,

therefore

THE COMMISSION PLACES HIGHEST PRIORITY ON THE APPROPRIATION THIS BIENNIUM OF FUNDS FOR PSYCHIATRIC INSTITUTES AT BOTH THE MEDICAL COLLEGE OF VIRGINIA (VCU) AND THE UNIVERSITY OF VIRGINIA.

2. Many mentally ill persons who would formerly have been hospitalized can now safely live in the community if modern medication and appropriate kinds of mental health care are available,

therefore

THE STATE SHOULD PROVIDE SUBSTANTIAL FUNDING FOR GREATLY INCREASED PROGRAMS TO KEEP PATIENTS OUT OF MENTAL HOSPITALS SUCH AS AFTER-CARE, PROTECTIVE SERVICES AND GERIATRIC SCREENING.

3. With increased reliance on community care of the mentally ill and mentally retarded, the Chapter 10 Boards (Community Mental Health and Mental Retardation Services Boards) will become a key part of the system for delivering services,

therefore

THE DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS SHOULD TAKE ALL NECESSARY STEPS TO INSURE THAT THERE IS A CHAPTER 10 BOARD SERVING EVERY LOCALITY IN VIRGINIA AND SHOULD CLARIFY THE POWERS AND DUTIES OF THE BOARDS AND THEIR RELATIONSHIP TO OTHER MENTAL HEALTH AGENCIES.

4. Although most elderly patients in the State mental hospitals do not need specifically psychiatric care, they must have humane care in some kind of institution,

therefore

ADMINISTRATIVELY SEPARATE GERIATRIC CENTERS SHOULD BE ESTABLISHED AT THE FOUR LARGE MENTAL HOSPITALS AND REGIONAL SATELLITES FOR LESS INTENSIVE CARE SHOULD BE SET UP BY THE CENTERS. THE MATCHING GRANTS TO LOCALITIES FOR HOMES FOR THE AGED AND NURSING HOMES, RECOMMENDED BY THE COMMISSION IN 1970, SHOULD BE APPROPRIATED.

5. Planning for the care of the mentally ill and mentally retarded in Virginia and the wisest use of resources has suffered from lack of knowledge of the identity of high-risk groups and of the effectiveness of different kinds of services,

therefore

THE COMMISSION RECOMMENDS THE FUNDING OF THE PROPOSED PSYCHIATRIC EPIDEMIOLOGY LABORATORY AT THE UNIVERSITY OF VIRGINIA MEDICAL SCHOOL.

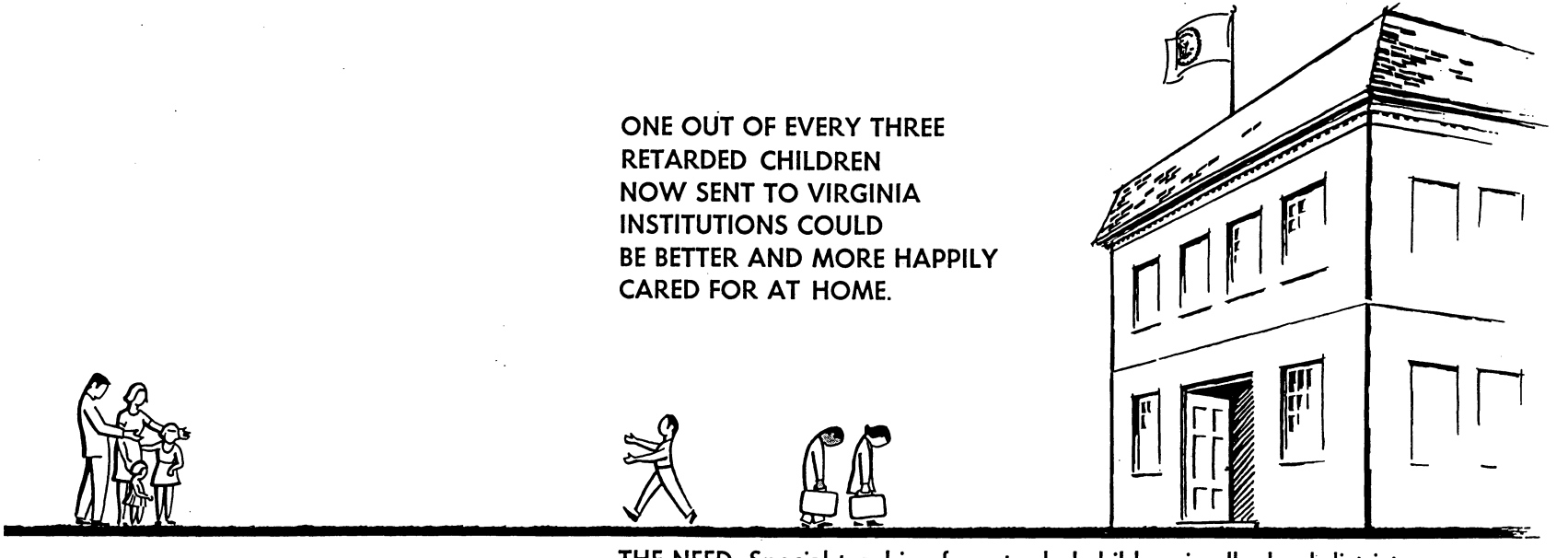
MENTAL RETARDATION

Introduction

Mental retardation is not an illness which can be cured but a lifetime condition. It is usually estimated that about 3% of the general population is retarded, in Virginia about 140,000 persons. Of these, about 98,000 are mildly retarded and educable. With the right kind of teaching they can learn elementary academic skills and with vocational training, be employed at simple jobs. About 39,000 are moderately retarded and trainable; that is, they can care for themselves, get around in the community and work under understanding supervision. Their social and emotional adaption is as important to the successful adjustment of mildly and moderately retarded persons as the degree of their intellectual handicap.

Thus, the vast majority of the persons who were the concern of this study are employable, living in the community and able to function in job and family. Yet a study of admissions to Lynchburg and Petersburg Training Schools and Hospitals from January 1, 1966 to December 30, 1970 showed that 35% of all persons admitted were only mildly and moderately retarded; 27% ambulatory, 8% with moderate physical disability. So about one-third of the persons now entering institutions might very well be able to live in the community with appropriate help. The Commission study has, therefore, centered on the less handicapped retarded.

The 2 percent of the retarded population who are severely and profoundly handicapped (about 2,800 persons) constitute



THE NEED: Special teaching for retarded children in all school districts.
Plus community services to help parents of mildly or moderately retarded children.

a permanently dependent population. The intellectual handicap of these individuals is frequently related to organic problems and multiple physical disabilities. This group is growing numerically due to the advances in medical science prolonging their life expectancy. The Commission has given this group much less attention for reasons of limitation of staff and time and not because of lack of recognition of the heavy burdens they constitute for their families.

The State of Virginia has made progress in recent years in providing programs and services to mentally retarded persons and their families. But this progress has not been uniform and the State's efforts have been limited to only a part of the total effort required. At present, the approach throughout the United States is to provide more comprehensive services, which are more community oriented, and which provide a continuity of care. Many more trained persons will be required to administer these programs to insure that they will provide quality care and training, and that the mentally retarded will not suffer from "benign neglect" in the community.

The Commission has concentrated its attention largely in a few areas. These are the prevention of retardation, education for all retarded children, community services for adults and planning and coordination.

Among the many subjects still needing concerted study, we see the following as very important:

1. The organization of the delivery of mental retardation services and the best relationships of the Department of Mental Hygiene and Hospitals, the Lynchburg and Petersburg institutions, the new Regional Training Centers and the Chapter 10 Boards.

2. Manpower needs and the feasibility of university affiliated facilities for training personnel.

3. Services in the community for the more seriously retarded including the multiple handicapped.

4. Community placement and follow up of retarded adults now in institutions.

5. Services to adults, including those by agencies other than the Department of Mental Hygiene, such as the Department of Vocational Rehabilitation, the Virginia Employment Commission and the Department of Welfare and Institutions.

6. New concepts in residential living.

7. The effectiveness of special education classes as they are actually functioning in Virginia.

Prevention of Mental Retardation

Some mental retardation can be prevented. While organized prevention programs cost money, it is only a fraction of the high cost of maintaining a severely retarded person for life. An example is the screening program for PKU in infants which was authorized by the 1968 General Assembly and is administered by the Department of Health, which has identified and treated over 40 children who might otherwise be severely retarded.

Rubella (German measles) can cause retardation if a mother has it during the first 3 months of pregnancy. Public health officials have determined that the best way to eliminate Rubella altogether is by inoculating all children. Ordinary measles is a disease which can cause brain damage as well as deafness and blindness in infants and young children and which can also be eliminated by inoculation. While measles inoculation (which is now combined with Rubella vaccine) should be given before age 2 for best protection, the only feasible means of enforcement at present is in connection with entry into school.

THE COMMISSION RECOMMENDS LEGISLATION TO REQUIRE EVERY CHILD TO BE INOCULATED FOR MEASLES AND RUBELLA BEFORE ENTRY INTO SCHOOL.

Retardation is also clearly associated with poor maternal health and malnutrition during pregnancy, various birth injuries and premature births. These conditions, in turn, occur more frequently to mothers who are poor or having an illegitimate child. Retardation also occurs more frequently when a mother

is very young or very old for child bearing or has already had five or more children. The State Department of Health tries to reach women in high risk groups through its Maternal and Child Health program. Three ways in which it could reduce retardation by services to them if the program had sufficient money are:

1. Meeting the already existing demand for family planning services,

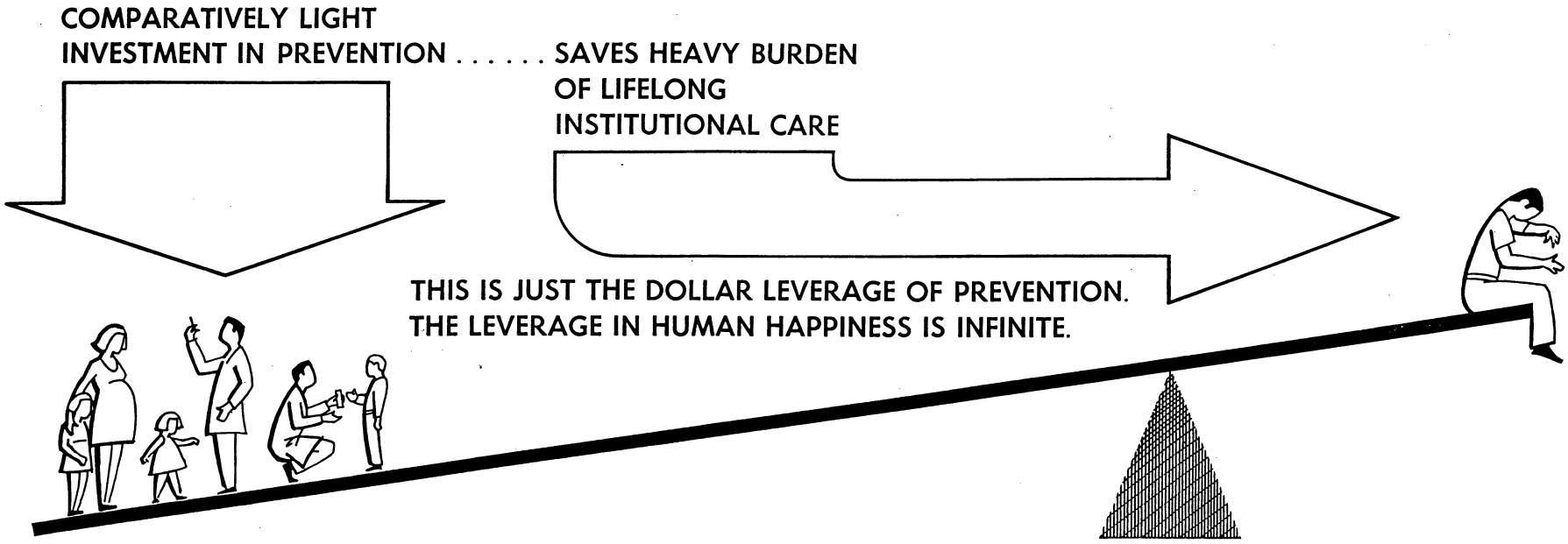
2. Paying for sterilization of women who have already had too many children and want no more,

3. Creating a roster of premature babies and setting up a program of active follow-up by public health nurses to advise the mother, check on the development of the infant and arrange special care if needed, and

4. Paying for the normal deliveries of medically indigent mothers. Fifteen percent of Virginia women having babies cannot pay their hospital bills (a figure which does not include mothers on welfare). Many of them make no hospital arrangements and in fact, wait until the last minute when they feel sure the hospital will not refuse them care. This increases the risk of birth injury.

