FINAL REPORT

of the

JOINT OVERSIGHT COMMITTEE

on

DEINSTITUTIONALIZATION

DECEMBER, 1981

FINAL REPORT

of the

JOINT OVERSIGHT COMMITTEE

on

DEINSTITUTIONALIZATION

DECEMBER, 1981

For information regarding content or
for copies of this report, contact:

Department of Fiscal Services
90 State Circle
Annapolis, Maryland 21401

Telephone: 841-3710
(858-3710 from Washington, D.C. area)

PROGRAM EVALUATION

JOINT OVERSIGHT COMMITTEE ON DEINSTITUTIONALIZATION

Delegate Frank B. Pesci, Sr., CHAIRMAN

Senator Dennis F. Rasmussen, VICE CHAIRMAN

Senator Aris T. Allen*

Delegate Kay G. Bienen

Senator John J. Bishop, Jr.**

Senator F. Vernon Boozer***

Delegate Thomas W. Chamberlain, Sr.

Delegate James R. Dietrich

Delegate Anthony M. DiPietro, Jr.

Senator Arthur Dorman

Delegate Raymond A. Dypski

Delegate Marilyn R. Goldwater

Delegate Paula C. Hollinger

Senator David M. King****

Delegate Robert R. Neall

Delegate Lewis R. Riley

Senator Verda F. Welcome

Delegate Jennie M. Forehand

Delegate Joan B. Pitkin

Committee Staff

E. Phillip Sayre, Committee Coordinator
Ann Marie Zalewski, Resource Staff
Carol J. Lawson, Legislative Counsel

*Senator Allen resigned from the General Assembly, effective October 31, 1981.
**Senator Bishop resigned from the General Assembly, effective September 14, 1981.
***Senator Boozer was appointed to fill Senator Bishop's vacancy.
****Senator King was appointed to fill Senator Allen's vacancy.

FRANK B. PESCI, SR.
LEGISLATIVE DISTRICT 23
PRINCE GEORGE'S COUNTY

ANNAPOLIS OFFICE:
203-B HOUSE OFFICE BUILDING
(301) 269-3232

DISTRICT OFFICE:
8311 FREMONT PLACE
NEW CARROLLTON, MD. 20784
(301) 577-8424

HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

COMMITTEE ON
ENVIRONMENTAL MATTERS

JOINT OVERSIGHT COMMITTEE ON
DEINSTITUTIONALIZATION
CHAIRMAN

LEGISLATIVE ADVISORY COUNCIL
SOUTHERN REGIONAL EDUCATION BOARD

JOINT BUDGET AND AUDIT
COMMITTEE

December 22, 1981

Honorable James Clark, Jr., President of the Senate
Honorable Benjamin L. Cardin, Speaker of the House of Delegates
Honorable Members of the General Assembly

The Joint Oversight Committee on Deinstitutionalization herewith submits its Final Report. In accordance with the May 1980 charge of the Maryland General Assembly's Legislative Policy Committee, the Joint Committee has completed its review and evaluation of deinstitutionalization in the mental hygiene and mental retardation/developmental disabilities programs in Maryland. This Final Report summarizes the two-year effort to ascertain the hurdles that must be overcome if the State of Maryland is to succeed in deinstitutionalizing these programs.

The foundation for this Final Report was established by the extensive work accomplished by the Joint Committee during the 1980 interim period, in which 23 meetings were held. The resulting passage of the Joint Committee's Senate Joint Resolution 61 during the 1981 Session expressed the deep concern of the Legislature in recognizing deinstitutionalization as a high State priority (Appendix A).

During the 1981 Interim, activities of the Joint Committee included 19 meetings and two tours of site inspections. One tour was to Harrisburg, Pennsylvania that provided visits to group homes and scattered site apartments in neighborhoods of two Pennsylvania counties which were operated by private nonprofit and by proprietary providers.

The Joint Committee followed through with its 1980 plans and received a spectrum of service delivery views on deinstitutionalization from persons representing (1) Parents, Guardians and Friends; (2) Citizens Advisory Boards; and (3) associations, organizations, and State agencies for the handicapped. It also received the views from officials of 15 subdivisions on deinstitutionalization for persons with mental illness, mental retardation,

and other handicapping disabilities that covered:

-- group homes in the neighborhood;
-- scattered site housing units;
-- the network of local services needed;
-- ideas on financing; and
-- the role institutions may serve.

A wealth of information has been gathered from these sources, which will be filed in the library of the Department of Legislative Reference.

Several pieces of proposed legislation were reviewed. The Joint Committee determined that just one legislative proposal offered the greatest promise of fulfilling its mission. That proposal, shown in Chapter IV, would create within the Executive Department "The Maryland State Deinstitutionalization Authority." Headed by a Policy Coordinator, its primary purpose is to establish a nonfragmented comprehensive State deinstitutionalization plan, and then to oversee its implementation.

The Joint Committee expresses appreciation to all the individuals, advocates, organizations, local government officials, and State agency representatives for their invaluable contributions.

I specially commend the members of the Joint Committee for their diligent application to completing the task assigned. The Joint Committee is indebted to the excellent support of its hard working staff and to the proficiency of Barbara Gahres, its secretary.

It is a pleasure to transmit this Final Report.

Respectfully submitted,

FRANK B. PESCI, SR., Chairman
Joint Oversight Committee on
Deinstitutionalization

TABLE OF CONTENTS

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

DEINSTITUTIONALIZATION ALTERNATIVES

The Joint Oversight Committee on Deinstitutionalization observes that deinstitutionalization (D/I) alternatives include the following modes or models listed below.

For Mentally Retarded/Developmentally Disabled Persons

- Apartment Residences (Described in Chapter I)
- Day Care Programs (Described in Chapter I)
- Special Education Services (Described in Chapter I)
- Foster Care (Described in Chapter I)
- Group Homes (Described in Chapter I)
- Respite Care (Described in Chapter I. May be accommodated in institutions, intermediate care facilities, apartments, foster care, or group homes.)
- Village Concept of Habilitation (Described in Chapter I)

For the Mentally Ill

- Denver, Colorado community-based crises intervention and hospital prevention programs
- Foster Care (Described in Chapter I)
- Fountain House Model (Psychological rehabilitation services for the chronically mentally ill. Fellowship and transitional employment placement programs.)
- Halfway House (E.g. - St. Luke's House, a transitional living environment in which to gain skills to live more independently in the community.)
- "On Our Own" (A self-help, reinforcing association of former in-patients of psychiatric hospitals.)
- PLASE Program in Baltimore City (Intended as level one housing for transitional care, level two housing for maintenance care.)
- Private Group Homes (Described in Chapter I)
- Supervised Apartments (Described in Chapter I)

DEINSTITUTIONALIZATION AS A HIGH PRIORITY

On November 23, 1981, the Governor addressed a letter to the Chairman of the Joint Committee announcing the inclusion in the F.Y. 1983 budget of an allocation of $2.5 million to enhance community programs for the mentally ill, the mentally retarded, and the non-retarded developmentally disabled (Appendix C). The Joint Committee commends the Governor for his proposal to close the Henryton Center by June of 1985.

The Governor's program is praiseworthy and the Joint Committee endorses it, but the Joint Committee believes that there is still need for funding a long-range plan of care for the mentally ill, the mentally retarded, and the developmentally disabled who are capable of living in, and benefiting from, the environment of a community residence.

The Joint Committee believes that it and the several advocate groups served as the catalyst for the action taken by the Governor on November 23, 1981.

REMOVE THE FRAGMENTATION OF SERVICES

The Joint Committee believes the issue of "fragmented services" remains and needs to be addressed further at both the Executive and Departmental levels.

PREVENT INSTITUTIONALIZATION AS A CONDITION FOR COMMUNITY PROGRAMS

The Joint Committee favors action by the Committee on Mental Health Laws' Subcommittee on Article 59 to develop policy language that facilitates access to community-based programs without the necessity of first being committed to an institution.

ACCURATE DATA BASE AS PREREQUISITE

The Joint Committee is pleased that the Department of Health and Mental Hygiene has begun to address the issue of establishing an accurate data base for the mentally retarded. However, for the Mental Hygiene Administration, a statistical printout of bed utilization, net releases, admissions and re-admissions is not sufficient information on the mentally ill. There is a need to ascertain (1) the level of care required by the mentally ill patients, (2) where this care can best be provided, (3) a survey of the present network of services available, and (4) what is needed in the community to meet the determined needs.

A SINGLE FINANCING FORMULA FOR LOCAL HEALTH DEPARTMENTS

The Joint Committee is concerned about a real, consistent commitment of funds to implement deinstitutionalization. The Single Financing Formula offered an approach that would foster its realization. Nevertheless, the Joint Committee supports adherence to the Department of Health and Mental Hygiene's reallocation plans for the Mental Hygiene and Mental Retardation/ Developmental Disabilities Administrations. Furthermore, the Joint Committee recommends that progress on the reallocation of funds from institutions to the community be monitored regularly by the appropriate legislative committees. Special attention should be given to see that reallocated funds do indeed follow patients transferred from institutions to the community, as well as apply to persons on community waiting lists.

STUDY OF HEALTH NEEDS AND DEVELOPMENT OF A FISCAL INCENTIVE PROGRAM

Whether or not a Single Financing Formula ever becomes a reality, it would be beneficial for the Department of Health and Mental Hygiene to establish appropriate health needs indicators for local health service needs. Knowing what is needed, by a known number of people in each county and Baltimore City, would allow for more equitable distribution of funds budgeted for each local health department. The Joint Committee recommends that legislative oversight be maintained over the implementation of the MHA and MRDDA reallocation plans to ensure that money continues to follow patients transferred from institutions to the community.

SHIFTING FUNDS FROM INSTITUTIONS INTO COMMUNITY-BASED SERVICES

The Joint Committee is encouraged by the Department's Executive Plan for the Mental Hygiene Administration (MHA) during fiscal years 1983 - 1985 (Appendix F). This Plan represents a new strategy to reallocate staff and funds from major State hospitals to community-based programs within existing budget appropriations. Since it did not include new money to accelerate deinstitutionalization, the Joint Committee was heartened by the November 1981 MHA Accelerated Deinstitutionalization Plan (Appendix G). The $700,000 in new F.Y. 1983 money approved by the Governor will increase needed support for MHA's psychosocial programs and enable 50 more patients in the community to be served (see Appendix H.)

The Joint Committee remains wary that the reallocation of funds from a State institution is largely contingent on an institution's success in reducing inpatient days. Any increase of admissions in other institutions could result in a new reallocation of funds to these facilities.

The Joint Committee supports the retention of funds freed for reallocation from institutions to community-based programs, provided a concrete plan for the use of these funds is approved during each year's budget process.

The Joint Committee recommends that group homes and alternative living arrangements in the community be exempted from the new procurement provisions of Article 21 of the Maryland Annotated Code.

OBTAINMENT OF NON-STATE FUNDS

In view of the current context of the Reagan Administration's policies, this recommendation should be creatively pursued with respect to funds from the private sector. Means of permitting and obtaining funds and services from private business, private foundations, United Way, individual and organization volunteers, foster care, and other innovative approaches should be diligently explored.

CONTRACTED SERVICES AS ALTERNATIVE TO DIRECT SERVICES

The Joint Committee continues to support contractual arrangements that encourage private provider initiatives, proprietary as well as nonprofit.

REVISION OF MENTAL HYGIENE'S MASTER FACILITY PLAN

This remains an important issue. Since "community-based State facilities" are in fact State-run hospitals with inpatient services, this situation reinforces the need for the Department to further clarify its terms concerning facilities.

DELICENSING OF STATE HOSPITAL BEDS

The Joint Committee position is unchanged. It looks for legislation providing for delicensing of beds to be introduced by individual Committee members.

LIMIT CAPITAL IMPROVEMENTS TO LIFE SAFETY REQUIREMENTS

The Joint Committee questions the expenditure of large sums of money for "quality of care" projects in institutions if similar expenditures can be more effective and beneficial in the community.

The Joint Committee requests that the Fiscal Committees distinguish more sharply between expenditures for existing institutions (in which a long term absence of projected community-based alternatives exists for certain clients), and similar expenditures that can be used more wisely to develop alternative living arrangements in the community.

SOUTHERN MARYLAND RETARDATION CENTER

The Joint Committee is aware of the many years that the Southern Maryland Retardation Center has been in the planning stage and the commitments made to build this facility. Acknowledging the nature of the rural area involved (as distinguished from an urban or suburban area), the Joint Committee believes that certain living arrangements in a rural setting are valid alternatives that may promote normalization. However, the Joint Committee continues to support and encourage group homes and supervised apartments in scattered sites within established neighborhoods to promote maximum client normalization.

ASSISTANCE TO EMPLOYEES AFFECTED BY DEINSTITUTIONALIZATION

The Joint Committee urges a continued commitment to assist the relocation with any needed prior training of employees whose positions are affected by deinstitutionalization.

CHAPTER I

INTRODUCTION

ORIGIN OF ITEM

In May 1980, the Maryland General Assembly's Legislative Policy Committee established the Joint Oversight Committee on Oeinstitutionalization for the purpose of conducting a two-year study of deinstitutionalization in the mental hygiene and mental retardation programs in the State of Maryland. This issue is of deep concern to the legislature, and although it is said to be a high priority of the Oepartment of Health and Mental Hygiene, there has been little progress over the past five years towards its implementation.

BACKGROUND

While the definition of deinstitutionalization is three-pronged — (1) preventing unnecessary admissions to and retention of people in large State hospitals, (2) finding and developing appropriate less restrictive alternatives in the community for daily living, and (3) improving conditions, care and treatment for those who need to be in hospitals — the emphasis of the State in terms of dollars and staff has been directed toward the third prong, improving institutions. Therefore, the major goals of the Joint Committee were to ascertain deterrents to the total concept of deinstitutionalization and to make recommendations which address the total process of deinstitutionalization.

1980 INTERIM ACTIVITIES

Ouring the 1980 Interim, the Joint Committee (1) made an extensive review of the literature concerning deinstitutionalization, (2) conducted a pilot study of a project aimed at deinstitutionalizing the mentally ill, and (3) held bi-weekly meetings on Tuesday evenings and Wednesday mornings to hear testimony from State Oepartments and Agencies, experts on the process of deinstitutionalization, and interest groups. A detailed Interim Report was issued covering the Joint Committee's activities and the testimony it heard.

At the completion of its first year of study, the Joint Committee concluded that there were several major stumbling blocks to the deinstitutionalization process in Maryland. These were: (1) the absence of high level responsibility and accountability for a deinstitutionalization process; (2) the lack of overall planning; (3) the lack of internal coordination within the Department of Health and Mental Hygiene, and the lack of external coordination with other service providers and Oepartments; (4) the fragmentation of funding and the lack of substantial new money required to develop continuum of care programs which must be in place before large numbers of people can be moved out of institutions; (5) the absence of hard data pertaining to the needs of the institutionalized population, and the number and needs of those in the community who are not receiving services; and (6) the conflicting pressure to upgrade existing facilities while, at the same time, deinstitutionalizing people.

As a result of its findings, the Joint Committee made nineteen recommendations for immediate attention and listed nine additional items for consideration during the 1981 Interim. The status of each of the nineteen recommendations is addressed in Chapter II.

