# REPORT OF THE

# DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

# A PLAN FOR THOSE MENTALLY RETARDED PERSONS PRESENTLY RESIDING IN MENTAL HEALTH FACILITIES IN VIRGINIA

# TO

# THE GOVERNOR

# AND

# THE GENERAL ASSEMBLY OF VIRGINIA


HOUSE DOCUMENT NO. 21

COMMONWEALTH OF VIRGINIA
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# 1982 REGULAR SESSION
# ENGROSSED

## HOUSE JOINT RESOLUTION NO. 76

House Amendments in [ ] - February 10, 1982

*Setting forth the policy of the Commonwealth with regard to the institutionalization of mentally retarded persons and requesting a report from the Department of Mental Health and Mental Retardation.*

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Patron--Stambaugh

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Referred to the Committee on Health, Welfare and Institutions

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WHEREAS, in 1980 the General Assembly of Virginia agreed to House Joint Resolution No. 9, which set forth a declaration of policy of the Commonwealth for mental health, mental retardation and substance abuse; and

WHEREAS, the policy states that the basic principle behind establishing a statewide system of services for the mentally handicapped is "that in every instance, the appropriate treatment, training and care shall be provided in the least restrictive environment with careful consideration of the unique needs and circumstances of each person"; and

WHEREAS, [ ~~the Joint Subcommittee on Mental Health and Mental Retardation has found that~~ ] significant numbers of mentally retarded persons are admitted to state hospitals for the mentally ill in Virginia every year; and

WHEREAS, it is the sense of this body that mentally retarded individuals who need institutional care are most appropriately treated in state training centers for the mentally retarded; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That it is hereby declared to be the policy of this Commonwealth that mentally retarded persons should not be placed in state hospitals for the mentally ill for the purposes of long-term care; and be it

RESOLVED FURTHER, That the Department of Mental Health and Mental Retardation is requested to identify all [ ~~mentally retarded~~ individuals with a primary disability of mental retardation who are] currently residing in state psychiatric institutions and to develop a target date by which time all [ ~~mentally retarded persons~~ individuals with a primary disability of mental retardation] in need of treatment will be cared for in either a state training center for the mentally retarded or in a community program; and, be it

RESOLVED FURTHER, That the Department is requested to develop a procedure whereby mentally retarded persons in crisis situations may be admitted to and treated in a state hospital for the mentally ill until a physician determines that the period of crisis has passed. The mentally retarded individual should then be transferred to a state training center or an appropriate community program or returned home; and, be it

RESOLVED FINALLY, That the Department of Mental Health and Mental Retardation is requested to report on the implementation of the policy and on the development of the emergency procedure.

The report shall be submitted to the Governor and General Assembly prior to the 1983 Session of the General Assembly.

# EXECUTIVE SUMMARY

House Joint Resolution 76 charged the Department of Mental Health and Mental Retardation with 1) "develop(ing) a target date by which time all individuals with a primary disability of mental retardation will be cared for in either a state training center for the mentally retarded or in a community program," and 2) "develop(ing) a procedure whereby mentally retarded persons in crisis situations may be admitted to and treated in a state hospital for the mentally ill until a physician determines that the period of crisis has passed." This report sets forth procedures by the Department to meet that charge. This report provides the following:

1. A description and definition of the population(s) of mental retardation in state hospitals;

2. A description of the process whereby the severe and profoundly retarded can be placed in state training centers, along with timeframes for this placement;

3. A description of the process whereby the mildly and moderately retarded can be discharged into the community, along with timeframes for this discharge to be completed;

4. A description of how neurologically impaired individuals, who are also mild to moderately retarded and who show maladaptive behavior patterns, can be served in state facilities.

# A PLAN FOR THOSE MENTALLY RETARDED PERSONS IN MENTAL HEALTH FACILIIES IN VIRGINIA

## BACKGROUND

During the 1982 legislative session, House Joint Resolution Number 76 was passed. This Resolution emphasizes the basic principle that in a statewide system of services for the mentally handicapped, treatment, care, and training shall be provided in the least restrictive environment on the basis of unique, individual needs. Noting that certain mentally retarded individuals needing institutional care were being maintained in state hospitals, the Resolution declared a policy that mentally retarded persons should not be placed in state hospitals for the purpose of long term care. The Department of Mental Health and Mental Retardation was charged with the responsibility of identifying all individuals with the primary disability of mental retardation who needed continuing treatment and with the responsibility of providing services for those individuals either in a state training center or community based program. The Department was also to develop a procedure whereby mentally retarded persons in crisis could be admitted to a state hospital for treatment and transferred, if appropriate, to a training center or community program once the crisis passed.