THE COMMISSION RECOMMENDS INCREASED FUNDING OF MATERNAL AND CHILD HEALTH PROGRAMS THAT CAN REDUCE THE INCIDENCE OF RETARDATION.

The opportunity to prevent retardation and to lessen its severity does not stop at birth. Medical science has now shown that malnutrition in infancy and early childhood causes irreversible brain damage. And it is now known that retardation can have social as well as physical causes. Lack of mental stimulation from infancy on, lack of language learning that middle-class children get automatically from conversation with their parents, lack of the simple teaching inherent in "this is round—this is square"—all these can contribute to retardation in children. Mothers may be uneducated or over-burdened or neglectful, or they may need



to leave their children to go to work or may simply not understand the need for intellectual stimulation of young children. So, in neighborhoods of socio-economic deprivation, which are also areas of high risk of retardation, prevention must take the form of reaching mothers and their children with a wide range of services to improve every aspect—medical, nutritional, educational and mental health—of child care. To be successful, the services must seem useful to the people who need to be reached. Every survey of need in poverty areas contains recommendations for day care programs and nursery schools for children. Therefore, it seems realistic to designate the child development center as the coordinating unit for these services.

The Commission thus agrees with the first recommendation of the President's Committee on Mental Retardation to establish:

> . . . multi-service centers for prenatal care, infant care and day care, emphasizing education, with pediatric, psychological, psychiatric and other diagnostic services on a continuing basis. An integral part would be a parent education program to aid in the development of sound parent-child relationships. These centers would be community oriented and would be for *all* children.

These multi-service child development centers should serve *all* children because early segregation of the mentally retarded child is *not* in the best interest of the child. Children learn from one another. They respond to expectation. Most children under six can be readily managed in a group and in the family even if they are quite retarded.

However, it is essential that those children who are identified as mentally retarded are given special attention and training without being segregated from other children. Thus, these centers would need supervision and consultation from specialists in mental retardation and other learning disabilities, as well as in child development and mental health.

THE COMMISSION ENDORSES THE IDEA OF MULTI-SERVICE CENTERS, PARTICULARLY IN URBAN AND RURAL POVERTY NEIGHBORHOODS, WHICH WILL REACH CHILDREN AND THEIR FAMILIES WITH COORDINATED PREVENTIVE HEALTH, MENTAL HEALTH, EDUCATIONAL AND SOCIAL SERVICES THROUGH A CHILD DEVELOPMENT CENTER OPEN TO ALL CHILDREN IN THE COMMUNITY FROM INFANCY TO SCHOOL AGE, WITH FEES ON A SLIDING SCALE BASIS.

To establish such centers where they are needed in Virginia will be neither simple nor inexpensive. Four State Departments are involved, Welfare, Health, Mental Hygiene and Education. The support of the community, ample staff, both professional and indigenous, and the involvement of volunteers are all necessary to success. It is suggested that these multi-service centers could be administered interdepartmentally with local boards, a State level coordinating council and responsibility divided among the State agencies as appropriate.

The target group of children is large. Approximately 48,000 of Virginia's preschool age children (12%) fall below the poverty level. Another 30,000 are just above it. Of course, many of the infants and young children would not need day-care but rather other parts of the array of services. But it is vital to guard against the kind of underfunding that would reduce the program to merely a baby-sitting service to enable mothers to work which could leave the children worse off than before. The alternative to starting early infancy and preschool care is that many children who require these programs today may wind up in later years on welfare or in institutions for the mentally retarded or in correctional institutions.

THE COMMISSION RECOMMENDS THAT THE GOVERNOR SET UP A TASK FORCE OF OFFICIALS OF THE DEPARTMENTS CONCERNED, REPRESENTATIVES OF LOCAL GOVERNMENTS, POVERTY AREAS AND THE PUBLIC TO PRODUCE A PLAN, BUDGET AND FUNDING MECHANISM FOR MULTI-SERVICE CHILD DEVELOPMENT CENTERS TO SERVE ALL CHILDREN IN POVERTY NEIGHBORHOODS IN VIRGINIA.

Meanwhile, everything possible should be done in the 1972-74 biennium to use existing agencies for the early detection of and help to high risk children. The two new Consultation and Evaluation Clinics requested by the Department of Health should be funded and an additional pediatric nurse hired. The Department of Education should place special education teachers in the C & E Clinics. Mental Health Clinics should counsel the parents of retarded children.

Interdepartmental committees at the local level to implement and coordinate these services should be set up with the Developmental Disabilities Council assuming responsibility for furthering these programs.

THE COMMISSION SUPPORTS ADDITIONAL FUNDS FOR THE EARLY IDENTIFICATION AND TRAINING OF RETARDED CHILDREN.

Schools and Tuition Grants

The Commission firmly subscribes to the principle that all children in the Commonwealth are entitled to educational services to develop their potential to the utmost. It is also a matter of principle that children should be allowed to grow up with their parents, if at all possible.

However, for the parents of many retarded children the painful choice is now to let their children grow up without training which could improve their social, vocational and academic skills or to place them in Lynchburg or Petersburg. Of Virginia's 131 localities, 19 have no classes for either educable or trainable children. There are differences among professionals as to the extent to which mildly retarded children can benefit from being in a regular classroom rather than a special one and as to the possibility of misusing special classes to place children who are not so much retarded as simply poorly taught. But the Department of Education agrees that the number of special education classes in Virginia falls far short of the need. It is important that as the number of classes is expanded, the Department of Education makes sure that there are trained teachers, therapists and aides and that the quality of the classes is high.

Research by the Commission's staff clearly shows that the retarded child's reaching school age and failing to fit into the local school system is an important cause of institutionalization. Thirty-seven percent of admissions to Lynchburg and Petersburg Training School and Hospital were children from 6 to 15. Of these about two-fifths or 316 were only mildly or moderately retarded and could better have been accommodated in special education classes in their home communities. Even those who had no families would have been more appropriately placed in a foster home with public school education than in an institution at this age.

THE COMMISSION RECOMMENDS THAT *ALL* SCHOOL SYSTEMS BE *REQUIRED* TO PROVIDE APPROPRIATE EDUCATIONAL SERVICES TO EDUCABLE AND TRAINABLE RETARDED CHILDREN AND YOUTH.

Until the time when all school systems will have developed adequate special education programs, there should be tuition grants. Also, children with multiple handicaps are not now being served by public schools in the overwhelming majority of school systems. The State Department of Education has proposed tuition assistance to aid parents in the education of handicapped children through private nonsectarian schools approved by it. A parent who sends his child to such a school would be entitled to reimbursement by the local school board in an amount equal to three-fourths of the instructional cost but not to exceed four thousand dollars for a residential school or one thousand dollars for a nonresidential school. The locality would be reimbursed 60% of such expenditures by the State Board of Education.

This still requires the parent of a retarded child to pay for education and in some areas the burden will still be very heavy.

It remains to be seen whether this system of payments offers sufficient inducement to localities to develop public school programs. However, the proposal is a significant forward step.

THE COMMISSION ENDORSES THE DEPARTMENT OF EDUCATION'S PROPOSALS FOR EXPANDING SPECIAL EDUCATION CLASSES FOR THE TRAINABLE AND FOR TUITION ASSISTANCE TO HANDICAPPED CHILDREN.

Community Services for Adults

As society moves to reduce the institutionalization of retarded persons, certain new problems arise in making a satisfactory life for them in the community. While the more mildly retarded can hold jobs and live independently, they may need help in managing money and may easily find themselves in a crisis with which they cannot cope. The moderately retarded individual may need a special place to live, a job in a protected environment, welfare funds to help support him and arrangement for medical care in case of illness. Families may give this help, but often there are no relatives willing to help or the family has alienated the retarded person by trying to have him placed in an institution. In summary, if retarded adults are to make it in the community, they need to have a source of continuing individualized attention that no agency at this time has the responsibility of supplying. The Chapter 10 Boards of the Department of Mental Hygiene and Hospitals seem the agency best suited to organize this kind of help.

These protective services have a number of aspects but the essential idea is that it is a service to the *individual* retarded adult (or to the retarded child and his family) that helps him cope with his particular problems to avoid crises that might otherwise be solved by institutionalization. The services include:

a. First, to inform the client or his family of the resources available and then to bring private and public, local and State resources together and coordinate them to meet the individual's needs.

b. Second, to provide for the retarded adult an advisor-friend-sponsor on whom he can lean in time of crisis. The sponsor's watchful guidance could help prevent exploitation of a retarded person in his job or living arrangement or as a consumer. This job could be done very effectively by well-chosen volunteers, if there were staff to organize the service.

c. Third, to act as an "ombudsman" to receive and deal with complaints relating to the services or lack of services of public agencies.

THE COMMISSION RECOMMENDS THAT CHAPTER 10 BOARDS, WITH THE ADVICE OF THE DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS, SET UP PROTECTIVE SERVICES FOR RETARDED TO:

1. COORDINATE LOCAL AND STATE RESOURCES TO MEET THE INDIVIDUAL NEEDS,

2. PROVIDE INDIVIDUAL "SPONSORS" FOR RETARDED ADULTS, AND

3. DEAL WITH COMPLAINTS ABOUT LACK OF ADEQUATE SERVICES.

Mentally retarded persons, and particularly mentally retarded adults, have specific needs which are not being met by present guardianship provisions. As we focus more on community programs, mentally retarded persons face more personal decisions. These involve such matters as the selection of appropriate medical care, training, living arrangements, etc. There is a need for a personal coordinator or decision maker on a continuing basis.

There also is a need for more flexibility in guardianship provisions which would permit more expedient appointment of guardians and would also permit parents to provide in advance for the appointment of standby guardianships which would not become null and void when a mentally retarded child legally became of age.

On the other hand, present guardianship provisions are restrictive upon the rights of a ward. Even if a mentally retarded person has sufficient judgment to act on his own behalf for some of his personal matters, present law does not readily permit this. Thus, there is a need for limited guardianships, which would allow the retarded adult to function freely in areas where he is sufficiently responsible, but provide him with the protection of control where needed.

THE COMMISSION RECOMMENDS THE STUDY OF LEGAL PROVISIONS FOR STANDBY AND LIMITED GUARDIANSHIP FOR THE RETARDED.

Many retarded adults can live with their families if they are not an around-the-clock burden upon them. Some can become members of the work force if they are taught vocational skills. Some can perform useful, paid work in sheltered workshops. Others, more handicapped, need a place to spend their days learning self care, social and vocational skills to decrease their dependency.

When a mildly or moderately retarded adult lacks a home with family or friends but can spend his days on a job, in a workshop or day-care center, then a place to live may be what he needs to avoid institutionalization. Adult Living Centers can fill this need for an accepting, stimulating, safe place to live.

THE COMMISSION RECOMMENDS THAT CHAPTER 10 BOARDS BE ENCOURAGED TO SET UP ACTIVITY CENTERS, WORKSHOPS AND ADULT LIVING CENTERS TO REDUCE INSTITUTIONALIZATION AND THAT THESE BE SUBSTANTIALLY STATE-FUNDED.

Capital Outlay Program

At the present time State institutions are overcrowded and residents are housed in facilities that have long needed replacement. In July the rated capacities and actual numbers of residents in State institutions were as follows:

	Rated Capacity	*Resident Population*	*Waiting List*
LTS&H	3211	3550	500
PTS&H	1371	1963	41

Such factors as the general population increase, lengthening of life of severely retarded persons and the fact that some retarded people constitute too great a financial burden for families and communities to handle lead to the conclusion that there will be a continuing need for State institutional facilities of approximately the present capacity. A vigorous program of new community services will be necessary to prevent continuous growth in institutional service demand. New construction is urgently needed to replace buildings which should not house patients at both Petersburg and Lynchburg.

