REPORT OF THE

Commission on Deinstitutionalization

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

Senate Document No. 22

COMMONWEALTH OF VIRGINIA
RICHMOND
1986

MEMBERS OF COMMISSION

Dudley J. Emick, Jr., Chairman
Warren G. Stambaugh, Vice-Chairman
Joseph V. Gartlan, Jr.
Elmon T. Gray
Mary A. Marshall
Owen B. Pickett
Franklin M. Slayton
C. Jefferson Stafford

STAFF

Legal and Research

Susan C. Ward, Staff Attorney
E. Gayle Nowell, Research Assistant
Liz Cosler, Secretary

Administrative and Clerical

Office of Clerk, Senate of Virginia

TABLE OF CONTENTS

Statement of Senator Gartlan
and Delegates Marshall, Slayton and Stambaugh
Statement of Delegate Pickett
Statement of Senator Gray
Statement of Senator Emick
Report of the Commission
- Authority for the Study
- Activities of the Commission
- Summary of Findings and Recommendations of Joint Legislative Audit and Review Commission
- Summary of Recommendations of Department of Mental Health and Mental Retardation and Virginia Association of Community Services Boards
- Findings and Recommendations of the Commission
- Appendices

STATEMENT OF SENATOR GARTLAN
AND DELEGATES MARSHALL, SLAYTON AND STAMBAUGH

I. INTRODUCTION

The Commission on Deinstitutionalization held its last meeting on December 3, 1985. At that time, certain members concurred with the conclusions and recommendations of the Commission (as described in the report following this document), but felt that a greater degree of specificity was needed to guide the General Assembly and the Department of Mental Health and Mental Retardation in actions to address difficult problems associated with our service delivery system for the mentally disabled.

Further, we do not believe that all areas have been fully addressed by the Commission. Over the course of four public hearings, extensive testimony by staff of the Joint Legislative Audit and Review Commission (JLARC), and presentations by the Department, it became clear to us that legislative action was needed concerning a wide variety of issues.

For these reasons, we have written a "concurring majority" report to be published in tandem with the final report of the Commission.

This report draws heavily on the work of JLARC which provided research and technical assistance to the Commission over the past two years. We believe strongly that JLARC staff have accurately documented the status of deinstitutionalization in Virginia and we endorse many of the recommendations made by that agency as expressed in the following report.

We offer this report and its recommendations with the hope that this effort will significantly improve the quality of life, training and treatment afforded mentally handicapped Virginians.

Respectfully submitted,

Joseph V. Gartlan, Jr.,

Mary A. Marshall

Franklin M. Slayton

Warren G. Stambaugh

II. TABLE OF CONTENTS

I. INTRODUCTION

II. TABLE OF CONTENTS

III. SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

IV. QUALITY ASSURANCE AND SERVICE ACCOUNTABILITY UNDER THE CURRENT SYSTEM
- Program Standards and Oversight by the Department of Mental Health and Mental Retardation
- Data Collection, Planning and Evaluation
- Clarification of Roles on the Local Level
- Role of the Case Manager
- Involuntary Commitment

V. CAPACITY OF COMMUNITY PROGRAMS AND HOSPITALS
- Psychosocial Rehabilitation
- Transitional Employment
- Case Management
- Services for Mentally Retarded and Substance Abuse Clients
- Quality and Costs of State Hospitals
- Use of Local Psychiatric Hospitals

VI. HOUSING, RESIDENTIAL SERVICES AND ADULT HOMES
- State Housing Policy
- Increasing Housing Stock
- Tracking Clients in Adult Homes
- Mental Health Needs of Adult Home Residents
- Monitoring Placements in Adult Homes
- Restructuring the Adult Home System

VII. FISCAL ACCOUNTABILITY FOR COMMUNITY SERVICES. UNDER THE CURRENT SYSTEM
- Allocation of State Funds
- Financial Participation by Local Governments

VIII. TRANSITION TO A SINGLE SYSTEM OF CARE
- Future Policy Goals
- Oversight and Service Accountability
- Evaluating the Effectiveness of Service Delivery Systems
- Financing a Single System

APPENDIX A: ESTIMATED FISCAL IMPACTS

III. SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

The work of the Commission on Deinstitutionalization has spanned the last two years and culminates a decade of progress in improving services for mentally disabled persons in Virginia. The Commission is pleased to conclude that significant improvements have demonstrated the State's commitment to assist every citizen live as independently and as productively as possible.

Yet there is much more to be done to continue the progress made over the past ten years. No person appearing before the Commission felt that the service delivery system had reached it's potential, and further, there was unanimous consent that many clients still do not receive appropriate treatment, training and care.

The Commission divided it's inquiry to address six issues: (1) Deinstitutionization policies, (2) Quality assurance and service accountability, (3) Capacity of community programs, (4) Quality of hospitals, (5) Housing and residential programs, (6) Funding allocations and (7) Structure of service delivery system. From these inquiries, the Commission offers the following conclusions.

Deinstitutionalization Policy

Virginia has been successful in reducing the number of inappropriate admissions to State hospitals. However, the capacity of community service boards to serve the increased number of discharged clients is not sufficient. For this reason, community support services are not readily available for many clients discharged or diverted from State hospitals. In conjunction with two recessions and high unemployment, many clients have not readjusted successfully to the community. As a result, recidivism to State hospitals has increased.

It should be the policy of the State, therefore, to develop adequate community programs for those clients who have already been discharged from hospitals and who are residing in localities. The Commission concludes that the most effective way to address concerns related to the impact of deinstitutionalization is to enhance the programming capacity of the community service boards and to develop rigorous quality assurance procedures. Further, it should be the policy of the State not to discharge severely chronically mentally ill clients from State hospitals unless appropriate community services are in place for them.

Quality Assurance and Service Accountability

The State should be committed to offering high quality treatment, training and care for every person who enters the system whether it be in the community or an institution. To accomplish this

goal, the Department of Mental Health and Mental Retardation (the Department) is designated as having the responsibility for assuring quality statewide. Through the Department, the State should fulfill its commitment to continuously monitor, evaluate, and improve community and institutional programs. Only in this way can the State meet its goal of establishing a full continuum of quality services.

The vast majority of clients in the service delivery system are treated in the community. Under guidelines set by the Department, it is the responsibility of the community service boards to link and provide all clients with appropriate treatment and support services. To this end, all providers of local services must cooperate fully with Community Service Boards. Only in this way can citizens be assured that they will receive appropriate, timely and effective services which address their unique needs and special circumstances.

Capacity of Community Programs

Community programs are administered on a statewide basis through 40 community service boards. The availability of necessary programs, however, is limited in many areas of the state.

Our prevailing conclusion is that difficulties associated with deinstitutionalization can be attributed primarily to a lack of community resources. It should be the policy of the State that most mentally disabled persons can be treated effectively and in a cost-efficient manner through the provision of quality community services. To meet the goal of this policy, the State should continue to take actions so that each citizen shall have equal access to appropriate services regardless of his or her place of residency.

The first priority of the State should be to address the needs of the chronically mentally ill. This population has often been neglected. We are encouraged by recent innovative approaches for treating this population in the community through psychosocial rehabilitation, transitional employment programs and case management services.

There are also significant program gaps in services for mentally retarded, alcohol and drug abusers, children and dual-diagnosed citizens. Effective leadership and planning by the Department must be offered to ensure that necessary programs are made available to eligible clients.

Quality State Hospitals and Training Centers

The State's mental health hospitals and training centers play an essential role in the continuum of care. It should be the State's policy to provide quality care in hospitals, with emphasis

given to those clients requiring long-term highly structured treatment. The cost of operating institutions has increased rapidly in recent years due to improved staffing and actions to meet Medicaid requirements and standards imposed by the Joint Commission on Accreditation of Hospitals (JCAH). The State should be committed to consistent review and actions which stabilize institutional costs without impacting quality. As one step to this end, it should be the policy of the State to encourage the use of psychiatric beds in local hospitals for clients with short-term treatment needs.

Housing and Residential Programs

Mentally disabled persons require decent and safe housing in order to adjust to the community. The challenges to the State to meet this demand are significant. The responsibility for addressing the housing needs of the mentally disabled cannot and should not be the exclusive duty of one agency. It should be the policy of the State to take immediate actions which clarify the obligations of all State agencies and which result in the best use of available resources.

The State recognizes that the mentally disabled have special needs, and that during some periods they require special residential programs which provide treatment in addition to shelter. To this end, the State should be committed to ensuring that the community service boards provide extensive case management to clients and families and developing residential programs for clients who do not have the benefit of a family support system.

Adult homes provide housing to many of Virginia's mentally disabled population. Historically, adult homes have served the elderly population and thus do not have staff or programs to address the needs of the mentally ill. The State should be committed to improved regulation of adult homes and also to clearly defining the role of the adult home within the mental health system.

Fiscal Accountability Under the Current System

The State strives to use available funds in the most effective and cost-efficient manner. This obligation becomes more salient when projected federal budget cuts are considered. The State should be committed to increasing funds for the service delivery system, with special consideration given to increasing the capacity of community programs. Concurrently, it should be the policy of the State to continue to improve fund distribution mechanisms to ensure that available resources are directed to those populations with the greatest need and those jurisdictions with the highest level of demand.

As the State continues to take steps to improve the service delivery system, it is essential that local governments become a stable source of funds for community programs. It should be the policy of the State to financially assist and cooperate with the local governments in the mutual effort to provide quality services, and to ensure that the financial obligation is fairly distributed across the State.

Transition to a Single System of Care

The State currently funds two overlapping systems of care: hospital interventions and community programs. However, the operation of two systems is financially inefficient and confuses lines of responsibility. As a policy goal, therefore, the State should be committed to developing a "single system" of care. Under this approach, community service boards would be granted greater service and fiscal accountability for the delivery of programs to clients.

Implementation of a single system is not feasible at the present time, but it should be the policy of the State to cautiously implement intermediate steps toward this goal. A key step is the development of a single financing system whereby community service boards would be granted greater fiscal control over funds for inpatient services. It is the goal of the State to implement this financing system in FY 1990.

IV. QUALITY ASSURANCE AND SERVICE ACCOUNTABILITY UNDER THE CURRENT SYSTEM

The treatment and support needs of the mentally disabled are varied. For this reason, it is necessary that service providers from different agencies be involved in the service delivery system and that effective coordination, quality assurance and planning take place on both the State and local levels. It should be the policy of the State to ensure that these essential responsibilities are met.

PROGRAM STANDARDS AND OVERSIGHT BY THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

In it's recommendations to the Commission, the Department reported a proposal to shift the headquarters role to monitoring and evaluating community service board and hospital programs. We endorse this proposal and see it as complementary to the Joint Legislative Audit and Review Commission's (JLARC) conclusions and recommendations.

JLARC concluded that Department monitoring of community service board activities has not been sufficient to ensure high quality programming. Regardless of the General Assembly's preferences concerning the structure of the mental health system, strong and aggressive oversight by the central office is required to ensure that the State's priorities are met and that citizens receive the services they require.

JLARC's recommendations to improve existing standards for community service board programs are endorsed. Standards should fully address the performance and quality of the programs. Development of these standards should be a high priority for the Central Office. Further, we believe that procedures to enforce these standards should be implemented as soon as possible. The Department should report on progress in these areas prior to the 1987 Session of the General Assembly.

Three approaches to meet the above goals are urged. First, the Department should realign central office staff responsibilities to increase its capacity to perform service audits of community service boards. Second, the Department should identify existing model programs and use community service board staff in those programs to conduct peer review under guidelines set by the Central Office. Third, it is concluded that it may be necessary to increase staffing of the Central Office to implement these essential functions.

At the request of the Commission, the Department estimated administrative costs necessary to meet JLARC's recommendations in these areas. The Department reports that a total of $640,000 in general funds would be needed to establish ten positions required in the next biennial to develop and implement effective quality assurance mechanisms.

DATA COLLECTION, PLANNING AND EVALUATION

The ability to collect and analyze relevant and valid data is an essential element of the Department's quality assurance responsibilities. During the course of it's study, the Commission repeatedly heard that the Department and the community service boards were deficient in this area, and that this limitation significantly hindered the Department's ability to plan and evaluate system changes. JLARC, in its study, concurred with the above complaints. For example, JLARC specifically noted difficulties in collecting data for its evaluation because the community service boards did not have the resources or departmental direction to collect necessary data.

JLARC recommended that urged the General Assembly take steps to improve the planning and data collection of the Department in order to profile the target population, to monitor the status of the

system, and to ensure that policy and programmatic decisions are based on this information. JLARC also noted that the Department has not been effective in communicating the department's progress, future initiatives and funding needs to the General Assembly. To achieve this end, the Department has recently completed a comprehensive five year plan. JLARC recommended that this plan be updated annually.

To strengthen the State's monitoring and evaluation capabilities, we endorse JLARC's recommendation to increase the data collection capabilities of the community service boards. Further, we concur with the recommendation for the Department to take leadership in identifying specific and uniform data elements to be collected by community service boards. The data collected should focus on information most relevant to program, policy and funding decisions and should include unit cost information.

The Department of Mental Health and Mental Retardation estimates that a total of $4.49 million in general funds will be required in the next biennial to collect and analyze data at the state and local level. This estimate includes funding of five positions at the State level, 56 positions at the local level and funding for computer equipment.

We endorse JLARC's recommendation to amend the Code to require the Department to develop a six year plan to be updated annually on a schedule consistent with the needs of the General Assembly. The plan should be organized by disability area to reflect the different needs and policies associated with each population. Unmet need should be included. The plan should identify proposals and cost estimates for addressing system deficiencies.

CLARIFICATION OF ROLES ON THE LOCAL LEVEL

The majority of clients in the mental health system are served by community service boards. A number of other agencies, however, are involved in delivering services. JLARC concluded that there is a need to improve coordination among service providers to ensure that clients are referred and receive services in a timely manner from appropriate agencies. To this end, JLARC recommended specific improvements in the discharge process and additional actions for ensuring that clients receive appropriate case management and support services.

The Commission identified a need to clearly define the role and responsibilities of local agencies, and thus we endorse JLARC's recommendation that the Code be amended to specify that the annual plan and budget submitted by community service boards include a comprehensive assessment of clients to be served, an inventory of available services, including those provided by other agencies, an

explanation of services to be provided by state and local hospitals, and a demonstration of public participation in the plan. Similarly, we endorse the Department's recommendation that community service boards initiate formal agreements annually with all local service providers specifying how services will be provided to eligible clients. A statement emphasizing that top priority will be granted to the most disabled clients should be included in the agreement.

ROLE OF THE CASE MANAGER

It is the responsibility of community service board staff to ensure that clients are given ample support and supervision during discharge and client management processes. Specifically, community service providers must have knowledge of the client and have a support system in place prior to discharge from the hospital. Further, it is important that the client be discharged to a residential setting that is able to meet his or her basic shelter and financial needs. Finally, community service board staff must be readily available to prepare the client for discharge and to assist the client on arrival in the community.

There is concern about JLARC's conclusion that these basic steps are not consistently followed by hospital, community service board and other agency staff. We believe that statutory changes are necessary to clarify responsibilities and ensure compliance. According to JLARC, for example, some clients are discharged before income subsidies are in place.

JLARC's recommendation that the Department of Mental Health and Mental Retardation develop and implement a uniform discharge document to be used by all hospitals is endorsed. The document should include a checklist of all necessary health, financial, residential and treatment needs of the clients. The document should identify services which would be appropriate for the client, but which are not currently available. Specific strategies to locate and place clients in these services should be noted.

It is recommended that the Department of Social Services (DSS), the Department of Rehabilitative Services (DRS) and the Department of DMHMR modify standards to jointly ensure that SSI or other income subsidies are in place and available to eligible clients upon discharge from a state facility. We believe that it is inappropriate to discharge any clients directly into emergency shelters as these settings do not meet the basic shelter needs of citizens.

Case management is a key element of a community support system, yet JLARC concluded that the availability and quality of this service was limited across the State. As discussed later in this

report, JLARC identified the need for 124 case managers across the state. Funding of these positions would greatly enhance the community service boards ability to coordinate services and provide necessary outreach.

