REPORT OF THE
DEPARTMENT OF MENTAL HEALTH AND MENTAL
RETARDATION AND SUBSTANCE ABUSE SERVICES ON

Consumer and Family Participation Study

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 47

COMMONWEALTH OF VIRGINIA
RICHMOND
1994

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

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TO: The Honorable Lawrence Douglas Wilder, Governor of Virginia
Members of the General Assembly

House Joint Resolution 713, adopted by the 1993 General Assembly, requested the Department of Mental Health, Mental Retardation and Substance Abuse Services to convene a task force to explore various approaches to increasing consumer and family representation on community services boards. The Department established the Consumer and Family Participation Study Committee to address HJR 713. The Committee included representatives from all of the major constituency and advocacy groups listed in the resolution and others, with more than 20 members altogether. HJR 713 directed the committee to submit its report to me for presentation to the Governor and the 1994 session of the General Assembly. I have the honor of presenting herewith the report of the ***Consumer and Family Participation Study*** for your consideration.

Respectfully submitted,

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House Joint Resolution 713

EXECUTIVE SUMMARY

House Joint Resolution 713 (Appendix A), adopted by the 1993 General Assembly, requested the Department of Mental Health, Mental Retardation and Substance Abuse Services to convene a task force to *explore various approaches to increasing consumer and family representation on community services boards* (CSBs).

The Department assembled a study committee of 20 consumers, advocates, and providers to address the charge in HJR 713. The Committee decided to expand its exploration to include other ways, in addition to greater representation on CSBs, to increase consumer and family participation in and involvement with the services system. The Committee met three times, engaging in open exchanges of many different points of view in a spirit of reasonableness and responsible compromise, to produce the following recommendations.

RECOMMENDATIONS

1. The following definitions of consumers should be included in § 37.1-1 of the Code of Virginia:

    - A primary consumer is a current or former direct recipient of public or private mental health, mental retardation or substance abuse treatment, training or habilitation services.

    - A secondary consumer is an immediate family member of a primary consumer or the principal care giver of a primary consumer. A principal care giver acts in the place of an immediate family member, including other relatives and foster care providers, but does not have a proprietary interest in the care of the primary consumer.

2. All primary and secondary consumer **representatives**, as defined in this report, shall identify themselves as consumers to the appointing authority and the CSB board of directors, without specifying a particular disability (mental illness, mental retardation or substance abuse) identity associated with their consumer status. Consumers shall not be required to identify themselves beyond this level (e.g. with a general public declaration) unless they desire to do so voluntarily.

3. § 37.1-195 of the Code should be amended to include a strong expectation that consumers will be appointed to community services boards. The following sentence should be added at the end of the first paragraph of § 37.1-195:

    - Appointments to the community services board shall be broadly representative of the community, to include primary and secondary consumers as defined in § 37.1-1.

4. The Committee also recommends the following other ways to encourage and support increased consumer participation on and involvement with community services boards:

- consider expanding the size of community services boards from the current five to 16 members to seven to 18 members;
- the State Board should insure that the Department and CSBs, in conjunction with consumer and advocacy organizations, provide education and training about serving on boards to consumers, family members, other principal care givers, and advocacy groups;
- the Department and the Virginia Association of CSBs should identify several CSBs that have been successful in having consumers appointed and publicize this information;
- the State Board should urge CSBs to develop and use advisory boards or committees in meaningful ways to increase opportunities for consumers to participate;
- the State Board and Department should encourage local governments to advertise and solicit nominations for CSB appointments from consumers and advocacy groups;
- the Department, with the Virginia Association of CSBs, should develop and provide orientation and training activities for members of CSB boards of directors;
- CSB boards of directors should meet regularly with consumer groups to develop and maintain communication and exchange information;
- CSB boards of directors should provide opportunities for consumers to function as apprentice or trainee board members in order to establish a pool of experienced potential appointees;
- CSB boards of directors should offer experienced board members to serve as mentors for new members;
- boards shall provide appropriate accommodation when requested by members;
- the State Board should promulgate a strong policy on consumer involvement with and participation on CSBs;
- the Department and CSBs should also consider the following strategies:
  - employ consumers,
  - conduct consumer surveys,
  - train staff and CSB board members, and
  - use focus groups, public hearings, and forums.

