JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

THE VIRGINIA GENERAL ASSEMBLY

DEINSTITUTIONALIZATION AND COMMUNITY SERVICES

A Special Report
September 1979

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Deinstitutionalization and Community Services

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Joint Legislative Audit and Review Commission

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Preface

The Joint Legislative Audit and Review Commission has a statutory responsibility to carry out operational and performance reviews of state agencies and programs. §30-58.1,C, *Code of Virginia*, also charges JLARC to study functions of State agencies at the request of the General Assembly. This special study, "Deinstitutionalization and Community Services in Virginia," was initially requested by Delegate Richard M. Bagley and was completed in cooperation with the Legislative Commission on Mental Health and Mental Retardation which Delegate Bagley chaired from 1977 through 1979. Therefore, this report should be viewed as one part of a much larger legislative inquiry into mental health programs, services, and institutions.

The term "deinstitutionalization" can have several different meanings but the Department of Mental Health and Mental Retardation has not promulgated an official definition. At first, the term appeared to be most closely related to a goal of reducing the population of State mental health institutions by ten % yearly over a five-year period. Deinstitutionalization has also been seen as a concept which promotes mental health treatment in the least restrictive setting, and attempts to prevent the mentally ill from being inappropriately placed in institutions.

For this report, "deinstitutionalization" refers principally to the processes involved in transferring mentally ill and mentally retarded clients from a State institution to a community setting and, as part of the transfer, establishing appropriate linkages for treatment and support services. Assessing these two components of deinstitutionalization seems to be the most fundamental way to measure the Commonwealth's ability to establish a continuum of care for the mentally ill and mentally retarded. Such a system of care was recommended in 1970 by the Commission on Mental, Indigent and Geriatric Patients.

Our report format is designed to highlight each of 19 questions about the mental health system that we addressed on behalf of the legislature. Ten staff recommendations are presented in the report beginning at Page 5. The recommendations were transmitted to the Legislative Commission on Mental Health and Mental Retardation on October 8, 1979, and were subsequently endorsed.

On behalf of the JLARC staff, I wish to acknowledge the cooperation and assistance provided during the course of this project by the Department of Mental Health and Mental Retardation, Eastern State and Western State hospitals, Southeastern Virginia Training Center, Lynchburg Training School and Hospital, and community leaders in the Tidewater and Central Virginia communities visited as part of our case studies.

Ray D. Pethtel

December 14, 1979

Ray D. Pethtel

I. Introduction and Summary

In its most basic form, deinstitutionalization refers to the reduction of long-term stays in State institutions through the process of transferring mentally ill and mentally retarded clients from State institutions to appropriate services in the community. Successful client transfer requires coordination between State institutions and community agencies, and development of community services to meet the needs of discharged clients for continued treatment or supportive services, such as housing and day activities.

A "blueprint," which included the concept of deinstitutionalization, was proposed in 1970 for the mental health and mental retardation system in Virginia by the Governor's Commission on Mental, Indigent and Geriatric Patients. The commission advised that the State develop a "total commitment to the concept of a coordinated system of care focused on the patient rather than the agency or institution." Related recommendations in the two reports issued by the commission were:

- Develop alternatives in the community for hospitalized patients who could benefit from community placement.
- Facilitate continuity of care between State and community services.
- Regionalize the State Department of Mental Health and Mental Retardation (DMHMR) to guide a single system of institutional and community mental health care.

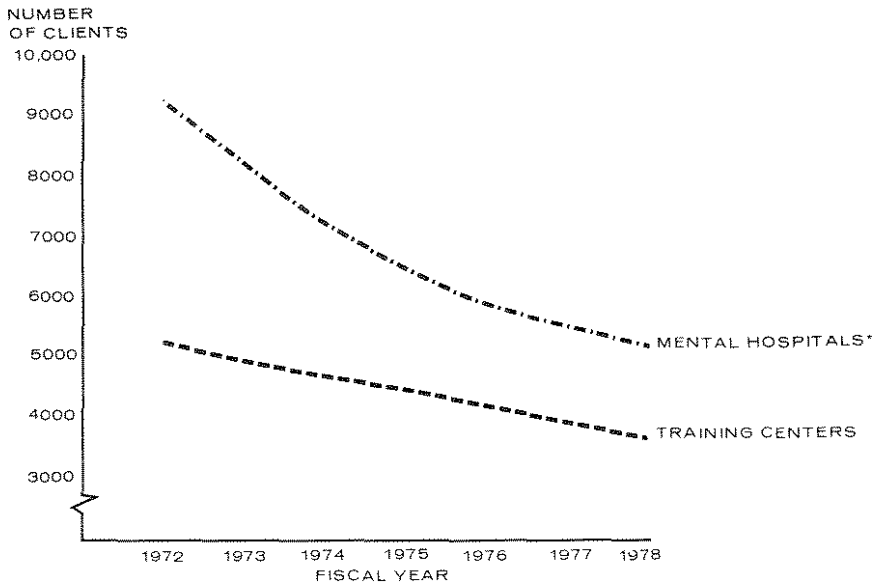
Progress has been made since the commission issued its reports. Populations of mental health hospitals and of mental retardation training centers have been reduced by approximately 44 and 28 percent, respectively (see Figure 1, page 2). During the last biennium alone, 21,718 people were discharged to the community, and over $50.8 million was appropriated for community services.

Current policies and procedures, however, are inadequate to ensure that community services are either available or delivered on a Statewide basis. Problems result from the existence of the two imperfectly linked institutional and community networks. Procedural deficiencies include lack of strong central leadership and evaluation, fragmented responsibility for service delivery, and inadequate assessment of client needs to support service development and funding decisions.

In great measure, coordination has depended on client initiative and the independent, often inconsistent efforts of institutional and community staff. Some potentially effective models exist, but a coordinated system of care has not been developed in the Commonwealth.

Figure 1

AVERAGE DAILY POPULATION IN STATE INSTITUTIONS



Source: JLARC representation of DMHMR data.

JLARC Review

This study of deinstitutionalization and community services is part of a comprehensive review of health care programs in the Commonwealth. It is a special study conducted in coordination with the Legislative Commission on Mental Health and Mental Retardation, chaired by Delegate Richard M. Bagley.

Purpose. The primary purpose of the study was to assess the State's ability to link clients with appropriate services after seven years of experience with deinstitutionalization. The three major study objectives, which relate to recommendations of the Governor's Commission on Mental, Indigent and Geriatric Patients, were:

1. Review procedures for transferring patients from State institutions to the community.

2. Assess the extent of organizational integration to link discharged clients with community services.

3. Discuss the potential of communities to meet the continuing needs of discharged clients.

Scope. This report focused on discharge procedures at State institutions for the mentally ill and mentally retarded and on availability of community services. Discussion involves the activities of State, local, and private providers of care to mentally ill and mentally retarded people. Particular attention was paid to interagency coordination.

DMHMR has the broadest program and oversight responsibilities. Other agencies and institutions that play a prominent role are the 36 local mental health and mental retardation service boards, the State mental hospitals and training centers for the mentally retarded, the State departments of Welfare, Rehabilitative Services, and Health, and the Virginia Housing Development Authority.

Methodology. In order to carry out this study, JLARC staff obtained and analyzed data from numerous sources. Due to the limited availability of consistent Statewide data, however, much of the study was based on rigorous fieldwork conducted at four State institutions and in six case study communities. Data sources were:

- DMHMR Automated Reimbursement System (ARS) for 1978;
- DMHMR Statistical Annual Reports, FY 1970 to FY 1978;
- JLARC survey of executive directors of Community Service Boards (CSBs);
- DMHMR licensure, community program, and budgetary data; and
- sample of client records.

Two sets of institutions and communities were selected for case study. Each set contained a major mental hospital, a training center for the mentally retarded, and three communities within the service area of both types of institutions (see Table 1, page 4).

The research methodology used for institutions involved:

- Structured interviews of 53 professional staff with responsibility for major aspects of the discharge process.
- Review of a representative sample of client records from the case study communities, in order to assess documentation of discharge procedures.

Table 1

CASE STUDY COMPONENTS

Case Study	Mental Hospital	Training Center	Communities
One	Eastern State Hospital	Southeastern Virginia Training Center	Hampton-Newport News Virginia Beach Western Tidewater Area[1]
Two	Western State Hospital	Lynchburg Training School and Hospital	Valley Area[2] Rappahannock Area[3] Covington Area[4]

[1]Suffolk, Franklin, Isle of Wight County, Southampton County.
[2]Staunton, Waynesboro, Augusta County.
[3]Fredericksburg, King George, Spotsylvania County, Stafford County, Caroline County.
[4]Covington, Clifton Forge, Alleghany County.

The research methodology used at each community involved:

- Comparable, structured interviews with staff of the CSB, including the executive director, fiscal officer, mental retardation coordinator, clinic director, and clinic staff.
- Site visits and structured interviews with program staff of services such as group homes, activity centers, and sheltered workshops.
- Structured interviews with representatives of the local governments, local welfare departments, and rehabilitative services counselors.
- Follow-up of client records reviewed at the institutions to determine what community services have been provided.

A technical appendix, which explains in more detail the methodologies and research techniques used in this study, is available on request.

Organization. The next chapter of this report discusses the organization and legislative basis of the mental health and mental retardation network in Virginia. Subsequent chapters explore trends in and the data base for analyzing deinstitutionalization, the process for linking the mentally ill and mentally retarded with community services, and the process for ensuring the adequacy of and accountability for community services.

Principal staff findings, conclusions, and recommendations drawn from the research, which have been transmitted to the Legislative Commission on Mental Health and Mental Retardation by the Joint Legislative Audit and Review Commission, are detailed below.

PRINCIPAL FINDINGS

Principal findings of the JLARC study on deinstitutionalization and community services in Virginia are:

- Considerable progress has been made in increasing funds for community services and reducing the populations of State institutions.
- Transfer of discharged clients to appropriate community services is inhibited by inadequate and inconsistently administered discharge procedures at State institutions.
- The needs of discharged clients are not being adequately met due to gaps in community services and to the limited capacity of existing services.
- A coordinated system of care for the mentally ill and mentally retarded has not been developed in the Commonwealth. Responsibility for service delivery is fragmented among numerous State and local agencies, without sufficient central policy or procedural direction.

Specific areas which require action by the General Assembly or DMHMR are institutional responsibilities, community services, and system development.

Institutional Responsibilities

1. *Release of Information.* Delivery of community services can be facilitated if community agencies are aware of client needs prior to discharge. Although client approval is a prerequisite to release of information by institutions, it is not consistently obtained in a timely manner by institutions.

Recommendation. DMHMR should immediately establish explicit procedures to be followed by all institutions for obtaining client consent as early as possible after admission. During the course of the client's hospitalization, appropriate community agencies should be provided with complete information regarding client treatment, progress, and post-discharge needs.

The General Assembly may also wish to address barriers to transfer of information between State institutions and community agencies by issuing a clear statement of legislative intent that CSBs are an integral component of the State's coordinated system of care, or by amending the Privacy Protection Act to exempt transfer of clinical information between State institutions and CSB clinics.

2. *Discharge Planning.* The transfer of clients to community services could be facilitated if discharge planning consistently included systematic identification of client needs for treatment and supportive services, and by the participation of community agencies in coordinating community services prior to the client's discharge. At present, notes relevant to post-discharge needs are scattered throughout the client's record, and community agencies do not regularly participate in planning prior to discharge.

Recommendation. DMHMR should require State institutions to use a single, standardized format for preparing a client discharge plan. The plan should include diagnostic and social background information, a comprehensive assessment of post-discharge needs, and a checklist of actions taken to facilitate application for community services.

In addition, institutions should actively solicit attendance by CSBs, local departments of welfare, and other relevant agencies at discharge planning conferences. Community agencies should put a high priority on attending these meetings. Decisions made by community agencies to assist clients should be recorded in the discharge plan.

3. *Patient Preparation.* In order to live successfully in community settings, many clients leaving State institutions need training in functional and social skills, instruction in the use of medication, and special counseling to ease the transition. Despite a demonstrated need for transitional programs, State institutions only provide this type of service to a small number of clients.

Recommendation. DMHMR should assess the need for and develop preparatory and transitional programs in the institutions. At a minimum, clients should receive: (1) adequate instruction on the use and effects of their medication; (2) daily living and social skill training as necessary; and (3) information on community services. Programs already in place at several institutions should be evaluated for effectiveness and possible expansion.

Community Services

4. *Service Availability*. Clients discharged from State institutions should have equal access to a basic core of community services throughout the State. Currently, there are numerous gaps in the range of services available, and discharged clients often receive only minimal services. Service inadequacies have restricted the ability of institutions to discharge clients.

Recommendation. DMHMR and the General Assembly should consider mandating delivery of a basic core of services for discharged clients. During the next fiscal year, a study should be conducted to specifically define the components of the mandatory core, identify the characteristics and numbers of clients who could benefit, and assess the full service costs.

Special attention should be given to the appropriateness of homes for adults as housing placements for discharged clients. DMHMR and the Department of Welfare should develop a plan for upgrading the quality of care delivered by homes for adults to aftercare residents and for implementing relevant licensure standards presently proposed by the Department of Welfare. DMHMR should:

- Assist CSBs in providing consultation and training for operators and staff of adult homes in the handling of psychiatric and medical emergencies, and the management of assaultive and disoriented residents.

- Require State hospital staff to prepare a discharge summary of the client's medical and social history in clear and simple language, and send the summary to the adult home, contingent upon the client's consent, prior to the client's placement in the home.

- Require State institutions to place mental aftercare patients only in adult homes which are in substantial compliance with licensing standards.

5. *Funding and Accountability*. Funding can provide the State with considerable leverage to ensure the efficiency and effectiveness of community programs. Currently, programs are funded by DMHMR, CSBs, and local governments without sufficient analysis of cost variations or performance results. Primary emphasis is on financial audits. Standards recently proposed by DMHMR do not address client progress, and most CSBs do not conduct formal program evaluations.

Recommendation. DMHMR should develop meaningful program definitions, cost reporting and contract formats, and performance criteria for community programs. At the outset, cost variations

among programs should be analyzed by DMHMR for the purpose of improving management efficiency.

Additionally, the General Assembly may wish to require that CSBs conduct formal written evaluations of contractual programs at regular intervals, and that DMHMR review and follow up CSB program evaluations and conduct program reviews of programs directly operated by CSBs.

6. *Case Management.* Many discharged clients require an array of community services provided by different agencies. In such cases, client access to services can be facilitated by one agency or person in the community having responsibility for case management. This includes helping clients to identify their needs and apply for services, as well as monitoring service delivery and client progress. Although some form of case management is provided by a number of human service agencies in Virginia, no agency is clearly responsible for coordinating comprehensive client care in the community.

Recommendation. DMHMR should require that CSBs provide case manager positions for both the mentally retarded and the mentally ill, and that these managers organize interagency teams to facilitate service delivery. Additionally, the General Assembly may wish to provide CSBs with statutory authority for case management, and to clearly establish the responsibility of CSBs for coordination of care for discharged clients in the community.

System Development

7. *Central Direction.* DMHMR has statutory authority for planning, funding, operation, and evaluation functions which could be used to facilitate development of a coordinated system. However, DMHMR has allowed the autonomy of system components to lead to inconsistent and inadequate patterns of interaction. Only recently, in response to legislative and executive concern, has the department begun to exercise limited authority.

Recommendation. The General Assembly may wish to issue a clear statement of legislative intent regarding the leadership role expected of DMHMR and the relative roles of CSBs and other relevant agencies. To ensure continued progress in achieving system integration, an independent body should continue to monitor the department's performance.

8. *Planning and Information.* A prerequisite to effective planning is systematic and ongoing analysis of client needs, available resources, and existing services. Current State mental health and mental retardation plans are not based on adequate information and do not establish priorities or implementation procedures.

Recommendation. DMHMR, in cooperation with the CSBs, should begin immediate development of systemwide information on client characteristics and needs, and on the capacity and quality of current services. Initially, DMHMR's Automated Reimbursement System and Individual Data Base should be improved and utilized to develop data which include accurate length of stay, history of previous hospitalization, community of discharge, type of placements, service needs, and service referrals. Annually updated data should be incorporated in DMHMR's funding priorities and the State plans to focus service development.

9. *Assessment of Impact.* Approximately 9,000 clients continue to be discharged from State institutions annually. It is essential that the State be aware of the impact of deinstitutionalization on clients, communities, and State and local expenditures. At present, DMHMR and other human service agencies do not maintain sufficient information to assess the full impact of deinstitutionalization. For example, reasons for the 30 percent increase in client recidivism since 1970 have not been explored. Further, information systems of State agencies such as the departments of Welfare and Rehabilitative Services do not document what may be substantial expenditures for services to discharged clients.

Recommendation. DMHMR and the CSBs should conduct an extensive, valid follow-up of the progress and status of clients discharged from institutions. In addition, data collected and maintained by State agencies should separately identify the number of mentally disabled clients served, the number of discharged clients served, the types of services provided, and the costs of services. This information should be available by locality.

DMHMR should take the lead in using the client follow-up and aggregated agency data as part of an ongoing effort to assess the human and monetary impact of the State's deinstitutionalization policy, identify unmet needs, identify potential as well as duplicative funding sources and services, and develop meaningful goals and procedures to coordinate service delivery and funding sources.

10. *Interagency Coordination.* Effective coordination at the State level requires meaningful agreements among human service agencies and appropriate roles for DMHMR's regional coordinators. However, agreements between DMHMR and other State agencies have not resulted in improved coordination at the local level. Additionally, DMHMR regional coordinators are primarily involved with program consultation and budget review, and perform little liaison among institutions, CSBs, and community agencies.