JLARC also questioned the high degree of variability in case management practices used by different community service boards. In some areas of the State, important case management functions were not performed consistently. We conclude, therefore, that in addition to increasing local capacity to perform this essential service, the General Assembly needs to take additional steps to ensure that priorities concerning the chronically mentally ill are met.

JLARC's recommendation that statutory changes be made to define the purposes of case management is endorsed. The purposes should include: (1) assessing client needs, (2) planning and coordinating service delivery, (3) linking clients to appropriate services, and (4) monitoring delivery of services in both inpatient and outpatient settings to ensure appropriateness of treatment in consideration of client's changing needs.

It is recommended that the Department develop and implement case management guidelines concerning responsibilities in the discharge process and in the community. In developing guidelines, the Department should: (1) establish a minimum level of case management services to be provided to all clients, (2) establish a direct link between the intensity of case management and client need, (3) ensure active involvement with hospital staff in the discharge process, (2) provide at least one face-to-face contact with the client within five days prior to discharge and (3) have at least one face-to-face contact with the client in residency within three days after discharge to assist in the community transition.

INVOLUNTARY COMMITMENT

In public testimony, the Commission repeatedly heard about "service refusers"--mentally ill persons who choose not to take advantage of services offered by community service boards. Those who refuse services were seen as being "at risk" for recidivism to State hospitals and for becoming part of the "homeless" population. JLARC's analyses could not substantiate or disprove this claim, but it was noted that an estimated 20% of all discharged clients refuse one or more services.

The issue of service refusers must be addressed to achieve deinstitutionalization goals. JLARC noted, for example, that once a person refused services, the community service board rarely followed-up on the client at a later date. We believe strongly that the incidence of refusal would be diminished by better case management.

Involuntary commitment is another viable alternative used in other states as a mechanism for ensuring that clients receive necessary services. Such a strategy would be especially valuable for those clients who require medication. According to testimony heard during the Commission's public hearings, regular use of medication is a powerful tool for preventing acute episodes which then require readmission to a hospital.

JLARC's recommendation that existing outpatient commitment statutes be amended during the 1987 Session is endorsed. Amended language could specify the purposes and limit outpatient commitment to those persons who (1) have a history of multiple hospitals and (2) who refuse to take required medications or who refuse to comply with other treatments. Procedures for enforcing the statutes should be clarified.

In order to ensure effective amendments, we recommend that the Department develop guidelines for implementation, provide training to community service boards and judges and report on any fiscal impact associated with the use of outpatient commitment prior to the 1987 Session.

V. CAPACITY OF COMMUNITY PROGRAMS AND HOSPITALS

The prevailing theme in the work of the Commission has been that the best way to address concerns related to the impact of deinstitutionalization is to provide funding to increase community service board service capacity, especially in the areas of psychosocial rehabilitation, transitional employment and case management. Further, continuing steps are required to ensure that quality hospital services are provided in a cost-efficient manner.

PSYCHOSOCIAL REHABILITATION

Psychosocial rehabilitation or "clubhouse" programs provide essential opportunities and services which promote clients' abilities to live and work independently in the community. Throughout public testimony, psychosocial programs (a specific type of day treatment) were identified as the most effective treatment for chronically mentally ill clients. JLARC staff, in it's testimony, confirmed this opinion and noted that national experts view psychosocial rehabilitation as the key element in a community support system.

JLARC reported that psychosocial rehabilitation programs exist in 32 community service boards. The capacity of these programs, however, is limited. JLARC reported that an estimated 3,500 clients currently living in the community do not have access to this service. In addition to resource limitations, a lack of

transportation was identified by JLARC as a significant barrier resulting in clients not being able to receive this service. Further, the Commission heard that eight community service boards do not have this program. The number of clients in these localities who require such service could not be estimated, but clearly a high level of demand exists.

We endorse the JLARC recommendation that the General Assembly (1) appropriate funds to establish programs in the community service boards which have an absolute gap and to expand programs which do not have sufficient capacity to meet the current level of unmet need, and (2) mandate, through statute, that all community service boards operate psychosocial rehabilitation or equivalent programs, and (3) that funds be appropriated for the purchase of transportation vehicles.

Given the current service levels as compared with the demand, JLARC estimates that 1,452 additional slots are required across the State. A scheduled phase-in of 363 additional slots per year starting in FY 1987 will require a total of $9.0 million in general funds for the next biennial (FY 1987-363 slots, FY 1988-726 slots). JLARC estimates that given a phase in of 363 new slots per year, the State will meet the current level of unmet demand by FY 1990. Additionally, a one-time appropriation of $600,000 in general funds would be required in FY 1987 to purchase vans in order to transport clients to day support programs.

TRANSITIONAL EMPLOYMENT

In public testimony by clients, community service board staff, and national experts, the Commission learned that most chronically ill clients living in the community are capable of volunteer, part-time or full-time work. Indeed, the experience of work is a powerful therapy for many clients, and provides an effective and ongoing link to the community.

Currently, only 13 community service boards operate transitional employment programs for chronically mentally ill clients. These programs focus on developing clients' work adjustment skills, and assisting clients in obtaining volunteer or paid work. In Richmond, for example, clients are paid to maintain buildings and operate vending businesses.

JLARC reports that the capacity of existing programs is limited. In those community service boards which do have transitional programs, for example, 139 qualified clients cannot receive services. Twenty-seven community service boards do not have this program available to clients. While the level of unmet demand could not be measured, it is concluded that a great number of clients cannot receive this valuable service.

While the Department of Rehabilitative Services is mandated to provide assistance to the chronically mentally ill in developing work skills and finding employment, the Commission heard from JLARC that community service boards have very little contact with DRS staff. Concerns were raised that DRS policies result in this population being excluded from many of their programs.

We acknowledge the value of transitional employment programs in the rehabilitative processes. Given the availability of funds, we support expansion of these programs and endorse JLARC's recommendation to mandate and fund transitional employment programs on a statewide basis. Further, it is requested that DRS evaluate existing policies and to report to the General Assembly, prior to the 1987 Session, on ways in which the Department can redirect their existing resources to better serve an increased number of chronically ill clients.

The Department and DRS have proposed a joint program to operate transitional employment programs in the community service boards. It is estimated that a total of $3.8 million in general funds would be required in the next biennial to serve an additional 1000 clients on an annual basis.

CASE MANAGEMENT

Case management is a fundamental element of a mental health service delivery system. One of the clearest conclusions of the JLARC study was that case management is insufficient throughout the State. The outcomes are that (1) clients discharged from hospitals are not linked with the community system, (2) service coordination for individual clients is not consistently implemented and (3) outreach attempts to those clients who refuse treatment initially are rarely made. In other words, the status and mental health of clients in the community is not consistently monitored. This is one cause, JLARC concluded, for high recidivism rates at our State mental health facilities.

JLARC concludes that additional case managers are required in all community service boards. Data indicated, for example, that over 4,000 clients are currently receiving insufficient case management services. Specifically, case manager to client ratios averaged 1:57 in the community and, on average, each chronically ill persons received only 1.7 hours of case management each month. The Commission believes that this basic service should be available to all clients.

While JLARC concluded that a lack of staff was the primary barrier to case management, it was also reported that community service boards vary in their approaches to this service. In some

community service boards, priority was not given to this service. JLARC's recommendations concerning increased State regulation of case management are thus strongly endorsed. These recommendations are discussed specifically in Part IV (Service Accountability and Quality Assurance) and Part VI (Housing, Residential Services and Adult Homes)

JLARC's recommendation to enhance community service board capabilities to provide case management services is endorsed. Additionally, it is proposed that statutory changes be made to mandate that case management be provided to all eligible clients. Finally, it is recommended that the Department develop standards for case management and to report on its efforts prior to the 1987 Session.

The Department concurs with JLARC's recommendation that a total of $5.8 million in general funds is required in the next biennial to fill existing case management service gaps. This estimate would provide funding to establish 124 case managers on the local level in FY 1987.

SERVICES FOR MENTALLY RETARDED AND SUBSTANCE ABUSING CLIENTS

This study focused on policies for serving the chronically mentally ill. This does not suggest, however, that the State is not committed to improving the service delivery system for mentally retarded and substance abusers.

In it's report, JLARC presented data on services and unmet demand for these populations. In brief, the status of community services is not significantly better than that documented for the chronically mentally ill.

Adult development and sheltered workshops are key programs for the mentally retarded. JLARC concluded that about 3000 clients were currently receiving these services in about thirty community service boards. However, these community service boards reported an unmet demand of 1,500 additional clients. All CSBs operate or contract for at least one of the above programs, although the capacity of many CSBs is severely limited. Unmet demand could not be estimated for these community service boards, but it is clear that a high number of citizens are not being served.

Effective planning and funding will be required to address the current level of unmet need. In addition, the Commission is especially concerned about the future demand on the system. JLARC reported, for example, that 63% of the mentally retarded population currently live with their families. As parents get older and unable to supervise their children, the demands on the service delivery system will increase dramatically. Moreover, an estimated 1,744

mentally retarded youth (ages 18-21) are currently receiving special education in the public schools. As these students "age-out" of special education, their needs will have to be addressed by the service delivery system.

Significant service gaps also exist in the availability of treatment for substance abusers. Since 1978, the State hospitals have significantly decreased the number of beds available for substance abusers. As a result, community service boards have been given the responsibility to provide detoxification services to clients. However, JLARC noted that 14 community service boards do not have detoxification programs available to them.

A minimum continuum of care for substance abusers consists of detoxification services, case management and some type of long-term residential treatment facility. JLARC concluded that only 12 community service boards have developed this minimum standard of programs. Unmet demand, JLARC found, could not be estimated statewide because sufficient programs do not exist and thus community service board staff have no reason to collect systemmatic data.

It is recommended that the Department identify priority services and to prepare cost estimates for meeting demand for services to mentally retarded and substance abusing clients. A report and plan of action should be presented to the General Assembly as soon as possible.

QUALITY AND COSTS OF STATE HOSPITALS

We affirm that our State hospitals have an essential and unique role within the service delivery system and strongly endorse the need for quality services in the State's mental health institutions. Further, we acknowledge that some chronically mentally ill clients require a setting where twenty-four hour, highly structured treatment is offered.

We concur with JLARC's conclusion that the State has been successful in reducing inappropriate admissions and improving staffing in hospitals during the past ten years. However, as the role of the community service board continues to become more significant within the service delivery system, it will be important to re-examine the role of the State hospital within the continuum of care so that this setting will be used in the most appropriate manner possible.

We also recognize that increased funding to improve the quality of hospitals is necessary, especially in response to recent Medicaid and JCAH evaluations. There is concern, however, about the rising costs of hospitalization, and that appropriations to hospitals

comprise 79% of the mental health budget. Steps will be necessary in the near future to control these costs. We are convinced that more comprehensive planning is required to address this difficult issue.

To ensure the appropriate use of state and private hospital programs, we endorse JLARC's recommendation that the Department to complete a study, prior to the 1987 session, which clarifies the role of the State hospitals within the service continuum. The study should address: (1) populations to be served, (2) admission and discharge statutes, (3) training for prescreeners and judges and (4) budget estimates for hospitals.

We concur with JLARC's recommendation that the Department submit a plan for stabilizing long-term hospital costs. In addition to outlining accreditation needs, the plan should ensure that any future census reduction occur after an expansion of community capacity. The report should be submitted in time for review prior to the 1987 session.

USE OF LOCAL PSYCHIATRIC HOSPITALS

JLARC concludes that the State mental hospitals are overutilized. The Commission was particularly concerned that 34% of all clients stayed in the State hospitals for less than two weeks. This period of time indicates that many clients do not require "asylum". Moreover, short lengths of stay disrupt the client's community support network and present significant difficulties in service coordination.

Short lengths of stay are expensive to the State. Daily costs for admission units (where short-term clients are treated) in the State hospitals are much more expensive than beds in other units, averaging between $142 and $230 dollars a day.

Using local private hospitals for acute clients is a viable and effective strategy for community service boards. However, JLARC reports that only ten community service boards have resources to provide this alternative. While the per patient day costs are somewhat higher at local hospitals, lengths of stay are shorter than at State hospitals resulting in lower "costs per episode". Further, the Health Cost Review Commission reports that private psychiatric beds are underutilized across the State. This raises excellent possibilities for community service boards to negotiate attractive and affordable rates for their short-term clients.

We endorse JLARC's recommendation to increase the utilization of local psychiatric hospitals for short-term treatment of chronically ill clients. Specifically, funds should be made available to the community service boards for the development and

expansion of these programs. The Department should provide active technical assistance to community service boards in securing contracts with local hospitals.

As discussed in Chapter VIII, the Department has proposed a two-year pilot program to test the management and effectiveness of community support and hospital diversion programs. The key element of this pilot is the use of local inpatient services in the Tidewater and Valley areas of the State. The Department estimates that a total of $1.4 million in general funds is required in the next biennium to develop alternatives to hospitalization and purchase local inpatient services in FY 1987 and FY 1988 for these two areas. At the end of the pilot program the Department is required to show the programmatic and cost implications of this approach.

VI. HOUSING, RESIDENTIAL SERVICES AND ADULT HOMES

It is concluded that the lack of a housing policy and limited housing stock across the State is one of the primary reasons why deinstitutionalization policies have not been fully successful. Adequate housing is a key element of a community support system. All groups providing testimony to the Commission argued that actions to improve housing would greatly enhance the quality of the service delivery system. Adult homes play a large, yet unplanned, role in the service delivery system. There was clear consensus that actions are required to improve the quality of this residential setting.

STATE HOUSING POLICY

One of the most important findings of the JLARC report was that many agencies have housing responsibilities but that the State does not have a policy for housing the mentally disabled. Thus, agency responsibilities are not clarified and coordinated data gathering and planning is not completed. As a result, the State does not have a plan for implementing corrective actions.

As noted by JLARC, the issue of "street people" clearly reflects the lack of coordination among State agencies. While many of the homeless have mental health needs, almost all require financial or supportive services typically provided a variety of agencies. The common characteristic of all homeless persons is that they need shelter. But because the needs of these persons cross agency boundaries, no agency has taken the lead in developing a plan for serving this population. We conclude that until housing responsibilities are defined, the homeless will not be adequately served.

We concur with JLARC that two steps must be taken to address housing issues facing the State. First, legislation is needed to identify responsibilities of each State agency in meeting the housing needs of the mentally disabled. Second, the State's ability to identify and meet the housing needs of the mentally disabled population must be improved.

We endorse the Committee on Housing for the Disabled's recommendation that an Interagency Coordinating Council on Housing for the Disabled be created through statute. The purpose of this Council would be to promote leadership and ensure coordination among the different agencies which have responsibility for providing housing services to the mentally disabled. It is recommended that this Council report directly to the Secretaries of Commerce and Resources and Human Services. Primary staff work should be completed by HCD and the Department. To serve this function, and to initiate coordinating housing and mental health planning, we endorse JLARC's recommendation that the Department create an Office of Residential Services within the Central Office.

Concurrently, there is a significant need to improve the State's ability to identify the housing needs of mentally disabled populations, and to develop plans to meet these needs. We request that the Department of Housing and Community Development conduct a comprehensive needs assessment to identify the demands for housing this population. As part of this plan, issues related to zoning laws and restrictive covenants should be addressed and recommendations made. Consistent with JLARC's recommendation, we also request that HCD create and implement a housing plan in cooperation with other agencies and the above-mentioned Interagency Council on Housing.

INCREASING HOUSING STOCK

JLARC's research estimated that 35% of the 1800 chronically ill persons living in the community reside in inadequate housing. That is, many clients do not live in safe or clean environments, do not have access to mental health services and do not receive basic supervision.

Both the Committee on Housing and JLARC concluded that the Virginia Housing and Development Authority could play an important role in increasing housing stock across the State, but that currently the authority's involvement was inadequate. The Committee on Housing for the Disabled reviewed the use of State-funded rental programs in other States, and it is believed that this approach could be viable for Virginia as an additional strategy for helping disabled persons live in adequate housing.

