REPORT OF THE

JOINT SUBCOMMITTEE ON MENTAL HEALTH

AND MENTAL RETARDATION

TO

THE GOVERNOR

AND

GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 22

COMMONWEALTH OF VIRGINIA
1982

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TABLE OF CONTENTS

Report of the
Joint Subcommittee on Mental Health
and Mental Retardation
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
January, 1982

To: The Honorable Charles S. Robb, Governor of Virginia
and
The General Assembly of Virginia

HISTORY OF THE JOINT SUBCOMMITTEE

In 1977, House Bill No. 1935 created the Commission on Mental Health and Mental Retardation. The Commission conducted a comprehensive review of Virginia's system of state and community services for mentally handicapped individuals. In 1980, the Commission issued a report and recommendations to the Governor and General Assembly of Virginia (House Document 8, 1980). The recommendations adopted by the General Assembly called for sweeping changes in the delivery of services to the mentally ill, mentally retarded and substance abuser. One of the many proposals offered by the Commission and adopted by the General Assembly was the appointment of a joint subcommittee to monitor statewide implementation of the Commission's recommendations and to ensure that the intent of the legislative effort was carried out.

House Joint Resolution No. 10 of the 1980 Session of the General Assembly established the Joint Subcommittee on Mental Health and Mental Retardation. Five members were appointed to the Joint Subcommittee from the House Committee on Health, Welfare and Institutions and three members were appointed from the Senate Committee on Education and Health. Delegate Frank M. Slayton of South Boston was chosen to serve as Chairman of the Joint Subcommittee and Senator Elliot S. Schewel of Lynchburg as Vice-Chairman. Other members of the Joint Subcommittee were: Delegate Evelyn M. Hailey of Norfolk; Senator Edward M. Holland of Arlington; Delegate Joan S. Jones of Lynchburg; Senator Frank W. Nolen of New Hope; Delegate Warren G. Stambaugh of Arlington; and Delegate W. Ward Teel of Christiansburg.

The Joint Subcommittee was created for a term of two years. The recommendations of the Commission on Mental Health and Mental Retardation were to guide the work of the Joint Subcommittee in assuring that proposed administrative policies and procedures were enacted and that the improved system would provide the most appropriate treatment, training and care for individuals with mental disabilities throughout Virginia.

The Joint Subcommittee convened once in 1980 to hear from the Department of Mental Health and Mental Retardation about plans for implementation of the Commission's recommendations. In June of 1980, the Department began to establish task forces comprising department personnel, representatives of the community services boards, interest groups and the public. Each task force was charged with developing specific recommendations outlined by the Commission on Mental Health and Mental Retardation. For example, one group was responsible for defining the core services to be offered by community services boards. Another task force was charged with the study of individuals who are both mentally ill and mentally retarded. In November, 1980, the Joint Subcommittee began receiving monthly progress reports on all the activities of the Department and task forces relative to the recommendations of the Commission.

In January, 1981, the Joint Subcommittee met at Central State Hospital in Petersburg, Virginia. The Department of Mental Health and Mental Retardation presented a series of six-month progress reports on efforts to plan for and to effect the Commission's recommendations. After meeting with representatives of the Department, the Joint Subcommittee toured Central State Hospital.

In May, the Washington Post published a series of articles about Western State Hospital. The articles alleged that patient abuse and neglect had become daily occurrences at the hospital. The Joint Subcommittee was alarmed by the allegations printed in the Post . Members expressed concern about the charges and agreed that the validity of the accusations needed to be investigated.

The June meeting of the Joint Subcommittee was dominated by the concerns about Western State Hospital. The Joint Subcommittee discussed the allegations with William J. Burns, Ph.D., Director of Western State Hospital, Leo E. Kirven, Jr., M.D., Commissioner of Mental Health and Mental Retardation, C. W. Brett, Deputy Commissioner and Anne S. Goodman, Employee Relations Director of the Department. The Joint Subcommittee decided to hold a public hearing in Staunton during the month of August to hear from employees of Western State Hospital regarding the charges of patient abuse and neglect and of employee unrest.

Simultaneously, the Local Human Rights Committee, a citizen's group which monitors the care of individuals in state institutions for the mentally handicapped, was instructed by the State Human Rights Committee to conduct an in-depth investigation of the situation at Western State. In addition, the Mental Health Association of Charlottesville-Albemarle began an independent investigation of Western State Hospital on behalf of the Mental Health Association in Virginia.

The Joint Subcommittee conducted its public hearing on August 10, 1981 on the grounds of Western State Hospital. Forty-six persons addressed the legislative group during the thirteen-hour hearing. The Joint Subcommittee heard the preliminary findings and recommendations of the Local Human Rights Committee. The members also received the report of the Charlottesville-Albemarle Mental Health Association. Additional documentation with regard to the patients and staff of Western State was submitted to the Joint Subcommittee prior to and following the August public hearing. An issue paper prepared by the staff for the Joint Subcommittee detailing the concerns expressed about Western State Hospital is included in Appendix B of this report.

The Joint Subcommittee held six regular meetings during 1981. Each meeting involved extensive and careful review of the progress made by the Department of Mental Health and Mental Retardation toward implementing the recommendations outlined by the Commission in 1980. The Joint Subcommittee also called on the heads of other state human services agencies, community services boards, the Secretary of Human Resources, the Secretary of Public Safety and the Secretary of Administration and Finance to review various projects relating to programs and services for the mentally handicapped. In addition, the Executive Secretary of the Supreme Court presented a report and recommendations on cost containment within the involuntary mental commitment fund.

Throughout the year, members of the Joint Subcommittee toured state hospitals and training centers to view facilities, observe programs and to meet and interview staff. These visits to the state facilities provided an opportunity for the Joint Subcommittee members to discuss the administration and operation of each institution with the directors and staff. The most rewarding experience of the visits was the opportunity to observe patients and residents participating in productive and therapeutic programs and to talk with many hospitalized individuals. Although programming for persons institutionalized in state hospitals and training centers has improved over the years, the Joint Subcommittee was disappointed to note that many individuals remain idle and are frequently unable to leave the wards. This idleness was attributed by hospital directors most often to a lack of staff and resources to provide effective programs and recreational opportunities for the patients and residents.

The Joint Subcommittee expresses its appreciation to each of the facility directors and to the staff who assisted with the visits. The frank and open communication with persons directly involved in mental health, mental retardation and substance abuse services proved invaluable to the Joint Subcommittee's work.

During the past two years, the Joint Subcommittee has worked with the Department of Mental Health and Mental Retardation and the community services boards in conducting its legislative oversight responsibilities. The Joint Subcommittee is encouraged by efforts to carry out the policies of the Commission on Mental Health and Mental Retardation. It believes, however, that a great deal of work lies ahead for the Commonwealth before the Commission's goals can be realized. The Joint Subcommittee, therefore, offers its recommendations to the Governor and 1982 Session of the General Assembly with the anticipation that these proposals will expedite the work of the Department of Mental Health and Mental Retardation, the State Board and community services boards toward achieving the policy directives that have been established legislatively for mental health, mental retardation and substance abuse services in the Commonwealth. The legislative recommendations of the Joint Subcommittee to the Governor and 1982 Session of the General Assembly are included in Appendix A of this report.

RECOMMENDATIONS

Continuing the Joint Subcommittee

Although progress has been made toward implementation of the 1980 recommendations of the Commission on Mental Health and Mental Retardation, the Department, State Board and community services boards have not yet achieved the continuum of service delivery envisioned by the Commission. Administrative changes within the Department of Mental Health and Mental Retardation over the past year, including the appointment of a new Commissioner, have slowed efforts toward realizing the policy directives and goals adopted by the General Assembly in 1980.

The Joint Subcommittee believes that continuing legislative oversight is needed to assure that these policy goals and directives are met. It is recommended that the Joint Subcommittee on Mental Health and Mental Retardation be continued for two years. The focus of the Joint Subcommittee's work shall be to provide guidance to the Department and community services boards in interpreting the intent and in refining and implementing the policies of the Commission on Mental Health and Mental Retardation.

Among the goals that still need to be achieved are: universal community services board coverage; full implementation of core services and formula funding; effective and comprehensive preadmission screening, predischarge planning and case management services; appropriate accreditation and certification of all state hospitals and training centers; provision of adequate staff for all state facilities; and a determination of the most effective allocation of funds between state institutions and community programs. In its report, House Document No. 8, 1980, the Commission on Mental Health and Mental Retardation documented the goals of the Commonwealth for each of the concerns listed above. The Department of Mental Health and Mental Retardation has confirmed that these policies and goals continue to be valid and timely, two years later. It is the job of the Commonwealth to strive to reach these goals without further delay. The Joint Subcommittee shall continue its legislative monitoring of these efforts to ensure that the goals are attained.

The Executive Secretary of the Supreme Court has presented a number of recommendations to the Governor and General Assembly to contain costs incurred by the Commonwealth in the process of the involuntary commitment of individuals to state hospitals for the mentally ill. Included with the cost containment proposals is the recommendation that the quality and effectiveness of Virginia's involuntary civil commmitment laws be evaluated along with the actual procedures and practices followed to commit a person to a state hospital.

It is recommended that in addition to continuing its legislative oversight responsibilities, the Joint Subcommittee shall conduct an evaluation of the statutes governing commitment in Virginia. The Joint Subcommittee shall submit its recommendations regarding the commitment laws concurrently with any other recommendations it deems appropriate to the Governor and 1983 and 1984 Sessions of the General Assembly.

University-Department Affiliations

During the August public hearing conducted at Western State Hospital by the Joint Subcommittee, physicians and psychologists cited the hospital's affiliation with the University of Virginia as one of the most positive aspects of their practice. In his remarks to the Joint Subcommittee in October, Dr. Joseph J. Bevilacqua, Commissioner of Mental Health and Mental Retardation, reiterated the benefits which accrue to state hospitals and training centers and to the universities and medical schools because of such cooperative affiliations. Dr. Bevilacqua emphasized the need to strengthen relationships between educational institutions which train mental health professionals and the Department of Mental Health and Mental Retardation. He stated that the training of mental health professionals in Virginia should include experience with the public sector through practicums and internships in the state hospitals and training centers. Furthermore, the Department should focus on in-service training, education and recruitment of qualified personnel in all of the state facilities for the mentally handicappedd.

The Joint Subcommittee concurs with Dr. Bevilacqua. It is therefore recommended that state-supported universities and medical schools be requested to strengthen relationships with the Department of Mental Health and Mental Retardation. Such affiliations shall seek to improve the capability of the Department to recruit and retain qualified professionals to work in state facilities

for the mentally handicapped. Concurrently, the educational institutions and the Department shall strive to establish internships and work experience opportunities for students and staff of the universities and medical schools.

