REPORT OF THE

COMMISSION ON MENTAL HEALTH AND MENTAL RETARDATION

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 8

COMMONWEALTH OF VIRGINIA
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Grace C. Horning, Secretary

House Appropriations Committee

William E. Schuerch

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SUMMARY

Report of the

Commission on Mental Health and Mental Retardation

DECLARATION OF STATE POLICY

The Commission offers a statement of policy to document the dedication of the Commonwealth to the provision of high quality services and care for its mentally handicapped citizens. The policy calls for a coordinated system of statewide services providing treatment, training and care in the least restrictive environment possible. A fundamental element in adhering to the principles of the declaration of policy is a system of case management.

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FINDINGS AND RECOMMENDATIONS

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SERVING THE INDIVIDUAL

The prevailing theme of this report is the individualization of services for mental health, mental retardation and substance abuse in a community setting close to the home of the mentally handicapped individual and his family whenever possible.

I. PREVENTION AND PUBLIC AWARENESS

State and local human service agencies should begin to place high priority on the initiation of prevention and public awareness programs. The Secretary of Human Resources is requested to guide human services agencies in the development of appropriate programs for prevention and public awareness.

II. GUARDIANS AND COMMITTEES FOR LEGALLY INCOMPETENT AND LEGALLY INCAPACITATED PERSONS

Legislation is recommended which revises the laws governing the appointment of guardians and committees. A definition of the term "legally incapacitated" is proposed to differentiate this condition from "legally incompetent." The court is authorized to order certain human services agencies to prepare a comprehensive evaluation of the alleged incompetent or incapacitated person to assist the court in an appropriate disposition of each case. Clear and convincing evidence must be presented as to the person's incompetence or incapacity and as to each provision in the court's order of appointment of a guardian or committee. Certain persons who have been adjudicated incompetent or incapacitated are authorized to petition the circuit court to restore them to competency or capacity.

The Commission proposes a new provision for the appointment of a standby guardian for a mentally handicapped person upon the petition of his parent or legal guardian.

SERVICE DELIVERY IN THE COMMUNITY

II. DEINSTITUTIONALIZATION AND COMMUNITY SERVICES

The Commission endorses the recommendations contained in the Joint Legislative Audit and

Review Commission Report entitled "Deinstitutionalization and Community Services in Virginia." The establishment of a joint subcommittee of the House of Delegates and Senate to monitor the Department of Mental Health and Mental Retardation during 1980 and 1981 is recommended.

III. ADMINISTRATION AND MANAGEMENT OF THE COMMUNITY-BASED SYSTEM

State Board: Legislation is proposed which authorizes the State Board to establish programmatic and fiscal policy to govern the operation of community services boards. The State Board is required to develop and adopt by July 1, 1982 a policy establishing a core of mental health, mental retardation and substance abuse services for community services boards. Funding incentives shall be developed by the 1982-84 biennium to encourage localities to choose from the core services. Programs outside the core services shall also be specified by the Board and be funded at a lower rate with State monies.

The State Board is required by July 1, 1981 to establish policy which mandates that each community services board institute by January 1, 1982, a reimbursement system to maximize the collection of fees from persons receiving services and from responsible third party payors.

A study by the State Board of the concept of "funds following the client" is proposed with a goal of the submission of recommendations to the 1982 Session of the legislature for several pilot projects during the 1982-84 biennium.

It is recommended that the State Board adopt suggested salary ranges with appropriate fringe benefits to apply to all community services board employees beginning with the 1982-84 biennium. A study by the State Board on the need for and cost of providing liability insurance for community services board members and employees is requested to be submitted to the 1981 Session.

Department: In its relations with community services boards, it is the role of the Department to provide statewide direction and emphasis for program planning and evaluation. The Department's regional representatives should focus on technical assistance and guidance for the boards.

Local Governments: Statutory revision of the 1968 legislation establishing community mental health and mental retardation services boards is proposed. By July 1, 1983 it is required that every political subdivision establish singly or in combination with another such subdivision a community services board. Sixteen localities do not participate in a funded board at this time.

Community mental health and mental retardation services boards are redesignated "community services boards" to recognize their additional responsibility for substance abuse services. A county or city which comprises a single board and the county or city whose designated official serves as fiscal agent for the board is required to annually audit the board and its programs, approve a grievance procedure for employees of the board and arrange for legal services for the board.

The State Board is requested to promulgate guidelines to govern contracts for services entered into by community services boards.

IV. MANAGERIAL SERVICES

The Commission recommends four managerial services that must be provided by every community services board in the State: (i) preadmission screening; (ii) predischarge planning; (iii) a prescription team; and (iv) case management.

Preadmission Screening and Predischarge Planning: All admissions to State institutions should be substantiated by referral of the local community services board. The board must be responsible for assessing the client's service needs, referring the client to appropriate services and presenting recommendations to the court regarding commitment to or certification for treatment in a State institution.

Commencing with the institutionalization of a mentally handicapped individual, a predischarge plan must be developed jointly by the State facility where the person is institutionalized and the community services board or community mental health clinic serving the locality to which he will return.

Prescription Team: The Commission recommends the establishment of an interagency prescription team coordinated by the community services board or clinic. The team shall be responsible for accomplishing the tasks of preadmission screening and predischarge planning, assisting the court in decisions regarding commitment to or certification for treatment in a State institution and working with State facilities and local services agencies to develop treatment plans for mentally handicapped individuals.

Effect of the Managerial Services: Prior to voluntary admission of a mentally ill, mentally retarded or substance abusing person to a State institution, the individual must have been screened by either the community services board or the community mental health clinic that serves the region. The prescreening report must recommend that the individual's service needs require hospitalization before the individual may be admitted voluntarily to a State facility.

Whenever a person is brought before the court for the purpose of voluntary commitment to a State institution, the judge must obtain a prescreening report from the community services board or clinic. The prescreening report must recommend that the individual needs hospitalization in order for the court to commit that person to a State facility.

In the case of involuntary commitments, the judge is encouraged to utilize the expertise of the community services board through the prescreening report process, but is not required to do so. The court is required by the Commission's statutory proposals, however, to inform the community services board that a person has been involuntarily committed to a State facility within ten days of the date of the commitment order.

The Commission recommends that the director of the State institution be required to furnish the community services boards a list of persons, who have consented to the release of such information, for whom predischarge plans are required.

The Criminal Justice Services Commission is requested to provide training for law-enforcement personnel in the recognition of mental disabilities and the proper handling of mentally disabled persons. It is proposed that the Executive Secretary of the Supreme Court provide information about the kinds of community resources available for commitment or certification hearings to the judges at the statewide judicial conferences.

Case Management: Local government, under the direction of the Department of Mental Health and Mental Retardation, is given the responsibility through the community services boards for the establishment of a case management system designed to monitor the care and treatment of its citizens in need of services for mental health, mental retardation and substance abuse.

It is requested that a two-year study of the "double diagnosis client" who is both emotionally disturbed and mentally retarded be conducted by the Department of Mental Health and Mental Retardation in cooperation with other relevant State and local agencies.

V. ZONING FOR COMMUNITY RESIDENTIAL FACILITIES

Current State policy concerning zoning ordinances relating to homes for mentally retarded and other developmentally disabled persons is affirmed.

STATE ADMINISTRATION OF THE SYSTEM

Significant weaknesses were found in the ability of the State Mental Health and Mental Retardation Board to make policy for this system. The Commission questions the ability of the central office of the Department as presently structured to effectively administer the State institutions and oversee the statewide network of community services.

I. STATE MENTAL HEALTH AND MENTAL RETARDATION BOARD

The Commission proposes a revision of Title 37.1 of the Code of Virginia which realigns the powers and duties of the State Board and Commissioner and which reestablishes the Board as a policy-making body.

II. PERSONNEL MANAGEMENT AND EMPLOYEE RELATIONS

The Commission supports the participation of the Department of Mental Health and Mental Retardation in the Personnel Management Decentralization Plan being implemented by the Department of Personnel and Training.

It is recommended that the directors of State facilities be employed pursuant to the Virginia Personnel Act and not be subject to an appointed four-year term of office. The Commission proposes repeal of the statutory requirement that the person appointed Commissioner of Mental Health and Mental Retardation be a doctor of medicine.

III. STATE FACILITIES

Maintenance: The Commission recommends the Department consider reallocating existing positions within the central office to better accomplish its management and oversight responsibilities of the institutional maintenance systems.

The Governor is requested to develop by the 1982 Session a timetable for closing and demolishing or transferring to another agency institutional buildings for which maintenance has become economically or programmatically impractical.

Staffing: In the Commission's public hearings, the staffing of State institutions emerged as a factor contributing to the dissatisfaction of many institutional employees. Institutional directors, with the assistance of the Department, must seek to achieve a reasonable balance of administrative, programmatic and direct care staff.

VTCC-MCV Agreement: The Commission endorses the Agreement recently negotiated between the Virginia Treatment Center for Children and the Medical College of Virginia which is intended to define the unique relationship between VTCC and the Departments of Psychiatry and Pediatrics at MCV-VCU.

The Commission opposes the location of a parking deck by MCV-VCU adjacent to the Treatment Center which in any way encroaches upon the Center's air or land space.

IV. QUALITY OF SERVICES PROVIDED BY THE SYSTEM

Standards for State Institutions and for Community Programs: The Department's responsibility to monitor the implementation of standards for the programs and services offered by State institutions and community services is affirmed.

Planning: Legislation is recommended to define the roles and responsibilities of the various State and local agencies involved in planning services for mental health, mental retardation and substance abuse.

Research: The Department's responsibility to promote and encourage research into the causes of mental illness, mental retardation and substance abuse is set out.

V. EFFORTS IN INTERAGENCY COOPERATION

The Commission reviewed several interagency efforts to coordinate and integrate human services. Concern is expressed about the lack of commitment and underutilization of resources by the Departments of Mental Health and Mental Retardation and Corrections and the Rehabilitative School Authority in implementing services for the State's mentally handicapped incarcerated population. A report is requested from the Governor's cabinet on efforts to improve this situation by the 1981 Session.

FINANCIAL MANAGEMENT OF THE SYSTEM

I. STATE AND LOCAL FISCAL POLICIES

Operational and Capital Outlay Budget Policies: Institutional budget requests for both operations and

capital outlay must be reviewed and scrutinized by the Department more closely. A priority list of capital outlay projects for each biennium and a plan prioritizing such requests for the following two bienniums should be developed and submitted to the State Board, Governor and legislature.

Formula Funding of Community Services: The Department is requested to develop formulas for distributing a substantial percentage, though not all, of State general funds for mental health, mental retardation and substance abuse services pursuant to criteria specified in the report. The remaining State general funds should be administratively distributed to service areas of great need.

Title XX Program: The Secretary of Human Resources is requested to study the Title XX program and report to the legislature in 1981 on the feasibility of alternative methods of mandating Title XX services and of distributing these funds.

II. BUDGET RECOMMENDATIONS FOR THE 1980-1982 BIENNIUM

Operational Budget: In developing its requests for appropriations within its budget target, the Department found that significant employee layoffs could result in 1980-82. The Commission recommends that $5 million be added to the Department's budget to provide salaries for existing departmental employees to maintain the current level of services.

The Governor is requested to develop a ten-year plan which, by 1990, will result in 60% of State general funds supporting institutional services and 40% supporting community services. The current ratio is 83% institutional services and 17% community services.

To begin working toward this funding balance, the Commission recommends that an additional $10 million be appropriated for community services board programs for 1980-82: $6.16 million for grants to local boards and $3.84 million for local substance abuse programs.

Capital Outlay Requests: The Commission endorses the funding of two capital outlay requests by the Department for 1980-82:

* Ten projects considered essential to the health or safety of patients and residents. Cost: $4 million.
* Renovation and addition to the Virginia Treatment Center for Children. Cost: $4.3 million.

Alternatives are suggested to two other departmental capital oulay requests involving Lynchburg Training School and Hospital and Southwestern State Hospital.

The Commission requests that an interagency task force study the relocation of the children's program at DeJarnette Center for Human Development with a report being submitted to the 1981 Session.

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Report of the
Commission on Mental Health and Mental Retardation
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
January 9, 1980

To: Honorable John N. Dalton, Governor of Virginia
and
The General Assembly of Virginia

HISTORY OF THE COMMISSION

The Commission on Mental Health and Mental Retardation was created pursuant to House Bill Number 1935 of the 1977 Session of the General Assembly. The legislation charged the Commission with the responsibility to conduct a "study of the care and treatment of the mentally ill and mentally retarded in Virginia as provided directly or indirectly by the several agencies operated or funded by public funds." The Commission was established to pursue the work initiated by the previous Commission on Mental, Indigent and Geriatric Patients which reported to the 1970 and 1972 Sessions of the General Assembly. At the same time, the evolution of nearly a decade had brought new challenges to the fields of mental health, mental retardation and substance abuse. The Commission on Mental Health and Mental Retardation was directed to review the system which had evolved and to present recommendations for improving and strengthening the care and treatment afforded Virginia's mentally handicapped citizens.

The members selected to serve on the Commission were: Delegate Richard M. Bagley of Hampton, Chairman; Senator Elliot S. Schewel of Lynchburg, Vice-Chairman; Delegate Bernard G. Barrow of Virginia Beach; Senator John C. Buchanan of Wise; Delegate J. Paul Councill, Jr. of Franklin; Delegate Arthur R. Giesen, Jr. of Verona; Richard S. Gillis of Ashland; Senator Omer L. Hirst of Annandale; Dororthy I. MacConkey, Ph.D. of Fairfax; Delegate Mary A. Marshall of Arlington; Delegate Frank M. Slayton of South Boston; and James C. Windsor, Ph.D. of Newport News. Dr. Leo E. Kirven, Jr., Commissioner of the Department of Mental Health and Mental Retardation served as an ex officio member of the Commission.

The Commission acknowledges with sincere appreciation the legal, research and administrative assistance of its staff from the Division of Legislative Services: Lelia B. Hopper, Staff Attorney; Martha A. Johnson, Legislative Research Associate; and Grace C. Horning, Secretary. The Commission also appreciates the contribution made to its work by William E. Schuerch of the House Appropriations Committee staff in the consideration of fiscal issues affecting the handicapped services system.

During 1977, the first year of the Commission's work, the members and staff endeavored to define the issues which required the Commission's consideration with a perspective toward legislative policy or statutory recommendations. Once defined, lists of the issues were distributed throughout the Commonwealth. The efforts of the Commission and the Department of Mental Health and Mental Retardation were concentrated on informing the public of the Commission's charge and of its interest in the statewide system of services for mental health, mental retardation and substance abuse.

In 1978, the Commission developed a schedule of public hearings and visits to every State institution and to selected community facilities. Public hearings were held in Danville, Roanoke, Hampton, Richmond, Abingdon, Falls Church and Staunton. By the end of November, 1978, the Commission had toured every State hospital and training center in Virginia. Tours of community facilities were coordinated by local community services boards which selected representative programs and services for the Commission's observation.

Tour of Southwestern Virginia Training Center for the Mentally Retarded

The Commission wishes to take this opportunity to express sincere appreciation to the dedicated men and women of Virginia who serve as members and staff of the community services boards. The Commission is indebted especially to everyone who participated in the work of this legislative study, either during the public hearings and tours or during the work of the subcommittees. The interest and cooperation exhibited throughout the State was encouraging to the members of the Commission in this joint endeavor to improve the State's system of services for mental health, mental retardation and substance abuse.

As the Commission conducted its public hearings and tours of the State facilities and community programs, administrative and programmatic problems were brought to its attention. In several instances, these problems were addressed immediately by the Commission and subsequently by the Department of Mental Health and Mental Retardation or the State Board. For example, when the Commission learned of personnel problems at Lynchburg Training School and Hospital, the Department and the State Board conducted an investigation into the problem and took steps immediately to address the concerns of those employees. Similarly, personnel problems at Southwestern State Hospital were investigated when the Commission learned of their existence during a public hearing in Southwest Virginia. The movement of patients and the restructuring of certain adult and children's programs at Eastern State Hospital was a result of the Commission's visit to that institution. After visiting the Virginia Treatment Center for Children in Richmond, the Commission secured the assurance of the Governor that there would be no further encroachments upon the property of the Treatment Center until the matter could be studied comprehensively by the Department and the Commission. The cash flow of community mental health and mental retardation services boards was improved by changes initiated at the Commission's request in the Department's method of forwarding funds to the boards for the first quarter of the fiscal year. The Commission's report documents the administrative changes that have been implemented to continue addressing these and other problem areas within the system. The fact that these concerns were given prompt attention is illustrative of the dedication of the Department and of the State Board to the work of the Commission. The Commissioner and staff of the Department and the members of the State Board were responsive to the Commission's concerns throughout the study.

The Commission wishes to express its gratitude to the Commissioner, the members of the State Board and to the departmental staff who accompanied the Commission throughout the State in the conduct of the public hearings and tours and during the work of the subcommittees. The stamina and dedication of these individuals is to be commended as a vital element in this legislative effort.

In 1979, the Commission assimilated the multitude of information obtained during the public

hearings and tours and divided the issues to be addressed among four subcommittees. The subcommittees were: the Subcommittee on State Administration, chaired by Senator Elliot S. Schewel; the Subcommittee on Patients and Residents, chaired by Dorothy I. MacConkey, Ph.D.; the Subcommittee on Community-Based Services, chaired by James C. Windsor, Ph.D. and the Subcommittee on Finance, chaired by Delegate Richard M. Bagley.

One of the issues brought to the Commission's attention was the quality and nature of education which should be provided handicapped children. This topic was not assigned to a subcommittee for study and is not addressed in this report. It is the sense of the Commission that the issue requires more intensive consideration than the Commission could devote because of the scope of its study and the comprehensive nature of its review of the State's system for mental health, mental retardation and substance abuse.

In June of 1979, the full Commission met in Northern Virginia to hear presentations by nationally-recognized professionals in the fields of mental health, mental retardation and substance abuse. Commission members participated in discussions concerning the impact of federal legislation on the service system and the nationwide trends in service delivery. As a result of this meeting, the Commission was better able to determine Virginia's progress as compared with other states in the national movement toward community-based care of the mentally disabled. The national experts who appeared before the Commission were: Fred J. Krause, Executive Director of the President's Committee on Mental Retardation; Dr. Carl Akins, Executive Director of the National Association of State Alcohol and Drug Abuse Program Directors; Harry C. Schnibbe, Executive Director of the National Association of State Mental Health Program Directors; and Valerie J. Bradley, President of the Human Services Research Institute in Washington, D.C.

After the meeting in Northern Virginia, the subcommittees set to work on the separate issues designated for their consideration. The full Commission did not reconvene until September of 1979 when the subcommittees were prepared to present their findings and recommendations.

Subcommittee on State Administration

During the summer of 1979, the Subcomittee on State Administration explored issues surrounding the role of the State Board, fiscal policy, personnel planning and development, State facilities, quality of services and interagency concerns. Serving with Senator Schewel on the Subcommittee were Delegate Giesen, Mr. Gillis and Senator Hirst.

To accomplish the Subcommittee's study of the State Board, the staff interviewed five of the nine State Board members, and the Subcommittee met personally with four Board members. These sessions comprised a full and candid discussion of the strengths and weaknesses of the Board as it currently operates. In succeeding Subcommittee meetings the Commissioner of the Department and the Secretary of Human Resources responded to concerns expressed by the Board members about the failure of the executive branch to adequately utilize the resources of the Board. The Commissioner and the Secretary expressed their opinions as to how the relationships of the Board to the Department and to the Governor could be clarified.

An examination of the unique relationship between the Medical College of Virginia and the Virginia Treatment Center for Children was conducted by the Subcommittee. The chairmen of the departments of psychiatry at the Medical College of Virginia and at the University of Virginia were present for this discussion and reviewed with the Subcommittee the current relationships between the State's medical schools and the institutions for mental health, mental retardation and substance abuse.

The Subcommittee was briefed on the principles and implementation of the new personnel program in the Department of Mental Health and Mental Retardation. The Department is one of two State agencies participating in a decentralized job classification program under the Department of Personnel and Training. Employee concerns brought to the Commission's attention at Lynchburg Training School and Hospital and at Southwestern State Hospital were considered, and the administrative steps which had been taken to address those concerns were reviewed.

In June of 1979, the Subcommittee on State Administration and the Subcommittee on Patients and Residents met in Northern Virginia on the fiscal issues related to the statewide system of services for mental health, mental retardation and substance abuse. Members of the Subcommittee

on Community-Based Services participated in this meeting as well. The joint meeting involved a briefing by the staff of the Commission and participants from the Departments of Mental Health and Mental Retardation, Health and Welfare.

The Joint Legislative Audit and Review Commission apprised the Subcommittee of its findings in its study on "Deinstitutionalization and Community Services in Virginia." JLARC's study provided insight into the Subcommittee's examination of the quality of the services provided by the statewide system of care and treatment for the mentally handicapped. This topic was explored further by discussing with personnel from the Departments of Mental Health and Mental Retardation and Welfare standards for State institutions and community programs and efforts to develop interagency agreements to effect the efficient delivery and monitoring of high quality services.

The Subcommittee reported its findings and recommendations to the Commission on September 24, 1979.

Subcommittee on Patients and Residents

The Subcommittee on Patients and Residents was assigned the responsibility of identifying the needs of the mentally handicapped individual who is living either in the community or in a State institution. Serving with Dr. MacConkey on the Subcommittee were Delegate Barrow, Senator Buchanan and Delegate Slayton. An examination of the State's obligation to its mentally handicapped citizens was a primary focus of the Subcommittee's work. In the course of its study, the Subcommittee met with representatives of the community services boards in Norfolk and Virginia Beach and with representatives of the private sector who provide long-term care for the mentally disabled.

The Subcommittee reviewed House Bill No. 2000 from the 1979 Session of the General Assembly, a revision of the laws governing guardians and committees for legally incompetent and legally incapacitated persons. The assistance of the Public Interest Law Center of Virginia and the Developmental Disabilities Protection and Advocacy Office is gratefully acknowledged in bringing the problems in this area to the Commission's attention and in providing draft legislation with which the Commission could work.

In its deliberations, the Subcommittee also focused on the mental health needs of persons in the criminal justice system. Representatives from the Department of Mental Health and Mental Retardation and the Department of Corrections participated in the Subcommittee's review of the programs and services rendered by each department for children and adults who have been committed to the Department of Corrections but who require treatment for mental illness, mental retardation or substance abuse.

The Subcommittee submitted its report and recommendations to the Commission on October 22, 1979.

Subcommittee on Community-Based Services

The Subcommittee on Community-Based Services was designated the task of evaluating the role of community services boards in the statewide provision of programs and services for mental health, mental retardation and substance abuse. Delegate Bagley, Delegate Councill and Delegate Marshall worked with Dr. Windsor in conducting the Subcommittee's study.

Initially, the Subcommittee selected eight community services regions of the State which reflected the geographic, governmental and organizational variations of the community services board system. From each of these regions, the chairman and executive director of the community services board were asked to meet in open session with the Subcommittee to discuss the roles and responsibilities of the board, its members and staff. Local governing officials from each of the eight regions were asked to attend a similar session with the Subcommittee to examine the relationship of community services boards with local governments. The discussions in each of the three sessions conducted by the Subcommittee were candid and enlightening. The issues considered in these sessions became the basis for further deliberations of the Subcommittee and for its recommendations to the Commission.

After hearing the perspective of the community services boards concerning their relationship

with the Department of Mental Health and Mental Retardation, the Subcommittee met with the staff of the Department to discuss their role as consultants and monitors of community-based services. The directors of community mental health services, community mental retardation services and community substance abuse services outlined their responsibilities and reviewed the kinds of assistance and guidance that they offer the localities.

The staff of the Joint Legislative Audit and Review Commission briefed the Subcommittee on the findings of JLARC's study, "Deinstitutionalization and Community Services in Virginia."

The Subcommittee's findings and recommendations were presented to the Commission on October 22, 1979.

Subcommittee on Finance

The Subcommittee on Finance was appointed to review the major fiscal issues brought to the Commission's attention during its study. The members who served on the Subommittee with Delegate Bagley were Delegate Barrow, Senator Buchanan, Delegate Giesen, Senator Hirst and Delegate Slayton. The Subcommittee reviewed the 1980-1982 budget requests of the Department, the target allocations established by the Governor and the Secretary of Human Resources and the addendum to the Department's budget request. Dr. Jean L. Harris, Secretary of Human Resources; Charles B. Walker, Secretary of Administration and Finance; Stuart W. Connock, Director of the Department of Planning and Budget; and Dr. Leo E. Kirven, Jr., Commissioner of the Department of Mental Health and Mental Retardation, assisted the Subcommittee in the consideration of these issues. Additionally, the Subcommittee reviewed the recommendations of the other subcommittees with a view toward coordinating the financial implications of their proposals. The recommendations of the Subcommittee were incorporated into the final report of the Commission.

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Dr. Leo E. Kirven, Jr., Mrs. John N. Dalton, Delegate Bagley

DECLARATION OF STATE POLICY

The work of the Commission on Mental Health and Mental Retardation has spanned the last two years of a decade of revolutionary changes in the attitudes of the judiciary, treatment professionals

and the public toward the place of the handicapped in our society. The Commission believes it is particularly appropriate to begin the 1980's with a commitment to capture this innovative spirit of the last decade. It is now our responsibility to make a reality of the programs and services necessary to effectively and humanely integrate the mentally disabled into our communities and to provide those unable to live independently quality treatment, training and care in the least restrictive environment. The Commission's view of the Commonwealth's commitment to these goals is set forth in the following declaration of policy.

The direct impact of mental illness, mental retardation and substance abuse on thousands of children and adults in the Commonwealth, as well as on the lives and resources of their families, demands the accessibility of a complex array of medical, social, educational, habilitative, rehabilitative and legal services. To effectively serve Virginia's mentally handicapped citizens, this array of services must combine the available resources of both the public and private sectors of service providers and must be available in or near the home community of the mentally handicapped person. The Commonwealth recognizes the magnitude of the problems of its citizens who have varying degrees of mental disabilities and the scope of services required to meet their challenge. Therefore, it is the policy of the Commonwealth of Virginia to establish, maintain and support the development of an effective system of treatment, training and care for mentally ill, mentally retarded and substance abusing citizens.

The basic principle of this statewide system is that in every instance, the appropriate treatment, training and care shall be provided in the least restrictive environment with careful consideration of the unique needs and circumstances of each person. At the same time, the individual's right to refuse such services shall be respected and preserved, with the exception of instances where the individual's behavior presents a danger to himself or others.

Early recognition, diagnosis and appropriate treatment or training, regardless of an individual's age or degree of handicap, are the fundamental elements contributing either to a cure or to the restoration of maximum capabilities for many Virginians. The responsibility for such intervention and care cannot and should not be the exclusive duty of any one agency of either the government or the health care community. In the same perspective, the prevention of mental illness, mental retardation and substance abuse depends upon the joint efforts of public and private agencies and individuals. The initiation of prevention programs and public awareness cannot succeed unless the providers of services and available resources join together to address the need for such programs. Therefore, it is the policy of the Commonwealth that all human service agencies, at both the State and local levels, shall jointly and cooperatively strive to assist citizens who have mental disabilities and to reduce the numbers of individuals defined as mentally handicapped who are subsequently enrolled in the treatment and training population.

To accomplish these policy goals, the statewide system of services for the mentally handicapped must be planned and provided as a continuum ranging from independent community life to institutionalization. Achieving the maximum potential from the continuum of services depends upon the effective leadership and guidance of the State provided through the management and oversight functions of the Department of Mental Health and Mental Retardation. Equally essential to the success of these services is the dedication to the provision of services by the localities and compliance with quality assurance standards by the community services boards and by the appropriate local agencies. Regardless of the location of an individual's entry into the system, each person's initial placement and continuation throughout the appropriate services shall be monitored by a system of case management at the local level. The case management mechanism shall function to carefully plan and effect every transition of the individual from one service to another. The individual shall receive either more intensive or less intensive care depending upon his particular circumstances.

High quality treatment, training and care for every person who enters the statewide system of services remains paramount in the policy of Virginia. Emphasis is urged on programs and services designed for children and the elderly. Prevention, early diagnosis and intervening treatment of mental disabilities may divert Virginia's youngest citizens from institutionalization and from the debilitating affects of mental handicaps. The appropriate treatment and care of older Virginians can enable them to enjoy independent living in their own surroundings outside institutional settings. This emphasis in no way diminishes the need to serve all Virginians with mental disabilities. The continuing focus must be the individual, regardless of age or degree of handicap. The State's commitment is to assist every citizen to live as independently and as productively as possible.

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FINDINGS AND RECOMMENDATIONS

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In its comprehensive review of the mental health, mental retardation and substance abuse system the Commission has focused (i) on the individual in the system who requires services, (ii) on the programs and services available to help the mentally handicapped in their communities and (iii) on the administrative structure at the local and State levels which permits the delivery of services to those individuals in need. This report presents in this order the findings and recommendations of the Commission which are aimed at strengthening the abilities of the judiciary and all levels of the executive branch to better serve the mentally ill, mentally retarded, alcoholic and drug addict within a continuum of care.

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SERVING THE INDIVIDUAL

The prevailing theme in the work of the Commission has been the individualization of services for mental health, mental retardation and substance abuse. The Commission recognizes that the problems of mental illness, mental retardation and substance abuse are distinct, but areas of common concern do exist. The Commission's report attempts to recognize the unique needs of mentally disabled persons and to address their mutual needs.

Fred T. Hatcher Work Activity Center, Danville

Until recently, persons having problems indicative of mental illness, mental retardation or substance abuse were segregated from the mainstream of society to be treated by either the private sector, if such treatment were affordable, or to be cared for in institutions operated by public agencies. Studies have proven, however, that institutionalization, no matter how modern or sophisticated, fosters the routinization of the lives of the patients and residents. The daily routine of an institutional environment contributes to the dependence of the patient or resident on others and not to his preparation for community life. Consequently, a new theory of treatment, training and

care has evolved, particularly during the past decade, in Virginia and in the nation. This theory encourages the move from large-scale institutional care to a more personalized model of treatment or training in a community setting close to the mentally disabled individual and his family. The aspiration of the State is to achieve a statewide system of treatment, training and care which focuses on a continuum of services available at the local level, in which institutions are an integral component. Unfortunately, the impetus to remove individuals from institutional care has superceded the development of viable alternatives for the appropriate care of the mentally handicapped at the community level.

It is insufficient to simply espouse the concept of deinstitutionalization and community placement. Our challenge is to design the least restrictive, most appropriate service models for each individual's needs. The Commission was encouraged during the tours in 1978 to see the variety of programs being developed at the community level, but more of such services are needed. A statewide network of group homes, supervised apartments, special foster care placements, sheltered workshops, adult activities centers, day hospitals, crisis intervention centers and other appropriate community services need to be developed and supported at all levels of government and by the private sector. The courts have consistently ruled that the evaluation of mentally disabled persons must lead to their placement in an environment least restrictive of their liberty. These rulings are hollow if the alternatives to institutional care do not exist and if the services available in the community are not the most beneficial to the mentally handicapped individual.

I. PREVENTION AND PUBLIC AWARENESS

During the early 1960's at the beginning of the national movement to establish community-based services, President John F. Kennedy singled out prevention as the most important task of professionals serving the mentally handicapped. Since that time, those professionals and others working with them have learned that the initiation and success of any program at the community level depends upon the willingness of the localities to accept the programs and the individuals for whom they are designed. Unfortunately, prevention has not had a high priority in the development of programs in the field of mental disabilities.

