Joint Legislative Audit and Review Commission

The Virginia General Assembly

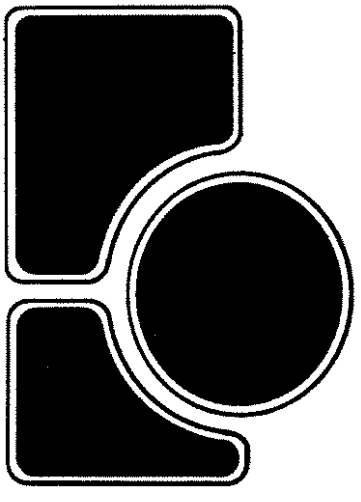
DEINSTITUTIONALIZATION AND COMMUNITY SERVICES

A staff report to the
Commission on Deinstitutionalization.

STAFF REPORT OF THE
JOINT LEGISLATIVE
AUDIT AND REVIEW COMMISSION ON

Deinstitutionalization and Community Services

TO THE
COMMISSION ON
DEINSTITUTIONALIZATION



COMMONWEALTH OF VIRGINIA
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PREFACE

Senate Joint Resolution 42 (1984) created the Commission on Deinstitutionalization, and directed that the staff of the Joint Legislative Audit and Review Commission provide technical assistance to the commission. This report presents the results of the research which we completed for the Commission on Deinstitutionalization. The findings and recommendations of the report were presented to the commission in August 1985, and the General Assembly acted on many of the recommendations in the 1986 Session.

Since our first report on Deinstitutionalization and Community Services in 1979, substantial improvements have been made in the Commonwealth's mental health system. Pre-admission screening and pre-discharge planning have been widely implemented. Community services boards have been established for every locality in the State, and generally the level of services available to clients has improved.

Our research for the Commission on Deinstitutionalization has shown, however, that much more remains to be done. At the State level, additional improvements in client management procedures are needed. Greater efforts are needed to ensure that clients are linked to local services. Improvements in outreach programs could be especially productive.

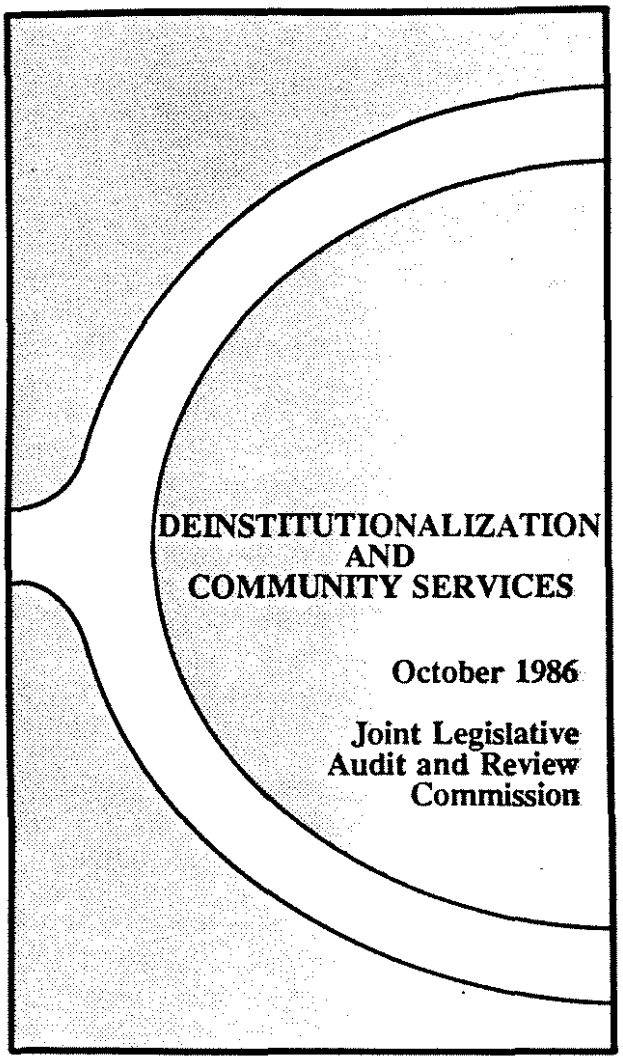
At the local level, the overwhelming need is for a broader range of services to ensure that the continuum of care is available to all clients. There is also a need for improved housing. Homes for adults should be more closely linked to the mental health system if they are to house chronically ill clients.

Finally, we found a need for improved accountablility. Responsibilities are currently split among several State and local agencies. Coordination of these services is critical to the success of clients in the community. While improvements have been made since 1979, additional efforts to provide for clear accountability would improve the service delivery system.

On behalf of the Commission staff, I wish to thank the Department of Mental Health and Mental Retardation, the Department of Social Services, and the 40 community services boards for their cooperation.

Philip A. Leone
Director

October 2, 1986



"Deinstitutionalization" refers to the process by which the primary treatment responsibility for the mentally disabled is transferred from State mental health and mental retardation facilities to service providers in community-based settings. The process of discharging clients and linking them successfully with community services involves a number of different agencies, treatment and support services, and procedures. The policy cannot be effective unless each and every component is implemented well.

Since the late 1960s, there have been sustained efforts across the country to encourage the deinstitutionalization process. These efforts have occurred for a number of reasons. First, the idea of limiting the role of large facilities and reducing institutional populations received the support of mental health professionals and policy specialists. Large state mental institutions were perceived by some observers as providing primarily a "custodial" type of care that carried a stigma and deprived clients of their liberty, dignity, and ability to reach their fullest potential. A working consensus was reached that therapeutic mental health care could occur most effectively and efficiently within the context of "normal home and community ties."

A JLARC REPORT SUMMARY

Deinstitutionalization first became legislative policy in Virginia in 1968 when the General Assembly passed Chapter 10 of Title 37.1, *Code of Virginia.* Chapter 10 enabled local jurisdictions to establish community health and mental retardation service boards. Between 1970 and 1972, legislative and executive interest in deinstitutionalization was expressed in reports from the Governor's Commission on Mental Health, Indigent, and Geriatric Patients (also known as the "Hirst Commission").

Spurred by findings of deplorable conditions and inadequate treatment in State residential facilities, the Hirst Commission made a number of policy recommendations supporting the concept of deinstitutionalization. The commission recommended that spending on community mental health services be increased and institutional populations be deceased. It also urged that State and community services be coordinated by increasing the leadership role of the Department of Mental Health and Mental Retardation (DMHMR). As a result of the Hirst Commission's recommendations, reduction of institutional populations became the policy of DMHMR in 1972, with the goal of reducing institutional populations by ten percent each year over a five-year period.

Recently, the policy of deinstitutionalization and community-based care for the mentally disabled has been questioned on a number of grounds. While there is consensus on the promise of deinstitutionalization, some observers have criticized the actual practice of deinstitutionalization as consisting of little more than the "dumping" of chronically mentally ill persons onto the city streets.

As a result of these concerns, Senate Joint Resolution 42 of the 1984 Session established the Commission on Deinstitutionalization to study the policies and practices in use in Virginia. The resolution called on the staff of the Joint Legislative Audit and Review Commission (JLARC) to provide technical assistance to the commission.

The Service Delivery System (pp. 7-11).

The formal mental health network consists of the Department of Mental Health and Mental Retardation (DMHMR), the State hospitals operated by DMHMR, and the 40 local community services boards (CSBs). The State Board of Mental Health and Mental Retardation is responsible for setting policy for the entire system. DMHMR is the primary source of funds for CSB services, provides technical assistance to the CSBs, and monitors the quality of local programs. The provision of community services is the primary responsibility of CSBs. Local services are offered to mental health, mental retardation, and substance abuse clients either directly by CSB staff or through contracts with private service providers. Over the past 15 years, 40 community services boards have been created across the State. Every city and county in Virginia is now served by, and provides financial support for, one of the CSBs. Residents are eligible to receive services from the CSB in which their locality participates.

In addition, a less formal network of State and local agencies provides a range of support services such as financial support, housing, and job training to the mentally disabled, as well as to the general population. While these are not mental health services, they are critical to the success of deinstitutionalized clients in the community.

The Deinstitutionalization Process (pp. 11-15).

The deinstitutionalization process begins when a client is first identified as having a need for mental health, mental retardation, or substance abuse services. A client might seek services voluntarily. Or, clients can be identified by courts, social service agencies, or other State and local agencies. Once a client has been identified, the CSB is responsible for preadmission screening, which is the process used to evaluate the client's need for hospitalization. Should hospitalization be required, the client is admitted to one of 15 State facilities for treatment. Ideally, as soon as the client is admitted, the process of pre-discharge planning begins. The purpose of pre-discharge planning is to ensure that a client's post-hospitalization service needs are identified, and that necessary resources are made available to the client upon discharge.

Upon discharge, the client is referred to the CSB responsible for the original preadmission screening. Services may be provided at the local level by a number of agencies or private providers. Services can include day treatment programs, psychosocial rehabilitation, transitional employment, counseling, medication monitoring, residential services, and many others. In some instances, inpatient treatment may also be available in the community.

The "Continuum of Care" Concept (pp. 16-18).

The diversity of clients discharged from State mental health hospitals and training centers as well as the changing nature of conditions such as mental illness and substance abuse create a need for a "continuum of community care." Continuum of care refers to the availability of a range of alternative services both to meet the treatment needs of different populations and to meet the changing treatment needs of clients as they acquire new skills and adjust to the community. The continuum of care should make available to each client the appropriate treatment, training, and care in the least restrictive environment.

The concept of a continuum of care was promoted by the Commission on Mental Health and Mental Retardation (also known as the "Bagley Commission") in 1980. The continuum of care was seen as a central element in establishing a comprehensive community-based system of care. The commission stressed the importance of accessibility of services to clients, regardless of where they might reside in the State. Thus, the commission recommended that each CSB provide mental health, mental retardation, and substance abuse services necessary to ensure that appropriate and adequate services are offered to all clients of all disabilities.

Through the Bagley Commission a list of core services was developed. Since 1980, the list has been modified and elaborated into a taxonomy of service categories. The taxonomy includes six core service categories: inpatient services, day support services, residential services, outpatient and case management services, prevention and early intervention services, and emergency services.

Client Management (pp. 19-32).

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

Under the Department of Mental Health and Mental Retardation's (DMHMR) client management procedures, the responsibility for managing a mentally disabled client's treatment program in both the hospital and the community rests with the community services board. Client management procedures are intended to ensure that: (1) hospital and CSB staff coordinate treatment plans, (2) the client's ongoing needs for treatment and supervision will be met in the community upon discharge, (3) inappropriate admissions are reduced, and (4) hospital stays are reduced to a minimum.

Client management is comprised of three primary activities: pre-admission screening, pre-discharge planning, and the transfer of primary treatment responsibility from the hospital to the community.

Pre-admission Screening. Overall, DMHMR's pre-admission screening guidelines have been successful in reducing the statewide hospital census and in establishing focused, working relationships between CSBs and hospitals. DMHMR and JLARC staff data indicate that the effectiveness of the pre-admission screening guidelines could be further enhanced by requiring all admissions to be screened by a CSB, further specifying criteria and procedures for hospital admissions, and providing training for all individuals who implement pre-admission screening procedures.

Recommendation (1). The General Assembly may wish to modify section 37.1-67.3 of the Code of Virginia to require that all candidates for hospitalization (including transfers from other facilities) be screened by the appropriate community services board. Specifically, the General Assembly may wish to require that a pre-admission screening assessment be obtained before any steps to detain or involuntarily commit an individual can be taken.

Recommendation (2). DMHMR should make local providers aware that all candidates for hospitalization must be screened by CSB staff.

Recommendation (3). DMHMR should develop specific operational criteria and provide additional specific procedures to be used by pre-admission screeners to ensure uniform implementation of evaluations of clients.

Recommendation (4). DMHMR should establish minimum qualifications for pre-admission screeners. Minimum qualifications should include completion of a training course which results in certification in the clinical and legal interpretation and implementation of pre-admission screening guidelines and procedures.

Pre-discharge Planning. In its 1979 report, JLARC staff found considerable deficiencies in the identification of client needs and in the coordination among institutional and community service agencies in providing services to clients upon their discharge. In response, DMHMR established pre-discharge planning as the key mechanism for ensuring that clients' post-hospitalization needs are identified and that necessary resources are made available in the community.

Pre-discharge planning is the process used in State facilities to prepare for the smooth transition of clients from the hospital to the community. The process has three major components: (1) notification of local service agencies of the pending discharge, (2) identification and arrangement for necessary community services, and (3) preparation of the client for his release.

While there has been significant progress in the development and implementation of pre-discharge guidelines, the usefulness of the pre-discharge plan is lessened when it fails to address comprehensively the client's community support and treatment needs, and when information concerning the client's discharge is not communicated to the CSB in a timely manner.

To be effective, pre-discharge planning must systematically assess each client's needs for treatment and support services. After the client's needs are identified, necessary program resources must be made available so that the client can make a successful transition from the hospital to the community.

Recommendation (5). DMHMR should develop a uniform pre-discharge assessment and planning instrument to be used by all State hospitals. To ensure comprehensive planning for the client's transition into the community, the form should include a checklist of necessary services including, but not limited to treatment, housing, nutrition, financial, rehabilitative, and medical needs.

Recommendation (6). DMHMR should establish and incorporate specific time guidelines into the client management guidelines for hospitals to use in preparing pre-discharge information for CSBs and for notifying CSBs of anticipated and actual discharge dates. These guidelines should ensure that CSBs have adequate time to prepare for the client's return to the community.

Recommendation (7). DMHMR should expand the pre-discharge planning guidelines to address the roles, responsibilities, and procedures for the use of temporary leave. In all cases, the decision to employ temporary leave should be jointly made by the hospital and CSB staff.

Linking Clients to Community Services. The majority of clients discharged from State hospitals are not fully recovered. According to DMHMR hospital data, 83 percent of those discharged are labeled improved, but "not recovered." In order to adjust to the community, therefore, these clients typically require one or more types of treatment or support. Without this assistance, it becomes more difficult for the client to make the adjustment from a highly structured hospital setting to an independent community setting. The timely and coordinated transfer of treatment responsibility from hospital to CSB staff is a pivotal first step in determining a client's success in adjusting to the community. Failure to make this transfer, and to establish a "service link" with the client reduces the opportunity to provide appropriate services and increases the chances of recidivism.

For the majority of clients who have been hospitalized, particularly for those with a history of multiple admissions, current practices in providing adequate support during the transition from the hospital to the community may be inadequate. Many clients must face this extremely stressful period of change alone.

Responsibilities and procedures for managing the client's transition from the hospital to the community need to be improved.

Recommendation (8). In order to reduce gaps in outreach and case management services, the General Assembly may wish to fund additional case manager positions. The Department of Mental Health and Mental Retardation should report to the General

Assembly on the specific mental health and mental retardation case management staffing needs of the community services boards.

Recommendation (9). The Department of Mental Health and Mental Retardation should develop specific guidelines for managing client transition from the hospital to the community. The guidelines should include: procedures for the identification of clients at risk; requirements for the assignment for each client of a primary CSB contact staff person who is accountable for the client's transition to the community; and standards for the use of outreach and case management.

Recommendation (10). To ensure that CSBs can provide essential services to "refusing" clients, the General Assembly may wish to amend Section 37.1-67.3 of the Code of Virginia to specify procedures for the implementation and enforcement of existing outpatient commitment laws. The procedures could be applied to clients with a history of multiple hospitalizations and who have been shown to benefit from treatment, but who do not comply with community treatment.

Community Services (pp. 33-46).

Chapter 10 of Title 37.1 of the Code of Virginia designates the community services boards as the key providers of mental health, mental retardation, and substance abuse services in the Commonwealth. In the 1979 JLARC study on Deinstitutionalization and Community Services, numerous gaps were found in the availability of community services. For more than 50 percent of all aftercare clients, the only service received was medication monitoring. JLARC staff recommended that the Department of Mental Health and Mental Retardation and the General Assembly consider mandating a basic core of services for discharged clients.

The success of clients in the community is directly influenced by the core services made available after discharge. As a part of this study, JLARC staff reviewed the availability and adequacy of each of the core services. Although improvements have been made in the development of services across the State since JLARC's 1979 report, there continues to be considerable unmet need for community services.

Services for Mental Health Clients. The needs of mental health clients, particularly the chronically ill, are vast and dynamic, necessitating a continuum of care that can adequately serve the individual needs of a diversity of clients. To prevent imbalances that can evoke acute episodes, many chronically ill clients require some level of medication maintenance. On some occasions, inpatient treatment may be necessary. A number of mentally ill clients also need support services to facilitate their community adjustment. Many lack necessary living skills such as cooking, personal hygiene, and money management. Others require training in basic work skills and experience in structured job environments. Most need assistance in accessing additional social and health services.

The variety of needs of the chronically mentally ill thus necessitate a range of community services that includes local hospitalization for acute psychiatric treatment, day support services providing opportunities for learning a variety of life and work skills, case management for securing needed assistance from other agencies and service providers, and outpatient services for psychological counseling.

The continuum of care must not only encompass the core service areas, but must also meet client needs for specific subcategories of services. As discussed in Chapter III, significant service gaps for the mentally ill exist in case management and outreach services. Additional service needs are apparent in inpatient care, day support programs, and outpatient services. The gaps in day support are significant because day support is viewed by mental health professionals as the foundation of community support for the chronically mentally ill.

In order for chronically ill clients to live successfully in the community, improved mental health services will be needed. To a large extent, the success of deinstitutionalization in Virginia is dependent on more uniform availability of mental health services at the local level.

Recommendation (11). The General Assembly may wish to amend Section 37.1-194 of the Code of Virginia to mandate

provision of psychosocial rehabilitation, transitional employment, and medication maintenance services for mental health clients.

Recommendation (12). The General Assembly may wish to give funding priority to the development and expansion of community services for the chronically mentally ill. The General Assembly may also wish to direct the Department of Mental Health and Mental Retardation to assess the need for services in each of the 40 CSBs, and to specifically identify inadequacies in psychosocial rehabilitation, transitional employment, and outpatient services.

Recommendation (13). In order to reduce State hospital utilization and broaden the continuum of care provided in the community, the Department of Mental Health and Mental Retardation should promote the development of local inpatient programs. The department should review the feasibility of alternative funding mechanisms which would provide incentives for the use of local inpatient beds, such as "buying" State hospital beds for clients. In addition, the department should provide technical assistance to CSBs in the development of programs, and in the development of contracts with local hospitals.

Services for Mental Retardation Clients. Currently, more than 7,000 mentally retarded clients receive community services in Virginia. Since 1979, there has been a shift in the type of client discharged from State training centers. In general, clients are more disabled and exhibit more behavior problems. It is anticipated that, in the future, clients discharged from training centers will be multi-handicapped (with physical and mental disabilities), lower functioning, and experiencing greater behavioral problems. Although there are few absolute gaps in services for the mentally retarded, there is a growing demand for services. The demand is for all types of service, from early intervention to day support and residential services. Existing gaps in services will make it difficult for CSBs to meet expected demand.

Recommendation (14). The Department of Mental Health and Mental Retardation should take immediate steps, in cooperation with the 40 community services boards, to identify service needs for mentally retarded citizens. The department should prepare a plan for implementing and funding priority service needs in the CSBs.

Services for Substance Abuse Clients. Substance abuse clients comprise 19 percent of the population discharged from the State's mental health hospitals. However, an additional 15 percent of the discharged population have substance abuse as a secondary or dual condition with mental illness. CSB staff reported that many clients have a history of abusing both alcohol and drugs. These clients have changed somewhat over the past five years, being characterized by the CSBs as younger, lacking adequate social support, and less prepared for discharge.

In general, the level of services available to substance abuse clients is poor. With the declining role of State mental health hospitals in the treatment of substance abuse, it is imperative that adequate services be available in communities across the State. At present, however, few CSBs offer even a minimum range of services for substance abuse clients (Table 3). Detoxification services are the most widespread, but can be effective only for short-term care of the client. Longer-term, continuous programs are needed to aid clients in maintaining their independence from alcohol and drugs and in learning the skills necessary to adjust to community living.

The lack of community-based detoxification and residential treatment programs for substance abusing clients is a critical deficiency in Virginia's mental health delivery system. With the reduction in the number of beds available in State hospitals, the need for services at the local level has become more important. But significant absolute gaps in substance abuse services have been identified across the Commonwealth.

Recommendation (15). The Department of Mental Health and Mental Retardation should take immediate action, in cooperation with the 40 community services boards, to identify service needs for substance abuse clients. The department should prepare a plan for implementing and funding priority service

needs in the CSBs. Special attention should be given to detoxification and residential treatment services.

Services for All Disabilities. In addition to those services designed specifically for the three major disability groups, certain services of a broader range are provided to all clients. These services include emergency, prevention, and transportation services. The adequacy of these services varies from CSB to CSB. The largest gap continues to be in transportation services.

Recommendation (16). The Department of Mental Health and Mental Retardation should assess the extent to which face-to-face emergency services are needed in each of the 40 community services boards. The department may wish to mandate the provision of in-person emergency services, and should provide sufficient funds and technical support to ensure that the required program is implemented statewide.

Recommendation (17). The Department of Mental Health and Mental Retardation should promote the use of prevention programs. The department should assess the need for additional funding and technical assistance.

Recommendation (18). The Department of Mental Health and Mental Retardation should establish a program for funding client transportation services in each of the 40 community services boards. The use of funds from core services to fund transportation needs should be discontinued.

Housing Services (pp. 47-64).

Housing is a critical need for many clients who leave State mental hospitals. Without housing that provides a secure environment and access to necessary services, a client's opportunity for a successful transition to life in the community is diminished. Because many aftercare clients are indigent, or have overtaxed their families' ability to care for them, the need for State-provided or subsidized housing is magnified. Present law, however, does not adequately assign responsibilities to ensure that discharged clients will be housed in an appropriate setting. Because the State has no policy with regard to housing for discharged clients, housing continues to be one of the most pressing needs for deinstitutionalized clients. In the 1979 JLARC report, *Deinstitutionalization and Community Services*, the need for additional housing was identified. Little improvement has been made in the past six years.

Housing Programs for the Mentally Disabled. The Commonwealth currently provides some direct housing services to the mentally disabled. But legal responsibility for locating and providing housing placements for mentally disabled clients is presently scattered among various State agencies. While several agencies have taken initiatives in providing housing opportunities, the need for better coordination and increased program capacity is evident.

Recommendation (19). The Department of Housing and Community Development (HCD) should collect and analyze data necessary to plan for adequate housing for the mentally disabled. The data collection effort and analysis should be conducted with the assistance of the Department of Mental Health and Mental Retardation, and be based on an assessment of the low-cost housing needs of the mentally disabled. Planning for the development of new or modified existing housing should reflect consideration for the needs of other low-income groups, such as the physically disabled.

HCD should take the lead responsibility in ensuring that an effective plan for meeting the housing needs of the mentally disabled is developed and implemented. The director of the Department of Housing and Community Development should report to the General Assembly concerning progress made toward development of the plan by January 1988.

Recommendation (20). The Department of Mental Health and Mental Retardation should cooperate in the development of a statewide housing plan, and should review methods for establishing a permanent, separate

funding stream drawn from new and existing monies devoted to the purpose of expanding residential services across the State. A coordinator of residential services should be established with the following duties: development of residential services; coordination of the efforts of other agencies in this area; integration of the programmatic needs of the mentally disabled with the need for housing stock; and dissemination of technical information concerning cost-effective residential programs to community services boards.

Recommendation (21). The Virginia Housing and Development Authority should develop and implement financing programs designed to create low-cost housing for the mentally disabled. VHDA might consider setting aside a percentage of its finance capital for this purpose, and cooperate with DMHMR in the dissemination of information regarding the use of VHDA financing by community services boards.

Recommendation (22). The Department of Social Services should evaluate the need to expand the use of auxiliary grants for mentally disabled clients. The plan should review alternatives which would broaden eigibility for auxiliary grants for residents of CSB-operated housing and other publicly provided housing for indigent clients.

Recommendation (23). The community services boards, with the assistance of DMHMR, should be required to develop adequate housing opportunities for their mentally disabled clients. The required amount of housing should be based upon the needs assessment developed by HCD. The CSBs should be permitted to create the types of residential services that best suit their respective areas and clients. Financing and rent subsidies from VHDA as well as expanded use of the auxiliary grant program should be evaluated as sources of funding.

Homes for Adults. Many aftercare clients are housed in licensed homes for adults. By State law (Sections 63.1-172 through 63.1-178), homes for adults must provide "protection, general supervision, and oversight of the physical and mental well-being of their residents." The Department of Social Services both licenses adult homes and administers the auxiliary grant program. Because a key eligibility requirement for the auxiliary grant program is residence in a licensed adult home, the State has in effect encouraged the development of the adult home industry as a major, yet largely unplanned, component of State policy toward housing and treating the mentally disabled.

The JLARC staff review of adult homes indicated that this unplanned component, as presently constituted, is a generally unsatisfactory alternative for State-provided housing for the mentally disabled.

Recommendation (24). Homes for adults should be required to maintain a minimal amount of trained staff and to provide adequate aftercare for deinstitutionalized residents. The Department of Mental Health and Mental Retardation should develop appropriate standards regarding acceptable qualifications for the staff of adult homes that house deinstitutionalized clients. At a minimum, the standards should stipulate that each such home have a licensed nurse and a trained social worker/activities director on its staff. As a means of subsidizing the necessary staffing improvements in adult homes that wish to house discharged clients, the General Assembly may wish to increase the auxiliary grant rate for future post-hospitalized clients.

Recommendation (25). Because district homes and CSB-operated adult homes are potential providers of low-cost, well-staffed supervised care for discharged clients (and other indigent and aged persons), the General Assembly may wish to consider the development of adult home alternatives by amending Section 63.1-183 of the Code to authorize State funding of district homes for the indigent aged, infirm, and disabled.

Recommendation (26). DSS should reclarify the responsibilities of local social service departments so as to ensure that residents of HFAs whose residence of origin is in other areas receive adequate protective services.