The Department of Mental Hygiene and Hospitals has given its highest priority to the replacement of the shamefully inadequate Eastview and Westview buildings at Petersburg Training School and Hospital. This can be accomplished by building 500 cottage and independent living unit beds at Petersburg ($7.0 million requested) and constructing the Southeastern Training School this biennium. In addition, there is an immediate need for a 200-bed building at Lynchburg for retarded persons who also have serious psychiatric conditions ($2.1 million requested).

The main thrust of the Department's construction program is now the building of a network of regional training centers to be closely related to communities, rather than the enlargement of Lynchburg and Petersburg. These Centers not only are more humane in scale but they place the retarded person closer to his family. The professionals at the Center can serve as consultants to community boards and services and conduct training programs

for retardation workers. The Department's plans are as follows:

Facility	*Biennium for Construct.*	*Capacity*	*Funds Approp.*	*Funds Requested In Millions*	*Funds Est.*
No. Virginia	1970-72	350	7.1		
	1972-74	158		2.6	
Southeastern	1970-72	350	5.8		
	1972-74	150		4.6	
Southwestern	1972-74	350		8.0	
Winchester	1972-74	350		.27	
	1974-76				7.73
Northern Neck	1974-76				
Danville	1978-80				
Charlottesville	1978-80				

The Commission suggests that the need for Regional Centers is so clear and the general ideas for architectural planning so far developed that construction of the Regional Center at Winchester could be started in the 1972-74 biennium as well as the Southwestern Center. It also supports the requests for additional funds for expansion of Northern Virginia and Southeastern Training Centers.

THE COMMISSION SUPPORTS THE CONSTRUCTION OF REPLACEMENTS FOR EASTVIEW AND WESTVIEW AT PETERSBURG, OF A PSYCHIATRIC BUILDING AT LYNCHBURG, AND THE RAPID DEVELOPMENT OF THE REGIONAL TRAINING CENTERS INCLUDING A FOURTH ONE THIS BIENNIUM.

Admission of Preschool Children to Institutions

Of the institutionalized preschool age children, 18% are mildly and moderately retarded without serious physical complications. Our knowledge of child development indicates clearly that all children need a nurturing relationship with a mother or mother substitute in order to realize their developmental potential. Thus, the institutionalization of already handicapped young children can only be justified if the presence of the child in the home constitutes such a stress to parents and siblings that the family unit as a whole is threatened. However, much education of parents, physicians, and judges is needed to counter the present view of many, that the early institutionalization of retarded children is the best solution for everybody concerned.

Although many mildly and moderately retarded children with no complicating physical problems (about 27 percent of the institutionalized population) are easier to care for in many respects than children of average and above average intelligence, they do present stressful problems if the mother is not relieved of caring for the child occasionally or for certain portions of each day. Hence, the establishment of day-care services equipped to work with retarded children, as indicated in the section on community services, is a preferable solution to institutionalization of these young children.

Legislation to prohibit legal commitment of mildly and moderately retarded preschoolers without complicating physical problems should be passed. This would enable the State institution to determine after professional study whether it was really necessary to place the infant or child there. The parents could be referred to helpful agencies in the community if the child was not admitted.

THE COMMISSION RECOMMENDS THAT NO CHILDREN UNDER SEVEN BE INSTITUTIONALIZED UNLESS A THOROUGH STUDY OF THE CHILD BY A MULTI-DISCIPLINARY TEAM REVEALS THAT THE CHILD NEEDS SUCH INTENSIVE SUPERVISION OR NURSING CARE AND THAT HE CANNOT BE MAINTAINED IN THE FAMILY OR COMMUNITY DAY-CARE PROGRAM UNTIL HE REACHES SCHOOL AGE.

Payment for Institutional Care

At the present time parents are required to pay for the institutional care of their children. This expense constitutes a lifelong burden especially for parents with mentally retarded children for whom insurance protection cannot be secured. It is strongly recommended that parents or close relatives be relieved of the obligation to pay for care when their institutionalized children, both the mentally retarded and mentally ill, are over 21 years of age. Also, it is recommended that parents not be required to pay for their children after five years of institutionalization whether that period is continuous or intermittent.

THE COMMISSION RECOMMENDS THAT PARENTS BE RELIEVED OF THEIR CURRENT OBLIGATION TO PAY FOR THE INSTITUTIONAL CARE OF CHILDREN OVER THE AGE OF 21 OR AFTER FIVE YEARS.

Planning and Advisory Council

In the final analysis the success of any mental retardation services plan depends upon the understanding of the retarded person's needs in the context of the total person. It must also be recognized clearly that the needs of retarded persons and their families have long been grossly neglected. Nobody in the Commonwealth is expected to endure the conditions that some of our handicapped fellow citizens have had to live under for many years. Therefore, parent groups have requested that they be well represented in the planning of services for their children. Their point is well taken.

The Commission is convinced that a planning and advisory council which will express the needs of consumers of service effectively is essential. The Council for the implementation in the State of the Federal Developmental Disabilities Act can, with certain changes, serve the purpose. The Federal Act groups under "developmental disabilities" not only the mentally retarded but also persons with epilepsy, cerebral palsy and other neurological handicaps similar to retardation originating in childhood (other than blindness and deafness). The concern of the Council with all these conditions will be helpful to the retarded, since in cases of serious developmental disability, it is quite common for an individual to have two or more overlapping conditions.

However, the Development Disabilities Planning and Advisory Council as set up in the State Plan developed by an Ad Hoc Committee and approved by the federal Department of Health, Education and Welfare must be changed in a number of ways if it is to be an effective force.

1. The mandate of the Council should be specified. The Council should report to the Governor. The function of the Council in terms of its planning and advisory role needs to be defined for the purpose of influencing State policy in relation to service and facility needs of developmentally disabled persons.

2. The composition of the Council should include at least one-third disabled persons and their parents, the commissioners of those State Departments most concerned and representatives of other agencies and organizations at local and State levels involved in delivery of services to the developmentally disabled.

A representative Council, meeting State needs as well as Federal legal requirements, could include eighteen to twenty-one members of which no more than seven would represent State agencies. At least one-third should be parents and at least three should represent poverty areas and minority groups. Local agencies and professionals directly involved in service delivery should also be represented. It is felt that the Council would be strengthened if a member of the Legislature and a university affiliated professional were included.

3. The Council should hire its own staff. In order for the Council to fulfill its overall planning and advisory responsibilities it needs to hire its own staff with professional training and competence in service planning for persons with developmental disabilities, as well as experience in service delivery, so that planning can be concrete and related to specific service needs. With-

out its own staff, the Council will not be able to fulfill its function of independently evaluating all the many different service needs of those it serves.

4. Some of the functions of the Council should include:

a. Insuring that sufficient data is obtained for realistic planning;

b. Identification and evaluation of existing services and facilities;

c. Establishment of State goals and priorities;

d. Periodic review and up-dating of State Plans; and

e. Insuring that plans are implemented.

It is recognized that the current level of federal funding is so minimal that the specific utilization of these funds this year will not make a significant difference in terms of service volume. But a broadly representative, staffed Council can have important impact in coordinating State, local and private services.

THE COMMISSION RECOMMENDS THAT THE DEVELOPMENTAL DISABILITIES PLANNING AND ADVISORY COUNCIL BE ESTABLISHED BY LAW, THAT IT REPORT TO THE GOVERNOR AND THAT IT BE BUDGETED FOR SUFFICIENT FUNDS TO HIRE A SMALL STAFF. AT LEAST ONE-THIRD OF ITS MEMBERS SHOULD REPRESENT CONSUMERS OF SERVICES AND THEIR FAMILIES AND THE REST SHOULD REPRESENT THE DIFFERENT DISCIPLINES DEALING WITH DEVELOPMENTALLY DISABLED AND THE VARIOUS DEPARTMENTS AND PRIVATE AGENCIES DELIVERING SERVICES AT BOTH THE STATE AND LOCAL LEVEL.

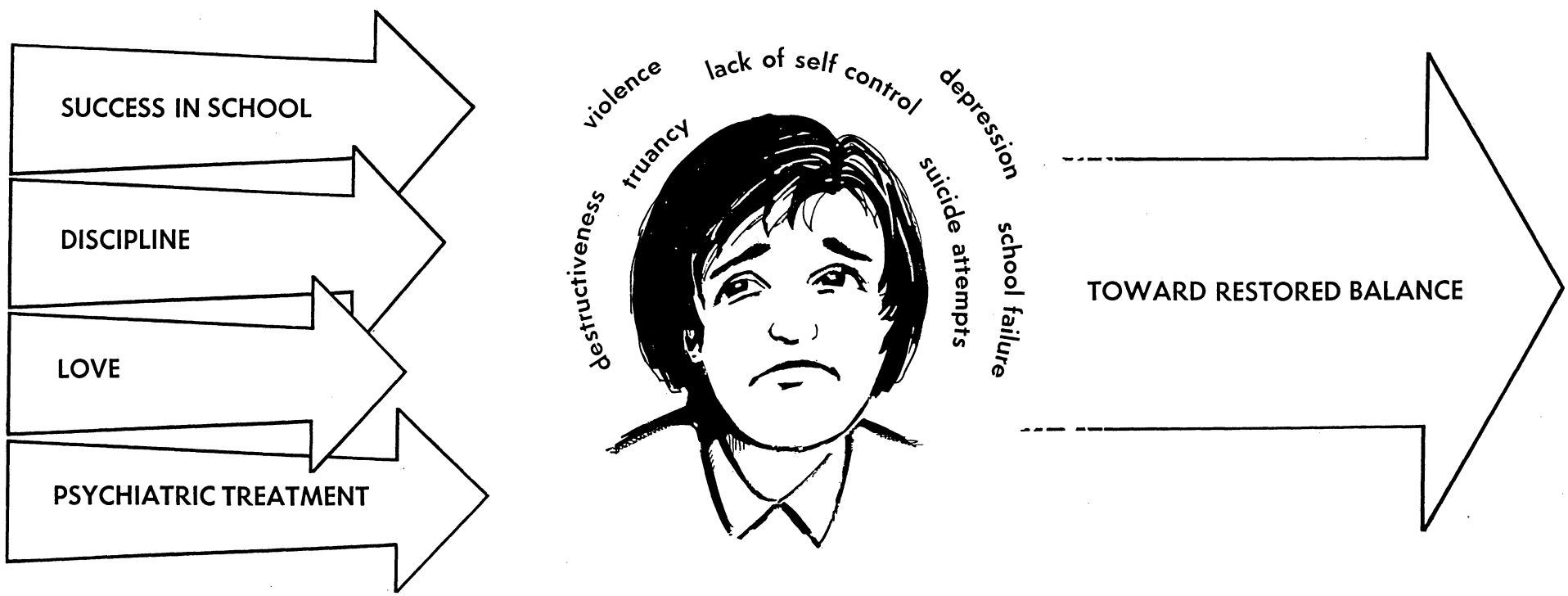
EMOTIONALLY DISTURBED CHILDREN AND YOUTH

Introduction

The words "emotionally disturbed child" are commonly used to cover a broad range of seriousness of social, emotional and educational problems in children. The Commission chose to focus its attention mainly on those children who have such serious behavior disorders that they are unable to function in ordinary family, school and/or community settings and the report uses the term "emotionally disturbed children" in this sense.

Some attention has also been paid to the needs of the much smaller number of children classified as psychotic. These include (1) the schizophrenic child who is characterized by withdrawal and disorganized thinking leading to bizarre and irrational behavior and (2) the autistic child who shows a profound withdrawal from the earliest phase of life and an inability to relate to people other than as inanimate objects.

An emotionally disturbed child might be described as one who experiences a disruptive amount of conflict within himself or between himself and others, who has insufficient behavioral control of himself and so engages in self-defeating, destructive behavior. His behavior may be delinquent (from 30 to 50% of the children in the State Training Schools are seriously disturbed) or it may not be. His intelligence may range from brilliant to retarded but he is likely to be a chronic school failure and educational underachiever. He usually suffers from low



self-esteem and typically feels depression and anxiety. He gets along badly not only with parents and teachers, but with other children—fighting or withdrawing, or both.

These are children whose needs are often neglected because it appears more rewarding to concentrate on those who can be helped more easily and with better chance of success. Yet, the seriously emotionally disturbed child frequently becomes a public charge in the mental health, correctional or welfare systems for long periods of his life.