Recommendation. State-to-State agreements should be revised to include mandatory implementation procedures, appropriate training of local personnel, and periodic monitoring to ensure that the agreements are facilitating interagency coordination. In addition, DMHMR regional coordinators should focus on fostering coordination of the activities of CSBs, institutions, and other relevant agencies within their regions.

II. Overview of Deinstitutionalization

A major effort during the last decade, both in Virginia and nationwide, has been to reduce the number of people in state institutions for the mentally ill and mentally retarded. The intent was to provide care in less restrictive community settings for clients who could benefit from it, and to eliminate inappropriate long-term institutionalization.

The result in the Commonwealth has been rapid reduction of institutional populations, but considerably slower development of procedures to meet the overall community service needs of discharged clients. Responsibility for implementing a process of deinstitutionalization, defined in this report as transferring clients from State institutions to appropriate community services, has been fragmented among numerous State and local mental health and mental retardation and human service agencies.

BACKGROUND

State governments have been highly involved in deinstitutionalization because State-operated institutions have traditionally been the primary providers of care. Virginia, like most states, continues to provide institutional care and to fund a large part of community services.

Medical and Legal Developments

Medical and legal developments have led to shorter institutional stays, as well as to an emphasis on care in settings less restrictive than those offered by institutions.

Medical Developments. Two parallel medical developments culminated during the 1960s: recognition of the negative effects of institutions on patients, and the use of psychotropic drugs, such as Thorazine, to control psychotic symptoms. Studies showed that patients often suffered as much from becoming dependent on the institutional environment as from the original illness, and that longer stays resulted in a poorer prognosis. The use of drugs to stabilize conditions also resulted in the early discharge of many patients.

Legal Developments. Three essential aspects of patients' civil rights have been specified in case law: the right to treatment; the right to this treatment in the least restrictive environment; and the right to liberty. Courts have ruled that people may not be involuntarily held in an institution unless treatment is being received that provides a realistic opportunity for a cure; moreover, there must be no less restrictive environment available.

Decisions of the lower courts were encompassed in a 1975 Supreme Court definition of the right to liberty. The Court ruled that civilly committed patients have the right to liberty if they are (1) not dangerous to themselves or others, (2) receiving only custodial care, and (3) capable of surviving safely in freedom by themselves or with the help of willing and responsible family members and friends.

Legislative Actions

Major federal and State legislation has reflected medical and legal concerns regarding undue reliance on institutional care and the need for less restrictive alternatives in the community.

Federal Legislation. Primary legislation on the federal level was the Community Mental Health Centers Act passed in 1963 (P.L. 88-164) and amended in 1975 (P.L. 94-63). The original act established the goal of reducing mental hospital populations by 50 percent within a ten-year period. The amendments stated that ". . . community mental health care is the most effective and humane form of care for a majority of mentally ill individuals."

As a result of this federal legislation, funds were authorized for building and staffing community mental health centers. States were required to implement a mental health plan to ensure the availability of noninstitutional care and to prevent inappropriate admissions to institutions. The country was divided into regional "catchment areas" of a size conducive to service by a mental health center. Due to funding limitations, only 570 federally funded centers were in operation as of May 1977. In Virginia, 13 community mental health centers have received construction or staffing grants.

State Legislation. Actions of the Virginia General Assembly during the same time period established the basis for delivery of community services, and incorporated court decisions into legislation that would protect patients' rights and make commitment to State institutions more difficult.

Chapter 10 of Title 37.1, *Code of Virginia*, was passed in 1968 to enable local jurisdictions to establish community mental health and mental retardation service boards. The boards were to serve geographic areas with a population of approximately 50,000, and provide a range of services, including inpatient and outpatient care, transitional services, and emergency services.

Due process for people subject to involuntary judicial commitment to State mental institutions was specified in 1974 and 1976 amendments to the *Code of Virginia* in Chapter 2, Title 37.1. Commitments now may not extend beyond 180 days unless new commitment

proceedings are initiated, and periodic reviews of the individual's condition must be conducted by the institution. Similarly, provisions were specified for certification hearings for admission of mentally retarded people to State institutions.

The Governor's Commission on Mental, Indigent and Geriatric Patients

The most comprehensive expression of legislative and executive intent appeared in two reports issued between 1970 and 1972 by the Governor's Commission on Mental, Indigent and Geriatric Patients. The commission, chaired by State Senator Omer L. Hirst, deplored the overcrowded conditions and inadequate treatment capacity of State institutions. It issued a "blueprint" for the future which included the concept of deinstitutionalization and attempted to delineate steps for improving institutional care and for developing community services for those who could benefit.

The commission urged the Department of Mental Health and Mental Retardation (then the Department of Mental Hygiene) to exert substantial leadership in developing a coordinated system of care focused on the patient. It defined this system as one which would provide the appropriate level of care required by patients entering the system, and then provide for the orderly transfer of patients to a more or less restrictive environment.

To improve institutional care, the commission advocated construction of smaller, regional facilities, improved staffing, and strengthened community involvement in hospital care. Particular attention was paid to the need for separate, specialized facilities for the care of geriatric patients.

Substantially increased State funding was recommended for the development of community services. For the mentally retarded, service needs included protective services, activity centers, and workshops and adult living centers. For the mentally ill, emphasis was placed on developing federally funded community mental health centers, and on strengthening the post-discharge care functions of State mental health clinics.

The commission envisioned a multifaceted leadership role for DMHMR. The responsibility of the department would extend beyond the improvement of institutions to the guidance of Community Service Boards, referred to as the "department's Chapter 10 Boards." The department was urged to provide a "continuous line of communication between hospital, community and central administration" and to provide "the impetus and direction" for developing community activities that would reduce reliance on institutional care. Key ingredients were to be development of regional administrative capacity, preadmission screening in the community, and a locus of authority in the community to meet the overall medical, social, and other needs of discharged clients.

Administrative Action in Virginia

Reduction of institutional populations became the policy of DMHMR in 1972. The action of DMHMR resulted from the recommendations of the Commission on Mental, Indigent and Geriatric Patients, and from awareness of court actions brought against other states to secure liberty for mental patients. The commissioner of DMHMR requested directors of State institutions to develop plans to reduce institutional populations by ten percent a year over a five-year period.

In 1972, few community services existed and coordination was minimal. CSBs had been receiving State funds for only two years and, in many areas of the State, were just beginning to function.

In 1974, DMHMR commissioned an outside consultant to study the impact of deinstitutionalization and to recommend management procedures. The consultant, Arthur Bolton Associates, stressed the importance of coordination between institutions, CSBs, and the central office. Major recommendations centered on determining the characteristics of institutionalized clients so that appropriate community services could be developed, and facilitating the transfer of clients and information between institutions and community agencies.

ORGANIZATION

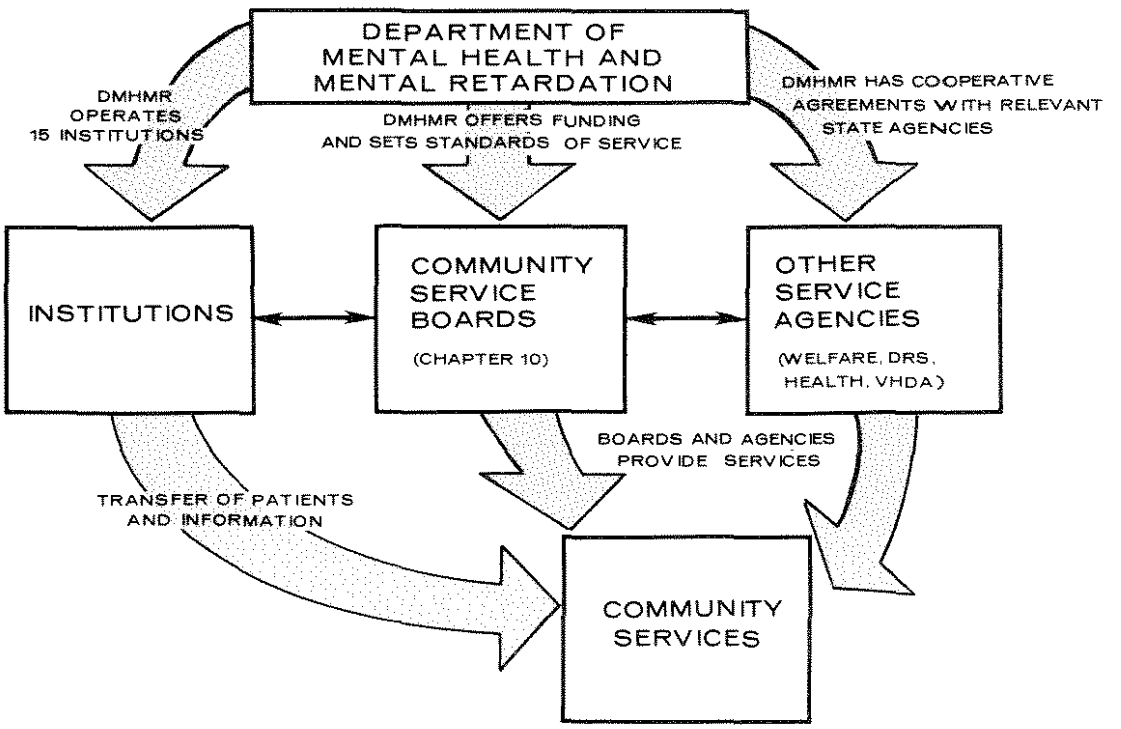
The process of deinstitutionalization involves two networks (Figure 2). One network is composed of agencies with formally defined mental health and mental retardation responsibilities. The other network is composed of human service agencies, such as the departments of Health, Welfare, and Rehabilitative Services, which provide supportive services to the general population as well as to mentally ill and mentally retarded clients. Therefore, extensive coordination is necessary to ensure that clients transferred to the community from State institutions receive the full range of necessary services.

Model Process

Based on extensive literature review and interviews with professionals throughout the Commonwealth, JLARC determined that a model deinstitutionalization process appears to have several essential components. Ideally, policies and procedures would be consistently established and implemented throughout the State. The needs of clients for treatment and supportive services, such as housing, financial assistance, and day activities, would be identified on an aggregate basis for the purpose of program planning and development

Figure 2

AGENCIES INVOLVED IN DEINSTITUTIONALIZATION PROCESS



Source: JLARC representation of DMHMR data.

of community services. A sufficient, uniformly-defined core of mental health and mental retardation and supportive services would exist across the State. For individual clients, discharge procedures at State institutions would involve adequate client preparation and close coordination with community agencies to effectively link clients with necessary services. One agency in the community would be responsible for case management to ensure that clients continue to receive an appropriate level of service.

Agencies Involved

In Virginia, considerable autonomy exists among agencies involved in the process of transferring clients from State institutions to appropriate community services. DMHMR has the broadest responsibilities. However, the department takes the position that there are dual institutional and community systems and that departmental authority over the system is limited.

Nevertheless, DMHMR is responsible for functions that affect coordination among other agencies and the quality of community services. For example, the department operates State institutions and has authority to provide funding, guidelines, and service standards for CSBs. The CSBs are the primary local or regional agencies for provision of mental health and mental retardation services. In addition, the department has entered into interagency agreements with the departments of Welfare, Health, and Rehabilitative Services and the Virginia Housing Development Authority. It appears that these operational responsibilities for funding, coordination and standard setting could provide DMHMR with considerable leverage for affecting the direction and policy of the system.

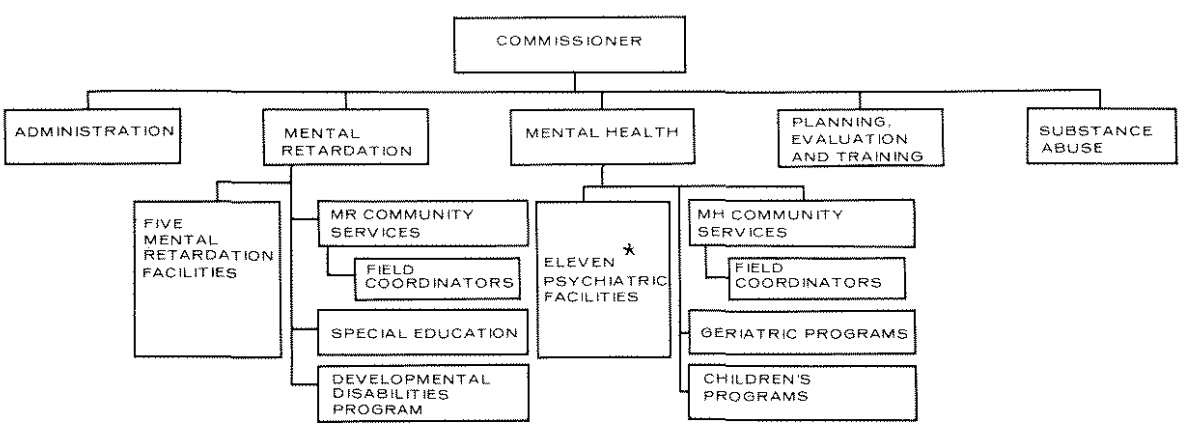
Formal Network

The formal or recognized mental health and mental retardation network is composed of DMHMR, the State institutions, and CSBs. Although the department technically operates State institutions, each receives a separate line item appropriation and establishes independent operating procedures. CSB policies tend to be a hybrid of State, local, and member preferences. The CSBs are funded in large part by the department, which is also empowered by statute (Section 197e, Chapter 10, Title 37.1, *Code of Virginia*) to provide guidelines and standards. However, the boards also receive local funds, and board members are appointed by local governments.

DMHMR. The department, headed by a commissioner, is organized into five divisions, each headed by an assistant commissioner (Figure 3).

Figure 3

DMHMR ORGANIZATION



*includes Hiram Davis Medical Center

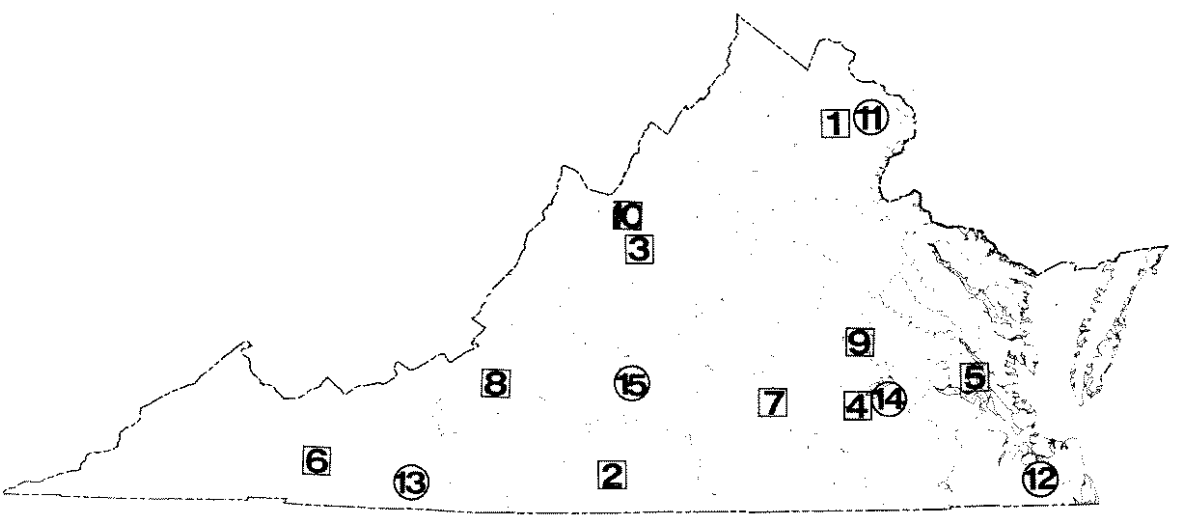
Source: JLARC representation of DMHMR data.

The mental health and mental retardation divisions are responsible for operation of the State hospitals and training centers, respectively, and for consultation, funding, and technical assistance to the CSBs. Consultation is primarily provided by five mental health and mental retardation regional coordinators in each division. Additional support services are available through the administrative division and the planning, evaluation, and training division.

State Institutions. A total of 15 State institutions provide inpatient care for mentally ill and mentally retarded people. Each of the institutions is headed by a director appointed by the DMHMR commissioner. The locations of State facilities are shown in Figure 4.

Figure 4

MENTAL INSTITUTIONS AND MENTAL RETARDATION FACILITIES IN VIRGINIA



MI INSTITUTION LOCATIONS
1 NORTHERN VIRGINIA MENTAL HEALTH INSTITUTE
2 SOUTHERN VIRGINIA MENTAL HEALTH INSTITUTE
3 WESTERN STATE HOSPITAL
4 CENTRAL STATE HOSPITAL
5 EASTERN STATE HOSPITAL
6 SOUTHWESTERN STATE HOSPITAL
7 PIEDMONT GERIATRIC HOSPITAL
8 CATAWBA GERIATRIC HOSPITAL
9 VIRGINIA TREATMENT CENTER FOR CHILDREN
10 DEJARNETTE CENTER FOR HUMAN DEVELOPMENT

MR INSTITUTION LOCATIONS
11 NORTHERN VIRGINIA TRAINING CENTER
12 SOUTHEASTERN VIRGINIA TRAINING CENTER
13 SOUTHWESTERN VIRGINIA TRAINING CENTER
14 SOUTHSIDE VIRGINIA TRAINING CENTER
15 LYNCHBURG TRAINING SCHOOL AND HOSPITAL

Source: JLARC representation of DMHMR data.

Five State training centers for the mentally retarded are currently in operation. The oldest and largest is Lynchburg Training School and Hospital (LTSH). Overcrowding at LTSH and

the inappropriate housing of mentally retarded clients in mental hospitals led the State to create four additional training centers.