We believe that VHDA has the financial resources and expertise to contribute more fully to this effort, and urge the Authority to consider the feasibility of financing programs for the chronically mentally ill. In the interim, we request that VHDA cooperate with the Department by providing technical assistance to community service boards on the availability and use of Authority resources. VHDA is directed to report their progress prior to the 1987 General Assembly. Similarly, we request that the Department of Housing and Community Development prepare a report prior to the 1987 Session on the benefits and costs of establishing a State-funded rental program.

Residential programs operated by the community service boards offer excellent placements for chronically ill persons as they have full access to a range of treatment services. The Commission heard testimony explaining how clients have successfully readjusted to the community by living in "supervised" apartments. In these programs clients usually live independently in rented apartments and have access to a community service board staff person for daily support and supervision. This type of program, the Commission learned, can be operated at a low cost. Unfortunately, JLARC reported that only 642 beds exist across the State. Broad support was also heard for the development of group homes for clients to receive short-term intensive supervision as they prepare to move to a less restrictive and less costly setting.

We acknowledge that community service board-operated residential settings are an important component of our community support systems, and encourage the Department to continue to provide leadership in the development of additional residential slots for clients requiring this intervention.

At the request of the Commission, the Department forecasted funding needs for residential programs. The Department proposes to expand community service board residential programs by 1372 beds over four years. JLARC concurs that this is a reasonable target until more complete needs assessments are completed. In the next biennial, the department proposes to allocate a total of $12.0 million in additional general funds to assist community service boards in creating 400 residential slots each year (FY 1987 - 400 beds, FY 1988 - 800 beds). An additional 572 slots would be required to be put on line beginning in FY 89.

Auxiliary grants are a major source of housing income for mentally ill persons. Currently, about 2430 mentally ill clients receive these grants at an annual cost of $ 9.1 million. However, only persons who live in adult homes are eligible for auxiliary grants. Given significant concerns raised about the quality of care provided by adult homes, coupled with the high quality of community service board housing, JLARC, Ernst and Winney and other groups

recommend that the auxiliary grant program be expanded to clients in community service board and other non-profit quality programs.

We concur with the JLARC recommendation that the auxiliary grant program be expanded to allow payments to clients living in residential programs operated by the community service boards.

The Department estimates that 350 chronically mentally ill clients would be eligible for auxiliary grants if the program was expanded to community service board programs at an annual cost of $900,000 in general funds in the next biennial. JLARC recommends that this program begin in FY 88, to allow for sufficient planning and modification of regulations.

TRACKING CLIENTS IN ADULT HOMES

Adult homes provide long-term shelter for an estimated 2430 aftercare clients. Adult homes have thus become an integral part of the deinstitutionalization process.

For regulatory purposes, DSS defines a deinstitutionalized person as a "post-hospitalized" client. DSS has developed special standards for homes which accept these clients. Any home which accepts a "post-hospitalized" client must sign a service agreement with the community service board and also have a yearly progress report conducted on each client. While these actions represent an awareness for increased regulation to meet the needs of chronically mentally ill clients, there are important limitations.

Foremost, the definition of "post-hospitalized" is limited. By regulation, a "post-hospitalized" client is one who enters an adult home immediately after discharge. A person who is discharged from a state hospital, lives at home for a week, and then moves into an adult home is not viewed as being "post-hospitalized". Thus, the accepting adult home does not have to meet regulations. The result is that many chronically mentally ill clients (who have recently been hospitalized) do not receive special services in the adult homes that they live in. Second, because of this limitation in definition, the State does not have any method for locating or monitoring many chronically mentally ill clients living in adult homes.

To improve regulation of adult homes and to help ensure that all chronically mentally ill persons receive appropriate residential services, we endorse JLARC's recommendation to make a statutory change identifying that, for the purpose of adult homes, a "post-hospitalized" client is defined as any client who has been in a mental health or mental retardation facility within the past two years.

To further help the State track the population, we recommend that hospitals be required to notify the appropriate community service board of any discharges to an adult home. We endorse the Ernst and Winney recommendation that each locality establish an interagency prescription team to foster greater cooperation among agencies in identifying and serving chronically mentally ill residents in adult homes.

MENTAL HEALTH NEEDS OF ADULT HOME RESIDENTS

JLARC staff concluded that, despite the prominence of adult homes, they operate independently of the mental health system. Adult homes are monitored by DSS, but this agency does not have expertise with the aftercare population. Adult home regulations do not address the mental health needs of the residents or serve a meaningful quality assurance function. Further, staffing is inadequate in many of the homes and links have not been established with the community service boards. For these reasons, immediate improvements are required concerning the adult home industry.

Adult homes which accept post-hospitalized clients are required to meet two special requirements. First, they must sign an agreement with the local community service board which identifies services to be provided by both entities. There is no requirement that this agreement be updated. Second, the adult home must contract with the community service board or a private provider to complete annual progress reports on each resident to monitor his or her mental health needs.

JLARC concluded that both regulations were ineffective, and furthermore, not consistently implemented or monitored. In many cases, neither community service board or adult home staff could specify to JLARC the nature of the community service board/adult home agreements. Progress reports reviewed by JLARC were completed in a cursory manner and often two clients had identical reports with only the names of the clients changed.

We endorse JLARC's recommendation that community service board/adult home agreements be updated annually. Additionally, a progress report should be completed on each post-hospitalized resident within two weeks of admission to the Home and at least once subsequently every six months. If community service board or the Department staff conclude that either of this regulations are not being satisfied, or that services are not provided, they should be required to lodge a complaint with DSS, which in turn must investigate the home within 30 days and issue a written assessment taking enforcement actions where necessary.

Many adult homes contract with private providers to complete progress reports on clients. JLARC noted that these reports were not complete and failed to clearly assess the client's service needs or treatment approaches. Furthermore, private providers have little or no interaction with community service board staff. Thus, some clients are relocated or admitted to state hospitals without the knowledge of the community service board staff. In this way, community service board staff lose accountability for chronically ill clients.

We endorse JLARC's recommendations to clarify and monitor the role of the private provider. DSS should amend regulations to specify that (1) the private provider must submit copies of all progress reports to the community service board, (2) the private provider must notify community service boards of all clients in adult homes for whom treatment has been discontinued and (3) the private provider must notify community service board staff whenever a client from an adult home has been admitted to a public or private hospital and (4) if the community service board or the private provider concludes that services agreed to in the contract are not being offered, a complaint must be issued to DSS and the Department and acted upon within 30 days.

MONITORING PLACEMENTS IN ADULT HOMES

The quality of adult homes, as reported by JLARC, ranges from very good to unacceptable. Even if stronger regulations and statutes were implemented, additional strategies are required to ensure that the chronically mentally ill population is offered shelter, safety, and access to mental health services. For example, JLARC noted that DSS does not have effective sanctions in which to enforce compliance with regulations. JLARC also concluded that protective services are not consistently offered by DSS to clients in adult homes and that staff do not coordinate actions with staff from community service boards. Underlying these issues is the fact that DSS staff typically do not have any training concerning the needs of the mentally disabled.

It is concluded that intermediate sanctions should be available to DSS in monitoring adult home placements. We thus endorse Ernst and Winney's recommendation that DSS be authorized to suspend admissions or transfer residents out of homes which are not in compliance.

We believe that DSS should clarify the role of the Protective Services Division in the Department of Social Services in protecting the rights of clients. Regulations should be amended to ensure that such services are available for all clients regardless of residence of origin. Finally, we believe that the Department should

provide formal training to adult home operators and DSS licensing staff to heighten their awareness of issues relating to the treatment of the mentally disabled.

RESTRUCTURING THE ADULT HOME SYSTEM

The recommendations in this report are directed toward immediate improvement in the quality of care offered by adult homes. Both JLARC and Ernst and Winney, however, suggested that long-term changes might be required in the adult home system.

Two broad options were outlined for the Commission. First, the State could maintain one level of care in the adult home system. The role of the adult home would be defined narrowly with restrictive admission requirements for those homes which choose to serve "post-hospitalized" clients. DSS would be authorized to deny reimbursement under the Auxiliary Grant Program until the client has been assessed and has been found appropriate for placement in the adult home. The second option would be for the State to maintain more than one level of care in the adult home system. The role of the adult home would be defined broadly, acknowledging the differential care of residents. A structure would be developed whereby providers are justly compensated and appropriated regulated for the differential services provided.

We request that DSS and the Department conduct a joint study endorsing a model for addressing the aftercare needs of clients in adult homes. We ask the study group to consider the two options described above and to report prior to the 1987 Session.

VII. FISCAL ACCOUNTABILITY UNDER THE CURRENT SYSTEM

It should be the policy of the State to use available resources in a way that best ensures that funds are directed to those populations with the greatest need and those areas with the greatest demand. Currently, the fund allocation method for mental health services does not meet these standards. Further, many local governments are not a reliable source of funds which further limits the ability of the State to meet demand.

DISTRIBUTION OF STATE FUNDS

Improved fiscal accountability would enhance the quality of the service delivery system. Currently, funds to community service boards are based primarily on funding history. Community service boards submit proposals for funds for specific programs based on local priorities. The Department reviews these requests and, within

the limits of available resources, attempts to provide funding for each community service boards first priority. This method is reasonable in terms of giving localities the flexibility to target resources to priority needs. However, the method does not consider State priorities, and as a result, services for the chronically mentally ill differ widely in scope and quality across the State. In sum, the current funding allocation system does not ensure that resources are directed to populations in the greatest need or areas with the highest level of demand.

We believe that the chronically mentally ill is the population most in need of expanded community programs, and that efforts to increase services for this population will best ensure the success of deinstitutionalization policies. We endorse JLARC's recommendation that the General Assembly identify programs for the chronically mentally ill as a funding priority.

In addition, we believe that funding priorities should be given to new programs and expansion of existing programs for the chronically mentally ill in FY 87 and FY 88. Special attention should be given to the targets and cost estimates compiled by JLARC and detailed earlier in this report.

As implied above, it is recognized that local priorities should be considered when the Department determines fund allocations. However, state priorities must also be met, and this has not occurred in a consistent fashion. Therefore, beginning in FY 88, we believe that the Department should employ a funding strategy which more clearly meets state and local priorities. It should be noted that different funding approaches could be used for different populations.

Prior to August 1986, the Department is requested to submit an updated plan which delineates the fund allocation method for community services. This plan should be the basis for fund distributions beginning in FY 88. The General Assembly should provide direction to the Department of Mental Health and Mental Retardation on how addition funds for community programs should be allocated.

LOCAL GOVERNMENT PARTICIPATION

As the State continues to take steps to improve the service delivery system, it will be important for local governments statewide to become a stable source of funds. Local government participation varies significantly across the Virginia. The ratio of State ot local match varies from 90:10 to 40:60. Further, many local governments have not increased their funding at a rate consistent with inflation.

As discussed in Chapter VIII of this report, we endorse a financing system whereby State funds are allocated to community service boards which considers, through formula, the amount of contributions given by local governments. It is expected that this method be implemented in FY 1990. In the interim, JLARC staff recommended that legislative actions be taken to ensure that local governments maintain their current level of financial participation and to prohibit local governments from withdrawing their membership from the community service board which services their area. Without this assurance, it will be difficult for the State or the community service boards to effectively plan and improve services.

Given the current status of the community service system, we believe that local governments should be discouraged from reducing their financial participation level in supporting community service boards. We recommend that this issue be addressed in the funding allocation study which was requested in the previous section of this report.

Many community service boards have increased their fee collections in recent years to increase the amount of funds for programs. We applaud this effort, and urge all community service boards to implement reimbursement systems which base fees or charges on actual costs for providing services and which thoroughly assess clients' ability to pay.

The Department is requested to establish statewide guidelines for community service board fee collections and to report progress and any fiscal impact prior to the 1987 session.

VIII. TRANSITION TO A SINGLE SYSTEM OF CARE

FUTURE POLICY GOALS

The State currently operates two systems of care which serve many of the same clients. When a person is in a State hospital, responsibility for the client is granted to the State. However, when that same client is discharged to the community, responsibility is granted to the local governments through community service boards.

We conclude that the operation of dual systems is financially inefficient and confuses lines of responsibility. This view was confirmed by JLARC's analysis. JLARC identified a high number of areas where the existence of dual systems results in cost inefficiencies and diminished accountability. Thus, available State resources are not utilized in the most efficient manner possible.

JLARC staff, the Department and national experts agreed that the development of a single system of care would be an effective

strategy for addressing system problems. The system of care recommended by these groups has three primary elements: (1) community service boards have primary responsibility for determining that type and quality of treatment required by clients, (2) the State, through the Department, provides rigorous oversight of the community service boards, and (3) a funding mechanism is established which grants community service boards fiscal control over a significant portion of State funds.

It is concluded that a single system of care offers the most effective strategy for improving the service delivery system. However, we believe that intermediate actions are required before this approach is implemented. As discussed in the remainder of this chapter, a sequence of steps are recommended. The final step, restructuring the financing system, should be possible to implement by FY 1990.

We endorse the recommendation of JLARC and the Department that the General Assembly adopt a policy goal for the development of a single system of care. Four changes to meet this goal are recommended. First, legislative actions are made to offer community service boards clear accountability for the quality of treatment offered to clients regardless of setting. Second, the Department would be designated as the primary State agency for oversight and for ensuring quality throughout the system. Third, community service boards would be granted greater control over use of State funds. Fourth, the State would fund a pilot program to allow an empirical test of key aspects of the service delivery system. It is recommended that these actions be implemented over the next four years and that a single system of care be operational in FY 1990.

We stress, however, that it is important to recognize that endorsements in this section of the report are independent of recommendations and changes to the current system included in Chapters III through Chapter VI. That is, regardless of whether the General Assembly chooses to adopt a single system of care policy, it is essential that other actions be taken to enhance the system as it currently exists.

OVERSIGHT AND SERVICE ACCOUNTABILITY

When a person is in crisis, it is important that mental health staff place that person in the appropriate treatment setting. In some cases, the appropriate treatment setting will be a state hospital. In other cases, it will be crisis-stabilization intervention, a day support program or outpatient therapy offered by the community service board. If the appropriate placement is not immediately made, the opportunities for effective mental health intervention are diminished.

Community service board staff are trained professionals and are most familiar with the range of possible treatments that can be offered to clients. We thus conclude, as do national experts, that local providers are best able to determine the appropriate treatment setting for mentally disabled persons in the State.

Under current statutes, prescreening laws have been established to ensure that citizens requiring mental health services are assessed by professionals prior to the delivery of treatment. This mechanism helps to ensure that an appropriate treatment decision is made. There is concern, however, that community alternatives are not fully explored.

We thus endorse the recommendation of JLARC and the Department that all candidates for admission to State hospitals be prescreened and committed directly to the community service board. The community service board, therefore, would be responsible for determining the appropriate placement of the client to either the hospital or a community program. In those cases where hospital staff maintain that there is no space available for a client, a mechanism should be established by the Department whereby the Central Office is responsible for resolving differences and ensuring that the appropriate treatment is offered. We recommend that this action be implemented in FY 88 to allow sufficient time for planning and preparation.

As indicated above, a single system requires effective oversight by the State to ensure quality and compliance. In Chapter IV, we concluded that greater oversight was required by the Department regardless of the structure of the mental health system. Simply, it is the State's responsibility to ensure that citizens receive appropriate care and that State funds are spent appropriately.

We thus recommend that the Department develop a comprehensive oversight plan for monitoring the community service boards performance. Such a plan should be State-administered, include extensive on-site review of programs, and include a sampling and review of current case records. This report should be submitted to the General Assembly by October, 1986.

EVALUATING THE EFFECTIVENESS OF SERVICE DELIVERY SYSTEMS

It is clear to all members of the Commission that the current system has not been effective in meeting policy goals. As discussed in this report, many of JLARC's recommendations are endorsed by us as solutions for improving the current system.

JLARC's review of the literature, and testimony by national experts have convinced that a single system is the most effective

strategy for serving the mentally disabled. While this has been demonstrated in other states, it has not been evaluated in Virginia. We conclude that comprehensive evaluation is needed. Such an evaluation is essential to improving the current system and, additionally, would provide valuable data concerning the benefits and potential limitations to implementing a single system of care. To this end, it is recommended that a two-year pilot program be implemented.