Core Services

One of the most fundamental recommendations of the Commission on Mental Health and Mental Retardation was 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. The requirement for core services was included in House Bill No. 95 which was passed by the General Assembly in 1980. Current law adopted in 1980 requires that the State Board "determine, subject to the approval of the General Assembly, a core of program services to be provided by community services boards by July 1, 1982." The State Board is directed by law to "specify other program services which the community services boards may provide." The Commission recommended that these "auxiliary" services be funded with a high percentage of local funds and a correspondingly lower rate of state matching funds. To encourage community services boards to establish core services, it was recommended that the core services be funded with a substantially high percentage of state dollars and a relatively low rate of local funds.

During 1981, the Department, State Board, community services boards and Joint Subcommitee devoted a great deal of time to the development of definitions for core services. The method for funding core and auxiliary services was an integral part of these deliberations. On December 16, 1981, the State Board adopted definitions of core services. The Joint Subcommittee offers these definitions to the Governor and General Assembly for approval during the 1982 Session of the General Assembly.

Definitions Of Core Services

Emergency Service:

Offers 24-hour telephone service dealing specifically with calls for crisis help, or can provide 24-hour walk-in services staffed with treatment personnel offering help for emergency problems 7 days per week, or can provide 24-hour emergency psychiatric services around the clock. May have detoxification capacity or availability.

Inpatient Service:

Offers comprehensive treatment to patients who need 24-hour hospitalization including state institutions.

Day Support/Outpatient Service:

Offers habilitation/rehabilitation programs; individual, group and family counseling services; may include educational components; may include detoxification programs.

Residential Service:

Offers alternative community living arrangements. This can include, but is not limited to, group homes, cooperative apartments, and/or domiciliary care. May include specific therapeutic and training supports.

Prevention/Early Intervention:

Offers consultation to community agencies, the public and other providers relating to mental health, mental retardation and substance abuse clients. Offers early intervention services for at-risk populations.

In addition to approving the core services definitions, the Joint Subcommittee on Mental Health and Mental Retardation requests that the Governor and General Assembly take certain actions with regard to the original statutory mandates adopted in 1980. It is recommended that the General Assembly repeal the requirement that the State Board develop auxiliary services to be provided by community services boards. The Joint Subcommittee proposes that localities be allowed to define non-core services in relation to community needs and to assume complete responsibility for funding any services that do not conform to the five core services definitions.

Formula Funding

Defining core services and developing a method of providing equitable funding for community services have been the two most time consuming endeavors of the Department, State Board, community services boards and the Joint Subcommittee over the past two years. In 1980, the Commission on Mental Health and Mental Retardation maintained that:

> 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 Commission recommended that the Department plan to fully implement formula funding in the 1982-84 biennial budget. Over the past year, however, the Department and the Joint Subcommittee have spent many hours debating various components of the formula proposed by the Department. The Department and the Joint Subcommittee believe that additional preliminary steps are required before formula funding of community services for the mentally handicapped can become a reality in Virginia.

It is recommended that the deadline for implementing a formula distribution of community services funds be extended from July 1, 1982 to July 1, 1984 and that a new system of funding institutional and community services be implemented over an eight-year period. In addition, the Joint Subcommittee recommends that the proposed addendum budget request of the Department of Mental Health and Mental Retardation for $11,027,900 to fund community services be adopted. These additional funds for community services are intended to be utilized to establish core services in each of the community services board areas that do not have core services in place at the present time.

The Department and the legislature need to continue to work toward conceptualizing a fair and equitable system of funding community services. As noted earlier, the Department has developed a plan which spans eight years. The plan calls for the implementation of formula funding and a shift of state funds to balance the ratio of state dollars for institutional and community programs. The Joint Subcommittee endorses the plan proposed by the Department and offers it to the Governor and 1982 Session of the General Assembly. The Joint Subcommittee recommends that the Department proceed to carry out the plan with the legislative oversight of the Joint Subcommittee during 1982 and 1983 and with monitoring of appropriate standing committees of the General Assembly thereafter. The plan to attain full implementation of formula funding and to realign the percentages of state funds for institutional and community services over the next eight years follows.

Funding Plan

It is recommended that an overall time frame of eight years be adopted to bring the service delivery system for mentally disabled persons into proper balance. This time frame is required in order to make necessary adjustments in budget allocations, to bring about changes in the expectations of service providers and individual communities and to reduce gradually the inappropriate use of state hospitals and training centers. In the 1982-84 biennium, the service delivery system will be prepared to operate under formula funding. Initially, the $11,027,900 requested in the Department's addendum budget for 1982-84 will be used to fill identifiable gaps in core services in certain communities. The Department will simultaneously offer technical assistance to communities known to overutilize inpatient services in order to reverse this trend. The Department will refine the formula and the data needed to sensitize the formula to the variations among community services board areas. A proposed formula will be ready by August 1, 1982. During the 1982-84 period, the formula will be reviewed by appropriate committees of the General Assembly and will be tested by the Department.

By July 1, 1984, the Department and community services boards will be ready to implement a formula-based system of financing community-based programs for the mentally handicapped. The formula-based system will shift, over a period of six years, the institutional and community ratios of state dollar distribution for services. Instead of accepting an arbitrary ratio of 60% of state funds to finance institutional services and 40% of state funds to finance community programs, as proposed in House Joint Resolution No. 16, 1980, the appropriate utilization of institutional beds for age-specific

population groups will determine the proper funding of institutional and community services. In this regard, the Department has begun to determine through observation and experience the need for community-based and institutional services. In addition, the Department will determine the level of dollar support needed to insure that appropriate care and treatment are available.

To assure appropriate utilization of inpatient facilities, the Department of Mental Health and Mental Retardation will set specific targets for each community services board with regard to appropriate use of state hospital and training center beds. The targets will be based on an analysis of all institutionalized persons in the state hospitals and training centers.

Three factors will be applied in the formula that is developed to distribute state dollars to community services boards. The factors and their proposed weights within the formula are: need for services, 60%; population, 40%; and a disincentive for inappropriate inpatient service utilization. The disincentive factor will be a reduction of the community services board's budget based on the per diem cost of the board's appropriate institutional bed use. The local match ratio will be determined by the same tax effort relative to taxing capacity that is used presently by the Department.

According to the formula which is based 60% on need for services and 40% on population, the Department will maintain the flow of state dollars to community services boards that meet established targets for appropriate institutional bed usage. Of equal importance will be the establishment of a capacity building fund that will be used by the Department to bring community services boards into compliance with targeted institutional bed utilization. The fund will also be used to upgrade state facilities to meet accreditation standards. The capacity building fund will be generated by setting aside a determined portion of the Department's biennial appropriation.

As noted earlier, a fully developed formula will be prepared by August 1, 1982. The Joint Subcommittee recommends that an interim report on the formula and on the implementation of core services be presented to the Joint Subcommittee on Mental Health and Mental Retardation as soon as practicable after its completion and not later than October 1, 1982. The formula and any additional recommendations for core services shall then be prepared for presentation to the House Appropriations Committee, the House Committee on Health, Welfare and Institutions, the Senate Committee on Education and Health, and the Senate Committee on Finance by January 1, 1983. A completed report on core services and on the implementation of formula funding shall be presented to the same committees of the House and Senate by October 1, 1983. The final report should focus on the impact of core services and formula funding on the 1984-1986 biennial budget.

Preadmission Screening For Involuntary Commitments

During the public hearing conducted by the Joint Subcommittee in August at Western State Hospital, it was recommended that preadmission screening be required for involuntary commitments to state hospitals. In testimony before the Joint Subcommittee, the Executive Secretary of the Supreme Court supported preadmission screening prior to involuntary commitments to prevent inappropriate admissions to state hospitals. Presently, only persons who are voluntarily admitted to state hospitals are required to be pre-screened. According to statistics presented to the Joint Subcommittee by the Department of Mental Health and Mental Retardation, preadmission screening has been effective in directing individuals to community services whenever possible. The Joint Subcommittee is aware, however, that individuals continue to be inappropriately placed in state hospitals and training centers. The Department estimates that approximately 25% of persons institutionalized in state hospitals for the mentally ill could function in a community setting if proper services were available.

The Joint Subcommittee anticipates that the establishment of core services over the next two years in all community services board areas will assure the availability of basic services for the mentally handicapped throughout Virginia. Every effort should be made to prevent the inappropriate utilization of services provided by the state hospitals and training centers. Therefore, the Joint Subcommittee recommends that in cases involving the involuntary commitment of an individual to a state hospital for the mentally ill, the judge shall be required to request that the community services board prepare a pre-screening report within 48 hours after the judge's request. The judge, however, will not be bound by the recommendations of the pre-screening report in formulating his decision to commit or not to commit the individual to a state hospital. In addition, the Joint Subcommittee recommends that if the judge does not receive the report within the 48-hour period, he shall proceed to dispose of the case without the board's or clinic's recommendation.

House Resolution No. 52

House Resolution No. 52 was agreed to by the 1981 Session of the General Assembly. The resolution requested that the Department of Mental Health and Mental Retardation develop an appropriate policy for limiting the amount of expenses for community services for which responsible parties should be liable. The premise of the resolution was that responsible parties should not be liable for expenses incurred by family members who participate in community programs after a certain time period has elapsed or a specified amount of money has been paid.

The Department established a task force to formulate recommendations to be presented to the Joint Subcommittee. The task force presented its findings and recommendations to the Joint Subcommittee in October, 1981. The task force proposed amendments to several sections of the Code of Virginia pertaining to liability for services rendered by community services boards or community mental health clinics. The proposed amendments accomplish 3 objectives:

1. To define a day of service and provide the means to determine the date when 60 months of service have been accomplished.
2. To provide financial relief subsequent to the actual payment of reasonable assessments for 60 months. Services provided by institutions and community services boards will be counted together in determining the 60 months of service provision.
3. To require persons seeking relief under the proposed statutes to assist in establishing evidence of their entitlement to relief.

The Joint Subcommittee offers these amendments to the Governor and the 1982 Session of the General Assembly with the recommendation that the statutory changes be adopted. The recommended statutory changes are included with the proposed legislation in Appendix A of this report.

CONCLUSION

The Joint Subcommittee on Mental Health and Mental Retardation respectfully submits its recommendations to the Governor and the 1982 Session of the General Assembly.

Respectfully submitted,

Frank M. Slayton, Chairman

Elliot S. Schewel, Vice-Chairman

Evelyn M. Hailey

Edward M. Holland

Joan S. Jones

Warren G. Stambaugh

W. Ward Teel

Appendix A

Proposed legislation for introduction to the 1982 Session of the General Assembly:

1. Joint resolution continuing the Joint Subcommittee on Mental Health and Mental Retardation.

2. Joint resolution requesting state-supported institutions of higher education to cooperate with the work of the Department of Mental Health and Mental Retardation.

