REPORT OF THE

Commission on Deinstitutionalization

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Interim Report of the
Commission on Deinstitutionalization
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
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To: Honorable Charles S. Robb, Governor of Virginia,
and
The General Assembly of Virginia

BACKGROUND OF 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. 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.

In September, 1983, the Human Resources Subcommittee of the Senate Finance Committee met with officials of the Department of Mental Health and Mental Retardation to review the budget proposed by the Administration. At that time, the proposed 1984-86 general fund target was about $20 million less than needed to maintain current services at the four large mental hospitals. The Department's plan to accommodate this shortage included accelerated discharge of patients and reductions in employment. The Subcommittee's resulting discussions with departmental officials revealed a lack of comprehensive information on services to discharged patients as well as the difficulties involved in gathering this information. In subsequent meetings, it was determined that special surveys would be required to obtain follow-up information and that privacy issues would have to be addressed.

The Subcommittee called increased attention to the issue of deinstitutionalization in background papers prepared during legislative budget hearings and in its final report to the Senate Finance Committee during the 1984 General Assembly. These papers showed that the patient population of Virginia's state mental institutions has decreased since the 1960's. In 1971-72, the average daily number of patients in state institutions was 13,529. The projected census for 1985-86 is only 6,717, a fifty percent decline over fourteen years. During the same period, however, the number of institutions has increased from six to sixteen, and the total number of employees will have increased from 6,718 to 10,384. As of November, 1983, the major hospitals were operating at only 66.5% of rated capacity. In response to a shift in emphasis from institutional to community care, funds for community services boards have risen from $45.6 million in general funds in the 1978-80 biennium to $122.9 million in 1984-86. The Subcommittee was informed that, even with these increases in funding to communities, some localities are unable to provide adequate support for patients released from hospitals.

Testimony presented to the Subcommittee by the City of Richmond in January, 1984, indicated a disproportionate share of homes for adults in that city, a large number of unlicensed boarding homes, and a lack of coordination for predischarge planning between Central State Hospital and the local community services board. A review of literature and reports from other cities and states indicated such problems were not unique in Richmond.

Concurrently with Senate activities, Delegate Richard M. Bagley, Chairman of the House Appropriations Committee, was encouraging efforts to secure funding for a replacement mental hospital at Marion. On January 9, 1984, a group of legislators and representatives of the executive branch visited Southwestern State Hospital. The group considered the options of building an entirely new hospital on a different site in Smyth County or erecting a new building on the existing site in Marion. As a result of the tour, a consensus emerged to provide a modern psychiatric institute on the existing campus, and to provide additional funds for demolition or renovation of existing buildings.

The group also visited a home for adults on Route 11, several miles south of Marion. There was concern that some patients may have been transferred from buildings on the Southwestern

State campus to a converted motel next to a busy highway, with no improvement in the quality of care, and that similar situations may exist across the State in perhaps as many as a dozen localities where former mental patients are residing. The visit generated a discussion of deinstitutionalization and the quality of care available to patients discharged from facilities for the mentally disabled.

A follow-up meeting was held to discuss a capital budget amendment for Southwestern State Hospital. However, in view of concerns about discharged mental patients in general, it was determined that a commission was needed to assess the results of the policy of deinstitutionalization. The commission would address such issues as the effectiveness of discharge planning, the availability of suitable housing and day support services, coordination of mental health and social services, the problem of the deinstitutionalized who become "street people," and the future of state institutions. The Department of Mental Health and Mental Retardation alone cannot resolve the issue of future use of facilities that may not be needed. The General Assembly may have to authorize consolidation of programs, buildings, or even entire institutions so that units which are no longer needed can be used for other purposes.

Senate Joint Resolution 42 was introduced as a result of this meeting.

HISTORY OF DEINSTITUTIONALIZATION IN VIRGINIA

Virginia's major deinstitutionalization efforts began in 1968 with the passage by the General Assembly of Chapter 10 of Title 37.1 of the Code of Virginia. This enabling legislation initiated local establishment and control of mental health and mental retardation services by community services boards. It also provided a means for implementation of the recommendations of the Commission on Mental, Indigent and Geriatric Patients ("Hirst Commission"), which found that

> the successful improvement of mental health services to both the mentally ill and the less fortunate of Virginia's citizenry requires a total commitment to the concept of a coordinated system of care focused on the patient rather than the agency or institution.

The Hirst Commission recommended in 1970 that the development of existing and planned community mental health services be integrated into hospital services by (i) facilitating continuity of care between state and community services through regional program administration, (ii) establishing community screening programs to avoid unnecessary institutionalization, (iii) developing alternative community care plans for hospitalized patients who can function in and benefit from community settings, and (iv) developing community mental health centers to the extent that they could be adequately staffed and supported.