Consumer and Family Participation Study

BACKGROUND

The 1993 General Assembly enacted House Joint Resolution 713, which requested that the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) convene a task force *to explore various approaches to increase consumer and family representation on community services boards* (CSBs). Appendix A contains a copy of the resolution. HJR 713 identifies several reasons for conducting this study.

- ★ Consumer and family involvement in service planning and decision making is essential to **creating a collaborative system of care** that focuses on the quality of life of people with or at risk of developing serious mental illness, mental retardation or severe alcohol or other drug dependence.

- ★ Nationally, consumers and family members are becoming more involved in developing treatment programs, policies, and regulations affecting the delivery of services.

- ★ Lack of opportunity for significant consumer and family member involvement in planning and policy and decision making has been identified as one of the barriers to an integrated system of quality care.

- ★ A working partnership among consumers, families, and service providers reduces the stigma of mental disability and promotes a shared vision of care and improved quality of life for consumers.

- ★ While some Virginia communities have meaningful participation of consumers and families on CSBs, membership and participation are not consistent statewide.

- ★ In a survey conducted by the Department for the 1991 Comprehensive State Plan, CSBs identified only 54 family members and two consumers out of 500 board members.

The Mental Health Planning Council, established pursuant to Public Law 99-660, has been very interested in expanding the roles and influence of consumers and family members in the services system. The Council played a vital part in securing the passage of HJR 713.

The Department's strategic examination of the public mental health, mental retardation, and substance abuse services system, the Visions process, also emphasizes the crucial importance of consumer and family involvement and participation. This emphasis is reflected in the documents produced by many of the six Visions

Committees. The Values, Mission and Participation Committee is examining ways to increase consumer and family participation.

House Joint Resolution 713 listed a broad range of organizations and interests that should be represented on the task force. It also allowed the Department to include other representatives. Study Committee members and the interests they represent are:

- James C. Windsor, Ed.D., Study Committee Chairman, former Chairman of the State Mental Health, Mental Retardation and Substance Abuse Services Board
- Mr. S. James Sikkema, President Mental Health Association of Virginia
- Ms. Joyce Kube, Parents and Children Coping Together
- Mr. Beverly Flemming, President Virginia Alliance for the Mentally Ill
- Ms. Ginger Quillen, President Virginia Mental Health Consumers Association
- Mr. Rob Gabriele, Mental Health Planning Council
- Mr. Lloyd Barrett, Regional Vice President Arc of Virginia
- Mr. LeRoy Aarons, Parents and Associates of the Institutionalized Retarded
- Mr. Franklin C. Rockwell, President Virginia Association of Drug and Alcohol Programs
- Mr. Henry Altice, Co-Chairman Coalition for Mentally Disabled Citizens of Virginia
- Mr. Raymond F. Burmester, Coalition Co-Chairman
- The Honorable Emilie F. Miller, Coalition Co-Chairman
- Mr. Gene Krumnacher, Piedmont Regional Community Services Board member, Virginia Association of CSBs representative
- Dennis I. Wool, Ph.D., Virginia Beach Community Services Board Executive Director and VACSB representative
- Mr. Tony Conyers, Virginia Municipal League
- Ms. Billie Lynch, Virginia Association of Counties
- Ms. Mary Ann Beall, State Mental Health, Mental Retardation and Substance Abuse Services Board member
- Mr. David Young, President, People First of Virginia
- Ms. Betty Williams, Family Support Advocacy Committee
- Ms. Rita J. Gliniecki, Blue Ridge Community Services Chairman

HJR 713 requires the Study Committee to submit a report to the Commissioner of the DMHMRSAS, who will submit it to the Governor and the 1994 Session of the General Assembly. This report fulfills that requirement. It is divided into five sections:

- Background
- Methodology
- Definition of Consumer
- Public Identification of Consumers
- Increasing Consumer Involvement

METHODOLOGY

Given the variety of expertise, breadth of interests, and depth of experience reflected among its members, the Committee relied on intensive group discussion and dialogue to conduct this study. The Committee met three times over the summer.