Recommendation (27). The General Assembly may wish to link the licensing of new adult homes to indicators of need in each area of the State.

Recommendation (28). DSS should require that each adult home that accepts deinstitutionalized clients have an individualized, detailed written agreement with a CSB. The agreements should be renewed yearly, and require that each home for adults: (1) have potential new deinstitutionalized residents screened by the CSB; (2) participate in active exchange of information concerning all CSB clients; and (3) allow free access to CSB staff.

Recommendation (29). The Department of Social Services and DMHMR should promote the exchange of information between licensing specialists and CSB staff regarding the suitability of adult homes as placements for deinstitutionalized clients.

Recommendation (30). DSS should expand the definition of "post-hospitalized" residents of adult homes to include any adult home resident with a recent history of hospitalization in a mental health or mental retardation facility.

Recommendation (31). DMHMR should require that CSBs provide each post-hospitalized resident of adult homes with at least one aftercare follow-up in the home.

Recommendation (32). The General Assembly may wish to empower DSS licensing specialists to levy fines and/or reduce grant reimbursement rates for homes that do not comply with DSS standards.

Service and Fiscal Accountability (pp. 65-72).

Virginia's service delivery system for mentally disabled persons has improved significantly in the recent past. One of the most important goals during this period has been the establishment of a comprehensive community-based system of care. JLARC staff analysis indicates that the State has not been fully successful in meeting this goal. The specific program and service deficiencies outlined in this report have contributed to the failure of the development of that comprehensive system. But a failure to assign accountability for the system has also made the goal more difficult to achieve. Assigning service and fiscal accountability is essential to the future development of a comprehensive service delivery system.

Service Accountability. Currently, the State operates or supports three overlapping systems which serve many of the same clients. State hospital services are provided by the Department of Mental Health and Mental Retardation. Community services are provided by 40 community services boards and funded largely through State and local general fund revenues. Finally, residential services are provided by adult homes which are supported in part by auxiliary grants and monitored by the Department of Social Services. The links in authority between these entities is often unclear, contradictory, or inoperable. As a result, accountability is diminished. Moreover, the operation of overlapping systems is financially inefficient.

The outcome of this situation is the limited effectiveness of State policies and programs. Because accountability for services is unclear, many clients do not receive the services they require. The overlapping systems, coupled with a lack of accountability, make it difficult to identify and address problems in the delivery system.

To improve accountability for the system, several actions of the General Assembly will be required. The roles of State hospitals and local service providers need clarification. Service priorities should be established, and certain core programs should be mandated for chronically ill clients.

Recommendation (33). The General Assembly may wish to reconfirm its intent to develop a comprehensive community-based system for serving the mentally ill, mentally retarded, and substance abusing citizens of the Commonwealth. The General Assembly may wish to specify that accountability for the provision of appropriate services rests with the community services boards.

Recommendation (34). The General Assembly may wish to direct DMHMR to develop a comprehensive plan which will assign full service and fiscal accountability to the CSBs. Such a plan should include procedures to ensure that State service priorities for the chronically ill are met, as well as procedures for establishing priorities in the development of local services for mentally retarded and substance abusing clients.

Recommendation (35). DMHMR should review certification standards for programs intended for chronically mentally ill clients. Minimum standards should be established and enforced. The standards should include required activities and objectives, staffing ratios, and hours of service per client.

Recommendation (36). The General Assembly may wish to express its intent concerning the role of State hospitals. The use of State hospitals might be reserved for those clients: (1) who are severely disabled and require long-term treatment in a highly supervised setting, and (2) who have low incidence disabilities that cannot be addressed in a community setting.

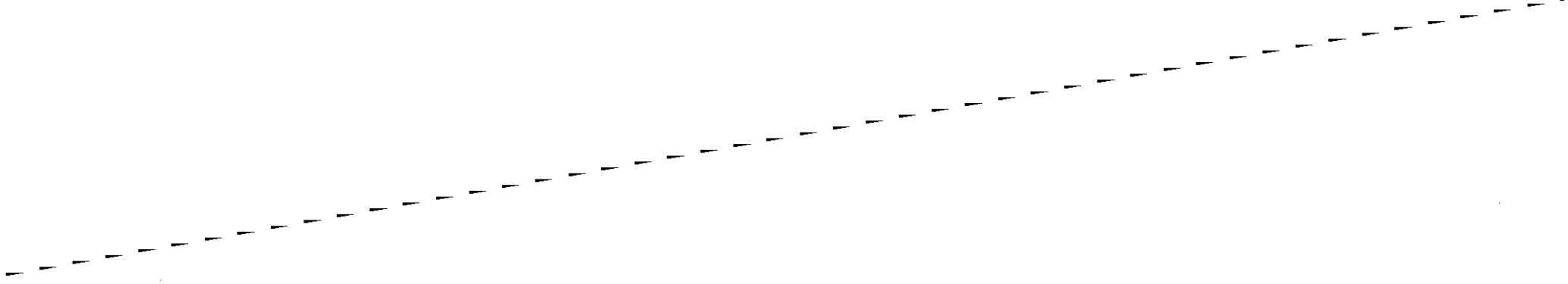
Fiscal Accountability. Establishing service accountability at the local level would increase the effectiveness and continuity of service provision. Improving the current mechanisms for allocating funds could also improve accountability. Current funding mechanisms do not ensure that available funds are directed to areas or populations with the greatest need. In addition, it will be necessary to maximize local government funding of community programs. The Code implies that local governments are to contribute to CSB funding, but does not specify the financial participation required.

Recommendation (37). The General Assembly may wish to direct DMHMR to develop a formula for allocating State funds directly to the community services boards on the basis of measurable and appropriate variables. The purpose of the formula should be to ensure availability of mental health services to all citizens.

Recommendation (38). The General Assembly may wish to direct DMHMR to develop a plan by which CSBs are fiscally accountable for the use of State mental health hospitals. Such a plan should provide incentives for the use of community services and disincentives for the use of State hospital beds.

Recommendation (39). The General Assembly may wish to amend Section 37.1-199 of the Code of Virginia to define clearly the financial involvement of local governments in the operations of CSBs. Amended language should ensure that individual local governments cannot reduce the absolute level of current contributions. Future contributions should account for increases due to inflation, and localities should not be permitted to substitute State funds for local contributions.

TABLE OF CONTENTS



I. INTRODUCTION

"Deinstitutionalization" refers to the process by which the primary treatment responsibility for the mentally disabled is transferred from State mental health and mental retardation facilities to service providers in community-based settings. The process of discharging clients and linking them successfully with community services involves a number of different agencies, treatment and support services, and processes. The policy cannot be effective unless each and every component is implemented well.

Trends in Deinstitutionalization

Since the late 1960s, there have been sustained efforts across the country to encourage the deinstitutionalization process. These efforts have occurred for a number of reasons. First, the idea of limiting the role of large facilities and reducing institutional populations received the support of mental health professionals and policy specialists. Large state mental institutions were perceived by some observers as providing primarily a "custodial" type of care that carried a stigma and deprived clients of their liberty, dignity, and ability to reach their fullest potential. A working consensus was reached that therapeutic mental health care could occur most effectively and efficiently within the context of "normal home and community ties."

The policy received impetus from the development of various psychotropic drugs that control psychotic symptoms and allow for earlier discharge of many patients. Additionally, various courts mandated that care for patients be provided in the "least restrictive alternative."

As a result, state governments across the nation established "deinstitutionalization policies" and mandated the reduction of institutional populations. Subsequently, the national resident population of state and local mental hospitals declined by nearly 75 percent, from 560,000 in 1955 to 138,000 in 1980.

Deinstitutionalization in Virginia. Deinstitutionalization first became legislative policy in Virginia in 1968 when the General Assembly passed Chapter 10 of Title 37.1, *Code of Virginia*. Chapter 10 enabled local jurisdictions to establish community health and mental retardation service boards. Between 1970 and 1972, legislative and executive interest in deinstitutionalization was expressed in reports from the Governor's Commission on Mental Health, Indigent, and Geriatric Patients (also known as the "Hirst Commission").

Spurred by findings of deplorable conditions and inadequate treatment in State residential facilities, the Hirst Commission made a number of policy recommendations supporting the concept of deinstitutionalization. The commission recommended that spending on community mental health services be increased and institutional populations be decreased. It also urged that State and community services be coordinated by increasing the leadership role of the Department of Mental Health and Mental Retardation (DMHMR).

As a result of the Hirst Commission's recommendations, reduction of institutional populations became the policy of DMHMR in 1972, with the goal of reducing institutional populations by ten percent each year over a five-year period.

In FY 1972, the average daily population in State institutions was 13,529. As a result of the policy to reduce institutional populations, the projected census for FY 1986 is about 6,700, a decline of more than 50 percent in 14 years.

Reconsideration of the Policy. Recently, the policy of deinstitutionalization and community-based care for the mentally disabled has been questioned on a number of grounds. While there is consensus on the promise of deinstitutionalization, some observers have criticized the actual practice of deinstitutionalization as consisting of little more than the "dumping" of chronically mentally ill persons onto the city streets.

More specifically, critics maintain that: (1) local service delivery systems lack coordination; (2) local service providers rely too heavily on drugs to control deinstitutionalized clients; (3) communities lack sufficient funds and popular support for community-based care; (4) community services have relatively higher costs; and (5) poorer patients tend to be the most likely to be abandoned by the system. Most importantly, critics emphasize that the number and adequacy of existing community services is not sufficient to meet the demand for these services.

The Commission on Deinstitutionalization

The recent national trend toward reconsideration of deinstitutionalization policies has also appeared in various forms in Virginia. Generally, concern has been voiced about the sufficiency of care provided by communities. Projected budget cuts for State institutions to be accommodated by accelerated discharge of patients, and an apparent increase in the number of unattended mentally disturbed (so-called "street people") have sparked renewed interest in the Commonwealth's policy on deinstitutionalization.

As a result of these concerns, Senate Joint Resolution 42 of the 1984 Session established the Commission on Deinstitutionalization to study the policies and practices in use in Virginia. The resolution called on the staff of the Joint Legislative Audit and Review Commission (JLARC) to provide technical assistance to the commission.

The commission directed the JLARC staff to conduct a follow-up study of its 1979 report, Deinstitutionalization and Community Services. In addition, the JLARC staff was requested to conduct research in other areas salient to deinstitutionalization policies. After an extensive review of Virginia's system of care, of deinstitutionalization in other states, and of past studies, JLARC staffed focused the research for the commission on six broad issues:

- client management;
- case management and client outreach;

- availability and adequacy of community mental health and mental retardation services;
- housing programs and policies;
- funding of community services; and
- accountability.

Most of these issues had been reviewed as a part of the 1979 JLARC staff report.

The 1979 JLARC Special Study

In 1977, the Commission on Mental Health and Mental Retardation (the "Bagley Commission") was formed. The commission requested that JLARC staff carry out a study of the progress of deinstitutionalization in Virginia. The resulting study was published in 1979. The findings and recommendations of that report, which were adopted by the Bagley Commission, included the following:

- progress had been made in reducing the populations of State institutions;
- funding for community services had been increased;
- discharges to appropriate community services were mishandled by State institutions;
- the needs of discharged clients had not been met because of the absence or limited capacity of important mental health services; and
- mental health service delivery as a whole was fragmented, uncoordinated, and lacking central policy direction.

On the basis of these and other findings, JLARC staff recommended that DMHMR:

- use a standardized client discharge plan;
- prepare needs assessments for discharged clients;
- develop a "core" of community services for discharged clients;
- exercise caution in the use of adult homes for discharged clients;
- develop cost reporting and performance criteria for community programs;
- improve case management to ensure that a single agency or individual is "clearly responsible for coordinating comprehensive client care in the community";

- take a position of leadership in the system (as mandated by the General Assembly);

- develop a system-wide base of information on client characteristics and needs, and on the capacity and quality of services;

- provide for follow-up on discharged clients; and

- develop mandatory implementation procedures to ensure interagency coordination.

In addition to adopting the JLARC recommendations, the Bagley Commission urged that the State's Mental Health and Mental Retardation Board set policy for the community services boards (CSBs), and do so in such a way that "funds follow the client". DMHMR was to provide CSBs with technical assistance in screening clients prior to admission. Local CSBs were to be established for all counties and cities, and were to have standardized operating procedures.

Many of the legislative recommendations made by JLARC and the Bagley Commission were enacted by the General Assembly, especially in the area of systematizing procedural aspects of admitting and discharging clients. Client pre-admission screening and pre-discharge planning became legal requirements, with the goal of integrating services and ensuring a "continuum of care" between CSBs and residential facilities. The thrust of more recent legislation has been to upgrade and improve the community care system through increased funding and through requirements for improved administrative procedures.

1983 Status-of-Action

In June 1983, the Commissioner of Mental Health and Mental Retardation reported to the JLARC staff on the status of the recommendations from the 1979 report. At that time, the following general actions were reported to have been taken to respond to the recommendations:

- The department "established definitions and interpretive guidelines for the statewide implementation of core services" (as outlined in House Resolution No. 77, 1982). The department allocated $2,318,700 to support the availability of core services in each community in FY 1983, and anticipated allocations of $5,101,300 in FY 1984 for the same purpose.

- Case management and pre-discharge planning were made available for priority populations in each CSB, although the number or percentage of clients receiving these services was not indicated in the report.

- A study conducted by DMHMR indicated that all voluntary and 90 percent of the involuntary admissions were screened. According to this study, 40 percent of potential admissions to State institutions were being diverted to community services.

- DMHMR had developed and implemented a community data system for each disability area to record information pertaining to the characteristics of clients and the services they receive.

- DMHMR had developed and implemented community standards for State-funded programs, and all programs were reported to be in compliance with the standards. The status report did not specify the standards used by DMHMR.

- After an analysis of possible approaches, DMHMR initiated establishment of a "performance contracting procedure" with the CSBs, and developed an "integrated quality assurance plan" for the central office, institutions, and the CSBs.

- DMHMR had taken steps to improve coordination with other State agencies.

Subsequent to the status-of-action report, DMHMR reported to various committees of the General Assembly that it was continuing to implement the recommendations of the 1979 JLARC staff report.

Study Methods

To a large extent, this study is a follow-up of the earlier JLARC staff report. The Commission on Deinstitutionalization was especially interested in determining the extent to which the process for discharging clients had been improved, and whether adequate services were available to clients in the community. The questions of interagency coordination and accountability for clients were also to be reexamined.

JLARC used a number of quantitative and qualitative methods to address the study issues. Given the importance of the chronically mentally ill population, the emphasis of the research was on that group, with secondary emphasis given to the mentally retarded and substance abuse populations. In contrast to the 1979 report, this study is based on statewide data and representative samples of clients in the mental health system.

Status of Aftercare Clients. A key method used to assess the status of deinstitutionalized ("aftercare") clients was to track them from hospitals to CSBs. A sample of 350 clients who were discharged from mental health hospitals during September and October of 1984 was randomly selected for this analysis. Hospital staff completed a questionnaire for each client on admission status, client management procedures, and service needs.

Follow-up questionnaires were then sent to the CSBs in which clients were discharged. Case managers at the CSBs provided information for each client on the length of community service, services received, adequacy of housing, and financial status. Complete data was obtained for all but seven of the 350 clients in the sample. Through this two-step analysis JLARC staff assessed the overall ability of the State and the communities to serve chronically mentally ill persons.

CSB Survey. To collect general, system-wide information about community programs, surveys were completed by the executive director and staff at each CSB. Data collected on the surveys addressed service levels for all disability groups, funding, service costs, and housing.

Review of Agency Records. JLARC staff reviewed data available at the agencies responsible for providing services to the mentally disabled. DMHMR's automated reimbursement data was used to select clients for the analysis of aftercare status. JLARC staff analyzed DMHMR's funding and expenditure data, and unit costs for 15 CSBs. Finally, data from the Department of Social Services was used to evaluate the auxiliary grant program, adult home regulations, and other housing issues.

Interviews. JLARC staff interviewed a wide range of professionals responsible for providing services to the mentally disabled, or for administering such programs. Face-to-face or telephone interviews were held with staff from all but a few of the 40 CSBs. Five detailed case studies were completed at selected CSBs: Richmond, Roanoke, Crossroads, Rapidan (Culpeper) and Planning District 19 (Petersburg). Additional visits were made to ten other CSBs.

Interviews were also held with DMHMR central office personnel, including division directors and other program, fiscal, and support staff. Additional interviews were completed with directors of the six major mental health facilities and with liaison staff within each institution. Interviews were also held with central office staff, regional supervisors, and licensing specialists with the Department of Social Services (DSS). Finally, selected interviews were held with staff from the Virginia Housing Development Authority, the Department of Rehabilitative Services, and the Department of Housing and Community Development.

Review of Homes for Adults. To examine the availability and quality of homes for adults used as housing placements for discharged clients, JLARC staff visited 21 homes for adults in four areas of the State. While the visits do not represent a generalizable sample of all homes, in combination with other methods the visits provided a reference for evaluation of homes and their relation to the State's mental health system. The homes selected for review were those which DSS licensing specialists considered to be the best and worst in each area. During the visits, JLARC staff interviewed operators, reviewed documentation, and inspected the facilities.

Report Organization

This report is organized according to the major service elements of the deinstitutionalization process. Chapter II provides background information concerning the overall system. Chapter III is a discussion of the management of clients at the State and local levels. Chapter IV is an evaluation of community mental health services. Issues related to the housing of clients in the community are addressed in Chapter V. Finally, Chapter VI addresses issues of service and fiscal accountability.

II. CLIENTS AND THE CONTINUUM OF CARE

Deinstitutionalization has made the mental health system far more complex than it was 20 years ago. The system that once consisted primarily of large State hospitals for the delivery of mental health services is now a complex network of State agencies, local community service boards, and private service providers. Ideally, this network of agencies provides for a "continuum of care," or a comprehensive range of services designed to serve a diverse client population.

For deinstitutionalized clients, however, the local community services boards and the private service providers are now the primary sources of mental health and associated services. The State continues to provide for institutional care where appropriate, and is responsible for coordination of the system as a whole.

THE SERVICE DELIVERY SYSTEM

The formal mental health network consists of the Department of Mental Health and Mental Retardation (DMHMR), the State hospitals operated by DMHMR, and the 40 local community services boards (CSBs). The State Board of Mental Health and Mental Retardation is responsible for setting policy for the entire system. DMHMR is the primary source of funds for CSB services, provides technical assistance to the CSBs, and monitors the quality of local programs. The provision of services to deinstitutionalized clients is the responsibility of the local CSBs.

In addition, a less formal network of State and local agencies provides a range of support services such as financial support, housing, and job training to the mentally disabled, as well as to the general population. While these are not mental health services, they are critical to the success of deinstitutionalized clients in the community.

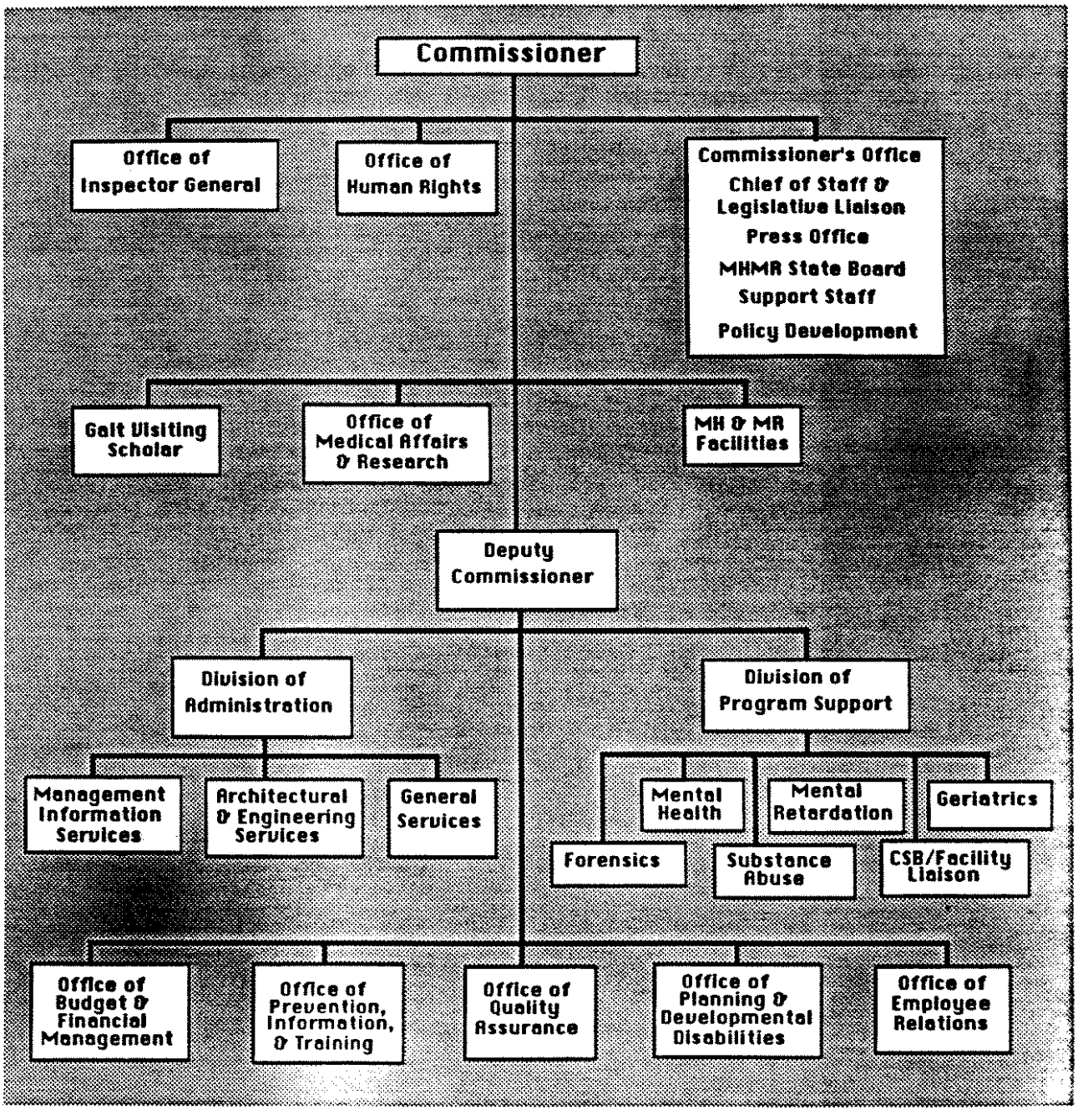
Department of Mental Health and Mental Retardation

The Department of Mental Health and Mental Retardation is organized into two major divisions and a number of offices (Figure 1), and is responsible for the planning, coordination, and provision of mental health, mental retardation, and substance abuse programs in the Commonwealth. The department operates the State's 15 inpatient treatment facilities for mentally ill, mentally retarded, and geriatric clients, providing intensive acute treatment and long-term care.

The department's central office also plays an important role in the community mental health system. The Offices of Mental Health, Mental Retardation, and Substance Abuse are responsible for programs in each of the three disability areas. These offices are charged with ensuring that core

Figure 1

ORGANIZATION OF THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION



Source: DMHMR.

services are available to the Commonwealth's citizens. The offices plan, develop, and monitor the policies and programs in the three disability areas.

A separate Office of CSB/Facility Liaison is responsible for coordinating the department's programs with those of the local agencies. The Liaison Office is organized geographically, with the 40 CSBs grouped into regions (Figure 2) that are congruent with Virginia's five health service areas. Each region is served by a central office liaison officer.

The Liaison Office serves as the initial link between the central office of DMHMR and the CSBs. The office develops CSB grant applications and performance contracting processes and documents, and coordinates CSB budget and contract reviews. The liaisons also monitor CSB activities to identify potential problem areas and to track the progress of specific tasks and projects.

Other divisions of DMHMR also frequently interact with the CSBs. Requests for funds, technical assistance, and program clarification are directed to the Commissioner's Office, and are dispersed according to the request. Central office staff are assigned as needed to work with the liaison in each specific area to help resolve the questions or concerns of the CSB.

Community Services Boards

The provision of community services is the primary responsibility of CSBs. Local services are offered to mental health, mental retardation, and substance abuse clients either directly by CSB staff or through contracts with private service providers. Over the past 15 years, 40 community services boards have been created across the State. Every city and county in Virginia is now served by, and provides financial support for one of the CSBs. Residents are eligible to receive services from the CSB in which their locality participates.