The Hirst Commission recommended concurrently that the state hospital system be strengthened through better definition of the role of state hospitals, improved staffing and services, and increased community involvement in hospital programs. The Commission recommended construction of new, smaller hospitals in metropolitan areas and the establishment of psychiatric institutes in connection with the medical schools.

The Hirst Commission was particularly concerned with the issue of coordination between state hospitals and local services.

> One of the major problems encountered in the area of community mental health services has been the lack of continuity of patient care between the state hospital system and the various community services. With limited staff and funding, most community services focus primarily upon the short-term, acute patients with the best chance of recovery. The others either end up in the state hospital or are lost in the "No Man's Land" between the two facilities.

To address this problem, the Hirst Commission suggested a reorganization of the state mental health system to provide assistant commissioners responsible for both hospital and community mental health services in the several regions of the State.

Some of the Hirst Commission's recommendations of 1970 were adopted, including construction of smaller psychiatric hospitals in Danville and Fairfax County, increased staffing at state hospitals, and establishment of geriatric centers at state hospitals. Other recommendations were not adopted, such as regional program administration.

In its second report in 1972, one of the three recommendations given highest priority by the Hirst Commission in the second phase of its study was the provision of "increased funds for community services for the mentally retarded and mentally ill because this is the key to reducing the population of the State institutions."

The 1979 report on Deinstitutionalization and Community Services issued by JLARC, conducted at the request of the Commission on Mental Health and Mental Retardation ("Bagley Commission"), chaired by Delegate Richard M. Bagley from 1977 through 1979, reported that progress had been made in deinstitutionalization since the Hirst Commission's 1970 and 1972 reports. Populations in state mental hospitals were reduced 44% and in training centers for the retarded 28%. In the biennium preceeding the 1979 report, over $50 million were appropriated for community services. However, JLARC found the following serious problems continuing in deinstitutionalization practices in Virginia:

1. Transfer of discharged clients to appropriate community services was inhibited by inadequately administered discharge procedures at state institutions.

2. The needs of discharged patients were not being adequately met because of gaps in community services and the limited capacity of existing services.

3. A coordinated system of care for the mentally ill and mentally retarded had not been developed in the State; responsibility for service delivery was fragmented among state and local agencies, without sufficient central policy or procedural direction.

JLARC also noted that there was no official definition of deinstitutionalization. For purposes of its study, JLARC defined it as "the processes involved in transferring mentally ill and mentally retarded clients from a state institution to a community setting and, as part of the transfer, establishing appropriate linkages for treatment and support services."

In its 1980 report (House Document No. 8), the Bagley Commission endorsed the JLARC findings and recommended to the 1980 General Assembly legislation that was designed to improve client management and coordination of the institutional/community system.

ISSUES IDENTIFIED FOR STUDY

The following is a list of specific issues within the scope of the Commission's study. Included in the discussion of each issue are relevant findings from the 1970 and 1972 reports of the Commission on Mental, Indigent and Geriatric Patients (Hirst Commission), JLARC'S 1979 report, and the 1980 report of the Commission on Mental Health and Mental Retardation (Bagley Commission). Progress on some of their recommendations is included as available.

Lack of information on status of persons discharged from state institutions pursuant to policy of deinstitutionalization.

In its 1979 study, JLARC noted that a systematic and ongoing analysis of client needs, available resources and existing services was needed for effective mental health and mental retardation program planning. It was recommended that, to address deficiencies in this area, the Department of Mental Health and Mental Retardation (DMHMR) and the community services boards (CSBs) cooperate to develop a system of information on client characteristics and needs, and the capacity and quality of current services. Data collected should include length of stay, history of previous hospitalization, community of discharge, type of placement, service needs, service referrals, and client follow-up. Privacy needs must be identified and resolved to accomplish client follow-up. The data, updated annually, should be incorporated into DMHMR's long-range plan and the resulting funding priorities and service development strategies.

Availability and cost of appropriate services in localities to care for the mentally handicapped.

JLARC noted in its study the importance of equal access to a basic core of community services throughout the State for clients discharged from state institutions. Gaps in such services were identified, resulting in retention of patients who could otherwise be discharged and provision of minimal services to some of those discharged. JLARC recommended identification by DMHMR and the legislature of mandatory basic core services.