Up to now the placement of these individuals in appropriate services has been constrained by 1) competing demands for beds in state facilities for the mentally retarded; 2) unavailability of appropriate community residential facilities; and 3) the lack of specialized programs for mentally retarded with behavioral or neurological impairments.

This report includes (1) a discussion of issues related to serving the mentally retarded, (2) a description of specific services for these individuals; and (3) a plan, timeframe and budget for providing these services.

## Assumptions

This service plan for those mentally retarded individuals currently in state hospitals was based on the following assumptions:

1) That mentally retarded individuals are best treated by professionals qualified to provide services to the mentally retarded in the least restrictive environment where needed support systems are available.

2) That a common criteria for the diagnosis of mental retardation is essential so that the population can be both specifically determined and treated within a common framework and that this criteria should be the classification system of the American Association on Mental Deficiency.

3) That in developing services for mentally retarded individuals all currently available resources should be utilized to provide a continuity of care between the community and the institution.

4) That new resources should be requested when the client's need for services is beyond those already available within the mental health and mental retardation system.

## Placement of Mentally Retarded Persons Currently in Psychiatric Hospitals

An assessment was conducted to identify the exact number of mentally retarded in the state hospitals and to determine the type and scope of service needs. As can be seen in Table 1, distinct groups emerged based on the overall level of dysfunction. The first group was mild-moderately retarded individuals who displayed no significant emotional/behavioral problems. Across the four major psychiatric hospitals, there were a total of 83 such persons, all of whom need community placement.

Table 1

LEVEL OF DYSFUNCTION BY FACILITY

| Level of Dysfunction | Central State Hospital | Eastern State Hospital | Southwestern State Hospital | Western State Hospital | Total |
|---|---|---|---|---|---|
| Mild/Moderate Retardation | 35 | 34 | 7 | 7 | 83 |
| Severe/Profound Retardation | 7 | 12 | 30 | 30 | 79 |
| Mental Retardation with Behavioral Disturbance or Neurological Impairment | 33 | 32 | 24 | 50 | 139 |
| Total | 75 | 78 | 61 | 87 | 301* |

The second category that emerged was severe-profoundly retarded individuals who displayed no significant emotional/behavioral problems. A total of 79 such clients (Table 1) were identified through the reassessment process. For these individuals, transfer to a training center or intermediate care facility for the mentally retarded (ICF-MR) was indicated.

* The above figures represent those mentally retarded individuals at Central, Eastern, Southwestern, and Western State Hospitals as of October 25, 1982.

Finally, 139 individuals (Table 1) were categorized as showing a neurological impairment and/or a behavioral disturbance. Approximately 75% of these clients are neurologically impaired. Differential diagnosis of neurological impairment verses mental retardation was permitted only through the more extensive nature of the reassessment process. For the remainder of clients in this third overall category, a behavioral disturbance was observed in combination with some degree of mental retardation. Paralleling the Final Report of the Dual Diagnosis Task Force,[1] the overall incidence of this combination (i.e., an emotional disturbance and mental retardation) was remarkably low.

The appropriate placement for each of these categories is as follows:

(1) The mild-moderately retarded need placement in community residential facilities with day support services.

(2) The severe-profoundly retarded need placement in state training centers or intermediate care facility for the mentally retarded.

(3) The mentally retarded neurologically or behaviorally disturbed need specialized services.

Mild-Moderately Retarded Persons

Two alternatives have been identified as realistic choices for serving the 83 mildly and moderately retarded individuals (Table 1) in the community.