DESCRIPTION OF TERMS FOR DEINSTITUTIONALIZATION ALTERNATIVES

For Mentally Retarded and Developmentally Disabled Persons

Alternative Living Arrangement

An alternative living arrangement is a place of residence that substitutes for the individual's own home or for the home of the individual's family. It affords living experiences appropriate to the individual's functioning level. (ACMRDD, Standards for Services for Developmentally Disabled Individuals, Revised 3/80.)

Apartment Residences

Apartment residences for mentally retarded persons are non-institutional housing which fall into three basic categories:

(1) apartment cluster - a functional grouping of a small number of apartments housing retarded persons with separate apartment housing supervisory staff.

(2) co-resident apartment - an arrangement in which retarded persons and supervisory staff share the same apartment.

(3) maximum independence apartment - apartment for two to four retarded adults who require occasional supervision which is provided one or two days a week. (Health Resources Dictionary, Central Maryland Health Systems Agency, Inc., Baltimore, Maryland, 1980.)

"Supervised apartments" are apartments in which a range of services appropriate to the habilitation needs of mentally retarded persons are arranged, coordinated, and overseen by case managers. These apartments fall into four categories of supervision for mentally retarded persons:

(1) apartments providing 30 hours of supervision per week;

(2) apartments providing 60 hours of supervision per week;

(3) apartments providing 90 hours of supervision per week; and

(4) apartments providing 120 hours of supervision per week.

Day Care

Day care provides habilitation services to individuals according to an individual program plan. Services are on a regular, repeated basis, and assist the individual to acquire and maintain those life skills that enable him or her to cope more effectively with the demands of their own person and their environments. Habilitation services in day programs is an organized program for acquiring, improving or maintaining a particular life skill. (Article 59A, Annotated Code of Maryland; ACMRDD Standards, pages 21-22.)

Domiciliary Care

Domiciliary care includes (but is not limited to) the provision of shelter, housekeeping services, board, facilities, and resources for daily living, personal surveillance, or direction in the activities of daily living. (Code of Maryland Regs. 10.07.03, Domiciliary Care Homes.)

Domiciliary Care Homes

Domiciliary care homes are institutions which admit aged or disabled persons, maintain the necessary facilities and provide a protective institution or home-type environment to persons who, because of advanced age or physical or mental disability, are not gainfully employed. (Code of Maryland Regs. 10.07.03, Domiciliary Care Homes.)

Education

Education is a socially directed process to facilitate learning and development through deliberate interventions. (ACMRDD Standards, page 22.)

"Special educational services," as used by the State Department of Education, means the educational services necessary to assure that all handicapped children are given the opportunity to reach appropriate levels of knowledge and learning skills consistent with their potential and includes the full range of these services, including special equipment, therapeutic treatments ancillary to education, and transportation, whether provided as part of or in addition to regular classroom placement or in separate public or private classes or facilities. (Education Article, § 8-401(a)(3), Annotated Code of Maryland.)

Appropriate special educational services are to begin as soon as the individual can benefit from them, whether or not the individual is of regular school age. (Education Article, § 8-402(b).)

Each county board of education (1) is responsible for the identification of handicapped children who need special educational services, including any school age children in day care centers under jurisdiction of the Mental Retardation Administration, and (2) shall provide or arrange for appropriate educational facilities and services for these handicapped children. (Education Article, § 8-411(c).)

Foster Care

Foster care is a special service rendered within the framework of a continuum of care to mentally retarded persons as an alternative to residential placement. The service offers placement and supervision to mentally retarded persons in the homes of people to whom they are not related by blood or marriage when no other suitable community plan is available for them. Such alternative situations consist of family homes, group homes, boarding homes, and nursing homes. These have proven to be a most viable and successful alternative to living in a State residential center (SRC).

Family care encompasses comprehensive utilization of community resources and professional disciplines. Those services available to the community at large should not be denied to any individual by virtue of his living in a foster care placement. Coordination and planning for the provision of services should be accomplished through the joint efforts of the agencies involved. (Three Year Plan for the Mental Retardation/Developmental Disabilities Administration, F.Y. 1983 - 85, page 93.)

Group Home

A group home is a residential type facility which admits at least four but not more than eight mentally retarded persons requiring specialized living arrangements, and provides for them a home under the care and supervision of responsible adult persons. If a public facility, the group home is called a "public group home." If a private facility, the group home is called a "private group home." (Article 59A, Annotated Code of Maryland.) Group homes are used as a vehicle for normalization. (Health Resources Dictionary, Central Maryland Health Systems Agency, Inc., Baltimore, Maryland, 1980.)

Respite Care

Respite care is the service provided for care of the mentally retarded individual through the temporary separation from his natural or surrogate family by placement in a public residential facility maintained by the Mental Retardation/Developmental Disabilities Administration. This service provides for one placement period up to 28 consecutive days or shorter placement periods or both as determined for each situation within any 12 month period, but not to exceed a total of 45 days within a 12 month period, in order to provide relief for parents or guardians with whom the retarded person ordinarily lives. (Title 10 DHMH, Subtitle 22 MRA, Chapter 06 Respite Care Services in Public Residential Care Facilities Serving the Mentally Retarded.)

Village Concept

Patterned after the developmental model for habilitation, the "village" concept for mentally handicapped persons is viewed by its proponents as a residential alternative to institutionalization. They also view it as a deinstitutionalization alternative to urban apartments or small neighborhood-based group homes.

Just as individuals in society are different, mentally retarded persons comprise a diverse group of individuals. Each person has his/her own needs, wants, and capabilities. Many can function in group homes or apartments in an urban setting. Others may be unable to cope in this environment, or actually regress.

Models of the "village" concept are exemplified by:

Innesfree in Virginia
New England Villages in Massachusetts
The Lambs in Illinois
Concord in West Virginia
L'Arch in Erie, Pennsylvania
Camphill in Copake, New York and in Kimberton, Pennsylvania
Annandale Village at Suwanee, Georgia

The "village" concept is not defined in law or regulation. Camphill Village in Copake, New York is certified as a private school for the mentally retarded. Because Camphill does not consider itself as a treatment facility but a way of life, the regulatory idea of an individual program plan is alien to it. The common theme of the village models is the sense of a community effort and a spirit of sharing that promote links of friendship and confidence among and between the retarded and the nonretarded (the latter includes staff, families, house parents, or other community residents with whom the retarded live and work).

The models differ mainly in the thread of work that ties the community together. The Lambs operates a pet store, a restaurant, and a mail order business. L'Arch uses community-sheltered workshops and activity centers. Concord developed its own activity center. New England Villages employ their residents in industry, in the community and also operate their own contract-sheltered workshop.

While the Camphill Village in New York tries to be largely self-sufficient, through such projects as its farm and bakery, it also makes every effort to both bring the community into the Village and the Village into the community. The former is achieved through many cultural events, such as concerts. The latter is accomplished through such ventures as their support of the factory for the making of orthopedic beds which provides support for Villagers and developmentally disabled and non-developmentally disabled individuals from the nearby area.

The Annandale concept in Georgia led to establishment of a non-profit village for the mentally handicapped adult and retired persons. It is based on the development over the next three years of an environment of mutual assistance — retired persons teaching and working with the handicapped — the handicapped caring for the elderly.

Typically located in a rural setting (does not preclude open suburban land), activities that help to support the village may include gardens, greenhouses, as well as larger scale farming; arts and crafts; bread and cheese making (raw milk and bakery licensing required). Annandale is planning to build a shopping center run by the retarded.

Annandale is subsidized by individual tuition, personal donations, and gifts with the goal of mimimum cost to the Villager. With this in mind, the Annandale staff requests support from interested individuals as well as organizations capable of contributing to the Annandale community.

Annandale recently constructed a 12-unit studio apartment complex for mentally retarded adults to be subsidized by federal Section 8 Housing Assistance Funding. To be supervised by a live-in house manager, eligibility is determined by financial eligibility (below a maximum income limit of $10,700) and personal capabilities to maintain an apartment.

None of these village models receive state funds. Generally, these villages do not accept the whole range of mental disability. Following are the criteria for admission to Annandale, which offers a variety of extra curricular learning or developmental opportunities outside the Village (outside employment, counseling, and education are coordinated by the staff):

- Nonpsychotic
- Educable I.Q. level
- Amenable to community living
- Capable of being trained to some productive job
- Capable of Self Care - feeding, dressing and personal hygiene
- 17 years old except in unusual situations
- Financial ability to pay the tuition fees
- Final acceptance is based on a one to three month evaluation to determine if the new Villager can adjust to community living and maintain or enhance the quality of Village life.

Annandale accepts Supplemental Security Income (S.S.I.), Champus, Medicare, and Social Security.

In general, such a village consists of two or more individual homes, renovated or newly built, that house four to eight retarded persons each with at least one staff person.

Work Activity Center (Workshop)

A "work activities center" was defined as a "workshop" or a physically separated department of a workshop having an identifiable program for clients whose physical or mental impairments are so severe that their productive capacities are inconsequential and there is no minimum wage guarantee. Unless designated as a regular work program, the term workshop includes work activities centers. (The Maryland Facility Plan, Maryland State Department of Education, Division of Vocational Rehabilitation.)

For the Mentally Ill

Day Care

This term is used by the Department of Health and Mental Hygiene only for services to the elderly, as follows:

(1) "Day care center for the elderly" means a place operated for the purpose of providing care for the elderly, with or without charging a fee, and includes a place designated for group care for four or more unrelated persons at least 60 years old.

(2) "Day care for the elderly" (DCE) means any program which provides personal care, supervision, and an organized program of activities, experiences, and therapies during the day in a protective group setting. Day care offers an individualized plan of care designed to maintain impaired aged persons at, or to restore them to, optimal capability for self-care. Provided on a short-term basis, day care for the elderly may serve as a substitute for or transition from an acute or special hospital, skilled nursing home, or home health program to personal independence. Provided on a long-term basis, DCE may preclude the necessity for institutionalization in long-term care facilities.

(3) "Day care participant" means a mentally or physically impaired person, 60 years old or older, whose illness or disability does not require 24-hour inpatient care but which may, in the absence of day care services, precipitate admission to, or prolong stay in, a hospital, nursing home, or other long-term care facility. Persons younger than 60 may be accepted with approval of the Department. Day care participants have a regular place of domicile. (Code of Maryland Regulations, 10.26.01, Day Care for the Elderly and Medically Handicapped Adults.)

Domiciliary Care and Domiciliary Care Home

These terms have the identical meaning previously given.

Education Programs

"Education" is a generic term referring to the process of training and the developing of knowledge, skills, abilities, etc. Within the context of the Mental Hygiene Administration, (MHA), "education programs" may refer to such diverse activities as:

(1) Formal scholastic curriculum related to basic educational requirements for children and adolescents. This is provided in State hospitals and residential treatment facilities by the State or the local departments of education (e.g., the RICA-Rockville model), or in combination of the two; these services may be available in local schools in the community for adolescents in inpatient units, or may be fully integrated into psychoeducational programs (e.g., the Children's Guild). Additionally, MHA may provide on-site mental health services to Level 5 educational programs in the local schools or free-standing schools (e.g., the Phoenix Center model).

(2) Community education programs, as those consultation and education (C & E) activities provided by most community programs as well as by the Prince George's County program specifically funded for C & E).

(3) Continuing education programs developed for MHA staff development (e.g., the Finan and Springfield series of workshops).

Foster Care

Foster care is the provision of care, board, and lodging by a provider (the foster care holder) in the provider's own home. There should be no more than three individuals so placed in any one provider's home at any one time. The environment, care, and food should be such as would be expected in the home of an average family. Each individual placement is made by an agency (public or private nonprofit) which is responsible for developing for each individual so placed a plan of care, treatment, or rehabilitation, and for supervision of the individual and the care holder to ensure that this plan is carried out. The agency is also responsible for recruitment and training of care holders and for financial arrangements with the care holder. Foster care placements can be short term for emergency purposes; longer term as a step toward other living arrangements; or, for all practical purposes, permanent.

Socially-impaired adults in these family settings receive home and supportive services and are capable of action for self-preservation in the event of an emergency. (Authority: Mental Hygiene Administration.)

Independent Living

Independent living is the aim of services to the adult mentally chronically disabled person. Overall, it means living in a personally chosen living space, in which the individual is able to choose between living alone or with some configurations of other persons. Financial responsibility rests with the individual, directly or through the individual's acceptance of support by a significant other.

Private Group Homes

Private group homes are residences established for the purpose of providing care or treatment for persons who have been or are presently under treatment for a mental illness. These residences carry out a program of normalization, provide a home-like environment, have a program designed to develop in their residents the ability to live independently, and assure availability of supervision commensurate with the needs of the residents. (Article 59, §§ 4-6, 58-69, Annotated Code of Maryland, Subtitle 21, Mental Hygiene Regulations 10.21.05 Group Homes for the Mentally Disabled, page 367, .02 Definitions.)

Supervised Apartments

(1) Level I - There are several criteria which must be met.

a. Lease is held by a local service provider and arrangements for meeting rent requirements are made by the provider.

b. Supervision and support services in activities of daily living, money management and crisis intervention are provided by paid staff.

(2) Level II -

These apartments are not leased by the service provider although they may have been located with the help of program staff. Residents are responsible for rental and sharing of household duties among the apartment mates. Program staff may remain available for consultation and crisis intervention, but in a much reduced role.

(3) A third type of apartment now being funded by MRDDA and potentially funded by Project HOME, is an apartment in which there are live-in staff. (Authority: Internal MHA correspondence dated October 14, 1981 regarding Definitions of Alternative Living Units.)

Community Mental Health Facilities

These facilities are private or State-operated inpatient units located within the jurisdictions they serve and licensed as general hospitals, special psychiatric hospitals or residential treatment centers for minors.

Examples of General Hospital Psychiatric Units providing acute care: Johns Hopkins, Sinai, Provident, Baltimore City Hospitals, University Hospital, Montgomery County General, Prince George's General, Sacred Heart, Peninsula General, etc.

State Community Mental Health Facilities

These facilities are inpatient hospital units operated by DHMH, licensed as special psychiatric hospitals, located within their geographic service areas and providing acute and subacute care as well as additional services such as outpatient care. The bed capacity of these units is between 46 and 175.

Examples:

(1) Walter P. Carter Center: Inpatient unit, emergency treatment unit and four satellite outpatient clinics.

(2) Thomas B. Finan Center: Inpatient unit, preadmission screening programs and three local health outpatient clinics.

(3) Highland Psychiatric Unit: Located at the Baltimore City Hospitals providing acute and subacute care and limited outpatient services to East Baltimore.

(4) RICA Programs: Serving adolescents between the ages of 12-17 for residential treatment, ages 13-20 for psychoeducational day treatment. Such units are linked with local education departments.

(5) Other: Upper Shore Community Mental Health Center.

Mental Hygiene Institutions

(1) Hospitals licensed as "Special Psychiatric" with bed capacity of over 200 and located outside of their catchment areas serving acute, subacute and chronic cases. Most of these institutions are for multipurpose utilization, thus serving other handicaps outside of mental illness.

(Examples: Spring Grove, Springfield, Crownsville, and Eastern Shore Hospitals.)