Sarah Bonwell Hudgins Regional Center, Hampton

The strategies for the prevention of mental illness, mental retardation and substance abuse are many and varied according to each discipline. Therefore, the responsibility of State and community human service agencies is to identify throughout the State the high-risk populations most vulnerable to mental disabilities. The agencies' next priority should be to arrest the evident causes of mental handicaps in those populations and to reduce the manifestation of mental disabilities whenever possible.

The Commission feels that significant attention should be focused on preventive measures which begin prior to and in the earliest stages of life. It is here that prevention and public awareness coincide. That is, an informed public should be aware of (i) the dangers of alcohol and drug abuse during pregnancy, (ii) the importance of pre-natal care, (iii) the nutritional requirements of early childhood; (iv) the necessity of immunization; (v) the need for early detection and treatment of metabolic and genetic disorders, infectious diseases and blood disease; (vi) the causes of lead poisoning; (vii) precautionary measures to prevent accidents; and (viii) the existence of counseling and support groups for single parents, divorced persons, families with elderly relatives living in the home, individuals with mental or physical handicaps and others experiencing stressful situations.

In 1976, the Committee to Study Preventable Causes of Mental Retardation issued a report which details the services, educational programs, publicity and coordination necessary to effectively prevent mental retardation. The report became House Document No. 15 of the 1976 Session of the General Assembly. In November, 1979, the Department of Mental Health and Mental Retardation conducted a follow-up conference to review the recommendations of the Committee's report. The consensus of the conference participants and of the members of this Commission attending the conference is that the recommendations included in House Document No. 15 of 1976 should be fully implemented. In addition, the Department of Health has been awarded one of three grants from the United States Department of Health, Education and Welfare to establish programs for the prevention and treatment of childhood accidents. Thus, there are a number of groups working in the State to prevent the known causes of mental disabilities. The Commission urges cooperation and coordination among these various organizations and encourages their continual progress.

A letter addressed to the members of the President's Commission on Mental Health in 1978 states:

> "Mental health...affects every one of us–depression, marital problems, drug and alcohol-related problems, inability to cope as the result of a death or serious accident, low self-esteem, social maladjustment problems, dealing with delinquent children, and so many more situations."

The letter is a reminder that nearly everyone experiences the problems of mental illness, mental retardation or substance abuse either personally or among family or friends. Yet, there is a need to positively adjust our attitudes toward the mentally handicapped on a daily basis. The primary barriers to community acceptance of mentally disabled individuals are fear and ignorance. It is the Commonwealth's responsibility to overcome these barriers by directing effective long-range and short-range strategies to change public attitudes. The Commission urges volunteer organizations such as the Virginia Association for Retarded Citizens and the Virginia Mental Health Association to continue and to increase their efforts to promote public awareness of the special problems and potentialities of mentally handicapped individuals.

Lynchburg Training School and Hospital

The Commission recommends that the Secretary of Human Resources be requested to guide State and local human service agencies to place high priority on the initiation of programs for prevention and public awareness. Five-year plans outlining the goals and objectives of these programs should be developed. Special consideration should be devoted to interagency efforts to accomplish the establishment of prevention and public awareness programs and to maintain their effective operation. The Secretary is requested to present an initial report detailing the plan to establish the programs to the General Assembly Session in 1981. A final report documenting the establishment of the programs should be submitted to the 1982 Session of the legislature.

II. GUARDIANS AND COMMITTEES FOR LEGALLY INCOMPETENT AND LEGALLY INCAPACITATED PERSONS

The Commission's focus on the individual in the mental health, mental retardation and substance abuse system emphasizes the necessity of providing quality care and treatment in the least restrictive environment within State and community residential programs. Recognition should be given also to the principle that the mentally handicapped person be permitted to function to the best of his ability in making decisions about his personal life and with regard to matters of finance and property. Such responsibility fosters independence and supports the mentally disabled person's efforts to live a normal life. It should be acknowledged that individuals with disabilities are often capable of doing many things for themselves.

When it is established by a court that a person is incapable of managing some or all of his personal or financial affairs, or both, because of age, illness or disability, a guardian may be appointed. Guardianship is a legal relationship which authorizes one person to become a substitute decision-maker for another. Partial or total authority may be given to a guardian (i) to make decisions about the place where the disabled person will live and the services he will receive or (ii) to manage and control that person's property and income or (iii) to perform both functions. Correspondingly, the person for whom the guardianship is established may lose the right to decide where he will live, to make contracts for goods and services, to go to court to enforce his rights, to hold or convey property, to make a will, to marry, to have children, to possess a driver's license or to vote.

A new statute in the Code of Virginia was enacted in 1975 and revised in 1976 to provide for the appointment of guardians for persons who are determined to be partially or wholly incapacitated by reason of mental illness or mental retardation (§ 37.1-128.1). This law was intended to provide a less restrictive form of guardianship than is created by a declaration of a person's incompetency (§ 37.1-128.02). Several shortcomings, however, remain in the law in this area. The Commission recommends that legislation be introduced in the 1980 Session of the General Assembly to remedy the deficiencies.

A basic flaw in the procedural statutes previously referenced (§§ 37.1-128.1 and 37.1-128.02) which differentiate between guardianship for reasons of incapacity and incompetency is that the statutory definitions for these conditions are the same. Much confusion still exists, therefore, among the bar and judges as to cases in which incapacity as opposed to incompetency is at issue. The Commission proposes to specifically define "legally incapacitated" and to repeal from the definition of "legally incompetent" any reference to physical conditions which may render a person incapable of taking care of his person or estate. To further differentiate between these two proceedings, it is recommended that, prior to an adjudication of incompetency, the court must find (i) that the person is not merely incapable of taking care of some of his affairs and (ii) that the utilization of a limited guardianship is not more appropriate. This provision is designed to insure that whenever possible the least restrictive form of guardianship is employed.

Other aspects of the proposal which should be noted are:

- Prior to a hearing to determine incompetency or incapacity, the court may order the community services board or the community mental health clinic to prepare a comprehensive evaluation of the current condition of the alleged incompetent or incapacitated person and of his past history relevant to the hearing process. The local welfare department may be ordered to assist in preparing any portion of the evaluation in which it has knowledge concerning the person. These provisions are meant to supply the court with appropriate resources to make informed decisions

about the nature and extent of the incompetency or incapacity of the person for whom a guardian is requested. The guardian's powers over his ward can then properly be determined.

- The burden of proof of clear and convincing evidence is the standard which is specified for the court's finding a person incompetent or incapacitated.

- Alleged incompetent and incapacitated persons shall be represented by an attorney, either privately retained or appointed by the court, on the hearing of any petition for appointment of a guardian.

- Alleged incompetent or incapacitated persons have the right to be present at the hearing if they so request or if their presence is requested by their attorney.

- Clear and convincing evidence is required to support each provision in the court's order appointing a guardian for a person determined to be incapacitated. The order of appointment is required to (i) state the nature and extent of the person's incapacity; (ii) define the powers and duties of the guardian; (iii) specify the duration of the court order determining incapacity; and (iv) specify any legal disabilities of the incapacitated person. These requirements are to protect both the ward and the guardian and to tailor each order of appointment so as to grant to the guardian only those powers necessary to provide for the demonstrated needs of the incapacitated person.

- Provision is made for the appointment of a standby guardian for a mentally ill or mentally retarded person upon the petition of his parent or legal guardian. Immediately upon the death or adjudication of incompetency of the last surviving parent of the person or of his legal guardian, the standby guardian assumes the duties of his office subject to confirmation of the circuit court within sixty days. This new addition to the law is meant to lessen the difficulties of transition caused by the death or incapacity of the last surviving parent of a mentally handicapped person or of his legal guardian. Where parents or guardians of disabled children have chosen to remain legally responsible for those children throughout the parents' or guardians' lives, the appointment of a standby guardian assures them that a competent adult remains willing and available to take over that responsibility when they can no longer fulfill it. (§ 37.1-128.2)

- Certain persons who have been adjudicated incompetent or incapacitated are authorized to petition the circuit court to declare them restored to competency or capacity. (§§ 37.1-128.02, 37.1-128.1 and 37.1-132.) This provision is to make clear that the guardianship process is reversible by following the same procedures initially used to establish guardianship. (§ 37.1-134.1)

Testimony before the Commission also recommended that the Code of Virginia be amended to provide for the appointment of a public guardian, other than the sheriff as the law now provides, when all other suitable candidates such as family or friends are unable or unwilling to serve. No feasible alternatives to the sheriff were recommended to the Commission, however, and thus no proposals in this matter are suggested in this report. The Commission anticipates that its extensive recommendations concerning guardians and committees will be of assistance in clarifying the legal rights of the disabled and the responsibilities of the bar, judiciary, law-enforcement and human service agencies in protecting those rights.

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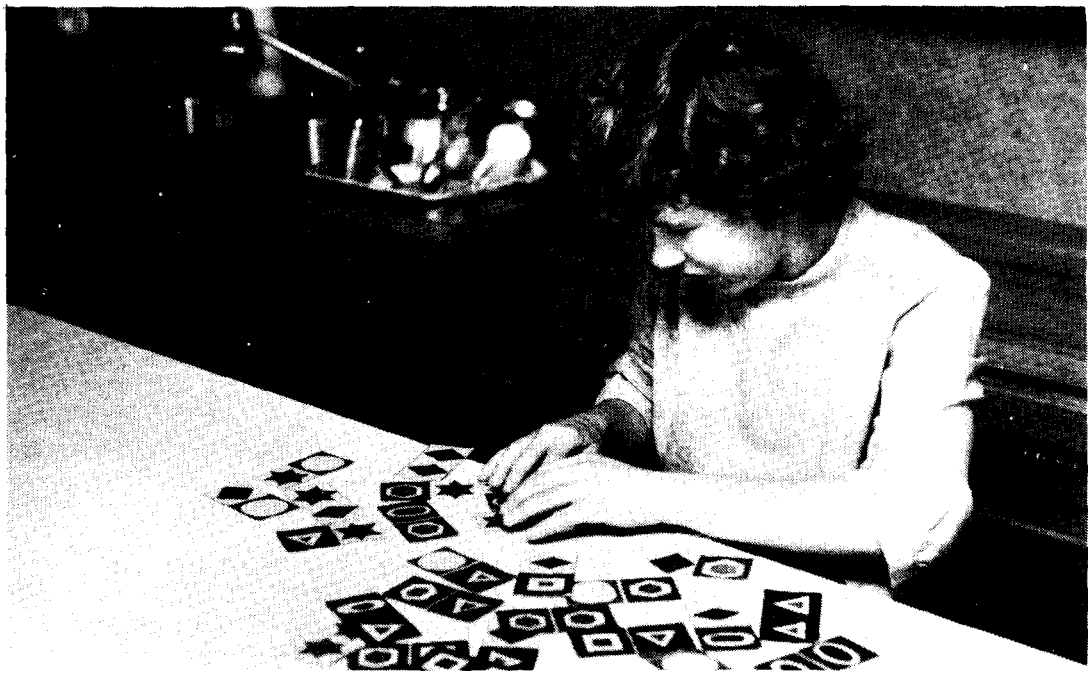
SERVICE DELIVERY IN THE COMMUNITY

I. HISTORICAL BACKGROUND

Guided by State legislation enacted in 1968, the Commission on Mental, Indigent and Geriatric Patients set the parameters for the community-based system of mental health, mental retardation and substance abuse services that exists today. The Commission's report in 1970 advocated a regionalized system across the State assisted by local coordinators who report to the central office of the Department of Mental Health and Mental Retardation. The report recommended that mentally handicapped individuals be screened "in the community for diagnostic purposes and referral to the proper services." Mechanisms to strengthen community involvement in the State hospital program were proposed also. The cooperation of all local human service agencies, schools, courts,

law-enforcement officials and the medical profession was solicited by the Commission to adequately address the needs of the mentally handicapped. Two years later, in 1972, the Commission issued another report which focused on the needs of the mentally retarded. This report recommended steps to implement a community-based system of services in every locality of the Commonwealth.

In 1974, the Department of Mental Health and Mental Retardation and the State Board commissioned the public policy research firm of Arthur Bolton Associates to conduct a ten-month study of mental health and mental retardation services in Virginia. The study was designed to produce information for planning and delivering the statewide system of community-based services initiated by State legislation and by the Reports of the Commission on Mental, Indigent and Geriatric Patients. In 1975, the Bolton Report presented recommendations for a more appropriate organizational structure of the Department of Mental Health and Mental Retardation and for a more effective system of community-based services. The broad recommendations of the study were to: "(i) identify the characteristics of persons recently admitted to state institutions for the mentally ill and mentally retarded; (ii) identify community service alternatives for people in risk of being institutionalized; (iii) develop community resources to meet identified needs; and (iv) screen all people for whom institutional placement is being considered." Specific suggestions to implement each of these recommendations were detailed in the report.



Pleasant View Home, Broadway

Today thirty-six funded community services boards control and manage locally-based services for mental health, mental retardation and substance abuse in Virginia. Approximately ninety percent of the State's population lives within the service areas of these boards. The citizen members of the community services boards provide a mechanism of citizen advocacy for mentally handicapped individuals in the community. The participation and expertise of interested citizens in the provision of community mental health, mental retardation and substance abuse services is vital to the continued tailoring of services designed to meet individual needs. In many instances, the autonomous nature of the community services boards has been the impetus required to provide appropriate treatment, training and care for mentally disabled individuals in the community. In other areas, however, local autonomy has resulted in procrastination and inadequate services. The decentralized control envisioned by the Commission on Mental, Indigent and Geriatric Patients and the Arthur Bolton Associates was intended to promote a unified and coordinated system of care. Unfortunately, the result is a pluralistic and competitive system in which some localities provide a wide range of effective services while other localities provide only a bare minimum or none at all. The State hospital program has remained isolated from community services in most areas of the State.

The recommendations of the Commission on Mental, Indigent and Geriatric Patients and of the

Arthur Bolton Associates to provide preadmission screening services and predischarge planning have been virtually ignored. While the State Mental Health and Mental Retardation Board was authorized by the legislature in 1976 to develop and institute preadmission screening to prevent inappropriate admissions to State facilities and programs, there is today no uniform practice in this area. Linkages between State institutions and community services continue to be inadequate. Patients and residents are being released to some communities which are either inadequately prepared for or unaware of their return.

The policy to deinstitutionalize patients and residents in State facilities for the mentally ill and mentally retarded became operational in the early 1970's with the growth of community services boards. The State worked with local governments to establish the community services boards and to support the programs and services necessary to care for individuals leaving State institutions and returning to community care. Statewide, the success of the deinstitutionalization policy in Virginia has been disappointing. During the public hearings in 1978, the Commission received testimony from the members and staff of community services boards and of local governments who acknowledged the inability of the localities to keep pace with deinstitutionalization. At every hearing, the Commission heard stories about individuals who were returned to community care and who were "lost between the cracks", failing to receive adequate follow-up care because of gaps in services. The transition of an individual from a State facility to community care has not been effectively managed: frequently, patients and residents leave State institutions with no plan for aftercare services in the community and with no responsible agent to monitor their progress.

II. DEINSTITUTIONALIZATION AND COMMUNITY SERVICES

At the request of the Commission on Mental Health and Mental Retardation, the Joint Legislative Audit and Review Commission conducted a study of the deinstitutionalization policy and its impact on community services in the Commonwealth. The information documented in that report and the recommendations proposed were an invaluable resource in the work of the Commission. The JLARC report, entitled "Deinstitutionalization and Community Services in Virginia," was completed and transmitted to the Commission in September of 1979 for inclusion in the Commission's report and for the implementation of recommendations to the Governor and the General Assembly.

The Commission endorses the findings and conclusions of the JLARC Report. The Commission's recommendations based on its own deliberations intentionally encompass many of JLARC's proposals. The JLARC Report is commended to the Governor and General Assembly for the adoption of the legislative proposals and to the State Board, Department of Mental Health and Mental Retardation and the community services boards for the implementation of the administrative recommendations.

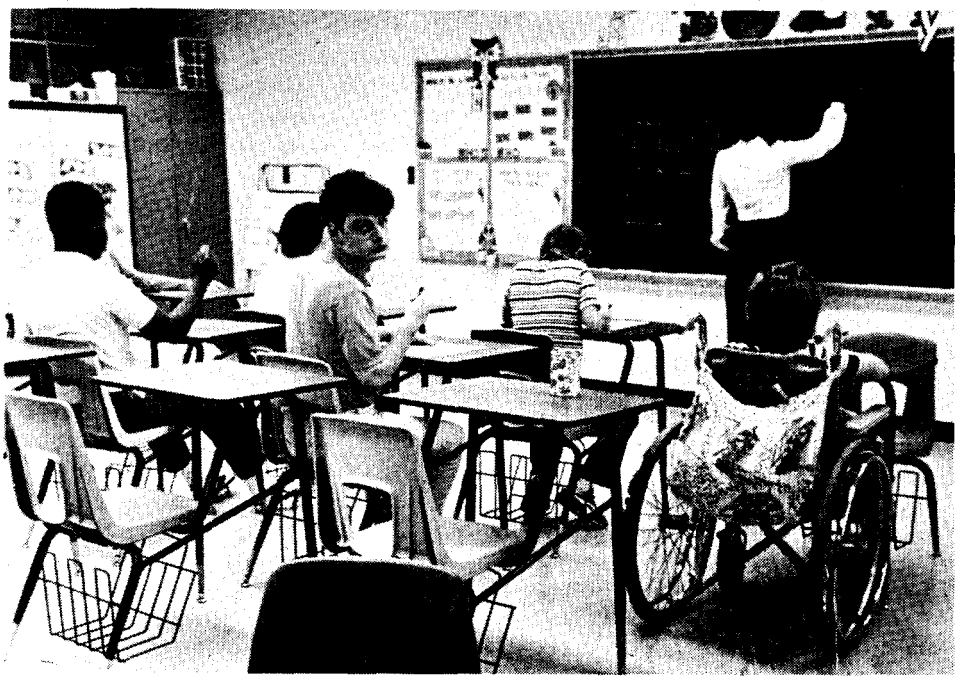
JLARC's findings and recommendations regarding community services for mental health, mental retardation and substance abuse were amazingly similar to the recommendations of the Arthur Bolton Associates in 1975 and of the Commission on Mental, Indigent and Geriatric Patients in 1970 and 1972. The JLARC Report states:

> "although progress has been made, a coordinated system of care for the mentally ill and mentally retarded has not been developed in the Commonwealth ... policies and procedures are inadequate to ensure that services are either available or delivered on a Statewide basis. Problems result from the existence of two imperfectly linked institutional and community networks. Procedural deficiencies include: [i] lack of strong central leadership and evaluation; [ii] fragmented responsibility for service delivery; and [iii] inadequate assessment of client needs to support service development and funding decisions."

The JLARC Report assesses the impact of the deinstitutionalization policy on State institutions and on community services. One of the findings is that the deinstitutionalization policy in Virginia has not been accompanied by a well-structured plan. The staff of the State institutions and community services boards were not adequately trained to manage the transfer of patients and residents from State facilities to community care. Therefore, problems evolved in the development of community-based services, funding of services, coordination among State and local services and in the transfer between State institutions and community programs of information about deinstitutionalized individuals. According to JLARC's study, these problems have never been resolved on a statewide basis.

Another unanswered question accompanying deinstitutionalization, according to the JLARC Report,

concerns the role of the State institutions in community-based care. Although the populations of the State hospitals for the mentally ill have been reduced, staffing levels have increased to meet the demands of a more intensive model of treatment. The JLARC Report states that "new admissions have relatively short periods of hospitalization, but recidivism is high and a large chronic population still receives long-term custodial care." The impact of these evolving trends in the State hospitals has never been assessed. Correlatively, the impact of deinstitutionalization on the State training centers for the mentally retarded has not been determined. The training centers are becoming populated primarily by individuals with severe handicaps, resulting in an increased reliance on the custodial function of the centers. The short-term treatment function of the training centers is still important; however, the appropriate role of the centers in community care has not been defined.



Southeastern Virginia Training Center for the Mentally Retarded

The JLARC Report reviews the funding patterns of community services from 1973 to 1979. The basic conclusion is that although total funds for community services have increased during the period of deinstitutionalization, actual funding trends are difficult to assess because of inadequate records to document statewide service trends and the costs of community services to deinstitutionalized persons.

In accordance with the findings and recommendations of the JLARC report and the independent study of this Commission, it is evident that continuing oversight of the State's mental health, mental retardation and substance abuse system is necessary. Therefore, the Commission recommends that a joint subcommittee of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health be appointed to monitor the ongoing performance of the Department of Mental Health and Mental Retardation during 1980 and 1981. The joint subcommittee will be responsible for assuring that the Department carries out the recommendations of both the Commission on Mental Health and Mental Retardation and the Joint Legislative Audit and Review Commission for effectively managing the statewide system of mental health, mental retardation and substance abuse services. The joint subcommittee will be requested to report its findings and recommendations, if any, to the Governor and to the 1981 and 1982 Sessions of the General Assembly.

III. ADMINISTRATION AND MANAGEMENT OF THE COMMUNITY-BASED SYSTEM

In order for comprehensive services to be delivered at the local level by community services boards, the coordination and cooperation of the State Mental Health and Mental Retardation Board, the Department of Mental Health and Mental Retardation and the participating local governments are required. The Commission proposes statutory and administrative revisions affecting these three

levels of the system to improve the administration and management of community-based mental health, mental retardation and substance abuse services in the Commonwealth.

State Mental Health and Mental Retardation Board

It is recommended that the Board be given specific statutory authority to establish programmatic and fiscal policy to govern the operation of community services boards. In order for the Board to comprehensively direct the mental health, mental retardation and substance abuse system, it must become more knowledgeable of and involved in the development of objectives for community services which will assist in achieving the goal of a continuum of care. The Commission recognizes that statutorily, the community services board system is a locally administered system of programs and services. The goal of achieving a unitary system of care, however, depends upon the existence of an uninterrupted sequence of programs and services available to the client whether he is a patient of a State institution or a resident in the community. Therefore, the State Board should be responsible for establishing policy in cooperation and coordination with appropriate State and local agencies to achieve a continuum of care between the State facilities and community-based services.

To make a reality of the goal of providing in Virginia a statewide, comprehensive community-based system of services, the Commission recommends that the State Board be required to develop and adopt a policy establishing a core of mental health, mental retardation and substance abuse services for community services boards by July 1, 1982. In developing a core of services, the Board should take into consideration the diverse geographic and demographic characteristics of the Commonwealth as well as the ability of the localities to administer the services. The list of core services for each of the three subject areas should be the minimum required to provide a continuum of care for citizens in need of mental health, mental retardation and substance abuse services. To encourage community services boards to select from the core the services it chooses to provide in its plan and budget, it is proposed that the State Board adopt a policy establishing a funding ratio which finances core services with a substantially high percentage of State dollars with the requirement of a low rate of local matching funds. This funding ratio should be utilized in the formulation of the 1982-84 biennial budget. The State Board shall be required also to specify other programs, outside the core, which a community services board may provide. It is recommended that these auxiliary services be funded with a high percentage of local funds and a correspondingly lower rate of State matching funds. The current funding scheme for salaries and operational costs of the community services boards should be reviewed in light of the Board policy adopted with regard to ratios for core and auxiliary services.

Funding for human services in the 1980's will be more restricted than in the previous decade. Every effort must be made to utilize available dollars to financially support the mental health, mental retardation and substance abuse system. The Commission recommends, therefore, that the State Board be required to promulgate rules and regulations by July 1, 1981 which mandate that each community services board institute a reimbursement system to maximize the collection of fees from persons receiving services under the jurisdiction or supervision of the board and from responsible third party payors. The community services boards should be required to have such a reimbursement system in place by January 1, 1982.

During the Commission's public hearings in 1978 and its deliberations in 1979, considerable interest was expressed in revising the State's current funding of community mental health, mental retardation and substance abuse services in order to implement the concept of "funds following the client." Currently, the cost of treatment received by citizens in State institutions is funded by State and some federal funds but includes no local monies. Community-based services are now funded by State and local funds. It is financially advantageous today, therefore, for localities to place clients in State facilities. Under the concept of "funds following the client," institutional as well as community programs would be funded jointly by the State and local governments. If a State hospital program is used by a citizen who resides within a board's jurisdiction, the board would be charged a unit cost for that institutional care. This mechanism is intended to provide financial incentives to localities to retain clients in community programs rather than to purchase inpatient services from institutions. The Commission believes there is considerable merit in this concept. There has been insufficient time, however, to fully consider the implications of this idea and to develop an adequate fiscal and programmatic recommendation for implementing such a financial system in Virginia. An operable management information system and procedures for uniform cost accounting must be in place before such a financial system can be utilized. The Commission recommends, therefore, that the State Board undertake research into this matter with the goal of recommending to the 1982 Session of the

General Assembly several pilot projects around the State to implement a form of the concept of "funds following the client." The recommendations of the Board should be submitted to the General Assembly by September 1, 1981 with plans to include the pilot projects in the 1982-1984 biennial budget.

Bristol Sheltered Workshop, Inc.

The Commission learned in its discussion with representatives of community services boards and participating local governments that there are wide discrepancies across the State in the salaries and fringe benefits of community services board personnel. The State funds a substantial portion of these salaries and is thus responsible for some consistent fiscal practices in this area. The Commission recommends, therefore, that the State Board be required to adopt suggested salary ranges with appropriate fringe benefits to apply to all community services board employees. Provision should be made for local governments to supplement the salaries included in the schedule. Monies to fund salary supplements should be appropriated by the local government in addition to the funds allocated for the community services board as the local match for State funds. Local boards should give serious consideration to using the suggested salary ranges in the development of their budgets for fiscal year 1982 and thereafter.

Also in the field of employee management, the Commission is concerned about the lack of State policy governing liability insurance for community services board personnel. With the promulgation and implementation of State standards for the operation of community-based programs, this is an issue of increasing importance. The Commission recommends that the State Board conduct a study on the need for and cost of providing liability insurance for community services board members and employees either at the State or local level. The results of the study should be submitted to the 1981 Session of the General Assembly.

Department of Mental Health and Mental Retardation

Throughout the work of this Commission, the need to develop a continuum of care in the delivery of mental health, mental retardation and substance abuse services has been emphasized. In its relations with community services boards, it is the role of the Department to provide statewide direction and emphasis for program planning and evaluation. In monitoring community programs the Department should aim to assure a continuity of services throughout the State. This central direction is essential to achieving a continuum of care.

Technical assistance and guidance should be the focus of the Department's regional representatives for mental health, mental retardation and substance abuse. Representatives of the

community services boards which met with the Commission indicated a universal need for more technical assistance from the Department. The development of community services is in relatively new stages in many regions of the State, and the expertise of central office staff is needed to assist board personnel in initiating and operating quality programs. With the emphasis on core services and the development of a statewide reimbursement system, as previously proposed in this report, the guidance of central office staff will become even more important in improving the functioning of community services boards.

Examples of areas where technical assistance from the State would be valuable, as indicated by some community services boards, include: (i) clinical data management systems; (ii) sources of funding for transportation to clinic and aftercare services; (iii) alternatives for detention of a person awaiting a commitment hearing; (iv) consultation toward improving clinic fee schedules, fee collections and other avenues of nontax revenue generation; (v) long-range planning for a comprehensive aftercare system; (vi) recruitment of appropriate staff; (vii) comparative data on salary ranges for comparable duties in other mental health services; and (viii) information regarding State level efforts to promote cooperation and coordination among all human service agencies.

Later in this report recommendations are made to mandate prescreening and predischarge planning for all persons admitted to and discharged from State institutions. The community services boards are given the primary responsibility for performing this function. In addition to the previous examples of technical assistance needed from the central office, the Commission suggests that the Department provide training for community services board personnel to enable them to meet their proposed statutory responsibilities in the areas of prescreening and predischarge planning. While the requirements of the judiciary of the State may vary from court to court, a general understanding of voluntary and involuntary commitment proceedings and of the contribution that can be made by prescreening reports and treatment recommendations would be beneficial to all local board staffs. The Department should be instrumental also in initiating the development of the managerial mechanisms necessary to make predischarge planning work for the client, the institution and the community services board. Training in prescreening and predischarge planning will be essential to their success.

The Commission also recommends that the Department ensure that the members of community services boards receive proper orientation and training which will enable them to fulfill effectively their responsibilities.

Local Governments

The legislation establishing community mental health and mental retardation services boards, Chapter 10 of Title 37.1 of the Code of Virginia (§ 37.1-194 et seq.), was enacted in 1968. Significant funding for these community services began in the early 1970's. As instrumentalities of local

Blue Ridge Comprehensive Mental Health Center, Charlottesville

government established at the option of the localities, community services boards have developed during the last twelve years at different rates and with various levels of sophistication. Sixteen localities are currently not participating as members of a funded community services board. These include the counties of Goochland, Powhatan, Highland, Bath, Rockbridge, Allegheny, Botetourt, Craig, Scott and Dickenson and the cities of Clifton Forge, Covington, Buena Vista, Lexington, Manassas and Manassas Park. These localities represent approximately 10% of the State's population. Botetourt and Scott counties and the cities of Manassas and Manassas Park do receive services from local community services boards.

The Commission believes it is imperative that every political subdivision of the State have mental health, mental retardation and substance abuse services available for its citizens. It is proposed, therefore, that every county and city shall establish, either singly or in combination with another political subdivision, a community services board on or before July 1, 1983. In order to provide a continuum of care from community-based to institutional services for the State's mentally handicapped, it is essential that local programs be accessible regardless of the area of the State in which the handicapped citizen resides.

In 1976, programs concerning alcohol and drug abuse were centralized in the Department of Mental Health and Mental Retardation, and the Division of Substance Abuse was established. At the same time community mental health and mental retardation services boards were given the responsibility to provide substance abuse programs for those citizens requiring this service at the local level. To recognize that local boards now have service responsibilities in three special disciplines, mental health, mental retardation and substance abuse, it is proposed that the term "community services board" be defined as a citizens board established by law which provides mental health, mental retardation and substance abuse services within the political subdivisions participating on the board.

During its deliberations the Commission met with members of community services boards, their executive directors and representatives of the local governments serving on the boards. Single as well as multijurisdictional boards from rural, urban and suburban areas participated in these discussions. The Commission was struck by the diversity in administrative practices which govern community services boards and the variety of their relationships with the participating local governments. Flexibility is needed at the local level to meet varying service needs with diverse resources. However, the pluralism which is characteristic of Virginia's community services boards and which can contribute to their strength cannot be allowed to lapse into unsatisfactory or nonexistent control over the administration of hundreds of employees and millions of dollars in programs.

The greatest confusion in the local board - local government relationship appears to exist in those boards made up of a combination of political subdivisions. The law presently provides in § 37.1-195 of the Code that in the case of multijurisdictional boards an official of one member city or county shall be designated as fiscal agent for the board. No other administrative authority or duties are required by the Code to be centralized. The Commission proposes that the county or city which comprises a single board and the county or city whose designated official serves as fiscal agent for the board shall annually audit the board and its programs and shall, in conjunction with the other participating political subdivisions in the case of joint boards, approve a grievance procedure which shall apply to all employees of the board and arrange for the provision of legal services for the board. The recommendation made earlier in this report to require local boards to institute reimbursement systems to maximize fee collections and payments from responsible third party payors under the direction of the State Board may require additional centralization of administrative practices among the local governments of a multijurisdictional board. The Commission recommends that any costs incurred by the political subdivision which provides for the administrative functions discussed in this paragraph should be assessed against the budget of the community services board as are other operational costs.