Early Childhood

In the section on mental retardation the idea of multi-service centers was introduced. They would reach parents in high-risk neighborhoods with health, mental health and social services by offering their children a nurturing and educational program. Such centers have great potential for reducing emotional problems as well as mental retardation.

Many serious behavioral disturbances in children are related to the stress of problem families and broken homes. Other parents simply do not know how to nurture, teach and discipline their children because they lacked "parent models" in their own lives. Child development programs are in an ideal position to reach poorly functioning mothers with education in "parenting."

Early childhood, we now know, is a time of tremendous learning potential. If the educational rather than the baby-sitting aspect of day-care is emphasized, there is an opportunity to develop good behavior patterns and to improve the chances of school success.

THE COMMISSION COMMENDS THE IDEA OF MULTI-SERVICE CENTERS FOR ALL CHILDREN IN POVERTY NEIGHBORHOODS AS A MEANS OF BRINGING PREVENTIVE HELP TO CHILDREN IN DISORGANIZED FAMILIES.

School Programs and Tuition Grants

A common characteristic of emotionally disturbed children is chronic school failure and educational under-achievement. This suggests that trouble in school is not only a symptom of disturbance but is itself an aggravating factor. Current evidence suggests that children with school problems can be helped better within the context of the regular classroom than by segregating them into special classes. The practice of labeling children as "ill," "retarded," or "emotionally disturbed" without the benefit of competent medical and psychiatric evaluation should be discouraged.

Every effort should be made to handle these children in the regular classroom. But, the classroom teacher must have help if she is going to be able to reach these immature, unsocialized children and also effectively teach the rest of her class. Teacher aides with warm, calm personalities working under the supervision of the teacher can offer encouragement, discipline and emotional stability to the disturbed child on a one-to-one or small group basis. The teacher should have specialized training and ongoing support from consultative mental health personnel. A crisis classroom for temporary removal of a disruptive child is another resource.

School curriculum should be revised to offer opportunities for success to children of varying interests, backgrounds, goals and capabilities.

THE COMMISSION RECOMMENDS THAT EVERY EFFORT BE MADE BY SCHOOL SYSTEMS TO KEEP CHILDREN WITH BEHAVIOR PROBLEMS IN THE REGULAR CLASSROOM BY ASSISTANCE TO THE TEACHER.

It must be recognized, however, that some children and adolescents are so seriously disruptive that the special class is the

only alternative to expulsion and possibly institutionalization. Such classes need guidance by mental health professionals.

There are special classes for emotionally disturbed children in only 10 localities in Virginia. Until such time as school systems are more able and willing to include these children, their right to education should be met by tuition grants. Because autism is a condition existing from earliest childhood, intervention by special schooling in the preschool years may improve the very discouraging prognosis for these children. Tuition grants should be available for preschool disturbed children when recommended on professional evaluation.

THE COMMISSION RECOMMENDS MORE FINANCIAL ASSISTANCE BY THE STATE TO LOCAL SCHOOL BOARDS FOR SPECIAL CLASSES AND REALISTIC TUITION GRANTS FOR EMOTIONALLY DISTURBED CHILDREN AND YOUTH NOT SERVED BY THE PUBLIC SCHOOLS INCLUDING THOSE OF PRESCHOOL AGE WHO NEED THERAPEUTIC PROGRAMS.

Residential Facilities

Some severely disturbed children and adolescents are too much in conflict with parents or parent figures to remain at home. Others do not have homes to be in. This should not necessarily mean that the child or adolescent should also be removed from his community to an institution. If the child can be managed within the local school system, then the locality should provide a living arrangement for him.

Group homes are suitable for children and youth who are so psychologically damaged that they have limited chances of adjusting to the emotional demands of a foster family setting. Probation homes should exist in every area to provide juvenile judges with an alternative to the Training Schools.

THE COMMISSION RECOMMENDS THAT GROUP HOMES AND PROBATION HOMES BE DEVELOPED THROUGHOUT VIRGINIA.

The behavior of some emotionally disturbed children and youth becomes intolerable to parents or schools or the law, often to all of them. At this point, the child is "sent away" and may end up at Eastern State Hospital or the Virginia Treatment Center, or at a juvenile correctional institution, or at Lynchburg or Petersburg depending on whether he is perceived as "mad or bad or stupid." Actually most have multiple problems.

The Children's Unit at Eastern State Hospital defines its function primarily as a treatment facility for psychotic children —that is, children whose perception and thinking are so far from normal that they do not relate to reality. It does evaluate non-psychotic children but does not keep them from treatment. However, 3 out of 4 children referred to the Unit are found to be *not* psychotic. These severely emotionally disturbed children were all known to one or more community agencies like the mental health clinic, the juvenile court or special education classes. Thirty percent are retarded. Over a third were truants. Forty percent were suicidal and 35% had physically attacked others. A third had juvenile court records. Ninety percent had already been diagnosed as disturbed but less than half had received psychotherapy. Their commitment to Eastern State shows that the community felt unable to cope with their problems yet the majority were discharged after about 2 months to return to the same condition which had fostered their maladjustment.

Virginia Treatment Center does treat emotionally disturbed, rather than psychotic children. It has only 40 beds and its primary mission is the training of psychiatric residents and other mental health professionals in the care of children. It has a very high cost per patient day which is characteristic of a teaching institution. The average stay is 5 months which is short for remolding severely disturbed children.

The Division of Youth Services of the Department of Welfare and Institutions reports that from 30 to 50% of their Train-

ing School population is so seriously disturbed that intensive, prolonged treatment is indicated and 20% are retarded. The institutions are crowded and the length of stay must be relatively short (average of 8 months).

At present neither the Department of Mental Hygiene and Hospitals nor the Department of Welfare and Institutions has the capability of caring for and rehabilitating severely emotionally disturbed children. Correctional agencies see them as so disturbed that their needs require psychiatric involvement. However, mental health clinics and Eastern State Hospital do not see them as appropriate referrals. Virginia Treatment Center can handle only a few. Obviously, regular school programs have not succeeded in educating or socializing these children.

There is a clear need for a separate, well staffed facility for severely emotionally disturbed children. It should combine a therapeutic environment with excellent individualized schooling with as much discipline and security as is necessary for effectiveness. It should be part of the Department of Mental Hygiene and Hospitals.

THE COMMISSION FINDS THE MOST URGENT NEED OF EMOTIONALLY DISTURBED CHILDREN IS FOR A NEW TYPE OF STATE FACILITY UNDER THE DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS. ACTION SHOULD BE TAKEN IN THE 1972-74 BIENNIUM TO BEGIN TO MEET THIS NEED.

The Department of Mental Hygiene has in DeJarnette Hospital an existing plant which might be used for this purpose. DeJarnette can house up to 100 children and is located so that it is possible to coordinate with the professional training programs in psychiatry, education and psychology at the University of Virginia. Present patients can be gradually phased out into private or State mental or geriatric facilities. The Department would design an appropriate program and assign staff.

Since 100 beds will clearly not meet the total need for this class of children, it is suggested that additional facilities be established, with planning and organization to proceed during the coming biennium, as follows:

a. Regional facilities of up to 100 beds to be established in major metropolitan areas with cooperation and participation of local governments, school systems and mental health centers.

b. Smaller satellite facilities in more rural areas which would have difficulty obtaining professional personnel. These could be attached to DeJarnette or Virginia Training Center or the regional facilities, whichever proves feasible.

THE COMMISSION RECOMMENDS SERIOUS CONSIDERATION BE GIVEN BY THE DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS TO DEJARNETTE HOSPITAL AS A SITE FOR SUCH A FACILITY. CONSIDERATION OUGHT ALSO TO BE GIVEN TO REGIONAL FACILITIES IN METROPOLITAN AREAS AND SATELLITES IN RURAL AREAS.

The staff at the Children's Unit at Eastern State Hospital would like to devote themselves to the long-term treatment of autistic and schizophrenic children. This could be done if there were a suitable facility for severely disturbed non-psychotic children (as recommended above), if more diagnosis were done by the mental health clinics and if Virginia Treatment Center were to add short-term crisis and evaluation services to its functions. It is not clear whether 35 beds at Eastern State would be sufficient to meet the State's needs but a carefully evaluated trial period under these circumstances should be attempted.

The budget at Eastern State is far below that of facilities outside the State system treating comparable children. Individualized treatment programs and adequate attention in crisis situations can only be provided on a very limited basis. The physical facilities are stark and cramped. More money must be invested in this Unit if successful treatments are to be expected.

THE COMMISSION RECOMMENDS THAT THE EASTERN STATE HOSPITAL CHILDREN'S UNIT BE DEVOTED TO PSYCHOTIC CHILDREN AND THAT IT BE UPGRADED.

There are more emotionally disturbed children under the care of the Youth Services Division of the Department of Welfare and Institutions than there are or will be any time soon in the institutions of the Department of Mental Hygiene and Hospitals. These children are as entitled to mental health services as are children living at home who are served by mental health clinics. Sufficient funds should be included in the Department of Welfare's budget to provide mental health services in the correctional institutions and in the Department of Mental Hygiene's budget to give consultation and back up services.

It may be appropriate to point out here that the juvenile training schools have 22% retarded children but no teachers specially qualified for teaching them. They also lack teachers with certification for dealing with disturbed children.

THE COMMISSION RECOMMENDS THAT THE JUVENILE CORRECTIONAL INSTITUTIONS DEVELOP MENTAL HEALTH SERVICES, RECEIVE CONSULTATION SERVICES FROM THE DEPARTMENT OF MENTAL HYGIENE AND PROPERLY STAFF SPECIAL EDUCATION CLASSES.

MANPOWER, TRAINING AND RESEARCH

The development of a superior mental health care system is dependent upon the availability of good training facilities, adequate salaries and forward-looking personnel policies. The most essential is the first—training. Virginia is not now training enough professionals and para-professionals to meet its needs and it cannot raise salaries high enough to rely on raiding other states. Excellent university programs which are closely related to the State mental health system have the added benefit of being a major recruiting attraction for the hospitals and clinics.

The recommendation of the Commission's 1970 report that Psychiatric Institutes be built at the two medical schools to train mental health personnel of all disciplines at the doctoral, masters and undergraduate levels was not implemented. Outstanding faculty members have been attracted to both Medical College of Virginia (VCU) and the University of Virginia in the last few years. Facilities at the Universities must be improved quickly and much needed space added or Virginia is going to lose these teams of highly qualified professors. Yet, they constitute the means of meeting our urgent manpower needs.

Site problems have held up the Psychiatric Institute at the Medical College of Virginia. While it is to be hoped that they can be resolved promptly, there is no logical reason for this to hold up construction at the University of Virginia. Psychiatric Institutes are essential, long overdue and are the Commission's highest priority capital outlay item for 1972-74.

THE COMMISSION RECOMMENDS THAT FUNDS BE APPROPRIATED THIS BIENNIUM FOR PSYCHIATRIC INSTITUTES FOR TRAINING AND RESEARCH AT BOTH THE MEDICAL COLLEGE OF VIRGINIA (VCU) AND THE UNIVERSITY OF VIRGINIA. FUNDS SHOULD ALSO BE APPROPRIATED FOR THE FURTHER DEVELOPMENT OF PROFESSIONAL TRAINING AND RESEARCH AT THE DEPARTMENTS OF PSYCHIATRY OF THE TWO UNIVERSITIES WITHOUT WAITING FOR THE CONSTRUCTION OF THE INSTITUTES.

There has been some progress in terms of increasing the professional staff in the institutions under the Department of Mental Hygiene. There are now 151 physicians in the State hospital system, as compared to 137 in 1969. However, it should be pointed out that 67 of these are unlicensed, and the number of board-certified psychiatrists has increased by only 2. The number of graduate psychologists has increased from 6 to 23; only 8 have Ph.D.'s. This is a pitifully small number, considering that there are 14,694 patients. There are 102 social workers, compared with 33 in 1969; however, only 29 of these have Master's degrees.

Salary continues to be the second critical factor in obtaining and holding personnel. The low State scale creates difficulties in obtaining both professional and sub-professional staff.

THE COMMISSION SUPPORTS HIGHER PAY SCALES FOR THE DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS WITH BROADER DISCRETION IN SETTING SALARIES AND BETTER FRINGE BENEFITS TOWARD THE GOAL OF MEETING NATIONAL SALARY AVERAGES IN ALL CATEGORIES.