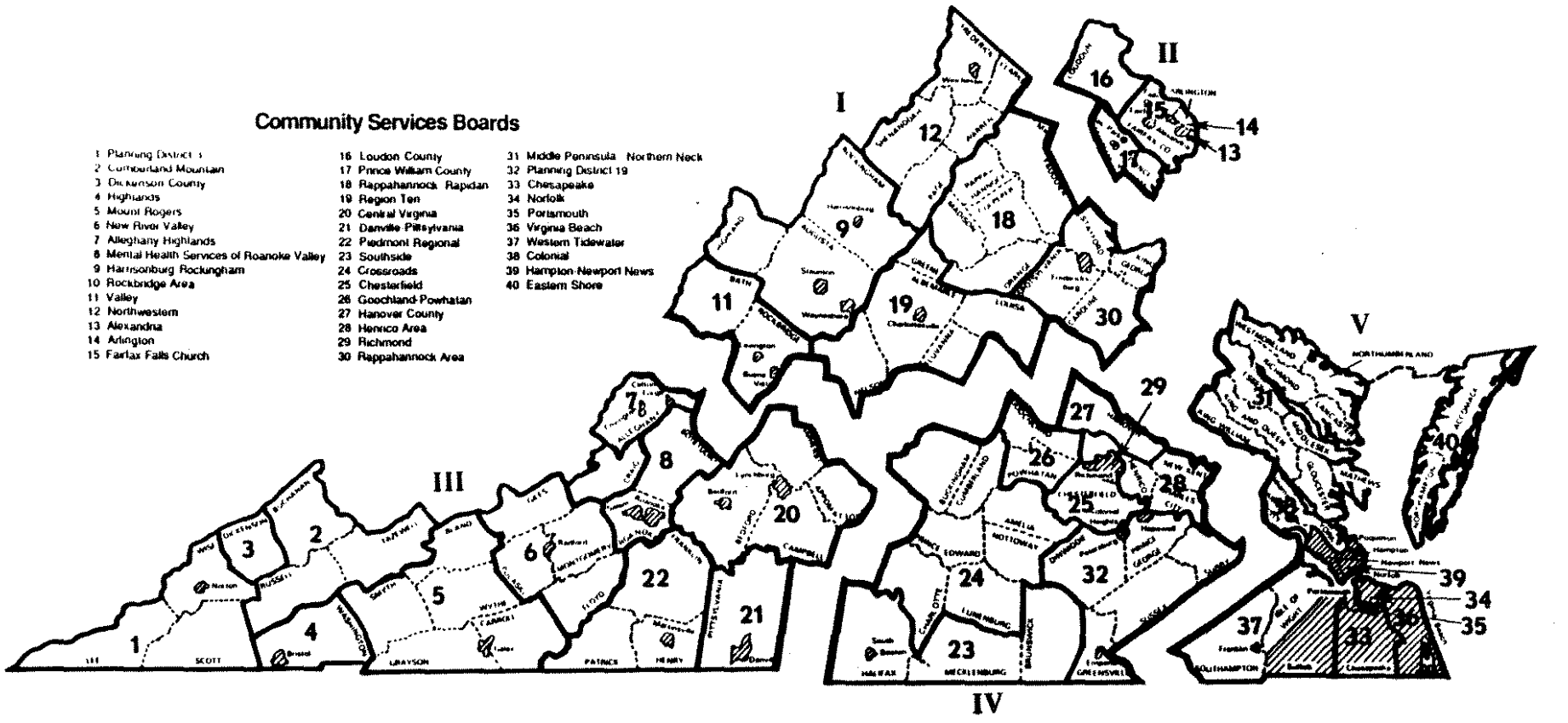
Sections 37.1-194 to 37.1-202 of the *Code of Virginia* provide the legal framework for the CSBs. Each CSB is required to create a board with between 5 and 15 members. The purpose of the local board is to set policy for the services offered by the CSB. The board also appoints an executive director who is responsible for general administration of the CSB, implementation of the board's policies, and supervision of the agency's programs. The organization of CSBs across the State varies widely. Typically, each CSB has a coordinator for each disability group who is responsible for daily supervision of programs. The type and scope of programs offered by the CSBs also varies widely across the State.

By law and regulation, the CSBs play a key role in the deinstitutionalization process. The CSBs are the primary intake point for clients entering the mental health system and the locus of the "least restrictive" care. CSBs are required to provide client pre-screening and pre-discharge planning and emergency services.

While DMHMR has supervisory and quality assurance responsibilities for local programs, the CSBs remain autonomous units. They are all partially funded from local funds, and are staffed by local government employees. CSBs have a great deal of discretion with regard to the services to be offered to

Figure 2

HEALTH SERVICE AREAS



Source: DMHMR.

citizens within their service area. State law requires only that CSBs provide emergency services. Other programs are optional and "may include inpatient services, outpatient and day-support services, residential services, prevention and early intervention services, and other appropriate mental health, mental retardation, and substance abuse programs necessary to provide a comprehensive system of services."

Support Service Agencies

A less formal network of agencies provide important support services for the mentally disabled. Many of these services target low income groups in the general population. Typically, the mentally disabled are unemployed, or have limited sources of income and thus, are eligible for such services.

Among the State agencies providing services are the Departments of Health, Social Services, and Rehabilitative Services. The Department of Social Services (DSS) has the largest role: providing income supplement through the auxiliary grants program. These grants are a major source of funding for housing the mentally disabled in homes for adults. DSS is also responsible for licensing adult homes, which is the housing often available for deinstitutionalized clients.

A number of local agencies also provide services or become involved with clients, further complicating the service system. For example, local jails, courts, and hospitals occasionally serve as intakes for State institutions. Non-governmental agencies like the Salvation Army, shelters for the homeless, and mental health outreach programs may also provide services.

The Deinstitutionalization Process

The deinstitutionalization process begins when a client is first identified as having a need for mental health, mental retardation, or substance abuse services (Figure 3). A client might seek services voluntarily. Or, clients can be identified by courts, social service agencies, or other State and local agencies.

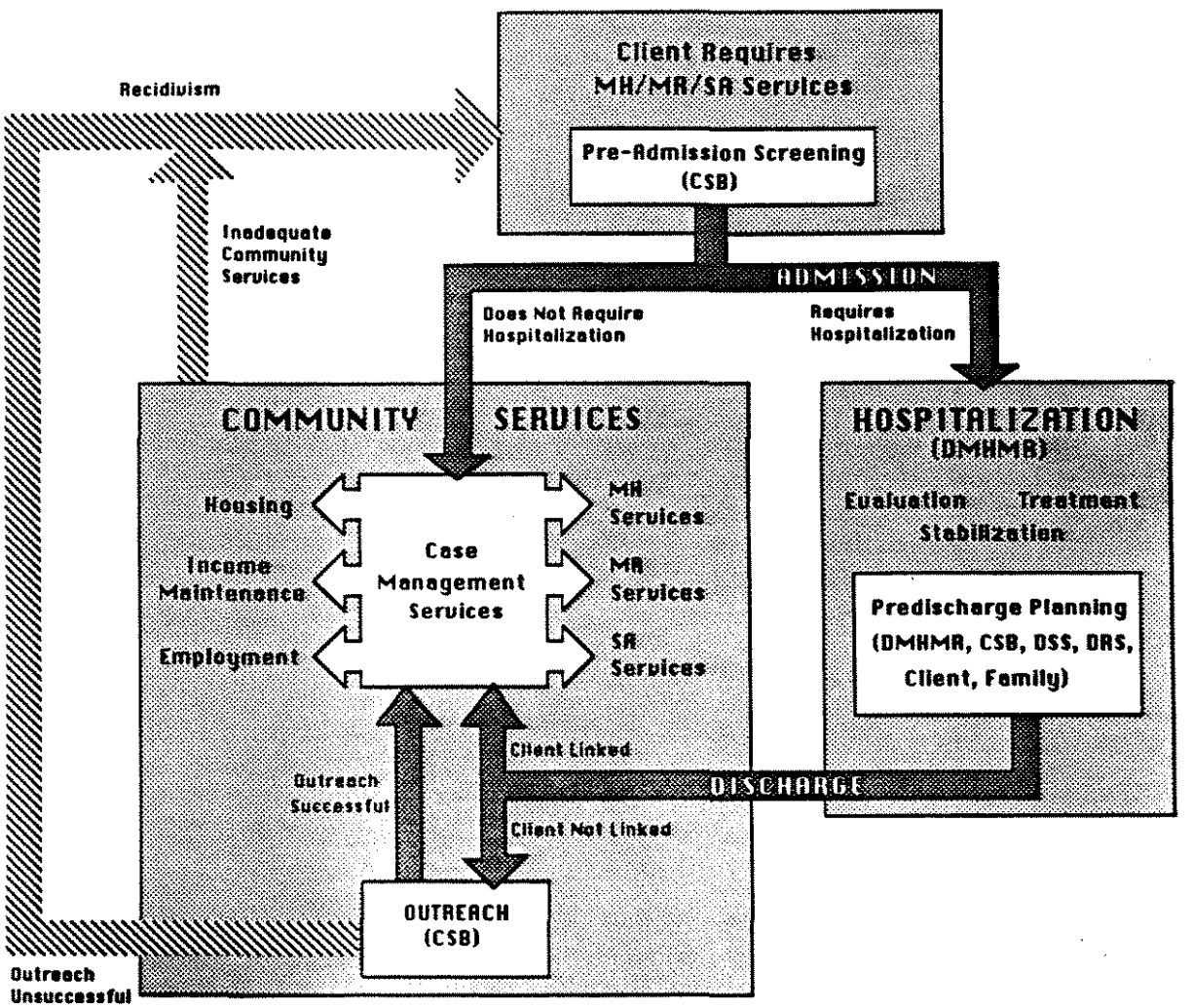
Pre-Admission Screening. Once a client has been identified, the CSB is responsible for pre-admission screening, which is the process used to evaluate the client's need for hospitalization. The evaluation is based on criteria specified by law in cases of involuntary admissions. DMHMR has established guidelines which extend the criteria to cover voluntary and substance abuse admissions.

Pre-admission screening helps to establish the local CSB as the agency primarily responsible for the client, even if admission to a State facility is indicated. It also serves to reduce the number of unnecessary admissions; many clients pre-screened can be served directly by the CSB. Pre-screening services are supposed to be available 24 hours a day, seven days a week.

Hospitalization and Pre-Discharge Planning. Should hospitalization be required, the client is admitted to one of 15 State facilities for treatment. Ideally, as soon as the client is admitted, the process of pre-discharge planning

Figure 3

THE DEINSTITUTIONALIZATION PROCESS



Source: JLARC staff graphic.

begins. The purpose of pre-discharge planning is to ensure that a client's post-hospitalization service needs are identified, and that necessary resources are made available to the client upon discharge. A number of individuals and agencies are involved in the process, including the client, the client's family, the CSB, State service agencies, and local agencies.

Discharge. Upon discharge, the client is referred to the CSB responsible for the original pre-admission screening. The CSB then implements the pre-discharge plan, and assists the client in obtaining the necessary services. The key actor in this step of the process is the case manager. The case manager is the CSB staff person responsible for linking the deinstitutionalized client with services in the community, and for monitoring the continued delivery of services to the client.

Community Services. Services may be provided at the local level by a number of agencies or private providers. Services can include day treatment programs, psychosocial rehabilitation, transitional employment, counseling, medication monitoring, residential services, and many others. In some instances, inpatient treatment may also be available in the community.

For clients who have not been linked with community services, outreach efforts become an important part of the process. Few of the clients discharged from State hospitals are "cured." Most require some level of community support in order to adjust to life in the community. Through outreach, CSBs can ensure that clients are linked to necessary services.

But even for clients who are recieving community services, especially those with chronic illnesses, the process is cyclic in nature. At some point, many clients become unable to function in the community setting, and re-hospitalization is necessary. These clients move through the system once again.

CLIENTS

Clients served in the community fall into one of three broad disability groups: mental health, mental retardation, or substance abuse. Mental health clients are those for whom the primary diagnosis is one or more of a number of mental illnesses. The great majority of active CSB clients are mental health clients -- ranging from individuals who seek counseling for special problems on a regular basis to individuals who are considered chronically mentally ill and require extensive mental health and support services. In a survey of CSBs, JLARC staff found that 39,586 clients (70.8 percent of all active clients) had a primary diagnosis of mental illness.

Mentally retarded clients are those who have significant handicaps in intellectual functioning and are in need of daily living and vocational training. CSBs reported that 7,100 (12.7 percent) of the clients served in the communities are diagnosed as mentally retarded.

Clients with substance abuse problems comprise the third disablility group. These clients typically present patterns of alcohol and/or drug abuse and require detoxification and support services for long-term community

adjustment. In the JLARC staff survey, CSBs identified 9,251 of these clients (16.5 percent) at the local level.

Within the three client groups, there are significant numbers of clients who have a "dual diagnosis." Such clients have been identified as having a secondary treatment need in addition to the primary diagnosis. Of the active clients identified by CSBs for the JLARC staff survey, 18 percent were diagnosed as having both mental health and substance abuse needs. Only two percent of the clients were diagnosed as having mental health and mental retardation needs.

Chronically Mentally Ill Clients

In recent years, deinstitutionalization has primarily involved mental health clients. To a large extent, mentally retarded clients who can be served in the community have been discharged, and substance abuse programs have been all but discontinued at the State hospitals. But many mental health clients continue to require periodic hospitalization, treatment, and return to the community. These chronically ill clients have been the focus of much of the deinstitutionalization process in recent years.

The chronically mentally ill comprise 79 percent of discharges from State hospitals. Additionally, chronically ill clients represent a plurality of all clients served in the community. Because of the demands that this group places on the community services boards, JLARC staff focused this review on chronically ill clients and their needs.

The chronically ill client population is mostly white, single, and young (Table 1). The age of the chronically ill population is significant. Because this group is active and mobile, service coordination is difficult. About 85 percent of the clients were not employed at the time of their admission to a State hospital. Nearly three-fourths had at least one prior admission to a State hospital. The importance of community services is highlighted by the fact that 82 percent were considered "improved/not recovered" at the time of discharge. As a result, 79 percent required medications, and most required some level of supervision.

Community services boards have varying levels of contact with chronically ill clients. Less than one-third (5,804 clients) fall under the category of "regular clients" -- those who receive day support, therapy, and/or residential services at least once a month.

A significant number of chronically ill clients (5,809, or about 32 percent) are "medication monitoring" clients. These clients are those whose primary contact with CSBs is for medication maintenance. These individuals receive regular medication checks by a psychiatrist but do not receive outpatient, day support, or residential services on any regular basis.

"Case management" clients (3,064, or 16.7 percent) primarily receive case management services and may only intermittently receive outpatient, day support, or residential services.

"Periodic clients" comprise approximately 6.8 percent (1,240 clients) of the chronically ill client population. This category involves clients who do not

Table 1

PROFILE OF CHRONICALLY MENTALLY ILL CLIENTS

AGE:	
Average Age	35 Years
Oldest Client	64 Years
Youngest Client	17 Years
SEX:	
% Male	58%
% Female	42%
EMPLOYMENT STATUS:	
% Unemployed Prior to Admission	85%
MARITAL STATUS:	
% Unmarried	83%
% Married	17%
MENTAL HEALTH STATUS AT DISCHARGE;	
% Improved, Not Recovered	82%
% Unimproved, Not Recovered	7%
% Other	11%
NEED FOR PSYCHOTROPIC MEDICATION:	
% Needing Psycotropic Medications	79%
KNOWN PRIOR HOSPITALIZATIONS IN THE PAST TWO YEARS:	
% with No Prior Hospitalizations	28%
% with 1 Prior Hospitalization	33%
% with 2 or More Prior Hospitalizations	39%
CAPABILITY OF LIVING IN THE COMMUNITY:	
% Requiring Supervision	79%

SOURCE: JLARC client follow-up.

fit into any of the previous three categories and who do not receive regular face-to-face contact with CSB staff or CSB contracted providers. Included in this category are clients who receive emergency services without active follow-up and those who receive case management on an infrequent basis.

Approximately 13 percent of the chronically ill clients could not be classified by the CSBs into any of the above categories.

Clients in the case management, medication check, and periodic categories receive considerably fewer services than regular clients. For some, minimum contact with CSB staff is considered appropriate as they strive for

independent living in the community. In other instances, CSB and hospital staff may recommend a variety of support services (e.g., individual counseling or psychosocial rehabilitation), but the client may refuse the service or receive it on an irregular basis. In other instances, however, clients in these three categories are unable to receive additional services because the services do not exist or are inadequate to serve all who need them.

THE "CONTINUUM OF CARE" CONCEPT

The diversity of clients discharged from State mental health hospitals and training centers as well as the changing nature of conditions such as mental illness and substance abuse create a need for a "continuum of community care" (Figure 4). Continuum of care refers to the availability of a range of alternative services both to meet the treatment needs of different populations and to meet the changing treatment needs of clients as they acquire new skills and adjust to the community. The continuum of care should make available to each client the appropriate treatment, training, and care in the least restrictive environment.

In the 1979 JLARC staff study on Deinstitutionalization and Community Services, numerous gaps were found in the availability of community services. For over 50 percent of all aftercare clients, the only service received was medication monitoring. JLARC staff recommended that the Department of Mental Health and Mental Retardation and the General Assembly consider mandating a basic core of services for discharged clients and to conduct a study to identify the basic services required.

Based on the staff recommendation, the concept of a continuum of care was promoted by the Bagley Commission in 1980. The continuum of care was seen as a central element in establishing a comprehensive community-based system of care. The commission stressed the importance of accessibility of services to clients, regardless of where they might reside in the State. Thus, the commission recommended that each CSB provide mental health, mental retardation, and substance abuse services necessary to ensure that appropriate and adequate services are offered to all clients of all disabilities.

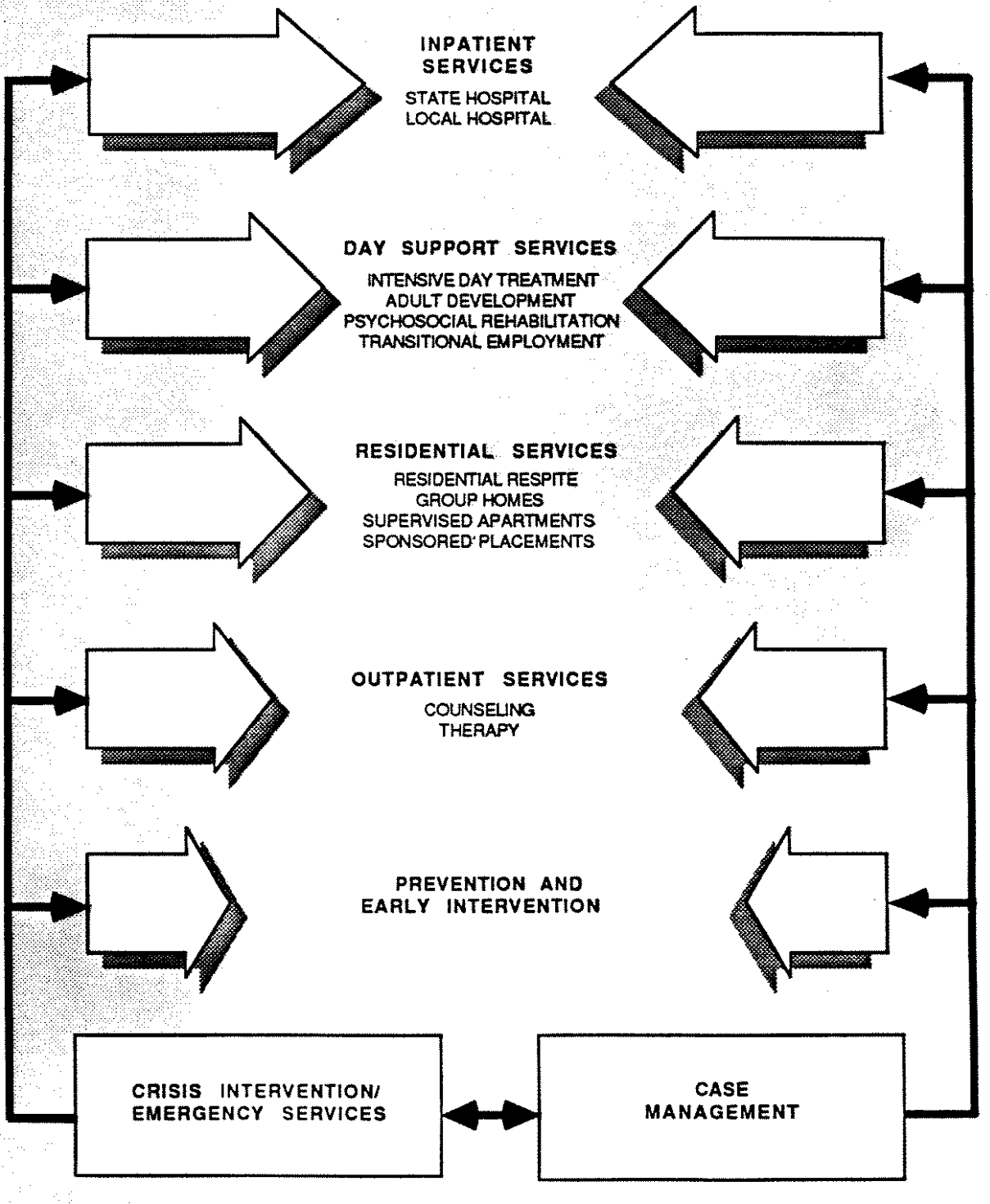
Through the Bagley Commission a list of core services was developed. Since 1980, the list has been modified and elaborated into a taxonomy of service categories. The taxonomy includes six core service categories:

- *Inpatient Services.* Inpatient services are those services that are delivered on a 24-hour basis in a hospital setting for mental health crisis stabilization, or for alcohol or drug detoxification.

- *Day Support Services.* Day support activities for all three disability groups include day treatment programs, psychosocial rehabilitation programs, transitional employment, adult developmental programs, and innovative day support arrangements such as supported placements in competitive work settings. Sheltered workshop programs, and educational and recreational services may also be offered to mentally retarded clients.

Figure 4

Continuum of Care for Mental Health Clients



SOURCE: JLARC staff graphic.

- *Residential Services.* Residential services involve overnight care in conjunction with intensive treatment or supervised living.

- *Outpatient and Case Management Services.* For mental health clients, outpatient services are provided on an individual, group, or family basis, usually in a clinic or similar facility. The services may include diagnosis and evaluation, counseling, psychotherapy, behavior management, and psychological testing. For substance abuse clients, outpatient treatment may include ambulatory detoxification, chemotherapy, and methadone maintenance.

  Case management services for all three disability groups involve identification of and outreach to potential clients, and the maintenance of the continuity of care to clients.

- *Prevention and Early Intervention Services.* Prevention activities are those such as consultation, education, and public information that seek to prevent or ameliorate the effects of mental illness, mental retardation, and substance abuse. Early intervention activities typically refer to infant stimulation services for developmentally delayed infants.

- *Emergency Services.* Emergency services are unscheduled services available 24 hours a day. They include crisis intervention, stabilization, and referral assistance, and may be provided over the telephone or face-to-face. Emergency services are intended to help reduce the need for hospitalization.

By calling for a comprehensive system of community care, the Bagley Commission proposed that this full range of services be made available in each of the community service boards. This review is focused to a large degree on the adequacy of these services at the community level, and the degree to which they are provided uniformly across the Commonwealth.

III. CLIENT MANAGEMENT

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

Under the Department of Mental Health and Mental Retardation's (DMHMR) client management procedures, the responsibility for managing a mentally disabled client's treatment program in both the hospital and the community rests with the community services board. Client management procedures are intended to ensure that: (1) hospital and CSB staff coordinate treatment plans, (2) the client's ongoing needs for treatment and supervision will be met in the community upon discharge, (3) inappropriate admissions are reduced, and (4) hospital stays are reduced to a minimum.

Client management is comprised of three primary activities: pre-admission screening, pre-discharge planning, and the transfer of primary treatment responsibility from the hospital to the community.

DMHMR has made significant progress in these areas since 1979. The Department has established pre-admission screening procedures for determining that no alternative to hospitalization exists in the community. Similarly, pre-discharge procedures are being implemented to ensure necessary support services are in place upon the client's discharge.

Despite improvements in recent years, however, problems persist in pre-admission and pre-discharge planning, the timely and coordinated transfer of information, and the adequacy of case management services. In some cases specific guidelines, improved training, and increased coordination among the community services boards, State institutions, and the judicial system would ensure more uniform implementation of these services.

PRE-ADMISSION SCREENING

The *Code of Virginia* establishes pre-admission screening as the mechanism whereby physicians, and CSBs, and their authorized agents determine an individual's need for hospitalization. In accord with legislative intent, DMHMR has articulated three goals for pre-admission screening:

(1) establishing a consistent method for the determination and documentation of a client's need for hospitalization,

(2) establishing a single point of entry into State psychiatric hospitals, and

(3) screening out people who are not in need of hospitalization, but who need other, more appropriate community resources.

Overall, DMHMR's pre-admission screening guidelines have been successful in reducing the statewide hospital census and in establishing focused, working relationships between CSBs and hospitals. DMHMR and JLARC staff data indicate that the effectiveness of the pre-admission screening guidelines could be further enhanced by requiring all admissions to be screened by a CSB, further specifying criteria and procedures for hospital admissions, and providing training for all individuals who implement pre-admission screening procedures.

Pre-Admission Screening Criteria and Procedures

Section 37.1-67.3 of the *Code of Virginia* outlines the circumstances under which a person may be involuntarily admitted to a State facility for treatment. DMHMR's client management guidelines elaborate on these criteria and extend them, in a modified form, to voluntary and substance abuse admissions.

The *Code* establishes a two-tier set of criteria for determining the need for hospitalization. Both components of the criteria must be met in order for an admission to be appropriate. The first level of criteria addresses the individual's mental condition and requires a determination that (1) the person is mentally ill, and (2) as a result of mental illness, the person is dangerous to himself or others, or is unable to care for himself. The second level of criteria requires an assessment of the availability of alternatives to hospitalization, and if available, why these alternatives are unsuitable.

Client management guidelines require that pre-admission screening services be made available by the CSB 24 hours a day, seven days a week. Also, the screening must be conducted by the CSB in which the client resides or in which the client is located at the time the screening becomes necessary.

Implementation of the pre-admission screening requirement by CSBs has been quite high. In the JLARC staff follow-up of 350 clients discharged from State mental health facilities, 88 percent of the clients had been screened prior to admission. Similarly, DMHMR's 1982 evaluation of pre-admission screening found that an average of "40% of pre-screened clients were diverted back into community based services." This 40 percent represents thousands of individuals who might have been hospitalized unnecessarily prior to the establishment of pre-admission screening procedures.

Barriers to Effective Pre-admission Screening

Pre-admission screening procedures could be further structured to ensure that legal and clinical aspects are considered in tandem to arrive at sound admission decisions. This interdependence could be achieved by: (1) requiring that all candidates for hospitalization be screened by a CSB, (2) further specifying guidelines to reduce discretion in determining the need for hospitalization, and (3) providing training for all those implementing pre-admission screening procedures.

Effects of Judicial Practices. While current statutes require that all voluntary admissions be coordinated through a CSB, pre-admission screening procedures can be bypassed when a judge is requested to commit an individual involuntarily to a State hospital, and a temporary detention order is issued. Section 37.1-67.3 of the *Code of Virginia* requires judges to request a pre-admission screening report from the CSB. If the CSB is unable to comply with the request within a specified time frame (typically 48 hours), a judge may order the client's involuntary admission to the State facility without the screening.