The first alternative would require developing and funding new community based facilities to supplement existing community residential services. Two budget requests have been initiated by the Department of Mental Health and Mental Retardation for the development of these services. The Department submitted a 1983 Mini Session Budget proposal for $480,000 to develop model community based programs throughout the state on the basis of documented need. Also, a proposal was submitted to the Governor's Office for the Southwestern Virginia Mental Health Institute and Related Community Services

(1) Final Report of the Dual Diagnosis Task Force, Department of Mental Health and Mental Retardation, September 30, 1981.

requesting four Intermediate Care Facilities for the Mentally Retarded (ICF-MR) of twelve beds each in the Southwestern region. Construction of these facilities would occur by the 1985-86 fiscal year and would then provide additional placements for the mentally retarded in the Southwestern region of the State. Implementation of both proposals would allow the discharge of all mentally retarded patients currently in state hospitals to the most appropriate treatment setting by the end of calendar year 1986. These proposals would provide a statewide network of community based facilities for the mentally retarded now in state hospitals. In Southwestern Virginia the 48 ICF-MR beds would be designed for 31 of the total 61 individuals from Southwestern State Hospital identified as mentally retarded as well as the mentally retarded with a behavioral disturbance or neurological impairment who are capable of benefiting from ICF-MR services. The remaining 17 beds would be filled by referral from Lynchburg Training Center and Hospital and from Southwestern Virginia Training Center who could likewise benefit from an ICF-MR program and who would reside in the southwestern region. The remaining mild-moderately retarded individuals who are residents of other regions of the state will be returned to their communities for placement in an residential program that will meet their individual needs. The request for $480,000 for the 5 group homes of six beds each would be used to start residential program in areas of the State other than the Southwest region where it can be documented that such services are not available for mentally retarded individuals awaiting discharge to the community.

Below is the summary budget for developing the supplemental residential programs.

Table 2

BUDGET - COMMUNITY ALTERNATIVES

FOR MILD-MODERATELY RETARDED INDIVIDUALS

| | Annual Operational Cost | Construction Cost |
|---|---|---|
| Five Group Homes of six beds each (1983-84 fiscal year) | $ 480,000 | |
| Southwestern State Hospital<br>Four ICF-MR Facilities of twelve beds each (1984-86 biennium) This includes day support services. | $1,226,400 | $1,440,000 |
| Subtotal | $1,706,400 | $1,440,000 |

The higher operational cost, especially staffing, for the ICF-MR beds results from the higher level of care for these residents. The group homes could become operational in fiscal year 1984 with the ICF-MR facilities phased in during the 1984-86 biennum. The implementation of both projects depends on the availability of funds.

The second alternative is to reserve every sixth community residential opening for the placement of a mildly or moderately retarded individual from a state hospital over the course of the next four years. Using this plan all 83 mildly or moderately retarded persons now in state hospitals would be placed in a community residential program by the end of 1986. This approach would demand no new resources in providing appropriate services for the majority of mentally retarded individuals currently in state hospitals. Even though there may be available space in some community based facilities for the mentally retarded, the present community facilities serve individuals with carefully specified needs, and admissions are limited to clients who clearly demonstrate these needs. The mildly and moderately retarded individuals now in state hospitals have not been discharged because sufficient residential community based facilities which would

meet their needs are not available. To place these individuals in existing community programs for the mentally retarded which are not designed to meet their needs would interfere with the capability of these programs to serve present clientele. To successfully implement this second alternative, some of the currently operating community facilities would have to restructure services to meet the needs of mentally retarded individuals now in state hospitals. These changes would seriously interfere with the capability of these programs to serve present clientele for whom services are needed. The result has been that the mildly and moderately retarded individuals have remained in state hospitals and have not been discharged to community programs.

Severe-Profoundly Retarded Persons

Transfer to a training center is recommended for all 79 severe-profoundly retarded individuals (Table 1) currently residing in state hospitals by 1986. The basis for this timeframe is data available from 1978-1982 indicating a yearly discharge rate from training centers ranging between 297 and 211. Given that the future discharge rate continues in this range it is proposed that every sixth open bed in a training center be filled through the transfer of a severe-profoundly retarded individual from a state hospital.

There are several implications to the immediate placement of these individuals. First of all, these clients must be placed on waiting lists which also include referrals from communities. At the same time, the training centers are filled to capacity with residents having long term needs. These needs result from the severity of their problems and make these individuals marginal candidates for community placement. Finally, the training centers, like the state hospitals, are being asked to operate under reduced resources which results in their inability either to maintain or increase resources to serve referral demand.