(2) Special Institutions:

Clifton T. Perkins: Licensed as a "special psychiatric," forensic hospital providing 230 beds and statewide local forensic evaluations as well as operating the Hamilton Halfway House.

CHAPTER II

REVIEW OF 1980 RECOMMENDATIONS

In order to overcome or mitigate the stumbling blocks to deinstitutionalization identified by the Joint Committee during the 1980 Interim, a list of conclusions and recommendations was presented in Chapter VI of the First Report of the Joint Oversight Committee on Deinstitutionalization. These recommendations were grouped by topic but were not presented in any priority order.

The following information reviews the nineteen recommendations, briefly outlines the events that have transpired concerning each recommendation, and indicates the Joint Committee's current position on them.

RESPONSIBILITY, ACCOUNTABILITY, PLANNING, AND COORDINATION

1. Deinstitutionalization as a High Priority

Background: Because the Joint Committee concluded during the 1980 Interim that a high level of commitment to deinstitutionalization is required before any major change can occur, it recommended that the Governor and the Legislature issue a joint statement announcing deinstitutionalization as a high State priority.

In December 1980, members of the Joint Committee met with the Governor to discuss the possibility of the Governor issuing an Executive Order, or supporting a Joint Resolution. At that time, either of these suggestions appeared to be acceptable to the Governor.

When no Executive Order was forthcoming, the Joint Committee submitted HJR 99 and SJR 61 during the 1981 Session (see Appendix A). The Senate Joint Resolution was passed and signed in April 1981 by the Speaker of the House and the President of the Senate.

Although a special request by the Chairman of the Joint Committee was extended to the Governor asking that he sign the Joint Resolution, the Governor did not sign it. His position, in addition to uncertainties about President Reagan's capping of Medicaid funds, was that he first would like the results of a review of State concern for deinstitutionalization by Secretary Charles R. Buck, Jr. and the staff of the Department of Health and Mental Hygiene before preparing an Executive statement on deinstitutionalization. (A copy of the Governor's March 4, 1981 letter is contained in Appendix B.)

Current Position: The Joint Committee was disappointed over the Governor's lack of action on the Joint Resolution, and repeatedly expressed a strong interest in receiving a formal executive statement on deinstitutionalization.

Finally, on November 23, 1981, the Governor addressed a letter to the Chairman of the Joint Committee announcing the inclusion in the F.Y. 1983 budget of an allocation of $2.5 million to enhance community programs for the mentally ill, the mentally retarded, and the non-retarded developmentally disabled (Appendix C). The Joint Committee commends the Governor for his proposal to close the Henryton Center by June of 1985.

The Governor's program is praiseworthy and the Joint Committee endorses it, but the Joint Committee believes that there is still need for funding a long-range plan of care for the mentally ill, the mentally retarded, and the developmentally disabled who are capable of living in, and benefiting from, the environment of a community residence.

Finally, the Joint Committee believes that it and the several advocate groups, served as the catalyst for the action taken by the Governor on November 23, 1981.

2. *Remove the Fragmentation of Services*

Background: During the course of the 1980 hearings, the Joint Committee became aware of the fragmentation of services for the mentally ill and mentally retarded due in part to the organizational structure of the Executive Departments. The Joint Committee unanimously agreed to send a copy of the 1980 Interim Report to the Governor with a cover letter expressing its concern over the fragmentation of services for the mentally ill and mentally retarded, and the lack of coordination of these services within the Executive Departments.

Testimony presented by Dr. Stanley R. Platman, Assistant Secretary for Mental Health, Mental Retardation, Developmental Disabilities and Addictions before the Joint Committee in June 1981 indicated that the Mental Retardation and Developmental Disabilities Administration (MRDDA) and the Mental Hygiene Administration (MHA) are cooperating in the handling of the emotionally disturbed mentally retarded (the "Sachs" population). In addition, there has been cooperation between the Department of Health and Mental Hygiene and the Department of Human Resources over nonnegotiated placement issues, but "it should be clearly understood that there are realistic problems between the two administrations."

Current Position: The Joint Committee believes the issue of "fragmented services" remains and needs to be addressed further at both the Executive and Departmental levels.

3. *Prevent Institutionalization as a Condition for Community Programs*

Background: The Joint Committee was concerned with the need for a person to become institutionalized in order to qualify for some community programs, such as Project Home. It therefore recommended that Article 59 of the Annotated Code be assigned to a committee, for the purpose of totally rewriting Article 59 along the lines of the Department of Health and Mental Hygiene's policy favoring community-based programs, and including statements in Article 59 aimed at keeping people out of institutions.

The Committee on Article 59, chaired by former Senator John J. Bishop, was requested to address this recommendation. A Subcommittee chaired by Leonard C. Redmond, III, Esq. has been assigned this recommendation for its study. This Article 59 Subcommittee has held several meetings and drafted legislation for the purpose of evaluating mentally ill persons prior to any institutionalization, to ascertain if a less restrictive environment is appropriate.

The first draft, based on the geriatric evaluation model of pre-screening, was rejected by the full Committee on Mental Health Laws. An effort is underway by the Article 59 Subcommittee to prepare a new draft that is considered acceptable for introduction in the 1982 Session.

The Committee on Mental Health Laws expressed agreement with the Joint Committee's 1980 recommendation to revise Article 59 for the purpose of preventing unnecessary institutionalization.

Current Position: The Joint Committee favors action by the Committee on Mental Health Laws' Subcommittee on Article 59 to develop policy language that facilitates access to community-based programs without the necessity of first being committed to an institution.

DATA BASE

4. *Accurate Data Base as Prerequisite*

Background: Because millions of dollars are being spent annually for services to the mentally ill and mentally retarded without an accurate data base on the people to be served or the types of services they need, the Joint Committee recommended that the Secretary of Health and Mental Hygiene give high priority to establishing an accurate data base pertaining to the population for those for whom the Mental Hygiene Administration and the Mental Retardation and Developmental Disabilities Administration are responsible. This data should include the evaluation of, and plans for, those persons in institutions, as well as the number of people in the community in need of service and the type of service they require. The Joint Committee requested that, by June 1, 1981, the Department submit plans for the initial data collection project and a system for updating the data.

On June 2, 1981, testimony was received from the Department of Health and Mental Hygiene concerning the establishment of a data base regarding the populations of mentally ill and mentally retarded persons in Maryland. Dr. Stanley R. Platman, Assistant Secretary, stated that although no new funds exist for the Mental Hygiene Administration, the current data system is fairly comprehensive and provides a great deal of information on institutional and community population variables, as well as special studies.

Dr. James A. Brahlek, Chairman of the Data System Task Force for the mentally retarded, reported on the progress the Task Force had made toward developing an input document on client identification and service

needs. Training and ongoing assistance in administering the document had begun, and implementation tests were expected to begin by July 1981. He reported that by January 1983 the Mental Retardation/Developmental Disabilities Administration anticipated the addition of a financial component to the data system.

Dr. Brahlek reported two major issues of concern to the Mental Retardation and Developmental Disabilities Administration. First, continued funding must be available to the Mental Retardation/Development Disabilities Administration (MRDDA) and the Data Processing Division in order to support and maintain the data system. Second, it is necessary to obtain a new fulltime position devoted to the continued training of provider agencies and the maintenance of system reliability.

Current Position: The Joint Committee is pleased that the Department of Health and Mental Hygiene has begun to address the issue of establishing an accurate data base for the mentally retarded. However, for the Mental Hygiene Administration (MHA), a statistical printout of bed utilization, net releases, admissions and readmissions is not sufficient information on the mentally ill. There is a need to ascertain the level of care required by the mentally ill patients, where this care can best be provided, a survey of the present network of services available, and what is needed in the community to meet the determined needs.

The Joint Committee recognizes that the Department of Health and Mental Hygiene does not have control over many needs of the mentally ill and mentally retarded, specifically — housing, income, food, transportation, vocational rehabilitation, social support, and advocacy. It is for this very reason that recommendation 2 was included in the First Report and sent to the Governor for his attention and needed direction to the Executive Departments.

FUNDING

5. *A Single Financing Formula for Local Health Departments*

Background: The Joint Committee realized that more efficient and effective action would not be sufficient to solve the funding problem. For this reason, it recommended in 1980 that a Single Financing Formula be implemented, utilizing the Manpower Ratio Method, to prevent fragmentation of funding and to provide new money for community-based programs. It requested that the Governor incorporate the formula in the Budget Bill for F.Y. 1984, and utilize it to develop the appropriations for local health services. The following provisions were to be included:

(1) That all non-residential health services be included in the Single Financing Formula;

(2) That no jurisdiction receive fewer dollars than appropriated under the existing formula in F.Y. 1981; and

(3) That no health programmatic component area be significantly reduced.

House Bill 465 was introduced during the 1981 Session to provide this method of financing local health services. Both the Department of Health and Mental Hygiene and Baltimore City testified against the bill before the House Appropriations Committee. The Committee gave the bill an unfavorable report. House Bill 465 is shown as Appendix D.

Because the Single Financing Formula encompasses a broader range of services than the charge of the Joint Committee, it agreed not to resubmit legislation to establish the Single Financing Formula but instead to request that the House Appropriations Subcommittee on Health and the Environment consider submitting similar legislation during the 1982 Session. To that end, a letter outlining the feeling of the Joint Committee and a copy of House Bill 465 were sent on October 15, 1981 to the Chairman of the House Appropriations Subcommittee on Health and the Environment. (See Appendix E.)

Current Position: The Joint Committee is concerned about a real, consistent commitment of funds to implement deinstitutionalization. The Single Financing Formula offered an approach that would foster its realization. This funding mechanism was developed by over 25 employees of the Department of Health and Mental Hygiene as the "Task Force on Community Services Financing" (report entitled, "Financing Community Health Services Through Local Health Departments Under a Single-Financing Formula: A Report to the House Appropriations Subcommittee on Health and the Environment," September 1, 1977).

In its review of this issue on October 28, 1981, the House Appropriations Subcommittee on Health and the Environment concluded that another statutory aid formula would further dilute the State's ability to develop its own budget. On that basis, the Subcommittee adopted the position that local health be considered along with other health priorities in the budgetary process and not be codified as a statutory funding formula.

Nevertheless, the Joint Committee supports strong adherence to the MHA and MRDDA reallocation plans of the Department of Health and Mental Hygiene. Furthermore, the Joint Committee recommends that progress on the reallocation of funds from institutions to the community be monitored regularly by the appropriate legislative committees. Special attention should be given to see that reallocated funds do indeed follow patients transferred from institutions to the community, as well as apply to persons on community waiting lists.

6. *Study of Health Needs and Development of a Fiscal Incentive Program*

Background: Following the consideration of the Single Financing Formula (which would calculate needed funds into the Local Health Administration, distributed through the planning/budgeting process), the Joint Committee recommended that the Department of Health and Mental Hygiene undertake a study to establish appropriate health needs indicators to compute basic local health services in relation to needs and population, instead of only calculating needs by means of the manpower ratio based upon population initially called for by the Formula.

In addition, the Department of Health and Mental Hygiene was asked to establish incentives for the local health departments to encourage community-based services. Thus far, the fiscal incentive has been to send citizens to institutions for care at no cost to their local government.

It appears that the Department of Health and Mental Hygiene is barely addressing this recommendation. The MRDDA data system could become part of a needs indicator study. The Joint Committee discussed other incentives for reallocation of funds from institutions to the community.

Current Position: Whether or not a Single Financing Formula ever becomes a reality, it would be beneficial for the Department of Health and Mental Hygiene to establish appropriate health needs indicators for local health service needs. Knowing what is needed, by a known number of people in each county and Baltimore City, would allow for more equitable distribution of funds budgeted for each local health department. The Joint Committee recommends that legislative oversight be maintained over the implementation of the MHA and MRDDA reallocation plans to ensure that money continues to follow patients transferred from institutions to the community.

7. *Shifting Funds from Institutions into Community-based Services*

Background: The Joint Committee requested the Department of Health and Mental Hygiene to establish guidelines as to what it considers an appropriate point for funds to be diverted from institutions to community programs, as significant reductions of inpatients occur. It further recommended that funds freed at that point flow immediately into community-based services.

On June 2, 1981, Dr. Stanley R. Platman, testified that the Mental Hygiene Administration (MHA) is developing a formula that would allow funds to flow from the regional centers to the community programs based on census reduction. Dr. Alp Karahasan, Director of the Mental Hygiene Administration, confirmed this proposal on August 25, 1981 by stating that in April 1982 the Mental Hygiene Administration planned to make an "identification of recipients and development of a basis for determining the amount of resources to be transferred from State hospitals to community programs."

"The basis for determining an amount to be transferred to community programs will consist of: (a) a hospital's and the community's success in reducing inpatient days (excluding days utilizied by patients with the primary diagnosis of alcoholism); (b) patient day charge; (c) community need; (d) the extent to which the hospital is above or below the average patient day charge; and (e) maintaining a portion of any savings for hospital enrichment."

Between F.Y. 1983 and F.Y. 1984 the Department plan is to shift funds and personnel to Program 12 (Community Services) in the institutions' budgets and eventually from the institutions' Program 12 to the Central

Office grants within Program 12. "Awarding of these funds will be done by the Regional offices based on continuing analysis of community needs and the impact of services funded through grants on hospital admissions. Increases in hospital admissions will result in a reallocation of Program 12 funds to the facilities." (See Appendix F, page 81.)

It is important to note that resources already have been reallocated to the community. Examples of this shifting of resources are: (1) the closing of the Ritchie Building and placement of mentally retarded clients in the community, (2) movement of positions in institutions to case management positions in Project Home, and (3) movement of funds from Mental Hygiene facilities with the movement of the Sachs population.

Current Position: The Joint Committee is encouraged by the Department's Executive Plan for the Mental Hygiene Administration (MHA) during fiscal years 1983 - 1985 (Appendix F). This Plan represents a new strategy to reallocate staff and funds from major State hospitals to community-based programs within existing budget appropriations. Since it did not include new money to accelerate deinstitutionalization, the Joint Committee was heartened by the November 1981 MHA Accelerated Deinstitutionalization Plan (Appendix G). The $700,000 in new F.Y. 1983 money approved by the Governor will increase needed support for MHA's psychosocial programs and enable 50 more patients in the community to be served (see Appendix H).

In the same spirit, the Joint Committee is pleased with the Governor's announcement to close the Henryton Center by June, 1985 (Appendix C). For the first phase, $646,000 is to be reallocated to place mentally retarded clients in community residences who already attend day programs in the community.

These initiatives appear promising, but the Joint Committee remains wary that the reallocation of funds from a State institution is largely contingent on an institution's success in reducing inpatient days. Any increase of admissions in other institutions could result in a new reallocation of funds to these facilities.

The Joint Committee supports the retention of funds freed for reallocation from institutions to community-based programs, provided a concrete plan for the use of these funds is approved during each year's budget process. (See recommended legislation, Chapter IV.)

The Joint Committee recommends that group homes and alternative living arrangements in the community be exempted from the new procurement provisions of Article 21 of the Maryland Annotated Code.

The appropriate budget analyst in the Department of Fiscal Services is requested to monitor the Department's progress in the implementation of its reallocation plans.