3. Joint resolution approving a core of program services for mental health, mental retardation and substance abuse services.

4. A bill repealing the requirement that the State Mental Health and Mental Retardation Board identify auxiliary services which may be provided by a community services board.

5. A bill requiring a judge to request a preadmission screening report from the community services board prior to the involuntary commitment of an individual to a state hospital for the mentally ill.

6. A bill limiting the financial liability of persons who are responsible for individuals receiving community services for the mentally handicapped.

HOUSE JOINT RESOLUTION NO. ...

Continuing the Joint Subcommittee on Mental Health and Mental Retardation of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health.

WHEREAS, the Joint Subcommittee on Mental Health and Mental Retardation was established pursuant to House Joint Resolution No. 10 in 1980; and

WHEREAS, the Joint Subcommittee has worked for two years, monitoring the administration of mental health, mental retardation and substance abuse services in Virginia and ensuring implementation of the recommendations of the Commission on Mental Health and Mental Retardation; and

WHEREAS, it is the sense of the Joint Subcommittee that a legislative forum should remain available for continued communication among legislators, state hospitals and training centers for the mentally handicapped, community services boards, the Department of Mental Health and Mental Retardation and the concerned public; and

WHEREAS, there is a continuing need for legislative oversight of the administration and operation of state and local mental health, mental retardation and substance abuse services to assure that a continuum of care is available for mentally handicapped persons who enter state institutions or who reside in the community; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee on Mental Health and Mental Retardation is continued. The Joint Subcommittee shall focus its oversight responsibilities on monitoring the work of the Department of Mental Health and Mental Retardation and community services boards. The Joint Subcommittee shall provide guidance for the fulfillment of the Department's and the boards' responsibilities within the human service delivery system of the Commonwealth.

In addition to continuing its oversight responsibilities, the Joint Subcommittee shall conduct a comprehensive evaluation of state statutes governing commitment of an individual to a state hospital for the mentally ill. The evaluation shall include a review of commitment policies and procedures utilized throughout the Commonwealth.

The members of the Joint Subcommittee shall continue to serve and any vacancies in the membership shall be filled through appointments made by the chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health.

The Joint Subcommittee shall submit any recommendations it deems appropriate to the 1983 and 1984 Sessions of the General Assembly.

The cost of this study shall not exceed $15,000.

HOUSE JOINT RESOLUTION NO. ...

Requesting state-supported institutions of higher education to cooperate with the work of the Department of Mental Health and Mental Retardation.

WHEREAS, during 1981, the Department of Mental Health and Mental Retardation has directed much effort toward evaluating the staffing requirements for state hospitals and training centers and determining the appropriate levels of care to be provided by state facilities and community programs for the mentally handicapped; and

WHEREAS, the Joint Subcommittee on Mental Health and Mental Retardation heard testimony in 1981 emphasizing the need to strengthen professional ties between state hospitals and training centers for the mentally handicapped and Virginia's universities and medical schools; and

WHEREAS, tremendous benefit can accrue to the citizens of the Commonwealth as a result of cooperative affiliations between the providers of services for the mentally handicapped and educational institutions which train individuals for practice in medical and mental health professions; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That state-supported institutions of higher education which train individuals to work in professions associated with mental illness, mental retardation or substance abuse are requested to develop cooperative relationships with the Department of Mental Health and Mental Retardation. The Department and state-supported educational institutions shall strive to improve the capability of the Department of Mental Health and Mental Retardation to recruit qualified professionals to work in state and community mental health, mental retardation and substance abuse programs.

In addition, the universities and medical schools shall cooperate with the ongoing work of the Department to evaluate staffing requirements for state hospitals and training centers and to determine the appropriate levels of care to be provided by state facilities and community programs for the mentally handicapped. The Department and educational institutions shall seek to foster internships and work experience opportunities for students and staff of the universities and medical schools; and be it

RESOLVED FURTHER, That the Clerk of the House of Delegates is requested to forward a copy of this resolution to each of the state institutions of higher education which train mental health and medical professionals.

HOUSE JOINT RESOLUTION NO. ...

Approving a core of program services for mental health, mental retardation and substance abuse services throughout the Commonwealth and requesting reports on core services and formula funding by the Department of Mental Health and Mental Retardation.

WHEREAS, one of the most fundamental recommendations of the Report of the Commission on Mental Health and Mental Retardation (H.D. 8, 1980) was 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 to be provided by community services boards; and

WHEREAS, § 37.1-194 of the Code of Virginia requires that "the State Mental Health and Mental Retardation Board shall determine, subject to the approval of the General Assembly, a core of program services to be provided by community services boards by July 1, 1982"; and

WHEREAS, during 1980 and 1981, the Department of Mental Health and Mental Retardation and the Joint Subcommittee on Mental Health and Mental Retardation devoted considerable time and effort to developing suitable definitions for core mental health, mental retardation and substance abuse services; and

WHEREAS, on December 16, 1981, the State Mental Health and Mental Retardation Board adopted the definitions of core services which will be utilized by the Department of Mental Health and Mental Retardation to determine whether each community services board is providing basic community mental health, mental retardation and substance abuse services; and

WHEREAS, the Commonwealth has had significant experience with the core services definitions adopted in 1981 by the State Mental Health and Mental Retardation Board because the definitions conform to minimal service designations for comprehensive community mental health centers' programs and for mental retardation and substance abuse programs; and

WHEREAS, core services are not mandated services which localities are required to provide, rather, the Department of Mental Health and Mental Retardation will provide monetary incentives in the 1982-1984 biennium for community services boards which do not provide the basic services defined as core services to develop programs which meet the core services definitions; and

WHEREAS, prior to the 1984-1986 biennium the Department of Mental Health and Mental Retardation will develop a formula for equitably funding community services boards which will include incentives for the boards to maintain existing services and to choose to provide new services which conform to the core services definitions; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the definitions of core services for mental health, mental retardation and substance abuse services adopted by the State Mental Health and Mental Retardation Board are hereby approved. The core services definitions shall be:

Emergency Service:

Offers 24-hour telephone service dealing specifically with calls for crisis help, or can provide 24-hour walk-in services staffed with treatment personnel offering help for emergency problems 7 days per week, or can provide 24-hour emergency psychiatric services around the clock. May have detoxification capacity or availability.

Inpatient Service:

Offers comprehensive treatment to patients who need 24-hour hospitalization including state institutions.

Day Support/Outpatient Service:

Offers habilitation/rehabilitation programs; individual, group and family counseling services; may include educational components; may include detoxification programs.

Residential Service:

Offers alternative community living arrangements. This can include, but is not limited to, group homes, cooperative apartments, and/or domiciliary care. May include specific therapeutic

and training supports.

Prevention/Early Intervention:

Offers consultation to community agencies, the public and other providers relating to mental health, mental retardation and substance abuse clients. Offers early intervention services for at-risk populations.

The core services definitions shall be used by the Department of Mental Health and Mental Retardation to assess the programs and services provided by community services boards and to determine whether the boards offer basic mental health, mental retardation and substance abuse services to the jurisdictions they serve. The core services definitions shall be an integral factor in planning the delivery of statewide mental health, mental retardation and substance abuse services and in developing a funding formula to equitably fund community services for mentally handicapped persons in the Commonwealth; and be it

RESOLVED FURTHER, That the Department of Mental Health and Mental Retardation is requested to submit an interim report on the implementation of core services and on formula funding to the House Committee on Appropriations, the House Committee on Health, Welfare and Institutions, the Senate Committee on Finance, and the Senate Committee on Education and Health by January 1, 1983; and be it

RESOLVED FINALLY, That the Department of Mental Health and Mental Retardation is requested to present a final report on core services and formula funding to the same committees of the House and Senate by October 1, 1983. The final report shall focus on the impact of core services and formula funding on the 1984-1986 biennial budget.

A BILL to amend and reenact § 37.1-194 of the Code of Virginia, relating to services provided by community services boards.

Be it enacted by the General Assembly of Virginia:

1. That § 37.1-194 of the Code of Virginia is amended and reenacted as follows:

§ 37.1-194. Purpose; services to be provided.–The Department, for the purposes of establishing, maintaining, and promoting the development of mental health, mental retardation and substance abuse services in the ~~State~~ *Commonwealth* , may make matching grants to assist any county having a population of approximately ~~fifty thousand~~ *50,000* or more or any city having a population of approximately ~~seventy-five thousand~~ *75,000* or more, or any combination of political subdivisions having a combined population of approximately ~~fifty thousand~~ *50,000* 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, mental retardation and substance abuse programs. 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~~ *1, 1983* .

The State Mental Health and Mental Retardation Board shall determine, subject to the approval of the General Assembly, a core of program services to be provided by community services boards by July ~~one, nineteen hundred eighty-two~~ *1, 1982* 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, referral and education services to the general public, and lay and professional groups.

(c) Consultation and evaluation services for courts, public schools, health and welfare agencies 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 substance abuse programs necessary to provide a comprehensive system of services.

A BILL to amend and reenact § 37.1-67.3 of the Code of Virginia, relating to involuntary admission and treatment of a mentally ill person to a state hospital for the mentally ill.

Be it enacted by the General Assembly of Virginia:

1. That § 37.1-67.3 of the Code of Virginia is amended and reenacted as follows:

§ 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 psychiatrist who is licensed in Virginia or one physician who is licensed in Virginia and who is qualified in the diagnosis of mental illness. The judge shall also summons other witnesses when so requested by the person or his attorney. The psychiatrist or 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 psychiatrist or 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~~ *shall request* from the community services board or community mental health clinic which serves the political subdivision where the person resides a prescreening report ~~which states~~ *, and the board or clinic shall provide such a report within forty-eight hours. The report shall state* 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 the prescreening report is not received by the judge within the specified forty-eight hour period, the judge shall proceed to dispose of the case without the board's or clinic's recommendation.* 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 ~~State~~ *state* hospital as provided for in this section, the court shall notify the appropriate 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.

A BILL to amend and reenact §§ 37.1-1, 37.1-105, 37.1-110 and 37.1-197 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 10 of Title 37.1 a section numbered 37.1-202.1, which sections pertain to reimbursement for expenses for certain mental health services.

Be it enacted by the General Assembly of Virginia:

1. That §§ 37.1-1, 37.1-105, 37.1-110 and 37.1-197 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 10 of Title 37.1 a section numbered 37.1-202.1 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.]

(2a) "Client", as used in Chapter 10 of this title, means any person receiving a service provided by personnel or facilities under the jurisdiction or supervision of a community services board;

(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~~ *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 management of the Commissioner;

(7) [Repealed.]

(8) "Hospital" or "hospitals" when not modified by the words ~~"State"~~ *"state"* or "private" shall be deemed to include both ~~State~~ *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 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 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 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.