At its initial meeting, DMHMRSAS Commissioner King Davis offered several points for the Committee to consider.

- ⊕ An increased focus on quality always starts with consumers of the service having the opportunity to define quality.
- ⊕ Increasing consumer and family involvement and participation in the system is a priority for the Department.
- ⊕ New knowledge about treatment, rehabilitation, prevention, and the etiology of mental disabilities is emerging constantly.

Dr. Davis expressed his hope that Committee members could integrate the variety of interests and parts of the system they represent in ways that have not occurred before.

Dr. Windsor reviewed the Committee's charge in HJR 713 and suggested a work plan to accomplish it. Possible key issues proposed for the study included:

- defining consumers and family members,
- proportions of representation across program areas (mental health, mental retardation, and substance abuse),
- proportions of consumer and family member representation,
- involvement of local governments,
- other ways to increase consumer and family involvement and participation, and
- implementation approaches.

The Committee reviewed current information about CSB board member appointments. § 37.1-195 and 196 of the Code of Virginia do not specify who shall be appointed to CSBs, except there is a limit of one elected local government official per locality. Results of the 1991 and 1993 profiles of CSB membership, gathered for the Comprehensive State Plan, are displayed in the following table.

Community Services Board Appointments			
	1991	1993	Change
Consumer Board Members	2	17	750%
Family Board Members	54	90	67%
Total Consumer/Family Members	56	107	91%
Total of All Board Members	490	494	NA
Percent of All Board Members	11%	22%	100%

The 1993 profiles show 28 CSBs (70 percent) with no consumer members and seven (18 percent) with no family members. The proportion of consumers and family members as a percentage of all appointments varies for individual CSBs from zero to 60 percent; the average is 22 percent. A concern was raised that this does not match espoused system values about consumer and family participation. While profile information may need to be updated, the overall picture is more important than the accuracy of individual CSB statistics.

§ 37.1-3 of the Code requires that no less than one-third of the State Board members be consumers or family members and that at least one member be a consumer and one be a family member of a consumer. § 51.5-47 through 52 require no less than 30 percent of all appointments to the 44 new Disability Services Planning Boards be consumers or family members of consumers.

This information and the work plan served as departure points for the Committee's deliberations, which extended through the second and third meetings. Frank discussions, open exchanges of many different points of view, and a spirit of reasonableness and responsible compromise characterized these very productive sessions. The results of those deliberations are reflected in the consensus recommendations in the remainder of this report.

DEFINITION OF CONSUMER

In the early history of community services boards (CSBs), many boards contained large numbers of parents as members. Now, this situation may have changed too much, with family members and consumers under represented. For CSBs to be more effective and accountable, appointments should be balanced among consumers, family members, professionals, and the general public. On Disability Services Planning Boards, a consumer is defined as a past or current recipient of services from the Department of Rehabilitative Services. Another concept defines consumer as the recipient of services and the customer as the agency buying or the community supporting the service.

The Committee reached consensus at its first meeting on *the value of consumer and family participation*. The emphasis or insistence on consumer representation presumes that a particular point of view needs to be communicated. Thus, it is important to define the consumer and to establish consumer credentials.

Possible definitions of consumers include people:

- presently receiving or who have received public services,
- presently receiving or who have received services,
- who identify themselves as consumers,
- with a diagnosis or disability identified by staff,
- at a specified functioning level or
- in the community/general population.

In their deliberations, Committee members voiced many observations, including the following comments, about the **definition of a consumer**.