8. *Obtainment of Non-State Funds*

Background: Because at least 135 federal programs existed directly or indirectly that could benefit the mentally and physically disabled, the Joint Committee recommended that a position within the Department of Health

and Mental Hygiene be assigned primary responsibility to aggressively explore and obtain new funding sources that assist Maryland in developing programs relating to deinstitutionalization of the mentally ill and mentally retarded. Funds from all sources, including CETA, Vocational Rehabilitation, Titles XVIII, XIX, and XX, were recommended for consideration and reevaluation in light of each target population.

Due to the federal fund cutbacks in F.Y. 1982, which are anticipated to continue into future years, the Department of Health and Mental Hygiene has not addressed this recommendation adequately.

Current Position: The Joint Committee is aware of the federal budget reductions. However, the recommendation to review all federal programs is to ascertain whether the State is taking full advantage of all available programs. In view of the current context of the Reagan Administration's policies, this recommendation should be creatively pursued with respect to funds from the private sector. Means of permitting and obtaining funds and services from private business, private foundations, United Way, individual and organization volunteers, foster care, and other innovative approaches should be diligently explored.

9. *Use of Governor's Maryland National Relations Office in Washington, D.C.*

Background: The Joint Committee recommended that the Department of Health and Mental Hygiene develop a closer working relationship with the Governor's Maryland National Relations Office in Washington, D.C.

The Department of Health and Mental Hygiene indicated a very good working relationship with its Washington liaison during the deliberations on the federal fund reductions.

Current Position: The Joint Committee is satisfied with the Department's efforts to utilize the Washington, D.C. liaison through the Maryland National Relations Office.

10. *Contracted Services as Alternative to Direct Services*

Background: The Joint Committee believes that the Department of Health and Mental Hygiene should be divested from the role of providing direct services wherever feasible and possible. The Department should steadily provide more contracted services and increasingly limit its role to planning, data control, and promoter and overseer of service delivery.

This position was reinforced during the 1981 Interim by a statement of Dr. Stanley R. Platman, who said, "It is our intent to contract out for services, whenever possible."

Current Position: The Joint Committee continues to support contractual arrangements that encourage private provider initiatives, proprietary as well as nonprofit.

INSTITUTIONS

11. Terminate New State Facilities

Background: The Joint Committee observes from the Department's MHA Executive Plan for fiscal years 1983 - 1985 (Appendix F, pages 8 - 9) that "... retention in a large institution for no clinical reason ... exacerbates the very conditions that treatment is intended to ameliorate." Further, "... additional evidence has developed indicating that treatment in smaller community-based inpatient units is far more effective than treatment in large State hospitals .... While inpatient treatment in a community-based facility is more effective than treatment in a State facility, alternatives to any type of inpatient treatment — day treatment, halfway houses, supervised apartments, to mention a few — often represent even more cost effective treatment for appropriate individuals than community-based inpatient treatment."

In 1980 the Joint Committee recommended that the Executive and the Legislature mandate the termination of new State hospital-based non-community oriented programs.

The Department of Health and Mental Hygiene has indicated that "no new State hospitals are planned for the Mental Hygiene Administration or the Mental Retardation/Developmental Disabilities Administration."

Current Position: The Joint Committee views the above statement about no new State hospitals as very positive. However, the Joint Committee desired clarification of terms such as "State hospitals" and "community-based State facilities." The Department responded by describing "State Community Mental Health Facilities" as inpatient hospital units operated by DHMH with a bed capacity between 46 and 175. Licensed as special psychiatric hospitals, they provide acute and subacute care and other services, such as outpatient care, within the geographic service areas they are located.

"Community Mental Health Facilities" are described as private or State-operated inpatient units located within the jurisdictions they serve and licensed as general hospitals, special psychiatric hospitals or residential treatment centers for minors.

The Joint Committee feels that these terms may lack the precision desired to assure that no more State hospital units will be built. The Joint Committee favors the development of small mental retardation community-based residential programs for which federal Title XIX funds would qualify. Terms for these residential programs should be clarified.

12. Revision of Mental Hygiene's Master Facility Plan

Background: Based upon testimony presented to the Joint Committee by the previous Mental Hygiene Administration Director, the Committee recommended that the Secretary of Health and Mental Hygiene direct the Mental Hygiene Administration to revise its 1980 Master Facilities plan to identify one or more State institutions for closure.

The 1980 Joint Chairmen's Report broadened this recommendation to include the entire Department of Health and Mental Hygiene. It stated:

> Master Facilities Plan: The Committee notes that the Department of Health and Mental Hygiene, in submitting its list of potential reductions included the closure of a number of State health facilities. The Committee also notes that the Department has presented capital facilities plans that do not indicate the closure of facilities is likely — given the emphasis on deinstitutionalization and the fiscal outlook. The Committee shall receive by September 1, 1981, the Secretary's plan for the timing of upgrades and closures. For each institution that his plan indicates are to be closed, he shall prepare a time phased implementation plan indicating the arrangements for patients, employees and facilities.

Because this item became a much broader project than just the revision of the Mental Hygiene Administration Master Facilities Plan, the Department of Health and Mental Hygiene requested an extention of time to complete the project. The Department responded on November 24, 1981 with an updated Master Facilities Plan for fiscal years 1982 - 1991. The summaries of the Plan applicable to the Mental Retardation and Developmental Disabilities Administration (MRDDA) and the Mental Hygiene Administration (MHA) are shown as Appendix I. It does not reflect the proposed closure of the Henryton Center.

Current Position: This remains an important issue. While the Bed-Day Utilization Table presented to the Joint Committee by Dr. Karahasan indicated a reduction in bed-day utilization at the four major regional hospitals, it also indicated an increase in bed utilization at the "community-based" State facilities (an increase of 50,067 bed days between 1978 and 1980). Since "community-based State facilities" are in fact State-run hospitals with inpatient services, this situation reinforces the need for the Department to further clarify its terms concerning facilities.

13. *Delicensing of State Hospital Beds*

Background: The Joint Committee realized that unless beds were delicensed, they would be refilled with new people. It therefore recommended that, as people are moved to community residences, an equal number of beds be delicensed from the State institutions. Residents should be moved in such a way as to depopulate whole units and/or cottages most in need of being emptied.

With the exception of the Mental Retardation/Developmental Disabilities Administration's clients in the Ritchie Building, this has not been happening. The previous statements under recommendation 12 would indicate that just the opposite is occurring because of the opening of new "community-based" State facility beds, new specialty beds, and clustered group home beds.

Dr. Platman testified that, unless legislation is enacted that prevents admission to specific facilities, the Department of Health and Mental Hygiene cannot deny appropriate legal admissions. In fact, "we (DHMH) continue to reduce capacity based on declining population and resource capacity. This has led to a squeeze on admissions and legislative critizism and even proposed legislation to force us to take admissions," according to Dr. Platman.

Current Position: The Joint Committee position is unchanged, and it looks for legislation providing for delicensing of beds to be introduced by individual Committee members.

14. *Limit Capital Improvements to Life Safety Requirements*

Background: In 1980 the Joint Committee recommended, excluding facilities for the criminally insane, that F.Y. 1982 Capital Budget items for existing institutions be limited to life safety projects.

The Committee was alarmed by the Department of Health and Mental Hygiene's request for approximately $35 million in F.Y. 1982 Capital Projects for State institutions for the mentally ill and mentally retarded.

Due to the anticipated review of the Mental Hygiene Administration Master Facilities Plan, the Department of Health and Mental Hygiene withdrew its request for $1.6 million to renovate two cottages at Crownsville. However, this same item has been given number one priority on the Department of Health and Mental Hygiene's request for capital projects in F.Y. 1983.

The 1980 General Assembly approved a $2.5 million request for renovation of the Tawes Building at Eastern Shore Hospital Center despite the fact that the renovation was for air conditioning, considered "quality of care," not "life safety." In addition, the General Assembly approved $2.3 million in capital projects at Rosewood Hospital Center.

Current Position: The Joint Committee questions the expenditure of large sums of money for "quality of care" projects in institutions if similar expenditures can be more effective and beneficial in the community.

Funds currently are going to develop modern replacement beds in institutions rather than to establish more appropriate beds in community settings. However, the $2.3 million in capital projects approved in 1980 for Rosewood Hospital Center includes $1.95 million to renovate the Tuerk and Turner Buildings, to provide 64 modern beds. ($110,000 was approved to prepare plans for the Richards and Finesinger Buildings; $250,000 for a steam distribution system.) The $1.95 million represents a cost of $30,469 per bed.

The Joint Committee requests that the Fiscal Committees distinguish more sharply between expenditures for existing institutions (in which a long term absence of projected community-based alternatives exists for certain clients), and similar expenditures that can be used more wisely to develop alternative living arrangements in the community.

For example, how many group homes, with an average of seven client beds each, would $2.5 million provide? Perhaps 12 new group homes could be constructed in communities for 84 clients. Perhaps 50 homes could be renovated for 200 clients. Or perhaps $2.5 million would furnish 250 to 300 or more supervised apartments for 1,000 clients.

The Joint Committee believes the time has come to terminate the "institution syndrome." Certainly, in today's society and with sums such as $2.5 or $2.3 million, it appears preferable to provide community-based living arrangements as the more feasible approach.

15. *Upper Shore Community Mental Health Center*

Background: In 1980 the Joint Committee recommended that the 99-bed mental health component of the Upper Shore Community Mental Health Center in Chestertown be opened and operated by a private, nonprofit community-oriented organization.

The Joint Committee spent several hours on June 16, 1981 receiving testimony concerning the Upper Shore Community Mental Health Center. Dr. Harold M. English, Superintendent, Eastern Shore Hospital Center, and several people representing private interests, presented their views pertaining to the operation of the new facility.

On June 2, 1981, Dr. Platman said, "It is our intent to attempt to contract out for services, whenever possible. However, if we should obtain the resources to operate Upper Shore in F.Y. 1982 and F.Y. 1983, we would initially operate it as a State facility." The facility with basic equipment has been unused since its completion over a year ago.

By November 1981, plans had become firm for the Mental Hygiene Administration to open 64 beds on March 1, 1982 at the Upper Shore facility with concurrent delicensing of 76 beds through closure of the Nice Building at the Eastern Shore Hospital Center.

Firm support also has been worked out for the Alcoholism Control Administration (DHMH) to contract the operation of another 20 beds for addiction treatment by a private, nonprofit provider in F.Y. 1983.

Current Position: Inasmuch as the problems that existed at the Upper Shore Community Mental Health Center are in the process of being adequately addressed, the Joint Committee supports the expeditious opening of the 84 beds designated for operation at the Upper Shore facility.

16. *Residential Centers in Harford County and Southern Maryland*

Background: The Joint Committee, in 1980, recommended that the Department of Health and Mental Hygiene discontinue its plans to establish the Harford County Residential Center and the Southern Maryland Retardation Center, but instead to continue its efforts to obtain privately operated scattered site group homes in established neighborhoods.

The original plans, if implemented, would result in facilities set apart from established community settings, violating the principle of locating such group homes in established neighborhoods to encourage the highest possible normalization of their residents.

After the publication of its First Report, the Joint Committee was requested by Senator Simpson and Delegates Quade, Sprague and Parlett to hear additional testimony on the Southern Maryland Retardation Center.

As a result of the meeting and testimony presented, the Joint Committee voted to delete any reference to the Southern Maryland Center from the First Report. A letter to that effect was sent to President James Clark and Speaker Benjamin Cardin.

Dr. Stanley Platman testified that "the Mental Retardation/Developmental Disabilities Administration does not intend to construct the Harford County Residential Center but it will develop a small central facility (23 beds) and scatter sites in Southern Maryland."

During the 1981 Interim the Joint Committee made a site visit to the proposed Southern Maryland Mental Retardation Center. It found that the location was two miles from the nearest store and was surrounded by fences in barbed wire farmland, a water treatment plant, the Spring Dell Center thrift shop, workshop and day care center, a small trailer park and military housing. The Joint Committee would have preferred that these homes had been located in a neighborhood setting.

On September 9, 1981, the Joint Committee heard testimony on behalf of J. Thomas Barranger, County Executive, Harford County. Included in the testimony was a history of the proposed Harford County Residential Center. The Residential Facility Advisory Committee has revised its proposal and is asking the Mental Retardation/Developmental Disabilities Administration to consider the construction or rehabilitation of one group home that will provide a residence for six persons presently inappropriately placed.

Current Position: The Joint Committee is aware of the many years that the Southern Maryland Retardation Center has been in the planning stage and the commitments made to build this facility (architectural plans now are being prepared). The Joint Committee commends the citizens of Charles County for their initiative in developing alternatives to large institutions. Acknowledging the nature of the rural area involved (as distinguished from an urban or suburban area), the Joint Committee believes that certain living arrangements in a rural setting are valid alternatives that may promote normalization. However, the Joint Committee continues to support and encourage group homes and supervised apartments in scattered sites within established neighborhoods to promote maximum client normalization.

STAFF

17. Training of Staff for Community-oriented Services

Background: In 1980 the Joint Committee recommended that the Department of Health and Mental Hygiene's program for the Education and Training of Professional Personnel and the State Board for Higher Education shift their emphasis of education for health care professionals and training for institutional staff from institutional type treatment to community oriented services.

The Joint Committee had concluded that deinstitutionalization will be, at best, a partial success as long as the emphasis continues to be on the use of educational resources to develop knowledge and technology for institutionalized treatment and maintenance.

Both the Mental Hygiene Administration and the Mental Retardation/ Development Disabilities Administration have some in-service training programs for their employees. However, the majority of educational opportunities, including in-service and particularly higher education, are institutionally oriented.

Current Position: The position of the Joint Committee remains unchanged. Training and education along the lines of the "developmental model" instead of the "medical model" are essential if community-based services are to be oriented to realistic habilitation and normalization.

18. Assistance to Employees Affected by Deinstitutionalization

Background: In 1980 the Joint Committee recommended that the Department of Health and Mental Hygiene establish time lines and procedures to retrain, redirect, relocate and counsel employees whose jobs at the institutions will be retrenched. When possible, employees should be transferred from institutions to other State service, to local health care centers, or to community-based programs. Consideration should also be given to a plan to rehire these employees under private contracts rather than as civil servants.

Testimony on August 11, 1981 from the Department of Health and Mental Hygiene described the closure of the Thomas Wilson Center as a good example of how well the Department is able to follow this recommendation. However, Dr. Platman expressed his concern that State and federal cutbacks and legislative actions were leading to workforce reduction rather than reallocation.

Current Position: The Joint Committee believes that personnel issues are of major importance if deinstitutionalization is to proceed successfully in Maryland. The Joint Committee was impressed by the chronology of careful planning that assisted the relocation of employees affected by the closure of the Thomas Wilson Center. The Joint Committee also is encouraged by the strong provisions of the "Employee Reassignment Plan

For Maryland State Government" prepared by the Department of Personnel. The Joint Committee urges a continued commitment to assist the relocation with any needed prior training of employees whose positions are affected by deinstitutionalization.

CONGRESSIONAL SUPPORT

19. Communications with Congress

Background: The Joint Committee, aware of several issues in 1980 before the United States Congress that dealt with barriers to community care, realized the importance of Congressional support of deinstitutionalization. Upon the Committee's recommendation, the 1980 First Report of the Joint Oversight Committee on Deinstitutionalization was sent to Maryland's two Senators and eight Representatives in Congress, with a covering letter requesting their support of appropriate federal legislation affecting deinstitutionalization.