We endorse the Department's pilot program for community service boards in the catchment areas of Eastern and Western Hospitals. The purpose of this pilot program is to demonstrate the effectiveness of placing accountability on the local level and the strategies in which the Department could ensure quality and fiscal accountability throughout the system. As part of the pilot program, the Department is requested to complete a comprehensive evaluation. The purpose of the evaluation would be to demonstrate that the use of community services reduces recidivism, hospital costs, and offers quality services to clients. Such an evaluation is essential to improving the current system. However, if an evaluation of this pilot program fails to demonstrate sufficient effectiveness, we would not support the implementation of a single financing system in FY 1990.

The Department estimates that if the pilot program is established, a total of $4.6 million would be required in the next biennial. The costs would allow for the development of community support programs in the pilot areas and extensive quality assurance and evaluation by DMHMR. JLARC has no position on the cost estimates for the pilot, but notes that such an approach is a viable implementation strategy consistent with recommendations offered by the agency.

FINANCING A SINGLE SYSTEM

As discussed in Chapter VII, JLARC concluded that improvements were required in the method of allocating funds which are currently appropriate for community services. The Commission endorses these short-term changes to the current system..

We conclude, however, that a single financing system is necessary to allow the State to more effectively control future costs and ensure that funds are used in the most appropriate and efficient manner possible.

Currently, hospitals and community service boards are funded separately. One result is that while the majority of clients are served by community service board's, 79% of state funds are directed to the hospitals. JLARC concludes that the separate funding is also

not cost-efficient. For example, it was noted that community service boards are not responsible for treatment costs when their clients are admitted to State hospitals. This arrangement serves as a disincentive for the community service board to employ more cost-efficient alternatives.

The current funding approach does not offer community service boards flexibility in using funds in the most cost-efficient manner possible to provide quality services. While the we conclude that an improved funding mechanism must account for State priorities, it is important for community service boards to have flexibility.

For these reasons, we conclude that a single financing system be implemented in Virginia. We recommend that, apart from Central Office activities, a funding stream should be reserved for the community service boards. The funds would be distributed through a formula. Community service boards would thus be responsible for using these funds to provide both community and hospital services.

It is requested that JLARC, DMHMR or a contracted organization conduct a comprehensive study of financing services for the mentally disabled in Virginia with the purpose being to develop a single financing system. The study should offer recommendations for ensuring that available funds are allocated in a fair and consistent manner. In developing recommendations, we direct that the study address strategies for: (1) allocating funds on the basis of appropriate and relevant variables, (2) centralizing fiscal control for both inpatient and outpatient services with the CSBs, (3) ensuring that all local governments contribute a fair and equitable amount of funds, (4) ensuring procedures for meeting special state priorities and (5) ensuring that community service boards have flexibility in using available funds. This report should be submitted for review prior to August, 1987.

We recommend that a single financing system be implemented in FY 1990.

APPENDIX A: ESTIMATED FISCAL IMPACTS

At the final meeting of the Commission on Deinstitutionalization there was agreement that additional funds should be allocated to increase the capacity of community treatment and support programs.

Specific funding amounts were not recommended by the Commission, but there was a clear concensus that legislative consideration should be given to the targets developed by JLARC staff with the cooperation of staff from the Department of Mental Health and Mental Retardation.

Appendix A presents the compilation of these allocation targets. They are presented here to to provide a range of cost estimates which will be necessary to enhance the service delivery system in Virginia.*

The Appendix begins with an overall summary of costs. On the subsequent pages, further breakdowns and explanations are offered in an order consistent with the chapters in the report.

---

* Presentation of the range of cost estimates does not constitute approval by any Commission member of specific funding recommendations.

SUMMARY OF COST ESTIMATES

Two funding summaries are presented. The first focuses on services for the CMI population and service accountability. The second focuses on services for substance abuse and mental retardation services. For each summary, two tables have been prepared. The first table shows total costs by year. The second table breaks down the total costs necessary for "additional capacity" as well as funds for "maintenance" of the new capacity.

The programmatic recommendations of the JLARC study were to expand community support programs for chronically mentally ill (CMI) clients (see Chapter III) and to expand housing opportunities (see Chapter IV).

The administrative recommendations of the JLARC study were that DMHMR enhance its evaluation, oversight, and program certification responsibilities (see Chapter II). Additionally, DMHMR proposes a pilot program to improve service and fiscal accountability (see Chapter VI).

Services for Chronically Mentally Ill	FY87	FY88	Total
CMI Psychosocial Rehab.(1)	$3.6	$6.0	$9.6 Million
CMI Transitional Employ.(2)	1.9	1.9	3.8
CMI Case Management	2.9	2.9	5.8
CMI Housing (3)	4.0	8.0	12.0
Auxiliary Grant Expansion	0.0	.9	.9
Service Accountability			
DMHMR Evaluation/Certification	.32	.32	$.64 Million
DMHMR Data Collection/Analysis	.20	.22	.42
CSB Data Management	1.60	1.67	3.27
CSB Computers	.80	.0	.80
DMHMR Pilot Program	2.30	2.3	4.60
Annual Total	$17.62	$24.21	$41.83

(1) JLARC estimates a need for an additonal $6.0 million in capacity-building funds in FY89-90 biennium
(2) Included in DRS budget addendum for FY87-88
(3) JLARC estimates a need for additional housing funds in the FY87-88 biennium. The amount is dependent on additional needs assessments to be completed by State agencies.

COST BREAKDOWN	FY87	FY88	Total
Additional Capacity	$17.62	$7.99	$25.61
Maintenance of New Capacity	0.0	16.22	16.22
			$41.83

JLARC identified gaps in services for MR and SA clients and recommended that improvements be funded subsequent to addressing services for the CMI population and after DMHMR provides a comprehensive needs assessment and plan (see Chapter II). DMHMR's position is that additional funding should be allocated in the next biennium. DMHMR provides the following estimates (see page 5 for detail).

MR and SA Services	FY87	FY88	TOTAL
SA Day Support	$2.0	$2.0	$4.0
SA Case Management	.55	.55	1.1
MR Day Support	2.0	2.0	4.0
MR Case Management	.55	.55	1.1
MR Housing	4.0	4.0	8.0
SA Housing	1.0	1.0	2.0
Annual Totals	$10.1	$10.1	$20.2

COST BREAKDOWN

	FY87	FY88	Total
Additional Capacity	$10.1	$0.0	$10.1
Maintenance of New Capacity	0.0	10.1	10.1
			$20.2

COST ESTIMATES FOR CHAPTER IV: QUALITY ASSURANCE AND SERVICE ACCOUNTABILITY UNDER THE CURRENT SYSTEM

Service Accountability in Communities

Improvements are necessary in clarifying statutes and in specifying the roles and responsibilities of CSB case managers. Corrective actions can be made at no cost to the State, and would result in improved service delivery. It is important to stress, however, that JLARC staff also recommend the funding of 124 additional case managers, at an annual cost of $2.9 M per year, statewide. The establishment of these positions is seen as a necessary step to ensure that new guidelines are implemented consistently and effectively.

Service Accountability on the State Level

JLARC concludes that there are two areas in need of corrective action which may require additional funding: (1) program evaluation and quality assurance by DMHMR and (2) data collection and analyis by DMHMR and the CSBs. JLARC concluded that CSBs did not have adequate resources to collect necessary data. DMHMR was thus requested to prepare cost estimates.

	FY 87	FY 88
Central Office(1)		
Program Management	$320,000	$320,000
Data Collection and Analysis	$205,875	$216,169
CSB(2)		
Staff for Data Management	$1,598,086	$1,677,990
Computer Hardware	$805,200	none

(1) The category of Program Management was developed by DMHMR based on adding ten central office staff to conduct CSB program evaluations and increased certification/licensing visits of CSB and private sector facilities. Five staff are requested to develop and operate the Central Office's data management responsibilities.

(2) DMHMR estimates that 56 CSB staff persons be funded to operate data systems and analyze data. Almost one million dollars is estimated to increase CSB computer resources to perform responsibilities.

COST ESTIMATES FOR CHAPTER V: CAPACITY OF COMMUNITY PROGRAMS AND HOSPITALS

The JLARC report identified widespread gaps in the availability of community services for the CMI population. Using JLARC's service level data, and DMHMR's unit cost data, the following cost estimates were determined for (1) psychosocial rehabilitation, (2) transitional employment and (3) case management.

PSYCHOSOCIAL REHABILITATION(1)

	FY87	FY88			Total
--Additional Capacity	$3.0	$3.0	$3.0	$3.0	$12.0
--Capital	.6	.0			
--Maintenance of New Capacity	.0	3.0			
	$3.6	$6.0			

(1) Thirty-two CSBs have psychosocial rehabilitation programs, but it is estimated that 3032 clients can not receive services. Eight additional CSBs do not have this program, and need could not be estimated. A lack of transportation is a barrier to providing day support to eligable clients in over three-quarters of the CSBs.

Funds will be used to develop programs, expand capacity, and maintenance of 1454 slots over a four year period. In FY 87, $.6 million is to be directed for aquisition of vans. Possible capital costs for facility acquisition could not be estimated.

TRANSTIONAL EMPLOYMENT (2)

	FY87	FY18	TOTAL
--Additional Capacity	$1.9	$.0	$1.9
--Maintenance of New Capacity	.0	1.9	$1.9
			$3.6

(2) Thirteen CSBs have transitional employment programs, but estimate that 139 clients can't receive this service. Twenty seven CSBs do not have this service and unmet need could not be estimated.

DRS estimates an annual cost of 1.9 million to provide transitional employment services to 1000 clients each year (submitted in DRS budget addendum).

CASE MANAGEMENT (3)

	FY87	FY88	TOTAL
--Additional Capacity	$2.9	$.0	$2.9
--Maintenance of New Capacity	.0	2.9	2.9
			$5.8

(3) Outreach and case management services are limited. CSBs report that over 4,000 CMI clients are not receiving appropriate case management services. JLARC estimates that 121 case managers are required system-wide to provide a minimum level of service, at a start-up cost of $2.9 million

DMHMR reports that this level of case management would be sufficient to meet additional JLARC recommendations concerning CSB involvement in addressing issues related to adult homes, client management and case management. When improved regulations and procedures are implemented, further review of staffing may be appropriate.

Services for Mentally Retarded and Substance Abuse Clients

JLARC identified significant service gaps for MR and SA clients, and recommended that DMHMR identify priority services and cost estimates for addressing demand. In response, DMHMR estimates:

--MR and SA case management: $2.2M in next biennium to fund 44 case managers, with a capacity to serve 2200 clients over a two year period..

--SA residential and day support: $6.0M in next biennium to develop 45 slots for short term intensive residential services to 1080 clients and to develop 180 day support slots to serve a total of 2400 clients over a two year period

--MR residential and day support: $12.0M in next biennium to expand programs to serve 400 clients in long term residential programs and 666 clients in day support programs over a two year period.

Use of State Mental Health Hospitals

JLARC staff conclude that to limit long-term costs and to develop a cost-efficient system, it will be necessary to enhance the use of local inpatient alternatives and to begin a well-planned and phased reduction in use of state hospitals. "Start-up" funds would be required for negotiating contracts with local hospitals and to improve the community support system. Cost-savings would be achieved by decreasing the use of state hospitals through enhanced community programming, serving short-term clients in local hospitals where length of stay would be shorter, and by reducing hospital staff and operations. The fiscal impact of these proposals is dependent on the strategies chosen by the General Assembly.

COST ESTIMATES FOR CHAPTER VI:
RESIDENTIAL SERVICES, HOUSING AND ADULT HOMES

EXPAND HOUSING (1)	FY87	FY88	Total
--New Capacity	$4.0	$4.0	$8.0
--Maintenance of New Capacity	.0	4.0	$4.0
			$12.0

EXPAND AUXIL.GRANT PROGRAM (2)			
--New Capacity	0.0	.9	.9
--Maintenance of New Capacity	0.0	.	0.0
--Less Local Share	0.0	(.2)	(.2)
			$.7

(1) DMHMR proposes to develop 1372 beds over a four year period. In the next biennium, DMHMR estimates that twelve million dollars will provide a minimum of 800 slots at an average cost of $10,000/slot. Residential service types would range from intensive supervised group homes to supervised apartments. An additional 572 slots would be required to be put on line beginning in FY 89.

Based on JLARC's study, it is estimated that 6781 clients are living in inadequate housing. Some of these clients can be served through better case managment in clients' homes and in liscenced adult homes. Further, DMHMR predicts that client turnover will increase the number of clients who can be served by a single slot. Given these considerations, DMHMR's estimate appears to be a reasonable target, until more systemmatic analyses are completed by state agencies.

(2) Many adult homes are not currently suitable for chronically ill clients. In addition to shelter, CSB programs provide treatment and full access to treatment services. Providing funds to clients in CSB housing would result in savings for CSBs which could then be used to expand programming capabilities. DMHMR estimates that 350 CMI would be eligible if the program was expanded. Clients receive an average monthly grant of $215. It is recommended that this program begin in FY 88, to allow sufficient planning and modification of regulations.

COST ESTIMATES FOR CHAPTER VII: FISCAL ACCOUNTABILITY FOR COMMUNITY SERVICES UNDER THE CURRENT SYSTEM

JLARC staff recommend that the General Assembly clearly identify the required financial participation of local governments. In making this determination it will be important to consider funding for existing programs as well as participation in the development of new programs. The fiscal impact is dependent on these decisions.

The JLARC report noted that revenues from CSB fee collections has grown substantially, due largely because of follow-up by local reimbursement officers and stricter criteria in determining the level of payment required by clients for selected services. JLARC reported that five CSBs do not have reimbursement officers. JLARC recommends that DMHMR establish state-wide guidelines and other strategies for enhancing fee collections. DMHMR identifies a need for eight reimbursement officers for CSBs and a coordinator on the State level, at a cost of $480,000 in the next biennium.

Other recommendations focus on mechanisms for distributing available General Fund dollars and would not require additional funds. Adoption of recommendations, however, would enhance fiscal accountability throughout the system and allow for a more efficient and effective use of funds.

COST ESTIMATES FOR CHAPTER VIII: TRANSITION TO A SINGLE SYSTEM OF CARE

As noted in Chapter III, significantly improving service accountability will require the funding of additional case managers and a strengthening of the Central Office's planning, monitoring and evaluation roles.

JLARC staff recommends that planning and implementation of a single system take place over a four year period. During this period, DMHMR and VACSB recommend pilot programs to demonstrate the effectiveness of a single system whereby local providers (CSBs) assume responsibility for service provision and fiscal accountability.

The DMHMR pilot program would involve CSBs in the Tidewater area which are served by Eastern State and CSBs in the Valley and Northern areas served by Western State. The purpose of the pilot

would be to demonstrate how CSBs could be granted program and fiscal accountability. DMHMR estimates that the pilot would cost $4.6 million over the next biennium. Funds would be used to expand community resourses in the participating CSBs to create the following services: Local inpatient services for 700 persons, 100 residential slots and 150 day support slots. At the end of the pilot project DMHMR would report on its evaluation of the pilot and offer recommendations for possible future implementation.

STATEMENT OF DELEGATE PICKETT

I concur in principle with the conclusions reached by the concurring majority report, but I would not attempt at this time to be quite as specific in setting forth the action which the Department must take in carrying out the new policy initiatives. The policy initiatives which I think should be taken, but which should be implemented by further work of JLARC and the Department are as follows:

1. That the Community Services Boards be given exclusive responsibility for the individuals who are chronically mentally ill (CMI) and have authority to determine the placement of all such persons whether it be in local facilities or in a state hospital.

2. That the Department have responsibility for coordinating and directing a uniform system of care for the CMI throughout the State, and that the Department be given all necessary powers and authority to implement such a program.

3. That the State recognize that there are some individuals who are so profoundly mentally handicapped that they are not able to function in a local setting and that appropriate State facilities be maintained to provide services for this type of individual.

4. That the responsibility for accommodating the needs of the CMI be recognized as a State responsibility and that appropriate funding and appropriate formulas be developed to properly finance services for this group of individuals, without penalizing those areas which have at their expense already established and now operate an effective service delivery system.

5. That the Department initiate and maintain an effecti system of cost containment for continuous evaluation and monitorin

of Community Services Boards to insure that the least expensive alternative, commensurate with the needs of the individual, is being provided.