The advantages and disadvantages of community services boards purchasing services versus their initiating and directing programs needed in the community were explored by the Commission. In many areas of the State, contracting for services works very well where such programs are available from the private sector. On the other hand, concern has been expressed about multiple layers of administration, little control and no supervisory responsibility over the extent or quality of services delivered by a contractor. It is the position of the Commission that a community services board, in determining whether to contract for services or to offer services under its own auspices, shall be responsible for providing services under arrangements which will maximize efficiency, economy and accountability. To assist local boards in determining whether the purchase of services

is the most effective and economical way to deliver mental health, mental retardation or substance abuse services, the Commission recommends that the State Mental Health and Mental Retardation Board promulgate guidelines to govern contracts for services entered into by community services boards. Such guidelines should address the responsibility of the board to evaluate the service provided for by the contract, the right of the board to have access to relevant records of the service vendor in evaluating the service, renewal of such contracts and any other appropriate terms and conditions of these contractual arrangements.

IV. MANAGERIAL SERVICES

The core services mentioned earlier in this report are vital to insure that a minimum level of services is available statewide. There are, however, specific services which the Commission believes are essential administrative mechanisms that must be established by every community services board in the State. In areas not covered by a community services board, the State-operated community mental health clinic which serves the region must be responsible for establishing these services prior to July 1, 1983, the date it is recommended that community services boards be established statewide. The managerial mechanisms cannot be optional services selected by localities, but must be required either administratively by the Department or statutorily by the General Assembly. The services are: (i) preadmission screening; (ii) predischarge planning; (iii) a prescription team; and (iv) case management. The Commission recommends that the Code of Virginia be amended to require the first three of these managerial services. Case management shall be administratively implemented through the community services boards or clinics under the direction of the Department of Mental Health and Mental Retardation to follow-up on the efforts of the prescription team.

Preadmission Screening and Predischarge Planning

Previous recommendations for preadmission screening services which have not been implemented were detailed earlier in this report. The 1975 Report of the Arthur Bolton Associates explicitly called for preadmission screening in the statement:

> "Many institutionalized people could be better served in the community. Placing these people out of the hospitals while continuing to admit and readmit similar groups of people into state hospitals is like operating a very expensive revolving door. A screening and referral service in every community would arrest this cycle. Nobody should be placed in a state institution without the recommendation of the screening service."

The Commission on Mental, Indigent and Geriatric Patients in 1970 and 1972 emphasized the need for a single point of entry into the system of services for mental health, mental retardation and substance abuse. In 1979 this Commission maintains that the "single point of entry" must be a

Piedmont Geriatric Center and Hospital

screening and referral service coordinated by the community services board. All admissions to State institutions should be substantiated by referral of the local community services board. The board must be responsible for: (i) assessing the service needs of the mentally handicapped individual; (ii) referring the client to the appropriate State or community services; and (iii) presenting recommendations to the court regarding commitment to or certification for treatment in a State institution.

If institutionalization is deemed the most appropriate placement for the mentally handicapped person, the community services board must begin immediately to plan for the discharge of the institutionalized person. Thus, predischarge planning must commence at the point of preadmission screening. Predischarge planning must be the joint responsibility of the State facility where the person is institutionalized and the community services board or community mental health clinic serving the locality to which he will return.

The Joint Legislative Audit and Review Commission Report, "Deinstitutionalization and Community Services in Virginia" revealed that a major barrier to the coordination of services to ease a client's transition from institutionalization to community care is that State institutions fail to obtain consent for the release of patient or resident information early in the treatment process. When the patient or resident returns to the community, information regarding service needs frequently is not available for use by the community services board responsible for the deinstitutionalized individual. This finding is in contrast to the notion that patients and residents of State facilities refuse to consent to the release of information relevant to their treatment.

The Commission recommends that upon the determination by the community services board that an individual's service needs demand institutionalization, the board, in cooperation with the State facility, shall seek immediately the necessary consent for the release of treatment information. The information shall be used to better coordinate community aftercare services for the institutionalized client.

Prescription Team

The most effective means of implementing the preceding recommendations for preadmission screening and predischarge planning is through an interagency prescription team. Under the direction of the community services board or clinic, the team is designed to (i) accomplish the tasks of preadmission screening and predischarge planning; (ii) be available to assist the court in decisions regarding commitment to or certification for treatment in a State institution; (iii) work with State facilities and local services agencies to develop treatment plans for mentally handicapped individuals.

The prescription team must be established and coordinated by each community services board or community mental health clinic in areas where services boards do not exist. The team shall always include representatives of the community services board or community mental health clinic that serves the region, the local social services or public welfare department, the local health department and the Department of Rehabilitative Services. Whenever it is suitable for the assessment of an individual's service needs, the social services staff of the appropriate State institution that serves the region shall be represented on the team. In cases concerning school-aged individuals in need of services for mental illness, mental retardation or substance abuse, the local school division shall be represented on the team. Other State or local agencies or private individuals may be invited to participate on the team as needed. Although the community services board or clinic is statutorily responsible for establishing and coordinating the team, the participating agencies and individuals are equally responsible for the effective operation of the team. The proposed statutory revisions make the team responsible for providing prescreening reports to the courts for decisions regarding commitment or certification for treatment. Exemplary models of the interagency team approach are functioning currently in the regions of the Valley Community Services Board and the Norfolk Community Services Board.

In order to integrate community services with the treatment, training and care provided by the State facilities, a representative of the community services board who serves on the prescription team must participate in the initial staffing decisions for any individual who is admitted to a State institution. Likewise, the State facility's participation in predischarge planning for individuals returning to community care is essential to the coordination of an effective plan for aftercare services.

In addition, the Commission proposes that current statutes be revised to include the provision of prescreening reports to the court on an emergency basis to assist in decisions regarding

institutionalization. The prescription team may designate a team member to compile the report for the court and to present it to the team after the court's decision has been rendered. This procedure permits the participation of local agencies in decisions of the court and promotes communication in the initial stages of an individual's entry into the system of services.

Effect of the Managerial Services on Community Services Boards, the Courts and State Institutions

The cooperative interaction of every individual and agency involved in the treatment, training and care of mentally handicapped persons is essential. The Commission heard testimony in 1978 which recounted the experiences of persons with mental disabilities who were shuffled among a variety of agencies and who may or may not have received appropriate assistance. The statutory revisions proposed by the Commission are intended to promote coordination among the community services boards, the courts and State institutions. The Commission's goal is to achieve a continuum of care in which the mentally handicapped person can be referred to effective programs and services operated by individuals who actively communicate among themselves to determine the service needs of the mentally disabled person.

The Commission recommends that prior to voluntary admission of a person to a State facility for mental health, mental retardation or substance abuse the individual must have been screened by either the community services board or the community mental health clinic which serves the region. A physician on the staff of the State institution and the prescreening report of the community services board or clinic must verify that the individual requires hospitalization. Concurrently, prior to the initiation of any court proceeding to certify a mentally retarded individual for admission to a State training center, the parent or guardian of the mentally retarded person must obtain a prescreening report from the community services board or clinic. The report must recommend that the mentally retarded person needs institutionalization before he can be admitted to a State facility for the mentally retarded.

The Commission recommends that whenever a person is brought before the court for the purpose of a voluntary commitment to a State institution for mental illness, mental retardation or substance abuse, the judge must obtain a prescreening report from the community services board or community mental health clinic. This prescreening report must recommend that the person alleged to be mentally disabled needs hospitalization in order for the court to commit that person to a State facility. In the case of involuntary commitments, the judge is encouraged to utilize the expertise of the community services board or clinic through the prescreening report process to determine the appropriate services for the person before the court but is not required to do so. The court is required, however, to inform the community services board or clinic that a person has been involuntarily committed to a State facility within ten days of the date of the commitment order.

To provide continuity of care from institutionalization to community life, the predischarge plan must be developed in a coordinated manner also. The Commission recommends that the State institution in cooperation with the community services board or clinic be required to develop a predischarge plan prior to the release of any institutionalized person whether he has been voluntarily or involuntarily committed. The predischarge plan must specify where the individual will live and how his nutritional needs will be met in the community. In addition, the anticipated method to be used to insure that the discharged patient or resident receives appropriate community services must be set out in the predischarge plan. If the mentally handicapped person or his guardian or committee refuses to consent to the release of necessary information for the predischarge plan, the director of the State institution shall direct the staff of the hospital or training center to develop a suitable plan with the information that is available. To further integrate services, the Commission recommends that the director of the State institution be required to furnish the community services boards a list of persons, who have consented to the release of such information, for whom predischarge plans are required. The list shall include the home addresses of these persons so that the community services boards can monitor each individual's return to the locality. Under current statutes, such lists are available to the community services boards only upon request. The Commission feels that the lists are fundamental to the provision of adequate aftercare services to an individual by community services boards and, therefore, should be required.

The involvement of the community services boards in court proceedings prior to the admission of an individual to a State institution is essential to the assurance that mentally handicapped persons are referred to the most appropriate treatment in the least restrictive environment possible. Equally essential is the participation of the community services boards in the planning process for a patient or resident's release to the community. Only through cooperation and coordination can the Commission's proposed unified system of treatment, training and care for the mentally handicapped be realized.

The Commission proposes that two resolutions be introduced in the 1980 Session of the General Assembly to promote a better understanding of the needs of mentally handicapped individuals by the personnel of the State's criminal justice system. Law-enforcement personnel and the judiciary need to be well-informed about the alternatives available for the treatment, training and care of mentally handicapped individuals. To prevent the inappropriate handling or detention of mentally disabled persons, the Commission recommends that the Criminal Justice Services Commission be requested to provide training for law-enforcement personnel in the recognition of mental disabilities and the proper handling of mentally handicapped persons. The Commission also encourages community services boards to support the work of law-enforcement officials in their service areas by apprising them of crisis intervention and similar services available through the board and by providing mental disabilities professionals to accompany police on calls for help when this is feasible and appropriate.

It is also proposed that the Office of the Executive Secretary of the Supreme Court be requested to provide information about the kinds of community resources available for commitment or certification hearings to the judges at the statewide judicial conferences. The resources of the community services boards regarding the diagnosis of mental disabilities and referral to the appropriate services should be utilized by the judges in any proceeding concerning the institutionalization of a mentally handicapped person. The Executive Secretary of the Supreme Court should be requested to work with community services boards in developing suitable information to be presented during the judicial conferences.

Case Management

The individualization of treatment, training and care for the mentally handicapped is an unrealistic aspiration without the existence of a mechanism to assure that the individual client is not lost within the system of services. A supportive case management system must be designed to monitor a single client's progress through the service system, refer him to appropriate services and advocate for his personal right to treatment or training in the least restrictive environment.

The 1978 Report of the President's Commission on Mental Health defines case management as "an expediting service." It further explains that "the case manager should be sensitive to the disabled person's needs, knowledgeable about government and private agencies that provide housing, income maintenance, mental health, health, and social services, and should be in close touch with the community's formal and informal support systems."

Because of the current national and State emphasis on community-based care, the Commission recommends that local government under the direction of the Department of Mental Health and Mental Retardation be responsible for the establishment of a case management system designed to monitor the care of its citizens in need of services for mental illness, mental retardation and substance abuse. The agency designated to implement the case management system for the locality should be the community services board. In areas not covered by a services board, the local government should delegate the responsibility for case management to the State-operated community mental health clinic which serves the region.

The case manager will provide the vital linkage of the patient or resident with the community and State services needed for the most appropriate treatment or training. To accomplish this linkage, the case manager must be able to refer the client to an array of local human service agencies, such as social services, public health, rehabilitative services and to a State institution if the proper treatment or training is not available in the community. Coordination among the variety of community-based services and cooperation with State facilities is essential to assure that individuals who need services are not lost either in the transition from the State hospital to the community or among the array of sevices available in the community.

The current lack of coordination among State and local agencies which provide human services is a major concern of the Commission. In many instances, the local agencies of the Departments of Mental Health and Mental Retardation, Welfare, Health, Corrections and Rehabilitative Services are providing services to the same individual. To prevent the duplication of programs and services and to assure a continuum of care statewide, State agencies must work together to plan a coordinated system of community-based care which emphasizes individualized treatment and training for all handicapped citizens.

The Commission maintains that local government, through the community services board or community mental health clinic, is responsible for identifying its mentally handicapped citizens in State institutions who are capable of returning to the community. The case manager, at the local

level, should be responsible for working with the staff of the State facility to plan aftercare services for every individual returning to the community. The case manager should work with the individual to assure that financial benefits such as Medicare and Medicaid, welfare benefits, insurance payments and opportunities for sheltered employment are maximized.

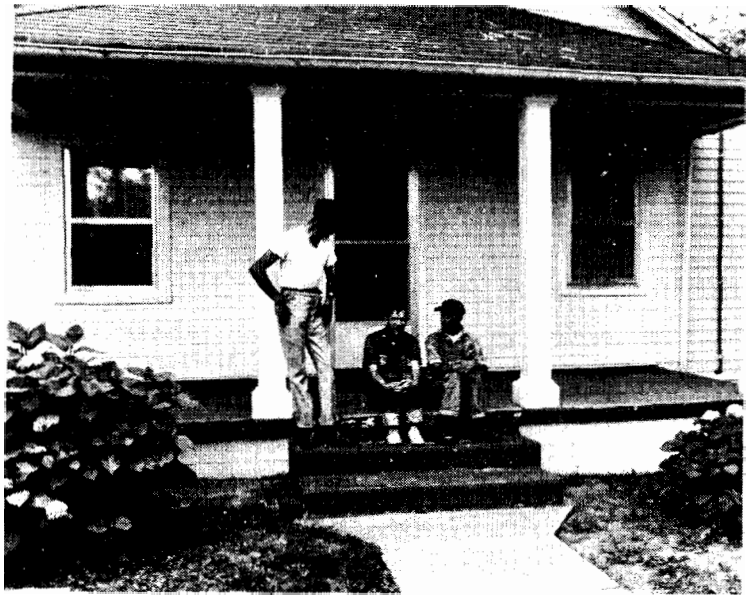
Every person who enters a State institution or who is a recipient of community-based services for mental health, mental retardation or substance abuse should be assigned a case manager at the local level. The case manager should be responsible for a specified number of clients for whom he obtains the most appropriate services, choosing from those services available in the community and in the State facility that serves the region. Instituting a statewide system of case management will be a vital step in achieving a continuum of care for all mentally handicapped individuals in the State.

The Report of the Joint Legislative Audit and Review Commission, "Deinstitutionalization and Community Services in Virginia", offers three recommendations relating to the function of case management. The Commission supports these recommendations and urges their implementation by the appropriate agencies. The recommendations are:

"(1) That the Department of Mental Health and Mental Retardation, in cooperation with the community mental health and mental retardation services boards, begin immediate development of systemwide information on client needs and the capacity and quality of current services. Initially, the Automated Reimbursement System and the Individual Data Base should be improved and utilized. The needs of both discharged and institutionalized clients should be assessed to focus appropriate service development, and data that are updated annually should be incorporated in the Department of Mental Health and Mental Retardation's funding priorities and in the State plans for mental health, mental retardation and substance abuse services.

(2) That the Department of Mental Health and Mental Retardation and the community mental health and mental retardation services boards cooperate to conduct a valid follow-up of discharged clients. It is essential that the State be aware of the impact of the deinstitutionalization policy on clients, communities and State and local expenditures. State agencies, such as the Departments of Welfare and Rehabilitative Services, should separately identify the costs of services provided to deinstitutionalized persons.

(3) That the Department of Mental Health and Mental Retardation assess the need for and develop preparatory and transitional programs in the State institutions. At a minimum, each client should receive: (i) adequate instruction on the use and effects of his medication; (ii) daily living and social skill training as necessary; and (iii) information on services and agencies available to assist him in the community. Model programs at several of the institutions should be evaluated for effectiveness and expansion."



Lynchburg Training School and Hospital

The Commission found that the individual who is not receiving services at either the State or the local level is the "double diagnosis" client. The double diagnosis individual is determined to be both emotionally disturbed and mentally retarded. Frequently, his condition may be complicated by physical handicaps. Thus, case management for these special individuals is essential because of the complexity of their disabilities. While a successful model for the care and treatment of these individuals has not been developed in any of the human service agencies, programmatic research in this area must be pursued.

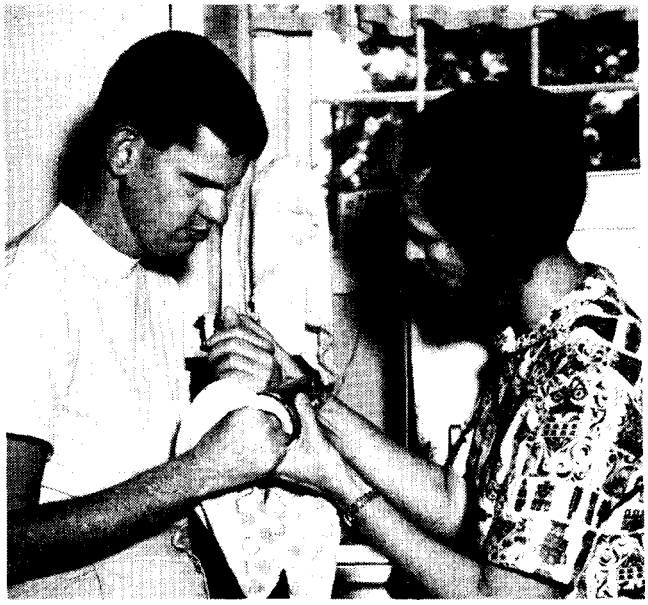
The Commission recommends that a two-year study of the double diagnosis client be conducted by the Department of Mental Health and Mental Retardation with the cooperation of other relevant State and local agencies. The Department should attempt to develop individualized program plans designed to treat and care for these multiply handicapped citizens. Consideration should be given to appropriate programs at both the State and local level of services for the mentally disabled. The Department should be requested to present an interim report to the Governor and the 1981 Session of the General Assembly and a final report in 1982.

V. ZONING FOR COMMUNITY RESIDENTIAL FACILITIES

The historical approach to residential services for the mentally handicapped and developmentally disabled has been to provide mere custodial supervision in an institutional setting. The dramatic change in the last decade in the legal, philosophical and political views of the rights of handicapped persons has resulted in an effort to integrate these individuals into the mainstream of society through the process of normalization.

The deinstitutionalization of mentally handicapped persons requires, however, that alternative living arrangements be available. Community-based residential facilities have been established as one alternative to institutionalization. Family care and group homes enable the mentally ill and mentally retarded to live within a natural community setting while receiving a broad range of specialized services. Although current thinking in the field of mental disabilities now supports community living arrangements, several obstacles impede the achievement of the goal of deinstitutionalization. The interests and needs of a number of groups must be accommodated in order to integrate the mentally disabled into community life. These groups include the handicapped, their families, the professionals who treat the handicapped, other citizens in the community, local governments and governmental planning bodies. A major obstacle to normalization is the unavailability of community facilites. Another is the control of property use by local governments through zoning.

Local zoning ordinances in the Commonwealth vary as to the nature and purpose of restriction. Typically, however, residential zones of real property are labeled according to the types of structures permitted within their bounds and the use to which these structures are put. The government's exercise of its zoning authority in making these determinations must bear a substantial



A group home in Fairfax

relation to the public health, safety, morals or general welfare of its citizens. Characteristic objections to the location of group homes in residential zones, frequently reflected in stringent zoning ordinances, include (i) the fear that there will be a decrease in the value of the surrounding property; (ii) concern that the character of the neighborhood will change, altering the quality and amount of services like police protection, water, sewer and garbage collection or materially changing traffic patterns; and (iii) the desire not to associate with mentally ill or mentally retarded persons who live in a community-based group setting. Other interests to be considered in the development of group homes which can be reflected in zoning regulations are the concentration of other related types of community facilities in given areas and the enforcement of building codes and standards which preserve the safety of the mentally and sometimes physically handicapped persons residing in the facilities. In the public hearings held by the Commission in 1978, all of these issues were raised by citizens as impeding the location of community facilities for the handicapped in desirable residential areas.

In 1977 the Virginia General Assembly enacted into law a policy concerning zoning ordinances relating to homes for mentally retarded and other developmentally disabled persons. Section 15.1-486.2 of the Code of Virginia states, in part:

> It is the policy of this State that mentally retarded and other developmentally disabled persons should not be excluded by county or municipal zoning ordinances from the benefits of normal residential surroundings. Furthermore, it is the policy of this State to encourage and promote the dispersion of residences for the mentally retarded and other developmentally disabled persons to achieve optimal assimilation and mainstreaming into the community. Toward this end it is the policy of this State that the number of such group homes and their location throughout the State and within any given political subdivision should be proportional, insofar as possible, to the population and population density within the State and local political subdivisions.

The Commission affirms this policy; however, testimony received during the public hearings and tours of the Commission in 1978 indicates that the State's policy is not being implemented by many localities. Residential facilities for the mentally handicapped are unable to locate in many communities because of public opposition to the facilities. Many local governments are allowing public attitudes to unduly influence zoning decisions which determine the location of group homes, halfway houses and other facilities. The Commission feels very strongly that local governments should make land use decisions regarding community facilities for the handicapped with the objective of assimilating these citizens as fully as possible into the life of the community. Every effort should be made to educate the public so that community acceptance of the mentally handicapped can become a reality throughout the State.

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STATE ADMINISTRATION OF THE SYSTEM

The Department of Mental Health and Mental Retardation is responsible for the employment of the largest number of personnel in the State and for caring for the largest number of citizens placed in institutional settings both voluntarily and involuntarily. Its duties with regard to community services are looming large on the horizon as community mental health and mental retardation services boards are fiscally and programmatically becoming integral components of the mental health, mental retardation and substance abuse system. In reviewing the management and functioning of the system from the State perspective, consideration was given by the Commission as to how the Secretary of Human Resources, the State Mental Health and Mental Retardation Board, the Commissioner and the central office of the Department of Mental Health and Mental Retardation are working together to provide guidance and purpose to the mission of the Department of Mental Health and Mental Retardation. It is a mission which reflects the commitment of the Commonwealth to provide quality treatment, training and care to its mentally handicapped citizens in a continuum of care in which the emphasis has changed from institutionalization to a comprehensive, community-based system where institutional care is a vital part.

Significant weaknesses have been found in the capacity of the State Mental Health and Mental Retardation Board to make policy for the human services system it is charged with overseeing. The Commission questions the ability of the central office of the Department as presently structured to effectively administer largely independent State hospitals and training centers and to oversee the statewide network of locally managed and locally operated programs which comprise the community-based system. While progress has been made toward achieving the previously-stated goal

of strengthening community services and the involvement of the State hospitals in a continuum of care, the State Board and the central office of the Department remain primarily institutionally-oriented. At this time there is no realistic substitute for the State hospital system, and it will continue to need the fiscal and management support of the Commonwealth. More direction must be given by the State Board and Department, however, to integrating institutional care and community services and to supporting the efforts of localities to strengthen community-based programs. More effective management, personnel, evaluative and fiscal controls are needed over the operation of State hospitals to make them part of a comprehensive system.

I. STATE MENTAL HEALTH AND MENTAL RETARDATION BOARD

The statutory authority of the State Mental Health and Mental Retardation Board is extensive. The Board has administrative duties, advisory responsibilities and rule-making powers. With regard to State residential programs, the Code of Virginia states in § 37.1-2: "For the supervision, management and control of the system of facilities, there shall be a single board of directors, to be known and referred to as the State Mental Health and Mental Retardation Board." In the legislation establishing community mental health and mental retardation services boards, however, there are no references to the State Board.

Given the complexity of the Department of Mental Health and Mental Retardation's operations within the structure of State government and the ability of a part-time citizens' body to function within that dynamic framework, the State Board is unable to meet its legislative mandate to be an operational board with wide-ranging responsibilities for the management of the State hospital system. Simultaneously, the Board is largely ineffective in making policy for the mental health, mental retardation and substance abuse system it is charged with overseeing, because it is too involved in the day-to-day operations of the system. The ability of the Board to develop policies to achieve a continuum of care from the community-based system through to State institutions is severely circumscribed by a lack of jurisdiction over community programs and by its general institutional orientation. The lines of authority between the Board, the Commissioner of the Department and the Secretary of Human Resources are not clearly drawn, and this adds further confusion to the Board's mission. The Commission has come to the conclusion that the talents of the men and women of the Commonwealth who have been appointed by the Governor to serve on the Board are being vastly underutilized and, consequently, the mental health, mental retardation and substance abuse system is suffering from a lack of direction. The Commission has several recommendations to address this problem area.

The legislation in Title 37.1 of the Code of Virginia which specifies the powers and duties of the State Board should be revised. Current statutes reflect a by-gone era when the Board was designed to function as a hospital board of directors actually involved in managing the operations of State hospitals. The revision should re-establish the Board as a policy-making body.

The Board should not become a merely advisory entity, however. It should retain its power to promulgate rules and regulations. It should be vested with the authority to review and comment (i) on all budgets and requests for appropriations for the Department prior to submission to the Secretary of Human Resources and the Governor and (ii) on all applications for federal funds. The Commission recommends that the Board be statutorily required to appoint an internal evaluation committee. This committee, to be made up of Board members, should be responsible for reviewing and evaluating the effects of the Board's policies and the performance of the Department in carrying out those policies. It is suggested that the workload of the Board could be best managed by the hiring of one staff person as secretary to the Board. This staff person should be directly responsible to the Board and be charged with coordinating the monitoring of the agency's policies and activities for the Board's benefit. The Commission recommends that § 37.1-5 of the Code be amended to implement this recommendation.

Traditionally, citizens appointed by the Governor to serve on the State Board have been assigned responsibility by the Board for the State hospitals and training centers in a specific area of the State. This practice has encouraged the administrative involvement of the Board members in the operation of the individual hospitals. The Commission suggests that this practice be discontinued to free board members from administrative duties and to focus their attention on the overall policies governing the system, including community-based care.

It is recognized that a basic dilemma with citizens' boards in government is how to provide for their substantial involvement in the operations of the executive branch without causing disruption and without conflicting with the constitutional responsibilities of the Governor. The Commission

believes, however, that bodies such as the State Mental Health and Mental Retardation Board provide a desirable bridge between the citizenry and the bureaucracy without which government becomes impersonal and possibly arbitrary. The challenge in the case at hand is to so delineate lines of authority for the establishment of policy and for the management and operation of the mental health, mental retardation and substance abuse system that gaps in responsibility do not result. The Commission recommends that the revision of the Board's statutory authority and a consequent restructuring of its administrative functioning reflect these principles: (i) the Board shall establish policy for the system; (ii) the Board shall evaluate the implementation of that policy by the Department which manages and operates the system and (iii) the Board shall advise the Commissioner and, through the Secretary of Human Resources, the Governor, and the General Assembly of its policy decisions and of its findings through monitoring the system's activities. It is important that the Commissioner and the Secretary understand that for the Board to establish policy, the Board members must be kept informed of significant programmatic and fiscal impacts on the system.

Rev. Louis H. Fracher, Mrs. Elsie R. Chittum, Delegate Bagley

Enough responsibility must be given to citizens' boards to attract capable and committed individuals to their service. The Commission believes that the statutory and administrative revisions recommended for the State Mental Health and Mental Retardation Board will accomplish this objective. The Commission further recommends, however, that the legal per diem for Board members be set at $50.00. While even this amount is only a token of appreciation for the many hours of work contributed by these citizens for the good of the State, this is the rate generally being paid to members of other State human service agency boards.

II. PERSONNEL MANAGEMENT AND EMPLOYEE RELATIONS

The Governor and the 1979 Session of the General Assembly received from the Secretary of Administration and Finance "The Plan for Personnel Management Decentralization and the Biennial Report on Personnel Management." (House Document No. 11 - 1979.) In the transmittal letter for the Report to the Governor and legislature, Secretary Charles B. Walker stated "... for the personnel management program to be materially improved, the respective agencies must shift their program from one of administering a paper system, to a program of employee relations management that will become an integral part of the management character of the agencies." The Department of Mental Health and Mental Retardation is one of two agencies in the executive branch selected as a model to test the proposed plan for personnel management decentralization.

> "The Department of Mental Health and Mental Retardation has been selected because of its size, geographic dispersion, and the Department's recognition of need for improving the Department's personnel management program. Moreover, the broad range of occupations within the Department offers one of the best proving grounds for a decentralized classification program.

The Department in recent months has elevated the agency personnel unit one organization level and is prepared to elevate the unit one additional step, so that the personnel staff will report directly to the Commissioner. Five agency level professional personnel positions have been established to assist with the development of the agency program. One such position is for a manager of classification. In addition, effective January 1, 1979, the chief personnel officers of each agency facility will report to the facility director." (House Document No. 11 - 1979, page 20.)

The principles of the personnel decentralization plan were explained to the Commission, and Department staff reviewed the anticipated benefits to the mental health, mental retardation and substance abuse system of participation in the plan. Part of the plan involves the development of a series of integrated personnel policies by the Department of Personnel and Training. State policy governing performance standards of central office employees and personnel in State institutions is intended "to clarify the employee's function, duties and responsibilities; motivate employees toward improved performances; develop a productive work relationship between the supervisor and the employee; give the employees an opportunity to present views regarding their performance; and provide for increased employee-employer communication." (See House Document No. 11 - 1979, page 18.) The Commission found that each of these areas needs particular improvement in the management and training of State institutional personnel. Under the plan, personnel management decentralization is to be implemented in each of the State institutions by July 1, 1980.

In the opinion of the Commission, the participation of the Department in the personnel decentralization plan is a satisfactory way to begin to resolve the complex personnel management and employee relations problems existing in the agency and in the State institutions. It should be noted, however, that in the current stages of the plan's implementation the problems brought to the Commission's attention have not been addressed. In particular the Department of Mental Health and Mental Retardation must be given the immediate authority to reclassify employees without the current review process required by the Department of Personnel and Training for the approval of all reclassified and new positions in the Department and in the State institutions operated by it. This step would allow the Department of Mental Health and Mental Retardation to be more flexible and responsive in meeting its personnel requirements.

It is incumbent upon the Department of Mental Health and Mental Retardation and the Department of Personnel and Training to see that better employee-management relations are fostered throughout the State system of services for the mentally handicapped and that the overall objectives of the new personnel plan are met. Equally essential to this process is continued oversight by the legislative branch (i) of the quality of care provided citizens in State institutions, (ii) of the morale of employees providing that care and (iii) of the success of the efforts of the executive branch to achieve its stated objectives in these areas.

The Commission recommends that two statutory changes be made in the appointment and qualifications of certain professional personnel within the Department. The Code of Virginia in § 37.1-42.2 requires the Commissioner to appoint the directors of each State facility for terms of four years. Under this arrangement the authority of the Commissioner to relieve a hospital director of his duties during that four-year term is questionable, and the performance standards upon which such a decision would be based are not clear.

With the full implementation of the new personnel management decentralization plan, the Department gives the hospital directors the authority and responsibility to train and manage their employees. The directors can then be held accountable for these management functions. The law should be revised so that the directors are employed pursuant to the Virginia Personnel Act and are not subject to an appointed four-year term of office. The directors should be subject to State standards of conduct and be evaluated by the assistant commissioner to whom they report under the same guidelines as other management employees.

The Commission's second recommendation in this area concerns the qualifications of the Commissioner of the Department. Section 37.1-42 of the Code of Virginia requires that the person appointed to be Commissioner of Mental Health and Mental Retardation be a doctor of medicine. The Commission proposes that this requirement be repealed. The administration of a human services system as complex as that for which this Commissioner is responsible requires management and interdisciplinary talents. While a medical education and clinical abilities may be desirable in the person who fills this position, it is unnecessarily restrictive for the Governor to be required to select such an individual. With the focus of the mental health, mental retardation and substance abuse system shifting from an institutional orientation to a continuum of care beginning in the community, the Governor should be permitted to consider persons to lead that system who have broad ranging administrative skills and professional backgrounds.