In 1982, the General Assembly agreed to HJR No. 77, approving definitions of five basic core services--emergency, inpatient, day support/outpatient, residential, and prevention/early intervention. HJR No. 77 also required the Department to report by October, 1983, on implementation of core services and development of a funding formula to more equitably allocate state resources. That report concludes that all areas of the State are now served by the CSB network of forty boards, funding has been initiated to begin filling absolute gaps in core services in communities to allow census reduction at large state institutions and to better serve the existing deinstitutionalized population, and CSB prescreening has been improved to divert inappropriate hospital admissions. The Department recommends, in developing a funding formula, that new state funds be provided to CSBs in the 84-86 biennium based on results of joint CSB and facility planning which will address filling service gaps, reducing state institutional census, meeting special population needs and building core service capacity. A final funding plan was completed by December 31, 1984.

Adequacy of client management and interagency cooperation.

JLARC cited the lack of adequate case management for discharged clients who require a variety of community services from different agencies. Case management includes assistance in identification of client needs and in application for services and monitoring service delivery and client progress. JLARC recommended that DMHMR require that CSBs provide case manager positions, responsible for organizing interagency teams to facilitate service delivery. In 1980, Chapter 10 of Title 37.1 was amended to require the establishment by each CSB of a prescription team of representatives from the spectrum of human services in the community. The team is responsible for integrating community services necessary to implement prescreening and predischarge planning for referred clients.

Quality of community residential care available to discharged clients, especially homes for adults, boarding homes, and emergency shelters.

JLARC emphasized a need to investigate the appropriateness of homes for adults as housing placements for discharged clients. It recommended that DMHMR and the Department of Social Services develop a plan to upgrade quality of care in homes for adults. This plan should require training for adult home staff in handling psychiatric and medical emergencies and managing assaultive and disoriented residents; provision of discharge summaries in lay language to adult home staff, as appropriate; and placement of discharged patients only in adult homes substantially complying with licensing standards.

JLARC also completed a review in 1979 of Homes for Adults in Virginia . In the study, JLARC focused on administration of licensing of the homes and administration of the auxiliary grant program. The study concluded that there was "no clear focus of responsibility in the Department of Social Services for planning, coordination and implementation of adult home activities."

The Department of Social Services, assisted by DMHMR, revised its standards in 1980 to require that any home for adults which accepts persons discharged from a state institution operated by DMHMR must enter into an agreement with the local CSB or similar private resource to ensure that appropriate services are available to the resident. The home must also obtain a summary of after-care service recommendations from the discharging institution and written progress reports from any local public or private facility providing service; client consent for release of information and right to refuse treatment are applicable.

Organization and management of the state hospital system.

The Commission on Mental, Indigent and Geriatric Patients, in its 1970 and 1972 reports, advocated the development of a "single system of care" for the mentally disabled. That Commission noted that such a system required the expansion of community-based services with a corresponding development of state hospitals and training centers as specialized facilities for care of the more severely disabled individuals who would continue to need institutional care.

In its investigation of progress on adapting the large state institutions to their role in a system guided by a policy of deinstitutionalization, the Bagley Commission in its 1980 report noted that there was no consistent, system-wide policy for routine physical maintenance of state hospitals and training centers; crisis-oriented maintenance resulted. That Commission recommended that DMHMR reallocate positions within the central office to allow more effective institutional maintenance. The Commission also recommended that as maintenance of buildings which are substandard or obsolete becomes economically or programmatically impractical, those buildings be demolished or their use transferred to another agency; the Commission asked the Governor to develop a timetable for such action by the 1982 Session of the General Assembly. The DMHMR submitted its resulting report to the 1982 Session of the legislature in Senate Document No. 5.

In 1979, JLARC reported that, between 1970 and 1978, hospital populations had been reduced and staffing increased. New admissions were hospitalized for relatively short periods, but recidivism was high and long-term care for this chronic population was emphasized over treatment. JLARC concluded that the impact of these trends be assessed in terms of effect on patient care and the desired role of large state hospitals; acute care may be better provided by smaller community-based facilities or in general hospitals.

The Commission on Mental Health and Mental Retardation in 1980 recommended that staffing be shifted from administrative/nondirect care to direct care. DMHMR addressed this recommendation with its DASH manpower plan in 1982; since then the Department's staffing strategy has included reduction of staff in addition to redistribution of staff.

Linkage between state institutions and community services.

In its 1979 report, JLARC stated that policies and procedures were

> inadequate to ensure that community services are either available or delivered on a statewide basis. Problems result from the existence of the two imperfectly linked institutional and community networks. Procedural deficiencies include lack of strong central leadership and evaluation, fragmented responsibility for service delivery, and inadequate assessment of client needs to support service development and funding decisions.... [A] coordinated system of care has not been developed in the Commonwealth.