Southside Virginia Training Center (SVTC) was established on the grounds of Central State Hospital in 1972. LTSH and SVTC have a bed capacity of 2,262 and 964 beds, respectively. Subsequent additions have been smaller, regional training centers in northern, southeastern, and southwestern Virginia. Bed capacities in regional centers range from 200 to 285 beds. Two additional centers are planned at Harrisonburg and Fredericksburg.

For the mentally ill, there are ten State-supported institutions. Four large, centralized facilities are designed to provide comprehensive services for both acute and chronic (i.e., long-term or multiple admission) patients. Each hospital operates an on-site geriatric treatment center. The total related bed capacity for each hospital is about 1,350 beds.

Two regional mental hospitals provide intensive treatment of mentally ill people requiring a limited period of hospitalization. They are the Northern and Southern Virginia Mental Health Institutes. Each facility has about a 110-bed capacity.

Specialized services are provided both for emotionally disturbed children and for geriatric patients. Children are treated at the DeJarnette Center for Human Development (40 beds) and at the Virginia Treatment Center for Children (65 beds), two small residential treatment centers. The geriatric centers, Piedmont and Catawba, have a capacity of about 255 and 300 beds, respectively.

Community Service Boards. Community services are provided through CSBs in areas that encompass over 90 percent of the State's population. Dickenson, Craig, Botetourt, Alleghany, Bath, Highland, Page, Goochland, Powhatan, and Rockbridge counties and Covington, Clifton Forge, Lexington, and Buena Vista are the only unserved localities (Figure 5). There are 36 active boards.

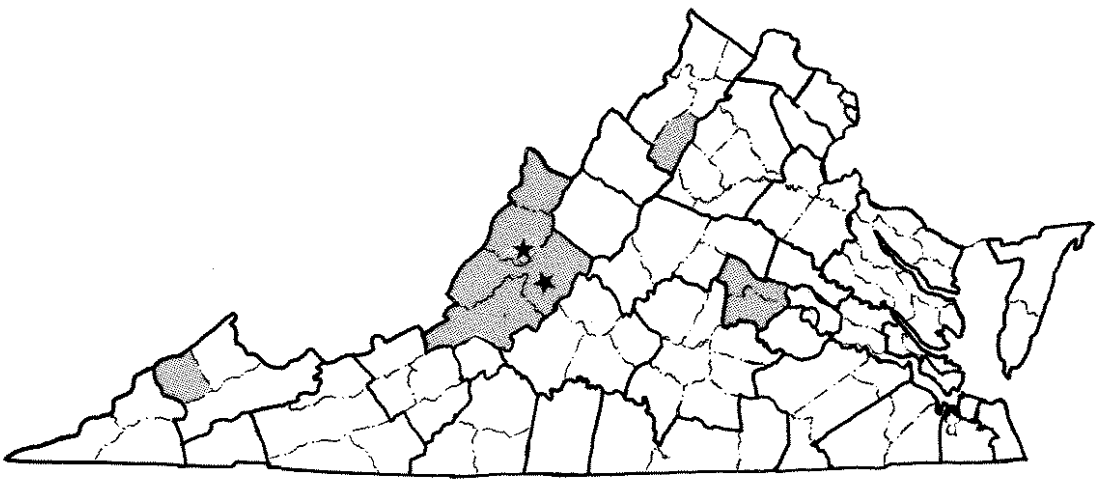
CSBs may be established by single or multiple jurisdictions. Each board employs a staff that generally includes a director, a coordinator of mental health services, who may also be the local clinic director, and a coordinator of mental retardation services.

Funded by State and local matching funds, the CSBs may provide the following services:

- outpatient and inpatient diagnostic and treatment services;
- aftercare for clients released from a mental hospital;
- therapeutic communities, halfway houses, group homes, or other residential facilities;

Figure 5

COMMUNITY SERVICE BOARD AREAS



- COMMUNITY SERVICE BOARD BOUNDARIES
- AREAS UNSERVED BY COMMUNITY SERVICE BOARDS
- ★ STATE CLINICS

Source: JLARC representation of DMHMR data.

- transitional services;
- partial hospitalization; and
- emergency services.

These services may be provided directly by the CSB or by a private, nonprofit or public agency on a contractual basis.

Two State-operated mental health clinics provide services to several localities not served by CSBs. The clinics are funded through a combination of State and local monies, and provide out-patient counseling and therapy and aftercare services.

The clinic located in Lexington serves Lexington, Buena Vista, and Rockbridge County. The part-time clinic in Clifton Forge serves Covington, Clifton Forge, Alleghany, Bath, and northern Botetourt County. The Clifton Forge clinic will expand to full-time operation in FY 1980. DMHMR also plans to open three additional clinics this year in Goochland, Powhatan, and Dickenson counties.

Informal Network

The informal or supportive service network is comprised of State and local agencies which purchase or directly provide services, such as counseling, income assistance, housing, and employment, for the mentally ill and mentally retarded. Key agencies include:

- State and local departments of Welfare;
- Department of Rehabilitative Services;
- Virginia Housing Development Authority;
- Associations for Retarded Citizens; and
- local philanthropic organizations.

DMHMR has, in some instances, established coordinative agreements with State agencies that provide supportive services. However, such agreements must be implemented by local affiliates over which little direct control is exercised by the State agency.

Conclusion

The policy of deinstitutionalization in Virginia is rooted in a number of medical, judicial, and legislative developments. Implementation is through a complex and fragmented organizational network. Specific direction has been provided by the Commission on Mental, Indigent and Geriatric patients, and through the operational recommendations of a management consultant employed by DMHMR. Nevertheless, in the absence of clear lines of authority, it can be expected that there will be gaps in coordination and service delivery.

III. Deinstitutionalization Trends

Since 1970, over 72,000 people have been discharged from Virginia's four major mental hospitals and five mental retardation facilities. The movement of clients from institutions to communities requires:

- Adequate advance planning.
- Appropriate staff training.
- Clarification of the changing roles and responsibilities of institutions and community agencies.
- Development of needed community services.
- Ongoing assessment of deinstitutionalization's impact on clients, services, and communities.

Planning for reduction of institutional populations and development of community services has not been adequate in the Commonwealth. Lack of accurate State and local data and adequate training has impeded clarification of roles and assessment of the overall impact of deinstitutionalization.

REVIEW AREA 1: Has DMHMR provided adequate guidance for implementation of the policy of deinstitutionalization?

Deinstitutionalization in Virginia began when DMHMR adopted the goal of reducing institutional populations by ten percent a year for five years. The magnitude of this effort required a well-structured plan and appropriate training for (1) the transfer of individuals to the community, (2) the concurrent development of appropriate community services, and (3) the linking of clients with those services.

Findings

- Planning and training did not keep pace with the rapid outflow of clients from the institutions. In the early years of deinstitutionalization, little planning and training was done. In later years, needs were recognized but relatively little planning or training directly related to deinstitutionalization was conducted.

- Advance planning was not adequate when DMHMR initiated its policy of deinstitutionalization. In a JLARC survey of Community Service Board (CSB) executive directors and institutional staff, only nine percent of the executive directors and seven percent of the institutional staff felt there was adequate advance planning.

- In 1972, one-year and five-year plans for the reduction of client populations were required of each institution. The two plans which the department was able to locate did not specify steps to implement vaguely-defined goals and objectives.

- DMHMR has not implemented the planning recommendations made in 1975 by a management consultant. Bolton Associates proposed that CSB budget plans and the State mental health and mental retardation plans include projected needs of clients able to be discharged.

- Statewide mental health and mental retardation plans were not adopted until 1976 and 1977, respectively. The mental health plan was intended to comply with a federal mandate. In both plans, general problems were discussed, but there was a lack of sufficient data on existing community services, client needs, or service costs.

• DMHMR training is essentially playing "catch-up" with the process of deinstitutionalization.

- During the early 1970s, institutional training focused on improving the quality and skills of hospital staff for dealing with the chronic population that was not likely to be discharged. Little emphasis was placed on training staff to identify clients to be discharged, or on the process for obtaining appropriate services in the community.

- The primary emphasis of the department's community training was to assist developing CSBs in understanding their roles and responsibilities.

- Currently, most DMHMR training occurs in response to institution or CSB requests. Data do not indicate the extent to which training relates to discharge planning or community service delivery.

• Of CSB directors whose agencies received planning or training assistance during FY 1979, a high proportion was not satisfied with the adequacy of the assistance.

CSB RATING OF DMHMR
PLANNING AND TRAINING ASSISTANCE

	Number of Valid Responses	Excellent	Good	Fair	Poor	No Assistance Provided
Planning	32	12.5%	18.8%	12.5%	25.0%	31.2%
Staff Training	31	6.4%	22.6%	32.3%	22.6%	16.1%

Source: JLARC survey of Community Service Board executive directors.

Conclusion

DMHMR has not provided adequate guidance for implementing deinstitutionalization. Absence of a well-structured plan and appropriate training for deinstitutionalization has contributed to problems in the areas of community service development, funding, coordination, and information transfer.

REVIEW AREA 2: Have the State mental hospitals changed as a result of deinstitutionalization?

Mental hospitals serve two functions: (1) short-term treatment, which encompasses drug therapy and intensive counseling; and (2) long-term care, with a secondary emphasis on treatment. Mental hospitals represent the most restrictive setting on a continuum of mental health care.

The four largest mental hospitals in Virginia are Eastern State, Western State, Central State, and Southwestern State. These hospitals pre-date the deinstitutionalization movement and, therefore, reflect changes in patient population, staffing, and organization.

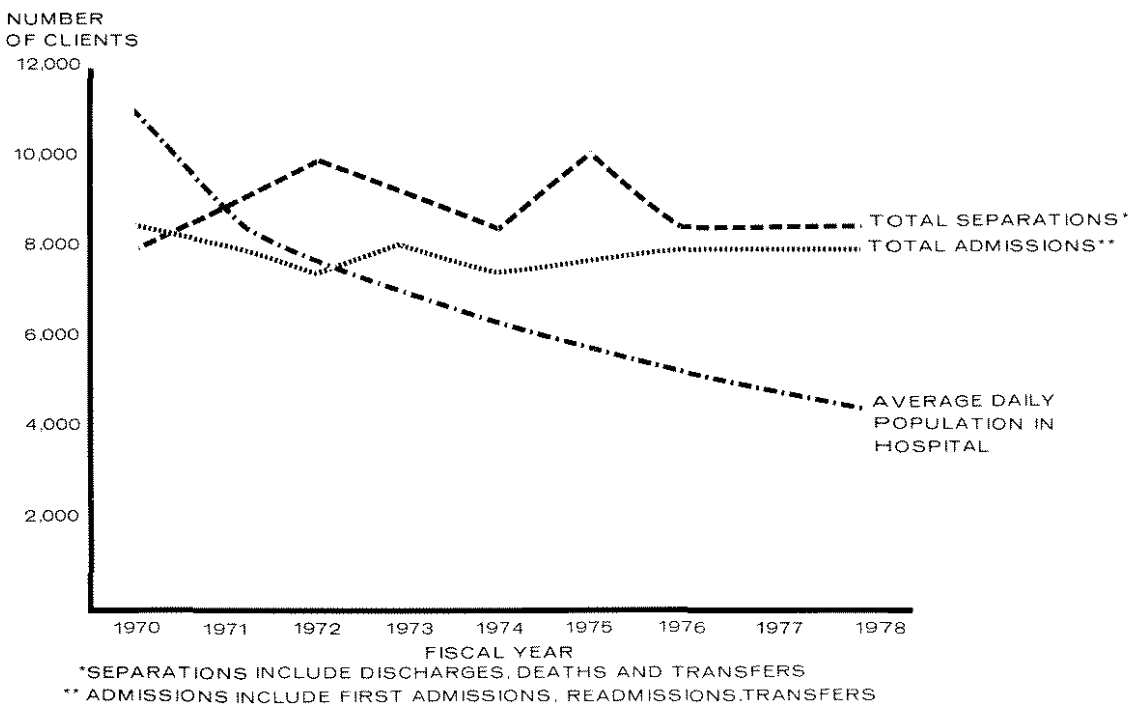
Findings

- The population of the four major hospitals was reduced by 59 percent between 1970 and 1978, even though admissions to these facilities remained constant. During this period there were 69,300 discharges from the facilities, an average of 7,700 per year.

- Not all of the population reduction at the four major mental hospitals was due to discharges from the system. Over half

was due to the transfer of residents to Piedmont and Catawba geriatric centers and Southside Virginia Training Center.

PATIENT FLOW AT THE FOUR MAJOR MENTAL HOSPITALS
(FY 1970-1978)



Source: DMHMR statistical annual reports.

•The population reduction indicates that residents are staying for shorter periods and that the long-term population has been

RECIDIVISM AT THE FOUR MAJOR MENTAL HOSPITALS

Year	Total First Admissions and Readmissions	Readmissions	Percent Readmissions
1970	8,232	4,490	55%
1972	7,577	4,551	61
1974	7,546	4,875	65
1976	8,053	5,586	69
1978	8,042	5,696	71

Source: DMHMR statistical annual reports.

somewhat reduced. Nevertheless, recidivism has been increasing. Over two-thirds of the people admitted to the four institutions have been hospitalized previously. Since 1970, the readmission rate has increased 29 percent.

- Most of the discharges at the mental hospitals have been recent admissions. The median length of stay for people discharged during 1978 was 38 days.

- A substantial portion of the current institutional population is less likely to be discharged, due to their need for a high level of services in the community. Hospital staff estimate that this group comprises 25 to 50 percent of the total institutional population.

- The median length of stay for residents currently in the institutions is two years, two months. Over 1,600 residents (37%) have been institutionalized longer than five years.

- Staffing at the hospitals has increased. There were 1.6 patients for each direct treatment employee at the mental institutions in 1978, compared to 3.0 patients in 1972. The extent to which increased staffing has affected the outcome of patient treatment has not been determined.

- Three of the four mental hospitals have reorganized into geographically-based units. This organizational structure is designed to promote institution-community interaction and enhance the transfer of individuals to and from hospitals.

Conclusion

Hospital populations have been reduced and staffing has been increased. New admissions are hospitalized for relatively short periods, but recidivism is high and a large chronic population still receives long-term care with a secondary emphasis on treatment. The impact of these trends should be assessed in terms of the effect on patient care and the appropriate role of major State hospitals. It might be desirable to meet the need for acute care in smaller community-based facilities or in general hospitals.

REVIEW AREA 3: Have the State mental retardation training centers changed as a result of deinstitutionalization?

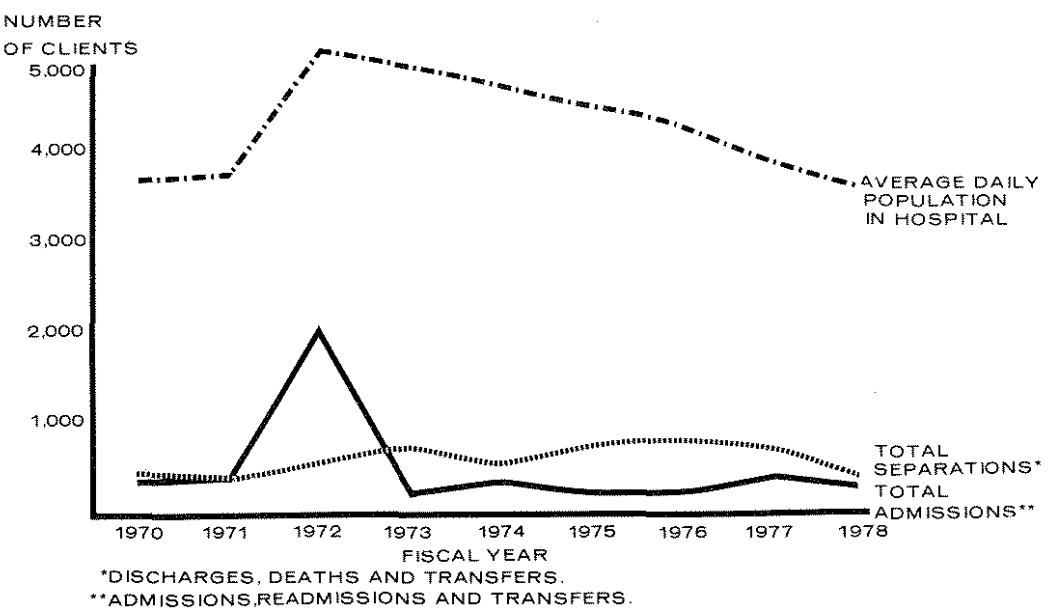
Prior to 1973, Lynchburg Training School and Hospital and Southside Virginia Training Center, two large, overcrowded

institutions, provided mainly custodial care for the mentally retarded. Three small training centers have recently been opened in Northern Virginia, Tidewater, and Southwest Virginia. Mental retardation facilities provide the most restrictive setting on a continuum of care for the mentally retarded.

Findings

- The total population in mental retardation facilities increased substantially in 1972, with the creation of Southside Virginia Training Center. This center housed approximately 1,600 mentally retarded individuals transferred from Central State Hospital. Since 1972, the population in mental retardation facilities has declined 28 percent.