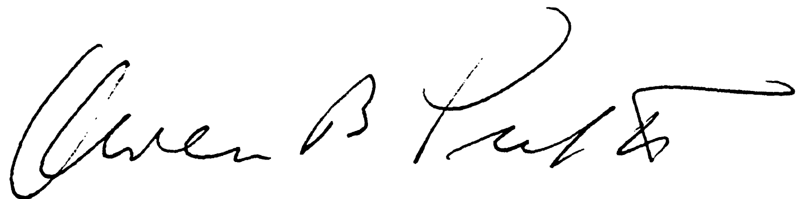
6. That the Department and the Community Services Boards in conjunction with the Virginia Housing Development Authority, immediately initiate a state-wide program to provide housing facilities for CMI at the local level.

7. That the administrative procedures set forth in the JLARC report with respect to the monitoring of individual patients and case management be implemented.

8. That the special needs of patients discharged from mental hospitals into adult homes be handled through separate contractual arrangements between the facility and the Community Service Boards rather than by attempting to establish through a licensing system various levels of care in adult homes.

9. That if the system of care for the CMI is to be partly financed with local funds, that each local government be required to participate and contribute on a uniform basis.

10. That each Community Service Board be required to establish and maintain a program of psychosocial rehabilitation and transitional employment for the CMI.

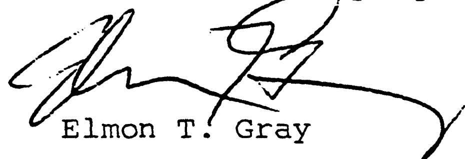


STATEMENT OF SENATOR GRAY

While I agree with much of the report I cannot at this time endorse the sweeping reorganization which it recommends.

I am disturbed by the differences in the resources and capabilities of the various Community Service Boards and I am not convinced that they are uniformly qualified to provide the necessary services to the mentally ill and mentally retarded. The differences in area facilities and resources vary greatly between rural and urban areas of the state. These capabilities need to be realistically inventoried and evaluated in order to address the disparity in service levels across the state. The formula for funding the Community Service Boards for monitoring discharged patients, for housing, rehabilitation and psychiatric and medical care as well as the supervision of mentally ill and retarded must address these regional differences if patients are to be humanely served.

Further I would have been more comfortable had the new commissioner who would administer the changes recommended been in place and involved in and supportive of such sweeping changes.



Elmon T. Gray

STATEMENT OF SENATOR EMICK

Caring for the mentally disabled in the most appropriate setting is a fundamental commitment of this Commonwealth. To keep this promise we must continue to improve both our state facilities and our local programs for the mentally ill and mentally retarded, as well as for drug and alcohol abusers. More effective management is required to assure accountability for the quality of care and to coordinate the various parts of the system.

The majority of Virginia's mentally disabled citizens can and should live in their home communities, but we must also acknowledge our responsibility for those who require long term care in public or private facilities. Serious problems have been created by the largely unplanned depopulation of our state facilities without adequate local services or coordination. These problems cannot be solved by further reductions in the institutional census or through wishful thinking that resources will always follow those clients to the locality. Too often deinstitutionalization has simply meant shifting costs to other levels of government.

The majority of mentally disabled Virginians and their families will benefit from the improvement of support services at the local level. At the same time we must recognize the most severely disabled patients will need higher quality treatment (and in some cases continuing, long term care) in the pastoral setting of our state facilities.

I dissent to the Commission's report and recommend the following:

1. Strengthen the governance of Virginia's mental disability system by developing a more effective organizational structure. The concept of a single system of care requires that responsibility be focused on the Commissioner of the Department of Mental Health and Mental Retardation (DMHMR). He must have the authority to direct and coordinate both our state facilities and our local programs as the chief executive officer of the system. This requires strengthening the managerial functions of the central office, a more visible regional presence, and more rigorous implementation of performance contracting with local community services boards. This also requires statutory change to return the State Board of Mental Health and Mental Retardation to its previous, advisory status. At the local level, accountability should be

increased by removing statutory restrictions on the appointment of local elected officials to community services boards. An action plan to strengthen the governance of the system should be developed by the Secretary of Human Resources prior to the 1987 General Assembly.

2. Improve the management of information among state facilities, community services boards and other agencies. Despite years of exhortations we do not have a single system of care. A fundamental roadblock to such a system is the lack of timely, usable information for managers at all levels to enhance coordination and assure accountability for performance. A single officer of DMHMR must have responsibility and authority to develop improved management information systems and to coordinate systems development with other affected agencies. Current statutes should be revised to require that clinical information follow the client to the community services board and to authorize research follow-up under controlled conditions. Achieving the goal of a single system of care will be impossible without better information.

3. Adopt no further targets to reduce the census of our state facilities at this time. Instead, improve the discharge process to assure placement in the most appropriate therapeutic setting, which may include state or local facilities depending upon the unique circumstances of each individual. Long term care of the severely and chronically disabled has traditionally been a responsibility of state government. This burden should not be shifted to local government unless and until adequate services and family support are available at the time of discharge in the locality from which the patient actually originated or in which the family now lives. In effect, there should be fewer discharges and each discharge should be better managed. Standardized procedures for pre-discharge planning and more specific criteria for placement are needed to ensure that individuals are placed in the most appropriate facility relative to their level of disability. Actions to improve the discharge process should be proposed by the Secretary prior to the 1987 session.

4. Improve the quality of care in our state facilities, with particular emphasis on increased direct care staffing, better rehabilitation and training programs, and improved physical plant maintenance. Immediate attention is required to provide sufficient direct care

staff for our state mental retardation training centers to assure continued Medicaid certification and to provide additional direct care staff for our state mental hospitals. Improving the quality of care also requires strengthening the leadership role of psychiatrists within our state mental hospitals so that active treatment is carried out under competent medical direction. Where appropriate, consideration should be given to the alternative of contracting out specific, selected services to increase operational effectiveness. As we improve the quality of care, we must also improve the public image and perception of our state facilities. This will require increased funding for the renovation of facilities as well as consideration of updating the names of our state hospitals to signify their role in the continuum of care. An action plan to improve our state facilities should be proposed by the Secretary of Human Resources prior to the 1987 session.

5. Improve existing housing options for the mentally disabled at the local level, through a more effective partnership with the private sector wherever possible. Following discharge from a state facility, the majority of mentally disabled persons can and should return home to live among family and friends. Adequate resources are needed to manage this transition. In particular, increased state support is needed to enable community services boards to continue their efforts to provide affordable housing. These efforts should include the renovation of older homes and the designation of subsidized apartments.

   I do not favor direct state capital outlay financing of 10-15 bed intermediate care facilities. Evidence to date suggests these facilities are just as expensive to build and operate as our existing state facilities (when all fund sources are considered). To the extent such facilities are needed consideration should be given to the expanded use of the private sector. Our experience under Medicaid with private nursing homes has shown that well managed private corporations can play a valuable role in upgrading the care of geriatric patients. However, an effective financing and regulatory mechanism must be in place before new facilities are built. Where additional facilities are needed for the chronically mentally ill or mentally retarded, specific performance standards must be developed along with immediate corrective actions by DMHMR to assure quality control.

The necessity for such action is underscored by the tragic death of a mentally retarded, emotionally disturbed child in a private group home in Richmond. However, the events of August and September, 1985, suggest an even more fundamental concern. I question the wisdom of placing severely disabled persons in small, decentralized group homes as a stop-gap measure (simply because no program is available at the state level). In this instance DMHMR does not have a cohesive program for dual diagnosed children or adults, with residential care in state facilities for those who need it. Local social service agencies have often had no alternative but to place these and other severely disabled persons in unsafe and inappropriate housing.

6. Expand housing options in our state facilities for those individuals who require a more intensive level of care for some period of time. State government should bear primary responsibility for those severely disabled patients for whom there is no family support and for whom the pastoral setting of our state facilities offers the most humane prospect for long term care. With proper renovation existing facilities can be operated as group homes at lower cost than traditional hospital wards. A public-private partnership may be possible to renovate older buildings or construct additional facilities on state-owned property. I oppose federal legislation (S.873) which would eliminate federal Medicaid funds by the end of the century for state training centers for the mentally retarded with more than 15 residents.

7. Discourage the transfer of discharged mental patients from one locality to another under the guise of placing those patients in "community-based" facilities. No significant public interest is served by transferring Northern Virginia's chronic patients from Western State Hospital in Staunton to a former hotel in Winchester which now operates as a home for adults. Such practices enable some localities to avoid the necessity of providing housing and other services at the expense of other localities. Prior to the 1987 session the Secretary of Human Resources should recommend steps to eliminate current financial incentives for transferring discharged patients.

8. Provide the resources for community services boards to improve their treatment and support services for the mentally disabled, and hold them accountable for the results. Caseloads of most community services boards

are unrealistically high already. Increased resources should be targeted to provide additional psychiatrists, psychologists, and other professionals trained in the care of the mentally disabled. Outreach, crisis intervention, case management, rehabilitation, day programs (such as clubhouses and sheltered workshops) and other support services must be improved. In short, community services boards should have full operational responsibility and accountability for the care of mentally disabled patients who are properly discharged into their respective localities.

9. Clarify the role of the Department of Social Services. Much of the responsibility for caring for the mentally disabled has been quietly transferred to local welfare departments. For example, a recent study concluded that half of all auxiliary grant recipients in homes for adults were former patients in our state facilities. The lines of accountability are difficult to follow when local welfare agencies become the primary housing bureaus or service providers for the mentally disabled. To address this problem statutory changes are needed in Section 37.1-98, Code of Virginia, which now requires local welfare agencies to provide housing and other social services to discharged mental patients.

   Responsibility for all services required at the local level by the mentally disabled should rest with the community services boards. Where the specific expertise or assistance of other agencies is required, clearly understood and fully communicated inter-agency agreements should be developed and monitored under the direction of the Secretary of Human Resources. Funds now appropriated to the Department of Social Services (DSS) for auxiliary grants for the mentally disabled should be transferred to DMHMR. In addition, the responsibility for regulating Homes for Adults should be transferred from DSS to the Department of Health. State law and regulations should provide a range of sanctions for homes which fail to meet standards, and the law should be strictly enforced. The Secretary of Human Resources should propose the necessary legislative and budgetary actions for introduction in the 1987 session.

10. Clarify responsibility for mentally ill and retarded offenders in local jails and state prisons. A comprehensive corrections mental health statute is needed to assign clear responsibility and authority for custody, treatment, and involuntary medication of

mentally ill and retarded criminal offenders. Under one possible approach, the Department of Corrections would be responsible for providing secure facilities for this purpose, but Corrections would contract with the Department of Mental Health and Mental Retardation (DMHMR) or with the private sector for treatment services. Under another approach, DMHMR could also expand its secure forensic units for those offenders who, in the judgment of medical professionals, should not be in prison. The Governor should direct the appropriate Cabinet Secretaries to appoint a task force to study these and other potential approaches and to make legislative and capital outlay recommendations prior to the 1987 General Assembly.

11. Place greater emphasis on prevention. Our medical understanding of mental illness and mental retardation is expanding rapidly. As a result, certain populations in our state facilities will probably be reduced over time. In order to facilitate this process of attrition efforts are needed to reduce future inappropriate admissions to our state geriatric centers and mental retardation training centers. However, we should not transfer current residents out of these facilities unless the family actively supports the move.

    DMHMR should develop a pilot program of grants to parents who can take care of their severely or profoundly retarded children at home instead of placing them in state facilities. This approach should take precedence over the currently proposed Medicaid waiver for community services.

12. Improve education and training. An increased supply of persons skilled in the care of the severely and chronically mentally disabled is essential to improving the quality of care. Improved relations with the Commonwealth's three medical schools are needed and steps have recently been taken in this direction, such as the establishment of the Galt Scholar program. A review of current academic programs at the graduate, baccalaureate, and community college level is needed to ensure compatability with the manpower needs of DMHMR. In addition, a more systematic approach to basic and on-the-job training for state and local employees is also needed. Communication between different parts of the system could be improved through regional training programs at our state facilities. A report on potential steps to improve education and training should be completed by DMHMR prior to the 1987 session.

Report of the

Commission on Deinstitutionalization
The Governor and the General Assembly of Virginia
Richmond, Virginia
January, 1986

To: Honorable Gerald L. Baliles, Governor of Virginia,
and
The General Assembly of Virginia

AUTHORITY FOR THE STUDY

The Commission was established for two years by Senate Joint Resolution No. 42, agreed to by the 1984 Session of the General Assembly (Appendix A). The Commission is to review the status of Virginia's deinstitutionalized citizens to examine the roles and responsibilities of state institutions and community services in serving these citizens. The Commission was directed to focus specifically on the following issues:

Lack of information on the status of persons discharged from state institutions
Availability and cost of appropriate services in communities to serve the mentally handicapped
Quality of community residential care available to discharged clients, especially homes for adults, boarding homes and emergency shelters
Adequacy of client management and interagency cooperation
Organization and management of the state hospital system
Linkage between state institutions and community services

A detailed review of the background of the study and a history of deinstitutionalization efforts in Virginia is contained in the interim report of the Commission (Senate Document No. 3, 1986).

ACTIVITIES OF THE COMMISSION

The Commission in 1984 held an organizational meeting to review the history and current status of deinstitutionalization activities and policy in the Commonwealth.

The four remaining meetings held during 1984 provided the Commission the opportunity to hear public comment on the issues and to visit representative community mental health programs and related service systems throughout Virginia. Public hearings were held in Richmond, Bristol, Falls Church and Portsmouth; tours included programs in those areas.

Specifically invited to comment at the hearings were community services boards, all state and local agencies providing community services to deinstitutionalized clients, private sector mental health professionals, interest and advocacy groups, local government administrators and officials, chambers of commerce, state legislators in each region visited, and all persons who had requested notification. All localities in the State were notified of at least one of the four meetings. Comments offered at the hearings are summarized in the Commission's interim report.

The tours of community facilities, coordinated with the cooperation and assistance of the representative community services boards and the Department, included visits to community mental health centers to see facilities and talk with staff supervising or providing an array of available services. These included intake, emergency, prescreening, predischarge and inpatient services and outpatient services such as therapy, forensic evaluation, and preventive, consultative and educational services, in addition to psychosocial rehabilitation programs and residential services. The Commission visited several sheltered workshops, substance abuse programs, and special residential programs for the chronically mentally ill. Special emphasis was placed on visits to homes for adults, now housing a significant number of deinstitutionalized clients. Because the adequacy of these facilities for this purpose has generated some controversy, the

Commission visited facilities representing a range of quality. The Commission visited several emergency shelters, utilized in some cases to temporarily house the homeless mentally ill.

The Commission appreciates the assistance of the Department of Mental Health and Mental Retardation, the community services boards serving the areas visited and the Department of Social Services for their assistance in planning and conducting the Commission's tours.

The Commission was assisted in its study by the Joint Legislative Audit and Review Commission (JLARC). JLARC updated the findings of its study on Deinstitutionalization and Community Services, completed in 1979 at the request of the Commission on Mental Health and Mental Retardation, chaired by Delegate Richard M. Bagley from 1977 through 1979.

JLARC's current study generally includes a replication of its 1979 study supplemented with research to meet the Commission's specific interests. The study assessed improvements in discharge policies and procedures, client information systems, interagency and intergovernmental coordination and case management, adequacy of community services provided in each of the forty community services board regions, adequacy of funding for institutional and community services, and the extent to which all citizens in need are served by the mental health system. JLARC used a case study approach similar to that used in the 1979 study and quantitative methods not previously used. The case studies allowed an assessment of the extent to which the JLARC 1979 recommendations have been implemented. The quantitative methods resulted in an improved base of statewide information on institutional and community mental health services and costs. JLARC reported its findings to the Commission in August, 1985.

In 1985, the Commission heard formal comment from the Department of Mental Health and Mental Retardation on the structure of the current service and funding system as it relates to deinstitutionalization and on Departmental actions and recommendations for improvement of the system. A representative of the Virginia Association of Community Services Boards addressed the Commission on the effectiveness of the current structure of the system from the community perspective.