Recommendations to remedy this deficiency included provision to appropriate community agencies of complete information on client treatment, progress and post-discharge needs; barriers to transfers of such information should be addressed. Community agencies should participate in discharge planning prior to discharge. Patients should be provided training in functional social skills and use of medication and be counseled prior to discharge to ease transition into the community.

To effect general development of a coordinated system consisting of both institutional and community components, JLARC recommended that the leadership role of DMHMR and the relative roles of CSBs and other relevant agencies be clarified. The 1980 legislation recommended by the Bagley Commission included provisions to clarify relationships.

In 1985, Senate Bill 704 amended provisions governing release of patient information to facilitate exchange of information between the CSBs and institutions in the absence of patient consent to release.

JLARC also suggested that an information system providing data for analysis of client needs and available resources should be developed to facilitate systematic planning. An assessment of the impact of deinstitutionalization on clients, communities and state and local budgets should be undertaken; follow-up on discharged clients should provide data on number of clients receiving services, types of services used and costs of services. It was also reported that interagency coordination needed improvement for the many discharged clients needing services provided by more than one agency.

STUDY DESIGN AND SCHEDULE

The Commission agreed to the study plan described below to carry out its investigation.

1. The Joint Legislative Audit and Review Commission (JLARC) will update the findings of its 1979 study and determine the extent to which its recommendations have been implemented and reasons for deficiencies in implementation. JLARC estimates that this will be a two-year effort, with findings reported to the Commission in July, 1985.

The research proposal developed by JLARC staff and approved by the Commission may be found in Appendix B of this report.

The proposal generally includes a replication of JLARC's 1979 study supplemented with research to meet the Commission's specific interests.

The study will assess 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.

The research proposal calls for the use of a case study approach similar to that used in the 1979 study and quantitative methods not previously used. The case studies will allow an assessment of the extent to which the JLARC 1979 recommendations have been implemented. The quantitative methods will result in an improved base of statewide information on institutional and community mental health services and costs.

2. Staff of the legislature's budget committees will prepare a funding history, including funding streams for various programs, financial incentives and disincentives, and alternative funding arrangements.

3. The Commission will conduct four regional meetings which will cover the central, southwest, northern, and Tidewater areas of Virginia. At those meetings, public hearings will be held to provide a forum for interest and advocacy groups; local elected, judicial and law-enforcement officials; community mental health professionals; representatives of state and other public agencies; and deinstitutionalized clients themselves.

The Commission will also visit community mental health facilities in each of these regions. Tours should include residential facilities such as group homes, homes for adults, and substance abuse centers as well as day support programs, including sheltered workshops, psychosocial clubhouses and outpatient clinics and programs.

In 1985, the Commission will assess the information gathered at its regional meetings and the data to be provided by JLARC in July, 1985. The Commission will review relevant studies and other literature and legal precedent on these issues. The Commission will offer its recommendations to the 1986 Session of the General Assembly.

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. A representative group of those notified addressed the Commission at each hearing. Many persons who did not testify submitted written testimony, all of which was provided to the members of the Commission. Comments offered at the hearings are summarized in this 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 the clubhouse programs and residential services. The Commission visited several sheltered workshops, some of which demonstrated innovative programs for assembly of high-technology items. Substance abuse programs were included in the Commission's itinerary. The Commission saw 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. The adequacy of these facilities for this purpose has generated some controversy; the Commission therefore visited facilities representing a range of quality. The Commission visited several emergency shelters, utilized in some cases to temporarily house the homeless mentally ill.

SUMMARY OF PUBLIC HEARING COMMENTS

The testimony presented at the Commission's four public hearings is summarized below. All testimony presented orally or offered in writing was reviewed and the major issues raised and comments or suggestions offered were extracted for the summary. The summary consists entirely of this material without comment or response from the Commission or its staff. The Commission has not endorsed the concepts presented.

The material has been organized in four main categories, including the general policy of deinstitutionalization, the availability of appropriate community resources, the operation and coordination of the mental health system in implementing deinstitutionalization, and funding issues.

Policy of Deinstitutionalization

The great majority of public comment received endorsed the general policy and concept of deinstitutionalization, in contrast to its practical success. Many speakers stated that the majority of the mentally handicapped could be served more effectively and at a lower cost in the community. However, they also noted a continued need for institutions, whether local or state, particularly for the chronically mentally ill and profoundly retarded. Hospital admission was recommended by some only to stabilize, not cure, the client, who, once stabilized, should be returned to the community for services. It was noted that the need for hospitalization can be reduced significantly by participation in a community support program.