Of the 43 cases in the JLARC staff follow-up of clients that were not screened, 65 percent were court-ordered admissions. The analysis did not identify why pre-admission screenings failed to occur in these specific cases. However, central office and CSB staff noted that in some instances, the CSBs are not notified by the courts. On the other hand, CSB staff are sometimes unable to attend commitment proceedings held at State hospitals due to the considerable time and travel involved.

Regardless of the causes, however, the likelihood of inappropriate admissions is increased when pre-admission screening is not used. For this reason, 89 percent of the CSBs surveyed by JLARC staff agreed that judges should be required to obtain a CSB pre-admission screening for involuntary commitments. DMHMR also supports mandatory pre-admission screening. In a 1982 study, DMHMR recommended that:

> Procedures for a temporary detention order should be modified so that a pre-screening assessment by the community services board must be performed before: (a) a person can be held in a local (or institutional detention setting), or (b) a commitment hearing can be held.

Given the importance of the pre-admission screening process, such a requirement seems reasonable.

Guidelines for Screening. In 1982, DMHMR found that pre-admission screening guidelines required significant interpretation in determining the client's mental condition. According to the department's evaluation, the need for hospitalization could not be validated for 36 percent of all admissions. As a result, DMHMR recommended that "the process should provide a set of clinically operationalized and procedurally standardized criteria by which to determine the appropriateness of hospitalization." In recent discussions with DMHMR staff, JLARC found that the majority of the study's recommendations for strengthening the guidelines had not been implemented.

Screener Training. The DMHMR study also found that, in some cases, deficits in the "skill level" of pre-admission screeners limited the effectiveness of the pre-admission screening procedures. Screeners are not required to have any specified qualifications or to receive any particular type of training. By its own admission, DMHMR's efforts to train screeners have been limited.

Improving Pre-admission Screening

The department's goal to have all admissions screened by a CSB is an important one. It is the first step in preventing inappropriate hospital admissions

and in establishing a relationship of accountability for ensuring that mentally disabled clients receive appropriate care in the community. While significant improvements have been made since 1979, the full potential of this important mechanism is not being reached. Improvements in pre-admission screening should focus on uniform implementation by CSBs, the courts, and DMHMR.

Recommendation (1). The General Assembly may wish to modify section 37.1-67.3 of the *Code of Virginia* to require that all candidates for hospitalization (including transfers from other facilities) be screened by the appropriate community services board. Specifically, the General Assembly may wish to require that a pre-admission screening assessment be obtained before any steps to detain or involuntarily commit an individual can be taken.

Recommendation (2). DMHMR should make local providers aware that all candidates for hospitalization must be screened by CSB staff.

Recommendation (3). DMHMR should develop specific operational criteria and provide additional specific procedures to be used by pre-admission screeners to ensure uniform implementation of evaluations of clients.

Recommendation (4). DMHMR should establish minimum qualifications for pre-admission screeners. Minimum qualifications should include completion of a training course which results in certification in the clinical and legal interpretation and implementation of pre-admission screening guidelines and procedures.

PRE-DISCHARGE PLANNING

In its 1979 report, JLARC staff found considerable deficiencies in the identification of client needs and in the coordination among institutional and community service agencies in providing services to clients upon their discharge. In response, DMHMR established pre-discharge planning as the key mechanism for ensuring that clients' post-hospitalization needs are identified and that necessary resources are made available in the community.

Pre-discharge planning guidelines were first disseminated in 1981. The department issued a more comprehensive version of the guidelines in 1984. These guidelines have been credited by both hospital and CSB staff for improving coordination and communication during the discharge planning process. However, the department needs to further enhance the effectiveness of pre-discharge planning by ensuring that the planning process is more systematic, comprehensive, and coordinated.

Pre-discharge Planning: Procedures and Implementation

Pre-discharge planning is the process used in State facilities to prepare for the smooth transition of clients from the hospital to the community. The process has three major components: (1) notification of local service agencies of the pending discharge, (2) identification and arrangement for necessary community services, and (3) preparation of the client for his release.

DMHMR's 1984 client management guidelines reaffirmed that the purpose of pre-discharge planning is to ensure that appropriate services are available to the client on arrival in the community. The guidelines also stated that the CSB has primary responsibility for planning and securing post-hospitalization services and for handling a variety of exceptional circumstances. These guidelines were well received by CSB staff interviewed by JLARC staff. However, there was also a strong consensus that CSBs could not always meet their responsibilities to provide for services because of the lack of appropriate resources.

The pre-discharge planning requirement has been implemented. Only eight percent of the clients in the JLARC staff discharge profile did not have some form of discharge plan in place prior to release. Further, all CSBs send a liaison to their primary mental health hospital on a regular basis to facilitate communication with clients and the hospital staff. Finally, an average of more than three people participated in developing pre-discharge plans. Specifically, hospital staff participated in 97 percent of the discharges with discharge plans, clients participated in 83 percent, the CSBs were involved in 74 percent, and family members were involved in 42 percent of the plans.

Barriers to Effective Pre-discharge Planning

While there has been significant progress in the development and implementation of pre-discharge guidelines, the usefulness of the pre-discharge plan is lessened when it fails to address comprehensively the client's community support and treatment needs, and when information concerning the client's discharge is not communicated to the CSB in a timely manner.

Comprehensiveness of Pre-discharge Plans. Client management guidelines specify that discharge planning must address "the full spectrum of a client's needs, including psychological or psychiatric, housing, financial, day support or psychosocial, vocational, educational, medical, social or recreational, legal, transportation, and case management and advocacy needs." The 1985 General Assembly strengthened section 37.1-98 of the *Code of Virginia* with the following language:

> The pre-discharge plan required by this paragraph shall, at a minimum, specify the services to be provided to the released patient in the community to meet the individual's needs for treatment, housing, nutrition, physical care and safety, and to link the individual with the appropriate service providers and human service agencies.

While pre-discharge planning has been widely implemented across State facilities, the guidelines do not appear to ensure full identification or receipt of necessary services.

In 1979, JLARC staff recommended that State hospitals use a single, standardized format for preparing client discharge plans. Yet, each hospital continues to use its own approach in developing pre-discharge plans and its own form for communicating this information to the CSBs. For example, only two of the six primary hospitals use forms which include a checklist of support services

required by the client. Similarly, not all forms include the client's legal status or diagnosis at the time of discharge.

The lack of comprehensiveness was also indicated by the data collected by JLARC staff. For example, for 54 of the 248 clients in the JLARC staff sample for which both hospitals and CSBs gave diagnoses, there were conflicts between the hospitals and the CSBs with regard to the clients' diagnoses. The majority of these cases involved a lack of consensus in identifying whether a client had a mental health or substance abuse diagnosis.

Housing did not appear to be consistently identified as a service need. In 64 cases, CSB staff judged clients to be living in inappropriate residential settings. When JLARC staff examined pre-discharge plans for these clients, only 39 percent had housing identified as a service need.

Coordination Between Hospitals and CSBs. The 1979 JLARC staff report found problems in the timely transfer of discharge information from the hospital to the CSB. At Eastern State Hospital, for example, the report noted:

> Hospital information on discharged clients, such as diagnosis and medications, was generally sent to clinics about one week after discharge. Delay could cause clinics problems in dealing with clients who arrive at the clinic before the information, and who are in crisis or are anxious about being discharged.

In response to this finding, notification of the CSB of the client's anticipated and actual discharge date is now negotiated and specified as part of the facility/CSB agreements required by the 1984 guidelines. Implementation of this requirement appears to be good. In 82 percent of the cases, CSBs received discharge summaries within one week of the clients' discharge dates.

But the guidelines do not specify how soon after discharge the client should be seen by CSB staff. Though early contact is considered important in linking clients with the services which will help them adjust to life in the community, only 48 percent of the clients in the JLARC staff sample were seen by CSB staff within one week of discharge. An additional 22 percent were seen within the second week, and 30 percent were not seen until after 15 or more days in the community.

Use of Temporary Leave. Temporary leave is a client visit home for a trial period of up to two weeks. There appears to be insufficient reference in the guidelines to the use of temporary leave and its impact on the discharge planning process. Often, when the visit is successful, the client will be discharged while on temporary leave rather than returning to the hospital. Without close coordination with the CSB, temporary leave can not only undermine the entire discharge planning process, but can have other serious consequences, as the following case study illustrates:

> *Southside CSB reported that a client was involuntarily committed to a State hospital. The CSB's liaison met with the client on several occasions and found that the client was still "too psychotic" to return to the community. In spite of this recommendation, the client*

was discharged on temporary leave. The CSB was not notified of the hospital's decision. Upon reentering the community, the client went to the CSB, threatening to kill the staff member who had conducted the client's pre-admission screening. Fortunately, that staff member was not in the clinic, and the client was successfully subdued.

While this case study represents an extreme example, it illustrates the need for coordinating temporary leave. DMHMR should expand the guidelines to include responsibilities and procedures for the use of temporary leave. Consistent with its role in managing all phases of the client's admission to and discharge from State hospitals, the CSB should retain responsibility for managing the client's transition into the community while on temporary leave. In no case should hospital staff unilaterally decide to release an individual on temporary leave. The use of temporary leave and the decision to discharge the client while he or she is in the community should be made jointly by CSB and hospital staff.

Improving Pre-discharge Planning

To be effective, pre-discharge planning must systematically assess each client's needs for treatment and support services. After the client's needs are identified, necessary program resources must be made available so that the client can make a successful transition from the hospital to the community.

Recommendation (5). DMHMR should develop a uniform pre-discharge assessment and planning instrument to be used by all State hospitals. To ensure comprehensive planning for the client's transition into the community, the form should include a checklist of necessary services including, but not limited to treatment, housing, nutrition, financial, rehabilitative, and medical needs.

Recommendation (6). DMHMR should establish and incorporate specific time guidelines into the client management guidelines for hospitals to use in preparing pre-discharge information for CSBs and for notifying CSBs of anticipated and actual discharge dates. These guidelines should ensure that CSBs have adequate time to prepare for the client's return to the community.

Recommendation (7). DMHMR should expand the pre-discharge planning guidelines to address the roles, responsibilities, and procedures for the use of temporary leave. In all cases, the decision to employ temporary leave should be jointly made by the hospital and CSB staff.

LINKING CLIENTS TO COMMUNITY SERVICES

The majority of clients discharged from State hospitals are not fully recovered. According to DMHMR hospital data, 83 percent of those discharged are labeled improved, but "not recovered." In order to adjust to the community, therefore, these clients typically require one or more types of treatment or support. Without this assistance, it becomes more difficult for the client to make the adjustment from a highly structured hospital setting to an independent community setting. The timely and coordinated transfer of treatment

responsibility from hospital to CSB staff is a pivotal first step in determining a client's success in adjusting to the community. Failure to make this transfer, and to establish a "service link" with the client reduces the opportunity to provide appropriate services and increases the chances of recidivism.

In addition to predischarge planning, the coordinated transfer of treatment responsibility has three steps. First, the CSB must make an initial contact with the client. Often, it is necessary for CSB staff to engage in outreach efforts in order to encourage and assist potential clients to participate in community treatment programs. Second, arrangements must be made to ensure that appropriate programs and staff are available for the client. Third, case management is necessary to ensure coordination of community services as the client's treatment and support needs change over time.

Of the 343 clients who could be followed-up by JLARC staff, 63 percent made contact with the CSB after discharge from a State hospital. About 40 percent of all clients received community treatment and support for more than four months. This indicates that in many cases, CSBs have been successful in encouraging clients to begin and continue treatment. An additional 23 percent of the clients received services for periods from two weeks to two months. These clients were "hooked into" the system, but did not maintain contact. In some cases, this shorter length of time is appropriate. For example, some clients can be stablized and require only infrequent contact with the CSB. In other cases, continued treatment was appropriate but not offered because the client refused to continue services.

While the transfer of responsibility appears to be working in a large number of cases, some additional improvements are necessary. There are several indications of the need for improvements. About 37 percent of the aftercare clients in the JLARC sample did not receive any community services after discharge. In 49 cases the clients would not have been expected to receive community services because they moved out of the State, went to private providers, or came under the custody of State or local correctional systems.

Excluding those not expected to be served, 72 clients did not receive any community services. Many of these clients refused to participate in CSB programs. Additionally, 36 of the clients did not receive services because of problems in coordination or communication between service providers. Examples of this include judges or hospital staff not informing CSBs that a client has been discharged.

Additionally, more than half of the clients discharged from hospitals receive less than two weeks of community intervention. While many of these clients refuse community services, outreach is not sufficient to ensure that linkages with community providers are made. Additionally, case management is not available to many clients. Thus, some clients are unlikely to sustain contact with the CSB. For those clients who, contrary to their own best interests or safety, refuse community services, outpatient commitment may be an additional mechanism to help link clients to essential services.

Outreach Services

Many aftercare clients are in vulnerable situations upon discharge from State hospitals. The vast majority are not "cured" and continue to have

difficulties adjusting to community living. Many are not familiar with the availability or location of community services. In addition, many clients are hesitant to present themselves to CSBs, and others refuse community services when offered to them. Outreach is the most effective service to "hook" these clients into the mental health system.

DMHMR's client management guidelines do not specify how soon after discharge a client should be seen by CSB staff. However, given the immediate needs of clients when discharged from a hospital there was a consensus among those interviewed by JLARC that the initial contact with CSB staff should be within one week. As noted earlier, an analysis of client follow-up data showed that only 48 percent of all discharged clients were seen by CSB staff within one week of discharge; and 30 percent did not have contact with CSB staff until two or more weeks after discharge.

To examine the adequacy of outreach, JLARC staff focused the analysis on those clients who failed to establish contact or who discontinued services with the CSB. That analysis shows that outreach is not conducted on a regular basis.

In JLARC's sample, 27 clients were identified who were known to CSB staff but who did not show up for an initial contact after discharge. Outreach attempts were made in only three of these cases. Moreover, when outreach attempts were made, they consisted of letters and phone calls. In no instance did CSB staff visit a client's home to perform outreach responsibilities.

A similar pattern was observed for 64 clients who established contact with the CSB, but then dropped out of the service delivery system. In these cases, only 29 of the clients (45%) received outreach services. Letters and phone calls were again the most frequent forms of outreach. Only one home visit was conducted.

In sum, the frequency of outreach does not appear sufficient to address aftercare clients' needs for assistance and supervision, or to ensure that eligible clients are "hooked into" the system. In interviews with JLARC staff, CSB staff stressed the importance of outreach, but consistently noted that staffing limitations restricted their ability to perform this function consistently.

Case Management Services

In a hospital, a client's basic needs for food, shelter, and medical care are met without the client having to make any effort. In contrast, community living requires the client to obtain services from a variety of different providers such as the community services board, the Department of Social Services, the Department of Health, the grocery store, and the bank. Case management services are designed to provide assistance to the client in obtaining services.

One of the important findings of JLARC's 1979 report was the need for increased availability of case management services in the community. The report concluded that no one agency had clear responsibility for coordinating comprehensive client care in the community. In 1982, DMHMR issued administrative guidelines that specifically outlined case management functions:

- Assessing both the client's needs for various support services and the availability of these services in the community.

- Planning necessary to the formulation of an individual Service Plan that indicates the client's service needs, the appropriate agencies to address the identified needs, the person responsible for coordinating receipt of services, and target dates for initiating identified services.

- Linking the client to the agencies, programs, or individuals who can best address client needs identified in the individual service plan.

- Monitoring the delivery of the services to ensure that services are received and continue to be appropriate in light of the client's changing needs.

Several models of case management are used in Virginia. In some CSBs, specific staff members are designated as case managers for each of the disability areas. In other CSBs, specific staff members are designated as case managers for all disability groups. In others, the responsiblity for case management lies with the outpatient services staff, or may reside with the staff of a client's primary service; for example, psychosocial rehabilitation counselors may serve as the case managers for the clubhouse members.

Case management is not a substitute for other necessary services. Both hospital and CSB staff stressed that when offered in conjunction with program services, it was effective in helping to maintain a service link in the community. For example, Planning District 19 CSB provides case management services to a group of 63 clients as part of a psychosocial program called Sycamore Center. The primary therapist provides case management services with a staff-to- client ratio of 1 to 30. Sycamore Center staff report tremendous success in preventing readmissions to State facilities in the program's first two years of operation, with a recidivism rate well below the statewide rate. Staff in other day support programs where case management is provided report similar successes in maintaining ongoing contact with the client.

Case Management for Mentally Ill Clients. Independent of the approach, the effectiveness of case management services depends on the size of the case manager's case load. Very large case loads severely constrain the case manager's ability to respond when a client loses contact with the CSB. Although no CSB has an absolute gap in mental health case management, excessive case loads indicate that the level of service provided may often be minimal at best. Case manager-to-client ratios range from 1:3 to 1:215, with a statewide median of 1:49. On the average, this ratio allows for only 1.8 hours of case management per chronically ill client per month. To some extent, this small amount of time per client may explain why the majority of outreach efforts consist of letters and phone calls, rather than the more effective approach of face-to-face home visits.

Statewide, the CSBs estimate that approximately 4,252 (28 percent) of the chronically mentally ill client population is not receiving the necessary amount of case management. To provide the appropriate level of services, CSBs report the need for 122 additional case management positions.

The lack of a sufficient number of case managers poses a number of problems. In Arlington, for example, the large number of clients per case manager allows only five minutes to be allocated per client for medication appointments. In other areas, an insufficient number of case managers creates a limited capacity to do any outreach to clients in the community and to follow-up on clients that have missed appointments. Caseload demands are considered by several CSBs to be too overwhelming to provide the constant and intensive service needed. More time is needed for assessment, planning, and advocacy. The Rappahannock CSB, for example, estimated that between 75 and 90 percent of its chronically ill clients receive inadequate assessments, and approximately half do not receive the full range of services available.

In addition, greater demands on CSBs to provide active discharge planning and linkages to resources requires considerable staff time. In some rural regions, geographic distances require staff travel, and decrease the time spent on direct client services.

Case Management for Mentally Retarded Clients. Case management services are also very important to the success of mentally retarded clients in the community. But the CSBs reported that case management services for mentally retarded clients are inadequate. Insufficient services are provided because of high client-to-case manager ratios.

The median statewide case manager-to-client ratio is 1 to 55. On average, mentally retarded clients receive only two hours of case management each month. As a result, the CSBs reported to JLARC staff that 32 percent of the mentally retarded clients statewide receive inadequate case management services. According to the community services boards, a total of 94.5 additional case managers are needed to serve the 2,258 clients with inadequate services.

Outpatient Commitment

Section 37.1-67.3 of the *Code of Virginia* outlines criteria for involuntary and voluntary commitment to State mental health hospitals. Section 37.1-67.3 also authorizes court-ordered outpatient treatment to serve the needs of those individuals who meet the criteria for involuntary commitment, but do not require hospitalization. This section of the *Code* is rarely employed because there are few specified procedures for its implementation and enforcement. Wisconsin, Hawaii, North Carolina, and the District of Columbia have enacted legislation or established procedures which make outpatient commitment more feasible and enforceable.

Outpatient treatment can include any treatment intervention prescribed to alleviate or prevent the person's deterioration as a result of mental illness. Treatment interventions include, but are not limited to use of medication, individual or group counseling, day treatment, psychosocial programs, supervision, and educational or vocational programs. North Carolina makes the use of outpatient commitment procedures contingent upon verification that necessary services are available for the client in an outpatient setting. The criteria for use of outpatient commitment across states are similar, but not identical. North Carolina's laws (Section 122-58.4), for example, base the decision on findings that:

(a) the respondent is mentally ill, and

(b) the respondent is capable of surviving safely in the community with available supervision from family, friends, or others, and

(c) based on the respondent's treatment history, the repondent is in need of treatment in order to prevent further disability or deterioration which would predictably result in a danger to oneself or to others, and

(d) his current mental status or the nature of his illness limits or negates his ability to make an informed decision to seek or comply voluntarily with recommended treatment.

The District of Columbia has employed outpatient commitment procedures for more than 13 years. The effectiveness of outpatient procedures was recently reviewed by staff at Saint Elizabeth's, the District's largest public mental health facility. Overall evaluations of the effectiveness of outpatient commitment were positive. The report concluded that, "the type of patient for whom it is most beneficial is one who has a history of multiple hospitalizations, has shown a good response to medication but lacks insight and fails to comply as a voluntary outpatient, and has frequent and severe relapses of the mental illness." The report also stressed that this approach is most effective with patients who have a stable residential situation that provides some measure of support and supervision.

The JLARC staff review of other states' statutes revealed that each state's procedures provide a mechanism whereby law enforcement officials can take a noncompliant individual into custody and return the individual to a designated clinic or physician for examination. The court is notified if the physician finds that the patient no longer requires outpatient commitment. If the determination is that the patient is dangerous to himself or to others, inpatient commitment proceedings are initiated.

The main criticism of the procedure raised in the evaluation by Saint Elizabeth's is that it is often difficult to enforce. Often, law enforcement officers may give custody orders low priority. There was agreement, however, that the mere threat of the involvement of the police motivated most patients to comply with outpatient treatment requirements. Other motivational aspects included being taken into custody and appearances before the judge.

Improving the Transfer of Treatment Responsibility

For the majority of clients who have been hospitalized, particularly for those with a history of multiple admissions, current practices in providing adequate support during the transition from the hospital to the community may be inadequate. Many clients must face this extremely stressful period of change alone. Responsibilities and procedures for managing the client's transition from the hospital to the community need to be improved.

Recommendation (8). In order to reduce gaps in outreach and case management services, the General Assembly may wish to fund additional case manager positions. The Department of Mental Health and Mental Retardation

should report to the General Assembly on the specific mental health and mental retardation case management staffing needs of the community services boards.

Recommendation (9). The Department of Mental Health and Mental Retardation should develop specific guidelines for managing client transition from the hospital to the community. The guidelines should include: procedures for the identification of clients at risk; requirements for the assignment for each client of a primary CSB contact staff person who is accountable for the client's transition to the community; and standards for the use of outreach and case management.

Recommendation (10). To ensure that CSBs can provide essential services to "refusing" clients, the General Assembly may wish to amend section 37.1-67,3 of the *Code of Virginia* to specify procedures for the implementation and enforcement of existing outpatient commitment laws. The procedures could be applied to clients with a history of multiple hospitalizations and who have been shown to benefit from treatment, but who do not comply with community treatment.

IV. COMMUNITY SERVICES

Chapter 10 of Title 37.1 of the *Code of Virginia* designates the community services boards as the key providers of mental health, mental retardation, and substance abuse services in the Commonwealth. In the 1979 JLARC study on Deinstitutionalization and Community Services, numerous gaps were found in the availability of community services. For more than 50 percent of all aftercare clients, the only service received was medication monitoring. JLARC staff recommended that the Department of Mental Health and Mental Retardation and the General Assembly consider mandating a basic core of services for discharged clients.

Through the work of the Commission on Mental Health and Mental Retardation (Bagley Commission), a group of core services was developed. Since 1980, the services have been modified and elaborated into a taxonomy of service categories. The taxonomy includes six core service categories as outlined in Chapter II.

The success of clients in the community is directly influenced by the core services made available after discharge. As a part of this study, JLARC staff reviewed the availability and adequacy of each of the core services. Although improvements have been made in the development of services across the State since JLARC's 1979 report, there continues to be considerable unmet need for community services.

There are significant gaps in services in each of the core areas. The three types of service gaps are:

- An absolute gap occurs when a CSB does not provide a core service. For example, a CSB that does not offer at least one day support program for mental health clients would have an absolute gap in day support services.

- A program gap occurs when a CSB lacks a necessary program within a core service category. For example, a CSB may offer adult development for severly disabled mental health clients but may also need a psychosocial rehabilitation program for higher functioning chronically mentally ill clients.

- A capacity gap occurs when a CSB offers a program that, at its current capacity, cannot adequately serve all clients who need the program. For example, a CSB that offers a psychosocial rehabilitation program but cannot adequately serve all who might benefit from the program is experiencing a capacity gap.

Virginia's community service system continues to have absolute, program, and capacity gaps in its core services.

COMMUNITY SERVICES FOR MENTAL HEALTH CLIENTS

Virginia's community service boards serve a variety of clients with mental health needs. Approximately 46 percent of the mental health clients served are considered chronically mentally ill. Chronically ill clients typically have a history of mental health hospitalizations and are considered at risk of acute psychiatric episodes requiring hospitalization. Individuals who are chronically mentally ill can have periods in which their mental health status is somewhat stable and in which there is little need for intense supervision. At other times, however, they may experience acute psychiatric episodes necessitating a more restrictive environment in which crisis stabilization can be provided.

The needs of mental health clients, particularly the chronically ill, are vast and dynamic, necessitating a continuum of care that can adequately serve the individual needs of a diversity of clients. To prevent imbalances that can evoke acute episodes, many chronically ill clients require some level of medication maintenance. On some occasions, inpatient treatment may be necessary. A number of mentally ill clients also need support services to facilitate their community adjustment. Many lack necessary living skills such as cooking, personal hygiene, and money management. Others require training in basic work skills and experience in structured job environments. Most need assistance in accessing additional social and health services.

The variety of needs of the chronically mentally ill thus necessitate a range of community services that includes local hospitalization for acute psychiatric treatment, day support services providing opportunities for learning a variety of life and work skills, case management for securing needed assistance from other agencies and service providers, and outpatient services for psychological counseling.

The continuum of care must not only encompass the core service areas, but must also meet client needs for specific subcategories of services. As discussed in Chapter III, significant service gaps for the mentally ill exist in case management and outreach services. Additional service needs are apparent in inpatient care, day support programs, and outpatient services. The gaps in day support are significant because day support is viewed by mental health professionals as the foundation of community support for the chronically mentally ill.