PATIENT FLOW AT THE MENTAL RETARDATION TRAINING CENTERS
(FY 1970-1978)

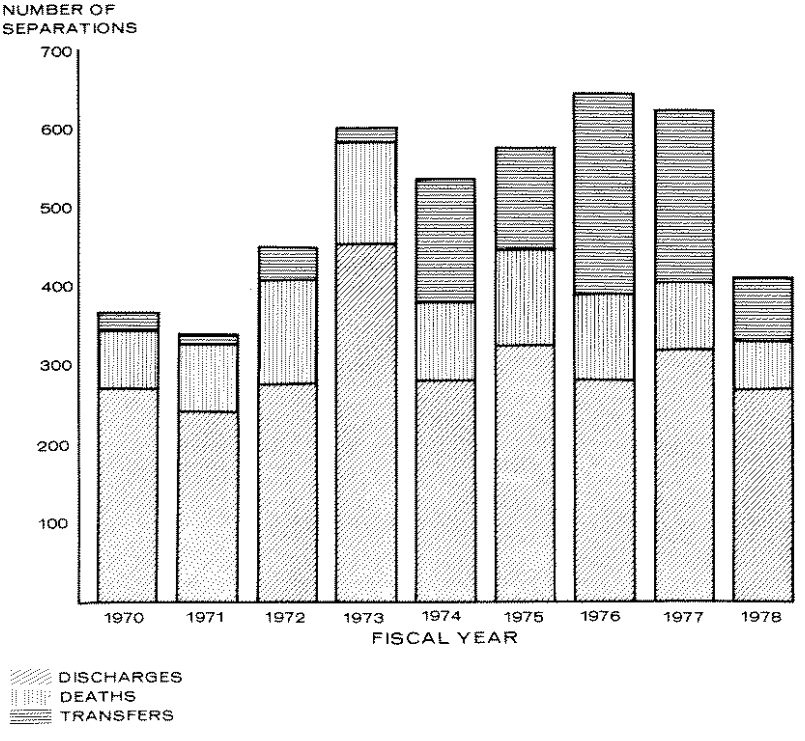


Source: DMHMR statistical annual reports.

- Overcrowded conditions at Lynchburg Training School and Hospital (LTSH) and Southside Virginia Training Center (SVTC) were finally alleviated by 1978, as a result of discharges, deaths, and transfers. Between 1972 and 1978, there were 625 discharges, 387 deaths, and 588 transfers from LTSH. During that period, LTSH eliminated 688 beds.

- Discharges from all mental retardation facilities have remained relatively constant since 1970, averaging about 300 annually. The opening of the new training centers between 1973 and 1976 resulted in many transfers from LTSH and SVTC to Northern Virginia Training Center (NVTC), Southeastern Virginia Training Center (SEVTC), and Southwestern Virginia Training Center (SWVTC).

SEPARATIONS FROM MENTAL RETARDATION FACILITIES
(FY 1970-1978)



Source: DMHMR statistical annual reports.

- Discharges have averaged about seven percent of the total population of mental retardation facilities since 1970. The new training centers have a higher discharge rate than LTSH and SVTC. Many of the discharges from the new centers were originally transfers from the two older institutions.

- Most of the discharges from State training centers have been recently admitted clients. The median length of stay for most of the clients discharged during 1978 was two years, three months. However, the median length of stay of residents currently in the facilities is nine years, seven months.

DISCHARGES FROM MENTAL RETARDATION FACILITIES
(FY 1978)

Facility	Average Daily Population in Hospital	Discharges	Discharge Rate*
LTSH	2,232	71	3.2%
SVTC	954	50	5.2
NVTC	215	35	16.3
SEVTC	183	65	35.5
SWVTC	206	46	22.3
All Facilities	3,790	267	7.0%

*Discharges as a percent of average daily population in the facility.

Source: DMHMR statistical annual report.

- According to DMHMR, in April 1979 there were 494 individuals in mental retardation facilities ready for discharge, but lacking appropriate community placements. Many of these individuals resided in the new training centers.

- Department and institutional personnel expressed concern that the new training centers were beginning to fill with potentially long-term clients. Estimates at SEVTC indicated that 10-25 percent of the total population of the facility may become long-term residents.

Conclusion

Each mental retardation training center now serves two functions: long-term care and intensive training. The three new training centers are oriented more toward short-term training, and return more residents to the community than the older facilities. Nevertheless, the residual population of individuals with severe handicaps may be growing at the training centers.

Long-term care could become a major training center function, with significant implications for their short-term training roles. The roles of all the mental retardation facilities should be more clearly defined. This is particularly important if the State decides to build two planned centers in Harrisonburg and Fredericksburg.

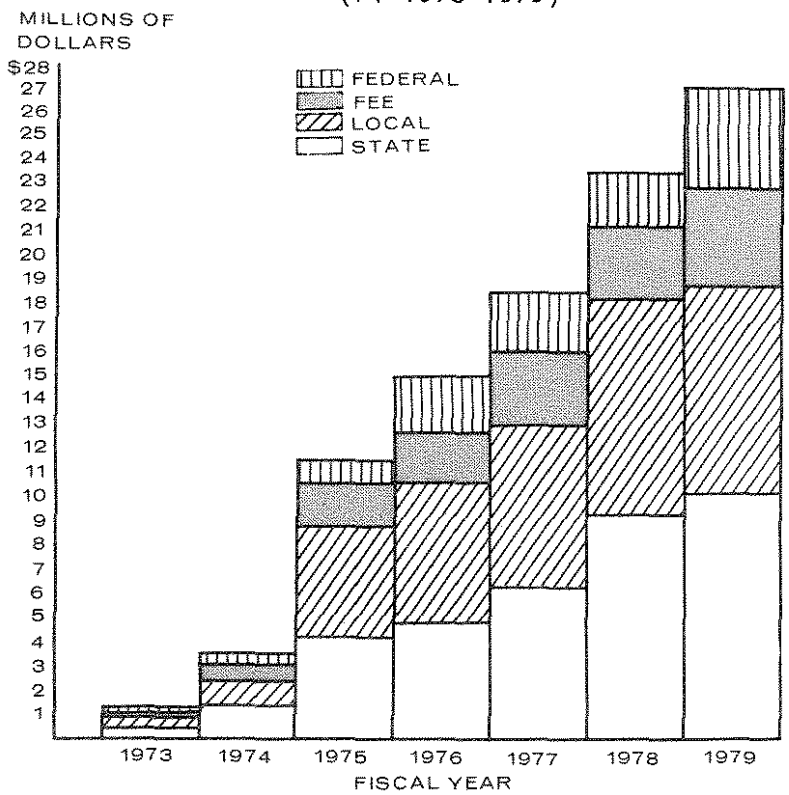
REVIEW AREA 4: Have funds for community services increased since the beginning of deinstitutionalization?

Many discharged clients require continuing community treatment or supportive services, such as housing and income assistance. Therefore, reduction in institutional populations created additional demand for community programs and a need for increased resources.

Findings

- Total revenues of CSBs for community mental health and mental retardation services have increased dramatically since FY 1973. Mental health funding has grown from $1.3 million to $27.4 million. Mental retardation funding has increased from $4 million to $16.7 million. According to DMHMR, the substantial increase in total community mental health funding is partially attributable to the transfer of clinics and associated funding from State to CSB control.

FUNDING SOURCES FOR COMMUNITY MENTAL HEALTH SERVICES (FY 1973-1979)

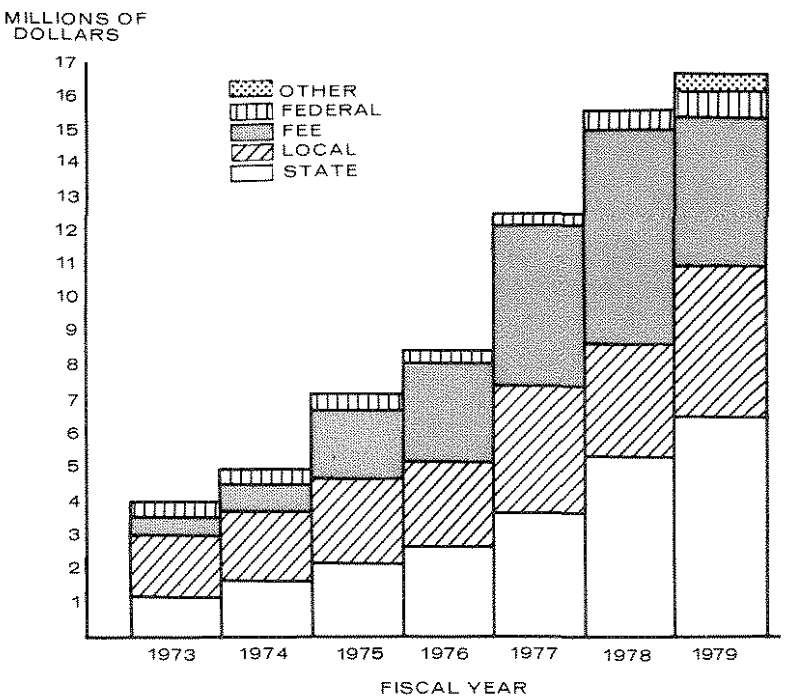


Source: DMHMR Division of Administration.

•All revenue sources for community mental health services have increased substantially since 1973. State funding, for example, rose from less than $500,000 to over $10 million. Local mental health funding went from slightly over $500,000 to $8.5 million during the same period.

•Mental retardation funding shows a large increase since FY 1975. According to DMHMR officials, this growth most likely reflects Title XX funding, which began on October 1, 1975. Title XX funds were used to support pilot programs in mental retardation services.

FUNDING SOURCES FOR COMMUNITY
MENTAL RETARDATION SERVICES
(FY 1973-1979)



Source: DMHMR Division of Administration.

•In addition to services funded by DMHMR, various community services are provided by other agencies. The total amount of funds expended for community services to discharged clients cannot be accurately assessed. In addition to the

$39 million spent by CSBs in FY 1978, funds were expended by other State agencies, such as the departments of Welfare, Health, and Rehabilitative Services and the Virginia Housing Development Authority.

- Department of Welfare records do not separately identify Title XX or other funds spent to provide discharged clients with services, such as counseling, companion services, foster care, and activity center programs.

- The Department of Welfare can identify three services for which Title XX funds were spent for the mentally disabled in FY 1978: (1) $3.6 million for Foster Care for Children; (2) over $1 million for child protective services; and (3) $3.4 million for employment services. However, these estimates include expenditures for all mentally ill and mentally retarded clients served under these programs, and do not separately identify those formerly in State institutions.

- The Department of Rehabilitative Services (DRS) cannot accurately determine the cost of services it provides to discharged clients or distinguish between mentally ill and mentally retarded clients. DRS estimates that $4.2 million was spent on services to mental health and mental retardation clients during FY 1978, in both the institutions and the communities. However, DRS could not separate institutional from community expenditures.

Conclusion

Total community funding and service development have increased since the policy of deinstitutionalization was implemented. However, it is difficult to assess actual growth, due to record inadequacies which do not provide historical data for service trends or permit a full assessment of funds expended for discharged clients.

REVIEW AREA 5: Is management information adequate to fully evaluate the impact of deinstitutionalization?

In order to evaluate the State's deinstitutionalization policy, valid information about discharged clients, their service needs, and the outcome of their discharge must be readily available for analysis. Management information is the base upon which programs should be assessed and rational changes made. Moreover,

local service agencies need information about potential clients and their needs to plan and develop services for them.

Findings

- Lack of valid, useful information prevents DMHMR from assessing the impact of discharging people from State institutions. Although DMHMR has a base for a management information system in the Automated Reimbursement System, institutions are not required to provide all data on the system. Information programmed but not routinely collected includes referral source, current legal status, occupation, previous hospitalizations, and placement upon release.

- Once clients have left the institutional system, there are no means to determine where they went, what services they received or whether they linked with appropriate service agencies. DMHMR has a potential tracking mechanism for the mentally retarded in the Individualized Data Base system. However, local agencies are not required to participate, and community-based data lack reliability and comparability.

- Concerns about client confidentiality have so far prevented an analysis of patient flow between institutions and community programs. However, over two-thirds of CSB executive directors surveyed favor a patient-tracking system which includes both institutions and communities.

- Some of the data that DMHMR reports has questionable validity. For example, department statistics record length of stay as the time from admission date to discharge date, although many clients are released on convalescent leave prior to discharge. Actual time in the institution is, therefore, significantly less than the recorded length of stay.

- DMHMR collects no information on the service needs of released patients. There are no aggregate data on the number or proportion of institutional residents who need clinic services, residential alternatives, day activities, and other services.

- Although recidivism is increasing, DMHMR does not collect data on the reasons for admission or readmission.

- Information collected by CSBs is insufficient to assess the impact of discharged clients. Four of the five CSBs visited attempt to compile some information about active cases. However, data collected by CSBs are typically limited to case load and admissions and discharges within programs. Only two CSBs visited collect any information about client characteristics. Information collected does not include an assessment of service needs or the number and length of previous hospitalizations.

- *In the Valley area, CSB staff collect information on the number of actual cases by program, locality of residence, age, sex, and the reason and source of referrals.*

- *In addition to demographic information, CSB staff in Virginia Beach collect data on number of dependents, household composition, client housing, employment, occupation, education, source of support, diagnosis, and level of disability. However, staff cannot routinely identify the number of clients with a history of hospitalization, or the number or length of hospitalizations.*

- *The Rappahannock Area CSB can only provide estimates of case load size and characteristics of clients served.*

Conclusion

Lack of valid information has prevented DMHMR and the CSBs from assessing the impact of deinstitutionalization. Neither DMHMR nor the CSBs compile sufficient data for proper evaluation, and the information that is collected is often not complete or valid. Nevertheless, data are currently available on the ARS and IDB systems which could be routinely analyzed and disseminated to the central office, institutions, and communities, and used for planning and evaluation. Both the department and the CSBs should assess the need for management information, and should implement new or improved systems.

IV. Deinstitutionalizing the Mentally Ill

Almost 8,000 clients are discharged annually from the four major mental hospitals in Virginia. Most of these people need continuing services after their release from the institution. Smooth transition of clients from the hospitals to communities requires:

- Identification of characteristics and service needs of discharged clients for use in program planning and development.
- Appropriate institutional procedures for identifying, preparing, and arranging services for clients to be discharged.
- Availability and provision of appropriate mental health and support services in the community to discharged clients.
- Coordinated efforts between institutions and community agencies to link discharged clients with community services.

Inadequate coordination between institutions and community agencies creates problems with regard to transferring information and linking discharged clients with community services.

REVIEW AREA 6: What are the characteristics of clients discharged from State mental hospitals?

The four major mental hospitals discharge over 700 clients each month. Most of these individuals need continuing care in the community. Client characteristics and service needs must be identified in order to plan and develop appropriate local services.

Findings

- The typical client is discharged after about five weeks. The client is a middle-aged male alcoholic or psychotic with a history of previous hospitalizations.
- The length of hospitalization differs substantially among clients with different diagnoses. Alcoholics tend to stay in the hospital the shortest amount of time; mentally retarded or psychotic individuals stay the longest.

CHARACTERISTICS OF DISCHARGED CLIENTS
(January 1978 to February 1979)

Sex		Age	
Male	71.3%	Under 20	7.1%
Female	28.7	21-30	27.6
		31-40	21.4
		41-50	19.0
		51-64	20.2
		65 and older	4.7
Diagnosis		**Type of Admission**	
Mental Retardation	3.3%	First Admission	28.2%
Organic Brain Syndrome	9.4	Readmission	69.4
Psychosis	35.5	Transfer	2.4
Alcoholism	28.4		
Other	18.1		
No Mental Disorder	1.6		
Undiagnosed	3.7		

Source: DMHMR Automated Reimbursement System.

LENGTH OF HOSPITALIZATION FOR DISCHARGED CLIENTS
(January 1978 through February 1979)

Diagnosis	Median Length of Stay	Number of Discharges
Alcoholism	12 days	2,509
Organic Brain Syndrome	112 days	834
Psychosis	168 days	3,130
Mental Retardation	51 days	288
Other	34 days	1,593
No Mental Disorder	39 days	142
Undiagnosed/Not Reported	6 days	330
All Diagnoses	38 days	8,826

Source: DMHMR Automated Reimbursement System.

- The majority of clients released from the mental hospitals need continuing care. As reported in DMHMR's Automated Reimbursement System, less than seven percent of discharged individuals are recovered or not mentally ill. Of the 54 discharges reviewed by JLARC at Eastern State and Western State, 50 clients were referred to mental health clinics, alcoholism programs, or other local service agencies.

- Most discharged clients require medication monitoring. Of the 41 non-alcoholic discharges reviewed by JLARC, 34 (83%) were receiving psychotropic medication.

- In addition to medication monitoring, discharged clients may have other service needs, such as housing, employment, day activity, income assistance, and counseling. Discharged residents do not necessarily need every support service because some return to their families and jobs, or have other supportive mechanisms.

- The functional levels and community service needs of clients with repeated short-term stays appear to be similar to those of clients who have been hospitalized for long periods. Long-term clients are generally associated with the term deinstitutionalization, but length of stay does not appear to be a valid determinant of client needs or characteristics. Institutional staff and CSB directors indicated that chronic and long-term clients may require multiple services, while acute (single episode) clients require predominantly therapeutic services.

SERVICES TYPICALLY NEEDED BY DISCHARGED CLIENTS*

Clients with Chronic Disabilities	Clients with Acute Disabilities
Medication Check	Medication Check
Day Activity	Counseling/Therapy
Independent Skills Training	
Income Assistance	
Housing	
Transportation	

*There is some disagreement between institutional and CSB staff about whether chronic clients benefit from vocational services or counseling and therapy.

Source: CSB survey and institutional staff.

Conclusion

People discharged from mental hospitals have widely varying characteristics, mental impairments, and needs for local services. Few clients recover from their mental illness while in the hospital and, therefore, need continuing care after discharge. However, client records do not identify service needs, and aggregate data do not exist. Service needs of discharged clients should be clearly identified, compiled, and analyzed for service planning and development.

REVIEW AREA 7: What procedures are used to discharge clients from State mental hospitals?

To ensure a smooth transition to the community, a well-structured process for releasing clients from mental hospitals is necessary. Successful release of an individual depends in large part on institutional efforts to (1) notify local service agencies about the pending discharge, (2) identify and arrange for necessary community services, and (3) prepare the client for release. Although procedures differ among the institutions, this process is generally known as discharge planning.