The ability of the medical schools of the Commonwealth to support the mental health, mental retardation and substance abuse system with persons educated in the disciplines required to provide quality care and treatment was examined by the Commission. The chairmen of the Departments of Psychiatry at the Medical College of Virginia and the School of Medicine of the University of Virginia met with the Commission and identified as a key obstacle in a better working relationship between the medical schools and the State services system the lack of young physicians who are entering the field of psychiatry. Recently, emphasis has shifted from physicians entering the mental health field to primary medical care. This situation coupled with decreased federal funding for training physicians for service in communities and State institutions and the discontinuance of the use of foreign medical graduates has reduced the ability of the medical schools to work cooperatively in the State's efforts to serve mentally handicapped citizens.

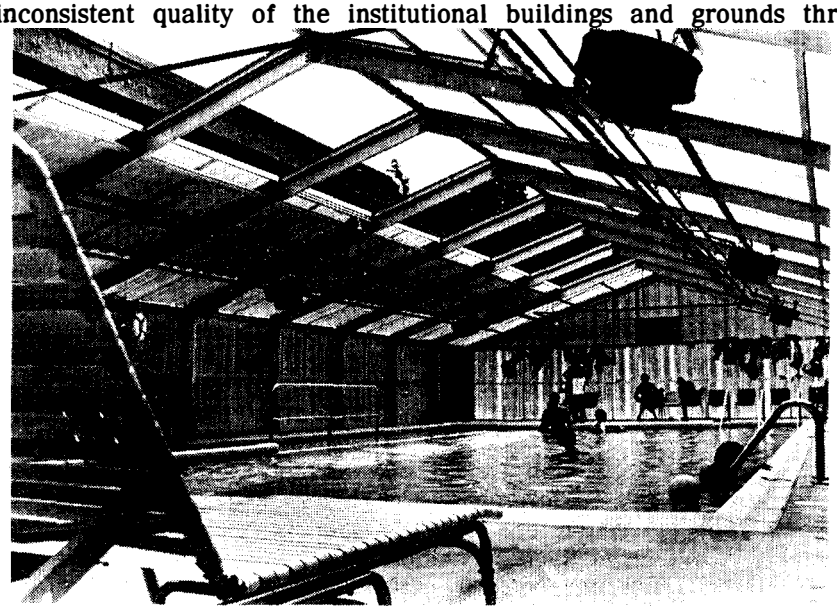
Despite these limitations, the Commission was impressed with the level of commitment by the departments of psychiatry to working with the State institutions and the central office of the Department. Model treatment programs, consultative services, continuing education programs and training opportunities have been developed which can be mutually beneficial to the schools and the mental health, mental retardation and substance abuse system. These efforts are to be commended. Continuing interchange is encouraged among officials from State hospitals, communities and universities as being essential to addressing the problems in this service delivery system.

III. STATE FACILITIES

The Commonwealth's system of services for its mentally ill, mentally retarded and substance abusing citizens has changed. The emphasis has shifted from a mutually exclusive system of State hospitals to a community-based system in which the State institutions are now an integral component of a broad continuum ranging from community services to institutionalization. Although the focus of the system may have shifted, the State hospitals and training centers remain a vital source of care for individuals who require the kinds of services not available in their communities. The Commission on Mental, Indigent and Geriatric Patients, in its 1970 and 1972 reports to the Governor and General Assembly, set the parameters for the development of a "single system of care" for the mentally disabled. While the reports advocated the move toward a community-based system, they recommended that the State hospitals and the training centers be strengthened to care for the more severely and profoundly disabled individuals who would continue to need institutional care. Ten years later, the State institutions require continued guidance and direction to better integrate the services they offer into the statewide system of treatment, training and care for the mentally ill, mentally retarded and substance abuser.

Maintenance

During the 1978 tours of the State hospitals and training centers, the Commission was dismayed to observe the inconsistent quality of the institutional buildings and grounds throughout the State



Northern Virginia Training Center for the Mentally Retarded

system. The Commission realizes that the task of maintaining many of the very old buildings in the system is a difficult undertaking. Nevertheless, the quality of patient and resident care depends, to a large degree, upon the quality of the physical plant of each State institution.

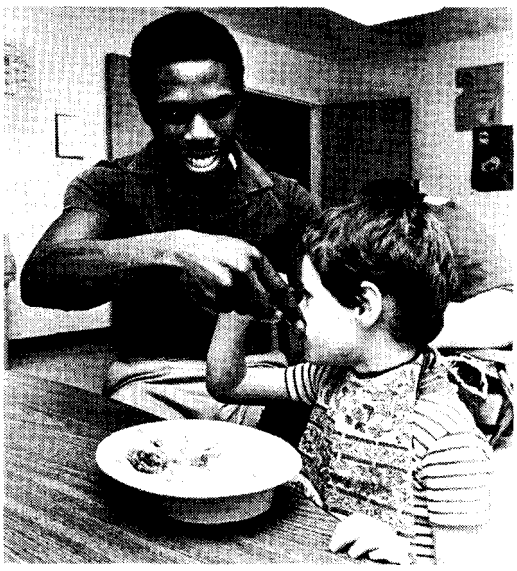
The Commission learned that there is no consistent, systemwide policy for the routine and preventative maintenance of the State hospitals and training centers. Maintenance personnel in the institutions have maintained the properties of their respective facilities. Traditionally, however, the maintenance of institutional property has occurred in response to a specific problem or an emergency rather than as a result of periodically scheduled maintenance efforts. The Department of Mental Health and Mental Retardation owns approximately five hundred and thirty buildings; yet, only one employee in the central office has been assigned half-time to the administration and central oversight of institutional maintenance.

The Department has developed a "Maintenance Manual," but it has never been adopted as State policy by the State Board. A revised manual of standard administrative practices and procedures is being written by the central office staff and will address the area of maintenance. The Department has not indicated, however, that the manual revision will be accompanied by any significant improvement in the efforts of the central office of the Department to monitor the maintenance function in State institutions.

The fact that major policy with regard to periodic maintenance schedules and preventative maintenance has not been developed previously is indicative of the low priority that maintenance has been assigned traditionally by the Department. In recent years, some improvement has occurred at individual institutions. Far more is necessary, however, before adequate maintenance programs exist on a systemwide basis.

The Department of Mental Health and Mental Retardation is responsible for the management of the institutional maintenance systems. The development of standards of quality and systemwide policy for the maintenance of the buildings, grounds and property of the State hospitals and training centers is a task that must be accomplished by the Department with the approval of the State Board. Additionally, the Department is the agent responsible for enforcing and monitoring all maintenance policies and standards of quality for the institutional system it administers. The Commission is aware that additional central office personnel will be needed to carry out this enforcement and monitoring function. Accordingly, it is recommended that the Department consider the reallocation of existing positions within the central office to accomplish the management and oversight of the institutional maintenance systems. By the Department's own estimate substantial savings in tax dollars could be realized from the proper upkeep of its property. Such savings have already been realized at some institutions. These savings more than justify the allocation of additional personnel to this area.

As the maintenance of buildings which are obsolete or substandard for the purposes of caring for patients or residents becomes economically or programmatically impractical, those buildings



Southeastern Virginia Training Center for the Mentally Retarded

should be closed and demolished or transferred to another agency, provided the mission of that agency is compatible with that of the Department of Mental Health and Mental Retardation. The Commission recommends that the Governor be requested to develop a timetable for such actions by the 1982 Session of the General Assembly.

Staffing

In the public hearings conducted by the Commission in 1978, the issue of the staffing of State institutions emerged as a factor contributing to the dissatisfaction of many institutional employees. The lack of sufficient numbers of direct care staff, especially during night shifts, was perceived by the employees to be a primary element in many instances of patient and resident neglect and abuse. The Commission is aware that the emphasis on deinstitutionalization has resulted in a decrease in the institutional population of the State hospitals and training centers. Even though the population of the State facilities has decreased, high ratios of staff to patients or residents are still necessary to provide the more intensive model of treatment and training practiced by the institutions. Additionally, sufficient professional and direct care staff must be available to care for the more severely disabled individuals for whom long-term institutionalization is the only alternative.

The Commission has discerned that, in meeting the demands of a changing institutional population, the State institutions have concentrated on the development of administrative and professional staff and have neglected the increasing demand for direct care staff. If the quality of care in the State institutions is to continue to improve, direct care staffing levels must be increased. Institutional directors must seek to achieve a reasonable balance of administrative, programmatic and direct care staff. Staffing patterns for all hours and all areas of the institutions must be appropriately balanced between supervisory personnel and direct care employees.

To address the staffing levels of the institutions, the Commission recommends that the Department assist the institutional directors in meeting the staffing levels required for certification by Medicare and Medicaid. The Commission further recommends that the Department address itself to the need for consistency in the ratios of administrative and direct care staff among similar institutions in the State system. As stated previously, the new initiatives in personnel management within the Department of Mental Health and Mental Retardation anticipate the resolution of many other concerns of the men and women who work in the State facilities for the mentally handicapped.

Virginia Treatment Center for Children - Medical College of Virginia Agreement

For seventeen years, the Virginia Treatment Center for Children (VTCC) and the Medical College of Virginia at Virginia Commonwealth University (MCV-VCU) have been working together to provide clinical services, medical training and research opportunities in conjunction with the care and treatment of emotionally disturbed children. Until the summer of 1979, no formal agreement existed between VTCC and MCV-VCU. A six month effort of individuals representing the State Board, the Department, Virginia Commonwealth University and the Medical College of Virginia resulted in a written agreement defining the unique relationship between VTCC and the Departments of Psychiatry and Pediatrics at MCV-VCU. The signatories of the Agreement feel that it will be an invaluable guide to the development and implementation of programmatic plans for VTCC in the coming years. The Commission endorses the Agreement, anticipating that it will provide the framework for an increasingly productive relationship between the medical education programs of MCV and the treatment of emotionally disturbed children by VTCC.

During the 1978 and 1979 Sessions of the General Assembly, there was considerable discussion about the provision of funds for the expansion and renovation of VTCC at its present location. A number of legislators were concerned over continuing the VTCC program in its present location because of encroachments upon the property by the construction of highways and buildings. It was the understanding of the members of the General Assembly that if the facility remained at its current location, there would be no further construction that would reduce the VTCC property or encroach upon the air space surrounding the property.

Prior to confirmation of the VTCC-MCV Agreement, the controversy surrounding the location of VTCC and the effect of an evolving master site plan for the MCV-VCU campus emerged as determining factors in the finalization of the Agreement. A major consideration in the development of the master site plan for the MCV-VCU campus is the need for and the location of additional parking space. The university is considering two locations for the proposed parking deck, (i) 13th Street in Richmond and (ii) adjacent to VTCC. If the plan does place the parking deck near VTCC, the President of VCU has suggested that the deck be built primarily underground with only two

floors above the ground minimizing the interference with the play area of the children at VTCC. The Commission finds this suggestion unacceptable. No decision on the location of the parking deck has been made as of the completion of this report.

The Commission feels very strongly that VTCC should remain in its present location because of the advantages of its relationship with the Medical College of Virginia. The Commission recommends that no future funds be appropriated to any building project of MCV-VCU if the location of the proposed parking deck or any other building encroaches upon the air or land space of VTCC.

IV. QUALITY OF SERVICES PROVIDED BY THE SYSTEM

Standards for State Institutions and for Community Programs

The assurance that high quality services are provided in the State institutions for the mentally ill and mentally retarded and in community programs depends upon the strong central direction of the Department of Mental Health and Mental Retardation.

The current policy of the Department is to utilize existing Medicare and Medicaid standards to measure the quality of the programs and services available to patients and residents of the State hospitals and training centers. The Department does not intend to impose additional layers of review on the State institutions for the evaluation of those programs and services which are currently measured by the criteria for Medicare and Medicaid certification. Recognizing that many of the State institutions are currently working toward full compliance with the certification standards of the Medicare and Medicaid programs and that notable progress has been made in this regard, the Commission recommends that the Department of Mental Health and Mental Retardation devote technical expertise and assistance to the directors of all of the State facilities to achieve full Medicare and Medicaid certification for all State hospitals and training centers. A long-term goal of the Department should be the accreditation of all State hospitals and training centers by the Joint Commission on the Accreditation of Hospitals. The Commission acknowledges that the criteria for accreditation change periodically making the task of meeting the standards increasingly difficult. However, attaining compliance with these standards results in the maximization of third party payments. This financial support is vital to the quality of care provided by the State institutions and to easing the financial burden on the families of patients and residents.

Unfortunately, full certification by Medicare and Medicaid and accreditation by the Joint Commission on the Accreditation of Hospitals will take a number of years to achieve. In those areas of the State hospitals not presently certifiable by Medicare and Medicaid, few standards exist to measure the quality of the programs and services being provided.

During the tours of the State facilities in 1978, the Commission noted with serious concern, the apparent lack of standardization in the quality of care among the various State hospitals and training centers. The Commission learned that the Department of Mental Health and Mental Retardation plans to institute additional quality assurance mechanisms to review the unregulated programs and services of State institutions. A proposed program budgeting mechanism requires the institutions to document the goals and objectives of specified programs and the numbers of patients to be served by each program. Plans for this method of evaluation envision the development of a quarterly reporting system similar to quarterly fiscal reports. The Department anticipates using this mechanism to review the projected success of a program against its actual results to justify the continuation or the cancellation of a particular program. Another mechanism the Department plans to utilize is extensive treatment planning and documentation review. This method of evaluation considers whether active treatment is being administered to the patients of the State institutions. If deficiencies are noted, the institution must file remediation plans and the attendant results with the Department.

The Department's efforts to evaluate the quality of the programs and services administered by the State hospitals and training centers and the resultant standards developed by the Department are intended to supplement, not to duplicate, the existing certification standards of the Medicare and Medicaid programs. Because the Department has begun only recently to develop minimal criteria for quality assurance to supplement existing certification standards, very little attention has been devoted to the implementation, monitoring and enforcement of the internal standards for State institutions. Additionally, the Commission learned from the staff of the Department that present standards are either inadequate or nonexistent in some institutional program areas, specifically, children's programs and psychosocial-oriented rehabilitation programs for the general adult population and the elderly.

It is incumbent upon the Department of Mental Health and Mental Retardation, as the central manager and overseer of the institutional system, to strive to develop standards of quality assurance for all of the programs and services in the State hospitals and training centers. The Department has an obligation to the patients and residents of the State institutions to effect the implementation of all standards for quality assurance and to monitor and evaluate the institutions' compliance with those standards.

Prior to 1979, standards for community programs did not exist. The need for standards was recognized by the Department of Mental Health and Mental Retardation in 1974, and by the Arthur Bolton Associates Report, issued in January of 1975. Federal initiatives in Title XX and in the Community Mental Health Centers Act provided impetus to the development of these standards. In 1976, the Department established the Office of Program Standards and Evaluation to direct the statewide effort to develop standards for community programs. The community program standards for the fields of mental retardation and substance abuse became effective January 1, 1979. The standards for community mental health programs will become effective July 1, 1980. Guidelines which are approximations of the newly developed standards have been effective for all three disciplines (mental health, mental retardation and substance abuse) since 1975. These standards provide a means of consistently evaluating community services and of holding local boards accountable for the quality of programs they fund. The Commission proposes that the Code of Virginia be amended to make clear that the Department has the authority to withdraw funds from any community program which is not in compliance with these State standards. Both the Department and the local boards have a responsibility to continually monitor the quality of community-based services. This statutory proposal is intended to insure a corresponding accountability for the expenditure of the tax dollars which support those services.

Hudson House Day Activity Center, Lynchburg

The Commission commends the work of the Department and of the participating representatives of the community services boards in developing these essential standards for community programs. It is now the responsibility of the Department of Mental Health and Mental Retardation to monitor carefully the implementation of the standards for community programs guaranteeing that mentally handicapped citizens have access to high quality services in every community of the Commonwealth. To achieve a statewide continuum of high quality care and treatment for mental illness, mental retardation and substance abuse, the Department must enforce the newly developed standards for community programs. Continual monitoring and evaluation of the effects of the standards is essential to the ongoing provision of community services and is a responsibility of the Department of Mental Health and Mental Retardation as the agency authorized to manage the statewide system of services.

Planning

Planning for mental health, mental retardation and substance abuse services is carried out variously by the State Mental Health and Mental Retardation Board, State advisory councils, the Department of Mental Health and Mental Retardation, the community services boards, planning district commissions and health systems agencies.

The current situation in Virginia requires that all official mental health, mental retardation and substance abuse plans be approved by the State Board. Advisory councils for each of the three specialty areas in the Department are required by federal law (mental health), State law (substance abuse) and by the State Board (mental retardation). The Department works with the community services boards to develop local data for the statewide plans applicable to the fields of mental health and mental retardation. The Department is required by State statute in § 37.1-216, however, to work with the planning district commissions to formulate plans and data for the field of substance abuse. Consequently, an integrated approach to planning the statewide provision of services for mental health, mental retardation and substance abuse does not exist because of the involvement of an array of State and local agencies in the planning process.

At the local level, very little planning occurs because of the lack of adequate funds available to support sub-State planning. The exchange of planning data between the community services boards and the Department is minimal.

To remedy the confusion inherent in the current planning process, the Commission recommends that legislation be introduced which will define the roles and responsibilities of the various State and local agencies involved in the planning process.

Southwestern State Hospital

Research

The Commission was told that the Department of Mental Health and Mental Retardation has neither the funds nor the personnel to undertake basic research. The Code of Virginia in § 37.1-24 restricts departmental grants for research into the causes of mental illness and mental retardation to the State institutions in cooperation with the State medical schools. Research grants cannot be made to community services boards directly. The Office of Research within the Department is used primarily to make the management staff aware of conditions in the mental health, mental retardation and substance abuse system.

The Commission concludes that it is the responsibility of the Department of Mental Health and Mental Retardation to establish agreements with the State medical schools to conduct the necessary research into the causes of mental illness, mental retardation and substance abuse and in related areas. The Department is responsible for directing research efforts throughout the State, but is not expected to actually conduct the research. It is the Department's job to identify the kinds of research needed and to cooperate with all promising research opportunities within the limits of the funds available.

V. EFFORTS IN INTERAGENCY COOPERATION

The cooperation of all of the State and local agencies involved in the delivery of human services is essential to assure that both children and adults in need of services receive the appropriate care. This is particularly cogent for the deinstitutionalized patients and residents of State institutions who are regularly returning to the communities. At the same time, interagency cooperation is crucial to the prevention of inappropriate institutional admissions. The General Assembly has demonstrated a commitment to caring for mentally handicapped individuals in the least restrictive environment, which in the majority of cases is the community. This commitment is reflected in requests to State agencies to better coordinate the delivery of human services throughout the Commonwealth. Interagency agreements and cooperative efforts have been initiated at the State level to foster this kind of interagency service coordination.

Catawba Hospital

Interagency Cooperative Services Agreement.

The Interagency Cooperative Services Agreement between the Department of Mental Health and Mental Retardation and the Department of Welfare was first entered into in July of 1976. It delineates the responsibilities of the two agencies in providing services to persons who are discharged from the State institutions and who return to the community. This Agreement was renegotiated during the summer of 1979 and includes, for the first time, preadmission screening as a component of this cooperative effort. In implementing the Agreement, however, the State agencies have experienced difficulty in persuading the community services boards and the local welfare boards to carry out the requirements at the local level. The primary concern of the Department of Mental Health and Mental Retardation and the Department of Welfare in the implementation of the Agreement is the responsibility for preadmission screening and case management. Earlier recommendations in this report regarding mandated managerial services should clarify the roles of the various human services agencies in this regard. The Commission does, however, charge the community services boards and local welfare agencies with the responsibility for implementing the Interagency Cooperative Services Agreement. The authority of the Department of Mental Health and Mental Retardation to withhold funds from community services boards which do not cooperate with the Agreement is acknowledged. The interagency effort at the State level is commended, and the Subcommittee advocates the expeditious implementation of the Agreement at the local level by the respective agencies.

Agreement for the Interdepartmental Licensure and Certification of Children's Residential Facilities.

On January 9, 1979 four State agencies agreed to collaboratively develop licensing and certification standards for children's residential facilities. A target date of February 1, 1980 was set

for the full implementation of the standards by the use of interdepartmental teams in the evaluation of facilities. This effort by the executive branch grew out of long expressed legislative concern that inadequate coordination and cooperation among the State human service agencies having licensing responsibilities was resulting in burdensome and expensive duplication of effort as well as gaps in regulation.

The Department of Welfare is the lead agency in the current effort to develop standards for the licensure and certification of children's residential facilities and will issue the core license for each affected facility. The Departments of Mental Health and Mental Retardation, Corrections and Education will certify the individual programs which fall within their areas of expertise. The Commission applauds the interagency cooperation of the State agencies in developing core licensure standards for children's residential facilities and looks forward to the timely finalization of those standards.

The participating State agencies and the Secretary of Human Resources are encouraged to pursue the further utilization of cooperative agreements in the licensing field. While the steps taken in the children's field are commendable, much work remains to be done in providing for the effective regulation of human resources for children in other than residential programs and for adults. As is pointed out in other sections of this report dealing with deinstitutionalization and homes for adults, cooperative and coordinative efforts between State and local agencies are essential to providing comprehensive, quality care and treatment.

Standards for Homes for Adults

The Department of Welfare, with the advice and consultation of the Department of Mental Health and Mental Retardation, recently revised its standards for the licensure of homes for adults. The new standards were adopted by the State Board of Welfare on July 19, 1979 and will become effective January 1, 1980. The revised standards require that any home for adults which accepts persons discharged from a State institution for the mentally ill or mentally retarded must enter into an agreement with the local community services board or similar private service to assure that certain services are available to the deinstitutionalized resident of the adult home. The standards require the State facility from which the patient is released to furnish information to the home for adults as to recommendations for the appropriate aftercare of the patient. However, the deinstitutionalized patient retains the right to refuse consent for the release of information regarding his treatment or to decline any of the services offered.

The report of the Joint Legislative Audit and Review Commission entitled "Homes for Adults in Virginia" estimates that there are approximately 1,500 to 2,000 deinstitutionalized persons currently residing in homes for adults. The Commission recognizes the urgent need to address the problems of deinstitutionalized patients and residents who return to community residences. The cooperation of the Departments of Welfare and Mental Health and Mental Retardation and the assistance of the community services boards is crucial to the effective aftercare of the mentally ill, mentally retarded and substance abusers who are discharged from the State hospitals and training centers. Enforcement and monitoring of the standards developed for community residential facilities such as homes for adults is essential to assure that high quality programs and services are available locally throughout the Commonwealth.

Services in the Criminal Justice System

The nature of the services being provided to mentally handicapped children and adults in the criminal justice system was also considered by the Commission. The members are concerned about the lack of commitment by the Department of Mental Health and Mental Retardation to develop programs to meet the needs of the mentally disabled children and adults being held in institutions run by the Department of Corrections. While it is recognized that many of these persons, especially the children, could have their needs for mental health, mental retardation and substance abuse services more successfully met at the community level, the fact is this is not an option once they are committed to the State corrections system. At the same time the Department of Corrections has failed to take advantage of the Department of Mental Health and Mental Retardation's availability to provide consultation, technical assistance, program development and evaluation and staff training in how to handle and treat the mentally handicapped children in State learning centers and the similarly disabled adults in the prison system.

The Report of the Office of the Secretary of Human Resources and the Secretary of Public Safety to the 1979 Session of the General Assembly in response to House Joint Resolution No. 49 (1978) was reviewed by the Commission. One of the purposes of this report was to identify the steps being taken by the executive branch to strengthen existing programs and to develop new ones in the Departments of Mental Health and Mental Retardation and Corrections to meet the inadequacies of the present service delivery system for emotionally disturbed, mentally ill and mentally retarded juvenile offenders. In the course of formulating the Secretaries' report, it was determined that the adult correctional population should also be included in identifying service gaps in this area. The Commission commends the interagency efforts in this regard but is not satisfied with the results.

The Youth Region of the Department of Corrections has identified forty-eight percent of its children as emotionally disturbed or mentally retarded or both, often with other complicating conditions. It is expected that the Youth Region will be responsible for 315 children who can be classified as emotionally disturbed, 60 of whom are seriously disturbed. About 130 retarded children, 35 of whom are also emotionally disturbed, and most of whom have multiple problems and handicaps will be in the juvenile correctional system. Additional numbers of emotionally disturbed and mentally retarded children will be maintained in special placements outside the State system while remaining the responsibility of the State Board of Corrections. The multihandicapped child is a further category of child requiring special services in the juvenile corrections' population. While parallel statistics are not available for the adult population, noteworthy numbers of retarded, emotionally disturbed and mentally ill inmates have been identified by the Department of Corrections.

The Commission is not convinced that existing resources of the Departments of Mental Health and Mental Retardation and Corrections and the Rehabilitative School Authority are being fully utilized or held accountable for developing and implementing services for the State's mentally handicapped incarcerated population. Recent commitments of the Secretaries of Human Resources and Public Safety to better coordinate the efforts of these agencies are encouraging, but the results of these commitments remain to be seen. This area requires continuing oversight by the legislative standing committees which have programmatic jurisdiction over these agencies and by the House Appropriations Committee and Senate Finance Committee to insure that the financial resources of the State in this area are utilized to best meet the service needs of our incarcerated populations.

The Commission recommends that the Secretary of Human Resources and the Secretary of Public Safety be requested to report to the House Committee on Health, Welfare and Institutions and the Senate Committee on Rehabilitation and Social Services in January of 1981. The report of the Secretaries should detail the results of their commitments to coordinate the efforts of the Department of Mental Health and Mental Retardation, the Department of Corrections and the Rehabilitative School Authority in providing services to mentally handicapped children and adults in the State's criminal justice system.

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FINANCIAL MANAGEMENT OF THE SYSTEM

Effectively administering the statewide system of services for mental health, mental retardation and substance abuse requires the implementation of sound fiscal policies to govern the use of funds for these programs. In considering the financial management of the statewide system of services, the Commission reviewed these issues: (i) operational and capital outlay budget policies of State institutions, (ii) formula funding of community services and (iii) the Title XX program. The budget requests for the 1980-82 biennium of the Department of Mental Health and Mental Retardation were considered by the Commission in determining how the fiscal policies of the agency coincide with the administrative and programmatic goals set by the Commission.

I. STATE AND LOCAL FISCAL POLICIES

Operational and Capital Outlay Budget Policies

In discussions with the executive branch, the Commission found that institutional budget requests for both operational and capital outlay funds are not submitted to the Governor in a coordinated

and integrated manner. Although all institutional budget requests are submitted through the Department, the Commission found that frequently these requests are not reviewed carefully by the central office to determine both fiscal and programmatic impact upon the statewide system of services.

In the development of budget requests for capital outlay for the 1980-82 biennium, a departmental priority list was compiled. This list was not routinely distributed to the appropriate legislative committees, however. Further, the list covered only the 1980-82 biennium. No plan or priorities for future requests were developed or submitted by the Department, although each institution submitted its requests and priorities to the Department, Governor and General Assembly for both the 1982-84 and the 1984-86 bienniums.

To better integrate institutional budget requests and departmental priorities, the Commission recommends that institutional budget requests for both operations and capital outlay be reviewed and scrutinized closely by the Department of Mental Health and Mental Retardation. Institutional requests should be reviewed and commented on by the State Board and sent to the Governor only after specific central review and approval by the Commissioner.

The Commission believes that the Department should develop and submit for each biennium a priority list of capital outlay projects and a plan prioritizing requests for the following two bienniums to the State Board for review and comment, to the Governor through the Secretary and to the General Assembly. Institutional requests for capital outlay projects in the interim sessions should be closely reviewed and a departmental priority list should be developed and submitted to the State Board, Governor and legislature.

Formula Funding of Community Services

Currently, State statutes provide inadequate direction to the Department for governing the distribution of State general funds to community services boards. Appropriations to community services have increased from approximately five to sixty million dollars since 1968. These funds have been allocated, however, primarily to boards which were established early and had significant local matching funds. The result in 1979 is a highly uneven distribution of State general funds supporting community services.

State general funds support no alcohol programs in eight community services board areas, yet State general funds varying from $0.40 per capita to $0.33 per capita are spent for alcohol services in other areas of the Commonwealth. Ten community services board areas do not fund any drug programs, while in other areas State general funds support drug programs with expenditures ranging from $1.65 per capita to $0.53 per capita. State general funds for mental health programs in various services areas range from $4.18 per capita to $1.64 per capita. Similar variations exist in the amount of State general funds supporting mental retardation programs, ranging from expenditures of $2.84 per capita to $0.71 per capita.

In 1975, the report of the Arthur Bolton Associates called for the development of a formula to distribute State funds to community services boards. Consequently, the Department began the development of formulas for the distribution of funds for mental health and mental retardation services. In 1979, these formulas were used as guidelines in considering the distribution of funds to community services boards. The formulas were utilized to determine the total available State mental health or mental retardation funds for each board and to determine the amount of local matching funds needed by each board to support its programs. It must be recognized that if these formulas were fully implemented, these State funds would be distributed solely on a per capita basis. Determination of the necessary local matching funds takes into account the locality's relative need for services, relative ability to pay and relative tax effort.

The Commission believes it is important to equitably fund community services boards as quickly as possible. The Department has failed to sufficiently develop and implement a comprehensive distribution procedure for community services State general funds. The incidence of need for services as well as population should, in the opinion of the Commission, be considered in the distribution of State general funds. Local match should consider only relative ability to pay and relative tax effort. Consequently, the Commission recommends that the Department be required to develop formulas for the distribution of funds for mental health, mental retardation and substance abuse community services. The Department should report to the Senate Finance Committee and the

House Appropriations Committee by November 1, 1980 on its recommendations for implementing formula funding and its findings with regard to the impact the formulas will have on the community-based system. Pending the approval of the formulas by these standing committees of the legislature, the Department should plan on fully implementing the formulas in the 1982-84 biennial budget.

In order to provide flexibility in funding community services the Department should consider distributing a substantial percentage, but not all of the State general funds for community services through the formulas. The remaining State general funds should be distributed administratively among community services boards which, in the discretion of the Department, need additional financial support to develop new programs or support particular services. Factors to be considered in the administrative distribution of these funds could be: a high percentage of discharged patients and residents in a service area; the unavailability of comparable private services; a high percentage of elderly citizens; and a heavy welfare caseload.

Title XX Program

Title XX of the Social Security Act of 1974 established a program of federal funds to encourage states to provide social services to individuals and families who meet certain eligibility criteria. Services for mental health, mental retardation and substance abuse are among the array of social services which may receive Title XX support. In Virginia, the Title XX program is administered by the Department of Welfare and the Commission for the Visually Handicapped.

During the Commission's study, a number of citizens and legislators expressed concern about the allocation of Title XX funds and the equitable distribution of such funds among social services throughout Virginia. The Commission recommends, therefore, that the Secretary of Human Resources be requested to study the Title XX program. The Secretary should consider the feasibility of alternative methods of mandating Title XX services and of distributing these funds. It is suggested that the results of the current evaluation of the Title XX program being conducted by the Joint Legislative Audit and Review Commission be considered by the Secretary in the formulation of the report. The Secretary is requested to report to the 1981 Session of the General Assembly.

II. BUDGET RECOMMENDATIONS FOR THE 1980-1982 BIENNIUM

In order for many of the Commission's statutory and administrative recommendations to be implemented, financial support for these recommendations is essential. Therefore, the budget and addendum requests of the Department of Mental Health and Mental Retardation for the 1980-82 biennium were reviewed by the Commission and recommendations for amending those requests are herein proposed.