Letters of response were received from Senators Mathias and Sarbanes, and from Representatives Dyson, Holt, Long, Mikulski, and Representative Spellman's staff.

Current Position: The Joint Committee encourages better communication between State officials of the Legislature and Executive Departments, and its Maryland Congressional Delegation. The degree to which federal actions may bear on deinstitutionalization efforts to assist the mentally ill, the mentally retarded, and persons with other handicapping disabilities, should prompt positive communications between our State officials and Maryland's Congressional Delegation.

CHAPTER III

SUMMARY OF JOINT COMMITTEE ACTIVITIES DURING THE 1981 INTERIM

The Joint Committee proceeded where it left off with a review of its 1980 Interim recommendations (see Chapter II). The agenda for the 1981 Interim included several hearings and considerations preplanned at the end of 1980.

REVIEW OF F.Y. 1982 CAPITAL BUDGET ITEMS

Pertinent aspects of the F.Y. 1982 Capital Budget were reviewed, including the following items approved in the 1981 Session:

(1) $2,460,000 - renovation of the Tawes Building, Eastern Shore Hospital Center;

(2) $110,000 - equipment for Intensive Treatment Building, Springfield Hospital Center; and

(3) $2,060,000 - renovation of Tuerk and Turner Buildings; planning for renovation of Richards and Finesinger Buildings - Rosewood Center.

The Joint Committee discussed the status of planning for the Southern Maryland Mental Retardation Center at LaPlata in Charles County. The Department of State Planning has approved a bid for architectural plans for a cluster of three group homes with 23 beds (up to $92,000 authorized for this purpose in the F.Y. 1979 Capital Budget). While the proposed location for these homes does not coincide with the Joint Committee's preference for privately operated scattered site group homes within established neighborhoods, it recognizes the prior years of concerned effort and commitments to have these facilities constructed.

PENNHURST DECISION

The Committee reviewed the impact of the U.S. Supreme Court's decision in the case of *Pennhurst State School and Hospital vs. Terri Lee Halderman et al.* Decided on April 20, 1981, this case centers around the question as to whether Section 6010 of the Federal Developmentally Disabled Assistance and Bill of Rights Act mandates the entitlement of mentally retarded persons to "appropriate treatment, services, and habilitation" in "the setting that is least restrictive of ... personal liberty" as a condition for federal allocation of funds to the State providing for their care.

The Supreme Court held that Section 6010 does not create in favor of the mentally retarded any substantive rights to "appropriate treatment" in the "least restrictive" environment. Section 6010 "findings" represent general statements of federal policy, not newly created legal duties. "... Congress made clear that the provisions of Section 6010 were intended to be hortatory, not mandatory."

However, in a letter dated June 16, 1981 from Stephen H. Sachs, Attorney General, to Charles R. Buck, Jr., Secretary of Health and Mental Hygiene, "... it would be a mistake to assume that Pennhurst provides a carte blanche 'legal blessing' of the status quo. It does not." (See Appendix J.)

Several issues in Pennhurst were remanded to the Third Circuit Court of Appeals for consideration. As one example of the fiscal impact of "institutional conditions" litigation could have against Maryland's institutions for the mentally retarded, Attorney General Sachs pointed out that, in F.Y. 1980, the estimated annual cost to fully implement all individual patient "plans of care" was in excess of $12 million.

The Attorney General concluded: "... the State's potential legal liability in this area was not completely, or even primarily resolved by the Pennhurst decision. Legally, we should do considerably more to improve institutional conditions and increase the number of community-based programs for mentally retarded patients. If we don't, we continue to assume the real risk that we will be ordered to do so by a State or federal court."

In the Joint Committee's review of legislation enacted during the 1981 Session that related to deinstitutionalization, special attention was given to House Bill 656 (Chapter 632). This legislation requires the Mental Retardation and Developmental Disabilities Administration (MRDDA) to prepare a plan for the placement in the least restrictive setting of residents in its State institutions over a three-year period.

(1) By July 1, 1982 -- based on an individualized program plan, an assessment of the number of residents who may function appropriately in less restrictive facilities.

(2) By July 1983 -- an assessment of the number, type, and location of alternative facilities needed in the community for the habilitation of all these residents. Includes a detailed listing of resources and procedures necessary to create these alternative facilities, accompanied by an analysis of the feasibility of transferring resources from State to community facilities.

(3) By July 1, 1984 -- a summary of the individualized program plans (IPPs) with a proposed schedule to relocate residents for whom the IPPs indicate a less restrictive placement is appropriate.

A system to monitor community services is to be developed. Importantly, MRDDA is authorized to transfer positions and funds from these institutions to its central administration to accomplish the provisions of this legislation.

REPORTS FROM THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE (DHMH)

The Secretary of Health and Mental Hygiene, Charles R. Buck, Jr., presented a likely picture of the distribution of anticipated federal block grant reductions. He stated that the federal budget cuts would not remove deinstitutionalization as a "high priority" but simply make it harder to achieve.

Dr. Stanley R. Platman, Assistant Secretary for Mental Health, Addictions, Mental Retardation, and Developmental Disabilities, reaffirmed the high priority of deinstitutionalization, but declared it is not a unilateral conception. Other areas that can make or break the lives of individuals currently deinstitutionalized or who will be, over which DHMH has no control, include:

- Housing. People leaving an institution require decent housing. In recent years part of that housing has been achieved for low income persons under Sections 202 and 8, U.S. Department of Housing and Urban Development. These programs now are in jeopardy because of federal budget cuts. Section 202 is being pulled back from the handicapped population.

- Income. People need money to live. Supplemental Security Income (SSI) is in jeopardy for persons with an alcohol or drug addiction problem.

- Food Stamps. Proposed cutbacks will impact on part of the Department's population being served.

- Transportation. Cutbacks will affect this area.

- Vocational Rehabilitation. A large number of employees are being laid off due to the federal cuts in block funds. The Department needs paid employment in shelter workshops, which also will suffer from cuts.

- Title XIX. DHMH needs funds from this source for health services, not just for mental health/mental retardation services.

- Legal advocacy and social support. Federal funds are being cut.

Nothing is more important than the attitude of the population. These are issues over which DHMH has no control. All these factors make up the safety net that is now threatened. Thus, Dr. Platman exclaimed, "DHMH can have the highest priorities in the world, but if these factors are missing, lives out there will suffer more than currently."

Reports were given on the current status of data base systems for the Mental Hygiene Administration (MHA - see Appendix K and Appendix L) and the Mental Retardation and Developmental Disabilities Administration (MRDDA - see Appendix L and Appendix M).

MHA now has a fairly substantial system and has no plans to "revamp" it. Actually, there are two Mental Health Statistical Systems as illustrated in both Appendix F and Appendix K. It surveys both on-going collections and examples of special studies conducted each August with a "one day census" of all persons in Mental Hygiene hospitals. It also provides examples of information from other sources, preventing duplicative efforts.

MRDDA is in the process of developing a client data system. More is reported on the status of the data base systems for MHA and MRDDA populations in Appendixes K, L, and M.

The Joint Committee held a hearing on ways of opening the new 99-bed Upper Shore Community Mental Health Center in Chestertown, Kent County. Alternative operations of the facility were discussed: (1) by the State, (2) by a nonprofit organization, and (3) by a proprietary corporation. Views were presented by representatives of the Medical Services Corporation, the Hospital Corporation of America, and Retirement Living, Inc.

An outstanding report on deinstitutionalization in Italy was presented to the Committee by Loren R. Mosher, M.D., Uniform Services University of the Health Sciences. His report is attached as Appendix N, entitled Italy's Revolutionary Mental Health Law: An Assessment.

SITE VISITS

Members of the Joint Committee benefitted from two arrangements for site visits. With the cooperation of MRDDA, the first arrangement provided site visits to the (1) Great Oaks Center, (2) the proposed site for the Southern Maryland Mental Retardation Center in Charles County, (3) Spring Dell Development Center in La Plata, and (4) group homes in St. Charles.

The second was arranged by Mel Knowlton, Director of the Bureau of Program Development for mentally retarded persons in Pennsylvania. In addition to members of the Joint Committee, members of the House Appropriations Subcommittee on Health and the Environment, personnel from the Department of Health and Mental Hygiene, the Department of Budget and Fiscal Planning, and the Governor's Office traveled to Harrisburg, Pennsylvania. A slide presentation of alternative living arrangements with questions answered by Mr. Knowlton, his staff, and providers preceded the site visits. These persons took small groups to group homes and scattered site apartments in the neighborhoods of two Pennsylvania counties. Sites operated by both nonprofit and proprietary providers were visited.

EMPLOYEES AFFECTED BY DEINSTITUTIONALIZATION

A full meeting was devoted to hearing views on deinstitutionalization from representatives of the Maryland Nurses Association, the Maryland Classified Employees Association, the State Employees Management and Professional Association, and the Maryland Chapter of the American Federation of State, County and Municipal Employees. The Department of Personnel and the Department of Health and Mental Hygiene's Chief of Personnel Services spoke of the State's commitment to assist employees who face layoffs under an Employee Reassignment Plan. The closure of the Thomas Wilson Center during 1981, with plans prepared in 1980, was submitted as an example of the effectiveness of such a reassignment plan (the chronology is in the files of the Joint Committee). Written statements, with case studies, were later submitted by the Division of Correction, Department of Public Safety and Correctional Services.

VIEWS OF PARENTS, GUARDIANS & FRIENDS, AND CITIZEN ADVISORY BOARDS

A lengthy meeting was held to hear a spectrum of views on service delivery concepts: "Alternatives on Deinstitutionalization Programs." Testimony and written statements were received (held in the Joint Committee's file) from persons representing Citizens Advisory Boards of institutions; Parents, Guardians and Friends associations; advocates of the "Village" concept as a residential alternative for mentally retarded persons; the Mental Health Association of Maryland (including "On Our Own" and St. Luke's House); coalitions for handicapped persons; the Maryland Society for Autistic Adults and Children; United Cerebral Palsy of Central Maryland; the Maryland Association for Retarded Citizens; and State offices for the handicapped and the developmentally disabled.

A list of participants is shown as Appendix O.

BLUE CROSS/BLUE SHIELD

Assigned by the Joint Committee in the 1980 Interim for investigation during the 1981 Interim, this subject dealt with the feasibility of requiring Blue Cross/Blue Shield to cover outpatient psychiatric services. Blue Cross representatives reviewed its interaction with deinstitutionalization of psychiatric patients from two points: (1) heading off new admissions to State hospitals, and (2) discharging a significant proportion of the chronic and inappropriately placed State hospital admissions. Cited was an excerpt from a final report (June 29, 1979) contracted by the National Institute of Mental Health, entitled Analysis of State Programs Which Mandate Mental Health Benefits Under Private Health Insurance (pages 46 - 47), which concluded that the availability of insurance for mental health services has little, if any, impact on deinstitutionalization or on potential future institutionalization.

Blue Cross indicated some of its available benefit programs that a deinstitutionalized population may utilize during the course of active treatment:

- Outpatient mental health counselling under Blue Cross basic, Blue Shield and Major Medical programs, with services performed in a doctor's office, hospital outpatient department or a community mental health center.
- Alcoholism Rehabilitation - Outpatient and Inpatient (now mandated)
- Drug Abuse Rehabilitation - Outpatient and Inpatient
- Psychiatric Day Treatment

The Blue Cross/Blue Shield concerns about mandated coverage are expressed in Appendix P, in which a distinction is drawn between social services and medical services.

Testimony also was received from representatives of the Maryland Chapter of the National Association of Social Workers.

LOCAL GOVERNMENT VIEWS ON DEINSTITUTIONALIZATION

The Joint Committee benefitted from two full meetings of testimony and written statements (held in the Joint Committee's file) from officials of the Counties and Baltimore City. Their views on deinstitutionalization for persons with mental illness, mental retardation, and other handicapping disabilities addressed:

-- group homes in the neighborhood;

-- scattered site housing units;

-- the network of local services needed;

-- ideas on financing; and

-- the role institutions may serve.

Fifteen local governments filed position statements with the Committee. All representatives supported deinstitutionalization, provided that the State is committed to the costs of expanding alternative living arrangements and the network of services they require, rather than shift the costs to the subdivisions. A continuing but reduced role of institutions also was articulated. A list of these reports is shown as Appendix Q.

Lastly, as the Joint Committee started its work sessions preliminary to this Final Report, it was able to view a film brought through the efforts of the Project Director of the Maryland Mental Health Manpower Project, The Fifty-First Minute. The film is a documentary on the Denver, Colorada community-based crises intervention and prevention of hospitalization programs.

OUTLINE OF 1981 INTERIM ACTIVITIES

5/19	Review of 1980 Committee recommendations. Review of F.Y. 1982 Capital Budget items. Discussion of Interim Schedule.
5/20	Pennhurst Case - How It Applies to Maryland. Review of 1981 Session Legislation. Discussion of Interim Schedule.
6/2	Reports from the Department of Health and Mental Hygiene.
6/3	Discussion of a possible Pilot Study.
6/16	Discussion of the Upper Shore Community Mental Health Facility. Deinstitutionalization in Europe - Special Focus on Italy.
6/30	Site visits to (1) Great Oaks Center, (2) proposed site for Southern Maryland Mental Retardation Center, La Plata, Charles County, (3) Spring Dell Developmental Center, and (4) group homes in St. Charles.

7/15	Harrisburg, Pennsylvania trip: (1) slide presentation and discussion, (2) visits to a number of homes for a variety of mentally retarded persons.
8/11	Views of Maryland Nurses Association, MCEA, AFSCME, and SEMPA on State employees affected by deinstitutionalization. Comments on employees affected by deinstitutionalization by Departments of Health and Mental Hygiene, and Personnel.
8/12	Hearing: Parents, guardians and friends of patients in mental retardation facilities, Citizens' Advisory Boards, and other organizations for the handicapped.
8/25	Report from the Director, Mental Hygiene Administration, on Deinstitutionalization plans for the Mental Hygiene Administration.
8/26	Hearing: Blue Cross/Blue Shield of Maryland concerning coverage for outpatient psychiatric services.
9/8 - 9/9	Hearing: County Officials (includes views on group homes in neighborhoods).
9/22 - 9/23	Committee Work Session.
10/23	Committee Work Session.
11/18	Committee Work Session.
11/25	Committee Work Session.
12/2	Committee Work Session.
12/8	Committee Work Session.
12/16	Committee Work Session.

CHAPTER IV

RECOMMENDED LEGISLATION

THE MARYLAND STATE DEINSTITUTIONALIZATION AUTHORITY

This legislation establishes the State's Deinstitutionalization policy and creates within the Executive Department a State Deinstitutionalization Authority, headed by a "Policy Coordinator" appointed by the Governor, to establish a Comprehensive State Deinstitutionalization Plan (CSDP) and to oversee its implementation. The Authority is empowered to develop a consolidated State Deinstitutionalization Budget consistent with the CSDP. The consolidated budget for deinstitutionalization will be recommended to the Governor by the Authority.