However, many of the positive comments received were qualified with perceived shortcomings in deinstitutionalization practice. The shortage of needed funds and community services was most frequently cited as an obstacle to success. Funds must follow the deinstitutionalized client from institution to community to ensure that resources are funded and available. To work, deinstitutionalization must be implemented on a case-by-case basis and not used as a means to reduce hospital census and save money. These decisions regarding individual clients should be based on criteria clearer than now exist for determining which patients should be retained in or discharged from institutions.

In its policy development, the Commission should define deinstitutionalization broadly enough to include the mentally handicapped who have never been in an institution but who need community services.

Several comments in opposition to the policy of deinstitutionalization noted that the effectiveness of deinstitutionalization is unproven.

Availability of Appropriate Community Resources

One of the comments heard most frequently was that for deinstitutionalization to work, the appropriate resources and services must be available in the community. This is not now uniformly the case in all localities in Virginia, according to testimony. One speaker stated that "deinstitutionalization is not necessarily going too fast, but the buildup of community mental health resources...is proceeding far too slowly."

With forty community services boards established, all areas of the State receive services. Core services have been defined and approved by the legislature and funds have been provided to fill gaps in these services. However, some programs and resources were repeatedly described as inadequate, either statewide or in certain localities, to serve the deinstitutionalized population.

The resource most frequently cited as inadequate was housing for all mental disability groups. Often, family ties have been severed, and clients cannot return home. They frequently cannot afford existing unsupervised housing. Boarding homes and other unsupervised and more affordable options are often substandard housing, grouped in areas that become ghettos of indigent deinstitutionalized clients. In addition, most clients need some level of supervision or support.

The demand currently exceeds the supply for a number of residential services, including long-term housing for the chronically mentally ill. Also needed is short-term supervised housing for emergency placement and for transitional placement immediately after discharge from institutions. Shelters are reportedly inappropriately used for these purposes; this practice contributes to what one speaker described as a "park-shelter-institution cycle." Most localities need additional group homes, supervised apartments, and nursing homes capable of housing the mentally handicapped.

Some communities have attempted to provide housing by establishing special foster care programs in conjunction with the local departments of social services, but have experienced problems paying foster parents because of social service regulations.

It was suggested that housing resources can be developed by assisting local agencies in utilizing federal HUD Section 202 and Section 8 programs and establishing a revolving fund for initial development costs as needed for access to federal funds.

One controversial housing option widely used for deinstitutionalized clients is the home for adults. These homes are licensed by the Department of Social Services to provide maintenance or care to four or more aged, infirm or disabled adults. Maintenance or care is defined by the Code of Virginia as "protection, general supervision and oversight of the physical and mental well-being of the aged, infirm or disabled individual." The supervision is, in practice, minimal as are regulatory requirements for programs or staffing.

While many speakers saw these homes as a useful resource for the deinstitutionalized client and a valuable collaboration between the public and private sectors, there were numerous complaints about their management and utilization. Some homes reportedly accept inappropriate residents, such as the chronically mentally ill, who need more structure and supervision. The mental health system is unable to closely monitor the quality of care and the development of new homes. Community services boards and the Department of Social Services should both participate in placement and licensing decisions and monitoring of placements. The boards, however, are reportedly not given the opportunity for involvement in some localities. Many homes used for this population are unlicensed because they have fewer than four residents; quality control therefore suffers. It was suggested that all homes should be licensed and that the Department of Social Services should more aggressively enforce licensing requirements. Staff should be qualified by training and experience to supervise the mentally handicapped.

The Commission was told that auxiliary grants, which provide funds to house many residents of homes for adults, should be raised to more nearly pay expenses. Currently private-pay residents must pay more to subsidize auxiliary grant recipients. These inadequate payments are threatening the development of smaller homes for adults, preferable to the larger homes, according to some speakers. Payment by level of care needed was suggested.

There were many complaints that homes for adults are concentrated heavily around areas where state hospitals are located. This is particularly true around Western State Hospital. Because operating costs for homes for adults are prohibitive in northern Virginia and housing therefore in short supply, patients from that area remain in the Valley area upon discharge. This causes development of large institution-like homes for adults in that area. It strains local human service resources and allotted bed spaces when these persons must be readmitted to the hospital.

A number of speakers described problems with establishment and distribution of group living facilities because of limitations in zoning or restrictive covenants in certain localities. This discourages development of facilities in suburban areas especially. The recent Virginia Supreme Court decision in Omega v. Malloy upheld the authority of restrictive covenants to bar establishment of group homes in housing developments restricted to single family use.