Mentally Retarded Persons Showing Neurological Impairments or Behavioral Disturbances

The term "neurologically impaired" refers to persons having brain damage as a result of cerebral palsy, epilepsy, trauma, strokes, etc. This neurological impairment can be diagnosed through the use of neuropsychological tests, neurological examinations, EEG's, and/or CAT scans. Persons with neurological impairments are often diagnosed as mildly retarded, moderately retarded or even as chronically mentally ill. In reality these individuals have generalized or specific brain damage. There is a combined total of 139

neurologically impaired and mentally retarded behaviorally disturbed persons in Central, Eastern, Southwestern, and Western State who need specialized treatment. The vast majority of these individuals need a rehabilitation program specializing in the treatment of neurological impairments. It is proposed that this program be provided through the development of a program at Central State Hospital and a program at Western State Hospital.

For the small number of clients showing only mental retardation in combination with severe behavioral problems, it is proposed that a specialized small behavioral program be developed at Lynchburg Training School and Hospital. The basic model for these programs is fully described on page eight. Admissions to these programs for those individuals showing neurological impairments with mild-moderate retardation and maladaptive behaviors would require specialized medical and psychological assessments of neurological impairment prior to admission. Those individuals showing neurological impairment with mental retardation would be placed in one of these three programs by the end of calendar year 1985. During 1983 staff would be selected and trained to work in these programs. Also at this time buildings would be selected and prepared to receive clients. In 1984, the staff of these three programs would work with the staffs of the Central, Eastern, Southwestern, and Western State Hospitals to admit clients that have been identified (Table 1) as appropriate for special placement at either Lynchburg Training School and Hospital, Central State Hospital, or Western State Hospital. It is expected that those individuals at Central or Western needing these specialized services will be served by the program at their facility. Each resident will continue in a planned treatment program and be prepared for discharge from that specialized program as a community placement becomes available. The number of beds proposed for each of these specialized programs would be reduced as individuals are discharged to the community. This approach allows these beds to operate under the census reduction plans currently in place for these facilities.

Program Model

It is extremely important to properly diagnose the neurologically impaired so that they can be appropriately treated and trained. Although these persons exhibit behavior similar to the mentally retarded or chronically mentally ill, the treatment or training may differ significantly. Some of the neurologically impaired will benefit from psychotropic medication and most will benefit from behavioral programming. It is recognized that

these neurologically impaired individuals will require specialized treatment and training before they can be placed in the community setting appropriate to their individual needs.

The reassessment of those identified as mentally retarded in Central, Eastern, Southwestern, and Western State resulted in a clearly identified population of mentally retarded who are neurologically impaired or behaviorally disturbed. These individuals exhibit behaviors much like the mentally ill. Staff serving these clients need specialized training in both the mental illness and mental retardation aspects of these individuals clinical needs. This training can be accomplished by retooling mental health professionals to deal with these special needs. Staffing patterns for such programs should include the following specialities: clinical psychiatry, nursing, clinical psychopharmacology, social work, psychology, occupational therapy, recreational therapy, and education.

The program while focusing on a behavioral approach should give special attention to the developmental needs of the individual. Negative behaviors such as self-abuse and aggression should be reduced or eliminated and replaced by behavior that will allow that individual to be successfully integrated into the community.

The goal of a program for these special needs clients is to provide the social and developmental living skills necessary for successful functioning in the community with minimal reliance on the support of the formal program. However, formalized support services must remain available to provide any needed follow-up.

## Crisis Services for the Mentally Retarded through State Hospitals

In response to the charge of House Joint Resolution 76, all six state mental health facilities will offer crisis stabilization services for mentally retarded persons in acute psychiatric distress. However, controls are needed to insure that these individuals do not continue in longer term programs within the state hospitals. Failure to adopt such controls may result in a reoccurrence of the current problem of mentally retarded individuals being inappropriately served in state hospitals on a long term basis.

The Department of Mental Health and Mental Retardation will work to improve the capacity of the hospitals to provide short term crisis stabilization to this population and with the community services boards to insure that a vacant slot/bed is maintained in the community for the return of the client when the acute psychiatric crisis has passed.

