DRAFT

SIGNATURE SHEET

REPORT OF THE JOINT SUBCOMMITTEE ON
MENTAL HEALTH AND MENTAL RETARDATION
TO THE
GOVERNOR
AND
THE GENERAL ASSEMBLY OF VIRGINIA
JANUARY, 1982

Please indicate your approval of the report by signing below your name and return this form and any dissenting reports, should you choose to submit one, by Friday, February 12, to:

Martha A. Johnson
Research Associate
Division of Legislative Services
State Capitol, P. O. Box 3-AG
Richmond, VA 23208

Respectfully submitted,

Frank M. Slayton, Chairman	Joan S. Jones
Elliot S. Schewel, Vice-Chairman	Frank W. Nolen
Evelyn M. Hailey	Warren G. Stambaugh
Edward M. Holland	W. Ward Teel

DRAFT #2

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12 HOUSE DOCUMENT NO.

13 COMMONWEALTH OF VIRGINIA

14 1982

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MEMBERS OF THE JOINT SUBCOMMITTEE

2
3 Frank M. Slayton, Chairman
4 Elliot S. Schewel, Vice-Chairman
5 Evelyn M. Hailey
6 Edward M. Holland
7 Joan S. Jones
8 Frank W. Nolen
9 Warren G. Stambaugh
10 W. Ward Teel
11 ------------
12 STAFF
13 Division of Legislative Services
14 Lelia B. Hopper, Senior Attorney
15 Martha A. Johnson, Research Associate
16 Angela S. Cole, Secretary
17 Administrative and Clerical
18 Office of Clerk, House of Delegates

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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: 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

1 the General Assembly established the Joint Subcommittee on
2 Mental Health and Mental Retardation. Five members were
3 appointed to the Joint Subcommittee from the House Committee
4 on Health, Welfare and Institutions and three members were
5 appointed from the Senate Committee on Education and Health.
6 Delegate Frank M. Slayton of South Boston was chosen to
7 serve as Chairman of the Joint Subcommittee and Senator
8 Elliot S. Schewel of Lynchburg as Vice-Chairman. Other
9 members of the Joint Subcommittee were: Delegate Evelyn M.
10 Hailey of Norfolk; Senator Edward M. Holland of Arlington;
11 Delegate Joan S. Jones of Lynchburg; Senator Frank W. Nolen
12 of New Hope; Delegate Warren G. Stambaugh of Arlington; and
13 Delegate W. Ward Teel of Christiansburg.
14 The Joint Subcommittee was created for a term of two
15 years. The recommendations of the Commission on Mental
16 Health and Mental Retardation were to guide the work of the
17 Joint Subcommittee in assuring that proposed administrative
18 policies and procedures were enacted and that the improved
19 system would provide the most appropriate treatment,
20 training and care for individuals with mental disabilities
21 throughout Virginia.
22 The Joint Subcommittee convened once in 1980 to hear
23 from the Department of Mental Health and Mental Retardation
24 about plans for implementation of the Commission's
25 recommendations. In June of 1980, the Department began to
26 establish task forces comprising department personnel,
27 representatives of the community services boards, interest
28 groups and the public. Each task force was charged with

1 developing specific recommendations outlined by the
2 Commission on Mental Health and Mental Retardation. For
3 example, one group was responsible for defining the core
4 services to be offered by community services boards.
5 Another task force was charged with the study of individuals
6 who are both mentally ill and mentally retarded. In
7 November, 1980, the Joint Subcommittee began receiving
8 monthly progress reports on all the activities of the
9 Department and task forces relative to the recommendations
10 of the Commission.
11 In January, 1981, the Joint Subcommittee met at Central
12 State Hospital in Petersburg, Virginia. The Department of
13 Mental Health and Mental Retardation presented a series of
14 six-month progress reports on efforts to plan for and to
15 effect the Commission's recommendations. After meeting with
16 representatives of the Department, the Joint Subcommittee
17 toured Central State Hospital.
18 In May, the Washington Post published a series of
19 articles about Western State Hospital. The articles alleged
20 that patient abuse and neglect had become daily occurrences
21 at the hospital. The Joint Subcommittee was alarmed by the
22 allegations printed in the Post . Members expressed concern
23 about the charges and agreed that the validity of the
24 accusations needed to be investigated.
25 The June meeting of the Joint Subcommittee was
26 dominated by the concerns about Western State Hospital. The
27 Joint Subcommittee discussed the allegations with William J.
28 Burns, Ph.D., Director of Western State Hospital, Leo E.

1 Kirven, Jr., M.D., Commissioner of Mental Health and Mental
2 Retardation, C. W. Brett, Deputy Commissioner and Anne S.
3 Goodman, Employee Relations Director of the Department. The
4 Joint Subcommittee decided to hold a public hearing in
5 Staunton during the month of August to hear from employees
6 of Western State Hospital regarding the charges of patient
7 abuse and neglect and of employee unrest.
8 Simultaneously, the Local Human Rights Committee, a
9 citizen's group which monitors the care of individuals in
10 state institutions for the mentally handicapped, was
11 instructed by the State Human Rights Committee to conduct an
12 in-depth investigation of the situation at Western State.
13 In addition, the Mental Health Association of
14 Charlottesville-Albemarle began an independent investigation
15 of Western State Hospital on behalf of the Mental Health
16 Association in Virginia.
17 The Joint Subcommittee conducted its public hearing on
18 August 10, 1981 on the grounds of Western State Hospital.
19 Forty-six persons addressed the legislative group during the
20 thirteen-hour hearing. The Joint Subcommittee heard the
21 preliminary findings and recommendations of the Local Human
22 Rights Committee. The members also received the report of
23 the Charlottesville-Albemarle Mental Health Association.
24 Additional documentation with regard to the patients and
25 staff of Western State was submitted to the Joint
26 Subcommittee prior to and following the August public
27 hearing. An issue paper prepared by the staff for the Joint
28 Subcommittee detailing the concerns expressed about Western

1 State Hospital is included in Appendix B of this report.
2 The Joint Subcommittee held six regular meetings during
3 1981. Each meeting involved extensive and careful review of
4 the progress made by the Department of Mental Health and
5 Mental Retardation toward implementing the recommendations
6 outlined by the Commission in 1980. The Joint Subcommittee
7 also called on the heads of other state human services
8 agencies, community services boards, the Secretary of Human
9 Resources, the Secretary of Public Safety and the Secretary
10 of Administration and Finance to review various projects
11 relating to programs and services for the mentally
12 handicapped. In addition, the Executive Secretary of the
13 Supreme Court presented a report and recommendations on cost
14 containment within the involuntary mental commitment fund.
15 Throughout the year, members of the Joint Subcommittee
16 toured state hospitals and training centers to view
17 facilities, observe programs and to meet and interview
18 staff. These visits to the state facilities provided an
19 opportunity for the Joint Subcommittee members to discuss
20 the administration and operation of each institution with
21 the directors and staff. The most rewarding experience of
22 the visits was the opportunity to observe patients and
23 residents participating in productive and therapeutic
24 programs and to talk with many hospitalized individuals.
25 Although programming for persons institutionalized in state
26 hospitals and training centers has improved over the years,
27 the Joint Subcommittee was disappointed to note that many
28 individuals remain idle and are frequently unable to leave

1 the wards. This idleness was attributed by hospital
2 directors most often to a lack of staff and resources to
3 provide effective programs and recreational opportunities
4 for the patients and residents.
5 The Joint Subcommittee expresses its appreciation to
6 each of the facility directors and to the staff who assisted
7 with the visits. The frank and open communication with
8 persons directly involved in mental health, mental
9 retardation and substance abuse services proved invaluable
10 to the Joint Subcommittee's work.
11 During the past two years, the Joint Subcommittee has
12 worked with the Department of Mental Health and Mental
13 Retardation and the community services boards in conducting
14 its legislative oversight responsibilities. The Joint
15 Subcommittee is encouraged by efforts to carry out the
16 policies of the Commission on Mental Health and Mental
17 Retardation. It believes, however, that a great deal of
18 work lies ahead for the Commonwealth before the Commission's
19 goals can be realized. The Joint Subcommittee, therefore,
20 offers its recommendations to the Governor and 1982 Session
21 of the General Assembly with the anticipation that these
22 proposals will expedite the work of the Department of Mental
23 Health and Mental Retardation, the State Board and community
24 services boards toward achieving the policy directives that
25 have been established legislatively for mental health,
26 mental retardation and substance abuse services in the
27 Commonwealth. The legislative recommendations of the Joint
28 Subcommittee to the Governor and 1982 Session of the General

1 Assembly are included in Appendix A of this report.

2 RECOMMENDATIONS

3 Continuing the Joint Subcommittee

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

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

23 Among the goals that still need to be achieved are:
24 universal community services board coverage; full
25 implementation of core services and formula funding;
26 effective and comprehensive preadmission screening,
27 predischarge planning and case management services;
28 appropriate accreditation and certification of all state

1 hospitals and training centers; provision of adequate staff
2 for all state facilities; and a determination of the most
3 effective allocation of funds between state institutions and
4 community programs. In its report, House Document No. 8,
5 1980, the Commission on Mental Health and Mental Retardation
6 documented the goals of the Commonwealth for each of the
7 concerns listed above. The Department of Mental Health and
8 Mental Retardation has confirmed that these policies and
9 goals continue to be valid and timely, two years later. It
10 is the job of the Commonwealth to strive to reach these
11 goals without further delay. The Joint Subcommittee shall
12 continue its legislative monitoring of these efforts to
13 ensure that the goals are attained.
14 The Executive Secretary of the Supreme Court has
15 presented a number of recommendations to the Governor and
16 General Assembly to contain costs incurred by the
17 Commonwealth in the process of the involuntary commitment of
18 individuals to state hospitals for the mentally ill.
19 Included with the cost containment proposals is the
20 recommendation that the quality and effectiveness of
21 Virginia's involuntary civil commmitment laws be evaluated
22 along with the actual procedures and practices followed to
23 commit a person to a state hospital.
24 It is recommended that in addition to continuing its
25 legislative oversight responsibilities, the Joint
26 Subcommittee shall conduct an evaluation of the statutes
27 governing commitment in Virginia. The Joint Subcommittee
28 shall submit its recommendations regarding the commitment

1 laws concurrently with any other recommendations it deems
2 appropriate to the Governor and 1983 and 1984 Sessions of
3 the General Assembly.

4 University-Department Affiliations

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

25 The Joint Subcommittee concurs with Dr. Bevilacqua. It
26 is therefore recommended that state-supported universities
27 and medical schools be requested to strengthen relationships
28 with the Department of Mental Health and Mental Retardation.

1 Such affiliations shall seek to improve the capability of
2 the Department to recruit and retain qualified professionals
3 to work in state facilities for the mentally handicapped.
4 Concurrently, the educational institutions and the
5 Department shall strive to establish internships and work
6 experience opportunities for students and staff of the
7 universities and medical schools.