The Department of Mental Health and Mental Retardation requested $288 million in State general funds for the 1980-82 fiscal year to maintain the present level of services. This request represented a 21% increase over the Department's adjusted appropriations for 1978-80 of $238.4 million. The Office of the Governor, however, set general fund budget targets, or the total amounts of monies, within which the agencies in the executive branch were to develop their budgets. The general fund budget target for the Department was set at $275 million, a 15.3% increase over the Department's adjusted general fund appropriations for 1978-80. The general fund budget request of the Department was $13 million more than the approved budget target. The Department adjusted its budget to meet its budget target.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

	1978-80 Appropriations	1980-82 Executive Request	% Increase
General Fund	$238.4	$275.0	15.3
Special Fund*	155.1	159.7	3.0
Total	$393.5	$434.7	10.5

* Special funds include all monies which are not State general fund tax dollars, i.e. federal and private grants, gifts.

The budget addendum of the Department for 1980-82 totals $41.2 million. This amount includes $9.8 million to maintain present services and $31.4 million to provide for increased services.

Operational Budget

In order to meet the Department's general fund budget target, the Secretary of Human Resources set three policies for the agency to follow in decreasing its general fund request:

1. Community services were to be maintained or increased.

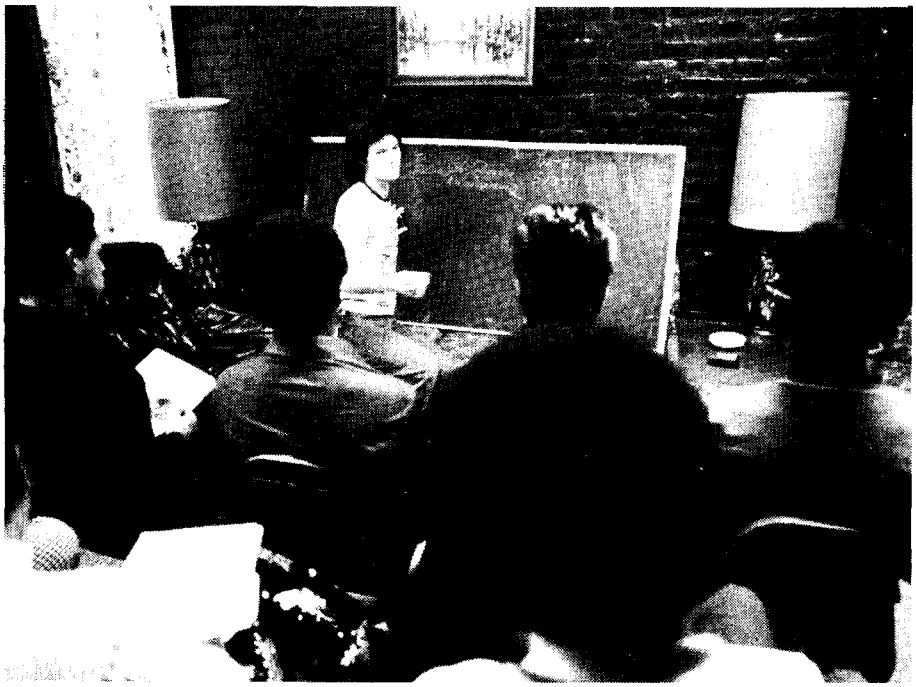
2. Revenue producing areas were not to be cut.

3. The level of established positions were not to be increased.

Working within these restrictions the Department found that significant employee layoffs could result during 1980-82. No other area of State government required the layoff of existing employees in order to meet budget targets. The Commission recommends, therefore, that $5 million be added to the Department's 1980-82 appropriations to provide salaries for existing departmental employees in order to maintain an adequate level of services.

State support of institutional services currently represents approximately 83% of departmental funds. The remaining 17% of these funds supports community services. During its study the Commission found there is statewide concern over this imbalance in funding institutional services when the emphasis in the system has been on deinstitutionalization and community services. In recognition of the growing importance of community programs, the Commission recommends that the Governor develop a ten-year plan which, by 1990, will result in 60% of State general funds supporting institutional services and 40% supporting community services.

To begin working toward this funding balance in the 1980-82 biennium, the Commission recommends that an additional $10 million be appropriated for community services board programs. The Department should utilize these funds to provide a 10% per year increase in grants to community services boards at a cost of $6.16 million. The remaining $3.84 million should be spent to fund substance abuse programs: $3 million for alcohol services and $840,000 for drug programs.



Second Genesis, Inc., Alexandria

Given the high level of inflation, the recommended 10% per year increase in grants to community services boards will maintain the growth of community services while recognizing the financial austerity of the times. In 1976-78 the biennial increase in these services was 75%; in 1978-80 it was 41%. This requested increase for 1980-82, including the increase in substance abuse funding, will provide a 34.4% biennial increase for 1980-82. This recommendation provides for the limited growth of community services during the next biennium above the amount required to keep pace with inflation.

The additional funds for substance abuse programs recommended by the Commission total $3.84 million. Three million dollars of this amount will substantially raise funding for all community alcohol programs. Lesser funded alcohol programs and boards without alcohol programs will receive priority in the distribution of these funds. At the present time, Virginia ranks last in total per capita funding of alcohol programs when compared with adjacent states.

1978 PER CAPITA ALCOHOL FUNDING BY SOURCE

	Federal	State	Local	Total
Georgia	$ .90	$1.08	$ .08	$2.07
Maryland	1.03	.84	.18	2.05
North Carolina	1.07	1.71	.38	3.16
Tennessee	2.16	.05	0	2.22
South Carolina	.87	.98	.52	2.38
Virginia	1.24	.57	.06	1.87
West Virginia	.96	*	.44	*

National Institute on Alcohol Abuse and Alcoholism (NIAAA), State Alcoholism Profile Information System, National Status Report. Vol. 1, p. 6; Vol. 2, p. 6; 1979.

* West Virginia reported state funding which failed to include substantial expenditures supporting a state hospital alcohol unit and state-operated community programs.

When comparing the per capita obligation of state general funds, Virginia ranks second to last among adjacent states. The additional $3 million recommended by the Commission should significantly improve community alcohol services in Virginia. The remaining $840,000 will provide drug programs in areas of the Commonwealth currently not serving these needs.

During 1979-80 mental health and mental retardation grant funds to community services boards were significantly higher than those funds allocated for substance abuse services.

STATE COMMUNITY SERVICE BOARD GRANT FUNDS

	1979-80 (millions)	%
Mental Health	$14.40	52
Mental Retardation	8.11	29
Substance Abuse	3.65	13
Administration	1.81	6
Total	$27.97	100%

The increase of general funds for substance abuse programs will bring these services closer to the funding level of mental health and mental retardation services.

Capital Outlay Requests

Capital outlay requests of the Department for 1980-82 totalled $54,075,750. These requests are not required to meet a budget target. First priority among these requests was given to ten projects considered by the Department to be essential to the safety or health of patients and residents. These ten projects total approximately $4 million and include these kinds of expenditures: installation of smoke detectors, replacement of a sewage pumping station, improvement of a water supply system, installation of an automated sprinkler system, compliance with life safety codes and construction of maintenance and storage buildings. Another top priority of the Department is renovation and construction of an addition to the Virginia Treatment Center for Children at a cost of $4.3 million. The Commission endorses both of these capital outlay requests of the Department and urges their favorable consideration by the 1980 Session of the legislature.

Eastern State Hospital

Two other priorities of the Department for capital outlay expenditures are:

* 100 bed facility for handicapped residents at Lynchburg Training School and Hospital. Cost: $6.4 million.

* Phase I replacement of Southwestern State Hospital. Cost: $7 million.

The Commission proposes that alternative actions be taken with regard to these capital outlay requests.

In lieu of constructing another facility on the grounds of Lynchburg Training School and Hospital (LTSH), the Commission recommends that funds be appropriated for a feasibility construction study during 1980-82 as to whether fifty additional beds for handicapped persons should be built at both Northern Virginia Training Center and Southeastern Virginia Training Center. Both of these training centers were built with support services for five hundred residents and currently have populations substantially below this number. This alternative would enable handicapped Lynchburg residents to

be transferred to other facilities and would result in decreasing the size of LTSH, presently the largest institution for the mentally retarded in the United States.

The Commission recommends that the Finley-Gale Building at Southwestern State Hospital be transferred to the Department of Corrections on July 1, 1980 for appropriate internal renovation for use in housing inmates. Appropriations for the internal renovation and operation of this facility should be included in the 1980-82 budget of the Department of Corrctions. It is further recommended that two feasibility studies be conducted during 1980 by the executive branch: the first to plan for the construction of a modern psychiatric State facility to serve the citizens of Southwestern Virginia as a replacement for Southwestern State Hospital; and the second to plan for the minimal renovation of Southwestern State Hospital (SWSH) for the appropriate use of the Department of Corrections in housing prisoners after the hospital is no longer needed by the Department of Mental Health and Mental Retardation. This second feasibility study should consider both the programmatic and construction aspects of the proposal. Reports on the results of these studies should be presented to the 1981 Session of the General Assembly. It should be noted that the utilization of the Finley-Gayle Building at SWSH by the Department of Corrections is supported by the surrounding localities. The Town Council and Chamber of Commerce in Marion and the Board of Supervisors in Smyth County have adopted resolutions endorsing this recommendation.

The relocation of the children's program at the DeJarnette Center for Human Development should be considered by an interagency task force consisting of the Departments of Mental Health and Mental Retardation and Education and the Secretaries of Human Resources and Education. The Commission requests that the results of this study effort be reported to the General Assembly prior to the 1981 Session. Funds for a feasibility study to minimally renovate the structure for use by the Department of Corrections to house inmates at or before the start of the 1982-84 biennuim should be included in the 1980-82 budget.

The Commission considered information regarding the use of the planning funds for the building of two regional centers for the mentally retarded in Fredericksburg and Winchester. These monies were approved in a bond issue in 1977 and have not yet been spent. A consultant employed by the Department of Mental Health and Mental Retardation is reviewing the need for these services and will report the results of the study in the spring of 1980.

****

Designing an administrative, legal and financial framework which provides for effective and appropriate mental health, mental retardation and substance abuse services throughout Virginia in a continuum of care has been the goal of the Commission's work. The Commission offers this report and its recommendations to the Governor, General Assembly and citizens of the Commonwealth with the hope that these efforts will significantly improve the quality of life, training and treatment afforded mentally handicapped Virginians.

Respectfully submitted,

Richard M. Bagley, Chairman
Elliot S. Schewel, Vice-Chairman
Bernard G. Barrow
John C. Buchanan
J. Paul Councill, Jr.
Arthur R. (Pete) Giesen, Jr.
Richard S. Gillis, Jr.
Omer L. Hirst
Dorothy I. MacConkey
Mary A. Marshall
Frank M. Slayton
James C. Windsor

Commission on Mental Health and Mental Retardation *
*** Not pictured is Senator John C. Buchanan**

APPENDICES

HOUSE BILL NO.

A BILL to amend and reenact §§ 37.1-1, 37.1-3, 37.1-5, 37.1-6, 37.1-9 through 37.1-13, 37.1-20.1, 37.1-22 through 37.1-24.2, 37.1-27 through 37.1-32, 37.1-34, 37.1-34.1, 37.1-39, 37.1-42 through 37.1-42.2, 37.1-58, 37.1-61, 37.1-64 through 37.1-67.3, 37.1-70, 37.1-71, 37.1-78, 37.1-95, 37.1-97 through 37.1-99, 37.1-121, 37.1-122, 37.1-124, 37.1-128.01, 37.1-128.02, 37.1-128.1, 37.1-132, 37.1-138 through 37.1-142, 37.1-179, 37.1-181 through 37.1-183.1, 37.1-185 through 37.1-187, 37.1-194 through 37.1-209, 37.1-214, 37.1-215, 37.1-217 through 37.1-220 and 37.1-223 of the Code; to add to the Code of Virginia sections numbered 37.1-10.1, 37.1-128.04, 37.1-128.2, 37.1-134.1, 37.1-179.1, 37.1-183.2 and 37.1-197.1; and to repeal §§ 37.1-2, 37.1-8, 37.1-20, 37.1-21, 37.1-25, 37.1-26, 37.1-43, 37.1-128.03, 37.1-180, 37.1-210 through 37.1-213 and 37.1-216 of the Code of Virginia, the amended, added and repealed sections generally revising the laws governing the administration of mental health, mental retardation and substance abuse services in the Commonwealth.

Be it enacted by the General Assembly of Virginia:

1. That §§ 37.1-1, 37.1-3, 37.1-5, 37.1-6, 37.1-9 through 37.1-13, 37.1-20.1, 37.1-22 through 37.1-24.2, 37.1-27 through 37.1-32, 37.1-34, 37.1-34.1, 37.1-39, 37.1-42 through 37.1-42.2, 37.1-58, 37.1-61, 37.1-64 through 37.1-67.3, 37.1-70, 37.1-71, 37.1-78, 37.1-95, 37.1-97 through 37.1-99, 37.1-121, 37.1-122, 37.1-124, 37.1-128.01, 37.1-128.02, 37.1-128.1, 37.1-132, 37.1-138 through 37.1-142, 37.1-179, 37.1-181 through 37.1-183.1, 37.1-185 through 37.1-187, 37.1-194 through 37.1-209, 37.1-214, 37.1-215, 37.1-217 through 37.1-220 and 37.1-223 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 37.1-10.1, 37.1-128.04, 37.1-128.2, 37.1-134.1, 37.1-179.1, 37.1-183.2 and 37.1-197.1 as follows:

§ 37.1-1. Definitions.—As used in this title except where the context requires a different meaning or where it is otherwise provided, the following words shall have the meaning ascribed to them:

(1) "Board" means the State Mental Health and Mental Retardation Board;

(2) [Repealed.]

(3) "Commissioner" means the Commissioner of Mental Health and Mental Retardation;

(3a) "Community services board" means a citizens board established pursuant to § 37.1-195 of the Code which provides mental health, mental retardation and substance abuse programs and services within the political subdivision or political subdivisions participating on the board.

(4) "Department" means the Department of Mental Health and Mental Retardation;

(4a) "Director" means the chief executive officer of a hospital or of a training center for the mentally retarded;

(5) "Drug addict" means a person who: (i) through use of habit-forming drugs or other drugs enumerated in the Virginia Drug Control Act as controlled drugs, has become dangerous to the public or himself; or (ii) because of such drug use, is medically determined to be in need of medical or psychiatric care, treatment, rehabilitation or counseling;

(6) "Facility" means a State or private hospital, training center for the mentally retarded, psychiatric hospital, or other type of residential and ambulatory mental health or mental retardation facility and when modified by the word "State" it means a facility under the supervision and ~~control of the Board~~ *management of the Commissioner* ;

(7) [Repealed.]

(8) "Hospital" or "hospitals" when not modified by the words "State" or "private" shall be deemed to include both State hospitals and private hospitals devoted to or with facilities for the care and treatment of the mentally ill or mentally retarded;

(9) "Alcoholic" means a person who: (i) through use of alcohol has become dangerous to the public or himself; or (ii) because of such alcohol use is medically determined to be in need of

medical or psychiatric care, treatment rehabilitation or counseling;

(10) [Repealed.]

(11) "Judge" includes only the judges, associate judges and substitute judges of general district courts within the meaning of chapter 4.1 (§ 16.1-69.1 et seq.) of Title 16.1 of this Code and of juvenile and domestic relations district courts within the meaning of chapter 8 ~~(§ 16.1-130 et seq.)~~ *11 (§ 16.1-226 et seq.)* of Title 16.1 of this Code, as well as the special justices authorized by § 37.1-88;

(12) "Legal resident" means any person who is a bona fide resident of the Commonwealth of Virginia;

(13) "Mental retardation" means substantial subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior;

(14) [Repealed.]

(15) "Mentally ill" means any person afflicted with mental disease to such an extent that for his own welfare or the welfare of others, he requires care and treatment; provided, that, for the purposes of chapter 2 (§ 37.1-63 et seq.) of this title, the term "mentally ill" shall be deemed to include any person who is a drug addict or alcoholic;

(16) "Patient" means a person voluntarily or involuntarily admitted to *or residing in* a facility according to the provisions of this title;

(17) "Private hospital" means a hospital or institution which is duly licensed pursuant to the provisions of this title;

(18) "Private institution" means an establishment which is not operated by the ~~Board~~ *Department* and which is licensed under chapter 8 (§ 37.1-179 et seq.) of this title for the care or treatment of mentally ill or mentally retarded persons, including psychiatric wards of general hospitals;

(19) "Property" as used in §§ 37.1-12 through 37.1-18 includes land and structures thereon;

(20) "State hospital" means a hospital, training school or other such institution operated by the Department for the care and treatment of the mentally ill or mentally retarded;

(21) [Repealed.]

(22) "System of facilities" or "facility system" means the entire system of hospitals and training centers for the mentally retarded and other types of facilities for the residential and ambulatory treatment, training and rehabilitation of the mentally ill and mentally retarded as defined in this section under the general supervision and ~~control of the Board~~ *management of the Commissioner* ;

(23) "Training center for the mentally retarded" means a regional facility for the treatment, training and rehabilitation of the mentally retarded in a specific geographical area.

§ 37.1-3. Appointment of members; terms and vacancies.– ~~The~~ *There shall be a State Mental Health and Mental Retardation* Board *which* shall consist of nine members to be appointed by the Governor, subject to confirmation by the General Assembly, if in session when such appointment is made, and if not in session, then at its next succeeding session. Appointments shall be made for terms of four years each, except appointments to fill vacancies which shall be for the unexpired terms. No person shall be eligible to serve more than two successive terms; provided that persons heretofore or hereafter appointed to fill vacancies may serve two additional successive terms.

§ 37.1-5. Chairman and secretary.–The Board shall select one of its members as chairman who shall receive no additional compensation as such. ~~It shall also appoint its secretary, who shall not be a member of the Board, and fix his compensation.~~ *The Board is authorized to employ a secretary to assist in the Board's administrative duties. The compensation of the secretary shall be fixed by the Board within the limits of appropriations made by the General Assembly, and such*

compensation shall be subject to the provisions of Chapter 10 (§ 2.1-110 et seq.) of Title 2.1 of the Code. The secretary shall perform the duties required of him by the Board.

§ 37.1-6. Office.–The *main office of the* Board shall ~~maintain an office~~ *be* in the city of Richmond ~~where all records of the Board shall be kept, except such as it finds neeessary to be kept at the respeetive State facilities under its supervision and management~~ .

§ 37.1-9. Compensation and expenses; provision for payment.–The members of the Board shall receive no salaries, but shall be paid their necessary traveling and other expenses incurred in attendance upon meetings, or while otherwise engaged in the discharge of their duties, and the sum of ~~twenty five~~ *fifty* dollars a day for each day or portion thereof in which they are engaged in the performance of their duties, ~~provided that such per diem shall not exeeed fifteen hundred dollars a year for each member~~

~~The compensation and expenses authorized to be paid to the members of the Board, the seeretary and the chief exeeutive officer of the Department shall be paid by the State Treasurer out of funds appropriated to the Board, and the several facilities under its supervision, on warrants of the Comptroller issued upon vouchers signed by it for such purpose~~.

§ 37.1-10. Powers and duties of Board.–The Board ; ~~in addition to other powers, functions and duties elsewhere conferred and imposed upon it,~~ shall have ~~full supervision, management and control of the system of facilities~~.

~~The Board is vested with all the rights, powers and privileges conferred upon eo.pc.ations under the laws of this State so far as they are applieable. The Board shall also have the power to take, hold, reeeive and enjoy any gift, grant, devise or bequest to the Department of Mental Health and Mental Retardation, or its predeeessors, or facilities operated by the Board, the same to be held for the uses and purposes designated by the donor, if any, or if not so designated, for the general purposes of the Board, whether given directly or indirectly; and to aeeept, exeeute and administer any trust in which it may have an interest under the terms of the instrument ereating the trust. The Board shall control and expend the funds appropriated to it by the State as may be provided by law~~ *the following powers and duties:*

1. To develop and establish programmatic and fiscal policies governing the operation of State hospitals and community services boards.

2. To ensure the development of long range programs and plans for mental health, mental retardation and substance abuse services provided by the State and by community services boards.

3. To review and comment on all budgets and requests for appropriations for the Department prior to their submission to the Secretary of Human Resources and the Governor and on all applications for federal funds.

4. To monitor the activities of the Department and its effectiveness in implementing the policies of the Board.

5. To advise the Governor, Secretary of Human Resources, Commissioner and the General Assembly on matters relating to mental health, mental retardation and substance abuse.

6. To make, adopt and promulgate such rules and regulations as may be necessary to carry out the provisions of this title and other laws of the Commonwealth administered by the Commissioner or the Department.

7. To ensure the development of programs to educate citizens and elicit public support for the activities of the Department and of community services boards.

§ 37.1-10.1. Internal evaluation committee of Board.–The Board shall appoint an internal evaluation committee to be composed of three members of the Board who shall review and evaluate the effects of designated policies of the Board and the performance of the Department and community services boards in carrying out those policies. The committee and any staff designated by the Commissioner shall have access to all records of the Department, State facilities and community services boards in carrying out these monitoring activities. The committee shall report

its findings to the Board which shall take such action thereon as it deems appropriate.

§ 37.1-11. Duties relative to new construction.–The ~~Board~~ *Commissioner* , subject to the approval of the *Board and the* Governor, shall select the site of any new State hospital and any land to be taken or purchased by the Commonwealth for the purposes of any new or existing State hospital. ~~It~~ *The Commissioner* shall have charge of the construction of any new building at any such State hospital, shall determine the design thereof, and for this purpose may employ architects and other experts or hold competitions for plans and designs. If any land or property is taken or purchased by the Board, title shall be taken in the name of the Commonwealth.

§ 37.1-12. Authority to tear down buildings.–If any building standing on property under the supervision and control of the ~~Board~~ *Commissioner* is in such a state of dilapidation or disrepair as to be, in the opinion of the ~~Board~~ *Commissioner* , dangerous to patients, employees of the ~~Board~~ *Department* or other persons frequenting such property, the ~~Board~~ *Commissioner* may, with the approval of the *Board and the* Governor, cause such building to be torn down or razed. For such purpose , the ~~Board~~ *Commissioner* may contract with any person on such terms as it deems expedient and may sell or otherwise dispose of the materials composing such building.

§ 37.1-13. Examination of properties; certain property not to be declared surplus.–The ~~Board~~ *Commissioner* is hereby authorized to examine the condition of properties under ~~its control~~ *his supervision* from time to time in the light of the practices and methods employed by ~~such Board~~ *the Department* in the care and treatment of persons admitted to any State facility in accordance with law. No property which is being used for the care and treatment of patients and which is required for such purpose or which is reasonably related to the present and reasonable future needs of the ~~Board~~ *Department* for care and treatment of patients shall be declared surplus.

§ 37.1-20.1. Employment of unlicensed physician by Department.–On and after January one, nineteen hundred seventy-seven, any physician who is unlicensed by this State shall not be employed by the Department for the practice of any of the healing arts or to provide services under the supervision of the ~~Board~~ *Commissioner* unless such physician is in an internship or residency program approved by the ~~Board~~ *Commissioner* .

§ 37.1-22. Receiving gifts and endowments.–The ~~Board~~ *Commissioner* may receive gifts, bequests and endowments to or for the respective State facilities in their names or to or for any patient in such facilities ~~, and~~ . When such gifts, bequests and endowments are accepted by the ~~Board, it~~ *Commissioner, he* shall well and faithfully administer such trusts.

§ 37.1-23. Establishing mental health clinics.–The Board ~~is authorized to establish and maintain~~ *may authorize the establishment of* mental health clinics for the purpose of advising, counseling, directing, and otherwise treating patients. ~~It may extend its~~ *The Board shall promulgate regulations governing such clinics which regulations may provide for the extension of* clinic services to such persons as may make application therefor and to other persons in need of psychiatric advice, counsel, and guidance.

§ 37.1-23.1. Establishing family planning clinics; who eligible to attend.–A. The Board shall ~~establish~~ *authorize the establishment of* family planning clinics in the State hospitals for the purpose of advising, counseling and educating patients about birth control. Each hospital shall conduct a minimum of one family planning session every three months.

B. The Department of Health shall secure and furnish the necessary medical personnel and educational and contraceptive materials subject to availability of funds and personnel.

C. All patients shall be eligible to attend the family planning clinics and to receive medical and educational services on a voluntary basis. Consent for the participation of patients not capable of giving legal consent shall be obtained as provided by law.

§ 37.1-24. Research into causes of mental illness, mental retardation, substance abuse and related subjects.–The ~~Board~~ *Commissioner* is hereby directed to ~~conduct at the several State facilities,~~ *promote* research into the causes of mental illness ~~and~~ , mental retardation *and substance abuse* throughout the Commonwealth. The ~~Board~~ *Commissioner* shall encourage the directors *at the several State facilities* and their staffs in the investigation of all subjects relating to mental diseases ~~and~~ , disabilities and mental health. In such research programs the ~~Board~~ *Commissioner* shall make use,

insofar as practicable, of the services and facilities of medical schools, and the hospitals allied with each such school.

§ 37.1-24.2. Separate facilities for geriatric patients; separate locations authorized.—(a) The ~~Board~~ *Commissioner* shall establish, within each State hospital which has resident geriatric patients, facilities for the care and treatment of geriatric patients. Such facilities shall be identified and designated as geriatric patient facilities and shall be separated in a reasonable manner from the remainder of the hospital.

(b) The Board may in its discretion, giving full consideration to needs and resources available, ~~establish~~ *authorize the establishment of* other geriatric facilities in locations apart from State hospitals.

§ 37.1-27. Commissioner to prescribe system of records, accounts and reports; access to records, etc.; annual reports.—The ~~Board~~ *Commissioner* shall prescribe and cause to be established and maintained at all of the State facilities

(a) A uniform, proper, and approved system of keeping the records and the accounts of money received and disbursed and of making reports thereof.

(b) An efficient system of keeping records concerning the patients admitted to or residing in each facility.

The ~~Board~~ *Commissioner* or ~~its~~ *his* duly authorized agent shall at all times have access to ~~the~~ *such* records, accounts and reports required to be kept under the provisions of this title. The ~~Board~~ *Commissioner* shall report at least annually on such statistical information as may be requested by the Governor or the General Assembly.

§ 37.1-28. Commissioner authorized to receive and expend social security, etc., payments for patients in State hospitals.—The ~~Board~~ *Commissioner* , under such regulations as the Administrator of the Federal Security Agency, the Civil Service Commission or the Railroad Retirement Board, respectively, may prescribe and with the approval of the Governor, may be appointed or function as the agency to which payments under the provisions of the federal Social Security Act as amended, any act providing retirement benefits for employees of the federal government or any of its agencies, or the Railroad Retirement Act, may be made on behalf of any beneficiary patients under its control. Such payments shall be expended for the use and benefit of such patient, to whom they would otherwise be payable, and the residue, if any, resulting from such payments shall be set aside in a special fund to the credit of the patient on whose account such payment is made. The charges provided for by law for the care of the patient shall be defrayed from such payment. The provisions of § 37.1-31 shall apply to any payments received under this section.

§ 37.1-29. Private funds provided for patients.—The ~~Board~~ *Commissioner* is hereby authorized and empowered, in ~~its~~ *his* discretion, to provide for the deposit with the director or other proper officer of any State facility, of any money given or provided for the purpose of supplying extra comforts, conveniences or services to any patient therein and any money otherwise received and held from, for or on behalf of any such patient.

§ 37.1-30. How such funds disbursed.—All funds so provided or received shall be deposited to the credit of such State facility in a special fund in a bank or banks designated by the ~~Board~~ *Commissioner* , and shall be disbursed as may be required by the respective donors, or, in the absence of such requirement, as directed by the director.

§ 37.1-31. Annual statements relative to funds; investments by Board.—The director of each State facility shall furnish the ~~Board~~ *Commissioner* annually a statement showing the amount so received and deposited, the amount expended, and the amount remaining in such special funds at the end of such year, and the Board shall have authority to invest so much as it may deem proper of the amount so remaining, in United States government bonds, or other securities authorized by law for the investment of fiduciary funds. The interest from such investments may in the discretion of the Board be expended as a part of a welfare fund of such State facility.

§ 37.1-32. Disposition of unexpended balances of funds belonging to former patients.—If any patient for whose benefit any such fund has heretofore or shall hereafter be provided, has departed

or shall hereafter depart from any such State facility, leaving any unexpended balance in such fund, and the director in the exercise of reasonable diligence, has been or shall be unable to find the person or persons entitled to such unexpended balance, the ~~Board~~ *Commissioner* may, in ~~its~~ *his* discretion and after the lapse of three years from the date of such departure, authorize the use of such balance for the benefit of all or any part of the patients then in such facility.

§ 37.1-34. Board may change names of facilities.–The Board shall have authority to change the names of hospitals and other facilities ~~under the control of the Board~~ *operated by the Department* .

§ 37.1-34.1. State facilities to be established.–(1) The Board is authorized to establish, *and the Commissioner shall thereafter* construct, equip and operate State facilities ~~within, or within a distance of twenty-five miles of, the territorial limits of the cities of Charlottesville, Danville, Fairfax, Norfolk, Richmond and Roanoke, which facilities shall be~~ for the custody, care and treatment of mentally ill persons.

(2) No such facility shall, however, be established unless the land on which the same is to be located can be acquired without cost to the Commonwealth and unless the site for such facility is approved by the Board *and the Governor* and necessary funds have been provided *by the General Assembly* .

§ 37.1-39. Creation and supervision of Department.–The Department of Mental Health and Mental Retardation is *hereby* established ~~under the supervision, management and control of the Board~~ *in the executive department responsible to the Governor. The Department shall be under the supervision and management of the Commissioner of Mental Health and Mental Retardation. The Commissioner shall carry out his management and supervisory responsibilities in accordance with the policies, rules and regulations of the Board* .

§ 37.1-42. Qualifications of Commissioner.– ~~No person shall be appointed~~ *The* Commissioner ~~unless he~~ *shall* be a person of proven executive *and administrative* ability ~~and a doctor of medicine,~~ and ~~unless he~~ shall have had ~~special~~ *appropriate* education and substantial experience in the ~~treatment~~ *fields* of mental illness and mental retardation.

§ 37.1-42.1. Duties of Commissioner.–The Commissioner shall be the chief executive officer of the Department and shall ~~perform such~~ *have the following* duties and ~~exercise such~~ powers ~~as may be imposed or conferred upon him by the Board and by law.~~ *:*

1. To supervise and manage the Department and its system of facilities.

2. To employ such personnel as may be required to carry out the purposes of this title.

3. To make and enter into all contracts and agreements necessary or incidental to the performance of the Department's duties and the execution of its powers under this title, including, but not limited to, contracts with the United States, other states, agencies and governmental subdivisions of this Commonwealth, consistent with policies, rules and regulations of the Board.

4. To accept, hold and enjoy gifts, donations and bequests from the United States government and agencies, and instrumentalities thereof and any other source. To these ends, the Commissioner shall have the power to comply with such conditions and execute such agreements as may be necessary, convenient or desirable, consistent with policies, rules and regulations of the Board.

5. To accept, execute and administer any trust in which the Department may have an interest, under the terms of the instruments creating the trust.

Unless specifically authorized by the Board to accept or undertake activities for compensation, the Commissioner shall devote his entire time to his duties.

§ 37.1-42.2. Employment and qualifications of directors of State facilities.–The Commissioner shall ~~appoint quadrennially, for terms to commence at the expiration of the terms of the present incumbents~~ *employ , subject to the provisions of Chapter 10 of Title 2.1 of the Code (§ 2.1-110 et seq.),* a director for each State facility who shall be skilled in hospital management and administration and meet such requirements as may be determined by the Commissioner, but need not be a physician.

Any director of a State facility employed pursuant to an individual contract prior to July one, nineteen hundred eighty shall be entitled to serve under the terms and conditions of that contract until its expiration. Thereafter, such director may, in the discretion of the Commissioner, be reemployed. Any such reemployment shall, however, be subject to the provisions of Chapter 10 of Title 2.1 of the Code (§ 2.1-110 et seq.).