Findings

- Prompt notification of local service agencies about clients is often hampered by the failure of the institutions to obtain timely approval for the release of confidential information. Of the two mental hospitals reviewed by JLARC, only Western State routinely secured the release upon admission.

RELEASE OF INFORMATION FROM STATE MENTAL HOSPITALS

		When Release of Information was Signed			
Facility	Number of Discharges Reviewed	Within 7 Days or Before Admission	Within 7 Days or After Discharge	Other Times	No Release in File
Eastern State	21	1	11	0	9
Western State	29	12	6	9	2

Source: JLARC record review.

- The hospitals do not have formal discharge plans for each client which contain all necessary clinical and social information, identified service needs, and discharge arrangements. Elements of the plans are scattered throughout the individual's record.

- Client needs after discharge are not comprehensively evaluated. Responsibility for defining the service needs of residents after release is fragmented among several different professionals, although unit social workers have primary responsibility. Neither Western State nor Eastern State have guidelines or checklists to ensure that all service needs are evaluated.

- The CSB clinics are the only local agencies which have routine contact with the institutions. Although clinic staff often visit the hospital once or twice a month, they usually participate in the diagnostic conferences in which new admissions are evaluated. Unless the resident is ready for release at that time, clinic personnel usually have no formal input into discharge planning.

- The mental hospitals have only limited programs to assist residents with the transition from the institution to the community. Although most residents need psychotropic medication in order to function adequately in the community, the institutions provide only minimal instruction on its use.

- Transitional programs, such as group therapy or classes in independent living and social skills, are usually limited to a few clients.

  -*Project Care at Western State Hospital was designed to enable chronic clients to be discharged by providing them with social, vocational, and living skills training. Although the program is serving about 40 individuals, Western State estimated that an additional 250 clients need these transitional services.*

- Convalescent leave is not used consistently and is not serving its designed function. Convalescent leave should serve as a trial release period, permit the institution to follow the client's progress, and allow the individual to re-enter the hospital without going through formal admission procedures. Neither Western State nor Eastern State has much follow-up contact after the client leaves the hospital.

TYPES OF DISCHARGES FROM STATE MENTAL HOSPITALS

Facility	Number of Discharges Reviewed	Type of Separation	
		Directly From Facility	From Convalescent Leave or Visit
Eastern State	24	8	16
Western State	30	19	11
Total	54	27	27

Source: JLARC record review.

Conclusion

Discharge planning at the State mental hospitals is inconsistent, and may result in the release of individuals who are not fully prepared or who do not have adequate services arranged in the community. Central office guidance in discharge planning has been minimal and, as a result, discharge planning procedures vary widely among the mental hospitals. Adequate central direction in discharge planning is necessary to ensure that a more effective and uniform process is implemented.

REVIEW AREA 8: How do State mental hospitals and community agencies interact to link discharged clients with community services?

Procedures for interaction between institutions and communities should ensure that the needs of discharged clients for continued treatment, housing, or other services are met in the community. Consistency and clear assignment of responsibility are essential because service delivery is fragmented among numerous providers.

Findings

- Survey responses of CSB executive directors confirmed JLARC's observation that procedures to link discharged clients with community services are not consistently adequate. Thirty-eight percent of all directors indicated that discharge planning was inadequate.

- Most discharged clients are seen at clinics for at least medication reviews and refills. In JLARC's review of 17 clients on medication, only five were not seen at a clinic, and only one of these cases could not be explained. Since the majority of clients are discharged on medication, the clinic is the primary point of contact with community services.

- Social service needs of clients are less likely to be addressed. Hospital contacts with local departments of welfare tend to involve financial rather than social service needs.

- Some arrangements have evolved between clinics and hospital units to identify local clients prior to discharge. Clinical personnel in each case study area have initiated systems of visiting hospital geographic units and seeking out local clients. In addition, clinics are beginning to provide some

form of case management to assist clients in obtaining services from multiple agencies in the community.

- *Virginia Beach and Staunton have identified many clients by participating in pre-admission screening, to the extent that the courts cooperate.*

- *Clients discharged to Virginia Beach or Staunton are assigned by the clinic liaison to a case manager or advocate on the clinic staff.*

- *Staunton involves local agencies, such as welfare, health, and legal aid, in team meetings to discuss the needs of individual clients prior to discharge.*

- Western State Hospital has recently initiated interagency agreements to formalize and clarify roles.

  - *An agreement with the Valley regional welfare office specifies roles in placing and providing financial support for clients in licensed homes for adults.*

  - *An agreement with the Culpeper clinic to facilitate continuity of care states that:*

    - *The center will designate hospital liaison to coordinate hospital admissions, staffings, and discharges, and to monitor residential placements in a "client advocacy" role.*

    - *The hospital will notify the clinic of admissions and discharges within specified time periods, and assist clients in filing for financial assistance prior to discharge.*

- Communication problems exist between Eastern State Hospital and community agencies.

  - Client census data sent to clinic contained no names or dates--only sex, diagnosis, and hospital building occupied by local admissions or discharges.

  - 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.

- Clients return to the community without prior notice and with emergency needs for housing and financial assistance. In Hampton and Newport News, an estimated 50 clients return annually under these circumstances.

Conclusion

Discharged mental health clients appear to be consistently transferred to clinics for medical needs, but other service needs are not comprehensively addressed. Arrangements by institutions and clinics show that the need for cooperative interaction and case management has been recognized. Agreements formulated by Western State may serve as useful models for the mental health system.

REVIEW AREA 9: What community services are provided to clients discharged from State mental hospitals?

The range of services needed by individual clients is not specifically identified either by mental hospitals or local clinics. The consensus among institutional and CSB staff is that community services should include: (1) medication monitoring; (2) emergency services; (3) day programs; and (4) supervised housing. A matrix of services available in case study areas is shown on page 43.

Findings

- For over 50 percent of all aftercare patients, the only community service provided is medication monitoring. Medication is provided to the client at the clinic and is reviewed about once a month.

  - *In Virginia Beach, 102 of 170 aftercare patients attend only the medication clinic.*

  - *In Western Tidewater, 270 of 350 aftercare patients are in a "medication only" category.*

  - *In four other areas visited by JLARC, CSB data are insufficient to determine the number of aftercare patients who are seen only for medication monitoring.*

COMMUNITY MENTAL HEALTH SERVICES
(FY 1979)

	DAY PROGRAMS							
	Medication Monitoring	Intensive Therapy	Structured Activity	After Hours Emergency Service	Group Homes/ Halfway Houses	Supervised Apartments	Foster Care	Homes for Adults*
Hampton-Newport News	●		●	- Staff on Duty At Hospital Emergency Room	- 7 Beds - 24 Hour Supervision - 7 from ESH			- 385 Beds
Virginia Beach	●	●	●	- Hotline After 9 p.m. - Staff On-Call for Visits		- 8 Beds - 16 Hour Supervision - 2 from ESH		- 70 Beds
Western Tidewater	●		●	- 24 Hour Hotline			- Unspecified Beds - 24 Hour Supervision - 39 Discharged Geriatrics	- 138 Beds
Valley	●		●	- Hotline Until Midnight on Weekdays	- 7 Beds - 24 Hour Supervision - 3 from WSH	- 8 Beds - Daytime Supervision - 5 from WSH		- 178 Beds
Rappahannock Area	●	●		- 24 Hour Hotline				- 123 Beds
Covington-Clifton Forge-Alleghany Co.	●							- 43 Beds

*Total beds for all residents. Number of aftercare residents unknown.

- Clinic staff report that they see unstable clients as often as necessary. Nevertheless, little personal follow-up is provided if clients fail to keep appointments. At least some clinic staff feel that it is the client's responsibility to keep appointments, and that follow-up is unnecessary.

- All CSBs visited by JLARC maintain some type of emergency service during standard clinic hours. However, only one of the six areas visited provide the 24-hour service with face-to-face outreach capability which is necessary for effective crisis intervention.

  - *In Hampton-Newport News, patients in crisis must travel up to 20 miles to the Riverside Hospital emergency room for treatment.*

  - *In the Valley area, there is no crisis service available from midnight to 8 a.m., and only telephone response from 5 p.m. to midnight.*

  - *In the Alleghany County area, the State clinic provides no emergency services.*

- Two types of day programs exist: (1) intensive, treatment-oriented programs, for people needing an alternative to hospitalization; and (2) activity programs, for discharged people who require a gradual transition to community life.

- Some level of day services is available in five of the six areas visited, although only Virginia Beach provides both types of programs. Relatively few aftercare patients receive either type of day service. In general, JLARC observed fewer participants in day programs than program staff indicated were on active rolls.

  - *In Virginia Beach, about 20 clients with acute mental disorders attend intensive therapy programs for several hours daily. The focus of this service is to keep disabled people out of State and private hospitals. The program is staffed by a master's level psychologist, a master's level social worker, two nurses, a bachelor's level social worker, and a mental health assistant. In addition, about 30 people with chronic mental disabilities attend a two-hour recreation and activity program twice a week.*

  - *The Hampton-Newport News CSB provides a day program in both cities for about 38 people. Most clients are aftercare patients who are given a progressive transition to the community. Activities include field trips, group recreation, and living skills training, with some supportive counseling. The program in each city is staffed by a nurse and an activity coordinator.*

- At least some clients require supervised housing placements in order to remain out of the hospital. Existing supervised placements are insufficient to provide transition for even a handful of discharged clients.

- Because supervised placements are limited, only relatively high functioning individuals are accepted into existing programs. Many chronic patients who need housing are placed in homes for adults. For the client group in homes for adults, supervision and mental health backup are minimal.

Conclusion

None of the areas visited by JLARC has an adequate service array currently in place. Moreover, data do not indicate the extent to which services beyond medication reviews are provided to discharged clients.

A high priority should be placed on: (1) systematic identification and analysis of the needs of discharged clients; (2) assessment of the services provided to discharged clients; (3) development of alternative supervised housing placements; and (4) improved availability of emergency services and day programs.

REVIEW AREA 10: What are the costs of community services provided to clients discharged from State mental hospitals?

The cost of providing community services is a significant determinant of the ability of CSBs to adequately serve clients discharged from State mental hospitals. Benchmark data for cost comparisons are a necessary part of the State's ability to ensure the efficient provision of community services to discharged clients.

Findings

- The lack of standard service definitions, complete utilization data, and comparability among programs prevent accurate cost comparisons between most programs. It is possible to provide general cost estimates for emergency services, some day programs, and supervised housing.

- No CSB visited attempts to calculate the cost of providing services to discharged clients.

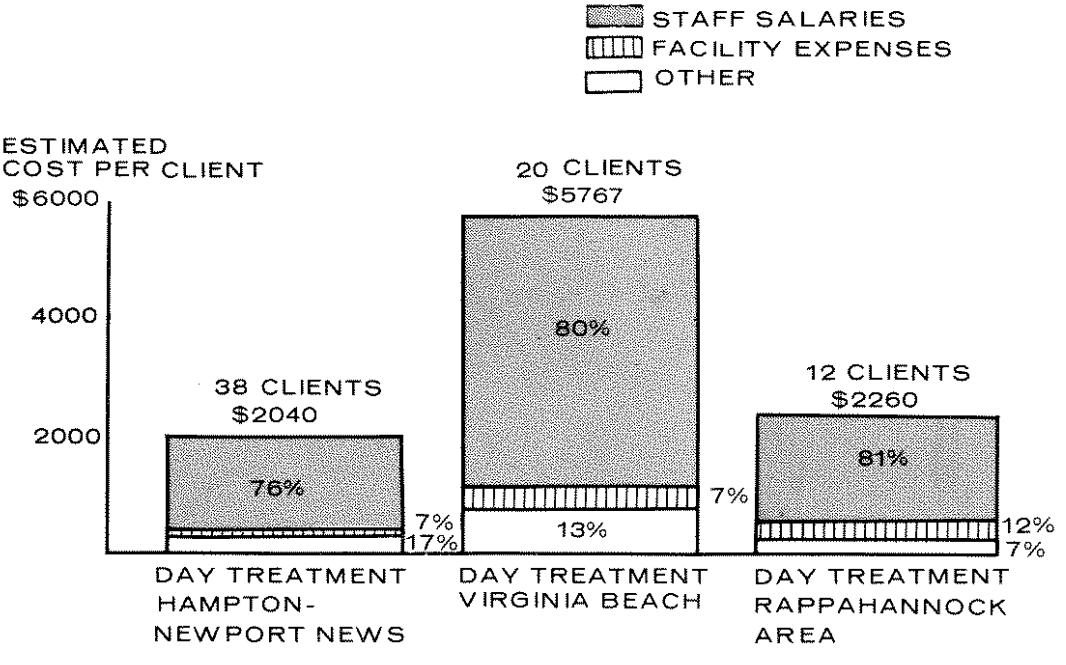
- The cost of providing emergency services varies substantially among CSBs, as does the configuration of programs. Staff salaries represent the major expenditure category for emergency services. The range is from a high of $327 to a low of $4 per day.

  - *In Hampton-Newport News, the cost is $327 per day, or 11.5 percent of the FY 1979 mental health budget. Five full-time counselors are on duty at two sites during clinic hours. After hours, additional counselors are on duty in the Riverside Hospital emergency room, but they do not make outreach visits.*

  - *In Virginia Beach, the cost is $315 per day, or 15 percent of the FY 1979 mental health budget. Five full-time counselors are on duty until 9:00 p.m. After hours, calls are relayed to a 24-hour hotline. Virginia Beach counselors are on call if face-to-face intervention is necessary.*

  - *In Western Tidewater, the cost is $4 per day, or .5 percent of the FY 1979 clinic budget. There is no*

DAY PROGRAMS:
ESTIMATED COST PER CLIENT
(FY 1979)



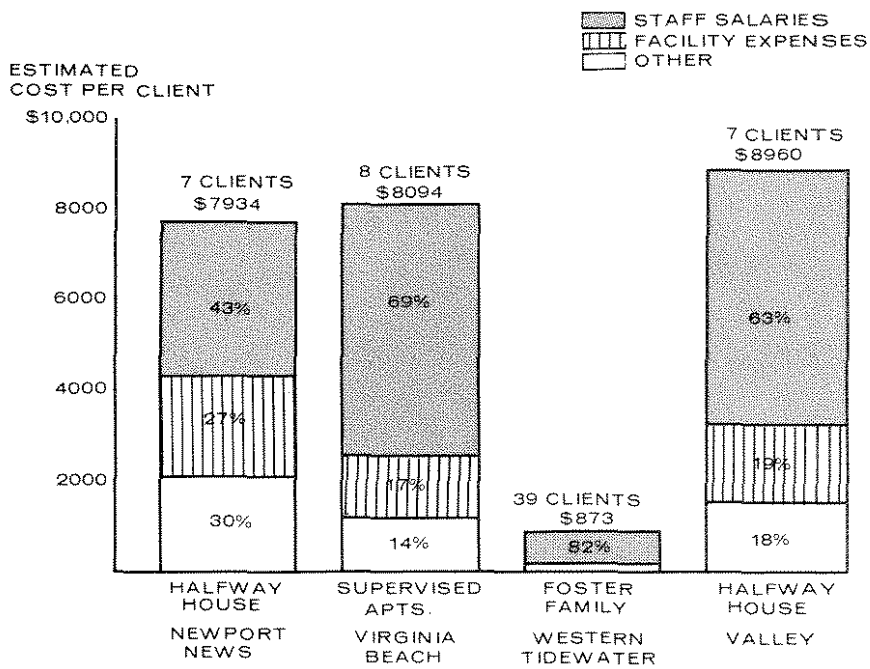
Source: JLARC analysis of CSB annual budget documents.

separate emergency service during clinic hours. After hours, a Portsmouth hotline answers emergency calls.

- The cost of providing day programs also varies considerably. Day programs in three CSBs are roughly comparable, and are scheduled several hours during weekdays. As with emergency services, staffing patterns appear to account for much of the cost variation. The Virginia Beach day treatment program has a large professional staff and is the most expensive.

- There appears to be some consistency in the per client costs of residential programs, although only the Hampton-Newport News and Valley programs are comparable. Again, staff and facility expenditures represent the major expense.

RESIDENTIAL PROGRAMS:
ESTIMATED COST PER CLIENT
(FY 1979)



Source: JLARC analysis of CSB annual budget documents.

Conclusion

Current data are insufficient to determine the cost of services provided to clients discharged from State mental hospitals.

There is substantial variation between CSBs in the number of discharged clients being served, in the services provided, and in the way those services are organized and budgeted. Analysis of the cost of providing community mental health services is a prerequisite to efficient service delivery. A high priority should be given to determining the cost of providing community services, and to analyzing variations in programs receiving State funds.

V. Deinstitutionalizing the Mentally Retarded

Although relatively few clients are discharged from Virginia's mental retardation facilities, those who are may need an array of support services in order to live in the community. The elements of discharge planning are similar to those for the mentally ill.

Over 2,700 clients have been discharged from the five mental retardation training centers since 1970. An effective process for linking these discharged clients with community services should include:

- Identification of the characteristics and service needs of discharged clients for use in program planning and development.
- Appropriate institutional procedures for identifying, preparing, and arranging services for clients to be discharged.
- Availability and provision of appropriate mental retardation services in the community to discharged clients.
- Coordinated efforts between institutions and community agencies to move clients back into community settings.

Fragmented responsibility for institutional and community care has led to problems in linking discharged clients with community services. Services have been expanded, but there has not been sufficient coordination between institutions and community agencies.

REVIEW AREA 11: What are the characteristics of clients discharged from State mental retardation training centers?

The needs of the mentally retarded are more easily identifiable than those of the mentally ill. However, service needs of mentally retarded individuals can vary substantially. In order to plan and develop local services for the mentally retarded, client characteristics and needs must be adequately identified.

Findings

- Clients released from State mental retardation institutions are generally under 20 years old. Almost 85 percent of the clients discharged are under 40.