§ 37.1-105. Who liable for expenses; amount.--Any person who has been or who may be admitted to any ~~State~~ *state* hospital ~~;~~ or who is the subject of counseling or receives treatment from the staff of a ~~State~~ *state* hospital shall be deemed to be a patient for the purposes of this article ~~;~~ ~~or the estate of any such patient or the person or persons legally liable for the support of any such patient,~~

The income and estate of a patient shall be liable for the expenses of his care ~~;~~ *and* treatment ~~and maintenance in such~~ *or training in a state* hospital ~~; provided that no parent, guardian, spouse or relative shall be liable for any expense which arose from the care, treatment or maintenance furnished to any patient subsequent to institutionalization of such patient in a State hospital for a period of sixty months~~ . *Any person or persons responsible for holding, managing or controlling the income and estate of the patient shall apply such income and estate toward the expenses of the patient's care and treatment or training.*

Any person or persons responsible for the support of a patient pursuant to § 20-61 shall be liable for the expenses of his care and treatment or training in a state hospital. Any such person or persons shall no longer be financially liable, however, when a cumulative total of 1826 days of (i) care and treatment or training for the patient in a state hospital; or (ii) the utilization by the patient of services or facilities under the jurisdiction or supervision of any community services board; or (iii) a combination of (i) and (ii) has passed, and payment for or a written agreement to pay the assessments for 1826 days of care and services has been made. Not less than three hours of service per day shall be required to include one day in the cumulative total of 1826 days of utilization of services under the jurisdiction or supervision of a community services board. In order to claim this exemption, the person or persons legally liable for the patient shall produce evidence sufficient to prove eligibility therefore.

Such expenses shall not exceed the actual per capita cost for the particular type of service

rendered and shall be determined no less frequently than annually by the Department in accordance with standard accounting practice ; ~~but~~ . In no event shall recovery be permitted for amounts more than five years past due. A certificate of the ~~Director or Assistant Director of Reimbursement of the Department~~ *Commissioner or his designee* shall be prima facie evidence of the actual per capita cost for the particular type of service rendered.

§ 37.1-110. Application for order to compel payment of expenses.– ~~Upon the failure of~~ *When* any patient or ~~of~~ his guardian, committee, trustee or ~~of~~ the person or persons legally liable for his expenses ; *fails* to ~~make payment of the same~~ *pay such expenses* , and ~~whenever~~ it appears from investigation that such patient, his guardian, committee, trustee ; or the person or persons legally liable for the support of ~~such~~ *the* patient ; *is able or* has sufficient estate ; ~~or there is evidence of ability~~ to pay such expenses, the Department shall petition the appropriate court having jurisdiction over the estate of the patient ; or *the court* for the county or city of which ~~he~~ *the patient* is a legal resident ; or from which he was admitted to a ~~State~~ *state* hospital ; ~~provided, however,~~ *for an order to compel payment of such expenses by persons liable therefor.* In any case in which a person or persons legally liable for the support of the patient is being proceeded against, the petition shall be directed to the appropriate court of the county or city in which such person or persons legally liable for the support of ~~such~~ *the* patient reside ; ~~for an order to compel payment of such expenses by persons liable therefor and in the following order:~~ .

~~First, by~~ The patient ~~or~~ *and* his estate ; ~~and second, by~~ *shall first be liable for the payment of his expenses and thereafter,* the person or persons legally liable for the support of ~~such~~ *the* patient. Such person or persons shall be the father, mother, husband, wife ; *and* child or children of the patient, ~~provided the child or children~~ *who* have attained the age of majority. Such persons shall be jointly and severally liable. The Department shall collect such part or all of such expenses from the several sources as appears proper under the circumstances and may proceed against all of such sources. The proceedings for the collection of such expenses shall conform to the procedure for collection of debts due the Commonwealth. ~~The legally liable persons shall be the father, mother, husband, wife, child or children of the patient, provided the child or children have attained the age of majority. Such persons shall be jointly and severally liable. Solely for the purpose of determining eligibility under the State plan for medical assistance, the father or mother, or both, of a patient under twenty-one years of age, shall be liable or financially responsible for the care, treatment and maintenance of their child only to the extent of any family health insurance benefits that are payable for such care. After the exhaustion of family health insurance benefits, in determining the eligibility of patients under twenty-one years of age, the income and resources of the father or mother shall not be considered available to that patient if he does not regularly share the common household even if the patient returns to the common household for periodic visits.~~

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

(a) Review and evaluate all existing and proposed public community mental health, mental retardation and substance abuse services and facilities 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, mental retardation and substance abuse services and facilities for its approval.

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

(d) In accordance with its approved program, 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 promulgated by the State Board.

(f) Appoint a coordinator or director of community mental health, 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 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, 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 *consistent with the provisions of § 37.1-202.1* 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 ; ~~provided, however,~~ . In accepting such grants the board shall not bind the governing body or bodies of the political subdivision or subdivisions of which it is an agency to any expenditures or conditions of acceptance without the prior approval of such governing body or bodies.

(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.

§ 37.1-202.1. Liability for expenses of services.–The income and estate of a client shall be liable for the expenses of services or facilities under the jurisdiction or supervision of any community services board which are utilized by the client. Any person or persons responsible for holding, managing or controlling the income and estate of the patient shall apply such income and estate toward the expenses of the services or facilities utilized by the client.

Any person or persons responsible for the support of a client pursuant to § 20-6l shall be liable for the expenses of services or facilities under the jurisdiction or supervision of any community services board which are utilized by the client. Any such person or persons shall no longer be financially liable, however, when a cumulative total of 1826 days of (i) care and treatment or training for the client in a state hospital; or (ii) the utilization by the client of services or facilities under the jurisdiction or supervision of any community services board; or (iii) a combination of (i) and (ii) has passed, and payment for or a written agreement to pay the assessment for 1826 days of care and services has been made. Not less than three hours of service per day shall be required to include one day in the cumulative total of 1826 days of utilization of services under the jurisidiction or supervision of a community services board. In order to claim this exemption, the person or persons legally liable for the client shall produce evidence sufficient to prove eligibility therefor.

Appendix B
Issue Paper
The Administration of Western State Hospital
Prepared by Martha A. Johnson, Research Associate
Staff, Joint Subcommittee on Mental Health and Mental Retardation

December 8, 1981

INTRODUCTION

In May of 1981 allegations of patient abuse and neglect at Western State Hospital in Staunton, Virginia were the subject of a series of articles published by the Washington Post . During interviews with the Post , some hospital staff contended that key members of the administrative staff were guilty of patient abuse by failing to rectify certain conditions at the hospital.

The charges of the hospital employees reflected negatively upon the entire hospital. Among the allegations were claims that sexual assaults and violence among patients had become commonplace occurrences. Insufficient numbers of staff and the lack of proper staff training had resulted in poor levels of treatment and practically nonexistent monitoring of the patients. Inappropriate admissions and improper classifications of patients were perceived to be blatant violations of patients' rights. In addition, it was charged that staff members who reported instances of patient abuse or violations of patients' rights were intimidated by administrative staff and wrongfully suspended from or relieved of their positions.

After reviewing the allegations, the State Human Rights Committee initiated an investigation of Western State Hospital by the Local Human Rights Committee. An additional in-depth investigation was conducted by the Mental Health Association of Charlottesville-Albemarle.

The chairpersons of both the Local Human Rights Committee and the Committee Studying Conditions at Western State Hospital of the Mental Health Association addressed the Joint Subcommittee on Mental Health and Mental Retardation during a thirteen-hour public hearing held on the hospital grounds on August 10, 1981. Forty-six persons addressed the Joint Subcommittee during the hearing. Much of the testimony focused on the allegations published in the Washington Post .

The issues addressed in the reports of the Local Human Rights Committee and the Mental Health Association provide a great deal of insight into the problems of the hospital. The reports are entitled: "The Investigation of Conditions at Western State Hospital: A Report by the Local Human Rights Committee, July 15, 1981," and "Inquiry Into Conditions at Western State Hospital: Report prepared by the Ad Hoc Committee of the Mental Health Association of Charlottesville-Albemarle, August 7, 1981." Issues addressed by both reports are:

1. Improper Commitment Classification

2. Violence Among Patients on Unit G-7 and 8

3. Incident Reports of Violence in Shenandoah Geriatric Treatment Center during 1980

4. Violent Patients

5. Medical Practice

6. Mentally Retarded Population

7. Overuse of Seclusion

Additionally, the Mental Health Association of Charlottesville-Albemarle delved into related issues such as: the accreditation status of Western State Hospital; staffing patterns and levels; the quality of the admissions and discharge processes at the hospital; and the departmental and internal responses to the problems identified in the course of the investigations. The State Human Rights Committee identified three areas of concern that were deemed inappropriate for investigation by the Local Human Rights Committee. These three issues are: intimidation of employees who have registered complaints of patient abuse; the quality of commitment hearings; and allegations of improper discharge and placement.

William J. Burns, Ph.D., Director of Western State Hospital, responded to the investigation of the Local Human Rights Committee in a letter dated August 7, 1981 addressed to Owen W. Brodie, M.D., Chairman of the State Human Rights Committee. Dr. Burns addressed the Joint Subcommittee on Mental Health and Mental Retardation during the public hearing in August and in a letter written in December, 1981, responding to specific concerns of the legislators.

This paper will deal first with the seven issues common to the two investigative reports. The review of each issue will document related concerns addressed by speakers at the public hearing of the Joint Subcommittee on Mental Health and Mental Retardation on August 10, 1981. The action taken by or the response of Western State Hospital's administrative staff to each issue identified will be recounted.

Other pertinent issues identified by the Local Human Rights Committee, the Mental Health Association and by individuals who spoke at the public hearing or who submitted documentation to the Joint Subcommittee will be addressed as well.

PRIMARY ISSUES INVESTIGATED

1. Improper Commitment Classification : Legislation enacted in 1974 (VA. Acts of Assembly 1974, Ch. 351) required the reclassification to "voluntary admission" for any person who was not charged with a crime but who was involuntarily committed to a state hospital prior to November 1, 1974. Consequently, some patients who had been admitted to the state hospitals as involuntary commitments automatically became classified as voluntary admissions. In June of 1981, the Local Human Rights Committee found that approximately 177 of Western State Hospital's patients were classified as voluntary even though their records included no written documentation of their consent to admission. Of the 177 patients, 126 had been involuntarily committed to Western State prior to September 1, 1974 but became voluntary admissions pursuant to the law enacted in 1974. These 126 patients were placed into a third classification, "administrative voluntary."