The ceiling placed on the salary of the Commissioner limits the salaries of other professionals in the Department. While a distinct improvement was made in this regard during the last biennium, the Commissioner's salary still is not high enough to be as competitive as it should be.

Existing legislation which was drawn up many years ago does not permit the Commissioner in Virginia to participate in a variety of consultation and professional activities, which would be important not only for his own continuing professional development, but would work to the advantage of the State. For instance, under present legislation, it is impossible for the Commissioner to sit on study sections or advisory councils of the National Institute of Mental Health, a most constructive task which many commissioners of other states do participate in.

THE COMMISSION RECOMMENDS THAT THE SALARY CEILING FOR THE COMMISSIONER OF MENTAL HYGIENE AND HOSPITALS SHOULD BE RAISED, AND THE PRESENT RESTRICTIVE LEGISLATION WHICH PERMITS HIM TO HOLD NO OTHER POSITION SHOULD BE CHANGED.

In the 1970-72 biennium, for the first time, the Department of Mental Hygiene and Hospitals has had funds available for research grants, most of which have been awarded. The formation of the committee to administer these funds has brought together investigators from many facilities and educational institutions, providing close research advice to the Commissioner and his staff. The development of research programs in various institutions throughout the State has already improved morale and the quality of professional endeavor.

One subject on which almost no research has been done in Virginia is the fundamental one of the extent of mental illness and mental retardation, the identification of high risk populations and situations and the evaluation of the effectiveness of different kinds of services and institutions. This information is absolutely essential to the wisest use of State resources of money and manpower, a major concern of this Commission. The Commission's staff consultant, Mrs. Margareta Miller, with the cooperation and assistance of the Department of Mental Hygiene, conducted some research into certain characteristics of the patients in State institutions. These very interesting studies, a list of which is included at the end of this Report, illuminated the complexity of the problems of identifying high risk groups by raising more questions than they answered.

Virginia has an exceptional opportunity to engage in productive research in the occurrence of mental illness and mental retardation and in the evaluation of the effectiveness of services. A nationally known researcher has become a Professor of Psychology at the University of Virginia and has proposed the establishment of a Psychiatric Epidemiology Laboratory at the University Medical School in collaboration with the Department of Mental Hygiene. A request for $200,000 for this purpose is included in the Department of Mental Hygiene request for funds for research.

THE COMMISSION RECOMMENDS THE FUNDING OF THE PROPOSED PSYCHIATRIC EPIDEMIOLOGY LABORATORY AND THE CONTINUATION OF OTHER RESEARCH FUNDS.

The Commission's 1970 Report emphasized that the development of manpower called for a third ingredient besides training and salaries. It described it in this way, "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 recruiting."

THE COMMISSION REITERATES ITS RECOMMENDATION FOR THE CONTINUATION AND EXPANSION OF THE FOLLOWING PROGRAMS:

1. SCHOLARSHIPS IN THE MENTAL HEALTH AND MENTAL RETARDATION FIELD,

2. COLLABORATION BETWEEN THE STATE DEPARTMENT OF MENTAL HYGIENE AND THE UNIVERSITIES, COLLEGES AND COMMUNITY COLLEGES,

3. IN-SERVICE TRAINING, AND

4. CAREER LADDERS SO THAT ALL EMPLOYEES CAN HAVE OPPORTUNITIES FOR ADVANCEMENT TO MORE RESPONSIBLE POSITIONS AND HIGHER SALARIES.

The training of personnel to work with the retarded has lagged far behind training relating to mental health and illness. The needs of retarded persons require attention from many disciplines—medicine, education, social welfare, vocational rehabilitation, recreation. A vigorous effort is necessary to coordinate the skills of professionals from all these fields to deliver programs of mental retardation training through in-service and degree programs.

THE DEVELOPMENTAL DISABILITIES COUNCIL SHOULD ENCOURAGE SERVICE AGENCIES TO JOIN WITH THE UNIVERSITIES, COLLEGES AND COMMUNITY COLLEGES TO DEVELOP COURSES AND TRAIN PROFESSIONALS AND OTHERS IN THE FIELD OF MENTAL RETARDATION.

COMMUNITY SERVICES

Chapter 10 Boards

The Chapter 10 Boards provide for the first time a vehicle for local promotion and control of the broad range of mental health and mental retardation activities. Since enabling legislation was passed as Chapter 10 of Title 37.1 of the Code of Virginia in 1968, twenty Community Mental Health and Mental Retardation Services Boards have been established by localities and groups of localities across the State. These Boards represent 41 cities and counties and 66% of the population of the State. They are empowered to plan, coordinate and evaluate local services, to make recommendations to local governing bodies, and to apply for State grants for services. The 1970 General Assembly appropriated $1.8 million in operating funds and $1.5 million in construction grants for the Boards. Grants are made on a 50-50 State-local basis, although legislation permits State support of salaries up to 75% in special cases. Their budgets for Fiscal 1970 range from $5,000 to $268,000 depending on the population and needs of the local area and activity of the Board.

Large areas of the State—generally the more rural areas—have not established Boards or have Boards which have not sought grants. The establishment of Boards has depended upon the capacity of a given locality to formulate a plan, execute an elaborate application for State funds, and raise local matching monies. These are considerable tasks for many localities without professional resources or organized volunteer groups.

Another hurdle has been the pressure of the State Division of Planning and Community Affairs to require Chapter 10 Board areas to be co-terminus with Planning Districts. Since the Chapter 10 Boards are primarily service oriented, this is not a logical requirement. It has had a paralyzing effect in rural areas where the distances to be covered for meetings, let alone for services,

are too great and where refusal of one Board of Supervisors to participate can block progress in many counties.

Another reason that local governing bodies have been slow to establish Chapter 10 Boards is cost. The 50-50 State-local sharing formula is a reasonable one for locally-chosen projects in localities of average wealth. It is an impossible burden to some of the rural counties which start with no mental health or mental retardation services of any kind.

A study of approved and submitted grant applications reveals that the areas with the best existing resources are utilizing the bulk of available State funds. This means that the gap between urban and rural areas in terms of volume and quality of services will continue to widen unless changes are made.

THE COMMISSION RECOMMENDS THAT THE CHAPTER 10 PROGRAM BE IMPLEMENTED THROUGHOUT THE STATE BY THE FOLLOWING MEANS:

1. THE DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS SHOULD DETAIL STAFF MEMBERS TO WORK WITH LOCALITIES ON FORMULATING THE INITIAL PLAN AND WRITING THE GRANT APPLICATION WHERE THIS IS NECESSARY,

2. CHAPTER 10 BOARD AREAS SHOULD BE OF A WORKABLE SIZE FOR DELIVERING SERVICES (ALTHOUGH THEY SHOULD NOT CROSS PLANNING DISTRICT LINES), AND

3. FOR POVERTY AREAS, TO BE DETERMINED BY SOME FORMULA USING AVERAGE INCOME AND LOCAL TAX BASE FIGURES, THE DEPARTMENT SHOULD MATCH GRANTS ON UP TO A 90-10 BASIS.

Chapter 10 Boards around the State have very varied ideas of what they ought to be doing. This was inevitable because the idea of the Boards was new to Virginia and neither the Legislation nor the regulations provided a clear picture of the exact role and way of functioning. Some Boards devoted themselves almost entirely to retardation projects, leaving mental health to the local clinics. Others have taken on the mental health responsibility by becoming the Board for the Clinic or Community Mental Health Center. Some administer services directly, others only contract for services. This unstructured situation may have had the advantage of allowing a variety of models to be tried, but it is time to look at how well these have worked.

THE COMMISSION RECOMMENDS THAT THE DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS CONFER WITH THE CHAPTER 10 BOARDS TO CLARIFY THEIR ROLE AND THE RELATIONSHIP OF THE BOARDS TO THE MENTAL HEALTH CLINIC SYSTEM. THE DEPARTMENT OF MENTAL HYGIENE SHOULD PROVIDE SYSTEMATIC ASSISTANCE TO MEMBERS OF THE CHAPTER 10 BOARDS IN UNDERSTANDING THE RESPONSIBILITIES AND OPPORTUNITIES OF THE BOARDS BY WRITTEN MATERIAL, TRAINING SESSIONS AND CONFERENCES ON MENTAL HEALTH AND MENTAL RETARDATION PROGRAMS.

Clinics

There are now 34 State-local mental health clinics ranging in size from one with a $930,000 annual budget in Fairfax County to one-day-per-week clinics in 5 localities. The costs are shared half and half by the State and the participating localities except in those areas which choose to supplement the State salary scale.

The Consultant to the Commission conducted a study of clinic operations by questionnaire. The results raise questions which warrant further study by the Department of Mental Hygiene and Hospitals.

The survey showed that clinic personnel spend only 4 or 5% of their time in consultation with other community agencies, such as the schools, the courts, and the welfare departments. Federal guidelines for Community Mental Health Centers recommend 10% of staff time for consultation. Ten percent may well be insufficient when consideration is given to the fact that other community agencies reach far more people more constantly than the clinic can hope to reach. Conveying to teachers, social workers, probation workers, ministers, policemen and others who work with the public, the insights and techniques of the mental health professions can help prevent individuals from reaching the kind of crisis requiring extended clinic services. This is especially true of contacts with the schools since 50% of the clinic's patient load is school age children and adolescents, a very high percent of whom have school failure or behavior problems as their main difficulty. Yet the clinics spend less than 2% of their time in contact with school personnel.

THE COMMISSION RECOMMENDS THAT MENTAL HEALTH CLINIC PROGRAMS INCLUDE MUCH MORE CONSULTATION WITH SCHOOLS AND THE OTHER COMMUNITY AGENCIES.

The survey showed that the preponderant activity of the clinics was individual therapy. Nearly 40% of the psychiatrists' time, for instance, was spent in one-to-one therapy. This raises the questions of whether this is the most effective use of professional personnel and of whether the use of group therapy has been sufficiently explored. Sixty percent of psychiatrists' time is spent with patients and families. This raises the question of whether the psychiatrist in a public agency functions most effectively as a clinician or as a team leader developing the program and the skills of others.

The survey indicated that the clinics are performing a service for thousands of after-care patients who have spent time in State hospitals. However, as shown in the after-care section below, this service is, in most clinics, limited to little more than overseeing the drug dosage and supplying the medicines. The question should be raised of what proportion of effort should be spent on the more seriously and intractably ill patients and how much on people with problems of adjustment to the difficulties of their life situations.

Individual clinics in the State have "model programs" focusing on specific problems such as drug abuse among adolescents, day care for severely handicapped individuals, consultative programs to school systems, excellent after-care work, crisis and walk-in services, etc. These special efforts should be thoroughly evaluated and if found effective, ways should be found to fully inform other clinics on how to set up such programs. Indeed there is generally a great need for special workshops bringing together clinic directors and other professional staff so that there can be a systematic sharing of program experiences.

In summary, the Commission feels that there is a need for a re-examination of the objectives and methods of the clinics. Because of the difficulty in obtaining psychiatrists, there has apparently been a tendency for some clinics to be run as publicly-funded private practices, engaging mainly in those activities of most interest to the psychiatrist in charge. It is time now to put emphasis on their accountability as public agencies. Clinics must be accountable to the locality to serve its most critically felt needs, whatever they are. They are also accountable to the State to engage in a broad program serving persons with all kinds of mental disabilities and serving the whole community through consultation with schools, courts, and other social agencies.