- The boundary line between public and private is blurring in some parts of Virginia and it will become more ambiguous with national health care reform.

- We need to clarify notions of consumer, customer, and client. This is a very complex subject with at least three distinct dimensions: consumers, family members, and the community. Also, are consumers those we serve now or those we want to serve in the future?

- The definition may blur with families of consumers who are extremely disabled. Then the family member may become the consumer.

- The definition needs to be as broad and inclusive as possible while still maintaining a focus on our service populations.

- Consumers will define themselves. Because of the stigma associated with disabilities, people who are not consumers would not identify themselves as consumers.

- Recipients of prevention services are consumers of those services but not of treatment services. Prevention falls under public health rather than mental health.

- Family members are secondary consumers and the vital role of care givers who are not immediate family members also should be recognized.

★ A consensus emerged that the definition should include recipients of public and private services. It was also recognized that board member effectiveness, while important, should not be defined only in terms of competencies that may deny appointments to consumers with cognitive disabilities. Instead, effectiveness should be assessed in terms of the different abilities, life experiences, and perspectives needed to assure a balanced and representative board. **The Committee adopted the following definitions of consumers and recommended that they be included in § 37.1-1 of the Code of Virginia, lending them increased visibility and authority.** Appendix B contains a copy of this proposed legislation.

- **A primary consumer is a current or former direct recipient of public or private mental health, mental retardation or substance abuse treatment, training or habilitation services.**

- **A secondary consumer is an immediate family member of a primary consumer or the principal care giver of a primary consumer. A principal care giver acts in the place of an immediate family member, including other relatives and foster care providers, but does not have a proprietary interest in the care of the primary consumer.**

Throughout the remainder of this report, the term consumer should be understood to include primary and secondary consumers, including immediate family members or other principal care givers.

PUBLIC IDENTIFICATION OF CONSUMERS

Considerable discussion occurred about the desirability, necessity or appropriateness of publicly identifying consumer appointments.

- Voluntary self disclosure of consumer status is desirable.

- Concerns about confidentiality and anonymity need to be recognized, especially in the alcohol and drug abuse community.

- Publicly identifying as a consumer was described as an act of courage that breaks down stigma.

- Public visibility affects credibility of representation.

- Being a publicly identified consumer binds that person to concerns of other silent consumers who cannot represent the broader consumer community.

- ♦ Consumer representatives need to be accountable back to the whole consumer community.

- ♦ Does public identification mean within the community services board (CSB) or before the general public?

- ♦ Identification of a consumer's specific disability (mental illness, mental retardation or substance abuse) is not as significant as his or her identity as a consumer generally.

- ♦ "Differently abled" was suggested in place of disabled.

- ♦ There is a need to have consumers appointed to CSBs who are able to publicly and willingly say what they want, need, and prefer.

- ♦ Disclosure of consumer status at some level (e.g., to the appointing authority) is needed to monitor and assess consumer representation and participation.

- ♦ Public disclosure of consumer status could help overcome the stigma associated with disabilities and dispel long-standing misperceptions held by the general public and many providers about the capabilities of consumers.

Committee members agreed it is useful and desirable for consumers of mental health and mental retardation services to be publicly identified in some way. Concerns exist about public identification of recipients of substance abuse services because confidentiality is a cornerstone of those programs. Mandatory self disclosure would be a disservice to that value and a possible violation of Federal regulations.

★ The Committee achieved a consensus about publicly identifying consumers and adopted the following position.

- ☞ *All primary and secondary consumer* ***representatives,*** *as defined in this report, shall identify themselves as consumers to the appointing authority and the CSB board of directors, without specifying a particular disability (mental illness, mental retardation or substance abuse) identity associated with their consumer status. Consumers shall not be required to identify themselves beyond this level (e.g. with a general public declaration) unless they desire to do so voluntarily.*

INCREASING CONSUMER INVOLVEMENT AND PARTICIPATION

The Committee agreed on the obvious value of consumer involvement and participation on community services boards (CSBs).