Inpatient Services

Inpatient hospital care is the most restrictive environment for the treatment of mental illnesses, and has traditionally been the responsibility of the State. State mental health hospitals currently provide an array of inpatient services including: (1) acute care and short-term stabilization, (2) diagnosis and evaluation, (3) care of low-incidence populations including the forensic mentally ill and dually diagnosed, and (4) long-term care of the chronically mentally ill. The first two services meet needs that can be addressed in the community.

To the extent that inpatient care can be provided at the local level, however, clients can be served in their own communities, and the need for large State institutions can be reduced. While the Commonwealth has a goal of reducing State hospital bed use, the unavailability of services at the local level, and the funding of hospital care makes realization of the goal difficult.

The Need for Local Inpatient Services. The average length of stay in State mental health hospitals has decreased significantly, from 61 days in 1976 to 26 days in 1984. Of the 350 discharged clients in the JLARC follow-up, 34 percent had hospitalizations of two weeks or less. Short lengths of stay complicate the provision of services to the client. First, the client's community support network is disrupted. Second, hospital and CSB staff are required to conduct pre-admission screenings, prepare pre-discharge plans, and coordinate the transfer of treatment responsibility for each admission. Short lengths of stay increase the chances of delays and poor coordination of services. Finally, short lengths of stay are expensive. In Virginia's hospitals, daily costs are between 42 and 120 percent higher for beds in admission units than for beds in other units.

Local inpatient programs provide a means to address the limitations of State mental health hospitals in providing short-term acute care. First, the use of local hospitals promotes continuity of treatment and allows the client to remain in the community. Second, client management is facilitated, and fiscal and programmatic accountability remains directly with the CSB throughout the client's hospitalization. Third, the use of local inpatient services helps to decrease the use of more costly State hospital beds. Yet, DMHMR has not encouraged the development of local inpatient programs as an alternative to State hospitals. Only ten CSBs currently have local inpatient programs, and thus, this treatment alternative is not available to most CSBs.

There is sufficient capacity in local hospitals to make inpatient programs available. According to the State Department of Health, approximately one-third of all local hospital beds across the State are empty on any given day. Low utilization of local hospitals and the need for local inpatient psychiatric services present possibilities for cooperation between CSBs and local hospitals. Specific financial incentives would be needed, however, to promote this cooperation.

Incentives for Local Inpatient Care. Currently, CSBs do not have any financial incentives to reduce their use of State hospital beds. CSBs have financial responsibility for the client only when treatment is offered in the community. When a client is placed in a State hospital, CSB financial responsibility is relieved and the State provides funds for treatment. Thus, funding responsibility for the client's care serves as a financial disincentive to providing treatment in the community.

Other states have addressed this problem by developing funding mechanisms whereby local service providers (such as the CSBs) pay for their use of State hospital beds as an incentive to reduce utilization. In Wisconsin, for example, local providers are allocated funds at the beginning of each year. The local providers then have the option of using the funds to provide either hospital or community treatment. Through this approach, Wisconsin has gradually reduced state hospital use over time. This type of mechanism might also be

expected to provide CSBs in Virginia with incentives to develop local inpatient treatment alternatives.

Day Support Services

Day support services for mentally ill clients fall into a continuum of their own, including adult development and day treatment, psychosocial rehabilitation "clubhouse" programs, and transitional employment. Table 2 summarizes the availability of day support programs.

Table 2

MENTAL HEALTH DAY SUPPORT SERVICES

	Adult Development/ Day Treatment	Psychosocial Rehabilitation	Transitional Employment
CSBs with Program	11	32	13
Clients Served	748	2,297	130
Clients Receiving Insufficient Services	369	3,032	139
CSBs without a Program	29	8	27

Source: Survey of CSBs.

Adult Development and Day Treatment. Adult development and day treatment programs for mental health clients provide multidisciplinary treatment and instruction to clients with serious pathological conditions requiring intensive treatment. The purpose of these programs is to help clients progress toward independent functioning in the community.

Significant program and capacity gaps exist in adult development and day treatment services. Only 11 of the 40 CSBs currently offer either an adult development or day treatment program, serving a total of 748 clients. The mental health directors of these CSBs estimated that 369 clients either needed more of these services or were currently not receiving any service. It is not known, however, how many clients are in need of these services in the 29 CSBs that do not have an adult development or day treatment programs.

Psychosocial Rehabilitation. Psychosocial rehabilitation programs (also known as clubhouses) have been cited as the most successful of the services for chronically mentally ill clients. Representing a shift from the traditional medical model of treatment for psychiatric disorders, the psychosocial model fosters independence and the attainment of life skills.

Currently, 32 CSBs offer psychosocial rehabilitation services. Although these programs serve a total of 2,297 clients, unmet demand is very high, with 3,032 clients receiving an insufficient level of service. Although some of the unmet demand for these programs is attributable to inadequate capacity in the programs, much of the problem is also due to inadequate transportation services. The lack of transportation was often cited as a key obstacle to clients' regular participation in clubhouse programs.

Program gaps were identified in eight CSBs. In these communities, none of the mentally ill clients served have clubhouse programs available to them. Since these CSBs serve a large number of chronically ill clients, it is clear that additional unmet demand exists for psychosocial rehabilitation services.

Transitional Employment. Transitional employment programs provide remunerative employment for those clients who require training before entering the competitive labor market. Programs may include work enclaves, specialized vocational training programs, and supported placements in competitive work settings.

As with other day support programs, there are significant program and capacity gaps in transitional employment services. Only 13 CSBs offer some type of program, serving 130 clients. The mental health directors in these CSBs estimated that services were needed for an additional 159 clients. Twenty-seven CSBs do not offer any type of transitional employment program for mental health clients.

Outpatient Services

Outpatient services include diagnosis and evaluation, counseling, psychotherapy, behavior management, psychological testing, and medication monitoring. These services are typically provided in clinics or in similar facilities on an individual, group, or family basis. More than 69 percent of the chronically mentally ill client population require some level of medication monitoring, and for 34 percent medication checks serve as the primary contact with CSB staff or contracted providers.

Outpatient services are available across the State, but are inadequate. While no CSB reported an absolute gap in outpatient services, 29 CSBs reported that their programs had inadequate capacity. Clinic caseloads are high, with as many as 159 clients per outpatient staff person. The overall statewide median staff-to- client ratio is 1 to 47.

One of the most commonly reported needs in the JLARC survey of CSBs was additional consultation time from psychiatrists and clinical psychologists. Limitations in psychiatric and psychological support reduce the time that can be spent on therapy and medication monitoring. In turn, these limitations create the situation in which staff can provide only minimal care to clients.

In addition to psychiatrists and clinical psychologists, CSB outpatient staff also appear to be needed. In Chesapeake, for example, outpatient staff also serve as emergency staff. As a result, they must provide consultation to

the courts on pre-admission screening and commitment for every case. As a result, the staff must reduce the time allocated to outpatient services.

In several areas of the State, the wide geographic coverage of the CSB and the distance from the clinics to outlying counties prohibit some clients from receiving outpatient services on a regular basis. In instances in which clients require medication but do not have transportation to the CSB for medication checks with the psychiatrist, CSB staff must either transport the medication to the client or mail the medication via certified mail. This pactice ensures that the medication reaches the client, but does not ensure that the client is using the medication properly, or that the medication continues to be appropriate.

Improving Mental Health Services

In order for chronically ill clients to live successfully in the community, improved mental health services will be needed. To a large extent, the success of deinstitutionalization in Virginia is dependent on more uniform availability of mental health services at the local level.

Recommendation (11). The General Assembly may wish to amend Section 37,1-194 of the *Code of Virginia* to mandate provision of psychosocial rehabilitation, transitional employment, and medication maintenance services for mental health clients.

Recommendation (12). The General Assembly may wish to give funding priority to the development and expansion of community services for the chronically mentally ill. The General Assembly may also wish to direct the Department of Mental Health and Mental Retardation to assess the need for services in each of the 40 CSBs, and to specifically identify inadequacies in psychosocial rehabilitation, transitional employment, and outpatient services.

Recommendation (13). In order to reduce State hospital utilization and broaden the continuum of care provided in the community, the Department of Mental Health and Mental Retardation should promote the development of local inpatient programs. The department should review the feasibility of alternative funding mechanisms which would provide incentives for the use of local inpatient beds, such as "buying" State hospital beds for clients. In addition, the department should provide technical assistance to CSBs in the development of programs, and in the development of contracts with local hospitals.

COMMUNITY SERVICES FOR MENTAL RETARDATION CLIENTS

Currently, more than 7,000 mentally retarded clients receive community services in Virginia. Since 1979, there has been a shift in the type of client discharged from State training centers. In general, clients are more disabled and exhibit more behavior problems. It is anticipated that, in the future, clients discharged from training centers will be multihandicapped (with physical and mental disabilities), lower functioning, and experiencing greater behavioral problems.

In addition, CSBs will need to serve greater numbers of clients who have never been institutionalized. Many clients who have lived with their families since birth are expected to require alternative living situations as their families age and become unable to care for them. Also, clients who have received services since the age of seven through the public schools as a result of Public Law 94.142 will require community services as they reach age 22.

Adequacy of Mental Retardation Services

Although there are few absolute gaps in services for the mentally retarded, there is a growing demand for services. The demand is for all types of service, from early intervention to day support and residential services. Existing gaps in services will make it difficult for CSBs to meet expected demand.

Early Intervention. Currently, 34 CSBs offer some form of early intervention program. Most of the early intervention efforts for mental retardation clients focus on infant stimulation programs for developmentally delayed infants and infants at risk of mental retardation.

Day Support Services. Day support services for mentally retarded clients include adult developmental programs, transitional employment and sheltered workshops, and education and recreation programs. Adult development programs involve instruction and training on independent functioning skills. Extended sheltered workshops provide remunerative employment for clients who are not prepared for work in a competitive work environment. Recreation programs provide enrichment and leisure activities carried out during the summer or throughout the year. All 40 CSBs offer some type of day support services. The results of the CSB survey indicate, however, that significant program and capacity gaps exist in day support services for mentally retarded clients.

Only 29 CSBs operate an adult development program, serving a total of 890 clients. Staff in these CSBs estimate that 498 clients who could benefit from their adult development programs are either unserved or underserved. In 11 CSBs, no adult development programs are offered.

Extended sheltered workshops are offered by 30 CSBs. Although 1,928 clients are served by these programs, 842 of these clients are reportedly receiving insufficient services, and 10 CSBs do not offer any employment programs. Because of the number of clients unserved, and because of the importance of employment opportunities to the success of clients in the community, CSB staff identified sheltered workshops as a critical need.

Recreation programs are offered by six of the 40 CSBs. These programs are typically ancillary programs, offered in addition to adult development or workshop programs. Currently, 408 clients are served by these programs. In just the six operating programs however, 106 clients are receiving inadequate services, and 34 of the CSBs provide no recreational programs.

Future Demand for Mental Retardation Services

Although deinstitutionalization of the mentally retarded occurred primarily during the late 1970s and early 1980s, the effects of the shift in the role of the State in serving mentally retarded clients will continue to be felt in the community service system. Clients who are anticipated to need additional services in the future include clients who are currently living with their families, clients who are currently served through the public schools, and clients currently living in training centers.

Clients Currently with Families. An estimated 4,550 mentally retarded clients (66 percent of the total client population) are presently living with their immediate families or with other relatives. One of the concerns for the future involves alternative housing for those clients whose families will no longer be able to care for them in their elderly years. Although some CSBs are working with families now to consider housing options in the future, without additional service, these efforts will have limited success.

Clients Currently Served Through Schools. Through Public Law 94-142, mentally retarded children receive educational services and other support services through the public schools until they reach age 22. Since the law was enacted in 1975, students who have attended school for a number of years are now requiring community day support services. For these individuals, the need for services can be more pronounced than for others because they have become dependent on a high level of support. Without adequate services to substitute for those currently provided in the public schools, these clients may be unable to live successfully in the community.

Clients Currently in Training Centers. CSBs estimate that 1,131 mentally retarded individuals who are currently in the State's training centers could be discharged if appropriate housing and community support services were available in the community. To serve these clients at the local level, however, CSBs report a need for residential programs, programs for the multihandicapped, and respite care programs.

Improving Mental Retardation Services

Significant gaps in services available for mentally retarded clients continue to exist. Because many CSBs have no programs in the area of day support, the full extent of the need for services cannot be measured.

Recommendation (14). The Department of Mental Health and Mental Retardation should take immediate steps, in cooperation with the 40 community services boards, to identify service needs for mentally retarded citizens. The department should prepare a plan for implementing and funding priority service needs in the CSBs.

COMMUNITY SERVICES FOR SUBSTANCE ABUSE CLIENTS

Substance abuse clients comprise 19 percent of the population discharged from the State's mental health hospitals. However, an additional 15

percent of the discharged population have substance abuse as a secondary or dual condition with mental illness. CSB staff reported that many clients have a history of abusing both alcohol and drugs. These clients have changed somewhat over the past five years, being characterized by the CSBs as younger, lacking adequate social support, and less prepared for discharge.

In some respects, substance abuse clients appear to overlap with both mental health clients and mental retardation groups. Many suffer emotional and mental health problems, often as a result of years of continued alcohol or drug abuse. Many are characterized as "socially retarded" or "functionally retarded", lacking a number of social and work skills. Thus, their service needs are diverse, ranging from outpatient counseling to a set of intensive treatment services.

The continuum of care for substance abuse clients refers to the need for a progression of services that can be provided to individual clients as they achieve greater independence from alcohol or drugs. The continuum involves medical and social detoxification services, primary care (28 days), and longer-term residential services. Day support and work programs, and outpatient services are also needed to teach basic skills, to prepare clients for the workplace, and to provide support during a client's adjustment to the community.

In general, the level of services available to substance abuse clients is poor. With the declining role of State mental health hospitals in the treatment of substance abuse, it is imperative that adequate services be available in communities across the State. At present, however, few CSBs offer even a minimum range of services for substance abuse clients (Table 3). Detoxification services are the most widespread, but can be effective only for short-term care of the client. Longer-term, continuous programs are needed to aid clients in maintaining their independence from alcohol and drugs and in learning the skills necessary to adjust to community living.

Table 3

COMMUNITY SERVICES FOR SUBSTANCE ABUSE CLIENTS

	Day Support	Detox	Primary Care	Therapeutic Community	Group Homes	Other Supported Supervised Living
CSBs With Program	11	26	20	11	12	8
Available Slots	92	441	406	295	122	78
Clients Served	107	380	150	275	103	163
Clients Receiving Inadequate Service	59	NA	52	25	42	NA

Source: JLARC Survey of CSBs.

Detoxification Services

Detoxification is the necessary, first-step service in the treatment of substance abuse. Detoxification refers to services provided in a hospital setting for three to seven days. There are two types of detoxification: medical detoxification and social detoxification. Medical detoxification involves hospital-based care for chronic substance abusers whose withdrawal from drugs or alcohol is considered life-threatening and requires medical attention. Social detoxification is nonhospital-based, medication-free treatment that provides an environment for safe withdrawal, as well as connections with other community support services.

The role of State mental health hospitals in substance abuse treatment has decreased significantly. Since 1979, there has been a decline in the availability of State hospital beds for substance abusing clients. Fewer than 50 beds are currently available in State hospitals for medical detoxification.

The continued decline of State hospital involvement in substance abuse services intensifies the need for community detoxification services statewide. Only 26 CSBs report some availability of local or regional detoxification services for their substance abuse clients. These programs can serve approximately 441 clients. During one three-month period in 1985, 380 clients received detoxification services in these facilities. The remaining 14 CSBs do not provide any community detoxification services.

Day Support and Residential Services

In addition to detoxification, comprehensive substance abuse treatment involves day support, and short and longer-term residential treatment. Statewide, this comprehensive range of substance abuse services is inadequate. Only 12 CSBs provide a minimum continuum of care, that is, local detoxification, primary care, and longer term residential treatment. Of these, only two also provide some type of day support service. Thus, access to treatment is limited and inequitable.

Day Support Services. Day support services for substance abuse include programs similar to those offered for mental health clients. Psychosocial rehabilitation programs provide training in social, life, and work skills; transitional employment programs provide remunerative employment to clients as they prepare for more competitive work environments; and day treatment or partial hospitalization programs provide multidisciplinary treatment for the chronic substance abuser.

Day support services for substance abuse clients are limited. Only 11 CSBs offer some type of day support -- eight offer day treatment programs, two offer psychosocial rehabilitation programs, and one offers a transitional employment program. A total of 107 clients are served by these programs. An additional 59 clients in the CSBs which offer these programs are reported to need the service.

Residential Services. The continuum of community care for substance abuse clients who do not have supportive living environments with family or friends includes a progressive set of residential services including

primary care (28-day treatment), therapeutic communities, and longer-term residential settings.

Primary care involves substance abuse rehabilitation services that can last up to four months, but typically last 28 days. A 28-day stay is typical because that is the limit that can be reimbursed. Therapeutic community refers to a psychosocial therapeutic environment in which an individual can reside for more than four months.

In Roanoke Valley, for example, Multi-Lodge is a 16-week residential treatment program for alcoholics. The program provides a home-like setting in which community living skills and basic social skills are stressed. For drug abusers, Roanoke Valley also has Hegira House, a 28-bed residential treatment center in which the length of treatment usually lasts up to a year. Hegira House provides an intensive therapeutic environment in which special attention is given to providing community living skills. Other types of longer term environments include supervised apartments, sponsored placements, and other supported living arrangements.

Only 20 CSBs reported having primary care facilities available, and only 11 reported having therapeutic community programs. DMHMR contends, however, that all CSBs have funds to purchase primary care or other substance abuse residential services. The discrepancy may be because some CSBs do not have local inpatient facilities from which to purchase primary care.

Longer-term residential services for substance abusers are even more scarce. Currently, 18 CSBs have some form of longer-term residential service for substance abusers, with 78 available slots. Ten CSBs have a group home or halfway house, and five CSBs have longer-term arrangements such as supported apartments or other supported living arrangments. Only three CSBs have more than one type of longer-term residential setting.

Improving Substance Abuse Services

The lack of community-based detoxification and residential treatment programs for substance abusing clients is a critical deficiency in Virginia's mental health delivery system. With the reduction in the number of beds available in State hospitals, the need for services at the local level has become more important. But significant absolute gaps in substance abuse services have been identified across the Commonwealth.

Recommendation (15). The Department of Mental Health and Mental Retardation should take immediate action, in cooperation with the 40 community services boards, to identify service needs for substance abusing clients. The department should prepare a plan for implementing and funding priority service needs in the CSBs. Special attention should be given to detoxification and residential treatment services.

COMMUNITY SERVICES PROVIDED TO ALL CLIENT DISABILITIES

In addition to those services designed specifically for the three major disability groups, certain services of a broader range are provided to all

clients. These services include emergency, prevention, and transportation services. The adequacy of these services varies from CSB to CSB. The largest gap continues to be in transportation services.

Emergency Services

Emergency services involve unscheduled mental health, mental retardation, or substance abuse services that are available 24 hours a day, seven days a week. Emergency services often provide the initial link for individuals who have never received community services as well as for those aftercare clients who do not initiate contact on their own. These services include crisis intervention, stabilization, and referral assistance, and can be provided over the telephone or in person. Cases handled include individuals who seek services on their own (i.e., walk-ins), home visits, jail interventions, and pre-admission screenings.

All CSBs have some type of emergency service available. In March 1985, for example, a total of 5,463 face-to-face cases and 19,759 telephone emergency calls were handled by the CSBs across the State. The number of cases handled by any one CSB varied considerably, with 1,217 in-person cases as the high and three cases as the low. Telephone emergencies handled by CSBs ranged from three in one community to 5,639 in another. The median number of face-to-face cases was 67; the median number of telephone emergencies was 121.

The emergency cases handled by CSBs, particularly face-to-face cases, may be only a portion of the need for emergency treatment. For example, during the JLARC staff case study visits, CSB staff noted that they frequently had to serve clients over the telephone because staff were not available to address emergencies in person. Several cases illustrate this problem.

> *In Crossroads there are no specified emergency staff; regular staff members rotate handling emergencies during the day. After hours, however, only telephone emergency services are available. Because Crossroads is a rural CSB and many of the staff live long distances from the office, the emergency calls are forwarded to staff homes.*
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> * * *
>
> *In other rural areas such as Southside and Harrisonburg-Rockingham, regular staff must perform after-hour emergency services in addition to their 40-hour work weeks. The director reported that some of these staff are not properly trained to provide such services but are the CSB's only resource for providing access to telephone and face-to-face emergency care after hours.*

In comparison, Richmond CSB has more extensive emergency services, with 24-hour face-to-face services available. In addition, the CSB has a mobile crisis intervention team which can address emergencies quickly.

Staff noted that such intervention appears to diminish the need for the use of State hospitals, since clients are treated before their disorder requires inpatient care.

Recommendation (16). The Department of Mental Health and Mental Retardation should assess the extent to which face-to-face emergency services are needed in each of the 40 community services boards. The department may wish to mandate the provision of in-person emergency services, and should provide sufficient funds and technical support to ensure that the required program is implemented statewide.

Prevention Services

Prevention services are designed to reduce the occurrence of mental illness, mental retardation, and alcohol and drug dependency and abuse. Many mental health professionals stress the importance of prevention efforts in averting mental illness and mental retardation. It is also important in educating the general community about mental health issues with which they may be unfamiliar and unaccepting. Efforts aimed at creating community understanding of mental illness and mental retardation have been considered particularly important in areas where public resistance has thwarted the development of group homes and other residential services.

Currently, 38 CSBs have some prevention programs. However, the time spent on prevention activities varies considerably across the State, from as little as three hours per month to as much as 2,480 hours a month. There are a number of factors accounting for this disparity, including different philosophies of the CSBs and a lack of guidelines from DMHMR concerning expectations for CSB prevention activities. The variation across CSBs indicates that clients do not have equal access to this important service.

Recommendation (17). The Department of Mental Health and Mental Retardation should promote the use of prevention programs. The department should assess the need for additional funding and technical assistance.

Transportation

Although not considered a "core service" by DMHMR, transportation has emerged as a major need. When surveyed by JLARC staff, 35 CSBs reported that the level of transportation services provided to clients is inadequate. The problem is most critical in rural areas. According to CSB staff, clients who require, but cannot receive regular services are more likely to deteriorate and to require rehospitalization than those who can receive services on a regular basis. Transportation to services is one of the major obstacles to clients' receiving treatment on a regular basis.

In visits to CSBs, JLARC staff encountered several instances in which a lack of transportation limited access to existing services. In the Planning District 19 CSB, for example, eligible clients can attend the psychosocial rehabilitation program for only one or two days each week when the CSB can arrange for a bus to pick them up. At the Crossroads CSB, some clients cannot receive appropriate day support services because of a lack of transportation, even though the existing program has space available.

DMHMR does not allocate funds for transportation services. Thus, all CSBs are in a position of shifting funds from other service areas in order to provide some level of transportation. These shifted monies have been used in a variety of ways by various boards, including the purchase of vans, payment for drivers, and transportation payments to individual clients. Thirty-six CSBs currently provide some tranportation support, involving 1,381 mental health clients (92 percent of whom are chronically mentally ill), 1,867 mental retardation clients, and 231 substance abuse clients. Given the status of funding for core mental health, mental retardation, and substance abuse services, it does not appear to be prudent for CSBs to have to provide for transportation services by transferring funds from other programs.

Recommendation (18). The Department of Mental Health and Mental Retardation should establish a program for funding client transportation services in each of the 40 community services boards. The use of funds from core services to fund transportation needs should be discontinued.

V. HOUSING SERVICES

Housing is a critical need for many clients who leave State mental hospitals. Without housing that provides a secure environment and access to necessary services, a client's opportunity for a successful transition to life in the community is diminished. Because many aftercare clients are indigent, or have overtaxed their families' ability to care for them, the need for State-provided or subsidized housing is magnified. Present law, however, does not adequately assign responsibilities to ensure that discharged clients will be housed in an appropriate setting. Because the State has no policy with regard to housing for discharged clients, housing continues to be one of the most pressing needs for deinstitutionalized clients. In the 1979 JLARC report, Deinstitutionalization and Community Services, the need for additional housing was identified. Little improvement has been made in the past six years.

HOUSING PROGRAMS FOR THE MENTALLY DISABLED

JLARC staff reviewed the current housing arrangements of clients in both the survey of CSBs and the follow-up of discharged clients. That review shows that most clients in the mental health system reside with their families or relatives, or in their own apartments or houses (Table 4). Currently, 13.5 percent of all clients in the community mental health system reside in homes for adults. Slightly more than three percent are served by CSB housing programs. For six percent of all clients, the current residence is unknown.

State Housing Programs and Services

The Commonwealth currently provides some direct housing services to the mentally disabled. But, legal responsibility for locating and providing housing placements for mentally disabled clients is presently scattered among various State agencies. While several agencies have taken initiatives in providing housing opportunities, the need for better coordination and increased program capacity is evident.

The Department of Mental Health and Mental Retardation. The need for stable housing is an acknowledged need for many aftercare clients and is seen as an integral part of the community support network. Specifically, Section 37.1-98 of the *Code of Virginia* stipulates that patients who are discharged from State hospitals will receive pre-discharge planning that specifies the "services to be provided to the released patient in the community to support his housing and nutritional needs...." Thus, DMHMR has a lead role in identifying appropriate housing placements for clients. In addition, DMHMR funds various residential programs, although housing is not a mandated "core" service for localities.

The Department of Rehabilitative Services. DRS provides several housing-related services, including Centers for Independent Living which provide information and referrals on housing. DRS staff noted, however, that

Table 4

CURRENT HOUSING OF THE MENTALLY DISABLED

Setting	Percent of All Clients	Percent of Recent Discharges
Family	45.9%	50.0%
Own Dwelling	14.1	12.0
HFA	13.5	4.1
CSB Programs	3.3	3.8
Nursing Home	1.6	0.6
Boarding Home/Hotel	9.6	1.7
Private Adult Home	1.8	1.5
No Stable Residence	2.1	1.2
Jail	N/A	5.7
Hospital	N/A	4.8
Other	2.1	8.2
Residence Unknown	6.0	6.4
	N=13,822*	N=343

*Excludes approximately 4500 clients from CSBs which did not have this information.