8 Core Services

9 One of the most fundamental recommendations of the
10 Commission on Mental Health and Mental Retardation was that
11 the State Mental Health and Mental Retardation Board be
12 required to develop and adopt a policy establishing a core
13 of mental health, mental retardation and substance abuse
14 services for community services boards. The requirement for
15 core services was included in House Bill No. 95 which was
16 passed by the General Assembly in 1980. Current law adopted
17 in 1980 requires that the State Board "determine, subject to
18 the approval of the General Assembly, a core of program
19 services to be provided by community services boards by July
20 1, 1982." The State Board is directed by law to "specify
21 other program services which the community services boards
22 may provide." The Commission recommended that these
23 "auxiliary" services be funded with a high percentage of
24 local funds and a correspondingly lower rate of state
25 matching funds. To encourage community services boards to
26 establish core services, it was recommended that the core
27 services be funded with a substantially high percentage of
28 state dollars and a relatively low rate of local funds.

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

10 Definitions Of Core Services

11 Emergency Service:

12 Offers 24-hour telephone service
13 dealing specifically with calls for
14 crisis help, or can provide 24-hour
15 walk-in services staffed with treatment
16 personnel offering help for emergency
17 problems 7 days per week, or can provide
18 24-hour emergency psychiatric services
19 around the clock. May have
20 detoxification capacity or availability.

21 Inpatient Service:

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

26 Day Support/Outpatient Service:

27 Offers habilitation/rehabilitation
28 programs; individual, group and family
29 counseling services; may include
30 educational components; may include
31 detoxification programs.

32 Residential Service:

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

1 Prevention/Early Intervention:

> 2 Offers consultation to community
> 3 agencies, the public and other providers
> 4 relating to mental health, mental
> 5 retardation and substance abuse clients.
> 6 Offers early intervention services for
> 7 at-risk populations.

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

20 Formula Funding

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

> 28 It is important to equitably fund
> 29 community services boards as quickly as
> 30 possible. The Department has failed to
> 31 sufficiently develop and implement a
> 32 comprehensive distribution procedure for
> 33 community services state general funds.
> 34 The incidence of need for services as

1 well as population should, in the
2 opinion of the Commission, be considered
3 in the distribution of state general
4 funds. Local match should consider only
5 relative ability to pay and relative tax
6 effort. Consequently, the Commission
7 recommends that the Department be
8 required to develop formulas for the
9 distribution of funds for mental health,
10 mental retardation and substance abuse
11 community services.

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

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

33 The Department and the legislature need to continue to

1 work toward conceptualizing a fair and equitable system of
2 funding community services. As noted earlier, the
3 Department has developed a plan which spans eight years. The
4 plan calls for the implementation of formula funding and a
5 shift of state funds to balance the ratio of state dollars
6 for institutional and community programs. The Joint
7 Subcommittee endorses the plan proposed by the Department
8 and offers it to the Governor and 1982 Session of the
9 General Assembly. The Joint Subcommittee recommends that
10 the Department proceed to carry out the plan with the
11 legislative oversight of the Joint Subcommittee during 1982
12 and 1983 and with monitoring of appropriate standing
13 committees of the General Assembly thereafter. The plan to
14 attain full implementation of formula funding and to realign
15 the percentages of state funds for institutional and
16 community services over the next eight years follows.
17 Funding Plan
18 It is recommended that an overall time frame of eight
19 years be adopted to bring the service delivery system for
20 mentally disabled persons into proper balance. This time
21 frame is required in order to make necessary adjustments in
22 budget allocations, to bring about changes in the
23 expectations of service providers and individual communities
24 and to reduce gradually the inappropriate use of state
25 hospitals and training centers. In the 1982-84 biennium,
26 the service delivery system will be prepared to operate
27 under formula funding. Initially, the $11,027,900 requested
28 in the Department's addendum budget for 1982-84 will be used

1 to fill identifiable gaps in core services in certain
2 communities. The Department will simultaneously offer
3 technical assistance to communities known to overutilize
4 inpatient services in order to reverse this trend. The
5 Department will refine the formula and the data needed to
6 sensitize the formula to the variations among community
7 services board areas. A proposed formula will be ready by
8 August 1, 1982. During the 1982-84 period, the formula will
9 be reviewed by appropriate committees of the General
10 Assembly and will be tested by the Department.
11 By July 1, 1984, the Department and community services
12 boards will be ready to implement a formula-based system of
13 financing community-based programs for the mentally
14 handicapped. The formula-based system will shift, over a
15 period of six years, the institutional and community ratios
16 of state dollar distribution for services. Instead of
17 accepting an arbitrary ratio of 60% of state funds to
18 finance institutional services and 40% of state funds to
19 finance community programs, as proposed in House Joint
20 Resolution No. 16, 1980, the appropriate utilization of
21 institutional beds for age-specific population groups will
22 determine the proper funding of institutional and community
23 services. In this regard, the Department has begun to
24 determine through observation and experience the need for
25 community-based and institutional services. In addition,
26 the Department will determine the level of dollar support
27 needed to insure that appropriate care and treatment are
28 available.

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

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

19 According to the formula which is based 60% on need for
20 services and 40% on population, the Department will maintain
21 the flow of state dollars to community services boards that
22 meet established targets for appropriate institutional bed
23 usage. Of equal importance will be the establishment of a
24 capacity building fund that will be used by the Department
25 to bring community services boards into compliance with
26 targeted institutional bed utilization. The fund will also
27 be used to upgrade state facilities to meet accreditation
28 standards. The capacity building fund will be generated by

1 setting aside a determined portion of the Department's
2 biennial appropriation.
3 As noted earlier, a fully developed formula will be
4 prepared by August 1, 1982. The Joint Subcommittee
5 recommends that an interim report on the formula and on the
6 implementation of core services be presented to the Joint
7 Subcommittee on Mental Health and Mental Retardation as soon
8 as practicable after its completion and not later than
9 October 1, 1982. The formula and any additional
10 recommendations for core services shall then be prepared for
11 presentation to the House Appropriations Committee, the
12 House Committee on Health, Welfare and Institutions, the
13 Senate Committee on Education and Health, and the Senate
14 Committee on Finance by January 1, 1983. A completed report
15 on core services and on the implementation of formula
16 funding shall be presented to the same committees of the
17 House and Senate by October 1, 1983. The final report
18 should focus on the impact of core services and formula
19 funding on the 1984-1986 biennial budget.
20 Preadmission Screening For Involuntary Commitments
21 During the public hearing conducted by the Joint
22 Subcommittee in August at Western State Hospital, it was
23 recommended that preadmission screening be required for
24 involuntary commitments to state hospitals. In testimony
25 before the Joint Subcommittee, the Executive Secretary of
26 the Supreme Court supported preadmission screening prior to
27 involuntary commitments to prevent inappropriate admissions
28 to state hospitals. Presently, only persons who are

1 voluntarily admitted to state hospitals are required to be
2 pre-screened. According to statistics presented to the
3 Joint Subcommittee by the Department of Mental Health and
4 Mental Retardation, preadmission screening has been
5 effective in directing individuals to community services
6 whenever possible. The Joint Subcommittee is aware, however,
7 that individuals continue to be inappropriately placed in
8 state hospitals and training centers. The Department
9 estimates that approximately 25% of persons
10 institutionalized in state hospitals for the mentally ill
11 could function in a community setting if proper services
12 were available.

13 The Joint Subcommittee anticipates that the
14 establishment of core services over the next two years in
15 all community services board areas will assure the
16 availability of basic services for the mentally handicapped
17 throughout Virginia. Every effort should be made to prevent
18 the inappropriate utilization of services provided by the
19 state hospitals and training centers. Therefore, the Joint
20 Subcommittee recommends that in cases involving the
21 involuntary commitment of an individual to a state hospital
22 for the mentally ill, the judge shall be required to request
23 that the community services board prepare a pre-screening
24 report within 48 hours after the judge's request. The
25 judge, however, will not be bound by the recommendations of
26 the pre-screening report in formulating his decision to
27 commit or not to commit the individual to a state hospital.
28 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.

1 3. To require persons seeking
2 relief under the proposed statutes to
3 assist in establishing evidence of their
4 entitlement to relief.

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

10 CONCLUSION

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

14

15 Frank M. Slayton, Chairman

16 Elliot S. Schewel, Vice-Chairman

17 Evelyn M. Hailey

18 Edward M. Holland

19 Joan S. Jones

20 Frank W. Nolen

21 Warren G. Stambaugh

22 W. Ward Teel

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3 Appendix A

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

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

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

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

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

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

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

1

2 D 1/22/82 Johnson C 1/25/82 bgh

3 HOUSE JOINT RESOLUTION NO.____

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

8

9 WHEREAS, the Joint Subcommittee on Mental Health and
10 Mental Retardation was established pursuant to House Joint
11 Resolution No. 10 in 1980; and
12 WHEREAS, the Joint Subcommittee has worked for two
13 years, monitoring the administration of mental health,
14 mental retardation and substance abuse services in Virginia
15 and ensuring implementation of the recommendations of the
16 Commission on Mental Health and Mental Retardation; and
17 WHEREAS, it is the sense of the Joint Subcommittee that
18 a legislative forum should remain available for continued
19 communication among legislators, state hospitals and
20 training centers for the mentally handicapped, community
21 services boards, the Department of Mental Health and Mental
22 Retardation and the concerned public; and
23 WHEREAS, there is a continuing need for legislative
24 oversight of the administration and operation of state and
25 local mental health, mental retardation and substance abuse
26 services to assure that a continuum of care is available for
27 mentally handicapped persons who enter state institutions or

1 who reside in the community; now, therefore, be it
2 RESOLVED by the House of Delegates, the Senate
3 concurring, That the Joint Subcommittee on Mental Health and
4 Mental Retardation is continued. The Joint Subcommittee
5 shall focus its oversight responsibilities on monitoring the
6 work of the Department of Mental Health and Mental
7 Retardation and community services boards. The Joint
8 Subcommittee shall provide guidance for the fulfillment of
9 the Department's and the boards' responsibilities within the
10 human service delivery system of the Commonwealth.
11 In addition to continuing its oversight
12 responsibilities, the Joint Subcommittee shall conduct a
13 comprehensive evaluation of state statutes governing
14 commitment of an individual to a state hospital for the
15 mentally ill. The evaluation shall include a review of
16 commitment policies and procedures utilized throughout the
17 Commonwealth.
18 The members of the Joint Subcommittee shall continue to
19 serve and any vacancies in the membership shall be filled
20 through appointments made by the chairmen of the House
21 Committee on Health, Welfare and Institutions and the Senate
22 Committee on Education and Health.
23 The Joint Subcommittee shall submit any recommendations
24 it deems appropriate to the 1983 and 1984 Sessions of the
25 General Assembly.
26 The cost of this study shall not exceed $15,000.
27 #

1

2 D 01/22/81 Johnson T 01/28/81 tmg

3 HOUSE JOINT RESOLUTION NO._____

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

7

8 WHEREAS, during 1981, the Department of Mental Health
9 and Mental Retardation has directed much effort toward
10 evaluating the staffing requirements for state hospitals and
11 training centers and determining the appropriate levels of
12 care to be provided by state facilities and community
13 programs for the mentally handicapped; and
14 WHEREAS, the Joint Subcommittee on Mental Health and
15 Mental Retardation heard testimony in 1981 emphasizing the
16 need to strengthen professional ties between state hospitals
17 and training centers for the mentally handicapped and
18 Virginia's universities and medical schools; and
19 WHEREAS, tremendous benefit can accrue to the citizens
20 of the Commonwealth as a result of cooperative affiliations
21 between the providers of services for the mentally
22 handicapped and educational institutions which train
23 individuals for practice in medical and mental health
24 professions; now, therefore, be it
25 RESOLVED by the House of Delegates, the Senate
26 concurring, That state-supported institutions of higher
27 education which train individuals to work in professions
28 associated with mental illness, mental retardation or