The Commission reviewed approaches to deinstitutionalization issues in other states and legal precedent influencing options in approaching deinstitutionalization. Significant legal issues reviewed included commitment procedures, right to treatment in the least restrictive setting and the effect of restrictive covenants on development of group homes for the mentally disabled.

The Commission attended a conference organized by the Department of Mental Health and Mental Retardation on "State of the Art: Caring for Persons with Chronic Mental Illness" in July. Conference activities included a round table discussion with and subsequent presentations by nationally renowned experts in treatment of chronic mental illness and service delivery systems.

SUMMARY OF FINDINGS AND RECOMMENDATIONS OF JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

System Overview: Clients, Services and Funding

Coordination among the agencies with roles in the service delivery system is vital to the success of deinstitutionalization. Inpatient treatment is provided by the Department of Mental Health and Mental Retardation (DMHMR) in fourteen facilities, and by ten community services boards (CSBs) through contracts with local private hospitals. Client management is a joint responsibility of hospital and CSB staff. The provision of community services is the primary responsibility of CSBs, either directly or by contract. DMHMR monitors the quality of the programs and provides technical assistance and funding. Housing and residential services are provided by about thirty CSBs and by private adult homes licensed by the Department of Social Services. The Department of Rehabilitative Services, Virginia Housing Development Authority and Department of Housing and Community Development also provide a variety of housing-related services.

The diversity of clients discharged from state mental health hospitals and training centers as well as the fluctuating nature of mental illness and substance abuse create a need for a continuum of community care. A list of core services developed by DMHMR includes the five core service categories of emergency services, prevention and early intervention services, inpatient services, outpatient and day support services, and residential services.

Historically, the state hospital has been the primary setting for the delivery of treatment services. As emphasis on community treatment increased, census in the state hospitals was reduced. In FY 1972, the average population in state institutions was 13,529. The projected census for FY 1986 is only 6717. Concurrent with census reduction, the State authorized and funded the establishment of forty community service boards which are responsible for providing services to all jurisdictions across the State. JLARC's survey results indicate that currently over 55,000 persons are receiving treatment and support from the community services boards.

Deinstitutionalization has primarily involved the chronically mentally ill (CMI) population. Census reduction in state hospitals has greatly reduced the number of licensed beds for these clients. Additionally, CMI clients represent a plurality of all persons served by CSBs. Because of the importance of this group in establishing state policy, JLARC focused on this group. The majority of active CSB clients are mental health clients. They number about 40,000. JLARC developed a profile of the CMI population as white, single, young, unemployed at admission to the state hospital, with at least one prior admission to a state hospital. Because this group is active and mobile, service coordination is difficult. However, those interviewed by JLARC agreed that this group has greater possibilities for community adjustment if effective treatment is offered at an early age.

Nationally, Virginia allocates an average amount of funds to support mental health services. This total funding, however, is skewed toward support for hospitals. While Virginia is above average in funding for hospitals, the State is significantly below average in allocations for community services.

Total funding for community-based programs has grown significantly since FY 1979. The overall budget for these programs has increased by 122% in actual dollars and by thirty-nine percent in inflation-adjusted terms.

Since 1979, funding for hospitals has increased. Large increases in Medicaid funds have compensated for the reduction in state general funds and account for the growth in actual hospital funding since FY 1979. The state share of Medicaid payments has been rising steadily during this period as a result of decreases in federal reimbursement rates.

The trend in state mental hospitals is one of continued census reduction accompanied by level or increased funding. Despite significant reductions in average daily census of the large mental health facilities, the average costs of hospitalizing an individual have been increasing steadily. Personnel costs account for the majority of this increase, but rising costs are also associated with decreasing lengths of stay and with DMHMR's efforts to have all mental health hospitals accredited by the Joint Commission on the Accreditation of Hospitals (JCAH).

Client Management and Use of State Hospitals

A primary goal of the state service system is to provide care in the least restrictive setting appropriate to the client's needs. Under the community-based treatment model, state hospitals and community services are seen as a unified continuum of care with state hospitals at the most restrictive end of the service continuum. In its broadest sense, the term "client management" refers to a variety of activities designed to ensure appropriate treatment for clients as they move from the community into and out of state-operated mental hospitals and training centers.

Under DMHMR's client management procedures, responsibility for managing a mentally disabled client's treatment program in both the hospital and the community rests with the CSBs. Client management procedures generally include preadmission screening, predischarge planning, and the transfer of primary treatment responsibility from the hospital to the community. DMHMR has made significant progress in these areas since 1979.

DMHMR and JLARC data indicate that the effectiveness of the prescreening guidelines could be further enhanced by requiring all admissions to be prescreened by a CSB, further specifying criteria and procedures for hospital admissions, and providing training for all individuals who implement prescreening procedures.

Predischarge planning guidelines have been credited by both hospital and CSB staff with improving coordination and communication during the discharge planning process. While

implementation of discharge planning is high, the guidelines do not ensure full identification or delivery of necessary services. Clients are frequently discharged without sufficient financial resources. Many clients do not receive necessary community services because they are not available. To be effective, discharge planning must systematically assess a client's needs for treatment and support services. After the client's needs are identified, necessary program resources must be made available so that the client can make a successful transition from the hospital to the community.

One of the main functions of client management is to reduce inappropriate admissions to state hospitals. However, CSBs do not have financial incentives to reduce use. Currently, CSBs have financial responsibility for the client only when treatment is offered in the community. When a client is placed in the hospital, CSB financial responsibility is relieved and the State provides funds for treatment. Other states have successfully addressed this problem by developing funding mechanisms whereby local service providers (CSBs) pay for their use of state hospital beds as an incentive to reduce utilization. Funding mechanisms to reduce hospital utilization can also significantly contribute to clear programmatic and fiscal accountability throughout the mental health system.

The most effective means to reduce use of state hospitals is the development of a comprehensive network of community treatment and support programs. This network does not exist in Virginia for the CMI population. A large number of absolute and capacity gaps exist across the State in key programs such as psychosocial rehabilitation and support services such as case management.

The use of local inpatient services, provided through contract and collaboration between local private hospitals and CSBs, also appears to be an effective and cost-efficient alternative to state hospitals and should be encouraged and supported by DMHMR and the General Assembly. State hospitals would be in a position to specialize their services to serve only those requiring long-term hospitalization and the low incidence groups, such as the forensic mentally ill, for whom community placements are infeasible.

Linkages to Community Services: Outreach and Case Management

A majority of clients discharged from state hospitals are not fully recovered or suffer from chronic mental illness, and therefore, typically require one or more types of treatment or support. The timely and coordinated transfer of treatment responsibility from hospital to CSB staff is a pivotal first step to the client's successful adjustment in the community.

In addition to predischarge planning, coordinated transfer of treatment responsibility includes three steps. First, hospital staff must send the discharge plan to the CSB, and community staff must make an initial contact with the client. CSB staff may need to engage in outreach efforts to encourage and assist potential clients to participate in community treatment programs. Second, appropriate programs and staff must be made available for the client. Third, case management ensures coordination of community services as the client's treatment and support needs change over time.

Data indicates that while the system is working in a large number of cases, improvements are necessary. Over half of the clients discharged from hospitals receive less than two weeks of community intervention.

The first step in ensuring contact with the client is the timely transfer of information from the hospital to the CSB. JLARC's discharge profile showed that eighty-four percent of the completed discharge summaries were forwarded to CSBs from hospitals within one week of the client's discharge date, in compliance with DMHMR guidelines. The guidelines do not specify, however, how soon after discharge the client should be seen by CSB staff. Given the immediate needs of clients when discharged from a hospital, the initial contact with CSB staff should be within one week. Analysis of the follow-up data indicated that eighteen percent of clients were not seen until the second week and twenty-eight percent did not have contact with CSB staff until two weeks or more after discharge.

The frequency of outreach does not appear sufficient to address aftercare clients' needs for assistance and supervision or to ensure that eligible clients are brought into the system. In

interviews with JLARC staff, CSB staff stressed the importance of outreach but consistently noted that staffing limitations restricted their ability to perform this function consistently.

A major finding of JALRC's 1979 report was the need for increased availability of case management services in the community. The report concluded that no one agency had clear responsibility for coordinating comprehensive client care in the community. Although no CSB has an absolute gap in case management, excessive caseloads indicate that the level of service provided may often be minimal at best. Statewide, it is estimated that approximately 28% (4102) of the chronically mentally ill client population is not receiving the necessary amount of case management. To provide the appropriate level of services, CSBs report the need for 117 additional case management positions.

Section 37.1-67.3 of the Code of Virginia outlines criteria for involuntary and voluntary commitment to state hospitals and authorizes court-ordered outpatient treatment, provided through a variety of modalities required to meet the needs of those individuals who meet the criteria for involuntary commitment but do not require hospitalization. These procedures are rarely employed because there are few specified procedures for its implementation and enforcement. Review of other states' statutes revealed that each state's procedures provide a mechanism whereby law enforcement officials can take a noncompliant individual into custody and return the individual to a designated clinic or doctor for examination. The court is notified if the doctor finds that the patient no longer requires outpatient commitment. If the doctor determines that the patient is dangerous to himself or others, inpatient commitment proceedings are initiated.

Community Services

Chapter 10 of Title 37.1 of the Code designates the CSBs as the key providers of mental health, mental retardation and substance abuse services in the Commonwealth. Although improvements have been made in the development of services across the State since JLARC's 1979 report, there continues to be considerable unmet need for community services. Limited and uneven funding to CSBs has inhibited the provision of an appropriate and adequate range of community alternatives to clients.

To date, of the five established core services, only emergency services are mandated by statute. In all service areas, there continues to be a significant number of service gaps.

Emergency Services - Emergency services involve unscheduled services that are available twenty-four hours a day, seven days a week and include crisis intervention, stabilization, and referral assistance. All CSBs have some type of emergency service available. The critical need for face-to-face emergency services that are accessible to all the Commonwealth's clients suggests that additional funding must be provided to those CSBs currently without adequate face-to-face emergency services.

Prevention Services - Prevention services are designed to reduce the occurrence of mental illness, mental retardation, and alcohol and drug abuse. Efforts aimed at creating community understanding of mental illness and mental retardation have been considered particularly important in areas where public resistance has thwarted the development of group homes and other residential services. JLARC was unable to fully examine prevention services due to data limitations and the lack of an evaluative criteria, but the variation across CSBs indicates that clients across the State do not have equal access to this important service.

Transportation - Although not considered a "core service" by DMHMR, transportation has emerged as a major need. Thirty-five CSBs report that the level of transportation is insufficient to adequately serve their clients' needs. The problem is believed to be most critical in rural areas. DMHMR does not allocate funds for transportation services. Thus, all CSBs are in a position of shifting funds from other service areas in order to provide some level of transportation. Funding from DMHMR is indicated and should be allocated according to the particular needs of the boards.

Approximately 46% of the mental health clients served by CSBs are considered chronically mentally ill (CMI). The variety of needs of the chronically mentally ill necessitate a range of community services that includes local hospitalization for acute psychiatric treatment, day

support services providing opportunities for learning a variety of life and work skills, case management for securing needed assistance from other agencies and service providers, and outpatient services for psychological counseling. Significant service gaps for the CMI exist in case management and outreach, local inpatient services, day support and outpatient programs. Sixty-three percent of the chronically mentally ill client population do not receive outpatient, day support, or residential services on a regular basis.

Substance abuse clients comprise 19% of the population discharged from the State's mental health hospitals. However, an additional 15% of the discharged population have substance abuse as a secondary or dual condition with mental illness. Case study interviews suggest that a large percentage have a history of abusing both alcohol and drugs. In some respects, substance abuse clients appear to overlap with both mental health clients and mental retardation groups. Thus, their service needs are diverse, ranging from outpatient counseling to intensive treatment services. The continuum of care for substance abuse clients includes medical and social detoxification services, day support, work programs and outpatient services to teach basic skills, to prepare clients for the workplace, and to provide support during a client's adjustment to a community. In general, the level of services for substance abusers is poor. With the declining role of state mental health hospitals in the treatment of substance abuse, it is imperative that adequate services be available to citizens of the Commonwealth in communities across the State. At present, however, only a few CSBs offer a minimum range of services for the substance abusing client. Detoxification services are the most widespread but can be effective only in the immediate care of the client. Longer-term, continuous programs are needed.

Currently, over 7,000 mentally retarded clients receive community services in Virginia. As with mental health and substance abuse clients, services needed include case management, outpatient services, day support services, and residential services. Since 1979, there has been a shift in the type of clients discharged from state training centers. In general, clients are becoming increasingly more disabled and exhibiting more behavior problems. Additional future concerns involve clients who have never been institutionalized. Many clients who have lived with their families since birth are expected to require alternative living situations as their families age and become unable to care for them. In addition, clients who have received services since the age of seven through the public schools as a result of Public Law 94-142 will require community services as they reach twenty-two years of age. Thus, expected future trends suggest the need for a variety and expansion of community services for the mentally retarded.

Housing for Mental Health Clients

Housing is a critical need for many clients who leave state mental hospitals. Without housing that provides a secure environment and access to necessary services, a clients' opportunity for a successful transition to the community is diminished. Because many aftercare clients are indigent or have overtaxed their families' ability to care for them, the need for state-provided subsidized housing is magnified. Present law, however, does not adequately assign responsibilities to ensure that discharged clients will be housed in even a minimally acceptable fashion. The result of this inadequacy of policy has been a fundamental lack of appropriate housing settings. A concerted effort toward reformulating agency roles and responsibilities is necessary. A clear legislative mandate, including a regular funding stream and assignment of specific agency responsibilities, is a first step toward ensuring that discharge clients are adequately housed.

The lack of clearly stated policy outlining agency responsibilities has hampered the development of housing alternatives. The result has been a lack of funding for housing development, a lack of documentation of housing need, a lack of interagency coordination, and a patchwork of primarily inadequate housing placements for clients.

Data from the JLARC survey of CSBs and the client follow-up indicates that a plurality of clients in the mental health system (44%) reside with their families or relatives. However, the family situations may often contribute to the problems of the mentally ill or may place unreasonable stress on the families of clients. Not all clients in unfavorable family settings require separate housing facilities. Day support, case management and temporary respite housing programs can often suffice.

None of the forty CSBs presently maintains a continuum of residential services. Ten CSBs offer no residential programs.

Many clients are housed in licensed homes for adults (HFAs). The Department of Social Services both licenses adult homes and administers the auxiliary grant program. Since a key eligibility requirement for the auxiliary grant program is residence in a licensed adult home, the State has in effect encouraged the development of the adult home industry as a major, largely unplanned and unsatisfactory component of state policy toward housing and treating the mentally disabled.

Homes for adults exist as a housing alternative largely outside of the community mental health system. Existing regulations do not guarantee the appropriateness of placing discharged clients in a given home. DSS inspectors lack effective sanctions with which to ensure compliance. There is confusion of responsibility for monitoring the placement of after-care clients. The six-month progress reports required by law for after-care residents of adult homes do not ensure that continuing residence in an HFA is appropriate for a given client. Record-keeping practices are widely variable and, in some cases, unsatisfactory. The required written agreements between CSBs and HFAs are ineffectual. DSS licensing staff report that they do not have routine contact with CSB and hospital personnel. The degree to which discharged clients who reside in adult homes are linked to community services varies considerably. DSS regulations do not require any background or training in mental health care for adult home staff, and many homes lack a sufficiently trained staff for caring for the mentally ill. Statute and regulation should address these deficiencies.

In several of the CSB areas visited by JLARC, a number of clients were residing in unlicensed private boarding homes or hotels. DMHMR should forbid hospitals and CSB staff to place the chronically mentally ill in unlicensed facilities.

Relatively few discharged clients could afford to live in adult homes without the assistance of auxiliary grants. Conversely, fewer discharged clients would be placed in such homes if the grants could be applied to other, more appropriate housing situations. The structure of the grant program encourages the development of adult homes across the State at the expense of alternative settings. Because by their nature adult homes do not generally provide appropriate mental health programming and care, the legislature may wish to consider the gradual diversion of auxiliary grant funds to alternative housing programs.