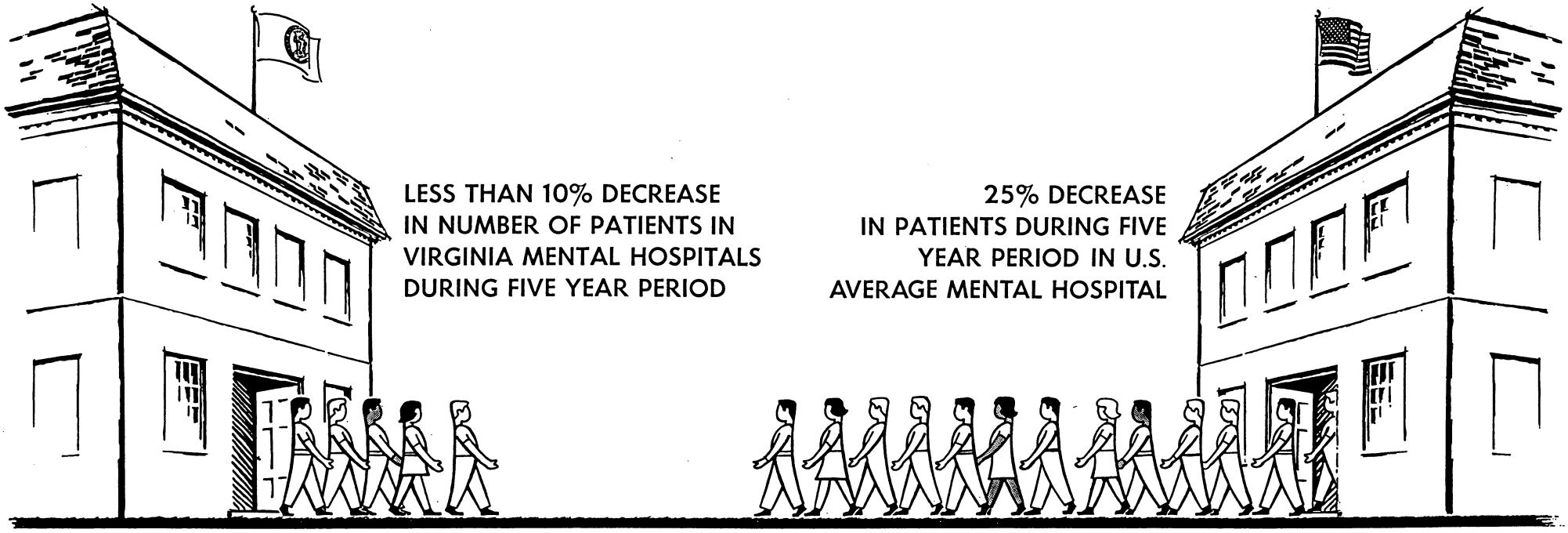
THE COMMISSION RECOMMENDS THAT THE DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS EMBARK ON A STUDY WITH CLINIC PERSONNEL AND REPRESENTATIVES OF THE COMMUNITIES TO FORMULATE STRONG POLICY GUIDELINES FOR CLINIC PROGRAMMING AND TO MAKE CLEAR THE RELATIONSHIP BETWEEN THE CLINICS AND THE DEPARTMENT.

Services to Reduce Institutionalization

Within the past decade, it has been discovered nationally that the number of hospital patients can be reduced through the use of modern drugs and by giving patients who could not make it entirely on their own in the community, an assortment of differing degrees of assistance. In this connection it must be realized that while much psychotic illness cannot be "cured," it is possible to reduce the disability through a combination of medical, social and educational services so that few of the mentally ill need spend a whole lifetime in a hospital. The Commission recommends the vigorous development of the programs to keep people out of hospitals which are described below. The central office of the Department of Mental Hygiene must provide the impetus and direction for building these activities into clinic and/or Chapter 10 Programs.

It must be realized that questions of equity and of political feasibility arise when a local government is asked to provide 50% of the funds for care of a person who otherwise would probably be in a State hospital at substantially greater cost—but cost to the State alone. Possibly the cost for community as well as institutional care should be shared by the State on the same basis, i.e., either the State pay for all these services or the community pay an equal proportion of institutional and community based services, as is the case in California. Under such a system the patient's needs rather than the system of payment would serve as the determining factor in case planning.

Short of such a sweeping change in the system of financing mental health care, it is possible to single out particular programs for a higher ratio of State funding. The 100% State-funded after-care program established in 1968 to work through the public health nurses and the clinics is a precedent.



VIRGINIA IS ONLY BEGINNING TO TAKE PART IN NATIONAL TREND TOWARD BRIEF, INTENSIVE CARE

THE COMMISSION RECOMMENDS THAT COMMUNITY PROGRAMS WHICH PROVIDE DIRECT SUBSTITUTES FOR HOSPITAL CARE (SUCH AS AFTER-CARE, DAY CARE AND GERIATRIC SCREENING) RECEIVE SUBSTANTIAL STATE FUNDING.

The clinic survey shows that the after-care patient is typically seen by a clinical psychiatrist once every two months for a brief check on the efficiency of his drug dosage and review of any side effects. The patient averages approximately 40 minutes a month total time with the other staff members.

On the average, less than 10% of the clinic staff time used for treatment is spent with after-care patients and their families, although numerically after-care patients and their families make up 60% of the case load.

After-care patients are very vulnerable to set-backs which may return them to the hospital and especially in need of guidance and reassurance in overcoming what are to them frequent crises connected with job and family. This needed supportive service does not require highly skilled professionals, but can be provided by trained aides or volunteers who have warm, strong personalities and who will listen and give practical assistance in times of stress. Only a few clinics have protective service programs which use such aides and volunteers at this time.

THE COMMISSION RECOMMENDS THAT THE DEPARTMENT EXERCISE LEADERSHIP TO BUILD A STRONG, USEFUL AFTER-CARE PROGRAM IN EVERY CLINIC, INCLUDING PROTECTIVE SERVICES.

Day care programs such as provided by the Arlington Clinic serving severely mentally ill persons are most significant in that they appear to offer a realistic alternative to State hospitalization for some patients. The Arlington program has a daily attendance of 65 at a cost of $7.00 per day. This program is based on a teaching-training model focused on useful activities. Although medical back-up services and professional direction are provided, most staff work is done successfully by emloyees with no graduate degrees in mental health. It would appear that this program not only relieves families by keeping patients occupied, but also provides sensible productive days for many persons who would otherwise become progressively alienated from families, communities, and productive self expression.

Patients in day care programs can learn skills or may work for pay. They are accepted in the program on a short-term or long-term basis depending upon individual needs. The staff accepts and facilitates occasional hospitalization and they will resume working with the patient after he returns to the community. The provision of transportation to a day care center must be an integral part of the program except in cities where there is ample bus transportation. Some communities will be able to rally volunteer drivers, but if the distances are too long a bus and driver must be funded.

Programs should also be developed to evaluate patients who are being suggested for hospitalization in one of the State mental hospital geriatric centers to determine their suitability.

THE COMMISSION RECOMMENDS THAT THE STATE SHOULD ENCOURAGE THE ESTABLISHMENT BY CHAPTER 10 BOARDS OR CLINICS OF DAY CARE PROGRAMS FOR PATIENTS WHO WOULD OTHERWISE NEED HOSPITALIZATION AND ALSO GERIATRIC SCREENING PROGRAMS.

STATE HOSPITAL SYSTEM

Progress Since 1970

The need to strengthen the State Hospital System which the 1970 Commission Report emphasized still exists. The major recommendations for better program planning, strengthening of services, more and better qualified staff, building new, smaller hospitals instead of increasing the size of existing ones, and more community involvement continue as essential goals for Virginia. We are pleased to report that important steps have been taken by the 1970 Legislature, Governor Holton, and the Department of Mental Hygiene and Hospitals in the last two years to implement the Commission's 1970 recommendations. These include:

1. An increase by the General Assembly of $16 million in the budget of the Department of Mental Hygiene.

2. Strengthening and reorganizing the central office staff.

3. A decrease of 4% in the resident population of State hospitals for the mentally ill in the last year. This is due in part to the establishment of a recommended geriatric screening program at Eastern State Hospital.

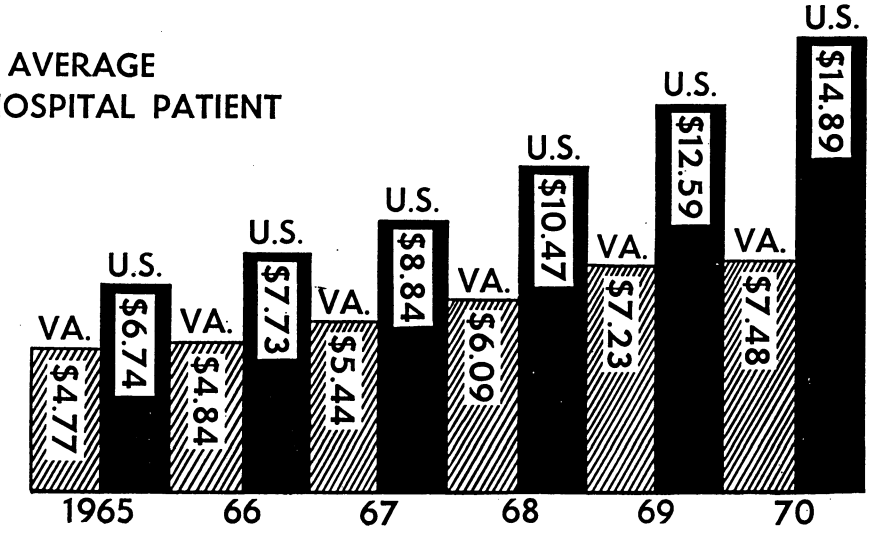
4. The beginning of an improvement of the staffing situation with special salary increases for physicians.

5. The reorganization of Central State Hospital into two institutions, one for the retarded and one for the mentally ill.

6. The appointment by the Governor of the Professional Advisory Council.

THE COMMISSION URGES CONTINUING ATTENTION TO THE GOALS AND RECOMMENDATIONS OF ITS 1970 REPORT.

VIRGINIA LAGS FAR BEHIND THE NATIONAL AVERAGE IN DOLLARS PER DAY FOR EACH MENTAL HOSPITAL PATIENT



EVEN NATIONAL AVERAGE IS WELL BELOW REAL NEEDS. Yet Virginia spent only half of that figure in 1970. Virginia's 19% budget increase in 1971 still leaves the Commonwealth far behind the national average.

Current Emphasis

With the decrease in the length of hospital stay and the increasing development of community services in Virginia, there is a need for a change in emphasis in the hospitals' approach to care. Continuity of care with the community, to which many patients will return after a short period in the hospital, has become a key to success.

The capital outlay program should work for this goal by increasing the capacity for intensive short-term care closer to the home community of the patient. The Psychiatric Institutes at Richmond and Charlottesville, which are of the highest priority in the view of the Commission, will supply some of these beds. The State should encourage the provision of in-patient psychiatric facilities in general hospitals in connection with establishment of Community Mental Health Centers by sharing in the cost. It must be recognized, however, that the cost of service in general hospitals is extremely high (in Northern Virginia more than twice as high as the State's excellent Northern Virginia Mental Health Institute, for example) and thus limited to acute patients needing very brief care. The State should proceed, therefore, to build additional regional mental hospitals in areas of the State showing a clear need for more service.

Geographic unitization of State hospitals would facilitate free flow of patients, records and staff between community facilities and the hospitals, thus furthering continuity of care.

THE COMMISSION RECOMMENDS THAT NEW HOSPITAL BEDS BE PROVIDED AT THE PSYCHIATRIC INSTITUTES, AS PART OF COMMUNITY MENTAL HEALTH CENTERS AND IN NEW SMALL REGIONAL HOSPITALS RATHER THAN INCREASING PSYCHIATRIC BEDS AT EXISTING HOSPITALS. GEOGRAPHIC UNITIZATION OF THE LARGE HOSPITALS SHOULD PROCEED.

There has been growing recognition of the benefits of behavior modification and social rehabilitation in increasing the therapeutic effectiveness of mental hospitals and improving the quality of institutional life. Staff with specific skills in this field at less than the professional level are needed. They could be provided by integrated hospital-community college training programs involving selected persons from the current attendant group as well as recruits from among our high school graduates.

THE COMMISSION RECOMMENDS ADDING A NEW TYPE OF WORKER TRAINED IN BEHAVIORAL AND SOCIAL REHABILITATION OF THE MENTALLY ILL.

The State must not neglect its responsibility to those patients who are so severely and chronically disturbed that they will require lengthy hospitalization. They are in need of a decent life in acceptable surroundings. Hence, in planning institutional buildings and services, there must be provision for the chronic patient to create a personal and more homelike environment for himself with opportunity for work, recreation and stimulation within the hospital setting. Without such stimuli, it is not possible for anyone to maintain or develop a sense of identity and personal dignity.

THE COMMISSION RECOMMENDS THAT PLANS BE DEVELOPED BY THE HOSPITALS TO PROVIDE A MORE HOMELIKE ENVIRONMENT FOR THOSE LONG-TERM PATIENTS WHO MUST STAY IN THE HOSPITALS.