Whenever any act required by law to be performed by a director ~~appointed~~ *employed* hereunder constitutes the practice of medicine as defined in § 54-273 of the Code and such director is not a licensed physician, such act shall be performed by a licensed physician designated by the director.

§ 37.1-58. Establishment and location.—The Board ~~is authorized and directed to establish, construct and equip,~~ *may authorize,* when funds are available, *the establishment of* treatment centers to provide for study, treatment and care, and for research into methods of treatment ~~,~~ of emotionally disturbed and mentally ill children.

§ 37.1-61. Admissions and transfers.—(a) Only mentally ill or emotionally disturbed children under sixteen years of age shall be admitted or transferred to a treatment center.

(b) Voluntary admissions may be made, in the discretion of the director, upon signed application.

(c) Transfers to the centers may be made as provided in § 37.1-48 with respect to transfers between other facilities ~~under the control of the Board~~ *operated by the Department* . Upon application made by any State department, institution or agency having custody of any child who is mentally ill or emotionally disturbed, such child may, with the approval of the Commissioner and subject to §§ 37.1-67.1 through 37.1-67.4, be admitted for study, care and treatment at the center.

§ 37.1-64. Admission procedures; forms.—(a) Any person alleged to be mentally ill to a degree which warrants hospitalization in a hospital as defined in § 37.1-1 of this title may be admitted to and retained as a patient in a hospital by compliance with any one of the following admission procedures:

(1) Voluntary admission by the procedure described in § 37.1-65;

(2) Involuntary admission by the procedure described in §§ 37.1-67.1 through 37.1-67.4.

(b) The Board shall prescribe and *the Department shall* prepare the forms required in procedures for admission as approved by the Attorney General. These forms, which shall be the legal forms used in such admissions, shall be distributed by the ~~Board~~ *Department* to the clerks of the general district courts and juvenile and domestic relations district courts of the various counties and cities of the State and to the directors of the respective State hospitals.

(c) Any person alleged to be mentally ill to a degree which warrants emergency hospitalization may be admitted to and retained as a patient in the State hospital closest to his domicile by compliance with the admission procedures provided in § 37.1-65 or §§ 37.1-67.1 through 37.1-67.4 of the Code.

§ 37.1-65. Voluntary admission.—Any *State* hospital may admit as a patient any person requesting admission who, *having been screened by the community services board or the community mental health clinic which serves the political subdivision of which the person is a resident and* having been examined by a physician on the staff of such hospital, is deemed to be in need of hospitalization *by the board or clinic and the physician* for mental illness ~~or~~ , mental retardation *or substance abuse* .

§ 37.1-65.1. Judicial certification of eligibility for admission of mentally retarded persons.—A. Whenever a person alleged to be mentally retarded is not capable of requesting his or her admission to a facility for the training and treatment of the mentally retarded as a voluntary patient pursuant to § 37.1-65 of the Code, a parent or guardian of such person or other responsible person may initiate a proceeding to certify such person's eligibility for admission as hereinafter set forth.

B. Prior to initiating any such proceeding, the parent or guardian or other responsible person seeking the person's admission shall first obtain *(i) a prescreening report from the community*

services board or community mental health clinic which serves the political subdivision of which the person who is alleged to be mentally retarded is a resident which report recommends admission to a facility for the mentally retarded and (ii) the approval of the facility to which it is proposed that the person be admitted. The ~~Department~~ *Board* shall promulgate rules and regulations establishing the procedure and standards for the issuance of such approval, which rules and regulations may include provision for the observation and evaluation of the person in a facility for a period not to exceed forty-eight hours. No person alleged to be mentally retarded who is the subject of a proceeding under this section shall be detained on that account pending the hearing except for observation and evaluation pursuant to the provisions of this subsection.

C. Upon the filing of a petition in any city or county alleging that any such person is mentally retarded, in need of institutional training or treatment and has been approved for admission pursuant to subsection B of this section, a proceeding to certify such person's eligibility for admission to the facility may be commenced. Such petition shall be filed with any judge as defined in § 37.1-1. A copy of the petition shall be personally served on the person named in the petition, his attorney, and his guardian or committee. Prior to any hearing under this section, the judge shall appoint an attorney-at-law to represent the individual. However, such person shall not be precluded from employing counsel of his choosing and at his expense.

C1. The person who is the subject of the hearing shall be allowed sufficient opportunity to prepare his defense, obtain independent evaluations and expert opinion at his own expense, and summons other witnesses. He shall be present at any hearing held under this section unless his attorney waives his right to be present and the judge is satisfied by a clear showing and after personal observation that such person's attendance would subject him to substantial risk of physical or emotional injury or would be so disruptive as to prevent the hearing from taking place.

C2. Notwithstanding the above, the judge shall summons one physician or clinical psychologist who is licensed in Virginia and who is skilled in the diagnosis of mental retardation. Such physician or clinical psychologist may be one who examined the individual pursuant to subsection B of this section. The judge shall also summons other witnesses when so requested by the person or his attorney. The physician or clinical psychologist shall certify that he has personally examined the individual and has probable cause to believe that he is or is not mentally retarded, is or is not capable of requesting his own admission, and is or is not in need of institutional training and treatment. The judge, in his discretion, may accept written certification of a finding of a physician or clinical psychologist provided such examination has been personally made within the preceding thirty days and there is no objection to the acceptance of such written certification by the person or his attorney.

C3. If the judge having observed the person and having obtained the necessary positive certification and other relevant evidence, specifically finds (i) that such person is not capable of requesting his own admission, (ii) that the facility has approved the proposed admission pursuant to subsection B of this section, (iii) that there is no less restrictive alternative to institutional confinement, consistent with the best interests of the person who is the subject of the proceeding, and (iv) that such person is mentally retarded and in need of institutional training or treatment, the judge shall by written order certify that the person is eligible for admission to a facility for the training and treatment of the mentally retarded.

D. Certification of eligibility for admission hereunder shall not be construed as a judicial commitment of such person but shall empower the parent or guardian or other responsible person to admit such person to a facility for the training and treatment of the mentally retarded and shall empower the facility to accept the person as a patient.

§ 37.1-67.1. Involuntary detention; issuance and execution of order.—Any judge as defined in § 37.1-1, may, upon the sworn petition of any responsible person or upon his own motion based upon probable cause, issue an order requiring any person within his jurisdiction alleged or reliably reported to be mentally ill and in need of hospitalization to be brought before him and, if such person cannot be conveniently brought before him, may issue an order of temporary detention. The officer executing the order of temporary detention shall place such person in some convenient and willing institution or other willing place ~~approved by the Board~~ for a period not to exceed forty-eight hours prior to *a* hearing . ~~and~~ *The institution or other place shall be approved pursuant to regulations of the Board. Such person shall* not *be detained* in a jail or other place of confinement for persons charged with criminal offenses, unless such confinement is specifically

authorized by such judge pursuant to regulations duly adopted by the Board, which regulations shall specify in which counties and cities such temporary detention in a jail or other place of confinement for persons charged with criminal offenses is authorized ; ~~provided, however,~~ . If the forty-eight hour period herein specified terminates on a Saturday, Sunday or a legal holiday, such person may be detained, as herein provided, until the next day which is not a Saturday, Sunday or legal holiday, but in no event may he be detained for a period longer than seventy-two hours. On such petition and prior to a hearing as authorized in § 37.1-67.2 or 37.1-67.3, the judge may release such person on his personal recognizance or bond set by the judge if it appears from all evidence readily available that such release will not pose an imminent danger to himself or others.

§ 37.1-67.2. Same; opportunity for voluntary admission.–The judge, when a person is produced pursuant to § 37.1-67.1, shall inform him of his right to make application for voluntary admission and treatment as provided for in § 37.1-65 and shall afford such person an opportunity for voluntary admission. The judge shall hold a preliminary hearing to ascertain if such person is then willing and capable of seeking voluntary admission and treatment. If the person is capable and willingly accepts voluntary admission and treatment, the judge shall require the person to accept voluntary admission for a minimum period of treatment and after such minimum period not to exceed seventy-two hours to give the hospital forty-eight hours' notice prior to leaving the hospital, unless sooner discharged pursuant to § 37.1-98 or § 37.1-99. Such person shall be subject to the transportation provisions as provided in § 37.1-71 *and the requirement for prescreening by a community services board or community mental health clinic as provided in § 37.1-65* .

§ 37.1-67.3. Same; involuntary admission and treatment.–If a person is incapable of accepting or unwilling to accept voluntary admission and treatment, the judge shall inform such person of his right to a commitment hearing and right to counsel. The judge shall ascertain if a person whose admission is sought is represented by counsel, and if he is not represented by counsel, the judge shall appoint an attorney-at-law to represent him. However, if such person requests an opportunity to employ counsel, the court shall give him a reasonable opportunity to employ counsel at his own expense. The commitment hearing shall be held within forty-eight hours of the execution of the detention order as provided for in § 37.1-67.1; provided, however, if the forty-eight hour period herein specified terminates on a Saturday, Sunday or a legal holiday, such person may be detained, as herein provided, until the next day which is not a Saturday, Sunday or legal holiday, but in no event may he be detained for a period longer than seventy-two hours. Prior to such hearing, the judge shall fully inform such person of the basis for his detention, the standard upon which he may be detained, the right of appeal from such hearing to the circuit court, the right to jury trial on appeal, and the place, date, and time of such hearing.

If such person is incapable of accepting or unwilling to accept voluntary admission and treatment as provided for in § 37.1-67.2, a commitment hearing shall be scheduled as soon as possible, allowing the person who is the subject of the hearing an opportunity to prepare any defenses which he may have, obtain independent evaluation and expert opinion at his own expense, and summons other witnesses. Notwithstanding the above, the judge shall summons one physician who is licensed in Virginia and who is skilled in the diagnosis of mental illness. The judge shall also summons other witnesses when so requested by the person or his attorney. The physician shall certify that he has personally examined the individual and has probable cause to believe that he is or is not mentally ill, that such person does or does not present an imminent danger to himself or others, and requires or does not require involuntary hospitalization. The judge, in his discretion, may accept written certification of a finding of a physician, provided such examination has been personally made within the preceding five days; and provided further, there is no objection to the acceptance of such written certification by the person or his attorney. *Prior to any adjudication that a person is mentally ill and shall be confined to an institution pursuant to this section, the judge may obtain from the community services board or community mental health clinic which serves the political subdivision where the person resides a prescreening report which states whether the person is deemed to be in need of institutional confinement, whether there is no less restrictive alternative to institutional confinement and what the recommendations are for that person's care and treatment.* If such judge having observed the person so produced and having obtained necessary, positive certification and other relevant evidence, shall specifically find that such person (a) presents an imminent danger to himself or others as a result of mental illness, or (b) has otherwise been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (c) that there is no less restrictive alternative to institutional confinement and treatment and that the alternatives to involuntary hospitalization were investigated and were deemed not suitable, he shall by written order and specific findings so certify and order such person

removed to a hospital or other facility designated by the Commissioner for a period of hospitalization and treatment not to exceed one hundred eighty days from the date of the court order. Such person shall be released at the expiration of one hundred eighty days unless involuntarily committed by further petition and order of a court as provided herein or such person makes application for treatment on a voluntary basis as provided for in § 37.1-65.

With respect to such person who does meet the criteria for involuntary treatment as specified in (a) or (b) above, but who is not in need of involuntary hospitalization and treatment as provided for in (c) hereof, he shall be subject to court-ordered out-patient treatment, day treatment in a hospital, night treatment in a hospital, referral to a community mental health clinic, or other such appropriate treatment modalities as may be necessary to meet the needs of the individual.

Within ten days of the date of the court order involuntarily committing a person to a hospital or other facility as provided for in this section, the court shall notify the community services board or the community mental health clinic which serves the area of which the committed person is a resident of the person's name and local address and of the location of the facility in which the person has been hospitalized.

§ 37.1-70. Examination of persons presented for admission.—Any person presented for admission to a hospital shall forthwith, and not later than twenty-four hours after arrival, be examined by one or more of the physicians on the staff thereof. If such examination reveals that there is sufficient cause to believe that such person is mentally ill, he shall be retained at the hospital; but if the examination reveals insufficient cause, the person shall be returned to the locality in which the petition was initiated.

The Board ~~is authorized to develop and~~ *shall promulgate rules and regulations to* institute pre-admission screening to prevent inappropriate admissions to the facilities and programs ~~under its control~~ *operated by the Department* .

§ 37.1-71. Transportation of person certified for admission to hospital.—When a person has applied or has been certified for admission to a hospital under § 37.1-65 or §§ 37.1-67.1 through 37.1-67.4, such person may be delivered to the care of the sheriff of the county or city who shall forthwith on the same day deliver such person to the proper hospital or the patient may be sent for by the director. When this is impossible such person shall be kept and cared for by the sheriff in some convenient institution approved ~~by~~ *pursuant to regulations promulgated by* the Board, until such person is conveyed to the proper hospital. The cost of care and transportation of any person so applying or certified for admission pursuant to § 37.1-65 or §§ 37.1-67.1 through 37.1-67.4 shall be paid from the State treasury from the same funds as for care in jail. The cost of care and transportation of a person certified for admission to a private hospital shall be paid by the petitioner.

If any hospital has become too crowded to accommodate any such person certified for admission therein, the Commissioner shall give notice of the fact to all sheriffs, and shall designate the hospital to which they shall transport such persons.

§ 37.1-78. Attendants to conduct persons admitted voluntarily to hospitals.—When application is made to the director of a hospital for admission pursuant to § 37.1-65, he may send an attendant from the hospital to conduct such person to the hospital. If for any reason it is impracticable to employ an attendant for this purpose, then the director may appoint some suitable person for the purpose, or may request the sheriff of the county or city in which the person resides to convey him to the hospital. The sheriff or other person appointed for the purpose shall receive only his necessary expenses for conveying any person admitted to the hospital. Expenses authorized herein shall be paid by the ~~Board~~ *Department* .

§ 37.1-95. Receiving and maintaining federal prisoners in State hospitals.—The ~~Board~~ *Commissioner* shall be authorized to enter into a contract with the United States, through the Director of the United States Bureau of Prisons or other authorized agent of the United States, for the reception, maintenance, care and observation in the State hospitals, or in such of them as may be designated by the ~~Board~~ *Commissioner* for the purpose, of any persons charged with crime in the courts of the United States sitting in Virginia and committed by such courts to such State hospitals for such purposes. All persons so admitted shall remain subject to the jurisdiction of the court by whom they were committed, and may be returned to such court at any time for hearing or

trial.

Any such contract shall require that the United States remit to the State Treasurer for each prisoner so admitted specified per diem or other payments, or both, such payments to be fixed by such contract.

It shall be the duty of the director of any State hospital to which a prisoner of the United States is so admitted to observe the patient, and, as soon as may be, report in writing to the court by which he is certified or committed as to his mental condition or such other matters as the court may direct.

No contract made pursuant to this section shall obligate the Commonwealth or the ~~Board~~ *Commissioner* to receive a federal prisoner into any State hospital in which all available accommodations are needed for patients otherwise admitted, or in any other case where, in the opinion of the director the admission of such prisoner would interfere with the care and treatment of other patients or the proper administration of the State hospital.

§ 37.1-97. Children born in State hospitals.—Any child born in a State facility shall be deemed a resident of the county, city or town in which the mother had legal residence at the time of admission. Such child shall be removed from such facility as soon after birth as the health and well-being of the child permit, and delivered to its father, or other member of its family. If unable to effect the child's removal as aforesaid, the director shall cause the filing of a petition in the juvenile and domestic relations district court of the county or city wherein the child is present, requesting adjudication of the care and custody of the child, under the provisions of § ~~16.1-178~~ *16.1-279* of this Code. If the mother has been a patient continuously for ten months the Department of Welfare shall have financial responsibility for the care of the child, and the custody of such child shall be determined in accordance with the provisions of § ~~16.1-178~~ *16.1-279* of the Code. The judge of such court shall take appropriate action to effect prompt removal of the child from the State facility.

§ 37.1-98. Discharge, conditional release, and convalescent status of patients.— *A.* The director of a State hospital may discharge any patient *after the preparation of a predischarge plan formulated in cooperation with the community services board or community mental health clinic which serves the political subdivision where the patient resided prior to hospitalization or with the board or clinic located within the political subdivision the patient so chooses to reside in immediately following the discharge* , except one held upon an order of a court or judge for a criminal proceeding, as follows:

~~a.~~ *1.* Any patient who, in his judgment, is recovered.

~~b.~~ *2.* Any patient who, in his opinion, is not mentally ill.

~~c.~~ *3.* Any patient who is impaired or not recovered and whose discharge, in the judgment of the director, will not be detrimental to the public welfare, or injurious to the patient.

4. Any patient who is not a proper case for treatment within the purview of this chapter.

The predischarge plan required by this paragraph shall, at a minimum, specify the services to be provided the released patient in the community to support his housing and nutritional needs and to link him with supportive local human service agencies. When a patient or his guardian or committee refuses to consent to the release of the required information to the community services board or the community mental health clinic for the cooperative development of a predischarge plan, the director of the State hospital shall direct hospital personnel to prepare such a plan as is appropriate.

~~d.~~ *B.* The director may grant convalescent status to a patient in accordance with ~~rules~~ *standards* prescribed by the ~~Commissioner~~ *Board* . The State hospital granting a convalescent status to a patient shall not be liable for his expenses during such period. Such liability shall devolve upon the relative, committee, person to whose care the patient is entrusted while on convalescent status, or the appropriate local public welfare agency of the county or city of which the patient was a resident at the time of admission. Provided, however, that the provision of social services to the patient shall be the responsibility of the appropriate local public welfare agency as determined by

policy approved by the State Board of Welfare.

~~c. Because he is not a proper case for treatment within the purview of this chapter, such patient~~ *C. Any patient who is discharged pursuant to paragraph A. 4. hereof* shall, if necessary for his welfare, be received and cared for by the appropriate local public welfare agency. The provision of social services to the patient shall be the responsibility of the appropriate local public welfare agency as determined by policy approved by the State Board of Welfare. Expenses incurred by the provision of public assistance to the patient, who is receiving twenty-four hour care while in a home for adults licensed pursuant to chapter 9 (§63.1-172 et seq.) of Title 63.1, shall be the responsibility of the appropriate local public welfare agency of the county or city of which the patient was a resident at the time of admission.

§ 37.1-98.1. Certain information to be furnished to community services boards.–The director of a State hospital or training school shall furnish to the community ~~mental health and mental retardation~~ services board ~~, upon its request,~~ a list of those persons and their home addresses within the locality or localities served by such board ~~who have been discharged~~ *for whom predischarge plans are required* from their hospital or training school *pursuant to § 37.1-98* , provided such person or their guardian or committee has authorized the release of such information.

§ 37.1-99. Discharge of involuntarily committed patients from a private hospital.–The person in charge of a private hospital may discharge any patient involuntarily committed who is recovered, or, if not recovered, whose discharge will not be detrimental to the public welfare, or injurious to the patient, or meets such other criteria as specified in § 37.1-98. The person in charge of such institution may refuse to discharge any patient involuntarily committed, if, in his judgment, such discharge will be detrimental to the public welfare or injurious to the patient, and if the guardian, committee or relatives of such patient refuse to provide properly for his care and treatment, the person in charge of such institution may apply to the Commissioner for the transfer of the patient to a State hospital.

The person in charge of a private hospital may grant a convalescent status to a patient in accordance with ~~rules prescribed~~ *standards established* by the ~~Commissioner~~ *Board* .

§ 37.1-121. Board with private families; costs and expenses.–The director of each State hospital may, subject to the approval of the Commissioner, place at board in a suitable family in this State approved *pursuant to standards established* by the Board ~~and under such rules and regulations as to it appear proper~~ , any patient in the hospital or who has been admitted thereto but not in residence, or who has been temporarily released therefrom, who is quiet and not dangerous. The cost of the board and lodging of such patients shall not exceed an amount determined by regulation adopted by the Board. Any patient so placed at board or the estate of any such patient or the person legally liable for the support of any such patient shall be liable for the cost of the board and lodging of such patient; provided, however, that the ~~Board~~ *Commissioner* shall ascertain the financial condition and estate of such patient, his present and future needs and the present and future needs of his lawful dependents and, whenever deemed necessary to protect him or his dependents, may agree to accept a sum for his board and lodging less than the cost to the State of his board and lodging, in which case the remainder of the cost of such board and lodging shall be at the expense of the Commonwealth and paid from funds appropriated for such purpose. Bills for board and lodging of any such patient shall be payable monthly by such patient or the person legally liable for his support. Payment thereof shall be made to the Department of Mental Health and Mental Retardation which shall forthwith pay all funds so collected in the general fund of the State treasury. The provisions of article 8 (§ 37.1-105 et seq.) of chapter 2 of this title shall apply, mutatis mutandis, to collections authorized by this section.

§ 37.1-122. Homes with provision for special training; costs.–The director of each State hospital may place at board under his direction and supervision in private homes or other facilities, with provisions for special training, such patients as he believes may be benefited from a period of training. The number of patients as well as the homes in which they are placed, shall be approved *pursuant to standards established* by the Board, and the cost to the Commonwealth for such patients shall not be limited by the amount specified in the preceding section (§ 37.1-121), but shall be upon terms prescribed by the Board.

§ 37.1-124. Visiting and investigation of condition of persons in homes and other institutions.–The ~~Board~~ *Commissioner* shall designate some competent person to visit patients who are boarded in

homes or other institutions as provided in the preceding sections, who shall visit these patients at intervals of not less than three months, to ascertain the manner in which they are being cared for, and shall make a written report to the director of the conditions found to exist. In any instance in which it is found that a patient is neglected, improperly cared for, or abused, he shall be removed.

§ 37.1-128.01. Definition of "legally incompetent".–"Legally incompetent" means a person who has been adjudicated incompetent by a circuit court because of a mental ~~or physical~~ condition which renders him incapable of taking ~~proper~~ care of his person or ~~properly~~ handling and managing his estate and such adjudication of legal incompetency shall include mental incompetency for the purposes of Title 24.1, unless the court specifies otherwise.

§ 37.1-128.02. Proceedings in circuit courts to determine legal competency.– ~~Any judge of a~~ *A. On petition of any person to the* circuit court ~~, when any person in his~~ *of a* county or city ~~is alleged to be legally incompetent~~ *in which resides or is located any person who* because of mental illness or mental retardation ~~upon the written complaint and information of any responsible person, shall issue his warrant, ordering such person to be brought before him. The court may issue the warrant on its own motion.~~

~~If a person is in a hospital or private institution under legal admission and he is found by the director or chief medical officer thereof after observation and examination to be mentally ill or mentally retarded to such a degree that the director or chief medical officer believes him to be legally incompetent, the circuit court of the county or the city of his residence, after reasonable notice to such person, shall, on the sworn certificate of the director or chief medical officer that such person is believed to be legally incompetent due to either mental illness or mental retardation, or upon such other evidence as the court may deem proper and require, determine if the person is legally incompetent because of mental illness or mental retardation.~~ *is incapable of taking care of his person or handling and managing his estate, the court, after reasonable notice to such alleged incompetent person of the hearing and of his right to be present, shall hold a hearing to determine if a committee should be appointed. Prior to the hearing, the court may order the community services board or the community mental health clinic for the county or city in which the alleged incompetent person resides or, if applicable, the State facility in which the alleged incompetent person is located, to prepare a comprehensive evaluation of the current condition of the alleged incompetent. Such evaluation may be based upon medical, psychiatric, psychological and social information taken for the purposes of this evaluation. Information compiled within the previous eighteen months, which assesses the alleged incompetent's physical, intellectual and functional abilities may also be considered. The local department of public welfare or social services for the county or city in which the alleged incompetent resides may be ordered to assist in preparing that portion of the comprehensive evaluation in which it has knowledge concerning the alleged incompetent. The reasonable costs of the evaluation may be taxed as part of the costs of the proceedings in the discretion of the court. In the absence of such a comprehensive evaluation, the court shall consider such other evidence as it may deem proper as to the abilities of the alleged incompetent person.*

If, after considering such other evidence as is presented in the hearing, the court ~~,~~ or jury *,* if one be requested, ~~shall determine if~~ *determines on the basis of clear and convincing evidence that* the person is ~~legally~~ incompetent ~~because of mental illness or mental retardation. For this purpose the court shall and the person may summon witnesses to testify under oath as to the condition of such person.~~

~~If the court finds the person to be legally incompetent because of mental illness it shall so adjudicate. If the court finds the person to be legally incompetent because of mental retardation it shall so adjudicate.~~ *, the court shall appoint a committee for him. The court shall specify whether the person is incompetent because of mental illness or mental retardation.*

No finding of incompetency shall be made unless the court finds that the person's inability to care for himself or handle and manage his affairs is total and that a finding of incapacity pursuant to § 37.1-128.1 or § 37.1-132 would not be appropriate.

B. The committee shall give such bond either secured or unsecured as may be required by the court and shall comply with all applicable provisions of Title 26 of the Code.

On the hearing of every petition for appointment of a committee, the alleged incompetent

person shall be represented by an attorney, either privately retained or appointed by the court. The court-appointed attorney shall be paid such fee as is fixed by the court to be taxed as part of the costs of proceeding. The court in which the petition is filed may, in its discretion, waive all fees and court costs in connection with such proceedings. The alleged incompetent person shall be present at the hearing if the person so requests or if his presence is requested by the attorney representing the person.

C. The person shall have the right to appeal to the Supreme Court if he be adjudicated ~~legally~~ incompetent because of mental illness or mental retardation. *In the discretion of the court, a petition for or the pendency of an appeal may suspend the judgment of the court, and the court may require that bond, either secured or unsecured, be given to protect the estate of the adjudicated incompetent person.*

§ 37.1-128.04. Definition of "legally incapacitated".—"Legally incapacitated" when used in reference to a person means that the person has been adjudicated incapacitated by a circuit court because of a mental or physical condition which renders him incapable of doing some but not all of the tasks necessary to care for himself or his estate. Such adjudication of incapacity shall not include mental incompetency for the purposes of Title 24.1, unless the court specifies otherwise.

§ 37.1-128.1. Appointment of guardian for person determined incapacitated because of mental illness or mental retardation.—A. On petition of any person to the circuit court of a county or city, in which *resides or is located* any person who by reason of mental illness or mental retardation ~~has become incapable, either wholly or partially, of taking proper care of his person or properly handling and managing~~ *lacks the capacity to do some but not all of the tasks necessary to care for himself or* his estate, ~~resides,~~ the court, after reasonable notice to such mentally ill or mentally retarded incapacitated person ~~and after~~ *of the hearing and of his right to be present, shall hold a* hearing ~~on the petition, if convinced that such person is incapacitated, either wholly or partially, to the extent above-mentioned, may~~ *to determine whether a guardian should be appointed. Prior to the hearing, the court may order the community services board or the community mental health clinic for the county or city in which the alleged incapacitated person resides, or, if applicable, the State facility in which the alleged incapacitated person is located, to prepare a comprehensive evaluation of the current condition of the person. Such evaluation may be based on medical, psychiatric, psychological and social information taken for the purposes of this evaluation. Information compiled within the previous eighteen months, which assesses the person's physical, intellectual and functional abilities may also be considered. The local department of public welfare or social services for the county or city in which the alleged incapacitated individual resides may be ordered to assist in preparing that portion of the comprehensive evaluation in which it has knowledge concerning the alleged incapacitated person. The reasonable costs of the evaluation may be taxed as part of the costs of the proceedings in the discretion of the court. In the absence of such a comprehensive evaluation, the court shall consider such other evidence as it may deem proper as to the abilities of the alleged incapacitated person.*

If, after considering such evidence as is presented in the hearing, the court or jury, if one be requested, determines on the basis of clear and convincing evidence that the person is incapacitated, the court shall appoint ~~some~~ *a* suitable person to be the guardian of his person or property, or both ~~, but only to the extent such incapacity is determined to exist and such shall be so specified by order of the court. Such~~ . *In selecting a guardian, the court shall give due regard to the preferences of the incapacitated person. Clear and convincing evidence shall be presented in the hearing to support each provision in the court's order of appointment, which order shall: (1) state the nature and extent of the person's incapacity; (ii) define the powers and duties of the guardian so as to permit the incapacitated person to care for himself and manage his property to the extent that he is capable; (iii) specify whether the* determination of incapacity ~~, either wholly or partially, may be~~ *is* perpetual or limited to a specific length of time as ~~determined appropriate by~~ the court ~~. If the court finds that such incapacity is partial, the order appointing a guardian shall designate same as a limited guardianship, but if the court finds that such incapacity is total as a plenary guardianship~~ *in its discretion may determine; and (iv) specify the legal disabilities, if any, of the person in connection with the finding of incapacity .*

B. The guardian shall have the same powers, duties, and liabilities which pertain to committees and trustees appointed under § ~~37.1-128.03~~ *37.1-128.02* or *§* 37.1-134, but such powers, duties, and liabilities shall be limited to matters within the areas where incapacity ~~has been~~ *is* determined ~~, and such~~ . *The* guardian shall give such bond ~~as is~~ *, either secured or unsecured, as may be* required

by the court *and shall comply with all applicable provisions of Title 26 of the Code .*

On the hearing of every ~~such~~ petition ~~, a guardian ad litem shall be appointed to represent the interest of the person for whom a guardian is requested, and he~~ *for guardianship, the alleged incapacitated person shall be entitled to be represented by an attorney, either privately retained or appointed by the court. The court-appointed attorney* shall be paid such fee as is fixed by the court to be taxed as part of the costs of the proceeding. The court in which the petition is filed may, at its discretion, waive all fees and court costs in connection with such ~~court proceeding~~ *proceedings . The alleged incapacitated person shall be present at the hearing if so requested by the person or by the attorney representing the person.*

If no person shall be appointed guardian within seven days from the determination of legal incapacity, either wholly or partially, the court on motion of any interested party, may appoint a guardian, or it shall appoint the sheriff pursuant to § 37.1-130.

C. A court determination of incapacity, either wholly or partially, pursuant to the provisions of this section shall not constitute an adjudication of legal incompetency as provided for in § 37.1-128.02 ~~, 37.1-128.03~~ or § 37.1-134. ~~If any person is determined to be incapacitated, either wholly or partially, as provided for herein, the clerk shall immediately notify the Commissioner and shall forward the Commissioner a copy of the findings of the court and the order.~~

D. The person shall have the right to appeal to the Supreme Court if he be determined to be incapacitated, either wholly or partially. *In the discretion of the court, a petition for or the pendency of an appeal may suspend the judgment of the court, and the court may require that bond, either secured or unsecured, be given to protect the estate of the person determined to be incapacitated.*

§ 37.1-128.2. Standby guardianship for mentally ill or mentally retarded persons.—On petition of one or both parents, natural or adoptive, or of the legal guardian to the circuit court in which such parent, parents or legal guardian reside, the court may appoint a standby guardian of the person or property, or both, of the mentally ill or mentally retarded child of the petitioners. The appointment of the standby guardian shall be affirmed biennially by the parent, parents or legal guardian of the child and by the standby guardian prior to his assuming his position as guardian by filing with the court an affidavit which states that the appointee remains available and capable to fulfill his duties.

Such standby guardian shall without further proceedings be empowered to assume the duties of his office immediately upon the death or adjudication of incompetency of the last surviving of the natural or adoptive parents of such mentally ill or mentally retarded person or of his legal guardian, subject to confirmation of his appointment by the circuit court within sixty days following assumption of his duties. If the mentally ill or mentally retarded person is eighteen years of age or older, the court, before confirming the appointment of the standby guardian, shall conduct a hearing pursuant to § 37.1-128.02 or § 37.1-128.1, whichever is appropriate. The requirements of the court and the powers, duties and liabilities which pertain to committees and guardians specified in § 37.1-128.02 or § 37.1-128.1, whichever governs the confirmation of the standby guardian, shall apply to the standby guardian in the assumption of his duties.