Adult home beds for deinstitutionalized clients are not spread evenly across the State's population centers. These homes tend to be located in rural areas and are remote to the State's population centers. The major state population centers of the Northern Virginia and Tidewater areas have very little adult home bed capacity. This has necessitated the "importing" and "exporting" of clients from original residences in these urban areas to rural areas which often offer fewer available community services. Smaller communities near state mental hospitals have large numbers of adult homes and per capita bed capacities. The influx of discharged clients into these rural areas has placed a burden on the "importing" community services boards.

Because of their overall superior levels of staffing, programmed activity and maintenance, publicly maintained adult homes should be considered by the General Assembly as a preferred alternative for housing deinstitutionalized clients.

Policy Considerations: Accountability and Allocation of Funds

Virginia's service delivery system for disabled persons has improved significantly in the recent past. One of the most important goals during this period has been the establishment of a comprehensive community-based system of care, but the State has had limited success in meeting this goal. Three broad areas need legislative attention. The first is accountability. On the local level, there are a number of different agencies which provide a variety of community services. While CSBs are designated as accountable for the coordination of services, there are a number of structural barriers to meeting this reponsibility. The second issue facing the State is the significant service gaps existing in the majority of CSBs for all populations. Report conclusions indicate a need for increased funding to develop community programs. Third, fiscal accountability issues must be addressed. Current funding mechanisms do not ensure that available resources are directed to areas or populations with the greatest need. The financial responsibilities of local governments also require clarification.

JLARC has offered recommendations to address specific and immediate problems in the

service delivery system. However, some key issues, described below, cut across and underlie these specific problems.

An effective continuum of care includes hospital treatment and community treatment and support. One of the primary conclusions of the study is that the community side of the continuum is insufficient to provide adequate treatment to those in need of services and requires additional funding. Given the limited availability of funds for this purpose, the General Assembly may wish to identify target populations and mandate selected programs for priority populations.

Hospitals continue to receive the majority of state funds. In order to reduce the use of state hospitals, legislation is recommended to identify the role of the hospitals and to assign fiscal accountability to the CSBs for their use. Throughout the study, the consensus was that the most appropriate and cost-effective treatment for the majority of handicapped persons is community-based services. There was also a consensus that the promise of deinstitutionalization has not been achieved, primarily because of inadequate community services. Management of the CMI population is central to the future success of deinstitutionalization policies, since they represent a plurality of all clients serviced and require the broadest range of community support. However, it is important to emphasize that there are equally high levels of unmet demand across the State for mental retardation and substance abuse services.

While Virginia's General Assembly has encouraged DMHMR and local governments to serve clients in the community and to decrease use of state hospitals, it is not clear which local services are viewed as state priorities. The General Assembly may wish to mandate that certain services be available across the State. The "core" services are broad categories and not specific programs. Thus, they do not offer a clear direction for CSBs. JLARC concludes that a consensus has been reached concerning the services necessary for a continuum of care for the CMI population. These are psychosocial rehabilitation, transportation, transitional employment, and case management and outreach. The General Assembly may wish to mandate that CSBs offer these core program services to the CMI population. It is also recommended that priority funding be offered to support this initiative.

An additional issue requiring legislative direction is the role of the state mental hospitals. Currently, general funds are allocated to hospitals more than to the community even though most clients are served in the community. In order to maximize future funding for community programs, it will be necessary to stabilize hospital costs. Recommendations concerning improved service accountability and expansion of local inpatient and community programs would reduce the use of state hospitals by decreasing the frequency of client recidivism. By clarifying the role of the hospital and making local providers fiscally accountable for hospital use, other states have reduced hospital use and shifted available funds into community programs.

Currently, the State operates or supports three overlapping systems which serve many of the same clients. Hospital services are provided by DMHMR. Community services are provided by CSBs and funded largely through general fund revenues. Finally, residential services are provided by homes for adults which are supported by auxiliary grants and monitored by DSS. Ineffective links in authority between these entities diminish accountability. Moreover, the operation of overlapping systems is financially inefficient.

DMHMR policy designates the CSBs as the accountable agency for ensuring that appropriate treatment is provided to clients in both the community and hospitals. JLARC research indicates, however, that the CSBs do not have the authority or financial resources to be held accountable. Legislative attention, specifically in the areas of client management, could result in a more effective service delivery system. Concurrently, financial resources to improve treatment and residential services would be required to make the CSBs clearly accountable for the delivery of services in the State.

From a fiscal perspective, there are areas where accountability needs to be enhanced. Establishing service accountability at the local level would increase the effectiveness and continuity of service provision. Currently, hospital and CSB funding represent two state funding streams for allocating funds for treatment. The result is that neither the hospital nor the CSB is fiscally responsible for the provision of cost-effective services. Further, the operation of dual systems diminishes the ability of the General Assembly to detect and propose corrective actions to develop an effective and cost-efficient system of care.

The General Assembly has not mandated the provision of specific services and has not identified priority populations to be served. As a result, the current funding mechanisms reflect the goal of giving a "fair" amount to all CSBs, largely independent of the magnitude of need existing in the catchment area.

As the locus of treatment continues to move toward the community, it is important that local governments share fiscal accountability with the State for the operation of CSB services. Currently, the *Code* does not mandate the degree of participation by local governments. Thus, local governments frequently view mental health services as a state obligation and do not give CSBs funding priority. Moreover, many local governments do not provide a stable source of funding for CSB services.

SUMMARY OF RECOMMENDATIONS OF DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION AND VIRGINIA ASSOCIATION OF COMMUNITY SERVICES BOARDS

The Commission requested comment on deinstitutionalization issues from the Department of Mental Health and Mental Retardation (DMHMR) and from the Virginia Association of Community Services Boards (VACSB). In addition, the Commission reviewed the Final Report: Auxiliary Grants Program Study prepared in 1985 by Ernst and Whinney for the Department of Social Services and containing recommendations on placement of the mentally handicapped in homes for adults. Major recommendations of these groups are summarized below.

Fiscal and Service Accountability

Both the DMHMR and VACSB proposed that community services boards assume full patient and financial management responsibility for all community and hospital placements. The Department would evaluate and monitor community and facility programs. Both groups agreed that making community services boards fiscally accountable for all placements would eliminate existing disincentives for use of community programs. The VACSB suggested that state contributions to programs be increased and the local match be eliminated.

Both DMHMR and VACSB recommended that service accountability of boards be enhanced by statutorily transferring responsibility for determining placement of the involuntarily committed client from the Department to the community services boards. In addition, the VACSB suggested that all candidates for hospital admission be prescreened by the appropriate board prior to admission.

Because service accountability must be accompanied by availability of required services, both DMHMR and VACSB recommended that provision of all core services, specified in § 37.1-194 of the Code, be required statewide.

VACSB also suggested enhancing service accountability by improving the discharge planning process, including immediate board involvement and better coordination of all community agencies involved in treatment and support after discharge. Income subsidies should be available upon discharge.

Financing Community Services and Hospital Utilization

Both DMHMR and VACSB urged expansion of community services, including local inpatient programs for all disability groups, necessitating a significant infusion of state funds. Once these community services are readily available, hospital utilization can and should be reduced. The Department also suggested that quality of state hospital programs be maintained and improved by continuing current efforts for accreditation of all Department facilities.

Housing

DMHMR and VACSB specified housing for the mentally disabled as a primary need. The Department suggested that housing be added with state funds and in yearly phases. VACSB recommends construction of group homes by the State with eventual operation by boards. Mechanisms available through state and local housing authorities should be used more.

The auxiliary grant program and use of homes for adults for the mentally disabled were

addressed. The Department, VACSB and Ernst and Whinney agreed that residential options should be expanded by use of auxiliary grants in facilities other than homes for adults. All three also agreed that auxiliary grants should be raised to more accurately reflect actual costs of services.

Improvements in use and management of homes for adults were suggested, including better training for staff in assessment and care of the mentally disabled. VACSB urged notification and consultation with the appropriate board whenever a mentally disabled person moves into a home for adults. Ernst and Whinney recommended better assessment prior to acceptance into residence and regular after-care and follow-up of those accepted.

All three groups recommended that the Department be involved in licensing and standard-setting for homes for adults desiring placement of deinstitutionalized clients. Currently, the Department of Social Services has sole responsibility. Ernst and Whinney suggested stronger intermediate sanctions against homes not complying with regulations.

All three groups urged efforts to better distribute homes for adults geographically. This effort should include attention to the problem of exclusion of group homes from residential areas by restrictive covenants.

FINDINGS AND RECOMMENDATIONS OF THE COMMISSION

Coordination of Elements of the Service System

Discussion

The Commission finds that accountability is not clearly established in the service delivery system. On the local level, coordination among service providers should be improved to ensure that clients are referred to and receive services from appropriate agencies. Processes for managing a client's transition from the hospital to the community should be improved.

Recommendations

To improve this transition, the Commission recommends the following improvements in the discharge planning process:

1. Development and use of a uniform discharge document. The document should include a checklist of all necessary health, financial, residential and treatment needs of clients; identification of all agencies to provide treatment and support to clients; and identification of services which the client needs but which are not currently available. (Appendix B)

2. The Departments of Social Services and of Mental Health and Mental Retardation should modify standards to jointly ensure that Supplementary Security Income (SSI) or other income subsidies are available to eligible clients upon discharge from a state facility. (Appendix C)

Developing a Single System of Care

Discussion

The State currently operates two systems of care which serve many of the same clients. These are the state institutions and the community services boards. Maintenance of overlapping systems limits accountability for service provision. Further, while community services boards are responsible for the care and treatment of all mentally disabled persons in the State, they do not have sufficient authority or resources to meet this responsibility.

Overlapping systems are also financially inefficient and hamper the ability of the State to monitor the system and correct problems. In addition, while data indicates that a comprehensive community support system may be more cost effective than hospital treatment, current funding mechanisms encourage increased use of hospitals and discourage development of and placement in community treatment programs.

These deficiencies can be addressed through the development of a single system of care. In such a system, a single agency would be responsible for ensuring the provision of appropriate services to all clients throughout the system. An effective monitoring system would ensure that clients are placed in the appropriate program. Finally, the existing financial system would be realigned to correspond to changes in service responsibility. A single system will not be fully operational until a comprehensive community system is established. Intermediate steps can be taken, however, which ensure that the system includes the components of service accountability, state monitoring and fiscal accountability.

Recommendations

To provide direction to the involved administrative agencies and to ensure a responsible transition to a single system, the Commission recommends the following:

1. The Department of Mental Health and Mental Retardation should modify client management guidelines to establish standards which reflect accountability of community services boards for service provision. The Department should forecast community services boards' resulting needs for staffing. (Appendix D)

2. The community services boards should prescreen all candidates for hospitalization. Responsibility for determining placement for involuntary treatment should be transferred from the Department to the appropriate community services board. (Appendix E)

3. The Department of Mental Health and Mental Retardation should develop a plan for a quality assurance mechanism to monitor compliance with service decisions. The system should be state-administered and include on-site review and reviews of samples of case records. (Appendix F)

4. JLARC should evaluate existing financing models used in other states which centralize fiscal control for inpatient and outpatient services. Information from this evaluation should be used to develop a cost-effective financing system for Virginia. (Appendix G)

Expanding Community Support Programs for the Chronically Mentally Ill

Discussion

A comprehensive community treatment and support system is essential for the delivery of appropriate services to mentally disabled citizens of the Commonwealth. However, current treatment, support and residential programs are not in sufficient supply to meet the current demand in the communities.

In its study, JLARC staff estimated that over 18,000 chronically mentally ill clients are currently living in the community. An effective system of community services for this population must include psychosocial rehabilitation, which provides day services to facilitate socialization, evaluation, training, education and advocacy in a supportive community environment focused on normalization. The system must also include transitional employment services, case management and outreach services, and adequate housing. JLARC research identified significant gaps in these fundamental programs and resulting deficiencies in service provision to many clients.

In its research, JLARC determined the extent of gaps in these basic services for the chronically mentally ill and developed recommendations for addressing these deficiencies, as summarized below.

Psychosocial Rehabilitation - Eight community services boards do not provide psychosocial rehabilitation. In addition, twenty-six boards with these programs report unmet need for active clients. An estimated 3,500 clients throughout the State are currently not served. JLARC recommends that all community services boards be required by statute to provide these programs. Funds should be appropriated to establish 1452 slots to provide services to the currently unserved population. JLARC's service level data and the Department's unit cost data indicate that implementation will cost about $30 million over a four-year period or about $9.6 million for the first biennium for additional capacity, maintenance of new capacity and capital costs.

Transitional Employment - Thirteen community services boards provide transitional employment services but estimate that 139 clients cannot be served because of lack of capacity. Twenty-seven boards do not provide this service. Approximately 1000 clients are not receiving transitional employment services. JLARC recommends that transitional employment programs be provided by all community services boards by statute. The Department of Rehabilitative Services should reevaluate existing policies to reduce barriers to serving the mentally disabled in current programs. Finally, funds should be appropriated to establish joint programs between the Departments of Rehabilitative Services and of Mental Health and Mental Retardation to provide these services to 1,000 chronically mentally ill clients annually. The Department of Rehabilitative Services estimates that these clients could be served for $7.6 million over four years, or $3.8 million for the 86-88 biennium, for additional capacity and maintenance of new capacity.

Case Management and Outreach - Improved case management will ensure continuity of treatment and reduce the number of clients needing to return to institutional settings. Case management services should specifically, by statute, include assessment of client needs, planning and coordination of service delivery, linkage of clients with appropriate services and monitoring of service delivery in both inpatient and outpatient settings to ensure appropriateness of treatment as client needs change. Department case management guidelines should reflect these elements, establish a minimum level of services to be provided, and establish a direct link between intensity of case management and client need. Case management efforts will be enhanced by a clear definition of the roles and responsibilities of the various state agencies providing community services.

While JLARC found that all community services boards provide some case management services, the boards report that over 4000 chronically mentally ill clients are not receiving adequate services. JLARC estimates that this service gap can be filled to provide a minimum level of service with the addition of 121 case managers statewide. Reaching this minimum service level will require about $2.9 million in each year of the next two biennia, or $11.6 million total over four years.

Housing and Residential Services - Adequate housing is a key element of a community support system. Clients need a stable residential environment to progress in the community. JLARC staff estimate that 35% of the chronically mentally ill population currently live in inadequate housing. The lack of housing for this population is one of the primary reasons why deinstitutionalization policies have not been fully successful.

JLARC's recommendations for addressing these housing deficiencies include improved coordination of agencies providing housing and mental health services; increases in available housing stock; improvement of the quality of residential services provided to post-hospitalized clients in homes for adults by improving placement and treatment procedures, particularly for the chronically mentally ill; and expansion of the auxiliary grant program, currently only providing funding to residents in homes for adults.

JLARC estimates that 6781 clients are living in inadequate housing. JLARC and the Department agree that housing needs can be met by adding 1372 beds over a four-year period. This target appears accurate in that some clients can be served through better case management in clients' homes and in licensed adult homes. Further, the Department of Mental Health and Mental Retardation predicts that client turnover will increase the number of clients who can be served by a single slot. In the next biennium, the Department estimates that $12 million will provide a minimum of 800 slots at an average cost of $10,000 per slot. Residential service types would range from intensive supervised group homes to supervised apartments. An additional 572 slots would be required to be put on line beginning in FY 1989.

Currently, only residents in homes for adults are eligible to receive auxiliary grant funds through the Department of Social Services. However, many adult homes are not currently suitable for chronically mentally ill clients. In addition to shelter, community services board programs provide treatment and full access to treatment services. Providing auxiliary grant funds to clients in community services board housing would result in savings for the boards which could then be used to expand programming capabilities. The Department of Mental Health and Mental Retardation estimates that 350 chronically mentally ill clients would be eligible if the program is expanded. Clients receive an average monthly grant of $215. JLARC recommends that this program begin in FY 1988 to allow sufficient planning and modification of regulations.

JLARC estimates costs to be $0.9 million in each of FY 1988, 1989 and 1990, less an annual local share of $0.2 million, or $2.1 in state funds over three years.

Recommendations

The Commission recognizes the need to increase the capacity of services in the areas of psychosocial rehabilitation, transitional employment, case management, and housing. These services are essential to the treatment of the chronically mentally ill. The Commission recommends that the General Assembly give priority to the development and funding of these services. In making decisions, the General Assembly should give careful attention to JLARC's findings and recommendations for program and funding actions.