The Authority will have the power to coordinate deinstitutionalization programs and functions throughout the State and facilitate their implementation through the administration of a deinstitutionalization program managers committee. Further, the Authority will identify and resolve policies or activities in various agencies that conflict, duplicate, or overlap, and ultimately achieve a single entry point for access to community-based services for the mentally ill, mentally retarded, and the developmentally disabled.

The legislation provides that the duration of the Authority shall be four years and that the Secretaries of designated State departments shall comprise its membership. The Authority is designated as the coordinating body for existing functions and services relating to Deinstitutionalization and is therefore not intended as a new layer of bureaucracy. The legislation is intended to reduce costs and increase efficiency by providing an interagency approach to development of deinstitutionalization and associated service delivery.

Typed by bb/Lawson
Proofread by _____
Corrected by _____
Checked by _____

By: Chairman, Joint Oversight Committee on Deinstitutionalization

A BILL ENTITLED

AN ACT concerning

The Maryland State Deinstitutionalization Authority

For the purpose of creating the Maryland State Deinstitutionalization Authority; providing that the Authority shall have certain powers relating to deinstitutionalization in this State; providing that there shall be a Comprehensive State Deinstitutionalization Plan; defining terms; and generally relating to administration of deinstitutionalization in this State.

BY adding to

Article - Health - General
Section 10-1A-01 through 10-1A-13, inclusive, to be under the new subtitle "Subtitle 1A. Deinstitutionalization"
Annotated Code of Maryland
(As enacted by Chapter ____ (H.B. 200) of the Acts of the General Assembly of 1982)

BY adding to

Article 41 - Governor - Executive and Administrative Departments
Section 486(e)
Annotated Code of Maryland
(1978 Replacement Volume and 1981 Supplement)

Preamble

WHEREAS, The law requires the Mental Retardation and Developmental Disabilities Administration to prepare a plan for the placement in the least restrictive setting of residents in its State institutions over a 3-year period; and

---

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter stricken from existing law.
Numerals at right identify computer lines of text.

WHEREAS, There is a need to monitor and coordinate the development of community services and to ensure that:

(1) The task of determining the number of mentally retarded people who may function appropriately in less restrictive facilities is completed by July 1, 1982; and

(2) An assessment of the number, type, and location of alternative facilities needed in the community for the habilitation of mentally retarded persons, a detailed list of resources and procedures necessary to create alternative facilities, accompanied by an analysis of the feasibility of transferring resources from State to community facilities is compiled by July 1, 1983; and

(3) A summary of the individualized program plans (IPPs) with a proposed schedule to relocate residents for whom the IPPs indicate a less restrictive placement is appropriate is completed by July 1, 1984; and

WHEREAS, The Mental Retardation and Developmental Disabilities Administration (MRDDA) is authorized to transfer positions and funds from State institutions to its Central Administration to accomplish the deinstitutionalization goals; and

WHEREAS, Many local governments have expressed support of deinstitutionalization provided that the State is committed to providing the costs of expanding alternative living arrangements and developing the network of services required; and

WHEREAS, There is a recognized need to establish a client data system for MRDDA, and lack of such a system is one of the impediments to deinstitutionalization; and

WHEREAS, Under the Mental Hygiene Administration's proposed 10-year plan a reduction of 800 patients is projected in State mental health facilities; and

WHEREAS, The General Assembly recognizes certain stumbling blocks to deinstitutionalization in this State including:

(1) The absence of high level responsibility and accountability for a deinstitutionalization process; (2) the lack of overall planning; (3) the lack of internal coordination within the Department of Health and Mental Hygiene, and the lack of external coordination with other service providers and departments; (4) the fragmentation of

funding and the lack of substantial new money required to develop continuum of care programs which must be in place before large numbers of people can be moved out of institutions; (5) the absence of hard data pertaining to the needs of the institutionalized population, and the number and needs of those in the community who are not receiving services; and (6) the conflicting pressure to upgrade existing facilities while, at the same time, deinstitutionalizing people; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That section(s) of the Annotated Code of Maryland (as enacted by Chapter ____ (H.B. 200) of the Acts of the General Assembly of 1982) read(s) as follows:

Article - Health - General

SUBTITLE 1A. DEINSTITUTIONALIZATION

10-1A-01. PURPOSE.

(A) IT IS THE POLICY OF THE STATE OF MARYLAND THAT PERSONS WHO ARE MENTALLY ILL, MENTALLY RETARDED, OR DEVELOPMENTALLY DISABLED SHOULD RESIDE IN COMMUNITY-BASED FACILITIES AND HAVE ACCESS TO INDEPENDENT LIVING ARRANGEMENTS RATHER THAN BE CONFINED IN STATE INSTITUTIONS OR RESTRICTIVE INSTITUTIONAL ENVIRONMENTS.

(B) (1) THE GENERAL ASSEMBLY RECOGNIZES A NEED TO PROVIDE ADEQUATE AND APPROPRIATE COMMUNITY-BASED CONTINUUM OF CARE SERVICES TO MEET THE DAILY LIVING NEEDS OF DEINSTITUTIONALIZED PERSONS.

(2) IT IS UNDERSTOOD THAT SUFFICIENT FUNDING FOR COORDINATION AND DEVELOPMENT OF COMMUNITY-BASED CONTINUUM OF CARE SERVICES AND INDEPENDENT LIVING ARRANGEMENTS MUST BE PROVIDED TO FACILITATE THE STATE'S DEINSTITUTIONALIZATION POLICY.

(C) THE GENERAL ASSEMBLY FINDS THAT ESTABLISHMENT OF COMMUNITY-BASED CONTINUUM OF CARE SERVICES FOR DEINSTITUTIONALIZED PERSONS REQUIRES:

(1) AN INTERAGENCY COMMITMENT OF RESOURCES AND PERSONNEL;

(2) THE DEVELOPMENT OF ADMINISTRATIVE POLICIES AND PLANS COMPATIBLE WITH AND SUPPORTIVE OF A PROGRAM OF DEINSTITUTIONALIZATION; AND

(3) PROVISIONS OF LAW SUFFICIENT TO SUSTAIN AND REINFORCE THIS DECLARATION OF STATE DEINSTITUTIONALIZATION POLICY.

(D) THE PURPOSE OF THIS SUBTITLE IS CONSISTENT WITH THE POLICY GOVERNING INTERAGENCY COOPERATION AND PROVIDING THAT THE HEADS OF THE PRINCIPAL DEPARTMENTS SHALL, UNDER THE DIRECTION OF THE GOVERNOR, BE RESPONSIBLE FOR THE COORDINATION OF PROGRAMS AND ACTIVITIES WITHIN AND BETWEEN PRINCIPAL DEPARTMENTS FOR THE ELIMINATION AND PREVENTION OF DUPLICATION AND OVERLAPPING OF PROGRAMS, ACTIVITIES, AND SERVICES WITHIN AND AMONG THEIR RESPECTIVE DEPARTMENTS.

10-1A-02. DEFINITIONS.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED:

(B) "AUTHORITY" MEANS THE MARYLAND STATE DEINSTITUTIONALIZATION AUTHORITY CREATED UNDER THIS SUBTITLE.

(C) "DEINSTITUTIONALIZATION" MEANS:

(1) PREVENTING UNNECESSARY ADMISSIONS TO AND RETENTION OF PEOPLE IN LARGE STATE HOSPITALS;

(2) FINDING AND DEVELOPING APPROPRIATE ALTERNATIVES IN THE COMMUNITY FOR DAILY LIVING; AND

(3) IMPROVING CONDITIONS, CARE, AND TREATMENT FOR THOSE WHO NEED TO BE IN INSTITUTIONS.

(D) "PROGRAM MANAGERS" MEANS EMPLOYEES WITHIN THE APPROPRIATE DEPARTMENTS WHO ARE DIRECTLY RESPONSIBLE FOR IMPLEMENTATION OF PROGRAMS AND POLICIES RELATING TO DEINSTITUTIONALIZATION.

(E) "POLICY COORDINATOR" MEANS THE CHIEF EXECUTIVE AND SECRETARY OF THE MARYLAND STATE DEINSTITUTIONALIZATION AUTHORITY.

10-1A-03. AUTHORITY CREATED.

THERE IS A MARYLAND STATE DEINSTITUTIONALIZATION AUTHORITY WITHIN THE EXECUTIVE DEPARTMENT.

10-1A-04. DURATION.

SUBJECT TO THE PROVISIONS OF ARTICLE 41, §§ 484 THROUGH 489, OF THE CODE, THE PROVISIONS OF THIS SUBTITLE CREATING THE MARYLAND STATE DEINSTITUTIONALIZATION AUTHORITY AND

RELATING TO THE REGULATION OF DEINSTITUTIONALIZATION AND ANY REGULATIONS PROMULGATED UNDER THIS SUBTITLE ARE OF NO EFFECT AND MAY NOT BE ENFORCED AFTER JULY 1, 1986.

10-1A-05. POLICY COORDINATOR; POWERS, DUTIES.

(A) THE HEAD OF THE MARYLAND STATE DEINSTITUTIONALIZATION AUTHORITY IS THE POLICY COORDINATOR WHO SHALL BE APPOINTED BY THE GOVERNOR.

(B) THE POLICY COORDINATOR SHALL:

(1) SERVE AT THE PLEASURE OF THE GOVERNOR AND REPORT DIRECTLY TO THE GOVERNOR;

(2) RECEIVE THE SALARY PROVIDED IN THE STATE BUDGET; AND

(3) EXERCISE THE POWERS, DUTIES, AND RESPONSIBILITIES OF OFFICE PROVIDED IN THIS SUBTITLE.

10-1A-06. MEMBERSHIP.

(A) THE AUTHORITY SHALL CONSIST OF THE SECRETARIES OF THE DEPARTMENTS OF:

(1) BUDGET AND FISCAL PLANNING;

(2) ECONOMIC AND COMMUNITY DEVELOPMENT;

(3) EDUCATION;

(4) HEALTH AND MENTAL HYGIENE;

(5) HUMAN RESOURCES;

(6) PERSONNEL; AND

(7) STATE PLANNING.

(B) THE GOVERNOR SHALL APPOINT 2 ADDITIONAL MEMBERS TO SERVE 4 YEAR TERMS.

(C) THE POLICY COORDINATOR OF THE AUTHORITY SHALL BE A MEMBER AS PROVIDED IN THIS SUBTITLE.

(D) WITH THE EXCEPTION OF THE POLICY COORDINATOR, AN APPOINTED MEMBER OF THE AUTHORITY SERVES WITHOUT COMPENSATION AND IS ENTITLED TO REIMBURSEMENT FOR EXPENSES IN ACCORDANCE WITH THE STANDARD STATE TRAVEL REGULATIONS.

10-1A-07. MEETINGS OF STATE AUTHORITY; OFFICERS.

(A) EACH YEAR, THE AUTHORITY SHALL HOLD AT LEAST 4 MEETINGS, WHICH SHALL OCCUR NOT MORE THAN 3 MONTHS APART.

(B) (1) THE AUTHORITY MAY HOLD SPECIAL MEETINGS AS NECESSARY.

(2) THE POLICY COORDINATOR SHALL ATTEND EACH MEETING OF THE AUTHORITY AND OF ITS COMMITTEES, EXCEPT WHEN THE TENURE, SALARY, OR THE ADMINISTRATION OF THE POLICY COORDINATOR'S OFFICE IS UNDER CONSIDERATION.

(C) THE AUTHORITY SHALL BE PROVIDED WITH ADEQUATE PERSONNEL AND FUNDING TO CARRY OUT THE FUNCTIONS OF THIS OFFICE.

10-1A-08. POWERS AND DUTIES OF THE STATE DEINSTITUTIONALIZATION AUTHORITY.

(A) IN ADDITION TO THE OTHER POWERS GRANTED AND DUTIES IMPOSED UNDER THIS SUBTITLE, THE AUTHORITY HAS THE POWERS AND DUTIES SET FORTH IN THIS SECTION.

(B) THE AUTHORITY SHALL:

(1) ESTABLISH THE COMPREHENSIVE STATE DEINSTITUTIONALIZATION PLAN (CSDP) DURING THE FIRST 6 MONTHS OF THE AUTHORITY'S EXISTENCE AND SHALL BEGIN IMPLEMENTATION OF THE PLAN NO LATER THAN 1 YEAR FROM THE EFFECTIVE DATE OF THIS SUBTITLE;

(2) CAUSE TO BE CARRIED OUT THOSE PROVISIONS OF THIS SUBTITLE THAT ARE WITHIN ITS JURISDICTION.

(C) THE AUTHORITY SHALL ADOPT BYLAWS, RULES, AND REGULATIONS FOR THE ADMINISTRATION OF THE AUTHORITY.

(D) THESE BYLAWS, RULES, AND REGULATIONS HAVE THE FORCE OF LAW WHEN ADOPTED AND PUBLISHED.

(E) THE AUTHORITY SHALL:

(1) DETERMINE THE DEINSTITUTIONALIZATION NEEDS OF THIS STATE;

(2) COORDINATE ALL ACTIVITIES RELATED TO DEINSTITUTIONALIZATION WITHIN THE STATE;

(3) RECOMMEND TO THE GOVERNOR AND THE GENERAL ASSEMBLY ANY LEGISLATION THAT IT CONSIDERS NECESSARY;

(4) TO THE EXTENT PRACTICABLE, CONSULT WITH EACH AGENCY THAT IS AFFECTED DIRECTLY BY ITS ACTIONS AND RECOMMENDATIONS BEFORE TAKING FINAL ACTION;

(F) ON THE RECOMMENDATION OF THE POLICY COORDINATOR, THE AUTHORITY MAY:

(1) ESTABLISH A SINGLE ENTRY POINT FOR THOSE COMMUNITY-BASED CONTINUUM OF CARE PROGRAMS NECESSARY TO SUPPORT DEINSTITUTIONALIZATION;

(2) SECURE, COMPILE, AND EVALUATE INFORMATION ON ANY MATTER WITHIN ITS AUTHORITY, ON THE FORMS IT REQUIRES, FROM ANY PERSON, AGENCY, OR INSTITUTION IN THE STATE.

10-1A-9. COMPREHENSIVE STATE DEINSTITUTIONALIZATION PLAN.

(A) THE COMPREHENSIVE STATE DEINSTITUTIONALIZATION PLAN (CSDP) SHALL:

(1) (I) SET FORTH BOTH LONG AND SHORT RANGE OBJECTIVES AND PRIORITIES FOR DEINSTITUTIONALIZATION AND METHODS AND GUIDELINES FOR ACHIEVING AND MAINTAINING THEM; AND

(II) IDENTIFY THE ROLE, FUNCTION, AND MISSION OF EACH INSTITUTION AND AGENCY RESPONSIBLE FOR DEINSTITUIONALIZED PERSONS IN THIS STATE.

(2) INCLUDE SPECIFIC PROGRAM AND BUDGET PROJECTIONS, NEEDS ASSESSMENTS, AND GENERAL ADMINISTRATIVE POLICY CONSIDERATIONS REGARDING DEINSTITUTIONALIZATION IN THIS STATE;

(3) DEVELOP AND COORDINATE THE CONSOLIDATED DEINSTITUTIONALIZATION BUDGET AS PROVIDED IN THIS SUBTITLE.