- Consumers are sensitized to issues involved in obtaining services in ways that other board members never could be.

- Consumers provide a different and valuable perspective on what it is like to need and receive services.

- Total quality management, now being implemented by many government agencies, encourages involving customers as a good feedback loop for organizations committed to quality.

The Committee considered various ways to increase consumer involvement. Much of the discussion concerned whether statutorily mandating consumer appointments to CSBs would increase current levels of participation by consumers since many CSBs already have consumers serving on them. Many Committee members supported a mandate. Other members expressed reservations about the feasibility of a mandate.

Members offered many comments, including those listed below, about a statutory mandate for consumer appointments to CSBs.

- Other states have enacted consumer participation mandates.

- Mandates are a simple solution but the wrong answer. They could lead to boards of unwieldy size and they are probably not possible now, given political realities.

- Mandates would be particularly difficult for multijurisdictional CSBs to implement, because of the complexity of balancing and distributing specific mandates and coordinating a variety of potential appointments among several local governments.

- § 37.1-195 establishes the number of appointments to CSBs. Currently, this ranges from five to 16 members. Implementing mandatory consumer appointments on CSBs with only five to ten members could be very difficult.

- Rather than specifying a number of consumers on CSBs, the mandate could identify a percentage of appointments for consumers to hold.

- One Committee member observed that meaningful social change comes from below rather than above. Therefore, instead of a legal mandate, consumer involvement should be stated as a goal, perhaps in a State Board policy that affirms the value and necessity of consumer participation on CSBs.

- A State Board policy, by itself, is not a viable approach. A Code change is needed because this issue affects local governments, which are not governed by State Board policies.

- While local governments would not disagree with the value of consumer representation, they would have serious reservations about mandates for consumer appointments to CSBs, viewing them as unrealistic and unworkable. This would be especially true for very detailed mandates, such as numbers of members, precise proportions, and particular types of disabilities. Instead, consumer participation should be stated as our goal and ways to reach it without mandates should be identified. Local governments would be very supportive of some method to set and monitor goals combined with ways to surface potential appointees and urge local governments to appoint significant numbers of consumers.

- Local governments want to place consumers on boards but such individuals are difficult to find. Volunteerism is a real problem, especially in rural areas.

- If encouragement and voluntary approaches had worked, this Committee would not exist. If it does not recommend mandated appointments, the Committee is wasting its time.

- A balance of consumers, professionals, and the general public should be maintained in appointments to CSB boards of directors.

- The membership provisions enacted for the State Mental Health, Mental Retardation and Substance Abuse Services Board in the last General Assembly session should be adopted for community services boards (CSBs). § 37.1-3 requires at least one third of the State Board appointments to be consumers or family members.

- Mandates are not the answer. Education and persuasion need to be used instead to increase consumer participation.

- HJR 713 establishes the need for more consumer involvement. Since it is necessary, it should be mandated. In an ideal world, persuasion would be enough. It has worked at many but not all places in the CSB system. Consequently, it needs to be mandated where it is not forthcoming.

- Even if a statutory mandate were enacted, quotas (e.g., proportional representation for each disability area) should be avoided.

- ◻ Local government concerns about mandates should be carefully considered. If local governments do not support a mandate, it will be very difficult to secure passage by the General Assembly.

★ The Committee reached the following consensus about enacting legislation to increase consumer participation on and involvement with community services boards (CSBs).

- ☞ *§ 37.1-195 of the Code should be amended to include a strong expectation that consumers will be appointed to community services boards.* This Code change should not mandate appointments at this time. If the recommended language does not achieve this result, a mandate can be added later. The language also should not specify quotas of different types of consumers. The following sentence should be added at the end of the first paragraph of § 37.1-195:

  Appointments to the community services board shall be broadly representative of the community, to include primary and secondary consumers as defined in § 37.1-1.