Respectfully submitted,

....

Dudley J. Emick, Jr., Chairman[1]

....

Warren G. Stambaugh, Vice-Chairman[2]

....

Joseph V. Gartlan, Jr.[2]

....

Elmon T. Gray[4]

....

Mary A. Marshall[2]

....

Owen B. Pickett[3]

....

Franklin M. Slayton[2]

....

C. Jefferson Stafford

[1]See statement of Senator Emick preceding this report.

[2]See statement of Senator Gartlan and Delegates Stambaugh, Marshall and Slayton preceding this report.

[3]See statement of Delegate Pickett preceding this report.

[4]See statement of Senator Gray preceding this report.

APPENDIX A

SENATE JOINT RESOLUTION NO. 42

Requesting a commission of the House of Delegates and Senate to review the status of Virginia's deinstitutionalized citizens.

Agreed to by the Senate, March 10, 1984
Agreed to by the House of Delegates, March 10, 1984

WHEREAS, the General Assembly is concerned with the quality of care provided to Virginia's mentally ill and mentally retarded citizens; and

WHEREAS, the General Assembly has endorsed the policy of providing a coordinated, statewide system of care of the mentally handicapped in the least restrictive environment; and

WHEREAS, the number of patients in Virginia's state mental institutions will have declined by fifty percent from the early 1970's to the mid 1980's, yet little information is available as to the status of persons discharged from state institutions under the policy of deinstitutionalization; and

WHEREAS, concerns have been identified with respect to the availability of appropriate facilities, programs, and services in Virginia's cities, counties and towns to care for the mentally handicapped; and

WHEREAS, reports have been received concerning the quality of care currently available to some discharged patients in homes for adults, boarding homes, and other community residential settings; and

WHEREAS, concerns have been identified with respect to the organization and management of the state hospital system; the linkage between state institutions and community services; the staffing and program requirements of institutions; the role of institutions in serving geriatric patients; the appropriate number, location, and size of institutions; and potential alternative uses for institutions or buildings which might be closed in the future due to the changing needs of the Commonwealth; and,

WHEREAS, federal, state, and local budget and employment constraints have combined to place increasing pressure on Virginia's mental health and mental retardation system; now, therefore, be it

RESOLVED that a Commission on Deinstitutionalization be established by the General Assembly to review the status of Virginia's deinstitutionalized citizens and to examine the roles and responsibilities of state institutions and community services.

The Commission shall present an interim report prior to the 1985 General Assembly and shall complete its report prior to the 1986 General Assembly.

The Commission shall be composed of eight members as follows: two members of the Senate Committee on Rehabilitation and Social Services and one member of the Senate Committee on Finance, appointed by the Senate Committee on Privileges and Elections, and four members of the House Committee on Health, Welfare and Institutions and one member of the House Committee on Appropriations, appointed by the respective Committee Chairman. Staff support shall be provided by the Division of Legislative Services. The staff of the Joint Legislative Audit and Review Commission shall provide such technical and other assistance as the Commission may require.

There is hereby allocated from the general appropriations to the General Assembly the sum of $13,000 for the purposes of this study.

APPENDIX B

SENATE BILL NO. .... HOUSE BILL NO. ....

A BILL to amend and reenact § 37.1-98 of the Code of Virginia, relating to discharge from state hospitals.

Be it enacted by the General Assembly of Virginia:

1. That § 37.1-98 of the Code of Virginia is amended and reenacted as follows:

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

1. Any patient who, in his judgment, is recovered.

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

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

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

The predischarge plan required by this paragraph shall, at a minimum, *(i)* specify the services ~~to be provided~~ *required by* the released patient in the community to meet the individual's needs for treatment, housing, nutrition, physical care and safety ~~,~~ *; (ii) specify any income subsidies for which the individual is eligible; (iii) identify all local and state agencies which will be involved in providing treatment and support to the individual; and (iv) specify services which would be appropriate for the individual's treatment and support in the community but which are currently unavailable. For all individuals discharged on or after January 1, 1987, the predischarge plan shall be contained in a uniform discharge document developed by the Department and used by all state hospitals.* ~~and to link the individual with the appropriate service providers and human service agencies.~~

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

C. Any patient who is discharged pursuant to paragraph A 4 hereof shall, if necessary for his welfare, be received and cared for by the appropriate local public welfare agency. The provision of social services to the patient shall be the responsibility of the appropriate local public welfare agency as determined by policy approved by the State Board of Social Services. Expenses incurred by the provision of public assistance to the patient, who is receiving twenty-four-hour care while in a home for adults licensed pursuant to Chapter 9 (§ 63.1-172 et seq.) of Title 63.1, shall be the responsibility of the appropriate local public welfare agency of the county or city of which the patient was a resident at the time of admission.

APPENDIX C

SENATE JOINT RESOLUTION NO.....

Requesting the Departments of Social Services, Mental Health and Mental Retardation and Rehabilitative Services to modify standards to ensure that income subsidies are available to clients upon discharge from a state facility.

WHEREAS, the Commission on Deinstitutionalization recognizes the need to ease clients' transition from the hospital to the community by improving the discharge planning process; and

WHEREAS, while the primary focus when dealing with patients suffering from chronic mental illness, mental retardation and substance abuse is on treatment and rehabilitation, the means to meet the clients' needs for safe and sanitary housing, adequate nutrition and clothing are also a critical consideration in their adjustment to community life; and

WHEREAS, many clients are dependent on Supplemental Security Income (SSI) or other income subsidies to maintain a manageable standard of living; and

WHEREAS, clients have reportedly been discharged from inpatient treatment programs before arrangements for their income subsidies have been completed; and

WHEREAS, many of these clients require repeated hospitalization, resulting in loss of eligibility for this funding, and sometimes must wait thirty to sixty days to requalify and receive payments under these programs; and

WHEREAS, deficiencies exist in providing services in this area due to the division of responsibilities among the Departments of Social Services, Mental Health and Mental Retardation and Rehabilitative Services ; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Departments of Social Services, Mental Health and Mental Retardation and Rehabilitative Services are requested to modify standards to jointly ensure that SSI or other income subsidies are in place and are immediately available to eligible clients upon discharge from a state facility; and, be it

RESOLVED FINALLY, That the Clerk of the Senate prepare a copy of this resolution for presentation to the Commissioners of the Departments of Social Services, Mental Health and Mental Retardation and Rehabilitative Services.

APPENDIX D

SENATE JOINT RESOLUTION NO.....

Requesting the Department of Mental Health and Mental Retardation to modify client management guidelines to reflect accountability of community services boards for service provision and forecast resulting staffing requirements of community services boards.

WHEREAS, the Commonwealth currently operates two systems of care which serve many of the same mentally disabled clients; and

WHEREAS, these systems, hospitals and community service boards, frequently overlap or leave service gaps, are financially inefficient and ultimately limit accountability; and

WHEREAS, recent data has shown that a comprehensive community support system may be more cost effective than hospital treatment, and, while community services boards are given the responsibility for the care and treatment of all mentally disabled persons in the Commonwealth, analyses indicate that they do not have sufficient authority or resources to meet these responsibilities; and

WHEREAS, the Commission on Deinstitutionalization (SJR 42, 1984) recently recommended that the community services boards be responsible for service provision to all clients, regardless of site of service, and that all candidates for hospitalization and other appropriate community services be prescreened and committed to a community services board; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Mental Health and Mental Retardation modify client management guidelines to establish standards to reflect community services board accountability and forecast their resulting staffing needs; and, be it

RESOLVED FINALLY, That the Clerk of the Senate prepare a copy of this resolution for presentation to the Commissioner of the Department of Mental Health and Mental Retardation.

APPENDIX E

SENATE BILL NO. .... HOUSE BILL NO. ....

A BILL to amend and reenact §§ 37.1-67.3 and 37.1-197.1 of the Code of Virginia, relating to involuntary admission and treatment for mental illness.

Be it enacted by the General Assembly of Virginia:

1. That §§ 37.1-67.3 and 37.1-197.1 of the Code of Virginia are amended and reenacted as follows:

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

If such person is incapable of accepting or unwilling to accept voluntary admission and treatment as provided for in § 37.1-67.2, a commitment hearing shall be scheduled as soon as possible, allowing the person who is the subject of the hearing an opportunity to prepare any defenses which he may have, obtain independent evaluation and expert opinion at his own expense, and summons other witnesses.

Notwithstanding the above, the judge shall require an examination of such person by a psychiatrist who is licensed in Virginia or a clinical psychologist who is licensed in Virginia or, if such a psychiatrist or clinical psychologist is not available, a physician or psychologist who is licensed in Virginia and who is qualified in the diagnosis of mental illness. The judge shall summons the examiner who shall certify that he has personally examined the individual and has probable cause to believe that he is or is not mentally ill, that such person does or does not present an imminent danger to himself or others, and requires or does not require involuntary hospitalization. The judge, in his discretion, may accept written certification of the examiner's findings if the examination has been personally made within the preceding five days and if there is no objection to the acceptance of such written certification by the person or his attorney.

~~If the person has not been examined by a psychiatrist or a clinical psychologist, prior~~ Prior to making any adjudication that such person is mentally ill and shall be confined to an institution pursuant to this section, the judge shall request from the community services board or community mental health clinic which serves the political subdivision where the person resides a prescreening report, and the board or clinic shall provide such a report within forty-eight hours or within seventy-two hours if the forty-eight-hour period terminates on a Saturday, Sunday or legal holiday. The report shall state whether the person is deemed to be mentally ill, an imminent danger to himself or others and in need of involuntary hospitalization, whether there is no less restrictive alternative to institutional confinement and what the recommendations are for that person's care and treatment. ~~If the prescreening report is not received by the judge within the specified period, the judge shall proceed to dispose of the case without the board's or clinic's recommendation.~~

If such judge having observed the person so produced and having obtained necessary, positive certification and other relevant evidence, shall specifically find that such person (a) presents an imminent danger to himself or others as a result of mental illness, or (b) has

otherwise been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (c) that there is no less restrictive alternative to institutional confinement and treatment and that the alternatives to involuntary hospitalization were investigated and were deemed not suitable, he shall by written order and specific findings so certify and order such person removed to a hospital or other facility designated by the Commissioner for a period of hospitalization and treatment not to exceed 180 days from the date of the court order. The judge shall also order that the relevant medical records of such person be released to the facility in which he is placed upon request of the treating physician. Such person shall be released at the expiration of 180 days unless involuntarily committed by further petition and order of a court as provided herein or such person makes application for treatment on a voluntary basis as provided for in § 37.1-65.

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

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

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

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

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

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

SENATE BILL NO. .... HOUSE BILL NO. ....

A BILL to amend and reenact § 37.1-67.3 of the Code of Virginia, relating to involuntary admission and treatment for mental illness.

Be it enacted by the General Assembly of Virginia:

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

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

If such person is incapable of accepting or unwilling to accept voluntary admission and treatment as provided for in § 37.1-67.2, a commitment hearing shall be scheduled as soon as possible, allowing the person who is the subject of the hearing an opportunity to prepare any defenses which he may have, obtain independent evaluation and expert opinion at his own expense, and summons other witnesses.

Notwithstanding the above, the judge shall require an examination of such person by a psychiatrist who is licensed in Virginia or a clinical psychologist who is licensed in Virginia or, if such a psychiatrist or clinical psychologist is not available, a physician or psychologist who is licensed in Virginia and who is qualified in the diagnosis of mental illness. The judge shall summons the examiner who shall certify that he has personally examined the individual and has probable cause to believe that he is or is not mentally ill, that such person does or does not present an imminent danger to himself or others, and requires or does not require involuntary hospitalization. The judge, in his discretion, may accept written certification of the examiner's findings if the examination has been personally made within the preceding five days and if there is no objection to the acceptance of such written certification by the person or his attorney.

If the person has not been examined by a psychiatrist or a clinical psychologist, prior to making any adjudication that such person is mentally ill and shall be confined to an institution pursuant to this section, the judge shall request from the community services board or community mental health clinic which serves the political subdivision where the person resides a prescreening report, and the board or clinic shall provide such a report within forty-eight hours or within seventy-two hours if the forty-eight-hour period terminates on a Saturday, Sunday or legal holiday. The report shall state whether the person is deemed to be mentally ill, an imminent danger to himself or others and in need of involuntary hospitalization, whether there is no less restrictive alternative to institutional confinement and what the recommendations are for that person's care and treatment. If the prescreening report is not received by the judge within the specified period, the judge shall proceed to dispose of the case without the board's or clinic's recommendation.

If such judge having observed the person so produced and having obtained necessary, positive certification and other relevant evidence, shall specifically find that such person (a) presents an imminent danger to himself or others as a result of mental illness, or (b) has otherwise been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (c) that there is no less restrictive alternative to institutional confinement and treatment and that the alternatives to involuntary hospitalization were investigated and were deemed not suitable, he shall by written order and specific findings so certify and order such person removed to a hospital or other facility *or other program licensed by the Department and* designated by the ~~Commissioner~~ *community services board serving the committed person's area of residence* for a period of ~~hospitalization and~~ treatment not to exceed 180 days from the date of the court order. The judge shall also order that the relevant medical records of such person be released to the facility *or program* in which he is placed upon request of the treating physician *or facility or program director* . Such person shall be released at the expiration of 180 days unless involuntarily committed by further petition and order of a court as provided herein or such person makes application for treatment on a voluntary basis as provided for in § 37.1-65.

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

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

APPENDIX F

SENATE JOINT RESOLUTION NO....

Requesting the Department of Mental Health and Mental Retardation to develop a plan to monitor service and fiscal management by community services boards.

WHEREAS, the Commonwealth currently operates two systems of care which serve many of the same mentally disabled clients; and

WHEREAS, these systems, hospitals and community service boards, frequently overlap or leave service gaps, are financially inefficient and ultimately limit accountability; and

WHEREAS, recent data has shown that a comprehensive community support system may be more cost effective than hospital treatment, and, while community services boards are given the responsibility for the care and treatment of all mentally disabled persons in the Commonwealth, analyses indicate that they do not have sufficient authority or resources to meet these responsibilities; and

WHEREAS, the Commission on Deinstitutionalization (SJR 42, 1984) recently recommended that the community services board be responsible for service provision to all clients, regardless of site of service, and that all candidates for hospitalization and other appropriate community services be committed to a community services board; and

WHEREAS, the Department of Mental Health and Mental Retardation is being requested to modify client management guidelines to establish standards to reflect community services board accountability and forecast their resulting staffing needs; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Mental Health and Mental Retardation is requested to develop a plan to monitor the service and fiscal management of such a locally based program. Such a monitoring program should be state administered and should provide, but not be exclusively limited to, on-site review and a sampling or review of case records; and, be it

RESOLVED FINALLY, That the Clerk of the Senate prepare a copy of this resolution for presentation to the Commissioner of the Department of Mental Health and Mental Retardation.

APPENDIX G

SENATE JOINT RESOLUTION NO.....

Requesting the Joint Legislative Audit and Review Commission to study existing financing models used in other states which centralize fiscal control for patient services for the mentally disabled.

WHEREAS, the Commonwealth currently operates overlapping systems which limit services and fiscal accountability; and

WHEREAS, the recent Commission on Deinstitutionalization (SJR 42, 1984) has recommended that service responsibility be realigned so that all services, community-based to institutional, to the mentally disabled be provided and managed through community services boards; and

WHEREAS, as the responsibility for treatment has shifted to the community, funds have not followed the client and current funding streams actually provide incentives for increased use of hospitals; and

WHEREAS, community services boards do not have sufficient authority and resources to meet their current and future service responsibilities; and

WHEREAS, changes in service responsibility therefore require a corresponding realignment of the existing financial system; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission conduct a study to evaluate existing financing models used in other states which serve to centralize fiscal control for patient services provided for the mentally disabled. The Commission shall report its findings to the 1987 Session of the General Assembly; and, be it

RESOLVED FINALLY, That the Clerk of the Senate prepare a copy of this resolution for presentation to the Director of the Joint Legislative Audit and Review Commission.