(B) THE PLAN SHALL PROVIDE A MECHANISM FOR COORDINATING THE FISCAL RESOURCES, PERSONNEL, PROGRAMS AND FUNCTIONS OF APPROPRIATE STATE DEPARTMENTS TO IMPLEMENT DEINSTITUTIONALIZATION IN THIS STATE.

(C) THE COMPREHENSIVE STATE DEINSTITUTIONALIZATION PLAN DEVELOPED BY THE AUTHORITY SHALL BE ADOPTED BY THE APPROPRIATE DEPARTMENT SECRETARIES AS THE OFFICIAL PLAN GOVERNING THE FUNCTIONS, DUTIES, AND PROGRAMS OF THE RESPECTIVE STATE DEPARTMENTS.

10-1A-10. CONSOLIDATED STATE DEINSTITUTIONALIZATION BUDGET.

(A) ON OR BEFORE A DATE SET BY THE AUTHORITY, EACH OF THE FOLLOWING AGENCIES SHALL SUBMIT TO THE BOARD ITS ANNUAL

OPERATING BUDGET REQUESTS AND PROPOSALS FOR CAPITAL PROJECTS FOR THE NEXT FISCAL YEAR:

(1) THE DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT;

(2) THE DEPARTMENT OF EDUCATION;

(3) THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE;

(4) THE DEPARTMENT OF HUMAN RESOURCES;

(5) THE DEPARTMENT OF PERSONNEL; AND

(6) ANY OTHER DEPARTMENT DESIGNATED BY THE AUTHORITY.

(B) IN CONSULTATION WITH THE DEPARTMENT OF BUDGET AND FISCAL PLANNING, THE MARYLAND STATE DEINSTITUTIONALIZATION AUTHORITY SHALL:

(1) REVIEW THE OPERATING BUDGET REQUESTS SUBMITTED TO IT; AND

(2) DEVELOP AND PRESENT TO THE GOVERNOR, ON OR BEFORE A DATE SET BY HIM, FOR HIS REVIEW, A CONSOLIDATED OPERATING BUDGET FOR DEINSTITUTIONALIZATION THAT INCLUDES THE OPERATING BUDGET REQUESTS OF THE AGENCIES AND INSTITUTIONS RESPONSIBLE FOR DEINSTITUTIONALIZATION PROGRAMS.

(C) THE REVIEW AND RECOMMENDATIONS OF THE AUTHORITY SHALL BE CONSISTENT WITH THE COMPREHENSIVE STATE DEINSTITUTIONALIZATION PLAN.

(D) THE AUTHORITY MAY NOT REDUCE, INCREASE, OR MODIFY THE OPERATING BUDGET REQUESTS OF THESE INSTITUTIONS AND AGENCIES, BUT SHALL INCLUDE ANY RECOMMENDATIONS AS TO THEM WHEN IT SUBMITS THE CONSOLIDATED OPERATING BUDGET FOR DEINSTITUTIONALIZATION.

(E) IN COOPERATION WITH THE DEPARTMENT OF STATE PLANNING, AND WITHOUT AFFECTING THE AUTHORITY OR RESPONSIBILITY OF THAT DEPARTMENT UNDER ARTICLE 88C OF THE CODE, THE MARYLAND STATE DEINSTITUTIONALIZATION AUTHORITY SHALL:

(1) REVIEW PROPOSALS FOR CAPITAL PROJECTS AND IMPROVEMENTS PROPOSED BY THE STATE AGENCIES AND BY PRIVATE AGENCIES SEEKING STATE FUNDS FOR CAPITAL PROJECTS AND IMPROVEMENT; AND

(2) DEVELOP AND SUBMIT TO THE GOVERNOR AND THE GENERAL ASSEMBLY RECOMMENDATIONS AS TO THESE PROJECTS, WHICH SHALL BE CONSISTENT WITH THE COMPREHENSIVE STATE DEINSTITUTIONALIZATION PLAN PROVIDED FOR IN THIS SUBTITLE.

10-1A-11. DEINSTITUTIONALIZATION PROGRAM MANAGERS COMMITTEE.

(A) IT IS THE RESPONSIBILITY OF THE MEMBERS OF THE AUTHORITY TO PROVIDE FOR IMPLEMENTATION OF THE PROVISIONS OF THIS SUBTITLE.

(B) THE AUTHORITY SHALL ESTABLISH A COMMITTEE OF DEINSTITUTIONALIZATION PROGRAM MANAGERS UNDER THE DIRECTION OF THE POLICY COORDINATOR.

(C) THE COMMITTEE CONSISTS OF THE PROGRAM MANAGERS OF EACH EXECUTIVE DEPARTMENT, AGENCY, OR POLITICAL SUBDIVISION DESIGNATED BY THE AUTHORITY WHO ARE CHARGED WITH IMPLEMENTING SPECIFIC FUNCTIONS AND DUTIES RELATING TO DEINSTITUTIONALIZATION IN THE RESPECTIVE EXECUTIVE DEPARTMENTS.

(D) THE COMMITTEE OPERATES AS AN INTERAGENCY OPERATIONAL POLICY BODY AND IS DIRECTLY RESPONSIBLE FOR DEVELOPING AND COORDINATING DEINSTITUTIONALIZATION OPERATIONS, PROGRAMS, SERVICES, AND FUNCTIONS COMMENSURATE WITH THE COMPREHENSIVE STATE DEINSTITUTIONALIZATION PLAN.

(E) THE COMMITTEE SHALL COORDINATE ACTIVITIES WITH POLITICAL SUBDIVISIONS AND PERFORM LIAISON FUNCTIONS NECESSARY TO ESTABLISH LOCAL COMMUNITY-BASED DEINSTITUTIONALIZATION PROGRAMS INCLUDING:

(1) PROVIDING FOR THE ADMINISTRATION OF A LOCAL FINANCING ARRANGEMENT SUFFICIENT TO SUPPORT SERVICES AND PROGRAMS RELATING TO DEINSTITUTIONALIZATION;

(2) PROVIDING FOR DEVELOPMENT OF COMMUNITY-BASED RESIDENTIAL FACILITIES AND SUPPORT SERVICES;

(3) PROVIDING TECHNICAL ASSISTANCE TO DESIGNATED LOCAL OFFICIALS; AND

(4) PROVIDING FOR A SINGLE ENTRY POINT FOR ACCESS TO SERVICES AND PROGRAMS FOR DEINSTITUTIONALIZED PERSONS.

10-1A-12. REPORT.

THE AUTHORITY SHALL SUBMIT AN ANNUAL REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY ON THE ACTIVITIES OF THE

AUTHORITY WITH RESPECT TO DEINSTITUTIONALIZATION AND THE STATUS OF DEINSTITUTIONALIZATION IN THIS STATE.

10-1A-13. ENFORCEMENT.

(A) THE AUTHORITY MAY INSTITUTE LEGAL PROCEEDINGS TO ENFORCE:

(1) THE PROVISIONS OF THIS SUBTITLE THAT ARE WITHIN ITS JURISDICTION; AND

(2) THE BYLAWS, RULES, AND REGULATIONS ADOPTED BY THE AUTHORITY.

(B) THE GOVERNOR MAY INCLUDE IN THE BUDGET BILL THE AMOUNTS RECOMMENDED BY THE AUTHORITY IN THE CONSOLIDATED DEINSTITUTIONALIZATION BUDGET TO BE ADMINISTERED BY THE RESPECTIVE DEPARTMENTS.

SECTION 2. AND BE IT FURTHER ENACTED, That section(s) of the Annotated Code of Maryland read(s) as follows:

Article 41 - Governor - Executive and Administrative Departments

486.

(E) THE MARYLAND STATE DEINSTITUTIONALIZATION AUTHORITY (ARTICLE HEALTH - GENERAL, § 10-1A-03) AND RELATED STATUTES AND REGULATIONS SHALL BE EVALUATED BY JULY 1, 1986.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 1982.

SENATE JOINT RESOLUTION No. 61
(11r3893) 33

Introduced by Senators Rasmussen and Bishop (Joint Oversight Committee on Deinstitutionalization)

Read and Examined by Proofreader:

_____
Proofreader.

_____
Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this_____ day of_____ at_____o'clock,_____M.

_____
President.

RESOLUTION NO. _____

A Senate Joint Resolution concerning

Deinstitutionalization

FOR the purpose of recognizing deinstitutionalization as a high priority of the State.

WHEREAS, The Maryland General Assembly's Legislative Policy Committee established the Joint Oversight Committee on Deinstitutionalization for the purpose of conducting a review and evaluation of deinstitutionalization in the mental hygiene and mental retardation programs in the State of Maryland. This issue is of deep concern to the legislature and remains the number one priority of the Department of Health and Mental Hygiene; and

WHEREAS, Deinstitutionalization defined as the process of preventing both unnecessary admission to and retention of people in large State hospitals, finding and developing appropriate alternatives in the community for housing, treatment, training, education, and rehabilitation of persons who do not need to be in State hospitals, and improving conditions, care and treatment for those who need to be in hospitals, focuses on people and humane programs for Maryland citizens rather than on places for people; and

---

EXPLANATION:
Underlining indicates amendments to bill.
~~Strike--out~~ indicates matter stricken by amendment.

WHEREAS, Several major stumbling blocks to the development of a deinstitutionalization process for Maryland continually surfaced in the testimony received by the Joint Committee and including (1) the absence of high level responsibility and accountability for a deinstitutionalization process; (2) the lack of overall planning; (3) the lack of internal coordination within the Department of Health and Mental Hygiene, and the lack of external coordination with other service providers and Departments; (4) the fragmentation of funding and the lack of substantial new money required to develop continuum of care programs which must be in place before large numbers of people can be moved out of institutions; (5) the absence of hard data pertaining to the needs of the institutionalized population, and the number and needs of those in the community who are not receiving services; and (6) the conflicting pressure to upgrade existing facilities while, at the same time, deinstitutionalizing people; and

WHEREAS, Before any major change can occur, there must be high level commitment to deinstitutionalization and responsibility for implementation, planning and coordination; now, therefore, be it

RESOLVED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Governor and the Legislature recognize deinstitutionalization as a high State priority; and be it further

RESOLVED, That copies of this Resolution be sent to the Honorable Harry Hughes, Governor; the Honorable Benjamin L. Cardin, Speaker of the House of Delegates; the Honorable James Clark, President of the Senate of Maryland, and Secretary Charles R. Buck, Jr., Department of Health and Mental Hygiene, 210 West Preston Street, Baltimore, Maryland 21201; and Secretary Kalman R. Hettleman, Department of Human Resources, 1100 North Eutaw Street, Baltimore, Maryland 21201.

Approved:

_____
Governor.

_____
President of the Senate.

_____
Speaker of the House of Delegates.

HOUSE JOINT RESOLUTION No. 99

11r3892 33

By: Delegate Pesci (Joint Oversight Committee on Deinstitutionalization)
Introduced and read first time: February 27, 1981
Assigned to: Ways and Means

Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 31, 1981

RESOLUTION NO. _____

HOUSE JOINT RESOLUTION

A House Joint Resolution concerning

Deinstitutionalization

FOR the purpose of recognizing deinstitutionalization as a high priority of the State.

WHEREAS, The Maryland General Assembly's Legislative Policy Committee established the Joint Oversight Committee on Deinstitutionalization for the purpose of conducting a review and evaluation of deinstitutionalization in the mental hygiene and mental retardation programs in the State of Maryland. This issue is of deep concern to the legislature and remains the number one priority of the Department of Health and Mental Hygiene; and

WHEREAS, Deinstitutionalization defined as the process of preventing both unnecessary admission to and retention of people in large State hospitals, finding and developing appropriate alternatives in the community for housing, treatment, training, education, and rehabilitation of persons who do not need to be in State hospitals, and improving conditions, care and treatment for those who need to be in hospitals, focuses on people and humane programs for Maryland citizens rather than on places for people; and

WHEREAS, Several major stumbling blocks to the development of a deinstitutionalization process for Maryland continually surfaced in the testimony received by the Joint Committee and including (1) the absence of high level responsibility and accountability for a deinstitutionalization process; (2) the lack of overall planning; (3) the lack of internal coordination within the Department of Health and Mental Hygiene, and the lack of external coordination with other service providers and

---

EXPLANATION:
Underlining indicates amendments to bill.
~~Strike--out~~ indicates matter stricken by amendment.

Departments; (4) the fragmentation of funding and the lack of substantial new money required to develop continuum of care programs which must be in place before large numbers of people can be moved out of institutions; (5) the absence of hard data pertaining to the needs of the institutionalized population, and the number and needs of those in the community who are not receiving services; and (6) the conflicting pressure to upgrade existing facilities while, at the same time, deinstitutionalizing people; and

WHEREAS, Before any major change can occur, there must be high level commitment to deinstitutionalization and responsibility for implementation, planning and coordination; now, therefore, be it

RESOLVED, BY THE GENERAL ASSEMBLY OF MARYLAND, That the Governor and the Legislature recognize deinstitutionalization as a high State priority; and be it further

RESOLVED, That copies of this Resolution be sent to the Honorable Harry Hughes, Governor; the Honorable Benjamin L. Cardin, Speaker of the House of Delegates; the Honorable James Clark, President of the Senate of Maryland, and Secretary Charles R. Buck, Jr., Department of Health and Mental Hygiene, 210 West Preston Street, Baltimore, Maryland 21201; and Secretary Kalman R. Hettleman, Department of Human Resources, 1100 North Eutaw Street, Baltimore, Maryland 21201.

Approved:

_____
Governor.

_____
Speaker of the House of Delegates.

_____
President of the Senate.

HARRY HUGHES
GOVERNOR

STATE OF MARYLAND
EXECUTIVE DEPARTMENT
ANNAPOLIS, MARYLAND 21404

March 4, 1981

The Honorable Frank B. Pesci
203 Lowe House Office Building
Annapolis, Maryland 21401

Dear Delegate Pesci:

When you and members of the Joint Oversight Committee on Deinstitutionalization met with me some time ago, I agreed to consider a joint executive-legislative statement on deinstitutionalization. It has proved to be extraordinarily difficult to draft a proposal for review. A statement that once again simply indicates general approval of the concept can only raise expectations. Without knowing when or how the concept may be implemented, this is not fair to the many Marylanders who are waiting and hoping that people whom they care deeply about can be cared for in different circumstances or with more individual attention.

At the same time, an attempt to define what can be done founders on one uncertainty after another. One of these is action of the General Assembly itself on the budget, both with respect to positions in our institutions and community service moneys. Another is President Reagan's proposed five percent cap on growth in Medicaid. If imposed, this can have a serious effect on support we have counted on for community residences for the retarded that would be licensed as ICF-MR facilities. Other Federal cuts may influence availability of a variety of generic support services needed by clients newly living in the community.

Secretary Buck proposes to devote staff and management time in early FY 82 to a review of State concern for deinstitutionalization. This has shown up in departmental priority lists for many years, properly in a very broad context across the Department. What are the implications of the no-growth (inflationary costs only) or limited increment budgets that many are predicting for the 80's? How can the State respond?

I would like the results of this review before proposing an Executive statement on deinstitutionalization. Accordingly, I will respond considerably later than we both expected originally to the desires of the Joint Committee. It is my hope that the delay will permit articulation of policy options based on sufficient detail to offer reasonable grounds for decision.