Source: JLARC Survey of CSBs and Client Follow-up.

the department does not actively serve the housing needs of the mentally disabled.

The Department of Social Services. DSS has responsibility for the licensure of homes for adults (sections 63.1-172 through 63.1-178 of *Code of Virginia*) and administers the auxiliary grant program which provides supplemental income for some residents of homes for adults, including the mentally disabled. Local departments of social services may also provide housing referrals and protective services, and grant general relief funds to needy clients.

Additionally, the *Code* authorizes the establishment of a statewide system of district homes for the "care and maintenance of indigent aged, infirm, or incapacitated persons." Only two district homes are currently in operation, however, because by statute the State does not fund such homes.

The Department of Housing and Community Development. HCD does not directly serve the mentally disabled, except as part of the general population requiring housing services. By law, the department is charged with the responsibility of planning and coordinating the development of housing in the Commonwealth. By law, HCD is responsible for:

- developing State housing and community development policies, goals, plans and programs.

- determining present and future housing requirements of the State and designing programs to coordinate the elements of housing production.

- assuming administrative coordination of the various State housing programs and cooperating with the various State agencies in their programs as they relate to housing.

Virginia Housing and Development Authority. VHDA was created to "provide a fully adequate supply of sanitary and safe dwelling accommodations" for low and moderate income families. VHDA's enabling legislation stipulates that low and moderate income families shall be defined with consideration to "the ability of such persons and families to compete successfully in the normal private housing market and to pay the amounts at which private enterprise is providing sanitary, decent and safe housing." Although VHDA is not specifically charged to provide housing for the mentally disabled, this population falls within the mandate given the authority.

The Impact of Scattered Responsibilities

As a result of scattered responsibilities for the housing of the mentally disabled, the development of housing alternatives has been limited. More specifically, housing opportunities have been limited by:

- a lack of funding for housing development;

- inadequate documentation of housing needs;

- a lack of interagency coordination; and

- a patchwork of inadequate housing placements.

Lack of Funding for Housing. Currently, there is no dedicated, stable source of funds to finance housing for needy clients. Community funding for housing from DMHMR must compete with a variety of equally vital service needs, including the core services. Thus, CSBs cannot rely on a regular funding stream with which to finance new housing initiatives. Similarly, income supplements through the Department of Social Services in the form of auxiliary grants are available only for clients residing in licensed homes for adults, or in adult family care homes. Residents of CSB housing are not eligible for auxiliary grants, regardless of their income.

Inadequate Documentation of Need. Because no single agency is responsible for housing, data on the housing needs of the mentally disabled is inconsistent, if available at all. The collection of such data is critical to the development of a sound funding policy. It is also essential to short-term and long-term planning for housing alternatives.

Lack of Interagency Coordination. Given the dispersed responsibility for housing policy and programs, interagency coordination is essential to ensure that clients are adequately served. But the lack of a comprehensive policy to

assign administrative responsibility for programs and services has contributed to inadequate coordination among agencies. This problem is present at both the State and local levels. No single agency has responsibility for establishing and implementing housing policy. There are no formal procedures or other means to ensure that the services of one agency are coordinated with those of another.

Lack of Adequate Placements. The overall effect of the defusion of responsibility for housing policy and services has been a lack of appropriate, affordable housing for the mentally disabled. The insufficient housing supply connotes a patchwork of essentially inadequate housing opportunities for some clients reentering the community.

The sufficiency of housing and residential programs varies across the State. Therefore, for those clients who lack sufficient housing resources of their own, community placement can be unpredictable and not at all comparable between clients. Even among CSB-operated housing programs, the availability of housing is inconsistent across the State.

CSB Residential Programs

For mentally ill clients, especially the chronically ill, a professionally supervised residential program is often most suitable. These programs can provide both a pleasant environment and adequate supervision. They offer programmed activity that can help the client achieve maximum adjustment to the community. Most importantly, these programs are generally designed to foster increased independence and eventual self-support.

Because clients are at differing stages of community adjustment, a continuum of residence-based programs is a requisite for the promotion of independent living and the avoidance of rehospitalization. Initially, rehospitalization may be avoided with crisis stabilization services. Stabilized clients may often require structured living programs like group homes or half-way homes. Supervised apartment programs offer a final step toward total independence for clients needing the least supervision.

None of the 40 CSBs presently maintain such a continuum of residence-based services. Data from a DMHMR survey of CSBs shows that residential programs are in acutely short supply. As seen in Table 5, 29 CSBs offered a total capacity of 642 residential slots during the month of March 1985. Eleven CSBs offered no residential programs whatsoever.

Improving Responsibilities for Housing the Mentally Disabled

Adequate housing and residential services are essential to an effective policy of deinstitutionalization. Without a stable home environment, clients cannot be expected to progress in the community. The Commonwealth needs a comprehensive housing policy and effective planning to ensure that appropriate housing for the mentally disabled is available. To expedite this goal, the various State agencies that provide housing services to this population need clearer responsibilities, reliable funding, and procedures to ensure coordination.

Table 5

CSB RESIDENTIAL PROGRAMS,* MARCH 1985

Type of Mental Health Residential Program	Number of Boards Offering	Number of Slots	Utilization Rate
Group Home	8	108	81%
Supervised Apartment	22	352	87
Sponsored Placements	7	39	74
Supported Living	5	87	77
Other	6	56	92%
State Total	29	642	

*Excludes crisis and inpatient programs.

Source: JLARC Survey of CSBs.

Recommendation (19). The Department of Housing and Community Development (HCD) should collect and analyze data necessary to plan for adequate housing stock for the mentally disabled. The data collection effort and analysis should be conducted with the assistance of the Department of Mental Health and Mental Retardation, and be based on an assessment of the low-cost housing needs of the mentally disabled. Planning for the development of new or modified, existing housing should reflect consideration for the needs of other low-income groups, such as the physically disabled.

HCD should take the lead responsibility in ensuring that an effective plan for meeting the housing needs of the mentally disabled is developed and implemented. The director of the Department of Housing and Community Development should report to the General Assembly concerning progress made toward development of the plan by January 1988.

Recommendation (20). The Department of Mental Health and Mental Retardation should cooperate in the development of a statewide housing plan, and should review methods for establishing a permanent, separate funding stream drawn from new and existing monies devoted to the purpose of expanding residential services across the State.

A coordinator of residential services should be established with the following duties: development of residential services; coordination of the efforts of other agencies in this area; integration of the programmatic needs of the mentally disabled with the need for housing stock; and dissemination of technical information concerning cost-effective residential programs to community services boards.

Recommendation (21). The Virginia Housing and Development Authority should develop and implement financing programs designed to create low-cost housing for the mentally disabled. VHDA might consider setting aside a percentage of its finance capital for this purpose, and cooperate with DMHMR in the dissemination of information regarding the use of VHDA financing by community services boards.

Recommendation (22). The Department of Social Services should evaluate the need to expand the use of auxiliary grants for mentally disabled clients. The plan should review alternatives which would broaden eligibility for auxiliary grants for residents of CSB-operated residential housing and other publicly provided housing for indigent clients.

Recommendation (23). The community services boards, with the assistance of DMHMR, should be required to develop adequate housing opportunities for their mentally disabled clients. The required amount of housing should be based upon the needs assessment developed by HCD. The CSBs should be permitted to create the types of residential services that best suit their respective areas and clients. Financing and rent subsidies from VHDA as well as expanded use of the auxiliary grant program should be evaluated as sources of funding.

HOMES FOR ADULTS

Many aftercare clients are housed in licensed homes for adults. By State law (sections 63.1-172 through 63.1-178), homes for adults must provide "protection, general supervision, and oversight of the physical and mental well-being of their residents." The Department of Social Services both licenses adult homes and administers the auxiliary grant program. Because a key eligibility requirement for the auxiliary grant program is residence in a licensed adult home, the State has in effect encouraged the development of the adult home industry as a major, yet largely unplanned, component of State policy toward housing and treating the mentally disabled.

Because adult homes are the only State-supported housing alternative that is available across the State, JLARC staff conducted a review of homes for adults as placements for aftercare clients. Included in this review was an evaluation of auxiliary grant program financial data, a review of the geographical placement of the homes, and a series of visits to homes across the State. The purpose of these efforts was to determine the extent and the adequacy of the role that adult homes play in the mental health system.

To evaluate the adequacy and effectiveness of policies that are intended to ensure the appropriateness of adult homes for aftercare clients, JLARC staff made unannounced visits (assisted by DSS licensure specialists) to homes in five case study areas: Roanoke Valley, Richmond, Valley (Staunton), Rappahannock-Rapidan (Culpeper, Orange) and Planning District 19 (Petersburg) CSBs. JLARC staff visited 21 homes in the five areas.

In order to document the potential for both optimal and unsatisfactory care currently available in adult home settings, JLARC staff visited several homes in each study area that, according to DSS licensure staff,

reflected the best and worst housing available to clients. The selection of homes in each area was based on consultation with local CSB staff and DSS licensing specialists. This strategy was chosen in order to ensure that the range of homes now licensed to accept deinstitutionalized clients was documented.

Additionally, JLARC staff reviewed DSS regulations and guidelines with DSS central office staff, DSS licensing specialists, licensing supervisors, and adult protective services staff. Local CSB staff and adult home operators were also interviewed. CSB staff were surveyed concerning adult homes.

The JLARC staff review of adult homes indicated that this unplanned component, as presently constituted, is a generally unsatisfactory alternative for State-provided housing for the mentally disabled.

Appropriateness of Adult Homes for the Mentally Disabled

Clients who are discharged from State mental facilities to adult homes are typically in need of:

- proper administration of psychotropic medicines;
- appropriate day activities and programs;
- supervision to avert assaultive or self-destructive behavior; and
- accessability to community mental health services.

Homes for adults exist as a housing alternative largely outside of the community mental health continuum of care. From a mental health standpoint, homes for adults operate at the discretion of the private owner and/or administrator. Existing regulations do not guarantee the appropriateness of a given home.

Existing Regulations Concerning the Mentally Ill. According to DSS licensing staff, regulations for the licensure of adult homes are designed to ensure a minimum standard for the needs of "frail, developmentally aging individuals." The regulations are not designed to ensure a minimum level or quality of mental health care. Thus, these regulations do not ensure the appropriate placement and subsequent care of the mentally ill in adult homes. Operators of homes, for example, are not required to have staff trained in understanding and serving the special needs of aftercare clients or the mentally retarded.

DSS standards also require that home operators and administrators be able to "protect the mental health" of residents. To meet this need, DSS regulations specify that each home that accepts discharged clients must (1) have a written agreement with the local CSB on file that specifies the services the CSB will provide and (2) obtain written verification of the progress of aftercare clients, and the appropriateness of the home every six months.

Compliance of Homes with DSS Regulations. JLARC staff found that the homes visited were generally in compliance with the letter of DSS regulations. Homes were generally clean, foodstocks plentiful, and medications

well-protected. Complete menus and adequate fire safety precautions were also evident. Concern for and and pride in the care for residents was apparent in many homes.

While adult homes were generally in compliance with DSS regulations, the minimum standards established by the regulations do not appear to ensure that homes are appropriate housing placements for the chronically mentally ill. Some are not staffed to meet the needs of aftercare clients and are generally unconnected to existing community services.

DSS inspectors lack effective sanctions with which to ensure compliance. Before 1979, DSS (then the State Department of Welfare) sanctioned non-compliant homes with a system of provisional licensure. In 1979, JLARC staff found that these provisional licenses were used in such a way as to enable non-compliant homes to "continue in business and eventually obtain a full annual license without complying." That is, homes were given provisional licenses for extended time periods, without ever fully complying with DSS regulations.

Since 1980, provisional licenses issued to non-compliant adult homes must be totally revoked or reinstated within six months. DSS licensing specialists report that non-compliant operators typically react to warnings and provisional licenses by temporarily meeting the regulation in question, while simultaneously violating other regulations. Since total revocation of a provisional license usually requires a legal action, DSS inspectors find it difficult to force compliance.

In 1979, JLARC recommended that DSS "develop and propose to the General Assembly intermediate sanctions to enforce compliance with State standards." This recommendation has not been implemented.

DSS licensure staff concur that many adult homes are essentially inadequate housing for the chronically ill population; one licensing inspector for example, said that the homes that accept discharged clients in his area are "totally inappropriate" for the mentally ill. In each case study area, at least one of the homes was thought by CSB and DSS staff to be a questionable setting for discharged clients. The following example is illustrative of the poor care provided in some homes:

> *JLARC staff entered a Richmond adult home during the lunch hour. The home was dark, dirty, and in apparent need of repair. Bed linen appeared to be filthy and residents were wandering about unattended. Only one staff person was on hand. The individual was busy preparing lunch, while also attending to other duties around the home. Although he had no training or related experience in caring for the mentally ill, the individual boasted that the home accepted the worst cases, clients that other homes would not accept.*

Monitoring Placements. Existing regulations intended to ensure the appropriateness of individual homes for aftercare clients are generally ineffectual. JLARC staff interviews with DSS staff revealed that there is confusion of responsibility for monitoring the placement of aftercare clients.

Although local departments of social services are authorized to provide "protective services," when a client is discharged to an adult home in a different city or county, the client's situation is likely to be neglected by the social services office of original residence. Thus, inappropriate placements or cases of abuse are only identified after a series of complaints or incidents, and some clients have no one who can be presumed to have responsibility to protect them from abuse or neglect.

> *An adult home in the Richmond area declared bankruptcy and closed. According to DSS staff, the operator apparently absconded with the SSI and auxiliary grant checks of the residents. Because these checks are issued to cover the coming month's expenses, many residents were without financial support for the remainder of the month. Because the residents were from other areas of the State, protective services were not initiated in time to recover or replace the residents' checks.*

* * *

> *A resident from a home in the Staunton area was taken to the hospital for a physical ailment. Upon hospitalization it was discovered that changes in the resident's psychotropic medication prescription had not been properly implemented by the staff of the adult home in which he resided.*

DSS licensing staff reported that they cannot be sure how often such similar instances of abuse or neglect occur. In 1979, JLARC staff recommended that "communication be improved between State mental hospitals, local welfare agencies, and other placement agencies. Information on placement of mental patients in licensed adult homes should be routinely shared with [DSS] to facilitate the monitoring of potentially illegal homes."

This recommendation has not been implemented. Specific responsibility for monitoring placements and sharing information about suspect homes has not been assigned. DSS should reclarify the responsibilities of local social service departments so as to ensure: (1) that all placement agencies (including CSBs and State hospitals) are aware of conditions in adult homes used to house discharged clients, and (2) that residents of homes for adults whose residences of origin are in other areas of the State receive adequate protective services.

Similarly, the six-month progress reports required by law for aftercare residents of adult homes do not ensure that continuing residence in an adult home is appropriate for a given client. The DSS licensure inspectors interviewed by JLARC staff felt that the forms were essentially paperwork exercises and not meaningful indicators of the progress or treatment of adult home residents.

According to DSS regulations, the progress reports need only be completed for those residents who come to a home directly from a State institution. This means that residents of homes who have been transferred from another home or other residence are not required to receive any form of

aftercare. DSS should expand the definition of "post-hospitalized" residents of adult homes to include any adult home resident with a recent history of hospitalization in a mental health or mental retardation facility.

Furthermore, the progress reports on file at most of the homes visited by JLARC staff were incomplete and not directed toward helping adult home staff understand or treat aftercare residents. At several homes visited by JLARC staff, the aftercare reports were photocopied and only the individual names changed from form to form.

Record-keeping at Adult Homes. The JLARC staff visits to adult homes indicated that record-keeping practices are widely variable and, in some cases, unsatisfactory. Several homes did not have hospital discharge summaries on file for residents who had histories of hospitalization. Others did not record daily administration of medicines to such residents, or were in general disarray. The variability of record-keeping practices make it impossible for appropriate agencies to monitor the treatment of adult home residents. DSS should devise and enforce a standard record- keeping format for homes that accept discharged clients as residents.

Relations Between Community Service Boards and Adult Homes. The required written agreements between CSBs and homes for adults are ineffectual. A review of written agreements in the adult homes visited by JLARC staff revealed that all homes were using a DSS "model" form that specifies a short and vague list of arrangements between homes and CSBs. Based on the JLARC staff visits in 21 adult homes, it appears that even a minimal amount of service coordination between homes and CSBs does not occur.

DSS licensing staff report that they do not have routine contact with CSB and hospital personnel. Since licensing specialists typically have the most frequent contact with individual adult homes, they could provide important information to CSB staff regarding the suitability of adult homes as placements for deinstitutionalized clients.

In theory, an extensive community support network could help to optimize the care of clients in adult homes. However, the degree to which discharged clients who reside in adult homes are linked to community services varies considerably. Whereas the clients residing at several homes received fairly extensive services from their local boards, some homes have virtually no contact with community services boards. CSB staff reported, in the JLARC survey, that 23 percent of the adult homes which house chronically ill clients do not have a working relationship with a CSB. Only 35 percent of the homes have adequate daily activities. Despite the importance of training in dealing with chronically ill clients, only 57 percent of the homes had received CSB training for their staffs.

The caseloads of the boards and transportation problems affect directly both the ability of the CSBs to provide services to adult home residents, and the willingness of home operators to access community services. The operators of several homes reported that CSBs were unreliable or slow in providing emergency services for their residents. Moreover, because many homes cannot easily provide transportation to CSBs, and because CSB staff are

often also limited in their ability to visit clients at home, interaction between homes and community services boards is limited.

To cope with the need for aftercare services for discharged clients, several homes in urban areas visited by JLARC staff employed private psychiatrists to provide aftercare services to their residents. Hiring a local physician to provide aftercare services relieves the adult home of the need to hire extra staff to transport residents to CSB service sites. The records kept by adult home operators at homes visited by JLARC staff, however, indicate that the aftercare provided by CSB staff is often more extensive and individualized than that provided by private physicians. JLARC staff identified several instances in which one private physician was providing aftercare to hundreds of adult home residents. CSBs report that about 37 percent of homes housing aftercare clients now use private physicians.

Staffing of Adult Homes. The primary purpose of DSS licensure is to maintain a minimum standard of general cleanliness and safety. It is not intended to ensure that homes are suitable for the mentally ill or the mentally retarded. DSS regulations do not require any background or training in mental health care for adult home staff. Adult home operators, though they may be personally concerned with providing a quality environment and appropriate care, may often lack the training and expertise necessary to guarantee a proper environment for discharged clients. As a result, DSS licensing specialists concur that many homes lack a sufficiently trained staff for caring for the mentally ill. One licensing specialist termed the staffing situation at adult homes with deinstitutionalized residents "frightening." The following incident was cited:

> *When a resident of one home threatened to commit suicide, the home's operator handed him an unloaded gun and encouraged him to carry out his threat. The case was investigated by DSS licensure staff and the operator was required to "screen" future potential residents and reconsider keeping the resident in question. The resident remains at this home and the operator has taken no steps to screen new residents.*

The operators of homes for adults are required to have a high school diploma or at least one year of related experience. Of the homes JLARC staff visited, several had extensively trained and specialized staffs, while other homes had virtually no trained staff. The most qualified staff were generally found at publicly maintained or non-profit homes.

Many of the homes visited by JLARC have little or no trained staff, as illustrated in Table 6. For example, 11 of the homes did not have a licensed practical nurse, and 12 did not have a full or part-time activities or recreation director. Most of the staff of the homes visited had virtually no background or training in mental health care, yet were caring for many deinstitutionalized clients. Although most homes claimed to employ a reasonable number of total staff, few of these staff were visible on the JLARC staff visits. Because trained staff require greater salaries than most adult home operators wish or can afford to pay, the General Assembly may wish to consider requiring minimum staffing standards for adult homes.

Table 6

STAFFING AT HOMES FOR ADULTS VISITED BY JLARC STAFF

	Total Residents	Percent Deinstitutionalized	Total Staff[1]	Activity Director	Licensed Nurses(LPN)
Roanoke					
Home A	137	80%	55	Yes	8*
Home B	74	70%	19	No	1
Home C	63	100%	18	Yes	1
Home D	44	100%	16	Yes	0
Home E	19	100%	5	No	1
Home F	5	80%	3	No	1
Home G	14	100%	3	No	0
PD19 (Petersburg)					
Home A	12	100%	3	No	0
Home B	27	100%	9	Yes	0
Home C	18	95%	5	No	1
Richmond					
Home A	100	95%	25	Yes	2
Home B	15	100%	3	No	0
Home C	16	100%	3	No	0
Home D	78	70%	24	Yes	4
Rappahannock-Rapidan					
Home A	56	75%	18	No	0
Home B	51	10%	14	Yes	1*
Home C	6	80%	5	No	0
Valley					
Home A	8	100%	5	Yes	0
Home B	31	66%	14	No	0
Home C	58	40%	28	Yes	17*
Home D	13	100%	2	No	0

*Includes one or more registered nurses

(1) total staff for all shifts; includes maintenance, food preparation, etc.

Source: JLARC Interviews with Adult Home Operators.

Auxiliary Grants Program

Few discharged clients could afford to live in adult homes without the assistance of auxiliary grants. The availability of this funding for clients has resulted in the development of adult homes across the State, especially in certain urban areas, and the areas near State hospitals. To some extent, the growth of the homes may be at the expense of alternative housing for the mentally disabled.

A total of 4,498 individuals receive auxiliary grants. Of this total, the State Department of Social Services estimates that approximately 2,000 discharged clients receive auxiliary grants which supplement the income of the residents in adult homes.

The expansion of the program represents a sharp increase from 1979, when only 2,500 individuals received auxiliary grants. The cost of the auxiliary grant program has escalated from $4,372,500 in FY1979 to $9,246,396 during FY1984.

To be eligible for an auxiliary grant, an individual must be eligible for Federal SSI, have less than $1,700 in countable resources, and have a countable income of less than the current cost of living in an adult home. The decision to supplement the income of residents of adult homes with auxiliary grants was made in 1974. The actual amount of the auxiliary grant each resident of an adult home receives equals the reimbursement rate the individual adult home has been assigned by DSS plus a thirty dollar personal spending allowance less the amount of the individual's SSI or other countable income. DSS assigns reimbursement rates to homes on the basis of their reported costs in providing care, with the vast majority of homes receiving the maximum $510 monthly rate ($560 in Northern Virginia.) The average size of the auxiliary grant is about $197 a month for disabled individuals.

For example, a typical auxiliary grant recipient resides in an adult home that has been assigned the maximum $510 monthly rate for 1984. Since an individual's SSI payment or other income is typically $300, he or she may be eligible for a $240 auxiliary grant, which covers the difference plus $30 for personal spending. Auxiliary grant payments are made to the eligible resident. In many instances, the operator of the adult home is authorized to cash and administer the grant recipient's check.

By federal regulation, the State must continue its present level of total auxiliary grant support. But, this funding may be assigned to other similar purposes. Because by their nature adult homes do not generally provide appropriate mental health programming and care, the General Assembly may wish to consider the expansion of the auxiliary grant program to include alternative housing programs for the mentally disabled.

Mismatch of Homes with Population Centers

Adult home beds for deinstitutionalized clients are not spread evenly across the State's population centers. As Table 7 demonstrates, homes for adults that are licensed to accept deinstitutionalized clients tend to be located in rural areas and are remote to the State's population centers. The major

Table 7

CAPACITY OF ADULT HOMES LICENSED TO ACCEPT AFTERCARE CLIENTS

CSB	Number of Homes	Capacity	Population*	Beds/10,000 Population
PDI	2	125	105,700	11.8
Cumberland	5	94	130,000	7.2
Dickenson	0	0	21,000	0.0
Highlands	18	474	69,200	68.5
Mt. Rogers	11	306	119,500	25.6
New River	6	269	150,500	17.9
Alleghany	2	134	28,200	47.5
Roanoke	11	534	229,700	23.2
Harrisonburg	2	46	81,400	5.7
Rockbridge	1	49	32,000	15.3
Valley	9	180	95,900	18.8
Northwestern	9	302	141,000	21.4
Alexandria	0	0	104,200	0.0
Arlington	0	0	150,300	0.0
Fairfax-Falls Church	0	0	687,900	0.0
Loudoun County	0	0	66,800	0.0
Prince William	1	73	196,700	3.7
Rappahannock-Rapidan	6	354	102,000	34.7
Region X	9	334	156,600	21.3
Central Virginia	2	83	205,500	4.0
Danville-Pittsylvania	6	164	112,900	14.5
Piedmont	3	283	134,100	21.1
Southside	6	106	82,300	12.9
Crossroads	5	53	85,800	6.2
Chesterfield	0	0	174,200	0.0
Goochland-Powhatan	0	0	27,500	0.0
Hanover	1	18	55,700	3.2
Henrico	0	0	209,200	0.0
Richmond	43	1180	208,300	56.6
Rappahannock	2	102	138,000	7.4
Mid-Penin/North-Neck	2	28	107,900	2.6
Planning District 19	8	129	162,900	7.9
Chesapeake	2	50	125,800	4.0
Norfolk	3	61	257,900	2.4
Portsmouth	1	31	101,400	3.0
Virginia Beach	0	0	307,600	0.0
W. Tidewater	9	267	96,400	27.7
Colonial	1	6	82,900	0.7
Hampton-Newport News	4	105	271,200	3.9
Eastern Shore	0	0	46,500	0.0
Virginia	190	5,940	5,662,600	10.5

*1985 Population projections from Department of Planning and Budget

State population centers in Northern Virginia and Tidewater have very little adult home bed capacity. Compared to the State average of 10.5 beds per 10,000 population, the densely populated Northern Virginia area CSBs have no beds available. This has necessitated the "exporting" of clients from their original residences in these urban areas to rural areas which often offer fewer community services.