1 substance abuse are requested to develop cooperative
2 relationships with the Department of Mental Health and
3 Mental Retardation. The Department and state-supported
4 educational institutions shall strive to improve the
5 capability of the Department of Mental Health and Mental
6 Retardation to recruit qualified professionals to work in
7 state and community mental health, mental retardation and
8 substance abuse programs.
9 In addition, the universities and medical schools shall
10 cooperate with the ongoing work of the Department to
11 evaluate staffing requirements for state hospitals and
12 training centers and to determine the appropriate levels of
13 care to be provided by state facilities and community
14 programs for the mentally handicapped. The Department and
15 educational institutions shall seek to foster internships
16 and work experience opportunities for students and staff of
17 the universities and medical schools; and be it
18 RESOLVED FURTHER, That the Clerk of the House of
19 Delegates is requested to forward a copy of this resolution
20 to each of the state institutions of higher education which
21 train mental health and medical professionals.
22 #

1

2 D 1/24/82 JOHNSON C 1/27/82 bgh

3 HOUSE JOINT RESOLUTION NO. ___

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

9 WHEREAS, one of the most fundamental recommendations of
10 the Report of the Commission on Mental Health and Mental
11 Retardation (H.D. 8, 1980) was that the State Mental Health
12 and Mental Retardation Board be required to develop and
13 adopt a policy establishing a core of mental health, mental
14 retardation and substance abuse services to be provided by
15 community services boards; and

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

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

27 WHEREAS, on December 16, 1981, the State Mental Health

1 and Mental Retardation Board adopted the definitions of core
2 services which will be utilized by the Department of Mental
3 Health and Mental Retardation to determine whether each
4 community services board is providing basic community mental
5 health, mental retardation and substance abuse services; and
6 WHEREAS, the Commonwealth has had significant
7 experience with the core services definitions adopted in
8 1981 by the State Mental Health and Mental Retardation Board
9 because the definitions conform to minimal service
10 designations for comprehensive community mental health
11 centers' programs and for mental retardation and substance
12 abuse programs; and
13 WHEREAS, core services are not mandated services which
14 localities are required to provide, rather, the Department
15 of Mental Health and Mental Retardation will provide
16 monetary incentives in the 1982-1984 biennium for community
17 services boards which do not provide the basic services
18 defined as core services to develop programs which meet the
19 core services definitions; and
20 WHEREAS, prior to the 1984-1986 biennium the Department
21 of Mental Health and Mental Retardation will develop a
22 formula for equitably funding community services boards
23 which will include incentives for the boards to maintain
24 existing services and to choose to provide new services
25 which conform to the core services definitions; now,
26 therefore, be it
27 RESOLVED by the House of Delegates, the Senate
28 concurring, That the definitions of core services for mental

1 health, mental retardation and substance abuse services
2 adopted by the State Mental Health and Mental Retardation
3 Board are hereby approved. The core services definitions
4 shall be:

5 Emergency Service:

6 Offers 24-hour telephone service
7 dealing specifically with calls for
8 crisis help, or can provide 24-hour
9 walk-in services staffed with treatment
10 personnel offering help for emergency
11 problems 7 days per week, or can provide
12 24-hour emergency psychiatric services
13 around the clock. May have
14 detoxification capacity or availability.

15 Inpatient Service:

16 Offers comprehensive treatment to
17 patients who need 24-hour
18 hospitalization including state
19 institutions.

20 Day Support/Outpatient Service:

21 Offers habilitation/rehabilitation
22 programs; individual, group and family
23 counseling services; may include
24 educational components; may include
25 detoxification programs.

26 Residential Service:

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

33 Prevention/Early Intervention:

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

40 The core services definitions shall be used by the
41 Department of Mental Health and Mental Retardation to assess

1 the programs and services provided by community services
2 boards and to determine whether the boards offer basic
3 mental health, mental retardation and substance abuse
4 services to the jurisdictions they serve. The core services
5 definitions shall be an integral factor in planning the
6 delivery of statewide mental health, mental retardation and
7 substance abuse services and in developing a funding formula
8 to equitably fund community services for mentally
9 handicapped persons in the Commonwealth; and be it
10 RESOLVED FURTHER, That the Department of Mental Health
11 and Mental Retardation is requested to submit an interim
12 report on the implementation of core services and on formula
13 funding to the House Committee on Appropriations, the House
14 Committee on Health, Welfare and Institutions, the Senate
15 Committee on Finance, and the Senate Committee on Education
16 and Health by January 1, 1983; and be it
17 RESOLVED FINALLY, That the Department of Mental Health
18 and Mental Retardation is requested to present a final
19 report on core services and formula funding to the same
20 committees of the House and Senate by October 1, 1983. The
21 final report shall focus on the impact of core services and
22 formula funding on the 1984-1986 biennial budget.
23 #

1

2 D1/24/82JOHNSON T1/26/82baj

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

6

7 Be it enacted by the General Assembly of Virginia:

8 1. That § 37.1-194 of the Code of Virginia is amended and

9 reenacted as follows:

10 § 37.1-194. Purpose; services to be provided.--The

11 Department, for the purposes of establishing, maintaining,

12 and promoting the development of mental health, mental

13 retardation and substance abuse services in the ~~State~~

14 Commonwealth , may make matching grants to assist any county

15 having a population of approximately ~~fifty thousand~~ 50,000

16 or more or any city having a population of approximately

17 ~~seventy-five thousand~~ 75,000 or more, or any combination of

18 political subdivisions having a combined population of

19 approximately ~~fifty thousand~~ 50,000 or more, or any city or

20 county or combination thereof which has less than the above

21 prescribed populations which the Department determines is in

22 need of such services, in the establishment and operation of

23 local mental health, mental retardation and substance abuse

24 programs. Every county and city shall establish, either

25 singly or in combination with another political subdivision,

26 a community services board on or before July ~~one, nineteen~~

1 ~~hundred eighty-three~~ 1, 1983

2 The State Mental Health and Mental Retardation Board
3 shall determine, subject to the approval of the General
4 Assembly, a core of program services to be provided by
5 community services boards by July ~~one, nineteen hundred~~
6 ~~eighty-two~~ 1, 1982 in order to provide comprehensive
7 community mental health, mental retardation and substance
8 abuse services within the political subdivisions served by
9 the board. ~~The State Board shall also specify other program~~
10 ~~services which the community services board may provide.~~
11 These program services may include:

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

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

18 (c) Consultation and evaluation services for courts,
19 public schools, health and welfare agencies and for the
20 public.

21 (d) Outpatient diagnostic and treatment services.

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

25 (f) Inpatient diagnostic and treatment services.

26 (g) Research and evaluation and training of personnel.

27 (h) Aftercare for the patient released from a mental
28 hospital and for the resident released from a training

1 center.

2 (i) Drugs and medicines, preadmission and post

3 admission.

4 (j) Therapeutic communities, halfway houses, group

5 homes or other residential facilities.

6 (k) Transitional services.

7 (l) Partial hospitalization.

8 (m) Emergency services.

9 (n) Drug abuse and alcoholism treatment programs.

10 (o) Community residences for the mentally ill and

11 mentally retarded.

12 (p) And other appropriate mental health, mental

13 retardation and substance abuse programs necessary to

14 provide a comprehensive system of services.

15 #

1

2 D 1/24/82 HOPPER T 1/25/82 bgh

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

7 Be it enacted by the General Assembly of Virginia:

8 1. That § 37.1-67.3 of the Code of Virginia is amended and

9 reenacted as follows:

10 § 37.1-67.3. Same; involuntary admission and treatment.

11 If a person is incapable of accepting or unwilling to accept

12 voluntary admission and treatment, the judge shall inform

13 such person of his right to a commitment hearing and right

14 to counsel. The judge shall ascertain if a person whose

15 admission is sought is represented by counsel, and if he is

16 not represented by counsel, the judge shall appoint an

17 attorney-at-law to represent him. However, if such person

18 requests an opportunity to employ counsel, the court shall

19 give him a reasonable opportunity to employ counsel at his

20 own expense. The commitment hearing shall be held within

21 forty-eight hours of the execution of the detention order as

22 provided for in § 37.1-67.1; provided, however, if the

23 forty-eight hour period herein specified terminates on a

24 Saturday, Sunday or a legal holiday, such person may be

25 detained, as herein provided, until the next day which is

26 not a Saturday, Sunday or legal holiday, but in no event may

27 he be detained for a period longer than seventy-two hours.

1 Prior to such hearing, the judge shall fully inform such
2 person of the basis for his detention, the standard upon
3 which he may be detained, the right of appeal from such
4 hearing to the circuit court, the right to jury trial on
5 appeal, and the place, date, and time of such hearing.
6 If such person is incapable of accepting or unwilling
7 to accept voluntary admission and treatment as provided for
8 in § 37.1-67.2, a commitment hearing shall be scheduled as
9 soon as possible, allowing the person who is the subject of
10 the hearing an opportunity to prepare any defenses which he
11 may have, obtain independent evaluation and expert opinion
12 at his own expense, and summons other witnesses.
13 Notwithstanding the above, the judge shall summons one
14 psychiatrist who is licensed in Virginia or one physician
15 who is licensed in Virginia and who is qualified in the
16 diagnosis of mental illness. The judge shall also summons
17 other witnesses when so requested by the person or his
18 attorney. The psychiatrist or physician shall certify that
19 he has personally examined the individual and has probable
20 cause to believe that he is or is not mentally ill, that
21 such person does or does not present an imminent danger to
22 himself or others, and requires or does not require
23 involuntary hospitalization. The judge, in his discretion,
24 may accept written certification of a finding of a
25 psychiatrist or physician, provided such examination has
26 been personally made within the preceding five days; and
27 provided further, there is no objection to the acceptance of
28 such written certification by the person or his attorney.

1 Prior to any adjudication that a person is mentally ill and
2 shall be confined to an institution pursuant to this
3 section, the judge ~~may obtain~~ shall request from the
4 community services board or community mental health clinic
5 which serves the political subdivision where the person
6 resides a prescreening report ~~which~~ ~~states~~ , and the board
7 or clinic shall provide such a report within forty-eight
8 hours. The report shall state whether the person is deemed
9 to be in need of institutional confinement, whether there is
10 no less restrictive alternative to institutional confinement
11 and what the recommendations are for that person's care and
12 treatment. If the prescreening report is not received by
13 the judge within the specified forty-eight hour period, the
14 judge shall proceed to dispose of the case without the
15 board's or clinic's recommendation. If such judge having
16 observed the person so produced and having obtained
17 necessary, positive certification and other relevant
18 evidence, shall specifically find that such person (a)
19 presents an imminent danger to himself or others as a result
20 of mental illness, or (b) has otherwise been proven to be so
21 seriously mentally ill as to be substantially unable to care
22 for himself, and (c) that there is no less restrictive
23 alternative to institutional confinement and treatment and
24 that the alternatives to involuntary hospitalization were
25 investigated and were deemed not suitable, he shall by
26 written order and specific findings so certify and order
27 such person removed to a hospital or other facility
28 designated by the Commissioner for a period of

1 hospitalization and treatment not to exceed one hundred
2 eighty days from the date of the court order. Such person
3 shall be released at the expiration of one hundred eighty
4 days unless involuntarily committed by further petition and
5 order of a court as provided herein or such person makes
6 application for treatment on a voluntary basis as provided
7 for in § 37.1-65.