To remedy these housing problems, speakers encouraged legislative intervention, incentives and supports for families to care for the mentally handicapped in their homes, and public education efforts.

Speakers also noted a need for more outpatient clinics, day treatment facilities, vocational rehabilitation programs for both the mentally retarded and mentally ill, day support programs, respite care for families, transportation services, prevention services, medical and dental services, outreach services, and programs for the dually diagnosed. There is a shortage of community-based crisis beds and services to prevent hospitalization, especially for the indigent. A new treatment method used increasingly but still in short supply is psychosocial rehabilitation, known also as clubhouse programs, for the chronically mentally ill. These programs provide training and employment support and assistance, community and peer support, and in some cases supervised transitional apartments.

Services for several disability groups were described as inadequate. These include the dually diagnosed, especially the mentally ill who are also mentally retarded or substance abusers. The closing of substance abuse treatment programs in the institutions is causing a service gap. Trained staff are needed in the community and in institutions to serve the hearing-impaired with mental disabilities. Transition programs in the community are needed for the mentally disabled leaving federally mandated public school programs when they reach the age of twenty-two. Special services are needed for clients who enter the criminal justice system, especially training for police and jail staff in working with the mentally disabled. A number of speakers believed that the chronically and severely mentally disabled were receiving inadequate attention and suggested that they should be given priority in development and utilization of community resources.

One speaker recommended expanding community services by encouraging the growth of the private sector. Several communities have reported that community services boards have refused regional community treatment services funds for substance abuse services to individuals not being seen in community services board programs, thus discouraging development of private resources.

Operation and Coordination of the Mental Health System

One speaker described the ideal mental health system as a continuum of care, focused on early intervention and prevention, with a full array of community services and well-staffed institutional facilities. The "system" addressed by many speakers is one which includes the institutional and community mental health programs, but also other community human service programs such as health and social services. The coordination of all these necessary services and successful guidance of the client through the system was the focus of much comment.

A single coordinated system of care was noted as the goal of the mental health system in Virginia since it was recommended by the Commission on Mental, Indigent and Geriatric Patients in 1970. Some progress is reported toward this goal since that time. Preadmission screening by community services boards is implemented statewide and has significantly reduced the number of unnecessary hospital admissions. Case management services are provided by every community services board. Patient management guidelines have been developed and disseminated, improving admission and discharge planning.

Some barriers to a single system still are reported, however. Existing data systems are inadequate to identify the mental health and physical needs of those discharged, to follow up on the service of those needs, and to identify the system's capacity to meet those needs. Now only those actually served are tracked in the data system. Some patients who may not be receiving services and are not tracked by the system are those discharged against medical advice, those discharged with no fixed address, or those who do not follow treatment recommendations.

Case management, or guidance of a client through the system from preadmission to postdischarge procedures, was frequently described as deficient. First, it should be the responsibility, as much as possible, of one person, so that clients, families, and other human service agencies have a single contact point. Case management should have an outreach component. The responsibilities of the numerous state and local agencies which serve the deinstitutionalized client should be clearly defined.

Discharge procedures were specified as an aspect of case management needing special attention. While improvements were noted, some problems and suggestions were offered. The basis for discharge decisions was questioned and closer examination suggested. Families and other local human service agencies should be involved in discharge planning. Clients should be assisted in applying for entitlements as a condition of discharge. Upon discharge, appointment of a public guardian was suggested to manage entitlement funds for those clients unable to manage their own funds.

Clients should be discharged only to the communities from which they were placed. If they return to a different locality, then the placing locality should provide funds for any local services provided by the receiving community.

Speakers recommended a freer flow of patient information for discharge planning between hospitals, community services boards and community service providers, particularly when a patient will not consent to release of patient information.

Conditional release of patients and mandatory community care were suggested as a means to manage clients who have a history of not following discharge treatment plans, including use of prescribed medication. Policies governing the patient's right to refuse treatment should be reviewed.

It was recommended that families of consumers of mental health services should be represented in development of policy governing the system.

It was also suggested that operations of both the institutional and community aspects of the public system should be based on a medical model. Psychiatrists should manage the system, which now emphasizes administration and nonclinical aspects too heavily and neglects a more appropriate medical emphasis.

Funding Issues

A significant number of comments were related to funding issues, particularly the effect on deinstitutionalization policy of the sources and amount of funding to both institutions and community programs.