Smaller communities, "in the shadow" of State mental hospitals, however, have large numbers of adult homes and per capita bed capacities. The Highlands area (near Southwestern State Hospital) has 68.5 beds per 10,000 population available for aftercare clients, more than four times the State average. The influx of discharged clients into this and other rural areas has placed a burden on the "importing" community services boards, and decreased the likelihood that the residents of such homes will receive adequate support services. Additionally, the cities of Roanoke and Richmond have disproportionately high adult home bed capacities.

Between 1979 and 1984, 32 new homes for adults have been licensed by DSS. The newer homes are centered in Richmond (13 new homes between 1979 and 1984) and the area surrounding Western State Hospital (11 new homes). Other areas have seen little or no growth in the number of homes for adults.

Using homes for adults as an unplanned response to the housing needs for the deinstitutionalized has promoted the concentration of adult homes in the areas near institutions. The General Assembly has acknowledged this situation by authorizing "hospital impact" funds to several CSBs; however, present policy encourages the continuing mismatch between population centers and adult homes.

Alternatives to Homes for Adults

Although licensed as adult homes, several of the facilities visited by JLARC staff were in fact publicly operated homes. Because of the overall superior levels of staffing, programmed activity, and maintenance that such homes are able to provide, publicly maintained adult homes should be considered by the General Assembly as a preferred alternative for housing deinstitutionalized clients. Such homes now exist under various forms of management.

CSB Owned or Subsidized Adult Homes. Because they can link their residents with CSB services and trained staff, CSB owned or subsidized adult homes are an attractive alternative to private adult homes.

The Valley Community Services Board subsidizes an adult home that is run by a social worker, for example. The facility houses eight individuals; all current residents are clients discharged from Western State Hospital who receive auxiliary grants. Rather than providing maintenance care for its residents, this home promotes the development of independent living skills: the residents assist staff in maintaining the facility, preparing meals, etc. Several former residents have obtained employment in the community and have moved to their own dwellings.

Although not all discharged clients possess sufficient living skills to be placed in this type of residence, it is the type of residential program that could be replicated across the State at minimal additional cost. This home is maintained with auxiliary grant payments and other income from its residents, and a $20,000 annual grant from the Valley CSB.

The Region X Community Services Board operates two adult homes. One houses 15 discharged clients and the other houses 12 clients. The homes are used both as transition points between the hospital and the community and as long-term residences for clients who need supervision and care on a permanent basis. Both homes have trained program directors and an assistant program director.

The two homes are operated with auxiliary grant payments and other income of their residents, and supplemental funds from the Region X CSB's census reduction grants. Approximately $60,000 beyond the auxiliary grant payments made to residents was required to maintain the two facilities last year.

District Homes. Authorized by Section 63.1-183 of the *Code*, district homes are publicly owned and operated facilities that are licensed as adult homes. JLARC staff visited the district home near Staunton. This home is operated by the five counties and six cities in the vicinity. Approximately 20 of the home's 60 residents are deinstitutionalized clients. However, because the district home is a publicly owned institution, these residents cannot receive SSI or auxiliary grants from the State. Instead, many residents receive General Relief, which is funded by State and local funds.

The district home has a clear staffing and programming advantage over the typical privately maintained adult home. In addition to a full-time activities director, the home has a social worker, four registered nurses and 12 licensed practical nurses. It has a craft shop, a snack bar, large day rooms, and a van that is used for recreational outings as well as transporting residents to medical and mental health services.

Publicly Owned Adult Homes. Orange County also operates an adult home. The Orange County home has staffing and programming advantages similar to the district home, but is subsidized by an adjoining nursing home operation. Residents have recently been declared ineligible for auxiliary grants, because they are ineligible for SSI payments. Five of the home's 51 residents are discharged mental health clients. Because of the discontinuation of the auxiliary grants for home residents, however, some of these residents may be forced to move into private adult homes in the Orange County area.

Boarding Homes

In several of the CSB areas visited by JLARC staff, a number of clients were residing in private boarding homes or hotels not subject to licensure. According to data collected from the CSBs, 16 CSBs are aware of unlicensed facilities that house four or more of their active clients. These unlicensed facilities are forbidden by law to offer any care or supervision to residents. Many residents of these homes, however, may be in need of treatment.

DMHMR should forbid hospitals and CSB staff from placing chronically mentally ill in unlicensed facilities. Furthermore, the General Assembly may wish to empower DSS to close unlicensed facilities that accept aftercare clients as residents.

Integration of Adult Homes into the Mental Health System

Existing housing policy has relied heavily upon private adult homes to meet the demand for supervised and low-cost housing for the mentally disabled. Adult homes, however, operate largely outside of the mental health system because they serve a variety of populations. Present law and regulations encourage this situation. Inasmuch as discharged clients typically have continuing need for mental health care and treatment, adult homes which accept mentally disabled residents should be linked more closely to the mental health system and/or gradually replaced by community-based residential alternatives.

Recommendation (24). Homes for adults should be required to maintain a minimal amount of trained staff and to provide adequate aftercare for deinstitutionalized residents. The Department of Mental Health and Mental Retardation should develop appropriate standards regarding acceptable qualifications for the staff of adult homes that house deinstitutionalized clients. At a minimum, the standards should stipulate that each such home have a licensed nurse and a trained social worker/activities director on its staff. As a means of subsidizing the necessary staffing improvements in adult homes that wish to house discharged clients, the General Assembly may wish to increase the auxiliary grant rate for future post-hospitalized clients.

Recommendation (25). Because district homes and CSB-operated adult homes are potential providers of low-cost, well-staffed supervised care for discharged clients (and other indigent and aged persons), the General Assembly may wish to consider the development of adult home alternatives by amending section 63.1-183 of the *Code* to authorize State funding of district homes for the indigent aged, infirm, and disabled.

Recommendation (26). DSS should reclarify the responsibilities of local social service departments so as to ensure that residents of HFAs whose residence of origin is in other areas receive adequate protective services.

Recommendation (27). The General Assembly may wish to link the licensing of new adult homes to indicators of need in each area of the State.

Recommendation (28). DSS should require that each adult home that accepts deinstitutionalized clients have an individualized, detailed written agreement with a CSB. The agreements should be renewed yearly, and require that each home for adults: (1) have potential new deinstitutionalized residents screened by the CSB; (2) participate in active exchange of information concerning all CSB clients; and (3) allow free access to CSB staff.

Recommendation (29). The Department of Social Services and DMHMR should promote the exchange of information between licensing specialists and CSB staff regarding the suitability of adult homes as placements for deinstitutionalized clients.

Recommendation (30). DSS should expand the definition of "post-hospitalized" residents of adult homes to include any adult home resident with a recent history of hospitalization in a mental health or mental retardation facility.

Recommendation (31). DMHMR should require that CSBs provide each post-hospitalized resident of adult homes with at least one aftercare follow-up in the home.

Recommendation (32). The General Assembly may wish to empower DSS licensing specialists to levy fines and/or reduce grant reimbursement rates for homes that do not comply with DSS standards.

VI. SERVICE AND FISCAL ACCOUNTABILITY

Virginia's service delivery system for mentally disabled persons has improved significantly in the recent past. One of the most important goals during this period has been the establishment of a comprehensive community-based system of care. JLARC staff analysis indicates that the State has not been fully successful in meeting this goal. The specific program and service deficiencies outlined in the preceding chapters have contributed to the failure of the development of that comprehensive system. But a failure to assign accountability for the system has also made the goal more difficult to achieve. Assigning service and fiscal accountability is essential to the future development of a comprehensive service delivery system.

SERVICE ACCOUNTABILITY

Currently, the State operates or supports three overlapping systems which serve many of the same clients. State hospital services are provided by the Department of Mental Health and Mental Retardation. Community services are provided by 40 community services boards and funded largely through State and local general fund revenues. Finally, residential services are provided by adult homes which are supported in part by auxiliary grants and monitored by the Department of Social Services. The links in authority between these entities is often unclear, contradictory, or inoperable. As a result, accountability is diminished. Moreover, the operation of overlapping systems is financially inefficient. The outcome of this situation is the limited effectiveness of State policies and programs. Because accountability for services is unclear, many clients do not receive the services they require. The overlapping systems, coupled with a lack of accountability, make it difficult to identify and address problems in the delivery system.

But establishing clear accountability for the services provided to mentally disabled clients does not mean that either the State hospital or the local community service network can be dismantled. An effective continuum of care will always have two broad service components: inpatient hospital care, and community treatment and support. The failure of State policy in the past has been the lack of clearly defined roles for the components of the system. Given the limited availability of funds for mental health services, it is important that the roles of State hospital and local community services boards be defined.

Committment to a Community-Based System

House Joint Resolution 9 (1980), articulates the Commonwealth's goals concerning persons with disabilities by stating:

> It is the policy of the Commonwealth of Virginia to establish, maintain, and support the development of an effective system of treatment, training and care for mentally ill, mentally retarded and substance abusing

> citizens. The basic principle of this statewide system is that in every instance the appropriate treatment, training and care shall be provided in the least restrictive environment with careful consideration of the unique needs and circumstances of each person.

Over the past 15 years, the State has made progress in achieving this goal by moving toward a community-based system of care. During this time the State transferred control of all mental health clinics to local entities. Forty community service boards have been established to provide services across all jurisdictions in the State. Concurrently, there has been a significant reduction in the State hospital census, and a majority of clients are now being served in the community.

There was strong agreement among those interviewed by JLARC staff, including DMHMR central office staff, hospital directors, CSB staff, and other mental health professionals, that the General Assembly's movement toward a community-based system was appropriate. Specifically, the consensus was that the most appropriate treatment for the majority of handicapped persons is through community-based services.

The benefits of a community-based system are also apparent from a financial perspective. Full implementation of a community system, concurrent with a decreased use of State hospitals, would result in long-term cost-savings to the State. From a system perspective, providing community treatment is less expensive than hospital treatment.

There are four primary reasons for lower costs in the community-based system. First, staff salaries are lower in the community, resulting in cost-efficiencies in the delivery of treatment services. Second, the capital costs of hospitals are high, while community services require a great deal less capital. Third, room and board in an inpatient hospital setting is more expensive than the majority of residential settings in the community. Finally, the majority of chronically ill clients do not require 24-hour treatment and care. Community services can thus be adjusted to the needs of specific clients.

While there was a consensus that community services offer significant treatment and cost benefits, there was also agreement that the promise of deinstitutionalization has not been realized. The cause, as expressed by those interviewed and those offering testimony at five public hearings, is the lack of sufficient community services to meet existing demand. The evidence in the preceeding chapters of this report supports this assessment. Thus, if the Commonwealth is to continue progress toward a community-based system, it is essential that services and progarms be enhanced.

Populations To be Served by Community Service Boards

While the State's policy in support of a community-based system is clear, the development of such a system in not mandated. While the State provides a large portion of the funds for mental health services, it has established few requirements specifying the processes and programs by which State goals should be achieved. Current mental health statutes differ from those in other areas such as social services, education, or health, for which specific

standards and programs are mandated. "Core" mental health services, while legislatively approved, are not mandated. As a result, the types of clients served, as well as the types of programs offered, vary widely across the State. For example, many CSBs serve a large proportion of chronically ill clients, while other boards have not targeted services to this group.

Development of adequate service alternatives for the chronically mentally ill population is central to the future success of deinstitutionalization policies, because these clients are the largest single group of clients served, and require the broadest range of community support. Efforts to enhance the State's service delivery system must, therefore, focus on this group. However, it is important to emphasize that there are equally high levels of unmet demand across the State for mental retardation and substance abuse services. Additionally, the level of services offered to "special" populations, such as children and the dually-diagnosed, was found in this report to vary considerably.

In order to ensure that those most in need receive appropriate treatment, seven states have enacted legislation establishing target populations with priority for receipt of community services. Texas, for example, places a first priority on serving those at "significant risk of placement in a state facility," including "former state facility patients for whom continuing care has been recommended." Similarly, West Virginia's legislature has placed first priority on serving the "medically indigent and chronically behaviorally handicapped." Other states are addressing this issue as well.

While the General Assembly has encouraged DMHMR and local governments to serve clients in the community, and to reduce the use of State hospitals, it is not clear which local services are viewed as State priorities. Since the State funds the majority of services, and has a public interest in ensuring that appropriate services are offered, the General Assembly may wish to mandate that certain services be available across the State.

The General Assembly has endorsed the goal that "core" services be available to all residents. However, the "core" services are broad categories, not specific programs. Thus, they do not offer clear direction for CSBs. Among the mental health professionals interviewed by JLARC staff, there was a clear consensus concerning the integral services necessary for a continuum of care for the chronically ill population. These essential services are psychosocial rehabilitation, client transportation, transitional employment, and case management/outreach. The availability of these services greatly increases the opportunities for chronically ill clients to live independently in the community. In the long-term, these services could help to reduce recidivism and State hospital use. For these reasons, the General Assembly may wish to mandate that CSBs provide certain core programs to chronically ill clients.

Role of State Hospitals

An additional issue requiring legislative direction is the role of the mental health hospitals. Currently, a majority of State general funds are allocated to hospitals, although most clients are served in the community. This situation is not projected to change in the future, according to DMHMR's five year plan. However, in order to maximize future funding for community programs, it will be necessary to stabilize hospital costs.

Virginia is not alone in confronting obstacles that complicate the funding of a comprehensive community-based service delivery system. A recent national study concluded that without strategic corrective actions, high hospital and low community service funding patterns would be self-perpetuating and continue to worsen. The JLARC staff review of policies in other states showed that many have taken "strategic corrective actions" to redirect funds from hospital services to community alternatives.

Use of State hospitals in Virginia remains high. Previous recommendations in this report concerning improved service accountability and expansion of local inpatient and community programs would reduce the use of State hospitals by decreasing the frequency of client recidivism. Two additional actions -- clarifying the role of the hospital and making local providers fiscally accountable for hospital use -- have been used by other states to reduce hospital use and to shift available funds to community programs.

Virginia law identifies the requirements for involuntary and voluntary commitments to State hospitals. However, legislative intent concerning the complementary roles of hospitals and community programs within the continuum of care has not been specified. Legislatures in some states have specifically articulated the role of state hospitals and identified the types of clients to be served.

In Wisconsin, for example, state hospitals can only be used when an individual has a special treatment need that cannot be met in the community. Colorado's statutes offer further elaboration and note that the community providers must demonstrate that a reasonable and determined effort has been made to find a community alternative and that the client requires a protected setting for an indeterminate period. A complementary approach used is to make community providers fiscally accountable for use of state hospitals. In Virginia, the CSBs are not accountable for the costs of inpatient care in State hospitals, and in practice, this is a disincentive to reduce hospital use.

Improving Service Accountability

To improve accountability for the system, several actions of the General Assembly will be required. The roles of State hospitals and local service providers need clarification. Service priorties should be established, and certain core programs should be mandated for chronically ill clients.

Recommendation (33). The General Assembly may wish to reconfirm its intent to develop a comprehensive community-based system for serving the mentally ill, mentally retarded, and substance abusing citizens of the Commonwealth. The General Assembly may wish to specify that accountibility for the provision of appropriate services rests with the community services boards.

Recommendation (34). The General Assembly may wish to direct DMHMR to develop a comprehensive plan which will assign full service and fiscal accountability to the CSBs. Such a plan should include procedures to ensure that State service priorities for the chronically ill are met, as well as procedures for establishing priorities in the development of local services for mentally retarded and substance abusing clients.

Recommendation (35). DMHMR should review certification standards for programs intended for chronically mentally ill clients. Minimum standards should be established and enforced. The standards should include required activities and objectives, staffing ratios, and hours of service per client.

Recommendation (36). The General Assembly may wish to express its intent concerning the role of State hospitals. The use of State hospitals might be reserved for those clients: (1) who are severely disabled and require long-term treatment in a highly supervised setting, and (2) who have low incidence disabilities that cannot be addressed in a community setting.

FISCAL ACCOUNTABILITY

Establishing service accountability at the local level would increase the effectiveness and continuity of service provision. Improving the current mechanisms for allocating funds could also improve accountability. Current funding mechanisms do not ensure that available funds are directed to areas or populations with the greatest need. In addition, it will be necessary to maximize local government funding of community programs. The *Code* implies that local governments are to contribute to CSB funding, but does not specify the financial participation required.

DMHMR's Funding Mechanisms

The limitations of the current funding approach have long been recognized. Problems were first highlighted in 1975, when a consulting firm recommended the development of a formula to distribute State funds. In 1980, the Bagley Commission found:

> The incidence of need for services as well as population should, in the opinion of the Commission, be considered in the distribution of State general funds. Local match should consider only relative ability to pay and relative tax effort. Consequently, the Commission recommends that the Department be required to develop formulas for the distribution of funds for mental health, mental retardation, and substance abuse services.

In response, the department formed a task force to study the development and implementation of a formula. In 1982, the task force recommended that an allocation formula be in place by 1985. This recommendation was not implemented. Most recently, in January 1985, the commissioner of DMHMR again endorsed the use of a formula to provide funds to the CSBs.

Currently, the State has two seperate funding streams for allocating funds for treatment: hospital funding and CSB funding. The result is that neither the hospital nor the CSB is fiscally responsible for the provision of cost-effective services. Further, the operation of dual systems diminishes the ability of the General Assembly to develop an effective and cost-efficient system of care. Establishing fiscal accountability at the local level would allow

improved evaluation of the system because responsibility would be placed with a single entity.

In the recent past, DMHMR allocated funds by first budgeting money to improve the quality of hospital services in developing requests. Allocations have been used to increase staffing and achieve JCAH accreditation. Remaining allocations were then used to provide "maintenance" increases uniformly across all CSBs. Special appropriations were then allocated to legislatively specified targets (e.g., high impact funds, residential services for Northern Virginia CSBs). Finally, remaining funds were allocated on a discretionary basis by DMHMR to address service gaps, census reduction programs, and limited housing. The current funding mechanisms reflect the goal of giving a "fair" amount to all CSBs; that is, an amount which is largely independent of the magnitude of need existing in the catchment area.

This approach has had a number of unintended results. First, the approach fosters overutilization of State hospitals because the majority of funds are allocated for treatment in that setting. Second, older, more established community services boards, which tend to have the most well developed services, continue to receive larger allocations. Third, many CSBs, not having sufficient program resources, have found it necessary to appeal directly to the Genreal Assembly for funds. Fourth, funds do not appear to be distributed fairly across CSBs. In FY 1984, for example, per capita allocations for mental health services ranged from $403 to $1,212. In sum, the current approach does not ensure that funds are directed to the greatest need.

Other states have implemented funding approaches to ensure a fair distribution of available funds. In enacting this legislation, a primary goal has been to establish fiscal accountability on the local level. That is, these states have determined that local providers are best able to direct funds toward the greatest need existing in the community. While some funds are typically mandated to meet state priorities, local providers choose how to use the remaining money.

Local Government Financial Participation

As the locus of treatment continues to move toward the local level, it is important that local governments share in assuming fiscal accountability with the State for the operation of CSB services. Until local governments become a stable and reliable source of funds, it will be difficult for CSBs to engage in effective long-term planning.

Section 37.1-199 notes that the State will pay up to 90 percent of total operational costs of the CSBs. This provision has been interpreted to indicate that local governments participating in a single community services board must contribute at least 10 percent of total funding necessary. In FY 1984, the local match varied greatly, from a low of 10 percent to a high of 67 percent. The average match was 37 percent, with 12 of the 40 community services boards receiving less than 15 percent of their funds from local sources, indicating a relatively low degree of participation.

Currently, the *Code* does not mandate the degree of participation by local governments. Thus, local governments frequently view mental health

services as a State obligation and give CSBs a low funding priority. Moreover, many local governments do not provide a stable source of funding for CSB services. For example, nine localities contributed less in FY 1985 than in FY 1981, even though the number of clients served increased greatly during that period. Similarly, 15 local governments decreased their FY 1985 allocations from FY 1984 levels.

Improving Fiscal Accountability

Current funding mechanisms do not ensure that allocations are directed to the greatest service needs. In addition, the current system of funding provides an unintended incentive for the use of State hospital beds. And local fiscal participation in CSB programs is unreliable.

Recommendation (37). The General Assembly may wish to direct DMHMR to develop a formula for allocating State funds directly to the community services boards on the basis of measurable and appropriate variables. The purpose of the formula should be to ensure availability of mental health services to all citizens.

Recommendation (38). The General Assembly may wish to direct DMHMR to develop a plan by which CSBs are fiscally accountable for the use of State mental health hospitals. Such a plan should provide incentives for the use of community services and disincentives for the use of State hospital beds.

Recommendation (39). The General Assembly may wish to amend Section 37.1-199 of the *Code of Virginia* to define clearly the financial involvement of local governments in the operations of CSBs. Amended language should ensure that individual local governments cannot reduce the absolute level of current contributions. Future contributions should account for increases due to inflation, and localities should not be permitted to substitute State funds for local contributions.

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

AGENCY RESPONSES

As part of an extensive data validation process, each State agency involved in a JLARC review and evaluation effort is given the opportunity to comment on an exposure draft of the report.

Appropriate technical corrections resulting from the written comments have been made in the final report. Page references in the agency responses relate to the exposure draft and may not correspond to page numbers in the final report.

Included in this appendix are responses from the following:

- Department of Social Services
- Department of Mental Health and Mental Retardation

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WILLIAM L. LUKHARD
COMMISSIONER

COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

September 3, 1986

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
910 Capitol St., Suite 1100
Richmond, VA 23219

Dear Mr. Leone:

The following are the Department's comments on the exposure draft of the Deinstitutionalization and Community Services Report.

Page 19:

The first paragraph implies that the purpose of the Auxiliary Grants (AG) Program is to supply a housing supplement for the mentally disabled. This implication is incorrect. The purpose of AG is to supplement the income of individuals in certain situations, as provided for by federal laws and regulations.

Page 83:

The third paragraph implies that homes for adults receive payments directly from the Auxiliary Grants Program for all residents. It further implies that residents pay none of their own money for the cost of care. In reality, less than one third of the licensed beds in homes for adults are occupied by individuals who receive AG. The eligible recipient receives the AG payment and combines it with personal income to meet the cost of care.

Pages 83-84:

"Only two district homes have been established, however, because by statute the State does not fund such homes". In the past, more than two District Homes have been in existence, but the others have either gone out of business or have converted to other forms of ownership. In regard to funding, although there is no money available for building District Homes, money is available through the General Relief Program (62.5% State and 37.5% local) at local option to supplement the income of eligible individuals up to the approved rate of the home. Therefore, cause and effect as presented are incorrect.

Page 85:

Lack of Funding for Housing - "Similarly, funding through the Department of Social Services in the form of auxiliary grants is intended only for clients in licensed

homes for adults, and cannot be used for CSB housing." The AG Program is not a housing subsidy program. The auxiliary grants program is an income supplemental program provided to aged, blind, or disabled Virginia residents. The person eligible for an auxiliary grant must reside in a home for adults (HFA) or an adult family care home (AFCH) and not have sufficient income (SSI, or other) to maintain himself/herself in the HFA of AFCH without the benefit of the auxiliary grant.

Page 89:

Recommendation (22). Since payment must go to eligible individuals, AG funds cannot be used to create housing. Individuals in some types of publicly provided housing do not meet SSI eligibility criteria and, therefore, are not eligible for SSI or AG. The establishment of publicly-provided housing must be undertaken very carefully so as not to preclude SSI eligibility.

In accordance with SJR #62 (1986) DSS and DMHMR are currently studying the expansion of the Auxiliary Grants Program.

Page 90:

"Because adult homes are the only State-supported housing alternative that is available across the State. . . aftercare clients." It appears erroneous to refer to adult homes as State-supported housing when approximately 85% of the income paid by residents to homes for adults is from non-Auxiliary Grant funds.

Page 93:

Last paragraph; should read "....non-compliant..." (not, "non-complaint")

Page 94:

"JLARC staff interviews with DSS staff revealed that there is confusion of responsibility for monitoring the placement of aftercare clients." Persons may enter HFAs through at least 4 different pathways. DSS is involved in many cases, especially with the MH/MR client, for the purposes of eligibility determination for an auxiliary grant. DSS staff cannot monitor the placement of clients in homes for adults if DSS is unaware that the aftercare client is residing in the HFA.

Page 95:

"Although local departments of social services are authorized to provide 'protective services', when a client is discharged to an adult home in a different city or county, the client's situation is likely to be neglected by the social services office of original residence. Thus, inappropriate placements or cases of abuse are only identified after a series of complaints or incidents, and some clients have no one who can be presumed to have responsibility to protect them from abuse or neglect." Adult protective service (APS) investigations are initiated upon receipt of a client specific complaint. Protective services are client specific and are not general oversight.

Policy is clear regarding the responsibility of the local agency (where the person resides) to provide protective services. If agencies are not receiving and promptly investigating APS complaints in homes for adults, they are not complying with policy. All of the staff of an HFA, including the operator/owner, are mandated to

report suspected abuse, neglect, and exploitation to the LWA and can be fined for failure to report.

Pages 95-96:

"In 1979, JLARC staff recommended that communication be improved between State mental hospitals, local welfare agencies, and other placement agencies. Information on placement of mental patients in licensed adult homes shall be routinely shared with [DSS] to facilitate the monitoring of potentially illegal homes. ...Specific responsibility for monitoring placements and sharing information about placements has not been assigned. DSS should reclarify the responsibilities of local departments so as to ensure: (1) that all placement agencies (including CSB's and State hospitals) are aware of conditions in adult homes used to house discharged clients, and (2) that residents of homes for adults who residences of origin are in other areas of the State receive adequate protective services."

The mechanism for the sharing of information is in place in the Code of Virginia - the Prescription Team. Section 37.1-197.1 of the Code of Virginia states - "In order to provide comprehensive mental health, mental retardation, and substance abuse services within a continuum of care, the CSB shall: (a) Establish and coordinate the operation of a prescription team which shall be composed of representatives from the CSB, social services or public welfare department, health department, Department of Rehabilitative Services... The team, under the direction of the CSB, shall be responsible for integrating the community services necessary to accomplish effective pre-screening and pre-discharge planning for clients referred to the CSB."