- Although only 22 percent of the clients currently in the facilities are mildly or moderately retarded, this group accounts for 58 percent of the discharges.

- Almost one-third of the 274 clients discharged between January 1978 and February 1979 were transferred from LTSH and SVTC to the three new training centers prior to their discharge.

CHARACTERISTICS OF DISCHARGED CLIENTS
(January 1978 through February 1979)

Sex		Type of Admission	
Male	58.8%	First Admission	53.5%
Female	41.2	Readmission	15.8
		Transfer	30.7
Age		**Level of Retardation***	
Under 20	46.7%	Borderline	3.0%
21-30	23.8	Mild	15.9
31-40	14.1	Moderate	39.4
41-50	5.3	Severe	22.0
Over 50	10.1	Profound	18.2
		Not Determined	1.5

*For 1977 discharges.

Source: DMHMR Automated Reimbursement System and additional DMHMR data.

- The lengths of stay for discharged clients vary widely, but are generally less than those of individuals remaining in the institution. Most discharged clients had been in the institution less than two and one-half years. About 25 percent, however, had lengths of stay longer than five years.

- The department has implemented the Individualized Data Base information system, which contains comprehensive demographic, functional, and clinical data on each client in the institutions. Use of the data system by local agencies, however, has been minimal.

LENGTH OF STAY FOR DISCHARGED CLIENTS
(January 1978 through February 1979)

Length of Stay	Number of Discharges	Percent
Less than 1 month*	58	21.2%
1 to 6 months	11	4.0
6 to 12 months	13	4.7
1 to 2 years	76	27.7
2 to 5 years	48	17.5
5 to 10 years	45	16.5
More than 10 years	23	8.4
Total	274	100.0%

*Many of the clients discharged within 30 days were admissions for respite care or evaluations.

Source: DMHMR Automated Reimbursement System.

- Many discharged clients return to live with their families. A substantial proportion, over 50 percent of the discharges reviewed by JLARC, require alternative residential placements such as group homes, supervised apartments, and homes for adults. Many clients now living with their families will need alternative placements in the future, as parents grow too old to care for them.

INITIAL PLACEMENTS OF SAMPLED CLIENTS
DISCHARGED FROM LTSH AND SEVTC
(January 1978 through February 1979)

Placement	SEVTC	LTSH	Both Facilities
Family	12	7	19
Group Home	5	1	6
Supervised Apartments	--	1	1
Foster Home	2	--	2
Home for Adults	--	4	4
Nursing Home	--	6	6
Other	2	4	6
Total	21	23	44

Source: JLARC record review.

- Typical community services needed by discharged clients include residential placements, income assistance, personal or vocational training, sheltered or competitive employment,

and transportation. Local service agencies do not have to provide each type of service to every client. However, each type of service appears to be needed in each community.

Conclusion

Individuals discharged from State mental retardation facilities require continuing services in order to function in the community. Although there are relatively few discharges from the institutions, documenting the characteristics and needs of this client group is essential for program planning and development. The department's information system should be more fully utilized for this purpose.

REVIEW AREA 12: What procedures are used to discharge clients from State mental retardation training centers?

Most mentally retarded people discharged from State institutions require a range of support services in order to function in the community. Key elements of the process for linking clients with community services include: (1) notifying local agencies of the pending discharge; (2) identifying and arranging any community services the client may need; and (3) identifying and providing any special training needed prior to discharge.

Findings

- Of the two mental retardation facilities reviewed by JLARC, only SEVTC routinely secures a release of information from resident or guardian upon admission or soon thereafter. Releases for over one-third of the clients reviewed at LTSH were not signed until within a week of discharge, preventing appropriate notification and planning with local agencies.

RELEASE OF INFORMATION FROM SEVTC AND LTSH

Facility	Number of Discharges Reviewed	When Release of Information was Signed: Within 7 Days or Before Admission	Within 7 Days or After Discharge	Other Times
LTSH	16	2	6	8
SEVTC	21	17	0	4

Source: JLARC record review.

- Local agencies are not routinely involved in discharge planning at the institutions. SEVTC has closer contact than LTSH with the service agencies in its catchment area, due to geographic proximity and SEVTC's participation in regular meetings with local service agencies in each community. However, institutional staff have primary responsibility for identifying and arranging local services for discharged clients.

- The criteria for discharge differ between SEVTC and LTSH. Clients at SEVTC are considered ready for discharge when training goals, specified in admission contracts, are met. At LTSH, clients generally have longer lengths of stay, and readiness for discharge is based on a clinical assessment of the individual's ability to function in a more independent setting.

- At all institutions, discharges are constrained by the lack of community services. DMHMR estimates that there are 494 clients in mental retardation facilities who are ready for release but cannot be discharged due to the lack of local services.

- Discharge arrangements at the institutions are handled by special discharge units rather than by staff from the treatment units. Coordination with local agencies, service arrangements, and follow-up are usually the responsibility of these discharge units.

- Many discharges from the institution follow a successful convalescent leave of up to a year. Convalescent leave allows the institution to monitor the individual's progress and provide additional training or services. After discharge there is no formal contact between the institution and the client.

  -*SEVTC has a family training program which allows follow-up and continued training during convalescent leave.*

  -*LTSH follow-up during convalescent leave is informal and at the initiative of individual staff.*

Conclusion

The discharge planning process differs substantially between the two facilities reviewed by JLARC. SEVTC appears to have a more effective process than LTSH. Notification of appropriate local agencies about pending releases and transfer of client

information is a significant obstacle to smooth transition at LTSH. Stronger central direction is necessary to ensure more consistent and effective discharge planning at the mental retardation facilities.

REVIEW AREA 13: How do State mental retardation training centers and community agencies interact to link discharged clients with community services?

It is frequently necessary to link discharged mentally retarded clients with educational, vocational, or residential community services. The life-long nature of the disability and the recent institutional emphasis on goal-specific training mean that clients and their families require extensive support in the community.

Findings

- Survey responses of CSB executive directors confirmed JLARC's observation that discharge planning is somewhat more adequate for the mentally retarded than for the mentally ill. Nevertheless, a higher degree of satisfaction is shown by directors in the SEVTC service area than in the LTSH area.
  - 60 percent of all directors indicated that discharge planning was adequate for the mentally retarded, compared with 45 percent for the mentally ill.
  - 72 percent of directors in the SEVTC area indicated that discharge planning was adequate, compared with 56 percent in the LTSH area.
- SEVTC has become a single entry point for most clients transferred from other institutions. Most mentally retarded clients eligible for discharge from other mental retardation facilities to the SEVTC service region are transferred through SEVTC.
- SEVTC has established itself as a focal point for service integration in its service area. Focus teams consisting of community agency representatives participate in pre-admission screening for SEVTC. Focus team agencies include local departments of health and welfare, rehabilitative services, public schools, and mental retardation programs.
  - For each client, focus team review includes assessment of non-institutional alternatives, identification of

inpatient treatment and post-discharge needs, and contractual agreement between the focus team coordinator (usually CSB staff), institution director and the client.

- Major strengths of the focus team include minimizing confidentiality constraints between institution and community, because clients release information to community agencies as part of the admissions process; highlighting service gaps, which can lead to cooperative efforts for program development; and promoting cooperation among community agencies.

  - --*The Hampton Welfare Department, SEVTC, and the CSB are jointly developing specialized foster placements for children.*

  - --*The Hampton-Newport News team now screens group home applicants.*

  - --*The Western Tidewater team screens activity center applicants and will screen for the new group home.*

- Deficiencies in the focus team concept include:

  - --Focus teams are not involved with all clients transferred to SEVTC from other institutions. Yet, these clients often have long-term institutional histories and few family ties.

  - --Focus teams are not formally involved in discharge planning at the institution. This may contribute to vaguely defined planning at time of admission. It may also hamper long-term monitoring of the client in the community. The follow-up responsibility of the institution ends after the client's convalescent leave.

  - --Focus teams lack staff to provide case management, which would involve monitoring service delivery and continued client progress after discharge. This need has been recognized. At least two teams plan to add case managers in FY 1980.

- Major coordination problems exist between Lynchburg Training School and Hospital and local community agencies. The following case study illustrates problems of inappropriate placement and inadequate and misleading information transfer.

  A mildly retarded man placed in a group home began having severe tremors and balance problems, for which the home sought general hospital treatment. Records

transferred to the home from Lynchburg did not indicate the client's medical or psychological history, or the reasons for a number of prescribed medications.

Several contacts with various personnel at Lynchburg were necessary for the home to obtain sufficient information to facilitate treatment of the client. LTSH had failed to inform the home that the medications were to control seizures and psychotic behavior.

Although the client had exhibited signs of personality disorder at the home, this was the first indication from LTSH that the client had a history of psychosis in addition to mental retardation. Continued behavior problems may result in the man's placement in a home for adults, where professional services will not be available.

LTSH also failed to notify the home that the man had relatives. The existence of family was discovered when the Civil Service Commission notified the man that he was eligible for benefits, due to his mother's recent death. A brother now visits the man occasionally at the group home.

- LTSH has not established consistent procedures for interaction with community agencies.
  - -CSBs are not provided with sufficient client information.
  - -LTSH directly contacts local agencies, such as welfare, for specific purposes. Interagency teams for LTSH do not exist.

Conclusion

The focus team concept, developed by SEVTC and to some extent by other training centers, has significant potential for interagency service delivery and development for discharged clients. Consideration should be given to establishing teams with sufficient case management capability on a Statewide basis. This would help to overcome some of Lynchburg's difficulties, particularly if focus teams were involved in discharge planning.

REVIEW AREA 14: What community services are provided to clients discharged from State mental retardation training centers?

Continued personal and vocational training is usually necessary for adults discharged from State training centers for the

mentally retarded. Training and education for mentally retarded people under 21 years old is the responsibility of public school systems. JLARC therefore concentrated on services for the adult population, which is the primary responsibility of CSBs.

A full continuum of training and support services is necessary to accept individuals with widely differing levels of retardation and move them toward independent living. Adult activity centers provide the most basic level of training. Vocational training and supervised housing are also necessary to maximize the client's potential for independence. A matrix of services available in case study areas is shown on page 58.

Findings

- A small number of service slots are available for the mentally retarded. Institutionalized clients must compete with community residents for services.

- Activity centers exist in five of the six areas visited. Curricula emphasizes training in personal hygiene, independent living skills, and adjustment to work environments. Several centers have recently been taken over by CSBs from local parent groups, and appear to be in transition toward programs of professionally-guided skill development for the clients. Nevertheless, equipment is very limited, and physical facilities typically are borrowed buildings or houses. Waiting lists for admission are common, and increased demand for services appears likely as succeeding groups of mentally retarded people graduate from public school programs.

  - *In Hampton-Newport News, the adult activity center has a capacity of ten and a waiting list of 20.*

  - *In the Rappahannock Area CSB, the activity center has a waiting list of seven, and is operated in a building loaned by a county school division.*

- Vocational services should provide a transition through (1) work adjustment training, which includes attention span and motor skill development; (2) vocational training, which includes skill development for specific occupational tasks; and (3) sheltered employment, where the client is paid for performing work. For those who are able, competitive employment is the goal.

- Sheltered workshops exist in all six areas visited by JLARC, although two workshops operate without CSB funding. Formal training programs are limited in variety and capacity, and workshops differ considerably in productivity and in the ability to move clients toward competitive employment.

COMMUNITY MENTAL RETARDATION SERVICES
(FY 1979)

	Adult Activity Center	Vocational Services/ Sheltered Workshop	Group Home	Supervised Apartments	Foster Care
Hampton-Newport News	- 10 Clients - 20 on Waiting List	- 182 Clients	- 4 Group Homes - 40 Beds - 24 Hour Supervision		
Virginia Beach	- 33 Clients - 8 on Waiting List	- 25 Clients		- 4 Supervised Apartments - 12 Beds - 16 Hour Supervision	
Western Tidewater	- 16 Clients	- 150 Clients			
Valley	- 26 Clients	- 83 Clients - 2 Shops			
Rappahannock Area	- 30 Clients - 7 on Waiting List	- 45 Clients	- 1 Group Home - 7 Beds - 24 Hour Supervision		
Covington - Clifton Forge - Alleghany County		- 40 Clients			

-*In Hampton, the Hudgins Center offers a full program of work adjustment, vocational training, and sheltered employment on one site, for about 200 clients.*

-*In Staunton, the Valley Workshop runs out of work at least twice a year and must lay off its clients. Work slow-downs are common, and staff members arrange recreational outings for clients during such periods.*

- Supervised housing options should encompass a range of foster care, fully-supervised group homes, partially-supervised apartments, and independent living arrangements. No area visited currently offers more than one level of residential placement, and three areas have no residential capacity.

- DMHMR has placed a priority on developing housing for the mentally retarded. It has secured Virginia Housing Development Authority (VHDA) funds for construction of five group homes for the mentally retarded, and requested a supplemental appropriation of $512,000 to support program costs for residents. Five more VHDA homes have been approved for construction.

- The need for supervised housing will intensify as parents of retarded individuals grow older or become incapacitated. Thirty-three of 35 CSB executive directors who responded to the JLARC survey identified the lack of supervised housing as a major service gap for the mentally retarded. Thirty-two executive directors cited insufficient funds as the primary reason for the gap.

- Residential programs in at least two CSB areas are not prepared to serve the type of client currently waiting in State institutions for discharge to communities.

-*In the Rappahannock Area CSB, the group home accepts only mildly or moderately retarded people, thereby restricting the acceptance of clients from LTSH.*

-*In Virginia Beach, the supervised apartment program provides 16-hour supervision, but only six of the last 16 people accepted into the program have come from State institutions.*

Conclusion

Although every area visited provides some services to the mentally retarded, a continuum of training and support is not adequately available in any area. In some communities,

services are only beginning to develop, and limited capacities restrict the ability of State institutions to release waiting clients.

High demand for supervised housing and training services will increase as parents of retarded people grow older or become unable to care for their children. Additional funding for supervised housing and training services will be necessary to meet that increased demand.

REVIEW AREA 15: What are the costs of community services provided to clients discharged from State mental retardation training centers?

As with community mental health services, the cost of providing community services is a major determinant of the ability of CSBs to adequately serve the mentally retarded. Benchmark data for cost comparisons are a necessary part of the State's capacity to ensure the efficient provision of community services to discharged clients.

Findings

- CSBs maintain inadequate data to determine the cost of providing services to discharged clients. Only one CSB visited attempts to calculate costs per client, and no CSB routinely compiles information on the number of discharged clients being served. Costs can be estimated only for activity centers and residential programs, because three of the six sheltered workshops exist independently from CSBs.

- Wide variation exists in the per client costs of services provided by CSBs. Despite some uniformity in the types of mental retardation services offered by CSBs, staffing, facility, and equipment expenditures vary considerably. In general, staff salaries and facility expenses represent the major expenditures for all mental retardation services.

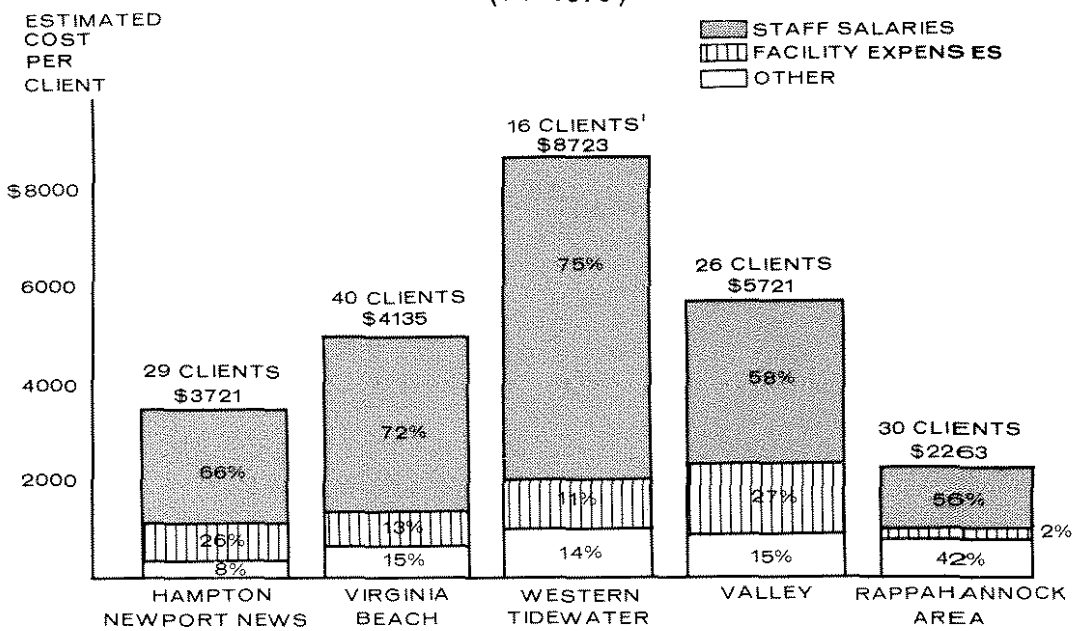
- The annual cost per client of adult activity centers ranges from $2,263 to $8,723. Some variation in the costs of adult activity centers can be explained in the way facility costs are budgeted.

  -*In Virginia Beach, the cost per client for the adult activity center is $4,135, reflecting artificially high facility costs. The center is housed in the*

borrowed parsonage of a church. The CSB pays only $450 per month in utility costs to the church, but claims an in-kind subsidy of $15,625 for the year.

-*In the Rappahannock Area CSB, the per client cost is $2,263. The center is located in a building provided by a county school division. However, the CSB claims no in-kind subsidy for the space and lists $860 as the total rent for the building. As a result, facility costs are artificially low.*

ADULT ACTIVITY CENTERS:
ESTIMATED COST PER CLIENT AND MAJOR EXPENDITURE CATEGORIES
(FY 1979)



[1] Includes both the adult activity program and day care for school-age children.