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

17 Within ten days of the date of the court order
18 involuntarily committing a person to a ~~State~~ state hospital
19 as provided for in this section, the court shall notify the
20 appropriate community services board or the community mental
21 health clinic which serves the area of which the committed
22 person is a resident of the person's name and local address
23 and of the location of the facility in which the person has
24 been hospitalized.

25 #

1

2 D 1/24/82 HOPPER C 1/26/82 smw

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

9

10 Be it enacted by the General Assembly of Virginia:

11 1. That §§ 37.1-1, 37.1-105, 37.1-110 and 37.1-197 of the

12 Code of Virginia are amended and reenacted and that the Code

13 of Virginia is amended by adding in Chapter 10 of Title 37.1

14 a section numbered 37.1-202.1 as follows:

15 § 37.1-1. Definitions.--As used in this title except

16 where the context requires a different meaning or where it

17 is otherwise provided, the following words shall have the

18 meaning ascribed to them:

19 (1) "Board" means the State Mental Health and Mental

20 Retardation Board;

21 (2) [Repealed.]

22 <u>(2a) "Client", as used in Chapter 10 of this title,</u>

23 <u>means any person receiving a service provided by personnel</u>

24 <u>or facilities under the jurisdiction or supervision of a</u>

25 <u>community services board;</u>

26 (3) "Commissioner" means the Commissioner of Mental

27 Health and Mental Retardation;

28 (3a) "Community services board" means a citizens' board

1 established pursuant to § 37.1-195 of the Code which
2 provides mental health, mental retardation and substance
3 abuse programs and services within the political subdivision
4 or political subdivisions participating on the board;
5 (4) "Department" means the Department of Mental Health
6 and Mental Retardation;
7 (4a) "Director" means the chief executive officer of a
8 hospital or of a training center for the mentally retarded;
9 (5) "Drug addict" means a person who: (i) through use
10 of habit-forming drugs or other drugs enumerated in the
11 Virginia Drug Control Act as controlled drugs, has become
12 dangerous to the public or himself; or (ii) because of such
13 drug use, is medically determined to be in need of medical
14 or psychiatric care, treatment, rehabilitation or
15 counseling;
16 (6) "Facility" means a ~~State~~ state or private
17 hospital, training center for the mentally retarded,
18 psychiatric hospital, or other type of residential and
19 ambulatory mental health or mental retardation facility and
20 when modified by the word "State" it means a facility under
21 the supervision and management of the Commissioner;
22 (7) [Repealed.]
23 (8) "Hospital" or "hospitals" when not modified by the
24 words ~~"State"~~ "state" or "private" shall be deemed to
25 include both ~~State~~ state hospitals and private hospitals
26 devoted to or with facilities for the care and treatment of
27 the mentally ill or mentally retarded;
28 (9) "Alcoholic" means a person who: (i) through use of

1 alcohol has become dangerous to the public or himself; or
2 (ii) because of such alcohol use is medically determined to
3 be in need of medical or psychiatric care, treatment,
4 rehabilitation or counseling;
5 (10) [Repealed.]
6 (11) "Judge" includes only the judges, associate judges
7 and substitute judges of general district courts within the
8 meaning of chapter 4.1 (§ 16.1-69.1 et seq.) of Title 16.1
9 of this Code and of juvenile and domestic relations district
10 courts within the meaning of chapter 11 (§ 16.1-226 et seq.)
11 of Title 16.1 of this Code, as well as the special justices
12 authorized by § 37.1-88;
13 (12) "Legal resident" means any person who is a bona
14 fide resident of the Commonwealth of Virginia;
15 (13) "Mental retardation" means substantial subaverage
16 general intellectual functioning which originates during the
17 developmental period and is associated with impairment in
18 adaptive behavior;
19 (14) [Repealed.]
20 (15) "Mentally ill" means any person afflicted with
21 mental disease to such an extent that for his own welfare or
22 the welfare of others, he requires care and treatment;
23 provided, that, for the purposes of chapter 2 (§ 37.1-63 et
24 seq.) of this title, the term "mentally ill" shall be deemed
25 to include any person who is a drug addict or alcoholic;
26 (16) "Patient" means a person voluntarily or
27 involuntarily admitted to or residing in a facility
28 according to the provisions of this title;

1 (17) "Private hospital" means a hospital or institution
2 which is duly licensed pursuant to the provisions of this
3 title;
4 (18) "Private institution" means an establishment which
5 is not operated by the Department and which is licensed
6 under chapter 8 (§ 37.1-179 et seq.) of this title for the
7 care or treatment of mentally ill or mentally retarded
8 persons, including psychiatric wards of general hospitals;
9 (19) "Property" as used in §§ 37.1-12 through 37.1-18
10 includes land and structures thereon;
11 (20) "State hospital" means a hospital, training school
12 or other such institution operated by the Department for the
13 care and treatment of the mentally ill or mentally retarded;
14 (21) [Repealed.]
15 (22) "System of facilities" or "facility system" means
16 the entire system of hospitals and training centers for the
17 mentally retarded and other types of facilities for the
18 residential and ambulatory treatment, training and
19 rehabilitation of the mentally ill and mentally retarded as
20 defined in this section under the general supervision and
21 management of the Commissioner;
22 (23) "Training center for the mentally retarded" means
23 a regional facility for the treatment, training and
24 rehabilitation of the mentally retarded in a specific
25 geographical area.
26 § 37.1-105. Who liable for expenses; amount.--Any
27 person who has been or who may be admitted to any ~~State~~
28 state hospital ~~,~~ or who is the subject of counseling or

1 receives treatment from the staff of a ~~State~~ state hospital
2 shall be deemed to be a patient for the purposes of this
3 article ~~, or the estate of any such patient or the person or~~
4 ~~persons legally liable for the support of any such patient,~~
5 .
6 The income and estate of a patient shall be liable for
7 the expenses of his care ~~,~~ and treatment ~~and maintenance in~~
8 ~~such~~ or training in a state hospital ~~, provided that no~~
9 ~~parent, guardian, spouse or relative shall be liable for any~~
10 ~~expense which arose from the care, treatment or maintenance~~
11 ~~furnished to any patient subsequent to institutionalization~~
12 ~~of such patient in a State hospital for a period of sixty~~
13 ~~months~~ . Any person or persons responsible for holding,
14 managing or controlling the income and estate of the patient
15 shall apply such income and estate toward the expenses of
16 the patient's care and treatment or training.
17 Any person or persons responsible for the support of a
18 patient pursuant to § 20-61 shall be liable for the expenses
19 of his care and treatment or training in a state hospital.
20 Any such person or persons shall no longer be financially
21 liable, however, when a cumulative total of 1826 days of (i)
22 care and treatment or training for the patient in a state
23 hospital; or (ii) the utilization by the patient of services
24 or facilities under the jurisdiction or supervision of any
25 community services board; or (iii) a combination of (i) and
26 (ii) has passed, and payment for or a written agreement to
27 pay the assessments for 1826 days of care and services has
28 been made. Not less than three hours of service per day

1 shall be required to include one day in the cumulative total
2 of 1826 days of utilization of services under the
3 jurisdiction or supervision of a community services board.
4 In order to claim this exemption, the person or persons
5 legally liable for the patient shall produce evidence
6 sufficient to prove eligibility therefore.
7 Such expenses shall not exceed the actual per capita
8 cost for the particular type of service rendered and shall
9 be determined no less frequently than annually by the
10 Department in accordance with standard accounting practice ~~,~~
11 ~~but~~ . In no event shall recovery be permitted for amounts
12 more than five years past due. A certificate of the ~~Director~~
13 ~~or Assistant Director of Reimbursement of the Department~~
14 Commissioner or his designee shall be prima facie evidence
15 of the actual per capita cost for the particular type of
16 service rendered.
17 § 37.1-110. Application for order to compel payment of
18 expenses.-- ~~Upon the failure of~~ When any patient or ~~of~~ his
19 guardian, committee, trustee or ~~of~~ the person or persons
20 legally liable for his expenses ~~,~~ fails to ~~make payment of~~
21 ~~the same~~ pay such expenses , and ~~whenever~~ it appears from
22 investigation that such patient, his guardian, committee,
23 trustee ~~,~~ or the person or persons legally liable for the
24 support of ~~such~~ the patient ~~,~~ is able or has sufficient
25 estate ~~, or there is evidence of ability~~ to pay such
26 expenses, the Department shall petition the appropriate
27 court having jurisdiction over the estate of the patient ~~,~~
28 or the court for the county or city of which ~~he~~ the patient

1 is a legal resident ~~,~~ or from which he was admitted to a
2 ~~State~~ state hospital ~~, provided, however,~~ for an order to
3 compel payment of such expenses by persons liable therefor.
4 In any case in which a person or persons legally liable for
5 the support of the patient is being proceeded against, the
6 petition shall be directed to the appropriate court of the
7 county or city in which such person or persons legally
8 liable for the support of ~~such~~ the patient reside ~~, for an~~
9 ~~order to compel payment of such expenses by persons liable~~
10 ~~therefor and in the following order:~~ .
11 ~~First, by~~ The patient ~~or~~ and his estate ~~, and second,~~
12 ~~by~~ shall first be liable for the payment of his expenses
13 and thereafter, the person or persons legally liable for the
14 support of ~~such~~ the patient. Such person or persons shall
15 be the father, mother, husband, wife ~~,~~ and child or
16 children of the patient, ~~provided the child or children~~ who
17 have attained the age of majority. Such persons shall be
18 jointly and severally liable. The Department shall collect
19 such part or all of such expenses from the several sources
20 as appears proper under the circumstances and may proceed
21 against all of such sources. The proceedings for the
22 collection of such expenses shall conform to the procedure
23 for collection of debts due the Commonwealth. ~~The legally~~
24 ~~liable persons shall be the father, mother, husband, wife,~~
25 ~~child or children of the patient, provided the child or~~
26 ~~children have attained the age of majority. Such persons~~
27 ~~shall be jointly and severally liable. Solely for the~~
28 ~~purpose of determining eligibility under the State plan for~~

1 ~~medical assistance, the father or mother, or both, of a~~
2 ~~patient under twenty-one years of age, shall be liable or~~
3 ~~financially responsible for the care, treatment and~~
4 ~~maintenance of their child only to the extent of any family~~
5 ~~health insurance benefits that are payable for such care.~~
6 ~~After the exhaustion of family health insurance benefits, in~~
7 ~~determining the eligibility of patients under twenty-one~~
8 ~~years of age, the income and resources of the father or~~
9 ~~mother shall not be considered available to that patient if~~
10 ~~he does not regularly share the common household even if the~~
11 ~~patient returns to the common household for periodic visits.~~
12 § 37.1-197. Same; powers and duties.--Every community
13 services board shall:
14 (a) Review and evaluate all existing and proposed
15 public community mental health, mental retardation and
16 substance abuse services and facilities available to serve
17 the community and such private services and facilities as
18 receive funds through the board and advise the appropriate
19 local governments as to its findings.
20 (b) Submit to the governing body or bodies of each
21 political subdivision, of which it is an agency, a program
22 of community mental health, mental retardation and substance
23 abuse services and facilities for its approval.
24 (c) Within amounts appropriated therefor, execute such
25 programs and maintain such services as may be authorized
26 under such appropriations.
27 (d) In accordance with its approved program, enter into
28 contracts for rendition or operation of services or

1 facilities.