  Appendix B contains a copy of this proposed legislation.

Committee members observed that many CSBs already include consumers on their boards of directors. The proposed revision of § 37.1-195 would provide direction to the remaining local governments to appoint consumers to the other community services boards, based on experience with the basic CSB legislation.

Chapter 10 of Title 37.1, the statute under which community services boards are created, was permissive until 1980. By then, local governments had established 36 CSBs that covered about 95 percent of the state's population. To assure the availability of services statewide, a legislative study commission recommended amending § 37.1-194 to mandate that all local governments establish or join a community services board by July 1, 1983. That mandate spurred the remaining localities to establish CSBs, achieving statewide coverage. This same approach should be used to address the issue of consumer appointments to CSBs.

☐ The Committee also discussed other **ways to encourage and support increased consumer participation on and involvement with community services boards.**

- ⊠ Consider *expanding the size of community services boards* from the current five to 16 members to **seven to 18 members.** This would increase opportunities for appointing consumers to CSBs and enable balance and representation concerns to be addressed more easily. There appeared to be general support for this proposal among Committee members.

- The State Board should insure that the Department and CSBs, in conjunction with consumer and advocacy organizations, *provide education and training* to consumers, family members, other principal care givers, and advocacy groups. Topics should include:

  ✓ general information about the Department and its functions,
  ✓ general information about community services boards,
  ✓ how to get appointed to a CSB, and
  ✓ how to be an effective board member if appointed.

  This recommendation also received strong support from many Committee members.

- The Department and Virginia Association of Community Services Boards (VACSB) should identify several CSBs that have been very successful in having consumers appointed. Develop *case studies* about how those CSBs did this and publicize the information in *Virginia Town and Country* and similar publications.

- The State Board should urge community services boards to develop and use *advisory boards or committees* in meaningful ways. This would increase opportunities for consumers to participate in CSB board of directors decisions and deliberations. Some CSBs already do this.

- The State Board and the Department should encourage local governments, city councils and boards of supervisors, to *advertise and solicit nominations actively* from consumers and advocacy groups for CSB appointments.

- The Department, in concert with the Virginia Association of Community Services Boards, should develop and provide *orientation and training activities for members of CSB boards of directors*, especially new members who are consumers.

- CSB boards of directors should *meet regularly with consumer groups* to develop and maintain communication and exchange information.

- CSB boards of directors should provide opportunities for consumers to function as *apprentice or trainee board members* in order to establish a pool of experienced potential appointees.

- CSB boards of directors should offer an experienced board member to serve as a *support person or mentor* for a new CSB member.

- Boards of directors shall provide appropriate accommodation when requested by members. This could include interpreter services, telecommunications devices for the deaf (TDD) or other assistive communication technologies, and personal assistance services or other accommodation required by the Americans With Disabilities Act.

- The State Board should promulgate and monitor the implementation of a *strong policy* on consumer involvement with and participation on community services boards (CSBs). This policy should:

  - ✓ reflect the intent of the revised § 37.1-195,
  - ✓ urge CSB boards of directors to use advisory boards or committees to increase consumer involvement in their operations,
  - ✓ require provision of the education and training described in a preceding recommendation, and
  - ✓ encourage balancing competing interests (mental health, mental retardation, and substance abuse) at the local level in appointments of consumers to CSBs.

- The Department and community services boards should also consider and use the following strategies to increase consumer participation on and involvement with CSBs:

  - ⊕ employ consumers,
  - ⊕ conduct consumer surveys,
  - ⊕ train staff and CSB board members, and
  - ⊕ use focus groups, public hearings, and forums.

CONCLUSION

The Consumer and Family Participation Study Committee has fulfilled its charge, as defined in House Joint Resolution 713. Through extensive deliberations and consensus building, the Committee developed a set of feasible and practical recommendations that, if carried out, would increase consumer involvement with and participation on community services boards substantially across Virginia. The Study Committee strongly endorses the legislative proposal in Appendix B of this report and urges expeditious implementation of that proposal.