The controversy about the "administrative voluntary" status arose because as involuntarily admitted patients each individual is required to be the subject of a judicial review every 180 days to determine whether his condition demands continued involuntary hospitalization. Judicial reviews, also known as recommitment hearings, are not required for patients who are classified as voluntary. Therefore, in 1974 when involuntarily committed patients were classified as voluntary or administrative voluntary admissions, those patients were no longer the subject of the 180-day judicial review. The administrative voluntary classification, however, is no longer used at Western State Hospital.

In his response to the State Human Rights Committee, Dr. Burns, Director of the hospital, stated:

> The hospital has never denied the existence of the "administrative voluntary" patients. Rather, we have sought clarification and guidance from the office of the Assistant Attorney General For Mental Health. When we were informed in March, 1981, that we should review these cases with consideration given to the need for commitment hearings, we initiated such action for all such patients. In addition, we subsequently decided to review not only the "administrative" voluntaries, but all voluntary patients within the hospital to assure that none were improperly classified.

The review of the 177 patients who were identified by the Local Human Rights Committee and whose records included no written documentation of their consent to admission to Western State Hospital, was conducted in the fall of 1981. Dr. Burns informed the Joint Subcommittee that all 177 patients were evaluated by clinical staff including physicians and psychologists at Western State Hospital. A total of 141 patients were reviewed in judicial proceedings. Eighteen signed voluntary papers, thus not requiring judicial hearings. Three patients died before certification proceedings were initiated. One patient was discharged. Fourteen patients remained in the life skills program at Western State as of December 7, 1981, waiting to be certified as mentally retarded. These certification proceedings were delayed until authorization could be obtained from the Commissioner of Mental Health and Mental Retardation for the life skills program to be designated as an appropriate unit for the temporary placement of mentally retarded patients at Western State. Authorization was received by the hospital and the certifications were scheduled for completion by the end of 1981.

Dr. Burns noted that all patients who are classified as voluntary admissions at Western State Hospital are routinely informed of the legal rights afforded by voluntary status.

A caveat to the hospital administration's review of all voluntary and administrative voluntary patients was included in the July, 1981 report of the Local Human Rights Committee (LHRC) which reads:

The LHRC wishes to emphasize that changes in commitment classification cannot be expected to effect any real changes for the patients involved, most of whom are elderly and chronically impaired. Broader policy issues such as providing more nursing home beds in the communities or assuring better representation in commitment hearings must be addressed before the judicial review of the "administrative voluntary" patients can be expected to have major significance.

The quality of commitment hearings and of recommitment hearings at Western State Hospital and throughout Virginia was questioned as a result of the controversy initiated by the administrative voluntary issue. At the August public hearing and in subsequent meetings of the Joint Subcommittee on Mental Health and Mental Retardation, legislators and others questioned the value of such proceedings in providing due process for and the appropriate treatment of the individuals who are the subject of the hearings.

Dr. Burns informed the Joint Subcommittee that a questionnaire designed to generate data on commitment hearings has been developed for Western State Hospital by an attorney who is also a member of the LHRC. After data is gathered on the hearings, the hospital advocate and the LHRC will analyze the information and present recommendations to the judiciary. The University of Virginia Institute for Law and Psychiatry has offered its assistance to Western State in the analysis of commitment proceedings. The project cannot begin, however, until the hospital advocate is relieved of the responsibility of acting as the advocate for Dejarnette Center for Human Development. Dejarnette anticipates hiring its own full-time advocate by January 31, 1982.

At its December meeting, the Joint Subcommittee received a report from the Office of the Executive Secretary of the Supreme Court on cost containment in the expenditure of funds for involuntary commitment of the mentally ill in Virginia. The Joint Subcommittee expressed its concern about both the quality of the proceedings and the significant amount of state funds that are required to pay the members of the judiciary who conduct the hearings, the attorneys who represent the patients, the examining physicians and witnesses.

The "Report of the Executive Secretary of the Supreme Court of Virginia on Cost Containment within the Criminal Fund and Involuntary Mental Commitment Fund," will be submitted to the Governor and the 1982 Session of the General Assembly. The report contains several recommendations to contain the costs of mental commitments. In addition, it is recommended that a thorough evaluation of state statutes governing involuntary civil commitment to a hospital for the mentally ill be conducted. The report proposes that the analysis determine and seek to improve the quality and effectiveness of the statutes governing commitment of the mentally ill and of commitment procedures followed throughout the Commonwealth.

2. Violence Among Patients On Unit G-7 and 8 : Unit G-7 and 8 of Western State Hospital was the area of the hospital singled out in the Washington Post articles as a place where violence and sexual assaults among patients had become almost daily occurrences. In the fall of 1980, problems arose when the patient census increased at the same time that the unit became severely understaffed, losing a physician, a psychologist, a nurse and 3 to 4 aides. At that time the unit contained 44 beds and was usually filled to capacity with new admissions of adult males from the geographical area it served. In some instances, forensic and civilly committed patients as well as mentally retarded patients were housed together on the unit. The incongruous mix of patients along with insufficient staff created an unhealthy atmosphere on the unit. An April 27, 1981 memo from a clinical social worker assigned to Unit G-7 and 8 addressed to his supervisor documents specific instances of sexual abuse among patients. The memo states in part:

> The problem here goes beyond management of homosexual conduct or the problems of sexual adjustment that occur in all institutions where one sex is involuntarily deprived of social and sexual access to the other.
>
> We have here a major group of known sexual offenders, mixed with another major group of known fighters.

On April 29, 1981 an Ad Hoc Committee of professional staff at Western State Hospital issued a report addressing the problems on the unit. According to Dr. Burns, the hospital administration began immediately upon completion of the report to implement the Committee's recommendations. Admissions to the unit were halted. Patient census was reduced from 44 to 38. Patients were transferred to other wards of the hospital to create a better mix of personalities and to make G Unit a long-term care unit. Staff members were transferred to the unit and additional personnel

positions were allocated. Simultaneously, physician hours on the unit were increased. The Mental Health Association noted in its August 7, 1981 report, however, that, "the services of an additional doctor are still needed for effective treatment."

At the August hearing, Lucy Smith, Director of Nursing and Chairperson of the Ad Hoc Committee, reported that the Office of the Attorney General had been asked to assist in developing a procedure to train hospital staff to deal with sexual abuse. The Joint Subcommittee learned that the Staff Development and Training Department of the hospital has prepared a sexuality training course.

Direct care staff of G Unit began participating in sexuality training workshops in the fall of 1981. All of the staff of G Unit is scheduled to participate in the workshops by January 31, 1982. Currently, all hospital units may take advantage of the sexuality training course. Unit Directors are required to make this a priority training project for 1982. A standing Committee for the Study of Human Sexuality Training, Policies and Procedures has been meeting on a regular basis to review, define and recommend policy and training needs hospital-wide with regard to human sexuality. A member of the LHRC is a member of the sexuality training committee and is monitoring the hospital's progress in this area for the LHRC.

Mrs. Wilma Rowe, who has worked at Western State Hospital for several years, has been assigned to G Unit full-time as program director. Mrs. Rowe and a recently hired psychologist for the unit have developed programs and activities to channel aggressive behavior in a positive direction. At the Joint Subcommittee's public hearing, Mrs. Rowe cited the lack of staff, money and training as primary reasons for recent problems at the hospital. She said that during her work at Western State, she has never witnessed patient abuse. Rather, she believes that patients are "misused" frequently because they fail to receive optimum care and treatment due to the overextension of staff and resources.

Several key positions on G Unit, including a full-time physician, licensed practical nurse, team leader, social worker and developmental technician are expected to be filled by January 1, 1982. According to Dr. Burns, addition of these personnel will allow full implementation of programming for the unit early in 1982.

In addition to the shortage of qualified hospital staff, the report of the Mental Health Association and speakers at the public hearing all indicated that state hospitals need to have better access to legal advice particularly in crisis situations. The two assistant attorneys general assigned to the Department of Mental Health and Mental Retardation handle the legal problems of the entire statewide system of services. Dr. Lawrence Sutker, a psychiatrist at Western State Hospital told the Joint Subcommittee that the controversy over the administrative voluntary patients at Western State could have been avoided if adequate legal advice had been available to the hospital.

3. Incident Reports of Violence in Shenandoah Geriatric Treatment Center during 1980: On May 19,1981, the Washington Post reported:

> Social workers in the hospital's geriatric center compiled a list of more than 600 violent incidents last year but say the hospital's administration has refused to acknowledge the problem.
>
> In one unit designated for Northern Virginians, officials mixed about 20 accused or convicted felons undergoing psychiatric examinations with a dozen chronically ill and vulnerable mental patients for about six months.

After investigation and review of patient incident reports which are filed for every accident that occurs to a patient, the Local Human Rights Committee found that:

> Incident reports...show that the level of incidents for Western State Hospital as a whole, decreased during the period 1/3/81-3/31/81. ...Despite decreases in the number of reported incidents, the Shenandoah Geriatric Treatment Center staff who testified were not satisfied that the number of injuries to patients, whether indicated in incident reports, was as low as it could be, and felt that as many as 30 more nursing and other empty positions would have to be filled before a satifactory level of safety could be achieved.

At the public hearing, Dr. Paul Hundley, Chief Psychologist and Acting Director of the Shenandoah Geriatric Treatment Center, recounted the immediate steps that had been taken to deal with problems on the geriatric units. Dr. Hundley has developed a Geriatric Risk Management System. The new system includes a better reporting form for assimilating data about geriatric

patients and the formation of a committee to review incident reports for the purpose of decreasing the risk of injury or abuse. Dr. Hundley stated that rather than increasing the number of direct care staff assigned to the geriatric wards, he would prefer the reduction of patient census through careful preadmission screening and predischarge planning. In order to accomplish this reduction in patient census, Dr. Hundley pointed out the need to better define the roles of the hospital, the community services boards and social services agencies for the care and treatment of the mentally handicapped person. He suggested that state institutions for the mentally ill and mentally retarded provide consultative services to nursing homes. Better communication with nursing homes might alleviate some of the red tape that is involved in discharging a geriatric patient in a state hospital to a nursing home where more appropriate care could be provided.

In December, 1981, Dr. Burns informed the Joint Subcommittee that sufficient levels of personnel had been assigned to the Shenandoah Geriatric Treatment Center to provide for basic levels of care and safety. Twenty-two of the 23 established registered nurse positions are filled. All 50 licensed practical nurse positions assigned to the unit are filled. Of the 188 psychiatric aide positions, only one is vacant. Of 43 charge-aide positions, 40 are filled. Dr.Burns noted, however, that "these numbers are still more sparse than we would like in order to insure more of a buffer in cases of illness, workmens compensation or other emergencies."

4. Violent Patients: Wards E-7 and 8 of Western State Hospital house all patients undergoing court-ordered evaluations. The Washington Post articles noted that in the summer of 1980, twenty "convicted or accused felons" were transferred from Central State Hospital to Western State. Forensic patients were mixed in with chronically ill patients on the Northern Virginia geographic unit. Charles Spraker, Unit Director on Wards E-7 and 8, told the Post , "We had violent incidents and fights almost every day."