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

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

12 (g) Prescribe a reasonable schedule of fees for
13 services provided by personnel or facilities under the
14 jurisdiction or supervision of the board and collection of
15 the same ~~; provided, however, that~~ . All fees collected
16 from board administered programs shall be deposited with the
17 treasurer of the political subdivision of which the board is
18 an agency, or, in the case of a joint board, with the
19 treasurer of the political subdivision specified by
20 agreement ~~; provided further, that~~ . Such collected fees
21 shall be used only for community mental health, mental
22 retardation and substance abuse purposes. ~~By January one,~~
23 ~~nineteen hundred eighty-two,~~ Every board shall institute a
24 reimbursement system to maximize the collection of fees from
25 persons receiving services under the jurisdiction or
26 supervision of the board consistent with the provisions of §
27 37.1-202.1 and from responsible third-party payors.

28 (h) Accept or refuse gifts, donations, bequests or

1 grants of money or property from any source and utilize the
2 same as authorized by the governing body or bodies of the
3 political subdivision or subdivisions of which it is an
4 agency.
5 (i) Seek and accept funds through federal grants ~~;~~
6 ~~provided, however,~~ . In accepting such grants the board
7 shall not bind the governing body or bodies of the political
8 subdivision or subdivisions of which it is an agency to any
9 expenditures or conditions of acceptance without the prior
10 approval of such governing body or bodies.
11 (j) Have authority, notwithstanding any provision of
12 law to the contrary, to disburse funds appropriated to it in
13 accordance with such regulations as may be established by
14 the governing body of the political subdivision of which the
15 board is an agency or, in the case of a joint board, as may
16 be established by agreement.
17 § 37.1-202.1. Liability for expenses of services.--The
18 income and estate of a client shall be liable for the
19 expenses of services or facilities under the jurisdiction or
20 supervision of any community services board which are
21 utilized by the client. Any person or persons responsible
22 for holding, managing or controlling the income and estate
23 of the patient shall apply such income and estate toward the
24 expenses of the services or facilities utilized by the
25 client.
26 Any person or persons responsible for the support of a
27 client pursuant to § 20-61 shall be liable for the expenses
28 of services or facilities under the jurisdiction or

1 supervision of any community services board which are
2 utilized by the client. Any such person or persons shall no
3 longer be financially liable, however, when a cumulative
4 total of 1826 days of (i) care and treatment or training for
5 the client in a state hospital; or (ii) the utilization by
6 the client of services or facilities under the jurisdiction
7 or supervision of any community services board; or (iii) a
8 combination of (i) and (ii) has passed, and payment for or a
9 written agreement to pay the assessment for 1826 days of
10 care and services has been made. Not less than three hours
11 of service per day shall be required to include one day in
12 the cumulative total of 1826 days of utilization of services
13 under the jurisidiction or supervision of a community
14 services board. In order to claim this exemption, the
15 person or persons legally liable for the client shall
16 produce evidence sufficient to prove eligibility therefor.
17 #

1

2 Appendix B

3 Issue Paper

4 The Administration of Western State Hospital

5 Prepared by Martha A. Johnson, Research Associate

6 Staff, Joint Subcommittee on

7 Mental Health and Mental Retardation

8 December 8, 1981

1

2 INTRODUCTION

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

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

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

28 The chairpersons of both the Local Human Rights

1 Committee and the Committee Studying Conditions at Western
2 State Hospital of the Mental Health Association addressed
3 the Joint Subcommittee on Mental Health and Mental
4 Retardation during a thirteen-hour public hearing held on
5 the hospital grounds on August 10, 1981. Forty-six persons
6 addressed the Joint Subcommittee during the hearing. Much
7 of the testimony focused on the allegations published in the
8 Washington Post.
9 The issues addressed in the reports of the Local Human
10 Rights Committee and the Mental Health Association provide a
11 great deal of insight into the problems of the hospital. The
12 reports are entitled: "The Investigation of Conditions at
13 Western State Hospital: A Report by the Local Human Rights
14 Committee, July 15, 1981," and "Inquiry Into Conditions at
15 Western State Hospital: Report prepared by the Ad Hoc
16 Committee of the Mental Health Association of
17 Charlottesville-Albemarle, August 7, 1981." Issues
18 addressed by both reports are:
19 1. Improper Commitment Classification
20 2. Violence Among Patients on Unit G-7 and 8
21 3. Incident Reports of Violence in Shenandoah
22 Geriatric Treatment Center during 1980
23 4. Violent Patients
24 5. Medical Practice
25 6. Mentally Retarded Population
26 7. Overuse of Seclusion
27 Additionally, the Mental Health Association of
28 Charlottesville-Albemarle delved into related issues such

1 as: the accreditation status of Western State Hospital;
2 staffing patterns and levels; the quality of the admissions
3 and discharge processes at the hospital; and the
4 departmental and internal responses to the problems
5 identified in the course of the investigations. The State
6 Human Rights Committee identified three areas of concern
7 that were deemed inappropriate for investigation by the
8 Local Human Rights Committee. These three issues are:
9 intimidation of employees who have registered complaints of
10 patient abuse; the quality of commitment hearings; and
11 allegations of improper discharge and placement.
12 William J. Burns, Ph.D., Director of Western State
13 Hospital, responded to the investigation of the Local Human
14 Rights Committee in a letter dated August 7, 1981 addressed
15 to Owen W. Brodie, M.D., Chairman of the State Human Rights
16 Committee. Dr. Burns addressed the Joint Subcommittee on
17 Mental Health and Mental Retardation during the public
18 hearing in August and in a letter written in December, 1981,
19 responding to specific concerns of the legislators.
20 This paper will deal first with the seven issues common
21 to the two investigative reports. The review of each issue
22 will document related concerns addressed by speakers at the
23 public hearing of the Joint Subcommittee on Mental Health
24 and Mental Retardation on August 10, 1981. The action taken
25 by or the response of Western State Hospital's
26 administrative staff to each issue identified will be
27 recounted.
28 Other pertinent issues identified by the Local Human

1 Rights Committee, the Mental Health Association and by
2 individuals who spoke at the public hearing or who submitted
3 documentation to the Joint Subcommittee will be addressed as
4 well.

5 PRIMARY ISSUES INVESTIGATED

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

23 The controversy about the "administrative voluntary"
24 status arose because as involuntarily admitted patients each
25 individual is required to be the subject of a judicial
26 review every 180 days to determine whether his condition
27 demands continued involuntary hospitalization. Judicial
28 reviews, also known as recommitment hearings, are not

1 required for patients who are classified as voluntary.
2 Therefore, in 1974 when involuntarily committed patients
3 were classified as voluntary or administrative voluntary
4 admissions, those patients were no longer the subject of the
5 180-day judicial review. The administrative voluntary
6 classification, however, is no longer used at Western State
7 Hospital.

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

10 The hospital has never denied the
11 existence of the "administrative
12 voluntary" patients. Rather, we have
13 sought clarification and guidance from
14 the office of the Assistant Attorney
15 General For Mental Health. When we were
16 informed in March, 1981, that we should
17 review these cases with consideration
18 given to the need for commitment
19 hearings, we initiated such action for
20 all such patients. In addition, we
21 subsequently decided to review not only
22 the "administrative" voluntaries, but
23 all voluntary patients within the
24 hospital to assure that none were
25 improperly classified.

26 The review of the 177 patients who were identified by
27 the Local Human Rights Committee and whose records included
28 no written documentation of their consent to admission to
29 Western State Hospital, was conducted in the fall of 1981.
30 Dr. Burns informed the Joint Subcommittee that all 177
31 patients were evaluated by clinical staff including
32 physicians and psychologists at Western State Hospital. A
33 total of 141 patients were reviewed in judicial proceedings.
34 Eighteen signed voluntary papers, thus not requiring
35 judicial hearings. Three patients died before certification
36 proceedings were initiated. One patient was discharged.

1 Fourteen patients remained in the life skills program at
2 Western State as of December 7, 1981, waiting to be
3 certified as mentally retarded. These certification
4 proceedings were delayed until authorization could be
5 obtained from the Commissioner of Mental Health and Mental
6 Retardation for the life skills program to be designated as
7 an appropriate unit for the temporary placement of mentally
8 retarded patients at Western State. Authorization was
9 received by the hospital and the certifications were
10 scheduled for completion by the end of 1981.
11 Dr. Burns noted that all patients who are classified as
12 voluntary admissions at Western State Hospital are routinely
13 informed of the legal rights afforded by voluntary status.
14 A caveat to the hospital administration's review of all
15 voluntary and administrative voluntary patients was included
16 in the July, 1981 report of the Local Human Rights Committee
17 (LHRC) which reads:

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

27 The quality of commitment hearings and of recommitment
28 hearings at Western State Hospital and throughout Virginia
29 was questioned as a result of the controversy initiated by
30 the administrative voluntary issue. At the August public
31 hearing and in subsequent meetings of the Joint Subcommittee
32 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

1 Court of Virginia on Cost Containment within the Criminal
2 Fund and Involuntary Mental Commitment Fund," will be
3 submitted to the Governor and the 1982 Session of the
4 General Assembly. The report contains several
5 recommendations to contain the costs of mental commitments.
6 In addition, it is recommended that a thorough evaluation of
7 state statutes governing involuntary civil commitment to a
8 hospital for the mentally ill be conducted. The report
9 proposes that the analysis determine and seek to improve the
10 quality and effectiveness of the statutes governing
11 commitment of the mentally ill and of commitment procedures
12 followed throughout the Commonwealth.
13 2. Violence Among Patients On Unit G-7 and 8: Unit
14 G-7 and 8 of Western State Hospital was the area of the
15 hospital singled out in the Washington Post articles as a
16 place where violence and sexual assaults among patients had
17 become almost daily occurrences. In the fall of 1980,
18 problems arose when the patient census increased at the same
19 time that the unit became severely understaffed, losing a
20 physician, a psychologist, a nurse and 3 to 4 aides. At
21 that time the unit contained 44 beds and was usually filled
22 to capacity with new admissions of adult males from the
23 geographical area it served. In some instances, forensic and
24 civilly committed patients as well as mentally retarded
25 patients were housed together on the unit. The incongruous
26 mix of patients along with insufficient staff created an
27 unhealthy atmosphere on the unit. An April 27, 1981 memo
28 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

1 prepared a sexuality training course.
2 Direct care staff of G Unit began participating in
3 sexuality training workshops in the fall of 1981. All of
4 the staff of G Unit is scheduled to participate in the
5 workshops by January 31, 1982. Currently, all hospital
6 units may take advantage of the sexuality training course.
7 Unit Directors are required to make this a priority training
8 project for 1982. A standing Committee for the Study of
9 Human Sexuality Training, Policies and Procedures has been
10 meeting on a regular basis to review, define and recommend
11 policy and training needs hospital-wide with regard to human
12 sexuality. A member of the LHRC is a member of the
13 sexuality training committee and is monitoring the
14 hospital's progress in this area for the LHRC.
15 Mrs. Wilma Rowe, who has worked at Western State
16 Hospital for several years, has been assigned to G Unit
17 full-time as program director. Mrs. Rowe and a recently
18 hired psychologist for the unit have developed programs and
19 activities to channel aggressive behavior in a positive
20 direction. At the Joint Subcommittee's public hearing, Mrs.
21 Rowe cited the lack of staff, money and training as primary
22 reasons for recent problems at the hospital. She said that
23 during her work at Western State, she has never witnessed
24 patient abuse. Rather, she believes that patients are
25 "misused" frequently because they fail to receive optimum
26 care and treatment due to the overextension of staff and
27 resources.
28 Several key positions on G Unit, including a full-time

1 physician, licensed practical nurse, team leader, social
2 worker and developmental technician are expected to be
3 filled by January 1, 1982. According to Dr. Burns, addition
4 of these personnel will allow full implementation of
5 programming for the unit early in 1982.