Source: CSBs, JLARC.

- Some of the per client cost differences for residential programs are related to unique local situations or to differences in facilities.

-*In Hampton-Newport News, the Hudgins residential program includes an allocated portion of the total administrative cost for the Hudgins Center. The allocated administrative costs represent $1,375 per client.*

-*The Transitional Living Centers in Hampton and Newport News were built with VHDA funds, and were designed by architects commissioned by VHDA. The two facilities*

meet most physical standards for State certification as Intermediate Care Facilities for the Mentally Retarded.

-*In the Rappahannock Area CSB, the group home is a converted boarding house rented by the non-profit agency which contracts with the CSB.*

Conclusion

At present, data are insufficient to determine the cost of services provided to clients discharged from State training centers. Substantial variation exists in the number of discharged people being served. Efficient service delivery requires determination of how many discharged clients are being served, and what the costs of service are. Relevant data should be developed for each publicly-supported program.

VI. Accountability

Sound management of the State's mental health and mental retardation system is necessary to ensure the adequacy and effectiveness of community services provided to discharged clients. Sound management entails:

- Planning the development of an appropriate array of needed services.
- Funding service providers in such a way as to ensure service delivery to the target population.
- Coordinating service delivery among myriad human service agencies and providers.
- Overseeing the service development and delivery processes.
- Evaluating the effectiveness of services provided to discharged clients.

Currently, system management and oversight is fragmented among the Department of Mental Health and Mental Retardation, 15 institutions, 36 Community Service Boards, local governments, and numerous other State and local agencies. Lack of central direction impedes development of a coordinated system.

REVIEW AREA 16: Has DMHMR ensured service delivery to discharged clients through interagency coordination?

Discharged clients frequently require services provided by more than one agency. Legislative and administrative actions have focused on specifying the roles of various agencies for the purpose of improving service delivery. Key State agency agreements involve DMHMR and the State departments of Welfare, Rehabilitative Services, and Health.

Findings

- DMHMR did not provide State institutions with discharge planning guidelines until November 1978. The guidelines were general and seemed primarily concerned with collecting information which the department did not have. Information

included name of community to which client was released, whether release of information was signed, and participating community agencies.

- DMHMR regional service coordinators do not fulfill the system integration function foreseen by the Commission on Mental, Indigent and Geriatric Patients and by Bolton Associates.

  - Major portions of coordinator time are spent in budget review and Title XX certification by checklist. Both of these are administrative functions being performed by clinically-trained personnel.

  - Coordinators operate within broadly-defined parameters. They have limited authority and no liaison with State institutions.

    - *In one case study community, the CSB director reported that some programs had been visited by the regional coordinator only once in three years.*

    - *Funds secured by a regional coordinator to provide an aftercare nurse were used by a CSB for other purposes.*

- Interagency agreements between DMHMR and the departments of Welfare and Rehabilitative Services have not significantly facilitated coordination.

  - Senate Joint Resolution 62, passed by the General Assembly in 1976, required DMHMR and Welfare to plan for community services prior to the release of clients from institutions.

    - The agreements did not prescribe mandatory procedures for either institutions or local departments of welfare.

    - Only general regional training was provided.

    - Institutional and local welfare staff included in case studies were generally unaware of provisions. Local welfare departments did not regularly participate in discharge planning.

  - Efforts to establish coordination between DMHMR and the Department of Rehabilitative Services (DRS) have included not only a State-to-State agreement, but also separate agreements between DRS and each institution and between local DRS offices and community clinics. DRS also has units within institutions. Nevertheless, these efforts at coordination have fallen short, and information and procedural gaps still exist.

--DRS's ability to track clients between institutions and communities is hampered by management information gaps. For example, a computer code currently used by DRS does not differentiate whether mentally disabled clients are mentally ill or mentally retarded, or whether service was provided in the community or in an institution.

--Field counselors appeared unaware of agreements and some DRS procedures. For example, the DRS unit at Eastern State does not uniformly transfer clients to DRS field counselors. At least one counselor had to rely on the mental health clinic for referrals and client information. Although DRS designates some field workers as psychiatric counselors, in the Western State area, the designated counselor handled only a few clients discharged from Western State and did not know who was responsible for any other clients.

•The 1978 aftercare agreement between the Department of Health and DMHMR appears to be effectively implemented. Its purpose was to reduce the aftercare involvement of local departments of health to specific situations and to establish aftercare functions in community mental health clinics.

-Between 1978 and 1979, many aftercare clients were transferred from local health departments to clinics in the case study communities.

-Both types of local agencies cooperated to ease the transition.

-Some clinics have limited outreach capability. Other clinics, such as in Staunton, reorganized to provide case management to aftercare clients.

•A major problem is the lack of a single agency responsible for monitoring client progress or service delivery to discharged clients in the community. A client case followed up by JLARC illustrates problems that are created when coordination breaks down.

A woman had been a DRS case prior to admission to Eastern State Hospital. She was diagnosed as schizophrenic and mentally retarded. Upon discharge, she was referred to a mental health clinic for follow-up of her medication, bi-monthly injections of Prolixin, a tranquilizer to control psychotic symptoms. Through the clinic she was referred back to DRS.

She was sent by DRS to the Woodrow Wilson Training Center for evaluation. Her records sent to Woodrow

Wilson did not indicate that she was taking Prolixin. During her stay at Woodrow Wilson, it came to the attention of the staff that medication was required and the clinic was contacted for information about medications.

The client returned home from Woodrow Wilson after 17 days. Her return was known to the local department of social services and to DRS. Although both agencies claim to have case management responsibilities, no attempt was made to notify the clinic.

A month later, a chance remark by a medicaid taxi driver alerted the clinic nurse that the client had returned. Efforts were then made to restabilize her medication.

Conclusion

Interagency coordination has generally not been effective in facilitating service delivery to discharged clients. Major problems include inadequacy of central direction, autonomy of local agencies, and lack of a single point of responsibility for clients in the community. Coordination could be enhanced by: (1) specifying a liaison role for regional coordinators; (2) including mandatory provisions in interagency agreements; and (3) assignment of overall case management to Community Service Boards.

REVIEW AREA 17: Has DMHMR ensured service delivery to discharged clients through planning, funding, and evaluation?

Central direction of community services is necessary to ensure that high quality services are provided to discharged clients Statewide. DMHMR has the authority to exert State oversight through planning, funding, and evaluation. The department has the responsibility to establish standards, direct spending, and monitor the quality of the system.

Findings

- Statewide planning has failed to recognize the specific needs of discharged clients. Current plans discuss general problems but lack adequate data on the availability and quality of community services, assessment of need, and costs.

- Although funding provides the State with leverage to ensure service delivery, DMHMR has not used this leverage to ensure delivery of a range of services to target groups including discharged clients.

  - Until recently, the department did not tie State funding for community services to program standards. State and federal monetary sanctions are now to be applied to all programs which do not meet newly-developed certification standards. Some DMHMR officials have expressed doubt that the political environment will permit funding to remain cut off. At issue is whether a low-quality program is better than none at all.

  - During fall 1977, DMHMR issued a memorandum requiring that certain basic services be provided in each CSB before the community would receive State funds for FY 1979. The department mandated that CSB services must include outpatient, aftercare, pre-admission screening, pre-discharge planning, diagnostic, evaluative, referral, and emergency services.

  - Program definitions are so broad that the mandated core is almost meaningless. For example, the State funds a wide variety of aftercare services.

    - *The Rappahannock Area CSB aftercare service consists of basic medication checks.*

    - *Virginia Beach aftercare services include case management, independent living skills training, therapeutic recreation, and medication checks.*

  - DMHMR allocates some additional community mental health funds to certain CSBs located near the State mental institutions. The department's perception is that these CSBs serve more aftercare patients than other areas and, thus, need the extra funds for additional staff. However, DMHMR does not have adequate information to determine how many clients are discharged to particular localities.

- Although evaluation of community programs is an effective mechanism for ensuring quality of care, DMHMR has not evaluated the quality of community programs for which it provides funding.

  - The department was indirectly given responsibility for developing standards by legislation. Section 37.1-197(e) of the *Code of Virginia* requires CSBs to:

    > Make rules or regulations concerning the rendition or operation of services and

facilities under its direction or supervision, subject to applicable standards or regulations of the Department. (emphasis added)

- The lack of State standards to ensure quality was cited by the 1974 Bolton Report as a major shortcoming. However, DMHMR has only recently developed certification procedures.

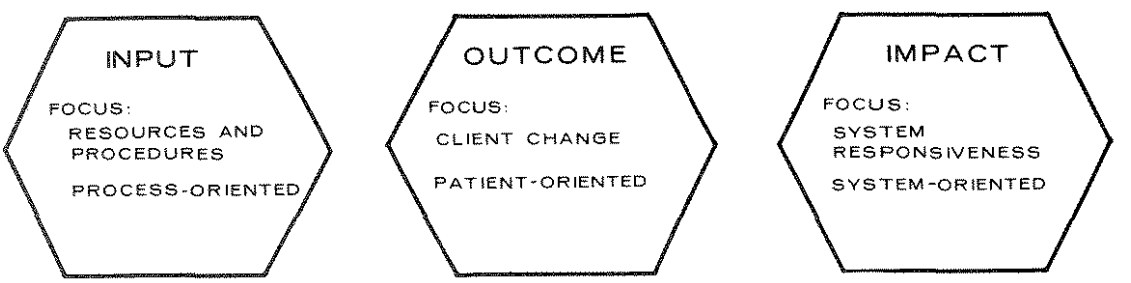
- Pressure for the development of standards came from external sources. Title XX funding for community services required that standards be developed for approval of a program as a certified vendor. The 1975 amendments to the Community Mental Health Centers Act also required the establishment of quality assurance systems in programs which receive federal funds.

  - Mental retardation standards were the earliest to be developed because mental retardation programs were the first to be funded by Title XX. These standards went into effect July 1, 1979. Variations in the initial level of compliance will be permitted except for those standards in which mandatory compliance is expected. Mandatory standards are concerned with health, safety, and minimum levels of services.

  - Mental health standards will be implemented July 1, 1980.

- DMHMR views evaluation as having three possible orientations: input, outcome, and impact. The department's newly-developed standards do not address the outcome or impact of the service delivery system to meet an individual client's needs or the overall need for services. Instead, the standards focus on inputs to ensure uniformity of facilities, personnel, planning, and management and clinical procedures.

ORIENTATIONS TO EVALUATION



Source: DMHMR.

Conclusion

DMHMR has failed to exert central oversight to ensure Statewide availability of high quality community services. Only recently has the department begun to use its potential leverages. Meaningful program definitions and core service requirements should be developed to support funding decisions and provide the base for evaluation. Moreover, some portion of services could be mandated for discharged clients.

REVIEW AREA 18: Have Community Service Boards ensured service delivery to discharged patients through planning, funding, and evaluation?

Development of an array of adequate and effective services requires sound management. CSBs are charged by State statute with planning, funding, and evaluating community services. Effective implementation of these functions can ensure the quality of services provided to all clients, including those discharged from State institutions.

Findings

- Effective planning could give CSBs a structured process for scheduling limited resources to meet identified needs. All but one CSB visited by JLARC attempt to plan for service development. However, the sophistication with which CSBs plan differs considerably.

  - Planning is typically regarded by CSB staff as a secondary priority. At present, only the Hampton-Newport News and Virginia Beach CSBs have plans which are adequate to guide the future development of services, including services for discharged clients.

  - The lack of management information about clients served hinders planning. Only two CSBs routinely collect any demographic data on active cases, and data collected do not meet requirements for effective planning.

    --*The Virginia Beach CSB has an automated client data system which includes a variety of demographic and diagnostic categories. Although*

CSB staff can generally analyze case loads, they cannot determine what services are provided to discharged clients.

--*The Rappahannock Area CSB can only provide estimates of case load size and characteristics of clients served.*

-An assessment of the needs of discharged clients is a prerequisite to the development of an effective plan. Although four CSBs report that some form of needs assessment has been conducted in the past three years, none dealt specifically with the needs of discharged clients.

--*The Hampton-Newport News CSB surveyed local human service agencies in order to identify clients in need of various types of services.*

--*The Virginia Beach CSB surveyed a sample of the general city population in order to estimate the number of people citywide who had emotional or mental disabilities.*

--*The Valley CSB, in conjunction with Western State Hospital, collected general information about the characteristics and living situations of some of their aftercare clients. However, the effort stopped short of estimating the number of people in need of various kinds of services.*

•Funding gives CSBs substantial leverage to specify the level and type of services to be provided, or to specify the client groups to be served. However, no CSB visited by JLARC requires contractual agencies to expend a specified level of effort toward discharged clients.

-According to the JLARC survey, 33 CSBs contract with private agencies for at least one program. Three CSBs contract for all mental health and mental retardation services, and 14 contract either for all mental health or all mental retardation programs.

-Contracts between CSBs and private agencies vary widely in level of specificity. In most cases, the emphasis is on financial accountability rather than on program effectiveness. The descriptions of services to be provided are too vague to be used as measures of service delivery.

•Evaluation of community programs is necessary to ensure service efficiency and effectiveness. Less than one-fifth of CSBs report that they conduct formal written evaluations

of programs at regular intervals. About half of the CSBs indicate that informal evaluations are done, either through regular visits to service sites or through impressions gained from day-to-day contact with program operators.

- No CSB visited has attempted a formal follow-up of its aftercare patients. The lack of client follow-up is a serious gap in monitoring the effectiveness of community services.

- Only one CSB visited conducted formal evaluations of either contracted or directly-delivered services.

  -- *In Hampton-Newport News, a comprehensive evaluation of the Sarah Bonwell Hudgins Regional Center was conducted by two CSBs in 1976-77. CSB and Hudgins staff credit the evaluation with correcting a number of serious flaws in existing programs and with improving service delivery.*

  -- *The Hampton-Newport News CSB has since adopted a three-year evaluation cycle, wherein programs in one functional area will be evaluated each year. Evaluation is based on a year-long investigation of administrative practices, professional practices, and program outcomes.*

- In some areas, there appears to be a trend toward more formal evaluations of service delivery.

  -- *In Western Tidewater, the clinic director plans to implement a peer review process, whereby all clinical cases will be periodically evaluated by a committee of mental health professionals.*

  -- *In Virginia Beach, CSB staff are developing a formal evaluation of their residential program, based on a modified version of the newly-adopted State standards for mental retardation programs.*

Conclusion

In general, CSBs have not adequately ensured the provision of quality services to clients, including those discharged from State institutions. Planning, funding oversight, and evaluation are all in varying stages of development in CSBs. Management practices appear to improve the longer a CSB has been in operation.

Priority should be given to planning and evaluating community programs. DMHMR should establish clear guidelines for contracts between CSBs and provider agencies, which specify

how types of services and performance are to be described and measured.

REVIEW AREA 19: How do local governments ensure service delivery to discharged clients through oversight of Community Service Boards?

Local governments appropriated $17.6 million (29.3%) of the total funds used to support community services in FY 1979. As a result, local governments could use funding leverage to ensure delivery of quality services.

Findings

- Contact between CSBs and local governments is limited. The principal contact occurs during the budget review process, according to 40 percent of all CSB executive directors surveyed by JLARC. Another 11 percent reported that meetings are scheduled only to discuss particular problems. Only 34 percent reported regular meetings between local government officials and the CSB.

- Despite expressed concern that CSBs are not sufficiently accountable to local governments, no locality visited by JLARC places special requirements on CSBs for periodic reporting, financial audits, or program evaluations. Programs are generally not visited by local officials.

- Concern over the share that each locality contributes to community services appears to prompt most scrutiny of CSB activities.

  - *Staunton, Waynesboro, and Augusta County require the CSB to provide utilization statistics showing the locality of residence of clients served.*

  - *Hampton and Newport News also require the CSB to provide figures showing client residence.*

  - *Stafford and Spotsylvania County administrators expressed frustration that they were unable to get locality of residence figures from the Rappahannock Area CSB.*

- Several localities serve as the supervising fiscal agent for CSBs. However, the nature of that supervision varies widely.

- *The Hampton-Newport News CSB will become its own fiscal agent for FY 1980, as a result of the City of Hampton's desire to make the board more independent.*

- *The Rappahannock Area CSB funds one full-time position in the Fredericksburg City Treasurer's office to conduct the CSB's fiscal activities.*

- *The City of Waynesboro's participation as the fiscal agent for the Valley CSB is limited to procedural review of financial transactions.*

- *Only one CSB visited by JLARC is well-integrated into the structure of local government. In Virginia Beach, where the CSB consists of a single jurisdiction, the CSB is regarded as a de facto department of city government. The CSB executive director attends regular staff meetings of the city manager, and all CSB staff are hired as city employees, using the Virginia Beach personnel system. The city attorney reviews all leases and contracts entered into by the service board.*

Conclusion

Participating local governments exercise oversight of CSBs primarily by reviewing requests for funding. As a result, local governments do little to require or ensure service delivery to discharged clients. Localities do not appear to place meaningful guidelines on CSB programmatic activities, and proof of service effectiveness is not required. The concerns of localities center around holding down the cost and growth of CSBs, and ensuring that each locality receives a level of services in proportion to the funds it contributes.

Appendices

TECHNICAL APPENDIX SUMMARY

JLARC policy requires an explanation of the research methodology used in each study. A technical appendix was prepared for this report and is available on request from JLARC, Suite 1100, 910 Capitol Street, Richmond, Virginia 23219.

The technical appendix includes a detailed explanation of the methods and research employed in the study. Each of these methodologies is outlined below.