In its investigation, the Local Human Rights Committee found:

> Whatever potential for violence among patients on E-7 and E-8 formerly existed has been reduced dramatically over the last year.... Additionally, since February, 1981, a policy has been implemented to assure that only non-violent criminal defendants are admitted to E-7 and 8 for pre-trial evaluation.

Dr. Burns informed the State Human Rights Committee that the problems on Wards E-7 and 8 had been resolved prior to the release of the series of allegations in the Washington Post . Dr. Burns indicated, however, that the goal remains to limit Wards E-7 and 8 to court-referred patients only. The shortage of male admissions beds throughout the hospital has resulted in the need to use E-7 and 8 for admissions.

As of December 7, 1981, the total population of Wards E 7 and 8 was approximately 50% court-referred patients and 50% civilly committed patients. Dr. Burns anticipates that the hospital reorganization which is expected to be completed by July 1, 1982 will result in Wards E 7 and 8 housing court-referred patients exclusively. The reorganizational plan calls for a centralized admissions service. This arrangement will allow for an increase in male beds throughout the hospital. Therefore, it should eliminate all necessity of using the court-referred program as a back-up for civil admissions.

A full-time forensic psychiatrist began work at Western State Hospital on September 1, 1981. Part of the psychiatrist's responsibility is to act as a liaison to the Institute of Law and Psychiatry at the University of Virginia. It is anticipated that this relationship will enable the Institute to be more of a resource for Western State in clinical, forensic and medico-legal issues.

5. Medical Practice: The extensive use of computerized axial tomography (CAT) scans and of an anticonvulsant drug known as Tegretol were cited by hospital employees who spoke to the Washington Post as specific instances of patient abuse by the medical staff at Western State Hospital. The question investigated by the Local Human Rights Committee was whether medical procedures were being used by hospital staff solely to conduct research, rather than being used as tools to provide therapeutic treatment for patients.

The Local Human Rights Committee found, "that there was no basis whatsoever for the allegations that either CAT scans or Tegretol had been used for research, research-related, or other non-therapeutic purposes." The Mental Health Association reported that its investigation was "unable to uncover evidence to either deny or affirm their [LHRC's] findings."

Dr. Burns informed the State Human Rights Committee that the availability of CAT scans and Tegretol "provided with expert consultation from the University of Virginia, gives Western State Hospital some additional sophisticated approaches to enhancing the level of patient care."

The Joint Subcommittee was told in August, 1981, that in-service training for physicians had increased over the past eight months. Mandatory training on emergency care was being implemented and training on both CAT Scans and the uses and side effects of Tegretol had been arranged.

6. Mentally Retarded Population: Allegations published in the Washington Post charged that mentally retarded patients were sexually abused frequently at Western State. These charges raised a broader question as to why mentally retarded persons are admitted to a State hospital for the mentally ill.

The Local Human Rights Committee was asked to compile figures on the number of mentally retarded persons at Western State, the areas of the hospital where they reside and the length of time each patient had been at the hospital.

The LHRC found 145 mentally retarded persons at Western State in June, 1981. Of those, 79 were determined to have a "current diagnosis of mental illness," 66 were "without a current diagnosis of mental illness." The report notes that the total mentally retarded population had decreased from 218 to 145 over the past six years; however, admissions of mentally retarded persons increased from 1980 to 1981. This increase was attributed to:

> 1) lack of community resources, public and private; 2) difficulties in pre-screening in differentiating between the mentally retarded client who is [also] mentally ill and the mentally retarded client who exhibits behavioral or adjustment problems related to mental retardation; and 3) the success and good reputation of the life skills program at Western State Hospital.

The LHRC found the majority of persons whose diagnosis includes mental retardation residing in the life skills unit which was designed to serve mentally retarded or dually diagnosed patients. Others were found in the geriatric treatment center and the deaf unit.

Dr. Burns concurred with the LHRC's findings and responded that, "most of these individuals could have their needs best met in settings specialized for care of the retarded. The stark reality, however, is that virtually *no* other alternatives are available for the vast majority of this population." Dr. Burns continued by stating that admissions of mentally retarded persons are "sometimes beyond the hospital's control due to inappropriate community pre-screening or court commitments. Once admitted, it is no easy matter to return such individuals to the community."

In their response to the investigation of the Local Human Rights Committee, the Association for Retarded Citizens in Virginia, the American Civil Liberties Union and others took a firm position on the admission of mentally retarded persons to Western State. Their position was, "Mentally retarded persons should not be at Western State Hospital under any circumstances!" Members of the group suggested that excess funds from the Valley Community Services Board ought to be reallocated to provide community day programs for mentally retarded patients at Western State. Another suggestion was that funds earmarked for two new regional facilities for the mentally retarded be used to reduce the inappropriate institutionalization of mentally retarded persons in hospitals for the mentally ill.

The Department of Mental Health and Mental Retardation conducted a study of persons whose diagnosis includes both mental retardation and mental illness. The results of the study were presented to the Joint Subcommittee in November, 1981.

7. Overuse of Seclusion: The Washington Post focused public attention on the use of seclusion by Western State Hospital. The paper reported that Western had been a "state leader" in locking patients in solitary confinement.

In January, 1980, Western State Hospital was granted a variance to the Rules and Regulations to Assure the Rights of Patients and Residents. The variance allowed registered nurses and Ph.D. psychologists to order the seclusion of patients in the absence of a physician.

The Local Human Rights Committee was requested to obtain from the hospital advocate data regarding the use of seclusion before and after the variance was granted. The LHRC was told that if

a significant discrepancy was revealed, the Commissioner could be asked to withdraw the variance and the LHRC could monitor seclusion statistics on a regular basis.

The Report of the Local Human Rights Committee summarized the data obtained on the use of seclusion for 1979, 1980 and January through May of 1981. The data revealed that the use of seclusion had declined significantly during the period. Consequently, the LHRC concluded that the variance had not led to an increase in seclusion of patients and that hospital staff had learned other methods of handling aggressive behavior. The LHRC indicated that the problems caused by the use of seclusion at Western State had been addressed by the hospital administration and by an outside review team in 1980.

The Mental Health Association and the Association for Retarded Citizens, et. al., questioned the conclusion of the LHRC that the use of seclusion had been addressed administratively. It was suggested that tranquilizing drugs may be used instead to reduce the need for seclusion.

The Association for Retarded Citizens, et. al., called for a written plan to rectify the problems of seclusion with follow-up review by the LHRC. The LHRC has not yet responded to this request, although the group does plan to monitor the progress of Western State Hospital in correcting problems identified during the investigation of the hospital.

This concludes the review of issues addressed by both the Local Human Rights Committee and the Mental Health Association of Charlottesville-Albemarle in their investigative reports.

OTHER ISSUES

Other issues that were not common to the two reports, but were identified either through the investigations or during the public hearing of the Joint Subcommittee on Mental Health and Mental Retardation are:

1. The Accreditation Status of Western State Hospital
2. Staffing
3. The Quality of Admissions and Discharges
4. The Harrassment and Intimidation of Employees
5. The Response of the Department of Mental Health and Mental Retardation and of the Hospital Administration

1. The Accreditation Status of Western State Hospital: The Mental Health Association of Charlottesville-Albemarle indicated in its report that Western State Hospital has never been accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) nor has the administration actively sought accreditation. The Association concluded that "by far the most important hindrance to accreditation appears to be the acute shortage of qualified personnel."

The Joint Subcommittee learned during the August hearing that the Department of Mental Health and Mental Retardation has required each state hospital and training center which is not accredited nor anticipating accreditation in the near future to conduct a self-survey. The self-survey is intended to determine the feasibility and projected cost for obtaining accreditation. Special attention has been given to the surveys of Eastern State, Central State and Western State because of the termination of Blue Cross participating status. In the spring of this year, Blue Cross announced that it would no longer pay 100% of allowable charges for treatment rendered by unaccredited state institutions. The Joint Subcommittee was told by the Department of Mental Health and Mental Retardation that the affected facilities would continue to receive from Blue Cross approximately 80% reimbursement for allowable charges. The self-surveys, however, are an initial step toward accreditation and full reimbursement status.

Dr. Tom Stage, Acting Executive Director of the Fairfax-Falls Church Community Services Board, presented hospital cost data to the Joint Subcommittee to substantiate the conclusion that Western State's level of funding is drastically low. Dr. Stage has been a consultant surveyor for JCAH for five years. He told the Joint Subcommittee that, "Hospitals with a per diem of $50 no longer are capable of being accredited. They are just not able to hire enough qualified staff to provide the direct patient care and the supervision of those persons providing the direct patient care to meet the standards of accreditation."

2. Staffing: The underlying problem of nearly every issue addressed during the public hearing and by the investigations was the inadequate numbers of direct care and professional staff at Western State Hospital. The Joint Subcommittee heard over and over the need for better training of staff and for increased efforts at recruiting and maintaining qualified staff. Mary Bradshaw, Chairperson of the Local Human Rights Committee, said that additional and well-trained staff are the two elements needed to provide a safe, secure environment at Western State Hospital. Mrs. Bradshaw indicated that in discussions with the LHRC, the hospital staff identified additional staff as the single most important need for Western State Hospital.

The Mental Health Association reported: "The extreme shortage of personnel at all levels prevents the meaningful delivery of treatment and the conduct of therapeutic activities on most units at WSH." Similarly the Association for Retarded Citizens, et. al., stated in its response to the LHRC Report: "In our opinion current direct care staffing levels at Western State Hospital and most likely at other Department of Mental Health and Mental Retardation institutions are so low that patient abuse and neglect are almost inevitable."

Physicians and nurses who practice at Western State Hospital told the Joint Subcommittee that heavy caseloads, low salaries and long hours create difficult working environments that discourage qualified professionals from coming to Western State and from staying there. The fact that the hospital is not accredited causes professionals to question whether their reputation may be damaged by working in such a facility. Psychologists and psychiatrists stated that their peers in private practice are never subjected to the amount of public scrutiny that daily haunts practitioners in state facilities.

It was suggested by several who spoke at the hearing that professional ties between Western State Hospital and the University of Virginia need to be strengthened. This relationship was cited by physicians, psychiatrists and psychologists as one of the most positive aspects of their work at Western State. Similar affiliations with other college and mental health professional training programs were encouraged.

A. W. Jeffreys, Ph.D., Director of Psychological Services at Western State Hospital for the past 27 years, spoke to the Joint Subcommittee and later documented his testimony in a letter. Dr. Jeffreys cited one problem not mentioned by other practitioners at the hospital. According to him, conflict arises when non-clinical administrators direct and supervise clinical professionals such as physicians and clinical psychologists.