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

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

22 Social workers in the hospital's geriatric center
23 compiled a list of more than 600 violent incidents last
24 year but say the hospital's administration has refused
25 to acknowledge the problem.

26 In one unit designated for Northern Virginians,
27 officials mixed about 20 accused or convicted felons
28 undergoing psychiatric examinations with a dozen
29 chronically ill and vulnerable mental patients for
30 about six months.

31 After investigation and review of patient incident
32 reports which are filed for every accident that occurs to a

1 patient, the Local Human Rights Committee found that:

> 2 Incident reports...show that the level of
> 3 incidents for Western State Hospital as a whole,
> 4 decreased during the period 1/3/81-3/31/81. ...Despite
> 5 decreases in the number of reported incidents, the
> 6 Shenandoah Geriatric Treatment Center staff who
> 7 testified were not satisfied that the number of
> 8 injuries to patients, whether indicated in incident
> 9 reports, was as low as it could be, and felt that as
> 10 many as 30 more nursing and other empty positions would
> 11 have to be filled before a satifactory level of safety
> 12 could be achieved.

13 At the public hearing, Dr. Paul Hundley, Chief
14 Psychologist and Acting Director of the Shenandoah Geriatric
15 Treatment Center, recounted the immediate steps that had
16 been taken to deal with problems on the geriatric units.
17 Dr. Hundley has developed a Geriatric Risk Management
18 System. The new system includes a better reporting form for
19 assimilating data about geriatric patients and the formation
20 of a committee to review incident reports for the purpose of
21 decreasing the risk of injury or abuse. Dr. Hundley stated
22 that rather than increasing the number of direct care staff
23 assigned to the geriatric wards, he would prefer the
24 reduction of patient census through careful preadmission
25 screening and predischarge planning. In order to accomplish
26 this reduction in patient census, Dr. Hundley pointed out
27 the need to better define the roles of the hospital, the
28 community services boards and social services agencies for
29 the care and treatment of the mentally handicapped person.
30 He suggested that state institutions for the mentally ill
31 and mentally retarded provide consultative services to
32 nursing homes. Better communication with nursing homes
33 might alleviate some of the red tape that is involved in

1 discharging a geriatric patient in a state hospital to a
2 nursing home where more appropriate care could be provided.
3 In December, 1981, Dr. Burns informed the Joint
4 Subcommittee that sufficient levels of personnel had been
5 assigned to the Shenandoah Geriatric Treatment Center to
6 provide for basic levels of care and safety. Twenty-two of
7 the 23 established registered nurse positions are filled.
8 All 50 licensed practical nurse positions assigned to the
9 unit are filled. Of the 188 psychiatric aide positions,
10 only one is vacant. Of 43 charge-aide positions, 40 are
11 filled. Dr.Burns noted, however, that "these numbers are
12 still more sparse than we would like in order to insure more
13 of a buffer in cases of illness, workmens compensation or
14 other emergencies."
15 4. Violent Patients: Wards E-7 and 8 of Western State
16 Hospital house all patients undergoing court-ordered
17 evaluations. The Washington Post articles noted that in the
18 summer of 1980, twenty "convicted or accused felons" were
19 transferred from Central State Hospital to Western State.
20 Forensic patients were mixed in with chronically ill
21 patients on the Northern Virginia geographic unit. Charles
22 Spraker, Unit Director on Wards E-7 and 8, told the Post ,
23 "We had violent incidents and fights almost every day."
24 In its investigation, the Local Human Rights Committee
25 found:

26 Whatever potential for violence
27 among patients on E-7 and E-8 formerly
28 existed has been reduced dramatically
29 over the last year.... Additionally,
30 since February, 1981, a policy has been
31 implemented to assure that only

1 non-violent criminal defendants are
2 admitted to E-7 and 8 for pre-trial
3 evaluation.

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

12 As of December 7, 1981, the total population of Wards E
13 7 and 8 was approximately 50% court-referred patients and
14 50% civilly committed patients. Dr. Burns anticipates that
15 the hospital reorganization which is expected to be
16 completed by July 1, 1982 will result in Wards E 7 and 8
17 housing court-referred patients exclusively. The
18 reorganizational plan calls for a centralized admissions
19 service. This arrangement will allow for an increase in
20 male beds throughout the hospital. Therefore, it should
21 eliminate all necessity of using the court-referred program
22 as a back-up for civil admissions.

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

1 5. Medical Practice: The extensive use of
2 computerized axial tomography (CAT) scans and of an
3 anticonvulsant drug known as Tegretol were cited by hospital
4 employees who spoke to the Washington Post as specific
5 instances of patient abuse by the medical staff at Western
6 State Hospital. The question investigated by the Local
7 Human Rights Committee was whether medical procedures were
8 being used by hospital staff solely to conduct research,
9 rather than being used as tools to provide therapeutic
10 treatment for patients.
11 The Local Human Rights Committee found, "that there was
12 no basis whatsoever for the allegations that either CAT
13 scans or Tegretol had been used for research,
14 research-related, or other non-therapeutic purposes." The
15 Mental Health Association reported that its investigation
16 was "unable to uncover evidence to either deny or affirm
17 their [LHRC's] findings."
18 Dr. Burns informed the State Human Rights Committee
19 that the availability of CAT scans and Tegretol "provided
20 with expert consultation from the University of Virginia,
21 gives Western State Hospital some additional sophisticated
22 approaches to enhancing the level of patient care."
23 The Joint Subcommittee was told in August, 1981, that
24 in-service training for physicians had increased over the
25 past eight months. Mandatory training on emergency care was
26 being implemented and training on both CAT Scans and the
27 uses and side effects of Tegretol had been arranged.
28 6. Mentally Retarded Population: Allegations

1 published in the Washington Post charged that mentally
2 retarded patients were sexually abused frequently at Western
3 State. These charges raised a broader question as to why
4 mentally retarded persons are admitted to a State hospital
5 for the mentally ill.

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

11 The LHRC found 145 mentally retarded persons at Western
12 State in June, 1981. Of those, 79 were determined to have a
13 "current diagnosis of mental illness, " 66 were "without a
14 current diagnosis of mental illness." The report notes that
15 the total mentally retarded population had decreased from
16 218 to 145 over the past six years; however, admissions of
17 mentally retarded persons increased from 1980 to 1981. This
18 increase was attributed to:

> 19 1) lack of community resources, public and
> 20 private; 2) difficulties in pre-screening in
> 21 differentiating between the mentally retarded client
> 22 who is [also] mentally ill and the mentally retarded
> 23 client who exhibits behavioral or adjustment problems
> 24 related to mental retardation; and 3) the success and
> 25 good reputation of the life skills program at Western
> 26 State Hospital.

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

32 Dr. Burns concurred with the LHRC's findings and

1 responded that, "most of these individuals could have their
2 needs best met in settings specialized for care of the
3 retarded. The stark reality, however, is that virtually <u>no</u>
4 other alternatives are available for the vast majority of
5 this population." Dr. Burns continued by stating that
6 admissions of mentally retarded persons are "sometimes
7 beyond the hospital's control due to inappropriate community
8 pre-screening or court commitments. Once admitted, it is no
9 easy matter to return such individuals to the community."
10 In their response to the investigation of the Local
11 Human Rights Committee, the Association for Retarded
12 Citizens in Virginia, the American Civil Liberties Union and
13 others took a firm position on the admission of mentally
14 retarded persons to Western State. Their position was,
15 "Mentally retarded persons should not be at Western State
16 Hospital under any circumstances!" Members of the group
17 suggested that excess funds from the Valley Community
18 Services Board ought to be reallocated to provide community
19 day programs for mentally retarded patients at Western
20 State. Another suggestion was that funds earmarked for two
21 new regional facilities for the mentally retarded be used to
22 reduce the inappropriate institutionalization of mentally
23 retarded persons in hospitals for the mentally ill.
24 The Department of Mental Health and Mental Retardation
25 conducted a study of persons whose diagnosis includes both
26 mental retardation and mental illness. The results of the
27 study were presented to the Joint Subcommittee in November,
28 1981.

1 7. Overuse of Seclusion: The Washington Post focused
2 public attention on the use of seclusion by Western State
3 Hospital. The paper reported that Western had been a "state
4 leader" in locking patients in solitary confinement.
5 In January, 1980, Western State Hospital was granted a
6 variance to the Rules and Regulations to Assure the Rights
7 of Patients and Residents. The variance allowed registered
8 nurses and Ph.D. psychologists to order the seclusion of
9 patients in the absence of a physician.
10 The Local Human Rights Committee was requested to
11 obtain from the hospital advocate data regarding the use of
12 seclusion before and after the variance was granted. The
13 LHRC was told that if a significant discrepancy was
14 revealed, the Commissioner could be asked to withdraw the
15 variance and the LHRC could monitor seclusion statistics on
16 a regular basis.
17 The Report of the Local Human Rights Committee
18 summarized the data obtained on the use of seclusion for
19 1979, 1980 and January through May of 1981. The data
20 revealed that the use of seclusion had declined
21 significantly during the period. Consequently, the LHRC
22 concluded that the variance had not led to an increase in
23 seclusion of patients and that hospital staff had learned
24 other methods of handling aggressive behavior. The LHRC
25 indicated that the problems caused by the use of seclusion
26 at Western State had been addressed by the hospital
27 administration and by an outside review team in 1980.
28 The Mental Health Association and the Association for

1 Retarded Citizens, et. al., questioned the conclusion of the
2 LHRC that the use of seclusion had been addressed
3 administratively. It was suggested that tranquilizing drugs
4 may be used instead to reduce the need for seclusion.
5 The Association for Retarded Citizens, et. al., called
6 for a written plan to rectify the problems of seclusion with
7 follow-up review by the LHRC. The LHRC has not yet
8 responded to this request, although the group does plan to
9 monitor the progress of Western State Hospital in correcting
10 problems identified during the investigation of the
11 hospital.
12 This concludes the review of issues addressed by both
13 the Local Human Rights Committee and the Mental Health
14 Association of Charlottesville-Albemarle in their
15 investigative reports.