For the purposes of this section, the term "child of the petitioners" includes the child of biological parents, a relationship established by adoption or a relationship established by a judicial proceeding which orders legal guardianship. The term shall not be exclusive of those persons eighteen years of age and over.

§ 37.1-132. Person because of age or impaired health incapable of taking care of person or property.—On petition of any person ~~, or any person in interest,~~ to the circuit court of the county or the city, in which *resides or is located* any person who by reason of advanced age or impaired health, or physical disability, has ~~become mentally or physically incapable of taking proper care of his person or properly handling and managing~~ *lost the capacity to do some but not all of the tasks necessary to care for himself or* his estate, ~~resides,~~ the court, after reasonable notice to such mentally or physically incapacitated person ~~and after~~ *of the hearing and of his right to be present, shall hold a* hearing ~~on the petition if convinced that he is incapacitated to the extent above-mentioned, may~~ *to determine whether a guardian shall be appointed. At the hearing the court shall consider evidence which may consist of comprehensive social and psychological*

information, as well as appropriate medical or psychiatric data assessing the proposed ward's capabilities.

If, after considering this and any other evidence presented in the hearing, the court or jury, if one be requested, determines on the basis of clear and convincing evidence that the person is incapacitated, the court shall appoint ~~some~~ *a* suitable person to be the guardian ~~or committee~~ of his person or property, ~~and the guardian or committee shall~~ *or both. Clear and convincing evidence shall be presented in the hearing to support each provision in the court's order of appointment, which order shall: (i) state the nature and extent of the person's incapacity; (ii) define the powers and duties of the guardian so as to permit the incapacitated person to care for himself and manage his property to the extent that he is capable; (iii) specify whether the determination of incapacity is perpetual or limited to a specified length of time, as the court in its discretion may determine; and (iv) specify the legal disabilities, if any, of the person in connection with the finding of incapacity.*

The guardian appointed pursuant to this section shall, unless otherwise limited by the court, have the same rights and duties which pertain to committees *, guardians* and trustees appointed under ~~§ 37.1-128.03~~ *§ 37.1-128.02, § 37.1-128.1* or § 37.1-134, ~~and~~ shall give such bond *either secured or unsecured* as is required by the court *and shall comply with all applicable provisions of Title 26 of the Code .*

On the hearing of every ~~such~~ petition ~~a guardian ad litem shall be appointed to represent the interest of the person for whom a committee or guardian is requested and he~~ *for guardianship, the alleged incapacitated person shall be represented by an attorney, either privately retained or appointed by the court. The court-appointed attorney* shall be paid such fee as is fixed by the court to be taxed as part of the costs of the proceeding. *The court in which the petition is filed may, at its discretion, waive all fees and court costs in connection with such proceedings. The alleged incapacitated person shall be present at the hearing if the person so requests or if his presence is requested by the attorney representing the person.*

If no person shall be appointed guardian within seven days from the determination of legal incapacity, either wholly or partially, the court, on motion of any interested party, may appoint a guardian, or it shall appoint the sheriff pursuant to § 37.1-130.

A court determination of incapacity, either wholly or partially, pursuant to the provisions of this section shall not constitute an adjudication of legal incompetency as provided for in § 37.1-128.02 or § 37.1-134.

The person shall have the right to appeal to the Supreme Court if he be determined to be incapacitated, either wholly or partially. In the discretion of the court, a petition for or the pendency of an appeal may suspend the judgment of the court, and the court may require that bond, either secured or unsecured, be given to protect the estate of the person determined to be incapacitated.

§ 37.1-134.1. Restoration of competency or capacity.—Any person who has been adjudicated incompetent or incapacitated pursuant to § 37.1-128.02, § 37.1-128.1 or § 37.1-132, may petition the circuit court of the county or city in which he resides or is located to declare him restored to competency or capacity. Upon the filing of any such petition, the court, after reasonable notice to the committee or guardian of such person, shall hold a hearing. If on the basis of evidence offered at the hearing, the court finds that the person has substantially regained his ability to care for his person and properly manage and handle his estate, it shall declare him restored to competency or capacity and discharge his guardian or committee.

§ 37.1-138. Fiduciary entitled to control and custody of person of ward.— *Subject to any conditions or limitations set forth in the order appointing him,* the fiduciary appointed under the provisions of this chapter shall be entitled to the custody and control of the person of his ward when he resides in the State, and is not serving a term of penal servitude.

§ 37.1-139. Taking possession of ward's estate and suits relative thereto; retaining for his own debt.— *Subject to any conditions or limitations set forth in the order appointing him,* the fiduciary shall take possession of his ward's estate, and may sue and be sued in respect to all claims or demands of every nature in favor of or against his ward, and any other of his ward's estate, and he

shall have the same right of retaining for his own debt as an administrator would have.

§ 37.1-141. Fiduciary to prosecute and defend.—All actions or suits to which the ward is a party at the time of qualification of the fiduciary and all such actions or suits subsequently instituted shall *, subject to any conditions or limitations set forth in the order appointing him,* be prosecuted or defended, as the case may be, by the fiduciary, after ten days' notice of the pendency thereof, which notice shall be given by the clerk of the court in which the same are pending.

§ 37.1-142. Preservation and management of ward's estate.— *Subject to any conditions or limitations set forth in the order appointing him,* the fiduciary shall take care of and preserve the ward's estate and manage it to the best advantage. He shall apply the personal estate, or so much as may be necessary, to the payment of the debts of his ward, and the rents and profits of the residue of his estate, real and personal, and the residue of the personal estate, or so much as may be necessary, to the maintenance of such person and of his family, if any.

§ 37.1-179. Definitions.— ~~(1)~~ For *the* purposes of this chapter ~~the term~~ .

"Mentally ill" person, in addition to the definition in subsection (15) of § 37.1-1, ~~shall include~~ *includes* any person who is a drug addict or alcoholic ~~; and the term~~ .

"Mentally retarded" person ~~shall include~~ *includes* any person within the definition in subsection (13) of § 37.1-1. ~~(2) The term~~

"Facility" or "institution" ~~as used herein shall mean~~ *means* any facility or institution not operated by an agency of the federal government by whatever name or designation which provides care or treatment for mentally ill or mentally retarded persons, or persons addicted to the intemperate use of narcotic drugs, alcohol or other stimulants including the detoxification, treatment or rehabilitation of drug addicts through the use of the controlled drug methadone. Such institution or facility shall include a hospital as defined in subsection ~~(2) of § 32.208~~ *1. of § 32.1-123* of this Code, out-patient clinic, special school, halfway house, home and any other similar or related facility.

~~(3) Notwithstanding § 37.1-180, the Board may annually license any suitable person to establish, maintain and operate, or to have charge of any facility or institution which provides care or treatment for mentally ill persons, or mentally retarded persons, or persons addicted to the intemperate use of narcotic drugs, alcohol or other stimulants.~~

§ 37.1-179.1. Authority of Commissioner to grant licenses.—The Commissioner, subject to rules and regulations promulgated by the Board, may license any suitable person to establish, maintain and operate, or to have charge of any facility or institution which provides care or treatment for mentally ill persons, mentally retarded persons or persons addicted to the intemperate use of narcotic drugs, alcohol or other stimulants.

§ 37.1-181. Expiration of license; renewal; license fees.—Licenses granted under this chapter shall expire with the last day of the year in which they are issued, or one year from the date of issuance, which shall be determined by the ~~Board~~ *Commissioner* , but may be renewed by the ~~Board~~ *Commissioner* . The Board may fix a reasonable fee ~~not in excess of fifty dollars~~ for each license so issued, and for any renewal thereof. All funds received by the ~~Board~~ *Department* under this chapter shall be paid into the general fund in the State treasury.

§ 37.1-182. Inspections.—All institutions, hospitals and homes operated under any such license shall be subject ~~to the supervision and control of the Board, and~~ to inspection at any reasonable time by any authorized inspector or agent of the ~~Board~~ *Department* . The ~~Board shall inspect~~ *Commissioner shall cause to be inspected* all such licensed institutions, hospitals and homes; provided that the ~~Board~~ *Commissioner* shall call upon other State or local departments to assist in said inspections and such departments shall render an inspection report to the ~~Board~~ *Commissioner* . After receipt of all inspection reports, the ~~Board~~ *Commissioner* shall make the final determination with respect to the condition of the institution, hospital or home so inspected. The Board may adopt and *the Commissioner shall* enforce such reasonable rules and regulations as may be necessary or proper to carry out the general purposes of this chapter.

§ 37.1-183.1. License required; exception; license not transferable; operation of existing

institutions; persons not to be committed, etc., to unlicensed institutions.—(1) No person shall establish, conduct, maintain or operate in this Commonwealth any facility or institution as defined in ~~subsection (2) of~~ § 37.1-179, for the care or treatment of mentally ill or mentally retarded persons, or persons addicted to the intemperate use of narcotic drugs, alcohol or other stimulants, including the detoxification, treatment or rehabilitation of drug addicts through the use of the controlled drug methadone, without first being duly licensed under this chapter, except where such facility or institution is exempt from licensing.

(2) No license issued under this chapter shall be assignable or transferable.

(3) No person may continue to operate any existing private facility or institution described in § 37.1-179 ~~(2)~~ unless such operation is approved and licensed, or exempt from licensing, as provided in this chapter.

(4) No person shall be committed, placed, treated, maintained, housed, or otherwise kept, voluntarily or involuntarily, at any facility or institution required to be licensed by subsection (1) of this section unless and until it be duly licensed by the ~~Board~~ *Commissioner* .

§ 37.1-183.2. Provisional license.—The Commissioner may issue a provisional license to a facility or institution which has previously been fully licensed when such facility or institution is temporarily unable to comply with all licensing standards. Such license may be issued for any period not to exceed ninety days and shall not be renewed. Such provisional license shall be prominently displayed in the facility or institution and shall indicate thereon the violations of licensing standards to be corrected and the expiration date of the license.

§ 37.1-185. Revocation or suspension of licenses; resumption of operation.—(a) The ~~Board~~ *Commissioner* is authorized to revoke or suspend any license issued hereunder, on any of the following grounds: (1) violation of any provision of this chapter or of any applicable and valid rule or regulation made pursuant to such provisions; (2) permitting, aiding, or abetting the commission of an illegal act in such institution, hospital or home; (3) conduct or practices detrimental to the welfare of any patient in such institution, hospital or home.

(b) Before any license issued under this chapter is so revoked or suspended, thirty days' written notice must be given the licensee of the date set for hearing of the complaint and he must be furnished with a copy of the complaint and shall be entitled to be represented by legal counsel at the hearing. The notice shall be given by the ~~Board~~ *Commissioner* by certified mail.

(c) If a license is revoked as herein provided, a new application for license may be considered by the ~~Board~~ *Commissioner* if, when, and after the conditions upon which revocation was based have been corrected and satisfactory evidence of this fact has been furnished. A new license may then be granted after proper inspection has been made and all provisions of this chapter and applicable rules and regulations made thereunder have been complied with and recommendations to such effect have been made ~~by~~ *to* the Commissioner upon *the* basis of an inspection by any authorized inspector or agent of the ~~Board~~ *Department* .

(d) Suspension of a license shall in all cases be for an indefinite time and the suspension may be lifted and rights under the license fully or partially restored at such time as the Commissioner determines, upon basis of such an inspection, that the rights of the licensee appear to so require and the interests of the public will not be jeopardized by resumption of operation.

§ 37.1-186. Review of Commissioner's refusal, revocation or suspension of license.—Any person aggrieved by the refusal of the ~~Board~~ *Commissioner* to issue a license or by ~~its~~ *his* revocation or suspension of a license may, within thirty days after receipt of notice of such action or within a reasonable time after its failure to take action upon a completed application for a license, obtain a review by the circuit court of the county or city in which such institution, hospital, or home is or is proposed to be located and a copy of the petition for review shall be filed with the ~~Board~~ *Commissioner* . Within five days after receipt of the copy, the ~~Board~~ *Commissioner* shall transmit to the court all of the original papers pertaining to the matter to be reviewed, and the matter shall be thereupon heard by the court as promptly as circumstances will reasonably permit. The court may enter such orders pending the proceeding as are deemed necessary or proper in accordance with the principles of equity jurisprudence and procedure. The hearing may be upon the record so transmitted, but the court may hear such additional evidence as it deems proper, and upon the

conclusion of the hearing, the court may affirm, vacate or modify the order appealed from. Costs may be ordered to be paid as the court deems proper in accordance with principles of equity. Any party to the proceeding may appeal from the decision of the court to the Supreme Court, in the same manner as appeals are taken from courts of equity generally.

§ 37.1-187. Proceeding to prevent unlawful operation of institution.–In case any such institution, hospital or home is being operated in violation of the provisions of this chapter or of any applicable rules and regulations made under such provisions, the ~~Board~~ *Commissioner* , in addition to other remedies, may institute any appropriate action or proceedings to prevent such unlawful operation and to restrain, correct or abate such violation or violations. Such action or proceeding shall be instituted in the circuit court of the county or city where such institution, hospital or home is located, and such court shall have jurisdiction to enjoin such unlawful operation or such violation or violations.

CHAPTER 10.

COMMUNITY MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES.

§ 37.1-194. Purpose; services to be provided.–The Department, for the purposes of establishing, maintaining, and promoting the development of mental health ~~and~~ , mental retardation *and substance abuse* services in the State, may make matching grants to assist any county having a population of approximately fifty thousand or more or any city having a population of approximately seventy-five thousand or more, or any combination of political subdivisions having a combined population of approximately fifty thousand or more, or any city or county or combination thereof which has less than the above prescribed populations which the Department determines is in need of such services, in the establishment and operation of local mental health ~~and~~ , mental retardation *and substance abuse* programs ~~to provide:~~ . *Every county and city shall establish, either singly or in combination with another political subdivision, a community services board on or before July one, nineteen hundred eighty-three.*

The State Board of Mental Health and Mental Retardation shall determine a core of program services to be provided by community services boards by July one, nineteen hundred eighty-two in order to provide comprehensive community mental health, mental retardation and substance abuse services within the political subdivisions served by the board. The State Board shall also specify other program services which the community services board may provide. These program services may include:

(a) Collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, other psychiatric disabilities, and mental retardation, alcohol and drug abuse.

(b) Informational ~~and~~ , *referral and* education services to the general public, and lay and professional groups.

(c) ~~Consultative~~ *Consultation and evaluation* services ~~to~~ *for* courts, public schools, health and welfare agencies ~~available~~ ~~to~~ *and for* the public.

(d) Outpatient diagnostic and treatment services.

(e) Rehabilitative services for patients suffering from mental or emotional disorders, other psychiatric conditions, mental retardation or alcohol or drug abuse.

(f) Inpatient diagnostic and treatment services.

(g) Research , *and* evaluation and training of personnel.

(h) Aftercare for the patient released from a mental hospital *and for the resident released from a training center* .

(i) Drugs and medicines, preadmission and post admission.

(j) Therapeutic communities, halfway houses, group homes ; or other residential facilities.

(k) Transitional services.

(l) Partial hospitalization.

(m) Emergency services.

(n) Drug abuse and alcoholism treatment programs.

(o) Community residences for *the* mentally ill and mentally retarded.

(p) And other appropriate mental health, mental retardation and ~~drug~~ *substance abuse* programs necessary to provide a comprehensive system of services.

§ 37.1-195. Community services boards; appointment and membership.–Every city, county or combination of counties or cities or counties and cities establishing a community mental health ~~and~~ , mental retardation *and substance abuse* services program, before it ~~may~~ *shall* come within the provisions of this act, shall establish a single community ~~mental health and mental retardation~~ services board, with neither less than five nor more than fifteen members. When any city or county singly establishes a program, the board shall be appointed by the governing body of the local political subdivision establishing such a program. When any combination of counties or cities or counties and cities establishes a community ~~mental health and mental retardation~~ services program, the board of supervisors of each county in the case of counties or the council in the case of cities shall establish the size of the board between five and fifteen members, shall elect and appoint the members of said board and shall designate an official of one member city or county to act as fiscal agent for the board.

The county or city which comprises a single board and the county or city whose designated official serves as fiscal agent for the board in the case of joint boards shall annually audit the total revenues of the board and its programs and shall, in conjunction with the other participating political subdivisions in the case of joint boards, approve a grievance procedure which shall apply to all employees of the board and arrange for the provision of legal services to the board.

No such board shall be composed of a majority of elected officials as members, nor shall any county or city be represented on such board by more than one elected official.

The board ~~so~~ appointed *pursuant to this section* shall be responsible to the governing body or bodies of the county or city or combination thereof which established such board.

§ 37.1-196. Same; term; vacancies; removal.–The term of office of each member of the community ~~mental health and mental retardation~~ services boards shall be for three years from the first day of January of the year of appointment, or, at the option of the governing body of a county or city, from the first day of July of the year of appointment, except that of the members first appointed, several shall be appointed for terms of one year each, several for terms of two years each, and the remaining members of the board for terms of three years each. The selection of members for one, two, and three-year terms shall be as nearly equal as possible with regard to the total number of members on the board. If a governing body has appointed members for terms commencing January one or July one but desires to change the date the terms of office commence, the governing body may, as the terms of the members then in office expire, appoint successors for terms of two and one-half or three and one-half years so as to expire on June thirty or December thirty-one. Vacancies shall be filled for unexpired terms in the same manner as original appointments. No person shall be eligible to serve more than two successive terms; provided that persons heretofore or hereafter appointed to fill vacancies may serve two additional successive terms. Any member of a board may be removed by the appointing authority for cause, after being given a written statement of the causes and an opportunity to be heard thereon.

§ 37.1-197. Same; powers and duties.–Every community ~~mental health and mental retardation~~ services board shall:

(a) Review and evaluate all existing and proposed *public* community mental health ~~and~~ , mental retardation *and substance abuse* services and facilities ; ~~both public and private,~~ available to serve

the community *and such private services and facilities as receive funds through the board* and advise the appropriate local governments as to its findings.

(b) Submit to the governing body or bodies of each political subdivision, of which it is an agency, a program of community mental health ~~and~~ , mental retardation *and substance abuse* services and facilities for its consideration.

(c) Within amounts appropriated thereon, execute such ~~program~~ *programs* and maintain such services as may be authorized under such appropriations.

(d) Enter into contracts for rendition or operation of services or facilities.

(e) Make rules or regulations concerning the rendition or operation of services and facilities under its direction or supervision, subject to applicable standards or regulations ~~of the Department~~ *promulgated by the State Board* .

(f) Appoint a coordinator or director of community mental health ~~and~~ , mental retardation *and substance abuse* services whose qualifications are approved by the Department and prescribe his duties. The compensation of such coordinator or director shall be fixed by the board within the amounts made available by appropriation therefor.

(g) Prescribe a reasonable schedule of fees for services provided by personnel or facilities under the jurisdiction or supervision of the board and ~~for the manner of~~ collection of the same; provided, however, that all fees collected from board administered programs shall be deposited with the treasurer of the political subdivision of which the board is an agency, or, in the case of a joint board, with the treasurer of the political subdivision specified by agreement; provided further, that such collected fees shall be used only for community mental health and mental retardation *and substance abuse* purposes. *By January one, nineteen hundred eighty-two, every board shall institute a reimbursement system to maximize the collection of fees from persons receiving services under the jurisdiction or supervision of the board and from responsible third party payors.*

(h) Accept or refuse gifts, donations, bequests or grants of money or property from any source and utilize the same as authorized by the governing body or bodies of the political subdivision or subdivisions of which it is an agency.

(i) Seek and accept funds through federal grants.

(j) Have authority, notwithstanding any provision of law to the contrary, to disburse funds appropriated to it in accordance with such regulations as may be established by the governing body of the political subdivision of which the board is an agency or, in the case of a joint board, as may be established by agreement.

§ 37.1-197.1. Managerial services required.—In order to provide comprehensive mental health, mental retardation and substance abuse services within a continuum of care, the community services board shall:

(a) Establish and coordinate the operation of a prescription team which shall be composed of representatives from the community services board, social services or public welfare department, health department, Department of Rehabilitative Services serving in the community services board's area and, as appropriate, the social services staff of the State institution serving the community services board's catchment area and the local school division. Such other human resources agency personnel may serve on the team as the team deems necessary. The team, under the direction of the community services board, shall be responsible for integrating the community services necessary to accomplish effective prescreening and predischarge planning for clients referred to the community services board. When prescreening reports are required by the court on an emergency basis pursuant to § 37.1-67.2 or § 37.1-67.3, the team may designate one team member to develop the report for the court and report thereafter to the team.

(b) Provide prescreening services prior to the admission of any person, who resides in a political subdivision served by the board, to a State hospital pursuant to § 37.1-65 or to a court of competent jurisdiction pursuant to § 37.1-67.2 or § 37.1-67.3, when requested by the court.

(c) Cooperate and participate in predischarge planning for any person, who prior to hospitalization resided in a political subdivision served by the board or who chooses to reside after hospitalization in a political subdivision served by the board, who is to be released from a State hospital pursuant to § 37.1-98.

§ 37.1-198. Mental health, mental retardation and substance abuse programs; approval of plan and budget; application for grant.—Any city, county or combination of counties or cities or counties and cities which establishes a community ~~mental health and mental retardation~~ *services* board administering a mental health ~~and~~ , mental retardation *and substance abuse* services program may apply for the assistance as provided in this act by submitting annually to the Department its plan and budget for the next fiscal year together with the recommendations of the community ~~mental health and mental retardation~~ *services* board thereon. No program shall be eligible for a grant hereunder unless its plan and budget have been approved by the governing body or bodies of each political subdivision of which it is an agency and by the Department.

§ 37.1-199. Same; allocation of funds by Department; withdrawal of funds.—(a) At the beginning of each fiscal year the Department may allocate available funds to the community ~~mental health and mental retardation programs~~ *services boards* for disbursement during the fiscal year in accordance with such approved plans and budgets. From time to time during the fiscal year, the Department shall review the budgets and expenditures of the various programs . ~~and~~ If funds are not needed for a program to which they were allocated, ~~it~~ *the Department* may withdraw such funds as are unencumbered, after reasonable notice and opportunity for hearing, and reallocate them to other programs. It may withdraw funds from any program which is not being administered in accordance with its approved plan and budget *or which is not in compliance with the standards for such a program as promulgated by the State Board .*

(b) Allocations to be made to each local board shall be determined by the Department after careful consideration of all of the following factors:

(1) The total amount of funds appropriated for this purpose,

(2) The total amount of funds requested by the local board,

(3) The financial abilities of all of the cities and counties participating in the local board to provide funds required to generate the requested State match,

(4) The type and extent of programs and services conducted or planned by the local board,

(5) The availability of services provided by the local board in the area served by it, and

(6) The ability of the programs and services provided by the local board to decrease financial costs to the Department and increase the effectiveness of patient treatment by reducing the number of patients being admitted to or retained in State hospitals from the cities or counties participating in the local board.

(c) Allocations to any one board shall not exceed the following proportions:

(1) For the construction of facilities: ninety per centum of the total costs of such construction.

(2) For salaries and other operational costs: ninety per centum of the total costs.

(3) [Repealed.]

(d) ~~Any~~ *All* fees collected may be kept by the board and used for operational costs.

§ 37.1-200. Same; withdrawal of county or city from program.—No county or city participating in a joint community ~~mental health and mental retardation program~~ *services board* shall withdraw therefrom without two years' notice to the other participating counties or cities unless the other counties or cities consent to an earlier withdrawal.

CHAPTER 11.

SUBSTANCE ABUSE SERVICES.

§ 37.1-203. Definitions.–As used in this chapter:

1. ~~The term~~ "Substance" ~~shall mean~~ *means* both alcoholic beverages and drugs.

2. ~~The term~~ "Substance abuse" ~~shall mean~~ *means* the use, without compelling medical reason, of any substance which results in psychological or physiological dependency as a function of continued use in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior.

3. "~~Division~~" ~~means the Division of Substance Abuse.~~

4. "~~Director~~" ~~means the Director of the Division of Substance Abuse.~~

§ 37.1-204. Department responsible for substance abuse services; qualifications of staff.– ~~There is hereby established in~~ The Department of Mental Health and Mental Retardation ~~the Division of Substance Abuse~~ *shall be responsible for the administration, planning and regulation of substance abuse services in the Commonwealth* . ~~The Director of the Division shall be appointed by~~ The Commissioner ~~and~~ *shall employ staff to carry out this responsibility who* shall have knowledge of and experience in both the fields of alcoholism and drug abuse.

§ 37.1-205. Powers and duties generally.–The ~~Division~~ *Department* shall have the following powers and duties:

1. To act as the sole State agency for the planning, coordination and evaluation of the State comprehensive plan or plans for substance abuse.

2. To investigate and *promote* research ~~continually~~ *concerning* the extent and scope of all problems relating to substance abuse within the Commonwealth.

3. To survey periodically existing and potential facilities and services available in State and local, public and private, agencies, institutions, and associations which can be cooperatively applied to the solution of existing and anticipated problems relating to substance abuse.

4. To coordinate, mobilize, and utilize the research and public service resources of institutions of higher education, all levels of government, business, industry, and the community at large in the understanding and solution of problems relating to substance abuse.

5. To formulate, in cooperation with federal, State, local and private agencies, a comprehensive State plan or plans for substance abuse, consistent with federal guidelines and regulations, for the long-range development of adequate and coordinated programs, services and facilities for research, prevention and control of substance abuse and for treatment and rehabilitation of substance abusers through the utilization of federal, State, local and private resources; to review such plan or plans annually and to make such revisions as may be necessary or desirable.

6. To promote the effectuation of the comprehensive State plan or plans for substance abuse in cooperation with other federal, State, local and private agencies.

7. To review and comment on all applications for State or federal funds or services to be used in substance abuse programs in accordance with § 37.1-206 and on all requests by State agencies for appropriations from the General Assembly for use in substance abuse programs.

8. To recommend to the Governor and the General Assembly legislation necessary to implement programs, services, and facilities for the prevention and control of substance abuse and the treatment and rehabilitation of substance abusers.

9. ~~To receive, take, hold and use for the purposes herein, any and every grant, gift, devise or bequest made to the Division.~~

10. , ~~To make and enter into all contracts and agreements necessary or incidental to the performance of its duties and the execution of its powers.~~

11. ~~To adopt policies and procedures, within the comprehensive State plan or plans for substance abuse,~~ To encourage and assist ~~localities~~ *community services boards* in the formation of locally based substance abuse prevention, education, crisis intervention, treatment and rehabilitation programs.

12. ~~To accord local units of government the authority to designate the agency responsible for the administration and operation of locally based substance abuse prevention and control programs.~~

§ 37.1-206. Review of applications for State or for federal funds or services.—A. No local or State agency which is empowered to issue final approval or disapproval of, or to make a final review and comment upon, any application for State or federal funds or services which are to be used in a substance abuse program shall take final action on or transmit such application until the application is first reviewed and commented upon by the ~~Division~~ *Department* , and thereafter such review and comment by the ~~Division~~ *Department* shall remain a part of the application documents.

B. Every applicant for any federal or State funds, services, loans, grants-in-aid, matching funds or services which are to be used in connection with any substance abuse program shall submit a copy of the application for such funds, services, loans, grants-in-aid, matching funds or services to the ~~Division~~ *Department* for review and comment, as provided in subsection A hereof.

C. The ~~Division~~ *Department* shall review and comment upon and return each application within forty-five days after receiving such application.

D. Each State agency requesting an appropriation from the General Assembly for substance abuse programs shall submit such request to the ~~Division~~ *Department* for review and comment and shall supply the ~~Division~~ *Department* with all relevant information including a full report on funds expended pursuant to prior appropriations. The ~~Division~~ *Department* shall provide the Governor and the General Assembly with its assessment of each such request for an appropriation by a State agency.

§ 37.1-207. Virginia Advisory Council on Substance Abuse Problems.—A. There is hereby established the Virginia Advisory Council on Substance Abuse Problems, hereafter referred to in this section as "the Council." The Council shall advise and make recommendations to the ~~Division~~ *Department* with respect to broad policies, goals and operations of the comprehensive State plan or plans for substance abuse.

B. The Council shall consist of fifteen members appointed by the Governor, one of whom shall be from the office of the Secretary of Human Resources, one of whom shall be from the State Health Coordinating Council, and five of whom shall represent State agencies with responsibility in the area of substance abuse. All of the above State members shall serve on the Council at the pleasure of the Governor. The remaining eight members shall be from the general public. The eight public members shall each have a professional, research, or personal interest in substance abuse and at least three of such members shall have knowledge of alcoholism and at least three shall have knowledge of drug abuse. When appointing members to the Council, the Governor shall assure that minority and low income groups are provided representation on the Council. Of the eight public members first appointed to the Council, two shall be appointed for terms of one year, two for terms of two years and four for terms of three years. Thereafter all appointments of public members shall be for terms of three years except an appointment to fill a vacancy which shall be for the unexpired term. The Council shall select one of its members as chairman who shall call all meetings.

C. No person shall be eligible to serve more than two successive terms, provided that a person appointed to fill a vacancy may serve two full successive terms.

D. The Council shall meet at least six times annually and more often if deemed necessary or advisable by the chairman.

E. The members of the Council shall receive no compensation for their services but shall be reimbursed for their actual and necessary expenses incurred in the performance of their duties.

F. The duties of the Council shall be:

1. To assist the ~~Division~~ *Board* in the formulation of policies and goals;

2. To assist in the development of and to review and comment on the comprehensive State plan or plans for substance abuse;

3. To review and comment on the ~~Division's~~ *Department's* annual budget *provisions regarding substance abuse* prior to submission *of the budget* to the *Board and* Secretary of Human Resources and on all applications for State or federal funds, or services to be used in substance abuse control programs;

4. To advise the ~~Division~~ *Department* on its recommendations to the Governor and the General Assembly on legislation;

5. To make investigations, issue special reports and make recommendations relevant to substance abuse upon the request of the *Board or* Governor.

§ 37.1-208. Department to provide for treatment and rehabilitation of addicts; cooperation of other agencies.–The ~~Division~~ *Department* shall provide for the treatment and rehabilitation of persons addicted to or involved in substance abuse. The ~~Division~~ *Department* shall seek and encourage cooperation and active participation of communities, organizations, agencies and individuals in an effort to develop comprehensive and meaningful drug treatment programs.

§ 37.1-209. Commissioner to contract for and establish hospital and clinic facilities.–The Commissioner shall contract for and/or establish such hospital and clinic facilities as are necessary to care properly for persons involved in substance abuse. The ~~administration, organization and~~ standards ~~of~~ *governing* these hospitals and clinic facilities shall be ~~such as are~~ established by the Board.

§ 37.1-214. Virginia Drug Abuse Advisory Council and Division of Drug Abuse Control abolished.–The Virginia Drug Abuse Advisory Council and the Division of Drug Abuse Control are hereby abolished and the title to and control of all property and records of every kind and description formerly held or controlled by such agencies shall be vested in the ~~Division~~ *Department* .

§ 37.1-215. Bureau of Alcohol Studies and Rehabilitation abolished.–The Bureau of Alcohol Studies and Rehabilitation under the State Board of Health is hereby abolished and the title to and control of all property and records of every kind and description formerly held or controlled by or on behalf of the Bureau shall be vested in the ~~Division~~ *Department* .