Dr. Burns has assured the State Human Rights Committee and the Joint Subcommittee that the administration of Western State Hospital is aware of the need for more staff, better qualified and trained staff and for increased efforts to improve communication among hospital staff at all levels. Recent publicity and disciplinary actions have inhibited the progress of a hospital-wide reorganization. Dr. Burns recommended that the hospital be monitored by the Local Human Rights Committee and that the reorganization be completed. The current plans are that the hospital will be completely reorganized by July 1, 1982. He emphasized the need for "vigorous efforts at recruitment" of qualified professionals and for in-service training for all staff. Both Dr. Burns and the Association for Retarded Citizens, et. al., expressed the need for development of a "pro-active" advocacy program at the hospital as a number one priority in assuring that qualified and caring staff are employed by the hospital. According to Dr. Burns, a pro-active advocacy program goes beyond simply investigating complaints. The staff of such a program take an active leadership and training role in creating greater staff and community awareness in the promotion of patient's rights and dignity. Advocates also function to generate interest in the quality of care provided by the hospital and throughout the system of state and community services. Dr. Burns stated that pro-active advocacy "is an advocacy program that guides staff to recognize that advocacy for patients is a responsibility of everyone and that there is more to advocacy than just investigating abuse allegations."

On September 28, 1981, Dr. Burns submitted to the Joint Subcommittee a review of the staffing requirements at Western State Hospital. The review has not been approved by Central Office but will be used as a tool to determine actual staffing needs of the hospital for budget requests for the 1982-84 biennium.

In addition, Medicus Systems, Inc. is conducting a manpower analysis of every state hospital and training center in Virginia. The analysis will help to determine the levels of care that the institutions

should be providing and the required staff for each facility. A final report on the Medicus Survey is to be completed in February, 1982.

Dr. Burns stated during the public hearing that the institutional directors are looking forward to the results of the Medicus survey. He said that the staffing of state hospitals depends heavily upon the choices and standards of the institutions and the community. Dr. Burns added that JCAH standards for staff are the norm or the accepted standard, but not the optimum to provide appropriate treatment and care.

3. The Quality of Admissions and Discharges: The last article published in the Washington Post series about Western State Hospital focused on life in the community for individuals who were former patients of the hospital. The article indicated that many of the deinstitutionalized had no place to go. Consequently, it was concluded that many reentered Western State where "nearly 75 percent of the patients admitted last year were readmissions."

The inappropriate admission of mentally retarded persons and others who could be treated more appropriately in a community setting was discussed in the Post and has been discussed earlier in this paper.

Hospital social workers told the Post that "the pressure is always on" to get people out of the hospital regardless of the availability of community resources.

Many who spoke to the Joint Subcommittee during the public hearing cited the need for greater community support services to handle chronically ill patients in community settings. According to hospital staff, the ability to decrease patient census at Western State depends upon adequate community facilities and upon aggressive preadmission screening and predischarge planning programs.

Dr. Burns supported this contention stating that many patients remain at Western State because of the lack of identified community placements. According to the State Human Rights Committee, this raises the questions of whether the statutory requirement for pre-screening is being observed and whether adequate community facilities have been established.

At the request of the Joint Subcommittee, Dr. Burns attempted to estimate the numbers of patients at Western State who could function in the community if appropriate services were available. Dr. Burns responded that:

> Various estimates have been projected and of course, due to the many complex variables inherent in mental illness, it is most difficult to be totally definite. However, the following estimates would represent the views of administrators and professionals regarding the present Western State Hospital population.
>
> In the Shenandoah Geriatric Treatment Center, out of a census of 413, there are approximately 137 patients who could be managed in other settings if appropriate community support systems were available. This estimate includes about 100 patients who could be managed in nursing homes if beds were available, 30 patients who need adult homes and 7 who could probably return to their families if the families were able and willing to maintain them.
>
> On the long term and life skills programs of the hospital there are approximately 125 patients who could be cared for in community alternatives that are presently unavailable. The life skills program also has about 30 patients who are appropriate candidates for a mental retardation training center.
>
> Overall, the figures involve approximately 300 residents that are perceived as not needing institutional care at Western State Hospital. This translates into an approximate figure of almost 30% for the present population.

John D. Beghtol, Assistant Director for Community Affairs and Cooperative Services at Western State, submitted written testimony to the Joint Subcommittee regarding the hospital's relationship with the community. Mr. Beghtol recommended that judges be required statutorily to obtain a pre-screening report from the community services board prior to either voluntary or involuntary admission to a state hospital or training center. Current statutes do not require judges to obtain a pre-screening report for involuntary commitments. If this change were enacted, community services boards could become involved immediately in predischarge planning for the individual, according to Mr. Beghtol.

In his statement, Mr. Beghtol argued that, "the present legislation allows a special justice or judge, and since July 1, 1981, magistrates, to bypass the established system. I firmly believe that any citizen faced with the possibility of being detained against his will, in a state hospital, has a right to be pre-screened by a mental health professional."

The quality of decisions to discharge patients from Western State and of decisions regarding the community placement of patients was questioned by the Association for Retarded Citizens and others as a result of the firing of eight social workers in July, 1981. Members of the Joint Subcommittee visited Western State on September 28, 1981 and were told that predischarge planning had not suffered as a result of the firings.

In testimony before the Joint Subcommittee, social workers at Western State reiterated the need for more community facilities to accomodate discharged patients. Nursing home placements, residential facilities, occupational opportunities and counseling services were emphasized as crucial needs of the communities that Western State serves.

4. Harrassment and Intimidation of Employees: In follow-up articles to the series on Western State, the Washington Post and many Virginia newspapers reported disciplinary actions taken against eight social workers by the hospital administration. The eight were suspended from their jobs and eventually were fired. Although other reasons were cited as the basis for the firings, the employees claimed that the job action and other forms of what they perceived to be "harrassment" by hospital administrators were a result of the employees' willingness to speak out about conditions at the hospital. Contrastingly, however, when offered the opportunity to voice their complaints to the Local Human Rights Committee, the eight employees refused to testify.

Bob Harrison, Employee Relations Manager for Western State Hospital, told the Joint Subcommittee that he sincerely does not believe that the majority of employees at Western State feel intimidated by the hospital administration. He said that hospital employees are aware of and are free to complain to the Central Office Employee Relations Division and the Office of Employee Relations Counselors. Mr. Harrison, reported that 49 grievances were filed at Western State during Fiscal Year 1980-81. Social workers at the hospital filed 29 of the 49 grievances and 8 grievances were filed by one other person. As of August 10, 1981, 11 of the 49 grievances had been resolved at the local level.

The Local Human Rights Committee, the Mental Health Association and the Joint Subcommittee have all assumed the position that the allegations of harrassment, intimidation and unfair disciplinary actions are best handled in the courts. The eight employees are asking the courts to reinstate them in their jobs at Western State.

The State Human Rights Committee issued a preliminary report on Western State on September 3, 1981 commending the Local Human Rights Committee and the hospital administration for the actions taken against the employees. The report states:

> No human rights system can succeed without the complete cooperation of all employees and the explicit support of the hospital director. In the present case, the Hospital Director directed the recalcitrant employees to cooperate and explained to them why he was doing so. We commend him for his actions.

5. The Response of the Department of Mental Health and Mental Retardation and of the Hospital Administration: The report of the Mental Health Association of Charlottesville-Albemarle concluded that "the problems at WSH could have been and should have been addressed more vigorously and adequately by the WSH administration and the Commissioner's office." The Association for Retarded Citizens, et. al., added:

> The majority of the issues at Western State Hospital have been known to the Department of Mental Health and Mental Retardation for years.... Why were the Local Human Rights Committee and the Advocate not actively investigating and advocating on these long ago?... There is a general failure within the Department to follow through on investigative reports and recommendations. There is a general inadequacy of abuse detection, reporting and follow-up.

Both the Local Human Rights Committee and the Mental Health Association made recommendations regarding the future administration of Western State Hospital. The Local Human Rights Committee has agreed, at the request of Dr. Burns, to monitor the operation of the hospital. The State Human Rights Committee has expressed its confidence that the hospital administration is

taking reasonable steps to assure the safety of patients at Western State. The Committee has stated: "To be sure, conditions at Western State need substantial improvement.... For the most part, however, it appears that conditions at Western State are compatible with the basic requirements for safe and humane patient care."

At the August public hearing, Dr. Burns expressed the desire that Western State Hospital be allowed to meet its own responsibilities in terms of reaching the goals of accreditation and certification. He stated that the reorganization of the hospital, scheduled for completion by July 1, 1982, will enable the administration to utilize more efficiently existing resources of the hospital and community. Dr. Burns gave the Joint Subcommittee his assurance that the hospital would not compromise on the issues of patients' rights and that an active advocacy system would be developed. The kind of advocacy system envisioned by Dr. Burns is described earlier in this paper. Dr. Burns also indicated the need for further study on recruitment, salaries and benefits for various staff positions throughout the hospital, citing a current inability to compete with the private sector for qualified professionals. The hospital is exploring various incentives that may result in better recruitment of professionals to Western State. Among the incentives are pay differentials set according to the shifts worked by licensed nursing personnel, flexible working hours and a closer affiliation with the University of Virginia.

Dr. Burns noted that communication among the hospitals, the Department and the legislature are essential to defining the goals of the statewide system of services. He said that if state hospitals are expected to lower their patient populations, then the community and every level of government must become involved in the process. Inappropriate admissions to state hospitals need to be identified and the individuals involved should be treated in community settings.

In a list of 16 recommendations, the Mental Health Association stated that, "the state legislature must immediately increase funding for WSH and other facilities under the control of the Department of Mental Health and Mental Retardation."

CONCLUSION

The Joint Subcommittee on Mental Health and Mental Retardation plans to continue its oversight responsibilities for another two years. During deliberations over continuing the legislative oversight, members of the Joint Subcommittee emphasized the need to prevent future situations like the disturbance at Western State Hospital in 1981.

The Joint Subcommittee is keenly aware that the problems and concerns raised at Western State Hospital are not unique. Similar issues arise at each of the state hospitals and training centers and frequently, must be dealt with immediately. The Department of Mental Health and Mental Retardation, administrators of the state hospitals and training centers, community services boards and concerned citizens must work jointly with the legislature to assure that patients and residents in state facilities for the mentally handicapped and in community programs are afforded the most appropriate treatment, training and care and that the rights of each patient and resident are preserved.