GERIATRIC SERVICES

The Commission reaffirms its findings in the 1970 report that a growing need exists for services and institutions for the elderly. It continues to hold that this need for growth should be met outside the State mental hospitals by construction of more homes for the aged and nursing homes by the private and public sectors and by coordinated programs to help the elderly to continue to live at home. There must be constant effort on the part of State and local officials to provide alternate methods of delivering health care to the aging, so many of whom are not mentally ill, in lieu of institutionalizing in mental health facilities.

Meanwhile, it is true that the State hospitals will continue to have an important role in geriatric care. Thirty-seven percent of the State hospital population (3,219 persons) is over 65. The Commission's study of Eastern and Western State hospitals in 1969 showed that while only 5% need intensive psychiatric care, another 37% have behavior problems that require continuous supervision. A large percent of newly admitted elderly patients are acutely, physically ill and need medical attention. Many patients have grown old in the hospital and regard it as home. Therefore, the Commission does not recommend the wholesale clearing out of elderly patients as some states have done.

It is recommended that emphasis be on providing a strong all around geriatric program of good medical care, nursing supervision, social stimulation and recreational services as well as a specifically psychiatric focus. With emphasis on intensive geriatric care some patients may be able to improve to the point that they can leave the hospital and others may be helped to lead a more satisfactory life in the institutions. It is proved that strengthening programs in social recreation and stimulation is helpful, mixing men and women, serving meals in inviting ways, having parties, and in general recognizing that these patients need a more varied and interesting life than is provided in our institutions. Physiotherapists, separate housekeeping and nursing staff, and volunteer involvement are essential components in strengthening the service. Every effort should be made to ameliorate visual, hearing, and speech problems. It should be noted that Medicaid covers State hospital services for patients over 65.

THE COMMISSION RECOMMENDS THAT ADMINISTRATIVELY AND BUDGETARILY SEPARATE GERIATRIC CENTERS BE ESTABLISHED AT EACH OF THE FOUR LARGE STATE HOSPITAL SITES AND AT PIEDMONT AND CATAWBA REPORTING TO THE DIRECTOR OF GERIATRIC SERVICES IN THE CENTRAL OFFICE OF THE DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS. STAFFING AT THE CENTERS SHOULD BE STRENGTHENED TO PROVIDE EFFECTIVE PHYSICAL AND SOCIAL REHABILITATION SERVICES IN ADDITION TO A PRIMARY EMPHASIS ON MEDICAL AND NURSING SERVICES.

The Commission has repeatedly stated its aim of bringing the care of the handicapped and disabled back close to their communities. One way this could be done for the aged is for the Geriatric Centers to establish small satellite nursing homes in communities needing such facilities. These would be the localities with low population density and little wealth which are insufficiently served by the private sector. These satellites would be under the supervision of the Geriatric Centers at the hospitals which would provide the back-up of physicians' care and hospitalization when needed.

Patients who could be appropriately cared for in satellite nursing homes would be those in essentially good physical health but who qualify for the diagnosis of "senility" and those who are not acutely ill but need simple physical care. When a patient's mental or physical condition deteriorated requiring intensive care beyond the scope of the nursing home, transfer to the Geriatric Center or the Medical-Surgical Unit of the State hospital could be easily accomplished.

It would be highly desirable if arrangements could be worked out to give similar medical service support to patients in private nursing homes who cannot afford care in a general hospital. Such a temporary arrangement during acute illness, could avoid permanent placement of the patient in the State hospital.

THE COMMISSION RECOMMENDS THAT SATELLITE NURSING HOMES, IN AREAS LACKING SUCH FACILITIES, BE DEVELOPED BY THE GERIATRIC CENTERS. THE SATELLITES WOULD RECEIVE MEDICAL CONSULTATION AND BACK-UP FROM THE CENTERS. SIMILAR COOPERATIVE ARRANGEMENTS FOR MEDICAL SERVICE SHOULD BE DEVELOPED WITH PRIVATE FACILITIES AND AGENCIES.

The Commission in 1969 found a serious unmet need for homes for the aged and nursing homes in certain areas of the State where the limited economy has not been attractive to the proprietary operator. The 1970 recommendation of the Departments of Mental Hygiene and Hospitals, Welfare and Institutions and Health and this Commission that the State appropriate $5 million to be supplemented by local funds and Hill-Burton funds for the construction of community geriatric centers was not acted on by budgetary authorities. The need still exists.

THE COMMISSION RECOMMENDS THAT STATE MATCHING GRANTS BE PROVIDED LOCALITIES FOR THE CONSTRUCTION OF PUBLIC AND NON-PROFIT NURSING HOMES WITH PRIORITIES FOR GRANTS BASED UPON UNMET COMMUNITY NEED.

The possible impact of a comprehensive program of community services on institutionalization is still unknown. A measure of its potential can be seen in the results of a very simple geriatric screening program at Eastern State Hospital which reduced geriatric admissions by 50%. A truly comprehensive program would include, in addition to a screening program, community placement, supportive geriatric services (i.e., meals on wheels, home health care, recreational services), expanded service to the aged by mental health clinics, income maintenance and transportation on a coordinated basis.

Pilot projects should have evaluative research built in so that outcome and cost for community care of handicapped elderly persons can be determined and used to guide future program decisions.

THE COMMISSION RECOMMENDS THAT ITS 1970 PROPOSAL ON LOCAL PILOT PROJECTS BE REACTIVATED WITH A FOCUS ON COMPREHENSIVE AND COORDINATED SERVICES.

There are lesser steps that can be taken immediately to help elderly people who are trying to make it in the community. As some aged people become mildly confused, they especially need friendly counsel and advice to prevent or cope with crisis situations which might otherwise overwhelm them.

THE COMMISSION RECOMMENDS THAT SPECIAL EFFORTS BE MADE TO INCLUDE ELDERLY PERSONS IN THE EXISTING HEALTH DEPARTMENT CLINIC PROGRAMS AND THAT PLANS BE MADE FOR ADEQUATE PROTECTIVE SERVICES THROUGH EXISTING WELFARE PROGRAMS INCLUDING COORDINATED VOLUNTEER SERVICES.

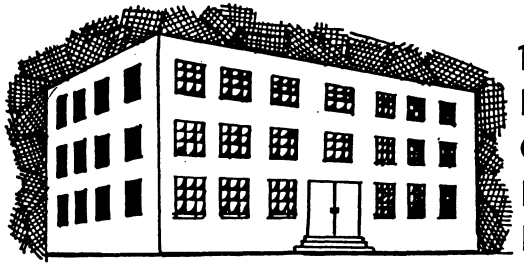
AND FINALLY

The Commission on Mental, Indigent and Geriatric Patients was established by Chapter 587 of the 1968 Acts of Assembly to study the needs of these patients and to make recommendations to meet such needs. In its Report to the Governor and the 1970 Session of the General Assembly, the Commission presented a challenge in the form of "a blueprint for the future, keyed to Virginia's needs and resources, to give hope for the mentally ill and dignity to the aged."

This challenge was well received and a great deal was done at that time to begin a substantial upgrading of State services for these people. During that Session the Commission was continued for another two years and was given the additional responsibility of studying the needs of the mentally retarded. This Report suggests to the people of Virginia the next steps in the substantial upgrading of mental health and mental retardation services, but from the point where we started, these accomplishments will not quite take us to the rightful place where Virginia belongs.

The Commission respectfully requests the General Assembly to continue it for two years in order to conduct the additional studies of retardation which we have outlined in the Report and to follow through on consideration of the relationships between State and local funds and agencies necessary to create comprehensive systems of care for the retarded, emotionally disturbed children, the mentally ill and the aged.

HOW VIRGINIA RANKS AMONG STATES



12th IN NUMBER OF PATIENTS IN MENTAL HOSPITALS

14th IN POPULATION

12th IN FAMILY INCOME

29th IN PER CAPITA INCOME

47th IN DOLLARS PER DAY AVAILABLE TO CARE FOR EACH MENTAL PATIENT

COST OF RECOMMENDATIONS

The care of Virginia's citizens who are handicapped by retardation, mental illness or old age cannot be improved without a substantial increase in State and local support. The Commission is convinced of this. It is equally convinced that in the long run, vigorous programs of prevention, reduction of disability and community care will prove more economical as well as more humane than a custodial approach.

The 1970 General Assembly increased funds for the Department of Mental Hygiene and Hospitals by $10 million over the original budget bill: $5,700,000 for the institutions, $3,300,000 for community services, $600,000 for leadership positions in the Central Office and $500,000 for research and training. The Commission feels that these increased expenditures are demonstrably bearing fruit in improved morale, better staffing, new programs and a small reduction in the number of hospital patients. But this was only a beginning, as a review of the 1970 recommendations will show.

This report reiterates those recommendations which could not be effectuated in the last biennium and adds many in its new fields of study, retardation and emotionally disturbed children and youth.

Because of the continuing and constructive exchange of ideas between the State Departments involved and the Commission, funds for most of the recommendations were included in Departmental requests to the Governor. The Department of Mental Hygiene request also includes $25 million for the improvement of care at the State hospitals and training schools which the Commission has not been able to study. Certainly continued improvement of these institutions is one of the Commission's goals.

The Commission, aware that requests always outrun fiscal resources, nevertheless urges these expenditures, not only to aid some of our most unfortunate fellow-men but to improve the quality of all our lives through the expression of compassion.

	Operations	*Capital Outlay*
OF HIGHEST PRIORITY		
2 Psychiatric Institutes		$13,000,000[4]
Increased community services for mental retardation and mental health		
Chapter 10 Boards	$ 2,300,000[4]	
Mental Health Clinics	4,195,000[4]	
Residential facilities for emotionally disturbed youth	*1,800,000*	
FOR THE RETARDED		
Increased funds for special education (includes disturbed children)	6,200,000[1]	
Larger tuition grants for handicapped children	634,000[1]	
Developmental Disabilities Planning Council	*80,000*	
Expanded Health Dept. programs		
Family planning and child health	212,000[2]	
Roster of prematures and voluntary sterilization	*200,000*	
Construction at institutions for the retarded		
Petersburg		7,000,000[4]
Lynchburg		2,100,000[4]
No. Va. Training Center—completion		2,300,000[4]
Southeast Training Center—completion		4,600,000[4]
Southwest Training Center—completion		8,000,000[4]
Planning—Winchester-Harrisonburg and Northern Neck		538,000[4]
FOR EMOTIONALLY DISTURBED YOUTH		
More group, probation, and detention homes under Dept. Welfare & Institutions	2,734,000[3]	
Mental health services for the juvenile correctional institutions	530,000[3]	453,000[3]
FOR MANPOWER TRAINING AND RESEARCH		
Further development of professional training at University Depts. of Psychiatry	1,400,000[4]	
Psychiatric Epidemiology Laboratory	200,000[4]	
Expansion of scholarship program	300,000[4]	
FOR GERIATRIC PATIENTS		
Administratively separate geriatric centers	*400,000*	
Matching grants to construct nursing homes (non-recurring expenditure)		*5,000,000*
FOR RETARDED AND MENTALLY ILL		
Relieving relatives of payment for patients in institutions for over 5 years	*1,900,000*	
FOR ADDITIONAL STUDY		
Continuing the Commission on Mental, Indigent and Geriatric Patients	*20,000*	
Included in requests of Departments Total	$18,705,000	$37,991,000
Not included in requests Total	*4,400,000*	*5,000,000*