16 OTHER ISSUES

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

21 1. The Accreditation Status of Western
22 State Hospital

23 2. Staffing

24 3. The Quality of Admissions and
25 Discharges

26 4. The Harrassment and Intimidation of
27 Employees

28 5. The Response of the Department of
29 Mental Health and Mental Retardation and
30 of the Hospital Administration

31 1. The Accreditation Status of Western State Hospital:

1 The Mental Health Association of Charlottesville-Albemarle
2 indicated in its report that Western State Hospital has
3 never been accredited by the Joint Commission on the
4 Accreditation of Hospitals (JCAH) nor has the administration
5 actively sought accreditation. The Association concluded
6 that "by far the most important hindrance to accreditation
7 appears to be the acute shortage of qualified personnel."
8 The Joint Subcommittee learned during the August
9 hearing that the Department of Mental Health and Mental
10 Retardation has required each state hospital and training
11 center which is not accredited nor anticipating
12 accreditation in the near future to conduct a self-survey.
13 The self-survey is intended to determine the feasibility and
14 projected cost for obtaining accreditation. Special
15 attention has been given to the surveys of Eastern State,
16 Central State and Western State because of the termination
17 of Blue Cross participating status. In the spring of this
18 year, Blue Cross announced that it would no longer pay 100%
19 of allowable charges for treatment rendered by unaccredited
20 state institutions. The Joint Subcommittee was told by the
21 Department of Mental Health and Mental Retardation that the
22 affected facilities would continue to receive from Blue
23 Cross approximately 80% reimbursement for allowable charges.
24 The self-surveys, however, are an initial step toward
25 accreditation and full reimbursement status.
26 Dr. Tom Stage, Acting Executive Director of the
27 Fairfax-Falls Church Community Services Board, presented
28 hospital cost data to the Joint Subcommittee to substantiate

1 the conclusion that Western State's level of funding is
2 drastically low. Dr. Stage has been a consultant surveyor
3 for JCAH for five years. He told the Joint Subcommittee
4 that, "Hospitals with a per diem of $50 no longer are
5 capable of being accredited. They are just not able to hire
6 enough qualified staff to provide the direct patient care
7 and the supervision of those persons providing the direct
8 patient care to meet the standards of accreditation."
9 2. Staffing: The underlying problem of nearly every
10 issue addressed during the public hearing and by the
11 investigations was the inadequate numbers of direct care and
12 professional staff at Western State Hospital. The Joint
13 Subcommittee heard over and over the need for better
14 training of staff and for increased efforts at recruiting
15 and maintaining qualified staff. Mary Bradshaw, Chairperson
16 of the Local Human Rights Committee, said that additional
17 and well-trained staff are the two elements needed to
18 provide a safe, secure environment at Western State
19 Hospital. Mrs. Bradshaw indicated that in discussions with
20 the LHRC, the hospital staff identified additional staff as
21 the single most important need for Western State Hospital.
22 The Mental Health Association reported: "The extreme
23 shortage of personnel at all levels prevents the meaningful
24 delivery of treatment and the conduct of therapeutic
25 activities on most units at WSH." Similarly the Association
26 for Retarded Citizens, et. al., stated in its response to
27 the LHRC Report: "In our opinion current direct care
28 staffing levels at Western State Hospital and most likely at

1 other Department of Mental Health and Mental Retardation
2 institutions are so low that patient abuse and neglect are
3 almost inevitable."
4 Physicians and nurses who practice at Western State
5 Hospital told the Joint Subcommittee that heavy caseloads,
6 low salaries and long hours create difficult working
7 environments that discourage qualified professionals from
8 coming to Western State and from staying there. The fact
9 that the hospital is not accredited causes professionals to
10 question whether their reputation may be damaged by working
11 in such a facility. Psychologists and psychiatrists stated
12 that their peers in private practice are never subjected to
13 the amount of public scrutiny that daily haunts
14 practitioners in state facilities.
15 It was suggested by several who spoke at the hearing
16 that professional ties between Western State Hospital and
17 the University of Virginia need to be strengthened. This
18 relationship was cited by physicians, psychiatrists and
19 psychologists as one of the most positive aspects of their
20 work at Western State. Similar affiliations with other
21 college and mental health professional training programs
22 were encouraged.
23 A. W. Jeffreys, Ph.D., Director of Psychological
24 Services at Western State Hospital for the past 27 years,
25 spoke to the Joint Subcommittee and later documented his
26 testimony in a letter. Dr. Jeffreys cited one problem not
27 mentioned by other practitioners at the hospital. According
28 to him, conflict arises when non-clinical administrators

1 direct and supervise clinical professionals such as
2 physicians and clinical psychologists.
3 Dr. Burns has assured the State Human Rights Committee
4 and the Joint Subcommittee that the administration of
5 Western State Hospital is aware of the need for more staff,
6 better qualified and trained staff and for increased efforts
7 to improve communication among hospital staff at all levels.
8 Recent publicity and disciplinary actions have inhibited the
9 progress of a hospital-wide reorganization. Dr. Burns
10 recommended that the hospital be monitored by the Local
11 Human Rights Committee and that the reorganization be
12 completed. The current plans are that the hospital will be
13 completely reorganized by July 1, 1982. He emphasized the
14 need for "vigorous efforts at recruitment" of qualified
15 professionals and for in-service training for all staff.
16 Both Dr. Burns and the Association for Retarded Citizens,
17 et. al., expressed the need for development of a
18 "pro-active" advocacy program at the hospital as a number
19 one priority in assuring that qualified and caring staff are
20 employed by the hospital. According to Dr. Burns, a
21 pro-active advocacy program goes beyond simply investigating
22 complaints. The staff of such a program take an active
23 leadership and training role in creating greater staff and
24 community awareness in the promotion of patient's rights and
25 dignity. Advocates also function to generate interest in the
26 quality of care provided by the hospital and throughout the
27 system of state and community services. Dr. Burns stated
28 that pro-active advocacy "is an advocacy program that guides

1 staff to recognize that advocacy for patients is a
2 responsibility of everyone and that there is more to
3 advocacy than just investigating abuse allegations."
4 On September 28, 1981, Dr. Burns submitted to the Joint
5 Subcommittee a review of the staffing requirements at
6 Western State Hospital. The review has not been approved by
7 Central Office but will be used as a tool to determine
8 actual staffing needs of the hospital for budget requests
9 for the 1982-84 biennium.
10 In addition, Medicus Systems, Inc. is conducting a
11 manpower analysis of every state hospital and training
12 center in Virginia. The analysis will help to determine the
13 levels of care that the institutions should be providing and
14 the required staff for each facility. A final report on the
15 Medicus Survey is to be completed in February, 1982.
16 Dr. Burns stated during the public hearing that the
17 institutional directors are looking forward to the results
18 of the Medicus survey. He said that the staffing of state
19 hospitals depends heavily upon the choices and standards of
20 the institutions and the community. Dr. Burns added that
21 JCAH standards for staff are the norm or the accepted
22 standard, but not the optimum to provide appropriate
23 treatment and care.
24 3. The Quality of Admissions and Discharges: The last
25 article published in the Washington Post series about
26 Western State Hospital focused on life in the community for
27 individuals who were former patients of the hospital. The
28 article indicated that many of the deinstitutionalized had

1 no place to go. Consequently, it was concluded that many
2 reentered Western State where "nearly 75 percent of the
3 patients admitted last year were readmissions."
4 The inappropriate admission of mentally retarded
5 persons and others who could be treated more appropriately
6 in a community setting was discussed in the Post and has
7 been discussed earlier in this paper.
8 Hospital social workers told the Post that "the
9 pressure is always on" to get people out of the hospital
10 regardless of the availability of community resources.
11 Many who spoke to the Joint Subcommittee during the
12 public hearing cited the need for greater community support
13 services to handle chronically ill patients in community
14 settings. According to hospital staff, the ability to
15 decrease patient census at Western State depends upon
16 adequate community facilities and upon aggressive
17 preadmission screening and predischarge planning programs.
18 Dr. Burns supported this contention stating that many
19 patients remain at Western State because of the lack of
20 identified community placements. According to the State
21 Human Rights Committee, this raises the questions of whether
22 the statutory requirement for pre-screening is being
23 observed and whether adequate community facilities have been
24 established.
25 At the request of the Joint Subcommittee, Dr. Burns
26 attempted to estimate the numbers of patients at Western
27 State who could function in the community if appropriate
28 services were available. Dr. Burns responded that:

1 Various estimates have been projected and of
2 course, due to the many complex variables inherent in
3 mental illness, it is most difficult to be totally
4 definite. However, the following estimates would
5 represent the views of administrators and professionals
6 regarding the present Western State Hospital
7 population.

8 In the Shenandoah Geriatric Treatment Center, out
9 of a census of 413, there are approximately 137
10 patients who could be managed in other settings if
11 appropriate community support systems were available.
12 This estimate includes about 100 patients who could be
13 managed in nursing homes if beds were available, 30
14 patients who need adult homes and 7 who could probably
15 return to their families if the families were able and
16 willing to maintain them.

17 On the long term and life skills programs of the
18 hospital there are approximately 125 patients who could
19 be cared for in community alternatives that are
20 presently unavailable. The life skills program also
21 has about 30 patients who are appropriate candidates
22 for a mental retardation training center.

23 Overall, the figures involve approximately 300
24 residents that are perceived as not needing
25 institutional care at Western State Hospital. This
26 translates into an approximate figure of almost 30% for
27 the present population.

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

1 In his statement, Mr. Beghtol argued that, "the present
2 legislation allows a special justice or judge, and since
3 July 1, 1981, magistrates, to bypass the established system.
4 I firmly believe that any citizen faced with the possibility
5 of being detained against his will, in a state hospital, has
6 a right to be pre-screened by a mental health professional."
7 The quality of decisions to discharge patients from
8 Western State and of decisions regarding the community
9 placement of patients was questioned by the Association for
10 Retarded Citizens and others as a result of the firing of
11 eight social workers in July, 1981. Members of the Joint
12 Subcommittee visited Western State on September 28, 1981 and
13 were told that predischarge planning had not suffered as a
14 result of the firings.
15 In testimony before the Joint Subcommittee, social
16 workers at Western State reiterated the need for more
17 community facilities to accomodate discharged patients.
18 Nursing home placements, residential facilities,
19 occupational opportunities and counseling services were
20 emphasized as crucial needs of the communities that Western
21 State serves.
22 4. Harrassment and Intimidation of Employees: In
23 follow-up articles to the series on Western State, the
24 Washington Post and many Virginia newspapers reported
25 disciplinary actions taken against eight social workers by
26 the hospital administration. The eight were suspended from
27 their jobs and eventually were fired. Although other
28 reasons were cited as the basis for the firings, the

1 employees claimed that the job action and other forms of
2 what they perceived to be "harrassment" by hospital
3 administrators were a result of the employees' willingness
4 to speak out about conditions at the hospital.
5 Contrastingly, however, when offered the opportunity to
6 voice their complaints to the Local Human Rights Committee,
7 the eight employees refused to testify.
8 Bob Harrison, Employee Relations Manager for Western
9 State Hospital, told the Joint Subcommittee that he
10 sincerely does not believe that the majority of employees at
11 Western State feel intimidated by the hospital
12 administration. He said that hospital employees are aware
13 of and are free to complain to the Central Office Employee
14 Relations Division and the Office of Employee Relations
15 Counselors. Mr. Harrison, reported that 49 grievances were
16 filed at Western State during Fiscal Year 1980-81. Social
17 workers at the hospital filed 29 of the 49 grievances and 8
18 grievances were filed by one other person. As of August 10,
19 1981, 11 of the 49 grievances had been resolved at the local
20 level.
21 The Local Human Rights Committee, the Mental Health
22 Association and the Joint Subcommittee have all assumed the
23 position that the allegations of harrassment, intimidation
24 and unfair disciplinary actions are best handled in the
25 courts. The eight employees are asking the courts to
26 reinstate them in their jobs at Western State.
27 The State Human Rights Committee issued a preliminary
28 report on Western State on September 3, 1981 commending the

1 Local Human Rights Committee and the hospital administration
2 for the actions taken against the employees. The report
3 states:

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

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

20 The majority of the issues at
21 Western State Hospital have been known
22 to the Department of Mental Health and
23 Mental Retardation for years.... Why
24 were the Local Human Rights Committee
25 and the Advocate not actively
26 investigating and advocating on these
27 long ago?... There is a general failure
28 within the Department to follow through
29 on investigative reports and
30 recommendations. There is a general
31 inadequacy of abuse detection, reporting
32 and follow-up.