To succeed, deinstitutionalization must be adequately funded. Adequate funding must also be earmarked for use by either institutions or community programs to avoid competition between the two areas for funding and to ensure that institutions can serve the more severely disabled population remaining after discharge of patients who can be treated in the community. Communities must be allotted their fair share of both institutional and community resources, based on population and need, and perhaps accounting for localities' community diversion efforts.

Hospital census reduction to address a lack of funds should not provide the motivation for deinstitutionalization. While community programs are generally shown to be less expensive per patient, costs are difficult to analyze because of variations in structure among programs and localities. Data about relative costs are thought by some to be inconclusive, particularly for the mentally retarded. Some speakers noted that if deinstitutionalization is implemented successfully, it is not necessarily cheaper than state institutions when total public costs are calculated rather than only that portion of costs met by state government. Costs of community care thus figured were generally believed justified, however. It was also noted that community care costs in some cases may be higher than for institutional care, but community care is of shorter duration and more clients are served.

The recommendation probably heard most frequently was to increase funding to the community programs serving deinstitutionalized clients. The Commission on Mental Health and

Mental Retardation in 1980 recommended that the State distribute 60% of its mental health funds to institutions and 40% to community programs; it is estimated that community programs still receive only about 20% of state funds. The State has reportedly transferred to the community only a portion of the funds used formerly when clients now in the community were in institutions. The community, however, now serves 4.5 clients for every patient in institutions, with facility census decreasing and clients in community programs increasing in number. Localities are strained to supplement community programs further, particularly with the loss of federal funding. Additional funding is needed not only for mental health programs, but for the many other locally provided human service resources provided to deinstitutionalized clients. It was suggested that current institutional funds be capped now and reduced over time.

The manner of allocation of state funds to the community services boards and other local human service agencies inspired comment. Some speakers described the current allocation method as inequitable and suggested a formula for allocation among community services boards based on population, poverty levels, the number of chronic clients, their level of need, and availability of community resources in the locality. High impact areas, such as those near state institutions, should be given special consideration in fund allocation.

Agreement was also recommended on how additional funds should be apportioned among other local human service agencies affected by deinstitutionalization, such as social services and law enforcement agencies.

A frequently offered recommendation was that funding should be allocated to the institutional and community systems by directing that funds follow the client. This method would eliminate biases toward institutional or community placements based on state or local source of funding. Communities would receive necessary funds to serve the population in need, even in high impact areas. Local officials could spend their allotment of mental health dollars by paying for an institutional space or using community services, as appropriate.

A number of sources of funding for deinstitutionalization was suggested, such as use of Medicaid waivers, restoration of Medicaid-funded intermediate-care facilities for the mentally retarded, changes in current state Medicaid policy to allow payment for psychiatric inpatient treatment in freestanding facilities, and reinstatement of Title XX reimbursement for services to clients receiving mental retardation and substance abuse services. Clients should be assisted in procuring federal benefits such as Supplementary Security Income, rent subsidies, food stamps, and benefits authorized by P.L.96-265. The latter, in part, provides for continuation of Supplementary Security Income (SSI) and Medicaid benefits for certain severely impaired SSI recipients who are employed. Speakers encouraged legislative change in insurance laws to increase coverage for treatment of mental illness, now limited to thirty days of inpatient care and $2000 in outpatient treatment. Insurance coverage of rehabilitative services, including psychosocial rehabilitation, was suggested as a means of encouraging establishment of private sector programs. One speaker suggested that mental health funds be raised by state lottery.

PLAN FOR COMPLETION OF THE STUDY

As the Commission continues its work in 1985, it will hear 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 community services boards will address the Commission on the effectiveness of the current structure of the system from the community perspective. The Commission will review approaches to deinstitutionalization issues in other states and legal precedent influencing options in approaching deinstitutionalization. In the summer, JLARC will present its findings to the Commission.

The Commission will utilize this information to formulate preliminary recommendations, followed by a period of public comment in the fall. Final recommendations will then be developed for submission to the 1986 Session of the General Assembly.

Respectfully submitted,

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

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

DEINSTITUTIONALIZATION: PRELIMINARY RESEARCH PROPOSAL

JLARC's proposed research for the SJR 42 Commission will seek to determine whether the existing mental health and mental retardation systems are meeting the needs of the citizens of the Commonwealth. Particular attention will be paid to studying the implementation of the various policy changes recommended in the 1979 report.