The responsibility for the establishment and coordination of the Prescription Team is placed with the CSB. DSS maintains that the most effective method to plan for comprehensive services for MH/MR clients is through the use of prescription teams. Prescription teams, by Code, are to develop pre-discharge plans for clients referred to the CSB.

Page 100:

"Of this total, the State Department of Social Services estimates that approximately 2,000 discharged clients receive auxiliary grants which pay for the care and shelter provided by adult homes." This sentence implies these individuals have no income other than AG and that AG pays for the entire cost of care. These implications are incorrect. Also, since we have no statistics on the number of AG recipients who are post-hospitalized, where did 2000 come from?

Page 102:

"To be eligible for an auxiliary grant, an individual must be disabled, have less than $1,600 in countable resources, and have a countable income of less than the current cost of living in an adult home." This section implies only disabled people are eligible for AG. That is incorrect. To be eligible for AG, an individual must (1) meet all the requirements for the federal Supplemental Security Income (SSI) Program, except for the income level, (2) must be living in a home for adults or adult family care home, and (3) have income that is below the total of the approved rate for the home and the personal care allowance. The eligibility requirements for SSI include an individual must be aged, blind, or disabled; a citizen or legal alien; have countable resources below $1,700; and not be residing in certain kinds of public homes.

"Auxiliary Grant payments are generally made to individuals who can be placed in adult homes as a necessary supplement to SSI income." This sentence may imply to some readers that AG can be paid prior to entry into a home. This cannot be done. This sentence further implies that individuals must be receiving SSI to be eligible for AG. However, many AG recipients do not receive any SSI income, since other income such as Social Security or pensions make them ineligible for SSI. Therefore, this implication is incorrect.

"The actual amount...plus a thirty dollar personal spending allowance less the amount of the individual's SSI and other countable income." The allowance is now $35. This sentence also implies all AG recipients receive SSI.

"DSS assigns....the maximum $510 monthly rate ($560 in Northern Virginia)." Present rates are $521 and $597.

"The average size....individuals." This statistic would be more meaningful if a date was attached.

"For example...rate by DSS." The typical home for adult rate in which AG recipients reside is $521.

"Since an individual's SSI payment is typically only $300...spending." The figures for SSI in the example would indicate the individual had other income. An example of a payment calculation using the current SSI amount follows. An individual receives SSI of $336 (the 1986 level) because he has no other income. Since he is in a home for adults where the rate is $521, the AG payment received by the individual is $220. If the same individual received SSA of $400, his AG payment would be $176, since $20 of his SSA is not counted as income in computing the AG payment.

"In most instances, the operator of the adult home is authorized to cash and administer the grant recipient's check." The Auxiliary Grant check goes to the recipient unless there is a court appointed representative. Therefore, if the operator cashes the recipient's check and handles his money, the recipient has presumably agreed to this procedure.

"The reason for the present exclusion of other housing alternatives for the mentally disabled....component." In 1974, three State programs for the aged, blind, and disabled were replaced by a federal program (SSI). When the State evaluated implementing an optional State supplementation program (AG) as allowed by federal regulations and law, there was insufficient money to supplement the income of all potentially eligible individuals. The State determined that the income of most individuals receiving assistance under the new program was higher than the income the individuals received under the old program. However, there was one major group for whom income was not higher. These were aged, blind, and disabled individuals who resided in homes for adults. Therefore, it was decided when funding became available that aged, blind, and disabled individuals who lived in homes for adults and were financially in need would be eligible for assistance from AG. Because of funding, federal pass-along compliance, Medicaid coverage for recipients, equitableness and the original intent of the program, major action to expand AG has not been taken.

Page 103:

"By federal regulation....for the mentally disabled." The first sentence implies that federal regulations require Virginia to continue our present expenditure rate. The sentence should be reworded to make it clear that Virginia chose to be in compliance with federal pass-along regulations by maintaining an expenditure level at least equivalent to the previous year.

The exact meaning of the second sentence is unclear. Eligibility for AG is not based on the purpose of a living arrangement but on financial need in a particular type of living arrangement. The State can choose, within federal guidelines, the types of living arrangements in which individuals are eligible for supplemental assistance (AG). The State does have the option, if it wishes to put up the money to supplement according to financial need all aged, blind, and disabled individuals who are receiving SSI or would be eligible for SSI except for income. However, once the State expands AG, funding cannot be retracted or the State loses Medicaid funds.

The implication of the third sentence is that Auxiliary Grant funds should only be used for the mentally disabled and not for blind, aged, or physically disabled individuals. These other groups of individuals may have as many special housing needs as the mentally disabled. Since money goes to eligible individuals, diverting the funds toward developing alternative housing programs for the mentally disabled cannot be done.

Page 103:

"The influx of discharged clients into this and other rural areas has placed a burden on the "importing" CSB..." This has also placed additional responsibilities on the "importing" DSS.

Page 104:

First paragraph - These numbers do not correspond with ours. In June 1979, we showed 314 licensed homes compared with 377 in June 1986, for a net gain of 63 statewide, not 32 as the draft reports. We show the net gains by regions as follows:

Lynchburg-	13
Northern Virginia-	5
Richmond-	13
Roanoke-	2
Southwest-	2
Tidewater-	14
Valley-	14

Third paragraph - "Because of the overall.....deinstitutionalized clients." Since individuals are ineligible for SSI in some publicly operated homes, they would not be eligible for Auxiliary Grants. However, the State could establish a program using other funds to provide assistance for individuals in these homes.

Page 105:

Table 7 is misleading as titled. Is it attempting to quantify the homes/capacity for those which have working agreements or accept post-hospitalized?

Page 106:

Second paragraph - "Rather than....themselves, etc." This sentence appears misleading since it is our understanding that the residents in this home assist staff with the maintenance, cooking, etc., and are not responsible for these tasks.

Third paragraph - "This homes is...Valley CSB." This sentence implies residents have no income other than AG that is used to pay the cost of care. This implication is incorrect.

Last paragraph - "The two homes...grants." This sentence also implies that residents have no other income.

Page 107:

First paragraph - "Instead, they are funded by the individual counties that run the home." Most residents in District Homes are receiving General Relief to supplement other income. General Relief is 62.5% State funds.

Third paragraph - "Residents have....publicly-operated." This sentence is misleading. SSI was discontinued because these individuals are in a publicly-operated home. Because these individuals are ineligible for SSI for a reason other than income, the State cannot assist them through AG. Some of these individuals are receiving payments from General Relief.

Page 108:

The first sentence - "The General Assembly....auxiliary grant funds." Since the Auxiliary Grants Program is a State supplementation program, individuals must meet all SSI requirements except for income. Individuals in some publicly-operated homes are not eligible for SSI, and thus cannot receive AG. Since this is federal law and regulation, no action by the General Assembly can make these residents eligible for AG.

In the section entitled Boarding Homes, the reference to "unlicensed" may be more accurately reflected as "not subject to licensure." Boarding homes that provide only room and board are not subject to licensure - even if the boarding home provides room and board to four or more people. The provision of maintenance and care to four or more people who are aged, infirmed, or disabled is the component that subjects a home, facility, etc., to licensure.

The last paragraph has a slant that appears inappropriate - or at least it sounds critical of the homes for adults as an industry for reasons that don't seem logical or fair. "Adult homes operate largely outside the mental health system" because they are outside the mental health system. Just as it wouldn't make sense to expect the families/relatives of MHMR clients (who reportedly care for 66% of the state's mentally retarded population, for example), to identify themselves as part of the "mental health system," neither does it make complete sense to expect licensed homes for adults in the private sector to behave as if they were part of

the formal mental health system. They are, collectively, a service industry that caters to a number of population groups, only some of which are the disability groups of interest to DMHMR. As long as the state elects not to provide and supervise public facilities, it must reconcile itself to the fact that it cannot exert an equivalent degree of control over the private sector operators, e.g., in where they locate, whom they choose to serve, what programs or services they elect to offer. In a private sector model one shapes by (minimum) regulations and, if elected, by incentives but one cannot fully control. Similarly, I'm not sure that it is accurate to say that laws and regulations "encourage" licensed homes to operate outside the mental health system; the laws permit them to fill a market need created by the substantial lack of other models.

Page 109:

Recommendation (24). This recommendation needs to be more precise in order to discriminate between discharged clients who need or don't need a home which provides this type of care/staffing. Increasing the educational requirements in HFAs would be an added protection for all types of residents, and, since it would be an additional cost to providers and consumers, it would be wise for the General Assembly to express itself on this issue.

Recommendation (25). Federal laws and regulations prevent individuals residing in our present District Homes from receiving SSI and AG. It should be noted that if these homes were certified for 16 residents or less, the individuals in the homes might be eligible to receive SSI and AG. As previously indicated, most individuals in District Homes are receiving General Relief in addition to other income.

Recommendation (26). Adult Protective Services are mandated services. This mandate is contained in Section 63.1-55.1-7 of the Code of Virginia and State Board of Social Services Policy. Adult protective service investigations are initiated upon the receipt of a client specific complaint of alleged abuse, neglect, or exploitation. Contrary to the concept of adult protective services as conveyed in this draft report, adult protective services are client specific and are not general oversight services.

Adult Protective Services policy is clear regarding the responsibilities of local departments of welfare/social services to receive reports and complaints of abuse, neglect, and exploitation; make prompt and thorough investigations to determine whether the person is in need of protective services; and to determine the service needs of the person.

The responsibility for providing services to a client does not always rest with the local department responsible for providing financial assistance to the client. The local department of welfare/social services serving the jurisdiction in which the client resides assumes responsibility for the provision of social services. The Department is currently evaluating the feasibility of requiring that active service cases be established for auxiliary grant recipients who reside in homes for adults.

Recommendation (27). The problem in Northern Virginia is not likely to be alleviated strictly by further differentials in the AG rate. The cost of land/structures is as much a factor as the higher costs of labor/services.

Page 110:

Recommendation (28). This recommendation requires clarification. If the CSB is in the proper relationship with the public mental hospitals, it would have been involved in discharge planning. If the client is coming out of a private mental hospital, is there a legal basis for requiring a citizen to use the CSB or be screened by it as a condition to purchasing residential care? DSS has a requirement for homes to exchange information with CSB's on mutual clients. The third part of this recommendation is also unclear - The homes should give CSB staff "free access" to what....the premises, the residents, the records? The home would be in violation of regulations and a complaint should be lodged if it is denying CSB staff reasonable access to their clients; on the other hand, regulations and legal rights prohibit the home from forcing a resident to access health care or from interfering with a resident's choice of health care providers - although the home is also required to re-evaluate its capacity to meet the needs of a resident who refuses health care. The homes operate under certain confidentiality requirements regarding disclosure of resident's records. Clarification is required before we can respond to this recommendation.

Recommendation (29). A regulatory authority cannot be placed in the position of recommending for or against particular homes or particular placements. Licensing staff may factually describe services and licensure status but no more. A recent legal interpretation of the adult statute does permit greater disclosure of compliance information to parties with a "bonafide" interest than previous policy permitted, and this may serve the need addressed by the report.

Recommendation (30). The term "recent" needs to be defined before we can act. Also, if "post-hospitalized" includes those who have been hospitalized in private psychiatric settings, we need to know how JLARC intends them to be addressed.

Recommendation (31). Do post-hospitalized include those exiting private hospitals?

Recommendation (32). It is the Department's belief and Ernst & Whinney's conclusion, that a fine system would be ineffective and far more trouble than it's worth. The homes that are small or cater heavily to AG grants tend to have more violations than the larger and more financially secure operations. The danger, under those circumstances, is that scarce funds would be diverted from resident care to pay the fine---which, in one sense, the taxpayer would also end up paying. Presumably, a fine system would be subject to appeal, tying up scarce staff and funding resources that are needed to perform more constructive licensure functions. Similarly, when the grant reimbursement rate is already low, reducing a grant might reduce the care to residents to a more dangerous level. Licensing standards are intended to define the floor of operations, below which the facility is not considered safe and is not permitted to exist, but licensure standards do not serve well to establish standards of quality and neither do they serve well as criteria for the placement function of matching individual residents to particular homes. For these purposes, other standards or criteria are needed.

Page 111:

Second paragraph - "Finally, residential services....Social Services." Since less than 15% of the income for home for adults beds in Virginia is paid by recipients from Auxiliary Grants payments, it does not seem appropriate to say adult homes are supported by Auxiliary Grants.

I hope these comments will be clear. Should further discussion be necessary to clarify these issues, please contact me.

Very Truly Yours,

William L. Lukhard

cc: The Honorable Eva S. Teig
Howard W. Cullum

COMMONWEALTH of VIRGINIA

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September 9, 1986

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
General Assembly Building, Suite 1100
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you for the opportunity to comment on JLARC's report, **Deinstitutionalization and Community Services.** I appreciate the cooperation we have experienced in working with JLARC staff throughout the development of this report. I also commend the comprehensive and constructive approach you have taken in dealing with a complex set of issues.

A major strength of the report is its recognition that a policy of massive reinstitutionalization is not fiscally, legally or programmatically possible. As the report reflects, the problems associated with deinstitutionalization cannot be remedied by a return to warehousing mentally disabled persons in large State institutions nor can they be addressed without new community resources. A service delivery system for the '80s and '90s will require a carefully developed balance of quality inpatient services in facilities of manageable size with adequately funded community support services equitably distributed and coordinated with other key agencies across the Commonwealth. This report helps us take a major step in the direction of such a coordinated system and acknowledges the Department's significant funding needs to develop community capacity.

As you know, JLARC's presentation to the Commission on Deinstitutionalization in the Fall of 1985 led to many of this report's recommendations being addressed in 1986 General Assembly session. A wide range of Code changes and study resolutions were approved during that session. In addition, the Department of Mental Health and Mental Retardation (DMHMR) has moved forward toward

implementing many of the final JLARC report recommendations. A response to the various JLARC recommendations is attached.

Before addressing the specific JLARC recommendations, I would like to provide an update on a number of DMHMR efforts that reflect, in a broader context, how the State-local system of care for the mentally ill is being managed. These efforts are:

1. **Balanced System:** DMHMR is working toward a balanced system of accredited State facilities providing specialized, costly inpatient hospital care and of community programs. The needs of the mentally ill can only be met by a service continuum of both facilities and community programs, not one at the expense of the other.

2. **Comprehensive Plan:** DMHMR has completed an extensive Five Year Plan that identifies service and funding needs for State facilities and CSBs. This Plan continues to serve as the Agency blueprint for budget submissions.

3. **State Board Policies:** The Code of Virginia gives the State Mental Health and Mental Retardation Board statutory responsibility **"to establish programmatic and fiscal policies for State facilities and CSBs"**. The Board is in the process now of revising and expanding on its policies to give the system clear direction for the future.

4. **Client Management:** Since April, 1984, DMHMR has placed clear client management responsibility on CSBs for getting mentally ill into and out of State facilities. Patient management guidelines are now being revised to further strengthen the process of moving clients between State facilities and CSBs.

5. **CSB Funding Allocation System:** DMHMR is currently working with CSB representatives to develop an equitable funding allocation system for distribution of future new State dollars.

6. **Department-CSB Performance Contracts:** DMHMR is now starting its third year of executing specific performance agreements with each CSB. These agreements identify specific types and units of services to be delivered by CSBs within their approved budgets.

7. **Community Human Rights:** A new system of community human rights regulations was approved by the State Board in April 1986. These regulations are now in the process of being implemented by CSBs. These community regulations provide a vehicle to ensure State-wide compliance with human rights requirements for community programs.

8. **CSB Evaluation System:** DMHMR is currently developing a new system of evaluating CSB programs. The system will be piloted in October 1986 with a March 1, 1987 implementation date. The full range of CSB operations will receive an extensive evaluation on a regular basis with the objective of improving local program operation and management.

I believe these steps are indicative of DMHMR's commitment to plan for, to manage and to oversee an effective, coordinated system of care for the mentally disabled.

Sincerely,

Howard M. Cullum

Howard M. Cullum
Commissioner

HMC/ehf

Attachment

ATTACHMENT

DMHMR Comments to JLARC Recommendations

Recommendations 1-7 (Prescreening and Discharge Planning)

We concur with the overall thrust of this set of recommendations which propose to strengthen the client and service management role of local CSBs in transitions to and from state hospital services. Prescreening by CSBs is critical in assuring that hospital services are targeted to persons requiring intensive inpatient psychiatric treatment. Adequate and timely discharge planning is equally important in providing for the transition back to the community. We therefore are pleased that the General Assembly in 1986 passed S 246, which requires CSB prescreening (Recommendation 1 and 2), as well as Senate bills (e.g., S 245, SJR 17) requiring specification of services needed on discharge and use of a uniform discharge document. Our **Patient Management Guidelines,** now being revised for promulgation as formal policy and associated regulations, also address these critical issues. Agreements with local providers regarding prescreening (Recommendation 2) and time guidelines for CSB-facility interactions in discharge planning (Recommendation 6) are now included. The revised versions of these guidelines will also discuss temporary leave (Recommendation 7) and include specification of minimal qualifications for prescreeners (Recommendation 4) as well as outlining general procedures for prescreening (Recommendation 3). Some flexibility in specific operational criteria and procedures is needed, however, to assure appropriate clinical management of widely varying situations.

Recommendations 8 & 9 (Case Management)

The report recommends that the General Assembly fund additional case manager positions. CSBs reported needing 122 positions; only 60 were funded in the 1986-88 budget. Additional CSB positions are still needed to provide outreach and case coordination. A CSB and Central Office work group is now in the process of developing case management guidelines (Recommendation 9).

In order to determine further how well the transition from hospital to community is managed by CSBs since the promulgation of the **Patient Management Guidelines,** DMHMR is now conducting an extensive study of all discharges from state facilities in FY-86 to determine their status and involvement in community services. This study should provide excellent guidance for further improvements in service management procedures.

Recommendation 10 (Outpatient Commitment)

Section 37.1-67.3 as amended by the 1986 General Assembly in H446 shifts priority for dispositional recommendations in commitment proceedings from DMHMR to local CSBs. This change is a positive step toward Recommendation 10 in that it strengthens the CSB's role to designate for judges outpatient programs which would be suitable as a court-ordered alternative to institutional confinement. Although we concur that more specific procedures for outpatient commitment warrant further consideration, it should be noted that similar laws have had limited impact in other states. The numbers of persons meeting criteria for involuntary treatment but not requiring hospitalization are generally limited, and the option of outpatient treatment is invalid if adequately-funded alternatives are not available in the community.

Recommendations 11-13, 16, 18 (Mental Health Community Services)

The report provides an excellent overview of the many serious needs of our CSB system for development in critical service areas. If we are to serve chronically mentally ill persons effectively in the community, JLARC recommends mandating the provision of psychosocial rehabilitation, transitional employment, and medication maintenance services (Recommendation 11). Although we strongly support the intent to expand community support services, we are seeking instead a mandate for the existing, more generic core services (e.g., outpatient/day, residential, emergency) to allow CSBs more flexibility in program model and organization. We also concur with JLARC's recommendation (Recommendation 16) that within such a mandate, emergency services should be uniformly available on a face-to-face basis. Wherever possible, emergency services should also include options for intensive community-based crisis stabilization services as an alternative to hospitalization. Where now available, these intensive emergency services help avoid unnecessary and costly hospitalization during brief exacerbations of major mental illness.

JLARC's recommendation that local inpatient programs should also be developed (Recommendation 13) is one the Department strongly supports. We have pursued funding for CSBs to purchase local inpatient services. We will continue to seek appropriate support for this important component of a basic continuum of services. Reports from many CSBs with local inpatient funds suggest that overall episode costs can be significantly lower through avoidance of lengthier state hospitalization and disruption of community support systems.

Although we concur with JLARC's recognition of the importance of transportation services, we do not agree with the Recommendation (18) that these services be funded separately from the core services. Transportation is an integral part of these other services and can better be budgeted as part of the initial program costs.

Overall, JLARC recommends that the General Assembly give funding priority to the development of community services for the seriously mentally ill (Recommendation 12). Clearly, we see this as a crucial recommendation. I believe our Department's Comprehensive Plan provides a sound basis for identifying needed services. Additionally, we are implementing a new, comprehensive evaluation system which I believe will assist us and CSBs in assessing the need for services and identifying inadequacies in key areas.

Recommendations 14, 15, and 17 (Mental Retardation, Substance Abuse, and Prevention)

This series of recommendations calls for DMHMR to identify service needs for the mentally retarded, substance abuse, and prevention activities and prepare a plan for funding priority service needs of CSBs. DMHMR completed a Comprehensive Five-Year Plan in 1985 that addresses these needs, priorities, and funding requirements. An updated Plan will be available by November 1, 1986, for the FY 87-92 time frame.

Recommendations 19-21, 23 (Housing for Mentally Disabled)

This series of recommendations parallels several of the earlier recommendations of a housing report by the Secretaries of Human Resources and Commerce and Economic Development which emphasized a stronger role for HCD (Recommendation 19) and VHDA (Recommendation 21) in meeting the housing needs of the mentally disabled. We strongly agree and look to continuation by Secretaries Teig and Bagley of the earlier Secretarial-level initiatives to further these interagency efforts. The need for a statewide housing

plan with adequate funding (Recommendation 20) is a strong Departmental priority. Given the existing expertise and emphasis on this service area within our disability offices, the establishment of a separate residential coordination position (Recommendation 20) is not supported. Attention should rather be focused on efforts at the Secretarial level to involve other agencies in meeting the critical goals of CSBs developing adequate housing opportunities through multi-agency support (Recommendation 23). Within our mini-budget priorities, we have requested $2.4 million for expanded housing opportunities for the mentally disabled.

Recommendations 22, 24-32 (Homes for Adults)

The majority of these items recommend actions by both Department of Social Services (DSS) and DMHMR to improve the quality of services available to mentally disabled residents of Homes for Adults (HFAs). We certainly concur that such improvements are needed. Our agency is now involved with DSS in work on three major legislative studies which focus on these recommendations:

- SJR 62 to expand the use of auxiliary grants (Recommendation 22).
- HJR 70 to examine aftercare needs of mentally disabled in HFAs and to consider differentially reimbursed levels of care (Recommendations 24 and 31).
- HB 30, Item 475 to study implementation of the recommendations of the auxiliary grant study, which included an emphasis on licensing and staffing of homes with significant numbers of post-hospitalized residents (Recommendations 24, 28, 29, and 32).

Specific improvements in how the two agencies cooperate in licensing, placement, follow up, training, and exchange of information for HFA residents will be identified and implemented as a result of these studies. Even with these improvements, however, significant problems in matching clients to appropriate placements will continue. Results to date of work on SJR 62 indicate Federal regulations will hamper efforts to expand auxiliary grant coverage to other settings (Recommendation 22). The focus on HFAs, even if these settings are better regulated and coordinated with CSBs, leaves many clients in settings which are either lacking in necessary supervision and treatment or overly restrictive. District homes (Recommendation 25), although potentially appropriate for some clients, are also too restrictive and non-normalizing for many others. The basic issue remains one of major resource requirements to support the development of a broader continuum of housing services for this population. Continuing work with DSS will help but will not eliminate these resource needs.

Recommendations 33-36 (Service Accountability)

This set of recommendations regarding community-based services and fiscal accountability is supportive of the Department's consistent policy initiatives to strengthen the role of CSB's in client service management. The 1986 General Assembly clearly stated in SJR 60 and HJR 85 that a comprehensive system of community-based services with accountability at the local level should be the policy goal of the Commonwealth (Recommendation 33). At the service delivery level, our **Patient Management Guidelines** make clear to CSBs our expectation that clients who enter a state hospital do not exit from CSB client management responsibility. At the system development level, our Comprehensive Plan supports this single system vision, providing a clear blueprint for the development of priority services (Recommendation 34). National studies, such as the recent Public

Citizen Health Research Group report, indicate that decentralization of program and fiscal responsibility to the local level is found in the better programs across the country (Recommendation 34). We concur with JLARC's comments on the importance of strengthened standards for local program accountability, and we are therefore developing an enhanced evaluation and licensing system to ensure the quality of CSB services (Recommendation 35). JLARC has also suggested the General Assembly express its intent regarding the role of state hospitals in providing long-term and highly-specialized treatment (Recommendation 36). We support this recommendation but believe that in many areas of the Commonwealth, state hospitals will also need to continue to provide acute treatment services where local private inpatient alternatives are not available.

Recommendations 37-39 (Fiscal Accountability)

The first of these recommendations (Recommendation 37), to develop a formula for the equitable allocation of funds, is one which the Department is already addressing in conjunction with a CSB work group. We believe such a formula will need to take into account significant need variables as well as population. The report also recommends that the General Assembly direct DMHMR to develop a plan whereby CSBs are provided incentives for using community services through fiscal accountability for use of state hospitals (Recommendation 38). We have worked with one state hospital and two of its CSBs in a project which demonstrates many of the strengths of such an approach in promoting reductions in inappropriate hospital use. We have also seen, however, that new funds for community services are still required for the success of such an approach. Given the escalating costs and accreditation/certification standards for hospital quality of care, our facilities' budget requirements are not quickly or significantly reduced by gradual, clinically-appropriate census reductions. It is on the basis of this understanding that we are working with the Secretary of Human Resource's office to plan pilots in community-based service management per the mandates of SJR 53 and the Governor's budget amendments. Established fiscal accountability at the local level for hospital and community services may have some significant benefits, but it will not eliminate the system's significant resource needs for critical service delivery.

With regard to JLARC's recommendation on maintaining the absolute level of local government's financial support to CSBs (Recommendation 39), the Department strongly supports a requirement to maintain current levels of local financial participation.

In conclusion, let me reiterate the Department's support for the major thrust of this report. JLARC's study reflects a system with the requisite know-how and commitment to community-based services for the mentally disabled but seriously lacking in the resources to make the system work as intended.

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