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

1 hospital administration is taking reasonable steps to assure
2 the safety of patients at Western State. The Committee has
3 stated: "To be sure, conditions at Western State need
4 substantial improvement.... For the most part, however, it
5 appears that conditions at Western State are compatible with
6 the basic requirements for safe and humane patient care."
7 At the August public hearing, Dr. Burns expressed the
8 desire that Western State Hospital be allowed to meet its
9 own responsibilities in terms of reaching the goals of
10 accreditation and certification. He stated that the
11 reorganization of the hospital, scheduled for completion by
12 July 1, 1982, will enable the administration to utilize more
13 efficiently existing resources of the hospital and
14 community. Dr. Burns gave the Joint Subcommittee his
15 assurance that the hospital would not compromise on the
16 issues of patients' rights and that an active advocacy
17 system would be developed. The kind of advocacy system
18 envisioned by Dr. Burns is described earlier in this paper.
19 Dr. Burns also indicated the need for further study on
20 recruitment, salaries and benefits for various staff
21 positions throughout the hospital, citing a current
22 inability to compete with the private sector for qualified
23 professionals. The hospital is exploring various incentives
24 that may result in better recruitment of professionals to
25 Western State. Among the incentives are pay differentials
26 set according to the shifts worked by licensed nursing
27 personnel, flexible working hours and a closer affiliation
28 with the University of Virginia.

1 Dr. Burns noted that communication among the hospitals,
2 the Department and the legislature are essential to defining
3 the goals of the statewide system of services. He said that
4 if state hospitals are expected to lower their patient
5 populations, then the community and every level of
6 government must become involved in the process.
7 Inappropriate admissions to state hospitals need to be
8 identified and the individuals involved should be treated in
9 community settings.
10 In a list of 16 recommendations, the Mental Health
11 Association stated that, "the state legislature must
12 immediately increase funding for WSH and other facilities
13 under the control of the Department of Mental Health and
14 Mental Retardation."

15 CONCLUSION

16 The Joint Subcommittee on Mental Health and Mental
17 Retardation plans to continue its oversight responsibilities
18 for another two years. During deliberations over continuing
19 the legislative oversight, members of the Joint Subcommittee
20 emphasized the need to prevent future situations like the
21 disturbance at Western State Hospital in 1981.
22 The Joint Subcommittee is keenly aware that the
23 problems and concerns raised at Western State Hospital are
24 not unique. Similar issues arise at each of the state
25 hospitals and training centers and frequently, must be dealt
26 with immediately. The Department of Mental Health and
27 Mental Retardation, administrators of the state hospitals
28 and training centers, community services boards and

1 concerned citizens must work jointly with the legislature to
2 assure that patients and residents in state facilities for
3 the mentally handicapped and in community programs are
4 afforded the most appropriate treatment, training and care
5 and that the rights of each patient and resident are
6 preserved.

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

1

2 DOCUMENTS RECEIVED BY THE JOINT SUBCOMMITTEE

3 ON MENTAL AND MENTAL RETARDATION

4 REGARDING WESTERN STATE HOSPITAL

5 STAUNTON, VIRGINIA

6 I. DOCUMENTATION RECEIVED DURING THE AUGUST 10, 1981 PUBLIC

7 HEARING, WESTERN STATE HOSPITAL

8 Written Statement of Dr. Bruce E. Baker, Fredericksburg,
9 Virginia, Chairman, Committee Studying Conditions at Western
10 State Hospital of the Mental Health Association of Virginia.

11 Letter dated August 7, 1981, from William J. Burns,
12 Ph.D.,Director, Western State Hospital to Owen W. Brodie,
13 M.D., Chairman, State Human Rights Committee; Dr. Burns'
14 response to the investigation of the State Human Rights
15 Committee.

16 Transcribed statement of Brendan Buschi, Former Director of
17 Social Work, Western State Hospital.

18 Written statement of Mr. David Colton, M.Ed., Unit Director,
19 Blue Ridge Treatment Unit (G Unit), Western State Hospital.

20 Transcribed statement of Mrs. Ann Craig, wife of Julius H.
21 Craig, former patient at Western State Hospital.

22 Written statement of Patricia G. Evey, Board member,
23 Pathways to Independence.

24 Letter dated July 23, 1981, from James Gianokos, former
25 patient at Western State Hospital, to Chan Kendrick,
26 Director, American Civil Liberties Union, regarding
27 experiences at Western State Hospital.

28 Presentation by Lynwood A. Harding, Associate Director,
29 Administration, Western State Hospital. Attached document:
30 Ten Year Analysis of Statistics on Western State Hospital.

31 Written statement of Bob Harrison, Employee Relations
32 Manager, Western State Hospital. Summary of Grievance
33 Activity FY 1980-81, Western State Hospital.

34 Mental Health Association of Charlottesville-Albemarle: (1)
35 Inquiry into Conditions at Western State Hospital: Report
36 prepared by the Ad Hoc Committee of the Mental Health
37 Association of Charlottesville-Albemarle; (2) Department of
38 Mental Health and Mental Retardation, Accreditation Survey
39 Report; (3) Press Release dated August 7, 1981 regarding the
40 report of the Charlottesville-Albemarle Mental Health

1 Association, submitted by Ted Hogshire, President,
2 Charlottesville-Albemarle Mental Health Association.

3 (1) Sample Memorandum of Understanding between Shenandoah
4 Geriatric Treatment Center at Western State Hospital and
5 community mental health clinics defining the roles of the
6 hospital and the clinic in community-hospital relations. (2)
7 Admission information for Shenandoah Geriatric Treatment
8 Center, submitted by Dr. Paul Hundley, Acting Director,
9 Shenandoah Geriatric Treatment Center, Western State
10 Hospital.

11 Written statement of Elizabeth P. Knighton, Executive
12 Director, Harrisonburg-Rockingham Community Services Board,
13 representing all the community services boards in Health
14 Systems Area I.

15 Written statement of Russell A. Langelle, Vice-President,
16 Pathways to Independence.

17 Written statement of Robert F. Mueller, Ph.D., citizen
18 member and chairman of the Western State Hospital grievance
19 panel which heard the grievances of Brendan Buschi.

20 Writtn statement of Thomas B. Stage, M.D. Psychiatric
21 Consultant for Medical Affairs and Acting Executive Director
22 Fairfax-Falls Church Community Services Board.

23 Written statement of John Turner, Former Director of the
24 Community and Family Services Department, DeJarnette Center
25 for Human Development.

26 Written statement of Craig Williams, Earl Burton and Edward
27 Wayland, attorneys representing nine employees fired from
28 Western State Hospital.

29 Written statement of Glenn R. Yank, M.D., Deputy Director
30 for Medical Affairs, Western State Hospital. Letter and
31 enclosed statements dated June 19, 1981, addressed to Mary
32 Bradshaw, Chairperson, Western State Hospital and Local
33 Human Rights Committee, from Dr. Glenn Yank. The letter and
34 enclosures refute accusations made about Dr. Yank by the
35 social work staff at Western State Hospital.

36 Western State Hospital Energy Conservation Committee Second
37 Annual Report.

38 II. OTHER DOCUMENTATION

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

44 Patient medical records for Julius H. Craig, patient at

1 Western State Hospital from May 24, 1977 to October 31,
2 1979.

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

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

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

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

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

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

32 Supplemental reports of the Local Human Rights Committee on
33 Western State Hospital, September 3, 1981 and December 11,
34 1981.

35 Preliminary report of the State Human Rights Committee
36 regarding conditions at Western State Hospital, September 3,
37 1981.

38 Letter and enclosed documentation dated October 2, 1981,
39 addressed to Lelia B. Hopper, Staff Attorney, from Edward M.
40 Wayland, Attorney, Charlottesville, Virginia. A total of
41 353 pages of information submitted on behalf of Brendan
42 Buschi and seven social workers who were fired from Western
43 State Hospital. The information is included in seven
44 folders which are labeled: (1) Geriatric Center - Survey of
45 Incident Reports; (2) Administrative Voluntary; (3) U.Va -
46 Research; (4) Raising the Issue of Patient Treatment; (5)
47 Geriatric Center - Patient Abuse; (6) Mental Retardation;

1 and (7) Patient Abuse - G Unit, J Unit, E Unit.

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

7 #

Master Copy
MH/MR Report
2/3/82

MH/MR Report

SIGNATURE SHEET

REPORT OF THE JOINT SUBCOMMITTEE ON
MENTAL HEALTH AND MENTAL RETARDATION
TO THE
GOVERNOR
AND
THE GENERAL ASSEMBLY OF VIRGINIA
JANUARY, 1982

Please indicate your approval of the report by signing below your name and return this form and any dissenting reports, should you choose to submit one, by Friday, February 12, to:

Martha A. Johnson
Research Associate
Division of Legislative Services
State Capitol, P. O. Box 3-AG
Richmond, VA 23208

Respectfully submitted,

Frank M. Slayton, Chairman	Joan S. Jones
Elliot S. Schewel, Vice-Chairman	Frank W. Nolen
Evelyn M. Hailey	Warren G. Stambaugh
Edward M. Holland	W. Ward Teel

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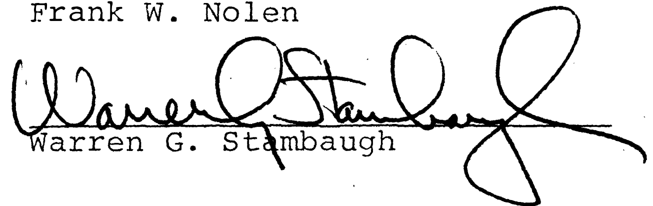
Evelyn M. Hailey	 Warren G. Stambaugh
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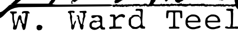
Edward M. Holland	 W. Ward Teel

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
RICHMOND, VA. 23214

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 chronology 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

JJB/jvh

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