The concerns voiced about Western State Hospital and the manner in which those concerns have been and will be addressed cannot be ignored. The Department, the hospital administration and the Local Human Rights Committee must continue to be aware of the issues raised during 1981 and must be able to assure the Commonwealth that each of the issues has been addressed and resolved. The Joint Subcommittee on Mental Health and Mental Retardation plans to utilize this paper and all of the data gathered during its review of Western State Hospital to monitor the ongoing operation of the hospital and all state facilities for the mentally handicapped during the next two years. The experience at Western State, the subsequent investigations and the legislative hearing provided the Joint Subcommittee members the opportunity to develop a great deal of insight into the operation of state facilities for the mentally handicapped and into efforts devoted to assuring the rights of patients and residents. The Joint Subcommittee believes that the Western State experience can contribute beneficially to developing an improved awareness about the statewide system of services for the mentally handicapped in Virginia.

DOCUMENTS RECEIVED BY THE JOINT SUBCOMMITTEE

ON MENTAL AND MENTAL RETARDATION

REGARDING WESTERN STATE HOSPITAL

STAUNTON, VIRGINIA

I. DOCUMENTATION RECEIVED DURING THE AUGUST 10, 1981 PUBLIC HEARING, WESTERN STATE HOSPITAL

Written Statement of Dr. Bruce E. Baker, Fredericksburg, Virginia, Chairman, Committee Studying Conditions at Western State Hospital of the Mental Health Association of Virginia.
Letter dated August 7, 1981, from William J. Burns, Ph.D.,Director, Western State Hospital to Owen W. Brodie, M.D., Chairman, State Human Rights Committee; Dr. Burns' response to the investigation of the State Human Rights Committee.
Transcribed statement of Brendan Buschi, Former Director of Social Work, Western State Hospital.
Written statement of Mr. David Colton, M.Ed., Unit Director, Blue Ridge Treatment Unit (G Unit), Western State Hospital.
Transcribed statement of Mrs. Ann Craig, wife of Julius H. Craig, former patient at Western State Hospital.
Written statement of Patricia G. Evey, Board member, Pathways to Independence.
Letter dated July 23, 1981, from James Gianokos, former patient at Western State Hospital, to Chan Kendrick, Director, American Civil Liberties Union, regarding experiences at Western State Hospital.
Presentation by Lynwood A. Harding, Associate Director, Administration, Western State Hospital. Attached document: Ten Year Analysis of Statistics on Western State Hospital.
Written statement of Bob Harrison, Employee Relations Manager, Western State Hospital. Summary of Grievance Activity FY 1980-81, Western State Hospital.
Mental Health Association of Charlottesville-Albemarle: (1) Inquiry into Conditions at Western State Hospital: Report prepared by the Ad Hoc Committee of the Mental Health Association of Charlottesville-Albemarle; (2) Department of Mental Health and Mental Retardation, Accreditation Survey Report; (3) Press Release dated August 7, 1981 regarding the report of the Charlottesville-Albemarle Mental Health Association, submitted by Ted Hogshire, President, Charlottesville-Albemarle Mental Health Association.
(1) Sample Memorandum of Understanding between Shenandoah Geriatric Treatment Center at Western State Hospital and community mental health clinics defining the roles of the hospital and the clinic in community-hospital relations. (2) Admission information for Shenandoah Geriatric Treatment Center, submitted by Dr. Paul Hundley, Acting Director, Shenandoah Geriatric Treatment Center, Western State Hospital.
Written statement of Elizabeth P. Knighton, Executive Director, Harrisonburg-Rockingham Community Services Board, representing all the community services boards in Health Systems Area I.
Written statement of Russell A. Langelle, Vice-President, Pathways to Independence.
Written statement of Robert F. Mueller, Ph.D., citizen member and chairman of the Western State Hospital grievance panel which heard the grievances of Brendan Buschi.
Writtn statement of Thomas B. Stage, M.D. Psychiatric Consultant for Medical Affairs and Acting Executive Director Fairfax-Falls Church Community Services Board.
Written statement of John Turner, Former Director of the Community and Family Services Department, DeJarnette Center for Human Development.
Written statement of Craig Williams, Earl Burton and Edward Wayland, attorneys representing nine employees fired from Western State Hospital.
Written statement of Glenn R. Yank, M.D., Deputy Director for Medical Affairs, Western State Hospital. Letter and enclosed statements dated June 19, 1981, addressed to Mary Bradshaw, Chairperson, Western State Hospital and Local Human Rights Committee, from Dr. Glenn Yank. The letter and enclosures refute accusations made about Dr. Yank by the social work staff at Western State Hospital.
Western State Hospital Energy Conservation Committee Second Annual Report.

II. OTHER DOCUMENTATION

Letter dated August 18, 1981, from John D. Beghtol, Assistant Director for Community Affairs and Cooperative Services, Western State Hospital, to Delegate Frank M. Slayton regarding Western State Hospital's relationship with the localities it serves.

Patient medical records for Julius H. Craig, patient at Western State Hospital from May 24, 1977 to October 31, 1979.

Letter dated September 1, 1981, from Dr. Jeffries, Director of Psychological Services, Western State Hospital, to Delegate Frank Slayton regarding the recruiting and maintaining of qualified clinical psychologist. Enclosed: Job descriptions, Western State Hospital.

Letter dated August 27, 1981 from Dr. Lawrence H. Sutker, Chief Psychiatrist, Shenandoah Geriatric Treatment Center, Western State Hospital, to Delegate Frank Slayton regarding involuntary commitment. Articles enclosed: (1) Lebegue and Clark, "Incompetence to Refuse Treatment: A Necessary Condition for Civil Commitment," American Journal of Psychiatry, August 1981; (2) §§ 64-7-31 through 64-7-52, Code of the State of Utah: statutes governing voluntary and involuntary commitments.

Documentation of issues in clinical practice and personnel disputes, Western State Hospital, submitted by Glenn R. Yank, M.D., Acting Deputy Director for Medical Affairs, Western State Hospital.

Report of the Local Human Rights Committee: Investigation of Conditions at Western State Hospital, July 15, 1981.

Response to the Local Human Rights Committee Report dated August 5, 1981 from: (1) Association for Retarded Citizens in Virginia; (2) American Civil Liberties Union; (3) Northern Virginia Association for Retarded Citizens; (4) Association for Retarded Citizens Staunton-Augusta County Area; and (5) Mental Health Association of Northern Virginia.

Western State Hospital Review of Staffing Requirements, submitted September 28, 1981.

Supplemental reports of the Local Human Rights Committee on Western State Hospital, September 3, 1981 and December 11, 1981.

Preliminary report of the State Human Rights Committee regarding conditions at Western State Hospital, September 3, 1981.

Letter and enclosed documentation dated October 2, 1981, addressed to Lelia B. Hopper, Staff Attorney, from Edward M. Wayland, Attorney, Charlottesville, Virginia. A total of 353 pages of information submitted on behalf of Brendan Buschi and seven social workers who were fired from Western State Hospital. The information is included in seven folders which are labeled: (1) Geriatric Center - Survey of Incident Reports; (2) Administrative Voluntary; (3) U.Va - Research; (4) Raising the Issue of Patient Treatment; (5) Geriatric Center - Patient Abuse; (6) Mental Retardation; and (7) Patient Abuse - G Unit, J Unit, E Unit.

Letter dated December 7, 1981, addressed to Martha A. Johnson, Research Associate, from William J. Burns, Ph.D., Director, Western State Hospital, responding to specific concerns of the Joint Subcommittee on Mental Health and Mental Retardation.

Appendix C

Responses to the Report

COMMONWEALTH OF VIRGINIA

FRANK W. NOLEN
24TH SENATORIAL DISTRICT
AUGUSTA, HIGHLAND AND ROCKBRIDGE
COUNTIES; CITIES OF BUENA VISTA,
LEXINGTON, STAUNTON AND WAYNESBORO
P. O. BOX 13
NEW HOPE, VIRGINIA 24469

COMMITTEE ASSIGNMENTS:
AGRICULTURE, CONSERVATION AND
NATURAL RESOURCES
COMMERCE AND LABOR
EDUCATION AND HEALTH
REHABILITATION AND SOCIAL SERVICES

SENATE

February 19, 1982

DISSENT REPORT

TO THE JOINT SUBCOMMITTEE ON
MENTAL HEALTH AND MENTAL RETARDATION
TO THE
GOVERNOR
AND
THE GENERAL ASSEMBLY OF VIRGINIA

I am withholding my signature and approval of this report, because I do not believe that we should approve core services until we have arrived at a method of funding such services. Furthermore, I feel that the core services approved by the State Board are too broad and general and therefore, make it almost impossible for anyone to determine just what services are being offered. It is my opinion that the services should be listed more specifically and in cookbook type fashion which would permit checkoffs as to which services are being offered by the Chapter 10 Boards. When we arrive at such a list of services, then we should develop a formula for distributing state money to localities based upon which of these services they provide. Each service should carry a multiplying factor that is weighted according to the cost of providing the service and the relative importance of that service.

I think that it would be appropriate to note that I do concur with the other matters included in the report.

Submitted by:

Frank W. Nolen

FWN/jp

COMMONWEALTH of VIRGINIA

JOSEPH J. BEVILACQUA, Ph. D.
COMMISSIONER

Department of
Mental Health and Mental Retardation

MAILING ADDRESS
P.O. BOX 1797
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February 18, 1982

The Honorable Franklin M. Slayton, Chairman
Joint Subcommittee of Mental Health and Mental Retardation
General Assembly Building, Room 454
9th and Capitol Streets
Richmond, VA 23219

Dear Mr. Slayton:

I have received and reviewed the final report of the Joint Subcommittee on Mental Health and Mental Retardation which will be sent to the Governor and 1982 Session of the General Assembly. I appreciate the opportunity to respond to the content of the report prior to the printing.

The long and arduous hours spent by the Subcommittee working with the Department of Mental Health and Mental Retardation Board and staff, the Community Services Boards, advocacy groups, and other interested persons is well reflected in this report. It includes a concise statement of the activities of the Subcommittee giving a chronolo of events and specific information on the areas of focus.

The recommendations identified in the report demonstrate a thorough review of the system and provide for me and my staff an excellent mechanism from which to continue our development of an integrated, single system of service delivery. I am supportive of the bills and resolutions formulated from these recommendations and have already begun the background work to prepare for their implementation.

As a new Commissioner, I found the Oversight Subcommittee a most supportive and helpful legislative endeavor designed not only to monitor the Department's progress in meeting the Bagley Commission's recommendations, but also to assist the Department with any difficulties or barriers identified in this implementation.

I wish to thank the members of the Subcommittee and the staff who spent a great deal of time and effort in the development of the report. Be assured, the staff of the Department of Mental Health and Mental Retardation will expend as much time as necessary to carry out the spirit of the report. With kindest personal regards, I am

Sincerely,

Joseph J. Bevilacqua, Ph.D.
Commissioner

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cc: The Honorable Joseph L. Fisher, Secretary of Human Resources