## Services to Forensic Population - Central State Hospital

Five mentally retarded individuals have been identified in the forensic unit. However, this is a special population which will not be transferred to a mental retardation facility because these individuals are placed in the forensic unit under criminal charges. Under this legal status these persons are not eligible for services in any other state mental health or mental retardation facility. A training/treatment program has been developed by Central State Hospital staff and Southside Training Center staff to serve this population in the Forensic Unit at Central State Hospital. In keeping with the intent to provide services to mentally retarded persons currently in state hospital, the goal of this program will be to provide the needed treatment and training only to those mentally retarded residents currently in the Central State Hospital forensic unit.

## Procedures For Implementing Services for all Mentally Retarded Persons

The following uniform procedures have been developed as guidance in promoting effective implementation of the statewide plan of services to mentally retarded persons:

1) No mentally retarded individual will be admitted to a state hospital unless that person is experiencing a crisis situation which brings about an emotional illness severe enough to warrant short-term admission to an acute psychiatric unit.

This stipulation pertains to both voluntary and involuntary admissions as determined through the pre-admission screening process of the referring community mental health center.

2) All persons meeting the above criteria will receive a primary diagnosis of mental illness and a secondary diagnosis of mental retardation. Upon admission to the state hospital this population will be known as the emotionally disturbed/mentally retarded (ED/MR).

3) All persons currently in a state hospital with a primary or secondary diagnosis of mental retardation have been reassessed using American Association on Mental Deficiency (AAMD) criteria. These criteria state that a diagnosis of mental retardation requires documentation: a) that retardation was developmental in nature with the onset before age 18; b) that intelligence quotient is two or more standard deviations below the mean; and c) that social behavior does not adapt to the appropriate level of functioning.

4) All individuals reassessed and found to be mentally retarded will have individualized discharge plans developed and placed in their medical charts. These plans will include the timetable for discharge with the destination of either a state training center, community based alternative, or other specialized alternative.

5) All mentally retarded individuals in the state hospitals will be provided training and treatment appropriate to their needs.

The policy whereby every sixth admission to a training center will be a mentally retarded individual from a state hospital will be effective until all clients certified for transfer to a training center are so placed. These transfers will be processed through the community services board in that individual's area of residence and will follow the established legal, policy and procedural requirements.

## IMPLICATIONS AND LIMITATIONS

In reviewing the available alternatives for implementing the mandates of HJR-76 consideration was given to two basic approaches. One consideration was to ask for funding to develop community based alternatives that readily provides the services needed for the majority of the mentally retarded persons in the state hospitals. This strategy allows training centers to continue using their resources to meet the present referral demands from the community without the additional responsibility of serving clientele from state hospitals. It also provides additional placement alternatives to serve not only those from state hospitals but from other sources who are currently on the waiting lists of present community programs. Finally, the variety of alternatives available would be expanded to allow a more distinct tailoring of services to the individual treatment needs of the mentally retarded client.

It is preferable to develop the first alternative that would provide a broad array of community based programs, but the realities of the present economic climate may require that a second less desirable approach be taken. This second approach seeks to make maximum use of the community and institutional resources that are currently available to us by: (1) reserving every sixth slot in existing community residential programs for the mildly or moderately retarded individuals now in state hospital; and (2) requiring that every sixth admission to a training center be reserved for the certifiable severely and profoundly mentally retarded client from a state hospital. This second approach if adopted will necessitate an adjustment of our current institutional and community service system as previously discussed.

## SUMMARY

This report presents a proposal for discharging the mental retarded persons currently served in state hospitals to either a training center or available community placement. A full exploration of alternatives resulted in the identification of two realistic choices. The first alternative would be to fund new community programs. A total of five group homes of six beds each would be developed on the basis of documented need at an operational cost of $480,000 in the 1983-84 fiscal year. In the 1984-86 biennium four ICF-MR facilities of twelve beds each would be built in Southwestern Virginia. The total construction cost for these ICF-MR facilities would be $1,440,000 and the annual operations cost would be $1,226,400. Fully funding these community based programs would provide an additional 78 slots for a more flexible approach in placing the mentally retarded now in state hospitals. The second approach is to totally rely on currently available institutional and community resources. Using this approach no new resources would be required. However, community based facilities would need to change present programs because of the special needs of the mentally retarded now in state hospitals.

Central State, Western State and Lynchburg Training School and Hospital will develop services to the mentally retarded who are neurologically impaired or behaviorally disturbed using the general model described within this report. Mentally retarded individuals now in the Central State Forensic Unit will be served through a special program designed to meet their unique needs.