APPENDIX A

GENERAL ASSEMBLY OF VIRGINIA--1993 SESSION

HOUSE JOINT RESOLUTION NO. 713

Requesting the Department of Mental Health, Mental Retardation and Substance Abuse Services to convene a task force to examine the feasibility of increasing consumer and family representation on community services boards.

Agreed to by the House of Delegates, February 4, 1993
Agreed to by the Senate, February 16, 1993

WHEREAS, consumer and family involvement in planning and decision making is essential to developing a collaborative system of care focusing on the quality of life of people with or at risk of severe mental disability or substance abuse problems; and

WHEREAS, nationally, consumers and family members are becoming increasingly involved in the development of treatment programs, policies and regulations affecting the delivery of services; and

WHEREAS, the lack of opportunity for significant involvement of consumers and family members in planning, policy and decision making has been identified as one of the barriers to a high quality, well-integrated system of care; and

WHEREAS, a working partnership between consumers, families and service providers reduces the stigma of mental disability and promotes a shared vision of care and improved quality of life for persons with severe mental disability or substance abuse problems; and

WHEREAS, while some Virginia communities have meaningful participation of consumers and families on community services boards, membership and participation are not consistent statewide; and

WHEREAS, although the number of consumers and family members on community services boards is not known, a survey conducted by the Department of Mental Health, Mental Retardation, and Substance Abuse Services for the 1991 Comprehensive Planning Process found, from a total of 500 membership seats, only 54 family members and two consumers; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Mental Health, Mental Retardation and Substance Abuse Services be requested to convene a task force to explore various approaches to increasing consumer and family representation on community services boards.

The task force shall include representatives of the following: the Mental Health Association of Virginia, Parents and Children Coping Together, The Virginia Alliance for the Mentally Ill, the Virginia Mental Health Consumers Association, Mental Health Planning Council of Virginia, ARC of Virginia (formerly the Association for Retarded Citizens), Parents and Associates of the Institutionalized Retarded, Virginia Association of Drug and Alcohol Programs, the Virginia Association of Community Services Boards, the Virginia Municipal League, the Virginia Association of Counties, and other appropriate representatives.

The task force shall submit a report to the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services who will submit this report to the Governor and the 1994 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Proposed Legislation

House/Senate Bill No. ______

A Bill to amend and reenact §§ 37.1-1 and 37.1-195 of the Code of Virginia, relating to consumers as members of Community Services Boards.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended as follows:

§ 37.1-1. Definitions. - As used in this title except where the context requires a different meaning or where it is otherwise provided, the following words shall have the meaning ascribed to them:

"Board" means the State Mental Health, Mental Retardation and Substance Abuse Services Board;

"Client," as used in Chapter 10 (§ 37.1-194 et seq.) of this title, means any person receiving a service provided by personnel or facilities under the jurisdiction or supervision of a community services board;

"Commissioner" means the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services;

"Community services board" means a citizens' board established pursuant to § 37.1-195 which provides mental health, mental retardation and substance abuse programs and services within the political subdivision or political subdivisions participating on the board;

"Consumer" or "primary consumer" means a current or former direct recipient of public or private mental health, mental retardation or substance abuse treatment, training or habilitation services. When modified by the word secondary, it means an immediate family member of a consumer or the principal care giver of a consumer. A principal care giver acts in the place of an immediate family member, including other relatives and foster care providers, but does not have a proprietary interest in the care of the consumer;

"Department" means the Department of Mental Health, Mental Retardation and Substance Abuse Services;

"Director" means the chief executive officer of a hospital or a training center for the mentally retarded;

"Drug addict" means a person who: (i) through use of habit-forming drugs or other drugs enumerated in the Virginia Drug Control Act (§ 54.1-3400 et seq.) as controlled drugs, has become dangerous to the public or himself; or (ii) because of such drug use, is medically determined to be in need of medical or psychiatric care, treatment, rehabilitation or counseling;