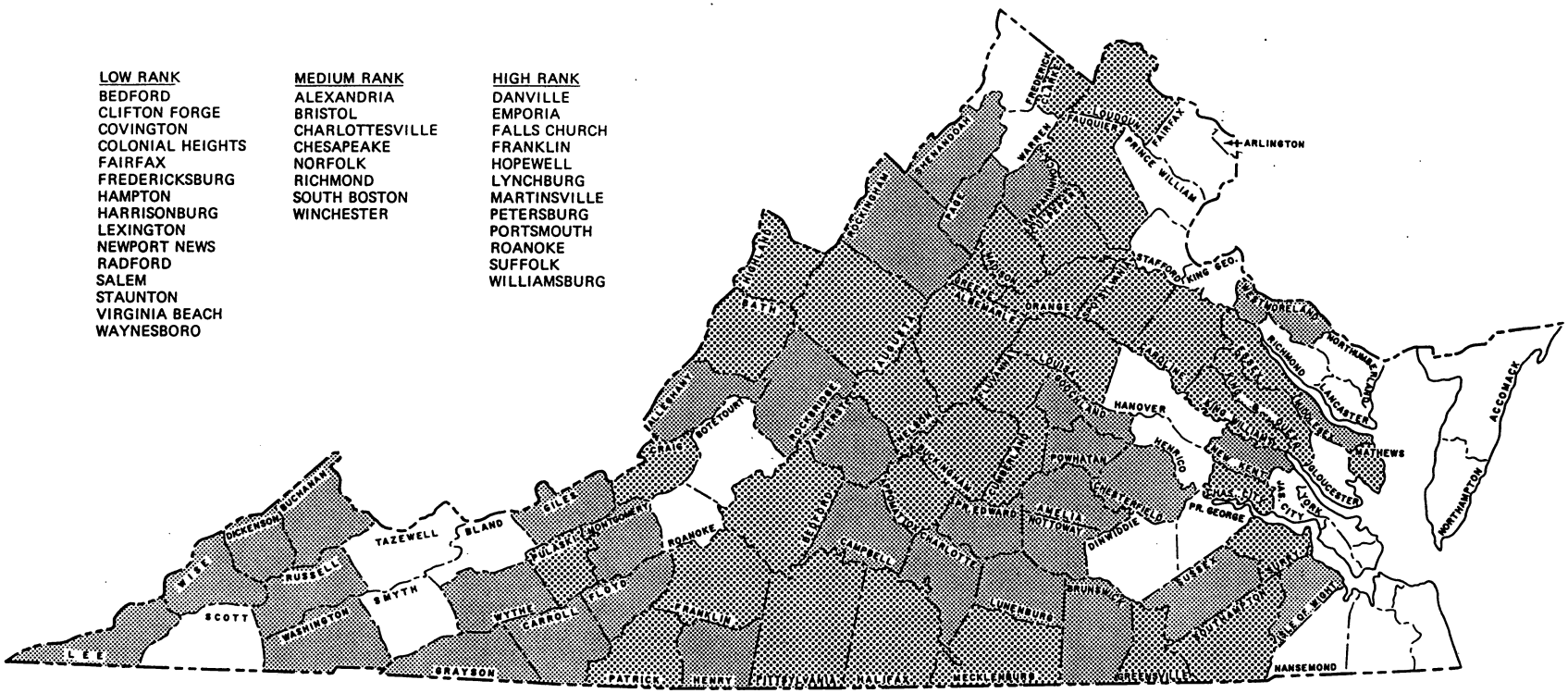
[1] Included in budget requests of Department of Education.
[2] Included in budget requests of Department of Health.
[3] Included in budget requests of Department of Welfare and Institutions.
[4] Included in budget requests of Department of Mental Hygiene and Hospitals.
Italics indicates that item is not in any departmental request.

Appendix A

RATES OF ADMISSIONS

OF MENTALLY RETARDED PERSONS BY COUNTY AND CITY
1966 - 1970

LOW RANK	MEDIUM RANK	HIGH RANK
BEDFORD	ALEXANDRIA	DANVILLE
CLIFTON FORGE	BRISTOL	EMPORIA
COVINGTON	CHARLOTTESVILLE	FALLS CHURCH
COLONIAL HEIGHTS	CHESAPEAKE	FRANKLIN
FAIRFAX	NORFOLK	HOPEWELL
FREDERICKSBURG	RICHMOND	LYNCHBURG
HAMPTON	SOUTH BOSTON	MARTINSVILLE
HARRISONBURG	WINCHESTER	PETERSBURG
LEXINGTON		PORTSMOUTH
NEWPORT NEWS		ROANOKE
RADFORD		SUFFOLK
SALEM		WILLIAMSBURG
STAUNTON		
VIRGINIA BEACH		
WAYNESBORO		



10 - 37 PER 100,000 GENERAL POPULATION

38 - 63 PER 100,000 GENERAL POPULATION

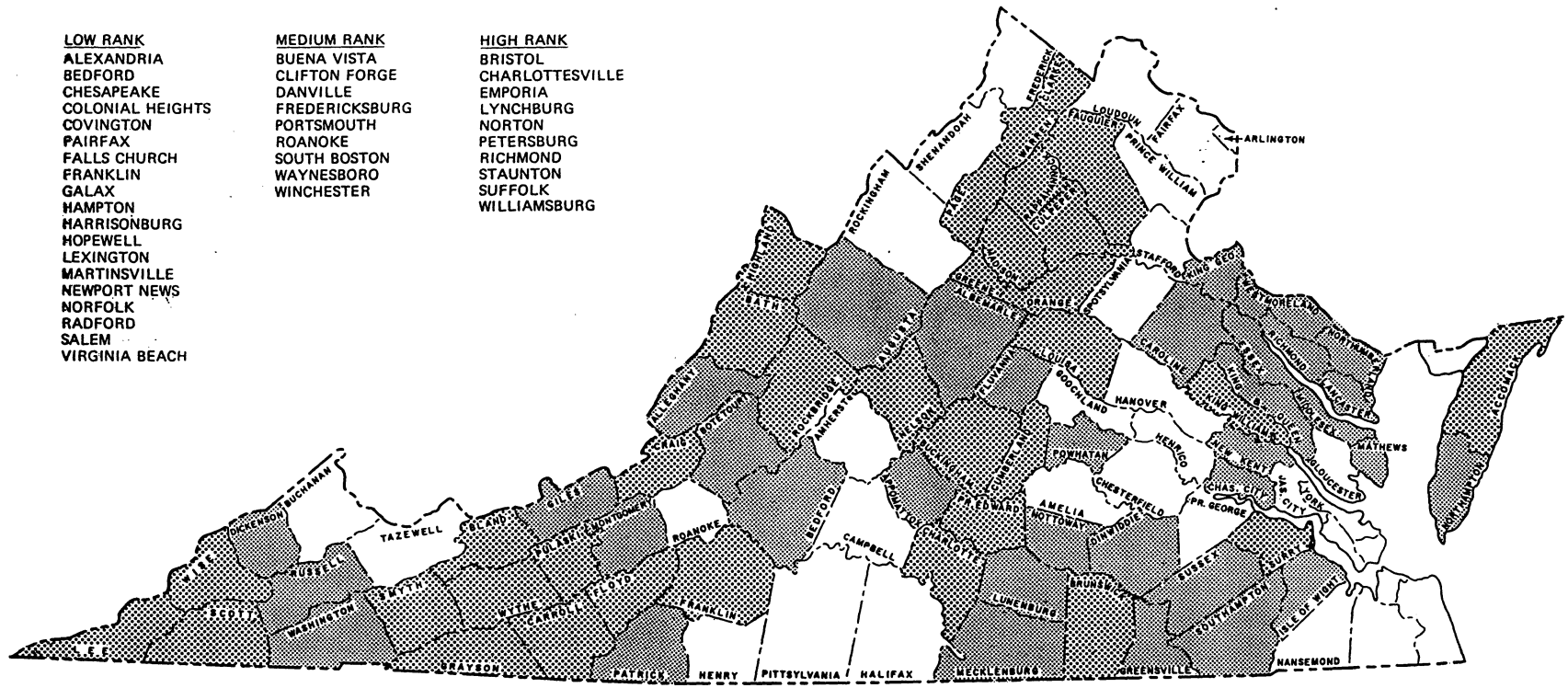
65 - 179 PER 100,000 GENERAL POPULATION

PERSONS ADMITTED TO LYNCHBURG TRAINING SCHOOL AND HOSPITAL (1207) AND PETERSBURG TRAINING SCHOOL AND HOSPITAL (903) BETWEEN JANUARY 1, 1966, AND DECEMBER 31, 1970

Appendix B

RATES OF INSTITUTIONALIZATION
(RESIDENT PATIENTS IN STATE MENTAL HOSPITALS BY COUNTY AND CITY)
JULY 1, 1971

LOW RANK	MEDIUM RANK	HIGH RANK
ALEXANDRIA	BUENA VISTA	BRISTOL
BEDFORD	CLIFTON FORGE	CHARLOTTESVILLE
CHESAPEAKE	DANVILLE	EMPORIA
COLONIAL HEIGHTS	FREDERICKSBURG	LYNCHBURG
COVINGTON	PORTSMOUTH	NORTON
FAIRFAX	ROANOKE	PETERSBURG
FALLS CHURCH	SOUTH BOSTON	RICHMOND
FRANKLIN	WAYNESBORO	STAUNTON
GALAX	WINCHESTER	SUFFOLK
HAMPTON		WILLIAMSBURG
HARRISONBURG		
HOPEWELL		
LEXINGTON		
MARTINSVILLE		
NEWPORT NEWS		
NORFOLK		
RADFORD		
SALEM		
VIRGINIA BEACH		



- LOW RANK, 134 - 184 PER 100,000 GENERAL POPULATION
- MEDIUM RANK, 185 - 267 PER 100,000 GENERAL POPULATION
- HIGH RANK, 268 - 640 PER 100,000 GENERAL POPULATION

Appendix C

STAFF STUDIES

The following staff studies were conducted by Mrs. Margareta Miller with the assistance of Mr. Philip Kahal, Mrs. Susan Bogart, Mrs. Patricia Merriman, and Mrs. Rose Marie Whitmore. This work would not have been possible without the help and cooperation of many people in the Department of Mental Hygiene and Hospitals.

1. Characteristics of the patients admitted to the Children's Unit at Eastern State Hospital.
2. Characteristics of the patients admitted to the Virginia Treatment Center with a follow-up interview of parents.
3. A survey of persons admitted to Lynchburg Training School and Hospital between January, 1966 and December, 1970, according to handicapping condition, age, sex, and place of residence.
4. A survey of persons admitted to Petersburg Training School and Hospital between January, 1966 and December, 1970, according to age, sex, and place of residence.
5. A survey of the resident population at the following State institutions according to age, sex, and place of residence.

   Eastern State Hospital
   Central State Hospital
   Western State Hospital
   Southwestern State Hospital
   De Jarnette Sanatorium
   Northern Virginia Mental Health Institute

6. A survey of the staffing patterns at the State mental hospitals and training schools according to services rendered.
7. A study of the State mental health clinics according to type of services rendered and costs per service unit.
8. A study of the Virginia State Plan in relation to the Developmental Disabilities Act of 1970.

ACKNOWLEDGMENTS

The Commission acknowledges with sincere appreciation the assistance given to it by the following persons:

The ex-officio members of the Commission, Dr. William S. Allerton, Commissioner of Mental Hygiene and Hospitals; Mr. Otis L. Brown, Director, Department of Welfare and Institutions; Dr. Mack I. Shanholtz, Commissioner of Health; Dr. Woodrow W. Wilkerson, Superintendent of Public Instruction and Mr. Julian P. Fox, Jr., Chief of Gerontology Planning, Division of Planning and Community Affairs, who gave us the benefit of their advice at the many meetings of the Commission.

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

The Commission's Staff Consultant, Mrs. Margareta Miller who produced many valuable and sometimes unique studies in a very short time, wrote illuminating staff reports and passed along to all who associated with her, her intense interest and enthusiasm, and her staff: Mr. Philip Kahal, Mrs. Susan Bogart, Mrs. Patricia Merriman, and Mrs. Rose Marie Whitmore.

The Division of Statutory Research and Drafting and especially Mr. John Banks who attentively and efficiently handled administrative matters for the Commission.

Dr. Ann Stewart, Director, Tidewater Mental Health Clinic; Dr. Harold Goldman, Director of Geriatrics, Eastern State Hospital; Dr. F. William Dinwiddie, Director, Edgemeade of Virginia, all of whom brought to the Commission helpful counsel in their respective fields.

Mr. John del Cardayré who contributed his ideas and experience to make this booklet more interesting.

Messrs. Charles Sheffield and David Bullock to whom we are deeply indebted for the sketches and charts.

The Virginia Association for Mental Health who allowed us to use material from their film strip presentation.

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Commission member Louise Palmer who wrote the Report from staff reports.

The many citizens of Virginia who shared their knowledge at the public hearing and by letter and memoranda.

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