Study Approach

As in the original 1979 study, the follow-up will involve several research areas: 1) Deinstitutionalization trends; 2) Deinstitutionalizing the mentally ill and the mentally retarded; and 3) Accountability. The study will combine an analysis of the statewide system with a more intensive analysis of several institutions and communities. System-level information will be obtained from several sources:

- DMHMR's Automated Reimbursement System (ARS)
- annual reports and other relevant institutional documents
- interviews with administrators of the state institutions
- interviews with the administrators of the CSBs
- records for a random sample of discharged clients.

The ARS system data will be analyzed to provide a description of clients treated in the State's mental health institutions. However, because the ARS system lacks data on a number of key variables (e.g., number of readmissions, type of treatment received), these data must be supplemented with data collected through other methods, from several other sources.

Among the data collection efforts proposed are a review of relevant documentation, interviews with staff in the institutions and CSB's, and a follow-up study of client records. This follow-up effort will involve collecting information from the records of a random sample of discharged clients, and tracking them through the hand-kept records maintained at the institutions and the CSBs. By collecting these data, more complete information can be obtained on prior hospitalizations and the types of services and treatment received by clients both before and after discharge. The analysis will result in an estimate of the number of clients, if any, that are unaccountable after a certain period of time following discharge. However, it will not provide any information on whether these clients become dropouts from the system, or actually become "street people."

Additionally, a sample of the records of clients who have been referred to CSB's during pre-screening will be examined. Analysis of the services provided to this group will help determine the broader impact of deinstitutionalization on the local mental health systems.

In addition to the statewide study, several case studies are also planned. Each case study will include in-depth interviews with institutional and community staff, as well as structured observations of selected wards and units. The focus of the case studies will be on process-level variables such as service delivery patterns and the quality of care provided.

Research Areas and Selected Issues

The following general research areas will comprise the scope of the study. Listed below each research area are substantive topics and selected questions that typify the focus of each aspect of the study.

Deinstitutionalization trends. The ARS system and other DMHMR data will be analyzed to determine:

1. Changes in state institutions since 1979 in the client population, staffing, quality of care, and admissions and discharge procedures.

   What are the criteria for deciding which clients will be admitted and discharged?

   How are the institutional populations changing? For example, are the severely mentally disabled becoming a larger proportion of institutional populations?

   What services are recidivistic clients receiving?

   Have the staffing levels changed since 1979? If so, in what ways?

2. Changes in the funding of community services since 1979.

   Are communities receiving sufficient funds for mental health services?

   What procedures are communities using when they contract for services?

3. Adequacy of management information for evaluation of the impact of deinstitutionalization.

Can discharged clients "slip through the cracks" between the data systems of institutions and communities?

Are the data collected by DMHMR and the CSB's sufficient to evaluate the effectiveness of the mental health system?

Deinstitutionalizing the mentally ill and the mentally retarded. JLARC will attempt to determine:

1. Characteristics of clients served by State institutions and CSB's.

What kinds of clients are being admitted to State institutions, and which clients are being discharged?

What is the average length of stay in an institution?

What kinds of clients are being referred to the CSB's during the pre-screen process?

2. Admissions and discharge policies and procedures at State institutions.

Is pre-discharge planning being conducted at all institutions? To what degree have improvements been made in the process since 1979?

To what extent do CSBs follow up on discharged clients?

3. Degree of cooperation between state institutions and communities in linking discharged clients with community services.

Where have prescription teams been implemented? To what degree are they viewed as effective in improving discharge procedures?

Are CSB's informed as to the service needs of discharged clients?

4. Migration patterns of discharged clients.

Are some communities receiving a disproportionate share of discharged clients?

Are CSB's keeping track of clients through case management?

5. Number and adequacy of services being offered in the community.

What community services are discharged clients receiving?

Are residents of homes for adults receiving community services?

How do the services required by patients referred to CSB's during pre-screening differ from those required by clients discharged from State instituitions?

What services are being provided by Federal, state, and local agencies other than DMHMR?

Accountability. The proposed research is designed to evaluate the present system of deinstitutionalization. Specifically, the focus is on who is taking ultimate responsibility for discharged individuals. Among the issues are:

Has DMHMR ensured service delivery to discharged clients through interagency coordination?

What responsibility does the discharging institution have for clients in the CSB's?

Have the Community Service Boards ensured service delivery to discharged clients through planning, funding, and evaluation?

Does the "core services" mandate appear to be an appropriate means for helping to ensure adequate service levels in the communities?

Do local governments ensure service delivery through oversight of the Community Service Boards?

Study Schedule

Comments on Reseach Proposal	Fall 1984
Completion of Detailed Research Design	Fall 1984
Completion of Fieldwork	Winter 1985
Report to SJR 42 Commission	Early Spring 1985
Publication of Final JLARC Report	Mid-Summer 1985