"Facility" means a state or private hospital, training center for the mentally retarded, psychiatric hospital, or other type of residential and ambulatory mental

health or mental retardation facility and when modified by the word "state" it means a facility under the supervision and management of the Commissioner;

"Hospital" or "hospitals" when not modified by the words "state" or "private" shall be deemed to include both state hospitals and private hospitals devoted to or with facilities for the care and treatment of the mentally ill or mentally retarded;

"Alcoholic" means a person who: (i) through use of alcohol has become dangerous to the public or himself; or (ii) because of such alcohol use is medically determined to be in need of medical or psychiatric care, treatment, rehabilitation or counseling;

"Judge" includes only the judges and substitute judges of general district courts within the meaning of Chapter 4.1 (§ 16.1-69.1 et seq.) of Title 16.1 and of family courts within the meaning of Chapter 11 (§ 16.1-226 et seq.) of Title 16.1, as well as the special justices authorized by § 37.1-88;

"Legal resident" means any person who is a bona fide resident of the Commonwealth of Virginia;

"Mental retardation" means substantial subaverage general intellectual functioning which originates during the development period and is associated with impairment in adaptive behavior;

"Mentally ill" means any person afflicted with mental disease to such an extent that for his own welfare or the welfare of others, he requires care and treatment; provided, that for the purposes of Chapter 2 (§ 37.1-63 et seq.) of this title, the term "mentally ill" shall be deemed to include any person who is a drug addict or alcoholic;

"Patient" or "resident" means a person voluntarily or involuntarily admitted to or residing in a facility according to the provisions of this title;

"Private hospital" means a hospital or institution which is duly licensed pursuant to the provisions of this title;

"Private institution" means an establishment which is not operated by the Department and which is licensed under Chapter 8(§ 37.1-179 et seq.) of this title for the care or treatment of mentally ill or mentally retarded persons, including psychiatric wards of general hospitals;

"Property" is used in §§ 37.1-12 and 37.1-13 includes land and structures thereon;

"State hospital" means a hospital, training-school or other such institution operated by the Department for the care and treatment of the mentally ill or mentally retarded;

"System of facilities" or "facility system" means the entire system of hospitals and training centers for the mentally retarded and other types of facilities for the residential and ambulatory treatment, training and rehabilitation of the mentally ill and mentally retarded as defined in this section under the general supervision and management of the Commissioner;

"Training center for the mentally retarded" means a regional facility for the treatment, training and habilitation of the mentally retarded in a specific geographical area.

§ 37.1-195. Community services board; appointment; membership; duties of fiscal agent. - Every city, county or combination of counties or cities or counties and cities establishing a community mental health, mental retardation and substance abuse services program, before it shall come within the provisions of this act, shall establish a single community services board, with neither less than five nor more than fifteen members, except that any board established by four or more cities, counties or combination thereof may consist of as many as sixteen members. When any city or county singly establishes a program, the board shall be appointed by the governing body of the local political subdivision establishing such a program. When any combination of counties or cities or counties and cities establishes a community services program, the board of supervisors of each county in the case of counties or the council in the case of cities shall establish the size of the board, shall elect and appoint the members of the board and shall designate an official of one member city or county to act as fiscal agent for the board. Appointments to the community services board shall be broadly representative of the community, to include primary and secondary consumers as defined in § 37.1-1.

The county or city which comprises a single board and the county or city whose designated official serves as fiscal agent for the board in the case of joint boards shall annually audit the total revenues of the board and its programs and shall, in conjunction with the other participating political subdivision in the case of joint boards, arrange for the provision of legal services to the board.

No such board shall be composed of a majority of elected officials as members, nor shall any county or city be represented on such board by more than one elected official.

The board appointed pursuant to this section shall be responsible to the governing body or bodies of the county or city or combination thereof which established such board.