1. Case Study Approach. The lack of adequate Statewide data and the wide variation in community services prompted JLARC to use a case study approach as the basis of our research. Two sets of institutions and communities were chosen for case study. A major mental hospital, a training center for the mentally retarded, and three communities within the service area of both institutions were included in each set.

2. Interviews at Institutions. Structured interviews were conducted with personnel in the mental health and mental retardation facilities in each case study area. A total of 53 professionals were interviewed, including institution directors, administrators, social workers, and medical personnel. Information was obtained on resident characteristics, discharge procedures, service needs of discharged clients, institution-community coordination, and system perceptions. Several of the questions were duplicated in interviews with community personnel and in the CSB Executive Director Survey to permit comparative analysis of the responses.

3. Community Visits. JLARC staff visited each of the six case study communities. A total of 125 local agency personnel were interviewed, including CSB staff, local government officials, and employees of the local health and welfare departments. Thirty-seven program sites were also visited, including mental health clinics, day programs, group homes, adult activity centers, and sheltered workshops.

4. Client Record Review. A sample of 98 records of clients discharged from the case study institutions between January 1978 and February 1979 was reviewed by JLARC staff. These records were used to analyze institutional discharge and referral procedures. In addition, a subsample of discharged clients was followed up in the case study areas to determine the adequacy of the institution-community linking process, the types of community services the client received, and the adequacy of the information sent to the community.

5. CSB Executive Director Survey. To broaden the scope of information on community services, a survey of executive directors of all 36 CSBs in Virginia was conducted. Questionnaires developed by JLARC staff included questions on local funding priorities, service gaps, DMHMR assistance to CSBs, and transfer of information from institutions.

6. Cost Estimates. JLARC staff used CSB budget data for FY 1979 to estimate the costs of four programs in the case study communities: residential programs for the mentally ill and for the mentally retarded, adult activity centers, and day programs. Several computations were necessary to make the various budgets comparable.

COMMONWEALTH of VIRGINIA

Department of
Mental Health and Mental Retardation

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November 26, 1979

Mr. Ray Pethtel, Director
Joint Legislative Audit and Review Commission
823 E. Main Street, Suite 200
Richmond, Virginia

Dear Ray,

Thank you for providing me with the opportunity to respond on behalf of the Department of Mental Health and Mental Retardation to the Joint Legislative Audit and Review Commission working paper "Deinstitutionalization and Community Services in Virginia." I would like to address four major issues in our response: (1) the history of institutionalization and deinstitutionalization in Virginia; (2) the philosophy and approach of the working paper; (3) specific inaccuracies or misconceptions which should be corrected prior to the publication of this report; and (4) comments on Section VII: "Preliminary Conclusions and Options."

I. Institutionalization and Deinstitutionalization in Virginia

Any report on deinstitutionalization in Virginia or in any other State should begin not with the definition of the term, but with the clear understanding and explanation of why deinstitutionalization became necessary. To do that we must study and clearly understand all of the factors and forces that brought about the institutionalization phenomenon in the first place. The mere statement of the number of persons residing in State institutions at a point in time clearly does not offer an analysis, or even a hint of the many interrelating processes which led to the over-use of State mental hospitals and mental retardation facilities.

I can assure you that there was a time in Virginia when a commitment to a State hospital could not be refused. The hospital system was expected to be the permanent haven for many different segments of our society, including the poor, the homeless, the unemployed, the deviant, the orphan, the aged, the anti-social, the underprivileged, the wanderer, the "peculiar" transient, the pennyless, and at times, the mentally ill and mentally retarded. These were acceptable criteria for admission and many local and State agencies including welfare departments, courts, police, health departments, schools, and other agencies participated actively in the process of admitting and commiting individuals to State mental hospital care.

In part, these actions were supported by a general philosophy that the State was responsible for providing room, board, and treatment for these various unfortunates. I maintain that this attitude and history of the role of State Mental Health and Mental Retardation facilities has been one of the major obstacles to the effective discharge of persons from State facilities. It should be well remembered that as the Department of Mental Health and Mental Retardation has made efforts to carefully screen persons who were considered for admission to State facilities and to return persons to the community, there have been many negative reactions at the State and local levels by many of the agencies and persons who participated in the "institutionalization" process. It is obviously a difficult task to return persons who have been sent away as "permanent" residents of the State hospital system to those communities where they had previously lived. To turn such opinions and philosophies around is not an easy job, particularly as the problem is addressed Statewide.

It should also be remembered that these local agencies were not the moving force of the deinstitutionalization process and did not initiate the process. Beyond the actions of the Department of Mental Health and Mental Retardation, the other major forces have been legal decisions, advocacy groups and other external pressures which have required an improvement in the care and treatment of the mentally ill and mentally retarded, both at the institution and community levels. These actions and events must be carefully understood prior to any evaluation of the State's "deinstitutionalization" process.

II Philosophy and Approach of the Working Paper

The Department of Mental Health and Mental Retardation typically identifies three types of evaluation. Evaluation of activity addresses the question "Have we done what we said we were going to do?" Evaluation of outcome answers the question "Have individuals or groups benefited from what we have done?" Evaluation of impact answers the question, "Has the program satisfied its initiating needs and expectations?"

In many respects, the current study "Deinstitutionalization and Community Services in Virginia" is primarily an impact evaluation study. It assumes an extended timeframe and deals with policies and structures rather than discrete services.

One of the major problems in conducting impact level evaluations is the selection of suitable criteria for determining whether the initiating needs and expectations have been satisfied. Ideally, these criteria should be set down before the initiation of the program. A second approach would be to have all parties analyze documents which call for or authorize the program and select relevant criteria. In the absence of such documentation, all affected parties can agree upon a suitable set of criteria.

In the present case, no criteria were established prior to the start of the deinstitutionalization program and the Department of Mental Health and Mental Retardation was not consulted in the selection of any of the retrospective criteria. The JLARC team selected three derivative recommendations of the Commission on Mental, Indigent and Geriatric Patients as study criteria. In both of its reports, the Commission made a total of 25 major recommendations. The three listed as reference criteria for this study are not

listed among these major recommendations. Interestingly, the first recommendation of the Commission did not deal with deinstitutionalization but rather with strengthening the State hospital system, including a request to strengthen community involvement (original emphasis) in the State hospital program.

I elaborate on the relative importance of the Commission on Mental, Indigent and Geriatric Patients' recommendations in the present report primarily to make the point that the deinstitutionalization program in Virginia should not be considered as the primary activity of the Department of Mental Health and Mental Retardation since 1972. I am attaching a copy of a report of our progress in accomplishing the goals of the Commission on Mental Indigent and Geriatric Patients to June 30, 1977. A review of this report will not only demonstrate our conscienciousness in accomplishing the goals of that Commission but also will identify the many areas in which the Department has been working over the past seven years. If I were to recapitulate our major progress over the past several years, I would say that it was in the development of community alternatives to institutionalization and to assuring that only those people in need of State hospital or training center services are admitted to these facilities. We continue to place a high priority on this responsibility.

JLARC NOTE:

The Commission on Mental, Indigent and Geriatric Patients made its intent clear when it stated: "At the risk of repetition, this Commission is convinced that the successful improvement of mental health services to both the mentally ill and mentally retarded and the less fortunate of Virginia's citizenry requires a total commitment to the concept of a coordinated system of care focused on the patient rather than the agency or institution."

A second major difference between the Department of Mental Health and Mental Retardation and the study team relates to the definition of the term "deinstitutionalization." The Department of Mental Health and Mental Retardation has endorsed the operational definition of the term deinstitutionalization as proposed by Dr. Bertram Brown, former Director of the National Institute of Mental Health. Dr. Brown described three essential components of deinstitutionalization: (1) the prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment; (2) the release to the community of all institutional patients who had been given adequate preparation for such a change; and (3) the establishment and maintenance of community support systems for noninstitutionalized persons receiving mental health services in the community.

Despite our suggestions, the study team chose to generate its own definition of deinstitutionalization as "reduction of long-term stays in State institutions through transfer of clients to the community." Several years ago, we realized that deinstitutionalization was a process not a goal. The current report deals with it as a goal, or an end unto itself. This perspective is not shared by mental health officials in other areas of the country. The definition selected by JLARC seems much to narrow to address fully the process which should be elaborated by their study.

As we have monitored the admission and discharge rates from State institutions, we have begun to realize that the term deinstitutionalization as used in Virginia and throughout the country is an inappropriate statement of the process of releasing patients from hospitals. When the term deinstitutionalization was first used, there were a large number of persons who had been in State institutions for a number of years and who had broken many of their ties with their home communities. At the present time a different set of circumstances prevails. For example, in 1977-78 nearly 57% of all persons admitted to State mental hospitals were discharged within 60 days. During that same year, over 87% of all persons admitted were discharged within less than 12 months and 94% of the patients discharged had remained in the hospital less than 24 months. In fact, of the 11,009 patients discharged from State mental hospitals in 1977-78, 10,380 had remained in the hospital less than two years.

As for the Training Centers for the Mentally Retarded, in 1977-78 only 267 residents were discharged, down from 328 in 1974-75. The average length of stay of Training Center residents discharged in 1977-78 was 3.9 years down from 9.4 years in 1976-77. One fourth of the residents of Training Centers who were discharged in 1977-78 stayed for less than 6 months and about one-third were in residence for less than one year. Approximately 57% of these residents remained in the institution for less than two years and 75% stayed in the training center for up to 5 years. Only 25% of the Training Center residents discharged in 1977-78 have been in a State institution for longer than 5 years.

The length of stay data from State Mental Hospitals and Training Centers suggest the term deinstitutionalization as first used in the early 1970's is no longer appropriate. The Department of Mental Health and Mental Retardation perfers the use of the term discharge, rather than the term deinstitutionalization, especially when discussing patients and residents who leave the facility after less than 24 months.

JLARC NOTE:

We believe the record is clear that neither the department nor the State Board have ever adopted, promulgated, or formally suggested a definition of "deinstitutionalization" for use in the mental health system; and the department did not suggest one for use in this study either. In fact, in June 1979, the former Assistant Commissioner for Mental Health reported to us that the Virginia Mental Health Advisory Council favored defining the term as "the process of eliminating institutionalization with its symptoms of inappropriate dependency, apathy and lack of motivation toward recovery."

A third major area of disagreement between the Department and the study team appears to be in the interpretation of our authority and responsibility for the development of the community based services. As I have stated above, the Department of Mental Health and Mental Retardation has not viewed deinstitutionalization to be the primary agency goal over the last seven years. Rather, we have seen our goal as the development of a continuum of services beginning in the community and including institutional care. While it is true that Chapter 10 of Title 37.1 of the Code does give the Department certain forms of influence over the Community Services Boards programs, the selection of programs to be offered in a particular community clearly resides with the local Services Boards.

To me the intent of the Chapter 10 legislation was for the local communities to develop their own leadership and capacity to care for their mentally disabled community members. The Department of Mental Health and Mental Retardation had a choice as to whether to allow local initiative to flourish or to identify a rigidly defined spectrum of services which would be easy to supervise and control but which would run the risk of stunting local development. We chose the former course and provided consultation, financial support, planning assistance and other services that we might cooperatively develop services at the local level. Throughout the history of the Community Services Boards development, however, we felt that local initiative was a necessary ingredient for the establishment and maintenance of a good continuum of services. We have "encouraged" such local initiatives but have not felt we should "mandate" all services for all communities across the Commonwealth. Perhaps now is the time to reevaluate that policy.

Now that we have considerable experience with the Community Services Board program, we recognize some of its limitations, including the fact that the Chapter 10 legislation, by distributing authority for Community Services to local governments, is as responsible for the maintenance of a fragmented system as the lack of policies and procedures. All the "clarified lines of authority" and "leadership from the Central Office" we can muster will not alleviate this fragmentation. It seems to me that we can have a locally controlled system with all the inherent benefits, and risks, or a coordinated, comprehensive system, but we cannot have both.

I would like to make several comments concerning the methodology of the study but since neither I nor any members of my staff have previewed or reviewed any of the survey team's questionnaires I am not able to do so. I would, however, point out at least one significant weakness in this study which is the failure to do any interviewing in the Northern Virginia area where there is considerable integration of institutional and community services. I refer especially to the cooperative efforts between Western State Hospital and the Northern Virginia Mental Institute and the various Community Mental Health Centers in Northern Virginia as well as to the cooperative efforts of the Northern Virginia Training Center and Community Services Boards in its area.

III Inaccuracies and Possible Misconceptions

JLARC NOTE:

The Department of Mental Health and Mental Retardation offered several clarifications of fact and interpretation of fact which were incorporated into the final report during the editorial review process. The departmental comments that were corrected have been deleted from this letter to avoid confusion. The remaining comments set forth various departmental positions or contain statements the department wished to make as a part of its formal response. Several explanatory notes have been inserted in the text of this letter.

Page 9: The Department of Mental Health and Mental Retardation position that there are dual institutional and community systems and that departmental authority over the community system is limited is consistent with Chapter 10

of Title 37.1 of the Code of Virginia. This is also the general philosophy of the State Mental Health and Mental Retardation Board who set policy for Department of Mental Health and Mental Retardation.

Page 11: The Department of Mental Health and Mental Retardation has not yet requested funds to plan two additional Training Centers. If these centers are built, they will be in the Winchester-Harrisonburg area and/or the Fredericksburg area.

Page 15: Not all of the 72,000 persons who have been discharged from the four major mental hospitals and mental retardation facilities since 1970 have been deinstitutionalized.

Page 17: The Department of Mental Health and Mental Retardation does prepare analyses of the number of clients able to be discharged from State facilities.

Primary emphasis of the Department's community training activities has been to assist developing Community Services Boards in understanding their roles and responsibilities because this was the greatest need as identified by the local Services Boards.

Page 18: The Conclusion to Review Area #1 suggests that there is no role for Community Services Boards in implementing efforts to appropriately place mentally ill and mentally retarded persons in community services. I feel this is an erroneous conclusion.

JLARC NOTE:

The report makes no such conclusion. On the contrary, half of the recommendations contained in the report recognize the importance of community/State interaction. We believe there needs to be improved communication and coordination between the department, the institutions, the Community Service Boards, and other providers of services to the mentally ill and mentally retarded.

Page 19: Whether or not a mental hospital is a most restrictive setting for a particular patient depends upon the capabilities of that patient and the availability of more appropriate services. Consider the case of an individual who either is bedridden, is totally disoriented, or is periodically destructive. In the absence of home-bound services or other community services, a State hospital setting would constitute a less restrictive setting than being isolated without services at home.

Page 20: The table on recidivism at the four major mental hospitals has collasped readmissions and transfers. Transfers refer to movement of patients within the State hospital system and are not equivalent to readmissions which refer to individuals who are returned to State Hospitals. True readmission rates of State Hospitals are as follows:

Year	Readmissions
1970	4,490
1972	4,551
1974	4,875
1976	5,586
1978	5,696

Page 21: The impact of increased staffing on patient care may not have been determined by the Joint Legislative Audit and Review Commission but has been determined by the Department of Mental Health and Mental Retardation.

JLARC NOTE:

The department has determined the impact of increased staffing in terms of workload and manpower requirements but it has not determined the impact of increased staffing on the quality of patient care.

Page 22: In a statement "Mental retardation facilities provide the most intensive type of care on a continuum from most restrictive to least restrictive," we question where intensive care fits on the continuum.

Page 30: Since 1975 the Department can calculate the number of days that a person remains on an inpatient status in a State facility.

Page 31: Community Services Boards are totally responsible for the type of data which they choose to collect.

JLARC NOTE:

We concur in the fact that Community Service Boards are totally responsible for the type of data which they choose to collect, and that is precisely the problem that needs to be corrected. The Commonwealth must have a reliable, comparable, and Statewide data base regarding client needs, service costs and utilization, and treatment outcomes at the community level. We recommend that DMHMR, in cooperation with the Community Service Boards, begin the immediate development of a Statewide information system to help guide future establishment of a coordinated system of mental health care.

Page 33: The statement that most of the individuals discharged from State hospitals are not cured is a very broad statement and needs further clarification. Who has defined who is cured and who is "not cured?"

JLARC NOTE:

According to DMHMR automated system data, 93 percent of all clients discharged from State mental institutions are "not recovered." We believe the department has supplied its own definition for the statement as used in the report.

IV Comments on Section VII: Preliminary Conclusions and Options

I regret that the preliminary conclusions stated in this report are of such a generalized nature considering the constricted scope of this study and the limited assumptions upon which it was based. I must admit that the

"Conclusions" are rather general statements with which any person knowledgeable about the delivery of disability services or any human services would likely not disagree. However, these conclusions themselves bear the same lack of specificity which has been attributed to the Department of Mental Health and Mental Retardation throughout this report.

Some of the actions suggested are already being conducted, for example, State-to-State contracts, full implementation of standards, discharge planning forms, preadmission screening, etc. Some areas appear to be beyond the scope of the Department, for example: matters dealing with the release of information. I would suggest that your staff consult with the Office of the Attorney General in reference to this matter.

I would also like to point out that on pages 76 through 79 the authors refer to options which appear to be out-and-out recommendations. I hope that these "options" would be expanded to include some estimate of the cost of implementing them. For example, in Area #5 (Service Availability) the prospect of mandating a basic core of services for discharged clients without providing adequate funding for this recommendation would be a cruel hoax on the Department and the clients whom we serve. I trust that you agree.

JLARC NOTE:

We concur--see Recommendation 4.

Once again, let me thank you for providing me the opportunity to respond to the working paper "Deinstitutionalization and Community Services in Virginia." I hope that my remarks will be of service to you and to the members of the Joint Legislative Audit and Review Commission. I would be happy to provide you with additional information if you feel it is warranted.

Sincerely yours,

Leo

Leo E. Kirven, Jr., M.D.
Commissioner

LEKjr/PRA/mmg

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