§ 37.1-217. Definitions.–As used in this chapter:

A. "Alcoholic" means a person who: (i) through use of alcohol has become dangerous to the public or himself; or (ii) because of such alcohol use is medically determined to be in need of medical or psychiatric care, treatment, rehabilitation or counseling;

B. "Approved treatment facility" means a public or private facility that has been approved *pursuant to standards established* by the Board;

C. "Intoxicated" means having mental or physical functioning substantially impaired as a result of the use of alcohol.

§ 37.1-218. Powers and duties of Department.–The ~~Division~~ *Department* shall:

A. Provide technical assistance and consultation services to State and local agencies in planning, developing and implementing services for alcoholics and intoxicated persons;

B. Develop a statewide plan for the prevention of alcoholism and the treatment of alcoholics and intoxicated persons which shall be revised annually and which shall contain (i) a statement of specific measurable objectives for the delivery of programs, (ii) the methods used to achieve the objectives, (iii) a schedule for achievement of the objectives and (iv) a method for evaluating the objectives;

C. Annually inventory or cause to be inventoried resources within the State for the prevention of

alcoholism and the treatment of alcoholics and intoxicated persons for the purpose of determining the need for additional services and the effectiveness of existing services and shall submit to the Governor and the General Assembly an annual report of the inventory of such resources;

D. Cooperate with the Department of Corrections and the Virginia Parole Board in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

E. Prepare, publish, evaluate and disseminate educational material dealing with the nature and effects of alcohol;

F. Develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons, which program shall include the dissemination of information concerning the nature and effects of alcohol;

G. Organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;

H. Sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons, and serve as a clearinghouse for information relating to alcoholism;

I. Specify uniform methods for keeping statistical information relating to the treatment of alcoholics and intoxicated persons and alcoholism, by public and private agencies, organizations and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

J. Assist in the development of, and cooperate with, alcohol education and treatment programs for employees of State and local governments and businesses and industries in the State;

K. Utilize the support and assistance of interested persons, including recovered alcoholics, to encourage alcoholics voluntarily to undergo treatment;

L. Cooperate with the Division of Motor Vehicles and the ~~Highway Safety Division~~ *Department of Transportation Safety* in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated;

M. Encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons and to provide them with adequate and appropriate treatment.

§ 37.1-219. Standards for treatment facilities; inspections; list of facilities; filing of information.—A. The Board shall adopt reasonable regulations prescribing standards for the sanitation, hygiene and safety of treatment facilities and standards to assure proper attention, service and treatment to persons treated in such facilities. The Board may categorize treatment facilities in accordance with the character of treatment, care or service rendered or offered and prescribe such standards for each category. Such standards must be met by a public or private treatment facility to be approved *pursuant to regulations promulgated* by the Board.

B. The ~~Division~~ *Commissioner shall* periodically ~~shall inspect~~ *cause to be inspected* approved public and private treatment facilities at reasonable times and in a reasonable manner.

C. The ~~Division~~ *Department* shall maintain a current list of approved public and private treatment facilities, which shall be made available upon request.

D. Each approved public and private treatment facility shall file with the ~~Division~~ *Department* such data, statistics, schedules and information as ~~the Bureau~~ *may be* reasonably ~~requires~~ *required* .

E. Upon petition of the ~~Division~~ *Commissioner* and after a hearing held upon reasonable notice to the facility, a general ~~district~~ court may issue a warrant to an officer or employee of the ~~Division~~ *Department* authorizing him to enter and inspect at reasonable times, and examine the books and accounts of, any approved public or private treatment facility which refuses to consent to

inspection or examination by ~~the Division~~ *authorized agents of the Department* .

§ 37.1-220. Programs for treatment of alcoholics and intoxicated persons.–A. ~~The governing body of any county, city or town or the governing bodies of any combination thereof within a planning district established as provided in §15.1 1403 of the Code, may, by ordinance or resolution or by concurrent ordinances or resolutions, establish a board or designate an existing board, commission or other agency, hereafter in this section referred to as "local board," to establish or cause to be established a comprehensive program for the treatment of alcoholics and intoxicated persons as provided in subsection C of this section~~.

B. ~~Such local board may establish by July one, nineteen hundred seventy eight within each planning district a comprehensive program for the treatment of alcoholics and intoxicated persons as provided in subsection C of this section. In any planning district which does not establish such a program, the Division shall establish by July one, nineteen hundred eighty, such a comprehensive program, if funds are provided by the General Assembly. The Division may, through contracts and grants provided through community mental health and mental retardation services boards, assist local boards in the establishment of such programs prior to July one, nineteen hundred seventy eight. When the Division is required to establish such programs after said date, it shall do so whenever possible through contracts or grants to local boards as administered by or through community mental health and mental retardation services boards. No county, city or town shall be required to provide any local funds for the comprehensive program for the treatment of alcoholics and intoxicated persons required by this section. The Commissioner may continue, or continue contracts for, such hospital and clinic facilities contracted for or established by him under the provisions of this chapter prior to January one, nineteen hundred seventy seven and may employ or assign for training therein such personnel as may be desirable.~~

C. The comprehensive programs for alcoholics and intoxicated persons ~~within each planning district shall be a coordinated program consisting of~~ *established by community services boards may include* :

1. Public information and education programs.

2. ~~Sufficient~~ Approved treatment facilities for facilitating access into care and rehabilitation by detoxifying and evaluating alcoholics and intoxicated persons and providing entrance into additional treatment programs. Such facilities shall have available the services of a licensed physician for medical emergencies and routine medical assistance.

3. ~~Sufficient~~ Approved treatment facilities providing inpatient or full-time residential treatment.

4. ~~Sufficient~~ Approved treatment facilities providing intermediate treatment or residential treatment that is less than full time.

5. Facilities providing outpatient and follow-up treatment where the client is not a full-time or part-time resident of the treatment facility. Such services may be offered in clinics, social services centers or in the patient's home.

D. No person who is not already within the correctional system may be referred to treatment programs operating within correctional institutions.

E. All appropriate public and private facilities and services shall be coordinated with and utilized in the program if possible.

F. ~~No county, city or town which has combined with another county, city or town to establish or designate a local board may withdraw from such combination without two years prior notice to the other counties, cities and towns in the combination unless the other counties, cities and towns consent to an earlier withdrawal.~~

§ 37.1-223. Procedure for adoption of regulations.–Prior to the adoption, amendment, or repeal of any regulation, the Board shall, in addition to the procedures set forth in the Administrative Process Act:

A. Present the proposed regulation to the Virginia Advisory Council on Substance Abuse

Problems at least thirty days prior to its adoption for the Council's review and comment.

B. ~~Forward the proposed regulation to all local boards designated or established pursuant to § 37.1-220 at least thirty days prior to its adoption.~~

2. That §§ 37.1-2, 37.1-8, 37.1-20, 37.1-21, 37.1-25, 37.1-26, 37.1-43, 37.1-128.03, 37.1-180, 37.1-210 through 37.1-213 and 37.1-216 of the Code of Virginia are repealed.

RESOLUTIONS OF THE COMMISSION ON MENTAL HEALTH AND MENTAL RETARDATION

A. Appointing a joint subcommittee of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health to monitor the ongoing performance of the Department of Mental Health and Mental Retardation. Requesting that the joint subcommittee report to the Governor and the General Assembly in 1981 and 1982.

B. Requesting that the State Mental Health and Mental Retardation Board study the concept of funds following the client with the goal of recommending to the 1982 Session of the General Assembly several pilot projects around the State. The recommendations of the Board should be submitted to the House Committee on Health, Welfare and Institutions, Senate Committee on Education and Health, House Appropriations Committee and the Senate Committee on Finance by September 1, 1981 with plans to include the pilot projects in the 1982-1984 biennial budget.

C. Requesting that the State Mental Health and Mental Retardation Board study the need for and the cost of providing liability insurance for community services boards' members and employees either at the State or local level. The results of the study should be submitted to the 1981 Session of the General Assembly.

D. Requesting the Criminal Justice Services Commission to provide training for law-enforcement personnel in the recognition of mental disabilities and the proper handling of persons with mental disabilities.

E. Requesting that the Office of the Executive Secretary of the Supreme Court provide information about typical community resources available for commitment or certification hearings to the judges at the statewide judicial conferences.

F. Requesting that the Secretary of Human Resources establish as a high priority the initiation and coordination of programs for prevention and public awareness of mental disabilities among State and local human service agencies.

G. Requesting that the Department of Mental Health and Mental Retardation conduct a study of the double diagnosis client. The Department should present an interim report to the Governor and the 1981 Session of the General Assembly and a final report in 1982.

H. Requesting that the Secretary of Human Resources and the Secretary of Public Safety report to the House Committee on Health, Welfare and Insitutions and the Senate Committee on Rehabilitation and Social Services in January of 1981 regarding the care and treatment of mentally handicapped children and adults in the State's criminal justice system. The report of the Secretaries should detail the results of their commitments to coordinate the efforts of the Department of Mental Health and Mental Retardation, the Department of Corrections and the Rehabilitative School Authority in meeting the needs of this population.

I. Requesting that the Governor develop a ten-year plan to alter the proportion of funds allocated to State institutions and community services from the current ratio of 83% - 17%, respectively, to 60% (institutions), 40% (community services).

J. Requesting that the Secretary of Human Resources study the Title XX program.

K. Requesting that the Governor develop a timetable for closing, demolishing or transferring to another agency substandard or obsolete buildings within the State's mental health, mental retardation and substance abuse system.

L. Setting forth the policy of the Commonwealth for mental health, mental retardation and substance abuse.

M. Requesting that the Department of Mental Health and Mental Retardation develop formulas for the distribution of funds for mental health, mental retardation and substance abuse community services.

N. Requesting that the State Mental Health and Mental Retardation Board adopt a policy establishing

a funding ratio for the core services to be provided by community services boards.

HOUSE JOINT RESOLUTION A

Requesting that the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health appoint a Joint Subcommittee on Mental Health and Mental Retardation.

WHEREAS, the Commission on Mental Health and Mental Retardation was created in nineteen hundred seventy-seven to study the services provided mentally handicapped citizens by the Commonwealth; and

WHEREAS, the Commission reported its findings and recommendations to the Governor and General Assembly in January of nineteen hundred eighty; and

WHEREAS, the recommendations of the Commission suggest a significant number of administrative policies and practices required to provide a more effective and efficient statewide system of programs and services for mentally ill, mentally retarded and substance abusing citizens; and

WHEREAS, the Department of Mental Health and Mental Retardation under the direction of the State Mental Health and Mental Retardation Board is responsible for administering Virginia's programs and services for the mentally handicapped; and

WHEREAS, it is the sense of the Commission on Mental Health and Mental Retardation and the General Assembly that continuing oversight of the statewide system of programs and services for the mentally handicapped is necessary; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, that the chairman of the House Committee on Health, Welfare and Institutions and the chairman of the Senate Committee on Education and Health are requested to appoint from the membership of the respective committees, a Joint Subcommittee on Mental Health and Mental Retardation.

The Joint Subcommittee shall monitor the ongoing administration of the mental health, mental retardation and substance abuse system of services in the Commonwealth. The recommendations of the Commission on Mental Health and Mental Retardation shall guide the work of the Joint Subcommittee in assuring that the proposed administrative policies and practices are implemented and that the system provides the most appropriate treatment, training and care for individuals with mental disabilities throughout Virginia.

The Joint Subcommittee shall conduct its oversight responsibilities for a term of two years and shall make any recommendations it deems appropriate to the Governor and the nineteen hundred eighty-one and nineteen hundred eighty-two Sessions of the General Assembly.

SENATE JOINT RESOLUTION B

Requesting that the State Mental Health and Mental Retardation Board study the concept of funds following the client throughout the statewide system of services for the mentally handicapped.

WHEREAS, during a series of public hearings in nineteen hundred seventy-eight and in subsequent deliberations, the Commission on Mental Health and Mental Retardation was introduced to an innovative concept of financing services provided mentally handicapped persons whose appropriate treatment, training or care may be provided by a State institution, by community services or both; and

WHEREAS, the Commission learned that currently the cost of treatment or training received by citizens in State institutions is funded by State and federal funds but includes no local monies, while community-based services for the mentally handicapped are financed by State and local funds; and

WHEREAS, these current funding practices provide financial incentives for localities to place individuals in State institutions, thereby relieving the locality of any financial responsibility for the individual; and

WHEREAS, the Commonwealth is dedicated to the policy of providing treatment, training and care for mentally handicapped individuals in the least restrictive environment which, in most instances, is the community rather than an institution; and

WHEREAS, under the concept of funds following the client the local community services board would be charged a unit cost for services rendered to an individual by a State institution, thus, providing financial incentives to retain the individual in community care except where institutionalization is imperative; and

WHEREAS, the Commission on Mental Health and Mental Retardation believes that there is considerable merit in this concept and that it should be studied comprehensively by individuals with expertise in Virginia's system for mental health, mental retardation and substance abuse; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the State Mental Health and Mental Retardation Board is requested to study the concept of funds following the client. The goal of the Board's research shall be to recommend several pilot projects in various regions of Virginia to implement this concept.

The recommendations of the Board shall be submitted to the House Committee on Health, Welfare and Institutions, Senate Committee on Education and Health, House Appropriations Committee and the Senate Committee on Finance by September one, nineteen hundred eighty-one with accompanying plans to include the proposed pilot projects in the biennial budget for nineteen hundred eighty-two through nineteen hundred eighty-four.

SENATE JOINT RESOLUTION C

Requesting that the State Mental Health and Mental Retardation Board study the feasibility of providing liability insurance for the members and staff of community services boards.

WHEREAS, during its study in nineteen hundred seventy-eight and nineteen hundred seventy-nine the Commission on Mental Health and Mental Retardation heard testimony concerning legal liability for the decisions and actions of the members and staff of community services boards which provide services for the mentally handicapped in localities throughout Virginia; and

WHEREAS, the community services boards' members and staff and the Commission on Mental Health and Mental Retardation expressed grave concern about the lack of State policy governing liability insurance for the boards; and

WHEREAS, the lack of State policy has resulted in a variety of practices among the community services boards which, in some regions, have purchased liability insurance for the members and staff and, in other regions, have not arranged such coverage; and

WHEREAS, the Commission on Mental Health and Mental Retardation believes that the provision of liability insurance for the members and staff of the community services boards requires further study to determine the need, the cost and the most appropriate method of providing liability insurance coverage for these individuals; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, that the State Mental Health and Mental Retardation Board is requested to study the feasibility of providing liability insurance for community services boards' members and staff. The study shall determine the actual need for liability insurance for the boards, the cost of providing the insurance if it is needed and whether the insurance should be provided by the State, the localities or both.

The recommendations of the State Board shall be submitted to the House Committees on Health, Welfare and Institutions and Corporations, Insurance and Banking and to the Senate Committees on Education and Health and Commerce and Labor prior to the nineteen hundred eighty-one Session of the General Assembly.

HOUSE JOINT RESOLUTION D

Requesting that the Criminal Justice Services Commission provide training for law-enforcement personnel in the recognition of mental disabilities and the proper handling of persons with mental disabilities.

WHEREAS, individuals experiencing the problems of mental illness, mental retardation or substance abuse may, in certain instances, require the assistance of law-enforcement personnel or may be contacted by law-enforcement personnel; and

WHEREAS, properly addressing the needs of mentally handicapped persons and understanding the manner in which mental disabilities may be manifested by an individual requires an awareness of the services available and requires training in the recognition of the symptoms of mental handicaps; and

WHEREAS, community services boards in the Northern Virginia area are allowing professionals skilled in the diagnosis and treatment of mental disabilities to work with law-enforcement personnel in crisis intervention; and

WHEREAS, these teams of mental health professionals and law-enforcement personnel are to be commended and encouraged to be established in every locality of the Commonwealth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Criminal Justice Services Commission is requested to provide training for law-enforcement personnel in the recognition of mental disabilities and the proper handling of persons experiencing the problems of mental illness, mental retardation or substance abuse. The training program shall apprise law-enforcement personnel of the community services available for the appropriate care, treatment and training of mentally handicapped individuals.

The Criminal Justice Services Commission shall cooperate with community services boards which have expertise in the fields of mental health, mental retardation and substance abuse to develop an appropriate training program and to promote coordination among law-enforcement personnel and the personnel of the community services boards.

HOUSE JOINT RESOLUTION E

Requesting that the Office of the Executive Secretary of the Supreme Court provide the judiciary information about community resources available to assist in commitment and certification proceedings for the mentally disabled.

WHEREAS, the Commission on Mental Health and Mental Retardation found that in court proceedings regarding the commitment or certification for treatment of mentally handicapped persons professional expertise is required in determining the appropriate services needed by the individual before the court; and

WHEREAS, the involvement of community services boards' personnel in these court proceedings allows the local boards to present recommendations for the appropriate services required by the mentally handicapped person as well as informing the local boards about residents of their jurisdiction who are entering State hospitals and training centers; and

WHEREAS, such cooperative efforts among the judiciary and community services boards foster coordination of the mentally handicapped individual's progress through the system of State and community services designed to provide treatment, training and care for persons with mental disabilities; and

WHEREAS, in order for such cooperative efforts to succeed, the judiciary must be aware of the community services for the mentally handicapped that are available throughout the Commonwealth and of the diagnostic and professional expertise available from the community services boards; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, that the the Office of the Executive Secretary of the Supreme Court is requested to provide to the district and circuit court judges at the statewide judicial conferences information about representative community resources available for court proceedings concerning mentally handicapped persons.

The Executive Secretary is requested further to work with the community services boards in developing this information so that the judiciary may be apprised of the expertise of community services boards' personnel in the diagnosis and treatment of mental disabilities.

SENATE JOINT RESOLUTION F

Requesting that the Secretary of Human Resources establish programs for the prevention of mental illness, mental retardation and substance abuse and for public awareness.

WHEREAS, previous generations in Virginia and across the nation have focused on the treatment and care of the mentally handicapped rather than addressing the causes of mental illness, mental retardation and substance abuse; and

WHEREAS, research into the causes of mental disabilities has revealed the need to initiate preventative programs which emphasize pre-natal care, proper nutrition, the need for immunization and other precautions that have been proven to promote mental health and to prevent developmental disabilities; and

WHEREAS, although programs for the prevention of substance abuse have evolved further than prevention programs in the mental health and mental retardation fields, more prevention programs are needed in all three disciplines to arrest the causes of mental disabilities; and

WHEREAS, the success of any human service program depends upon the willingness of the citizenry to accept the programs and the individuals for whom they are designed, thus, the public must be informed of the unique problems and potentialities of individuals who are mentally handicapped; and

WHEREAS, to accomplish the goals of initiating prevention programs and promoting public awareness, State and local human service agencies must work together to combine their professional and financial resources in establishing effective programs statewide; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Secretary of Human Resources is requested to establish as a high priority the initiation of prevention and public awareness programs among State and local services for mental health, mental retardation and substance abuse.

Special consideration should be devoted to interagency efforts to accomplish the establishment of effective prevention and public awareness programs and to maintain their effective operation.

A five-year plan for the development and implementation of these programs shall be compiled by the appropriate human service agencies under the direction of the Secretary of Human Resources.

The Secretary is requested to report the provisions of the plan to the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health in January of nineteen hundred eighty-one. The Secretary is requested to report to the same committees in January of nineteen hundred eighty-two to apprise the members with regard to the implementation of the plan.

SENATE JOINT RESOLUTION G

Requesting that the Department of Mental Health and Mental Retardation study the double diagnosis client.

WHEREAS, in its study from nineteen hundred seventy-seven to nineteen hundred seventy-nine, the Commission on Mental Health and Mental Retardation learned that individuals diagnosed as both emotionally disturbed and mentally retarded are not receiving services to appropriately address their multiple needs; and

WHEREAS, the double diagnosis individual frequently has physical disabilities which complicate the problems of emotional disturbance and mental retardation; and

WHEREAS, the complexity of this individual's handicaps increases the difficulty of developing an effective program for his appropriate treatment and care; and

WHEREAS, designing appropriate programs and services for the double diagnosis client is a perplexing problem in Virginia and throughout the nation; and

WHEREAS, the Developmental Disabilities Planning Council has studied the needs of children with multiple disabilities in the State, and Central State Hospital, the Southside Virginia Training Center and the Southside Community Services Board are cooperating to better serve multiply handicapped citizens in Southside Virginia; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Mental Health and Mental Retardation is requested to study the double diagnosis client.

The Department shall identify the approximate number of citizens with multiple disabilities and recommend an effective method of assuring that these citizens receive the services they need.

The experience and study of the Developmental Disabilities Planning Council and the State and community services in Southside Virginia should be utilized by the Department.

The Department is requested to present an interim report to the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health in the nineteen hundred eighty-one Session of the General Assembly and a final report in nineteen hundred eighty-two.

HOUSE JOINT RESOLUTION H

Requesting that the Secretary of Human Resources and the Secretary of Public Safety report on the coordination of services to mentally handicapped children and adults who are committed to the criminal justice system.

WHEREAS, House Joint Resolution No. 49 of the nineteen hundred seventy-eight Session of the General Assembly requested that the Secretary of Human Resources and the Secretary of Public Safety evaluate the effectiveness and efficiency of the Prescription Team which refers children committed to the Department of Corrections to appropriate services; and

WHEREAS, House Joint Resolution No. 49 requested further that recommendations be presented to the General Assembly regarding the improvement and coordination of existing services and the feasibility of developing new services to adequately address the needs of both children and adults who are incarcerated but who require treatment for mental disabilities; and

WHEREAS, the "Response of the Secretaries to House Joint Resolution No. 49" was presented to the General Assembly in December, nineteen hundred seventy-eight, identifying gaps in services to the State's mentally handicapped incarcerated population; and

WHEREAS, in nineteen hundred seventy-nine, the Commission on Mental Health and Mental Retardation studied the Response of the Secretaries and determined that continued oversight of the efforts to coordinate services to incarcerated individuals with mental disabilities is needed to assure that existing resources are utilized and that appropriate services are provided; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, that the Secretary of Human Resources and the Secretary of Public Safety are requested to report on the efforts to coordinate the services provided by the Department of Mental Health and Mental Retardation, the Department of Corrections and the Rehabilitative School Authority for the treatment and care of mentally handicapped incarcerated children and adults.

The Secretaries' report shall detail the measures implemented to assure that appropriate services are provided in an effective and efficient manner, appropriately addressing the needs of the State's incarcerated population who require services for mental illness, mental retardation or substance abuse.

The Secretary of Human Resources and the Secretary of Public Safety are requested to present their report to the House Committee on Health, Welfare and Institutions and the Senate Committee on Rehabilitation and Social Services in January of nineteen hundred eighty-one.

HOUSE JOINT RESOLUTION I

Requesting that the Governor address the percentage of State funds allocated to community mental health, mental retardation and substance abuse services.

WHEREAS, during its study from nineteen hundred seventy-seven to nineteen hundred seventy-nine, the Commission on Mental Health and Mental Retardation learned of the concern statewide over the proportion of funds which support State institutions for the mentally handicapped versus the proportion of funds supporting community-based services; and

WHEREAS, currently, approximately eighty-three percent of the State funds for services to the mentally handicapped supports State institutions while only seventeen percent of the State funds supports community-based services; and

WHEREAS, studies have proven that community-based care of the mentally handicapped is preferable to institutionalization; and

WHEREAS, the Commission on Mental Health and Mental Retardation supports the concept of providing appropriate care in the least restrictive environment which, in most instances, is the community; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Governor, in preparing the budget of the Commonwealth, is requested to alter the relative proportions of State funds for mental health, mental retardation and substance abuse that are allocated to State institutions and to community-based services.

The Governor is requested to develop a ten-year plan which, by nineteen hundred ninety, will result in sixty percent of the State's funds for the mentally handicapped being allocated to State institutions and forty percent allocated to community mental health, mental retardation and substance abuse services.

HOUSE JOINT RESOLUTION J

Requesting the Secretary of Human Resources to study the Title XX program.

WHEREAS, Title XX of the Social Security Act of 1974 established a consolidated program of federal financial assistance to encourage the states to furnish social services to individuals and families who meet certain eligibility criteria; and

WHEREAS, in Virginia, the Title XX program is administered by the Department of Welfare and the Commission for the Visually Handicapped under the guidance of the State Board of Welfare; and

WHEREAS, the Commission on Mental Health and Mental Retardation is concerned about the amount of Title XX funds distributed to programs for mental health, mental retardation and substance abuse and about the current procedure in the Commonwealth for the allocation of Title XX funds; and

WHEREAS, increasingly, citizens and legislators are expressing their sentiments about the allocation of Title XX funds and about the equitable distribution of those funds among the array of social services provided by the Commonwealth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Human Resources is requested to study the Title XX program in the Commonwealth.

Consideration should be given to the feasibility of alternative methods of mandating the services to be supported by Title XX funds and of distributing Title XX monies among social services throughout Virginia. The current evaluation of the Title XX program being conducted by the Joint Legislative Audit and Review Commission should be considered by the Secretary during this study.

The State Board of Welfare should refrain from approving the initiation of any new services funded with Title XX monies during the course of this study.

The Secretary of Human Resources is requested to report to the House Committee on Health, Welfare and Institutions, House Committee on Appropriations, Senate Committee on Education and Health and the Senate Committee on Finance prior to the nineteen hundred eighty-one Session of the General Assembly.

SENATE JOINT RESOLUTION K

Requesting that the Governor establish a timetable for closing, demolishing or transferring obsolete or substandard buildings throughout the State's mental health, mental retardation and substance abuse system.

WHEREAS, studies have proven that institutionalization fosters the routinization of the lives of patients and residents; and

WHEREAS, the Commonwealth has adopted the policy of deinstitutionalization which emphasizes the return of patients and residents in State institutions for the mentally handicapped to a less restrictive environment preferably in a community setting; and

WHEREAS, the implementation of the deinstitutionalization policy has reduced the population of the State institutions for the mentally handicapped and has resulted in a significant number of buildings being vacated; and

WHEREAS, it is the sense of the Commission on Mental Health and Mental Retardation that the bed capacity of the State institutions for the mentally handicapped should be limited to the capacity of the institutions as of July one, nineteen hundred eighty-one in order to encourage community-based care of mentally handicapped citizens; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Governor is requested to develop a timetable for closing, demolishing or transferring to another agency obsolete or substandard buildings in the State's mental health, mental retardation and substance abuse system.

The Governor is requested to present the timetable to the House Committee on Appropriations and the Senate Committee on Finance prior to the nineteen hundred eighty-two Session of the General Assembly.

HOUSE JOINT RESOLUTION L

Setting forth the policy of the Commonwealth for mental health, mental retardation and substance abuse.

WHEREAS, the work of the Commission on Mental Health and Mental Retardation during nineteen hundred seventy-eight and nineteen hundred seventy-nine has spanned the last two years of a decade of revolutionary changes in the attitudes of the judiciary, treatment professionals and the public toward the place of the handicapped in our society; and

WHEREAS, the Commission believes it is particularly appropriate to begin the nineteen hundred eighty's with a commitment to capture the innovative spirit of the last decade; and

WHEREAS, it is now the responsibility of the Commonwealth to make a reality of the programs and services necessary to effectively and humanely integrate the mentally disabled into our communities and to provide those unable to live independently quality treatment, training and care in the least restrictive environment; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the following statement shall be a declaration of policy documenting the dedication of the Commonwealth to the provision of high quality services and care for all mentally handicapped citizens.

Declaration of Policy

It is the policy of the Commonwealth of Virginia to establish, maintain and support the development of an effective system of treatment, training and care for mentally ill, mentally retarded and substance abusing citizens. The basic principle of this statewide system is that in every instance, the appropriate treatment, training and care shall be provided in the least restrictive environment with careful consideration of the unique needs and circumstances of each person. At the same time, the individual's right to refuse such services shall be respected and preserved, with the exception of instances where the individual's behavior presents a danger to himself or others.

It is the policy of the Commonwealth that all human service agencies, at both the State and local levels, shall jointly and cooperatively strive to assist citizens who have mental disabilities and to reduce the numbers of individuals defined as mentally handicapped who are subsequently enrolled in the treatment and training population.

The statewide system of services for the mentally handicapped must be planned and provided as a continuum ranging from independent community life to institutionalization. Regardless of the location of an individual's entry into the system, each person's initial placement and continuation throughout the appropriate services shall be monitored by a system of case management at the local level.

High quality treatment, training and care for every mentally handicapped person who enters the statewide system of services remains paramount in the policy of Virginia. The continuing focus throughout the Commonwealth must be the individual, regardless of age or degree of mental or physical handicap.

HOUSE JOINT RESOLUTION M

Requesting that the Department of Mental Health and Mental Retardation develop formulas for the distribution of funds for mental health, mental retardation and substance abuse community services.

WHEREAS, during its study from nineteen hundred seventy-seven to nineteen hundred seventy-nine, the Commission on Mental Health and Mental Retardation found that State funds supporting community services for mental health, mental retardation and substance abuse are distributed on a highly uneven basis; and

WHEREAS, current State statutes provide inadequate direction to the Department of Mental Health and Mental Retardation for governing the distribution of State general funds to community services boards; and

WHEREAS, the Department of Mental Health and Mental Retardation has begun the development of formulas for the distribution of funds for mental health and mental retardation services, but these formulas have not been implemented fully; and

WHEREAS, it is important to equitably fund community services boards as quickly as possible to provide a continuum of appropriate services for mental health, mental retardation and substance abuse throughout the Commonwealth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Mental Health and Mental Retardation is requested to develop formulas for the distribution of funds for mental health, mental retardation and substance abuse community services.

In the development of the formulas for the distribution of State general funds, the incidence of need for the services as well as population should be considered. The determination of local matching funds should consider only relative ability to pay and relative tax effort.

The Department of Mental Health and Mental Retardation is requested to report to the House Appropriations Committee and the Senate Committee on Finance by November 1, 1980. The report should include the Department's recommendations for implementing formula funding and the findings with regard to the impact the formulas will have on the community-based system of services for mental health, mental retardation and substance abuse.

HOUSE JOINT RESOLUTION N

Requesting that the State Mental Health and Mental Retardation Board adopt a policy establishing a funding ratio for the core services to be provided by community services boards.

WHEREAS, in its report to the Governor and the nineteen hundred eighty Session of the General Assembly, the Commission on Mental Health and Mental Retardation recommends that the State Mental Health and Mental Retardation Board be required to develop and adopt a policy establishing a core of mental health, mental retardation and substance abuse services for community services boards by July one, nineteen hundred eighty-two; and

WHEREAS, the core services for mental health, mental retardation and substance abuse should be the minimum services required to provide a continuum of care for mentally handicapped citizens of the Commonwealth; and

WHEREAS, the Report of the Commission on Mental Health and Mental Retardation recommends that the State Mental Health and Mental Retardation Board be required to specify other services, outside the core, which a community services board may provide its mentally handicapped citizens; and

WHEREAS, establishing the core of services and the list of auxiliary services for mental health, mental retardation and substance abuse is an essential step in the Commonwealth's progress toward achieving a community-based system of treatment, training and care for its mentally handicapped citizens; and

WHEREAS, the development of appropriate funding ratios for these services is fundamental to the implementation of the services throughout the Commonwealth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the State Mental Health and Mental Retardation Board is requested to adopt a policy establishing a funding ratio for the specified core of mental health, mental retardation and substance abuse community services.

The funding ratio shall finance core services with a substantially high percentage of State dollars with the requirement of a low rate of local matching funds. This funding ratio shall be utilized in the formulation of the biennial budget for nineteen hundred eighty-two through nineteen hundred eighty-four.

The State Board is requested further to adopt a funding ratio for services, outside the core, which a community services board may provide its mentally lhandicapped citizens. The funding ratio for these auxiliary services should require a high percentage of local funds to support the services and a correspondingly lower rate of State matching funds.

The State Mental Health and Mental Retardation Board is requested to report the funding ratios to the House Appropriations Committee and the Senate Committee on Finance by November one, nineteen hundred eighty.