Sincerely,

Harry Hughes

Governor

HARRY HUGHES
GOVERNOR

STATE OF MARYLAND
EXECUTIVE DEPARTMENT
ANNAPOLIS, MARYLAND 21404

November 23, 1981

The Honorable Frank B. Pesci, Sr.
Chairman
The Joint Committee on
Deinstitutionalization
Lowe House Office Building
Annapolis, Maryland 21401

Dear Chairman Pesci:

The Joint Committee on Deinstitutionalization has expressed a strong interest in receiving a formal executive statement on deinstitutionalization. I have delayed forwarding such a statement to the Committee in the hope that additional specificity about the State's commitment would be possible. Although we are still operating in an environment of fiscal uncertainty, important forward steps have been taken in the months since my last correspondence with you, both as to long-term plans and decisions about immediate State action.

The Mental Retardation and Developmental Disabilities Administration has pursued an analysis of the mentally retarded population to plan for a community-based model based on hours of service required for individuals. Given the possible shortcomings of extrapolation from a sample study (the findings of which have previously been shared with Committee staff), we now have a good sense of the resources in dollars and in the numbers of care providers that will be needed if the premise of the plan is followed. The financial increment, however, is substantial -- more than $50 million.

I indicated in my letter of September to members of the General Assembly that after accounting for moneys already committed for the FY 82 budget and for cost-of-living increases for State employees and recipients of public assistance, we can count on very limited funds to mitigate the worst of the Federal cuts and to accommodate any increases in State services or aid programs. I have already determined that the day activity center and associated transportation for the mentally retarded will be held harmless from some $700,000 in Federal

cutbacks. We do not now know the full Federal impact for this year because Congressional budget action is still incomplete. While cutbacks through block grant and entitlement programs have received much attention, the October 1 report from the Office of the Comptroller noted that changes in Federal tax policy are estimated to result in a $34 million decrease in State revenues in FY 83 and even greater decreases in subsequent years.

The above should lead all of us to use the greatest caution in undertaking long-term commitments. At the same time, we should strive for steady progress. Accordingly, I intend to include an increased allocation of $2.5 million in the FY 83 budget to enhance community programs for the mentally ill, mentally retarded and non-retarded but developmentally disabled.

This Committee is aware of the dramatic increase in psychosocial programs in Maryland in the last few years. Based, with local variations, on the Fountain House idea, they provide rehabilitation services for the chronically mentally ill. Their value has been demonstrated, but they are heavily dependent both on volunteers and on very uncertain sources of revenue so I am concerned about on-going quality of care and stability. To provide needed support and also to increase the size of the programs so they can receive fifty more patients from institutions, $700,000 is being provided to the Mental Hygiene Administration.

With respect to the mentally retarded, I am glad to tell you that I propose to close the Henryton Center. The physical plant at Henryton has been considered inadequate for a long time and its isolated location is particularly unsuitable. Over the next three years, the great majority of Henryton residents will be placed in community programs. The plan calls for an immediate freeze on admissions and the closure of a building or wing each year. Those clients most ready for community placement and who already attend day programs in the community will be selected first for community residences. The facility will be finally closed by June, 1985. For the first phase of this effort, I am allocating $646,000.

The plan to close Henryton is part of a short-term action initiative developed at my request by the MRDDA. It is expected that the incremental cost over four years will be $3 million.

When the closure is complete, the community residential network will have increased from an estimated 988 placements the end of this year to 1273. In 1979 that figure was 523. The cost can be modified to the extent the State is able to take advantage of Medicaid Title XIX funding for community services to the retarded. To this end, we will carefully evaluate the implementation plan for such funding to be included in the consultant report from the Kennedy Institute that is due in March.

I would add that all of the employees at Henryton will be offered comparable opportunities in State service as the phase-down occurs. This approach proved extremely effective in the similar closing of the Thomas Wilson Hospital Center.

The two allocations for mental health and the first step to closing Henryton leave a balance of $1.15 million. We are in the final stages of caring for the Sachs population, and the plan submitted to the Court contemplated costs of just over $1 million to complete the last needed residential placements and associated services for clients now in the Phillips Building at Crownsville. Our first obligation is to make this money available.

Based on actual placement and staffing requirements to date, however, we are now convinced that $1.1 million is sufficient to provide important services for people who are now in the community in addition to those mandated for the Sachs population. By a system of sequential initiation of service in FY 83, as experience demonstrates the funds will be in hand, we intend to implement thirty-five new residential placements. These are designed to prevent institutionalization, and ten of them will be designated for the non-retarded developmentally disabled.

Finally, using the same rolling service start, we expect to provide day programs for forty seriously retarded young people who have been in school programs, but have recently turned 21. By virtue of age, they are no longer eligible for education funding. The abrupt loss of guided activity is damaging to the individual and a heavy burden for most families. These efforts, too, will prevent institutional placements.

The program I have outlined does not accommodate all Maryland citizens who could profit by community services. I believe the allocation allows for significant progress with future commitments appropriate to our service system, staff capability and fiscal circumstances. I reiterate my personal support for efforts to avert institutional care, to encourage community placement with appropriate accompanying programs, and to provide compassionate developmental care to those in State institutions. Recognition of these aims will continue to be part of budget development in Maryland.

Sincerely,

Governor

H O U S E O F D E L E G A T E S

11r1783 No. 465 (PRE-FILED) 22

By: Chairman, Special Joint Oversight Committee on Deinstitutionalization

Requested: November 15, 1980

Introduced and read first time: January 14, 1981

Assigned to: Appropriations

A BILL ENTITLED

AN ACT concerning

Local Health Services - Method of Financing

FOR the purpose of establishing a new formula for the financing of local health services in the counties and Baltimore City; stating the services and programs to be funded by the formula; establishing manpower ratios for local health services; providing for determination of estimated basic community health services budgets for each jurisdiction; fixing the share of the estimated budgets of all jurisdictions between the State and local governments; providing that the counties and Baltimore City shall pay an adjusted share of the local estimated health budgets; providing for certain guaranteed levels of funding of these services, and for the limited duration of this Act; providing for the method of financing of local health services; and generally relating to the method of financing of local health services.

BY adding to

Article 43 - Health
Section 948 through 952, inclusive, to be under the new subtitle "Local Health Financing"
Annotated Code of Maryland
(1980 Replacement Volume and 1980 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That section(s) of the Annotated Code of Maryland be repealed, amended, or enacted to read as follows:

Article 43 - Health

LOCAL HEALTH FINANCING

948. -

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
Numerals at right identify computer lines of text.

(A) BEGINNING WITH THE STATE'S 1982 FISCAL YEAR AND EACH FISCAL YEAR THEREAFTER, A SINGLE FINANCING FORMULA SHALL BE USED FOR THE PURPOSE OF DETERMINING THE BASIS OF SHARING OF THE COST OF CERTAIN HEALTH SERVICES PROVIDED BY THE COUNTIES OF THE STATE AND BALTIMORE CITY.

(B) THIS FORMULA SHALL FIX THE RESPONSIBILITY OF THE STATE AND THE COUNTIES AND BALTIMORE CITY FOR FUNDING OF THE BASIC COMMUNITY HEALTH SERVICES DESCRIBED IN SECTION 949 OF THIS SUBTITLE.

949.

THE BASIC COMMUNITY HEALTH SERVICES AND THE PROGRAMS WITHIN EACH BASIC SERVICE WHICH ARE TO BE FUNDED BY THE SINGLE FINANCING FORMULA ARE DESCRIBED AS FOLLOWS:

(1) GENERAL COMMUNITY HEALTH SERVICES INCLUDES PROGRAMS FOR GENERAL ADMINISTRATION, COMMUNITY HEALTH NURSING, EPIDEMIOLOGY, VITAL STATISTICS, HEALTH EDUCATION, NUTRITION, SOCIAL SERVICES, EMERGENCY SERVICES, HEALTH PLANNING, OCCUPATIONAL THERAPY, PHYSICAL THERAPY, SPEECH PATHOLOGY, AUDIOLOGY, HEALTH EMPLOYEE TRAINING, AND LABORATORY SERVICES.

(2) PERSONAL HEALTH SERVICES INCLUDES PROGRAMS FOR CHILD HEALTH, SCHOOL HEALTH, CRIPPLED CHILDREN, DENTAL HEALTH, GROUP DAY CARE LICENSING, MATERNAL HEALTH (INCLUDING RAPE), FAMILY PLANNING, MENTAL RETARDATION (INCLUDING DEVELOPMENTAL DISABILITIES), HOSPITAL DISCHARGE PLANNING, ZOONOSIS, OCCUPATIONAL HEALTH, CHRONIC DISEASE, HYPERTENSION, CANCER SCREENING, GERIATRIC EVALUATION SERVICES, HOME HEALTH SERVICES, TUBERCULOSIS, VENEREAL DISEASE, COMMUNICABLE DISEASE, MENTAL HEALTH, ALCOHOLISM, DRUG ABUSE, ADULT HEALTH SERVICES, AND OTHER DIRECT HEALTH SERVICES.

(3) ENVIRONMENTAL HEALTH SERVICES INCLUDES PROGRAMS FOR FOOD PROTECTION, PUBLIC AND RECREATIONAL FACILITIES, HOUSING SANITATION, VECTOR CONTROL, HEALTH CARE/FAMILY CARE FACILITIES, COMMUNITY SANITATION, SOLID WASTE, PUBLIC SEWAGE AND WATER SUPPLY, AIR QUALITY, NOISE POLLUTION, RADIATION/HAZARDOUS PRODUCTS, STREAM/RIVER SURVEY, AND CONSUMER PRODUCT SAFETY.

950.

(A) THE SINGLE FINANCING FORMULA FOR BASIC COMMUNITY HEALTH SERVICES IS BASED ON THE USE OF MANPOWER RATIOS IN DEVELOPING AN ESTIMATE OF THE NEED FOR BASIC COMMUNITY HEALTH SERVICES IN EACH OF THE COUNTIES AND BALTIMORE CITY.

(B) THE FOLLOWING MANPOWER RATIOS WILL BE CALCULATED FOR EACH OF THE COUNTIES AND BALTIMORE CITY:

(1) EXECUTIVE DIRECTION

1 HEALTH OFFICER PER SUBDIVISION

(2) GENERAL HEALTH SERVICES

1 PHYSICIAN D PER 50,000 PLUS POPULATION

1 SANITARIAN III PER 7,000 POPULATION

1 COMMUNITY HEALTH NURSE III PER 3,000 POPULATION

(3) MENTAL HEALTH SERVICES

1 MENTAL HEALTH PROFESSIONAL PER 20,000 POPULATION

1 MENTAL HEALTH ASSOCIATE II PER 5,000 POPULATION

(4) MENTAL RETARDATION SERVICES

1 COORDINATOR, SPECIAL PROGRAMS III PER 7,500 POPULATION

(5) ADDICTION SERVICES

1 ALCOHOLISM COORDINATOR I PER 35,000 POPULATION

1 ALCOHOLISM COUNSELOR II PER 10,000 POPULATION

1 DRUG ABUSE COORDINATOR I PER 50,000 POPULATION

1 DRUG ABUSE COUNSELOR II PER 10,000 POPULATION

(6) ADMINISTRATION AND PROFESSIONAL SERVICES

1 ADMINISTRATIVE OFFICER I PER 50,000 POPULATION

1 STENOGRAPHIC CLERK II PER 10,000 POPULATION

1 PROFESSIONAL SUPPORT SPECIALIST III PER 25,000 POPULATION

951.

(A) AN ESTIMATED BASIC COMMUNITY HEALTH SERVICE BUDGET IS CALCULATED ANNUALLY FOR EACH COUNTY AND BALTIMORE CITY BY MEANS OF THE STEPS IN THIS SECTION.

(B) COMPUTE THE MANPOWER RATIOS REQUIRED BY SECTION 950 USING THE ESTIMATED TOTAL POPULATION FOR JANUARY 1 FOLLOWING THE BEGINNING OF EACH FISCAL YEAR TO PRODUCE AN ESTIMATED MANPOWER YIELD. THE ESTIMATED POPULATION SHALL BE DETERMINED BY THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE PRIOR TO THE SUBMISSION OF THE ANNUAL STATE BUDGET FOR THE FISCAL YEAR.

(C) (1) MULTIPLY THE ESTIMATED MANPOWER YIELD BY THE AVERAGE SALARY FOR EACH OF THE MANPOWER RATIOS TO PRODUCE A TOTAL SALARY DOLLAR ESTIMATE. THE AVERAGE SALARY AS USED IN THIS SUBSECTION IS FOR THE PURPOSE OF DETERMINING FUNDING ONLY AND DOES NOT REQUIRE ANY COUNTY OR BALTIMORE CITY TO MAINTAIN ANY AVERAGE SALARY LEVEL.

(2) THE AVERAGE SALARY, EXCEPT AS OTHERWISE STATED IN THIS SUBSECTION, IS THE FIFTH INCREMENT SALARY LEVEL OF THE STATE MERIT SYSTEM PAY PLAN THEN IN EFFECT FOR EACH OF THE MANPOWER RATIOS.

(3) THE AVERAGE SALARY OF A HEALTH OFFICER IN BALTIMORE CITY, AND IN BALTIMORE, ANNE ARUNDEL, PRINCE GEORGE'S, AND MONTGOMERY COUNTIES IS THAT OF A PHYSICIAN F; THE AVERAGE SALARY OF A HEALTH OFFICER IN ALL OTHER COUNTIES IS THAT OF A PHYSICIAN E. THE AVERAGE SALARY OF HEALTH OFFICERS IS FOR PURPOSES OF DETERMINING FUNDING ONLY AND DOES NOT ESTABLISH THE ACTUAL MANDATORY SALARY LEVEL FOR ANY HEALTH OFFICER.

(4) THE AVERAGE SALARY FOR A MENTAL HEALTH PROFESSIONAL IS THE AVERAGE OF THE AVERAGE SALARIES OF A PSYCHIATRIST D, PSYCHOLOGIST II DOCTORATE, SOCIAL WORKER IV, AND A PSYCHIATRIC NURSE II.

(5) THE AVERAGE SALARY OF A PROFESSIONAL SUPPORT SPECIALIST IS THE AVERAGE OF THE AVERAGE SALARIES OF A HEALTH EDUCATOR II, NUTRITIONIST II, PHYSICAL THERAPIST II, OCCUPATIONAL THERAPIST II, SPEECH PATHOLOGIST/AUDIOLOGIST II, AND A SOCIAL WORKER II.

(D) CALCULATE ONE-THIRD OF THE TOTAL SALARY DOLLAR ESTIMATE AS THE OPERATING EXPENSE ESTIMATE.

(E) CALCULATE 22 PERCENT OF THE TOTAL SALARY DOLLAR ESTIMATE AS THE FRINGE BENEFIT COST ESTIMATE.

(F) THE ESTIMATED BASIC COMMUNITY HEALTH SERVICES BUDGET IS THE TOTAL OF THE TOTAL SALARY DOLLAR ESTIMATE, THE OPERATING EXPENSE ESTIMATE, AND THE FRINGE BENEFIT COST ESTIMATE.

952.

(A) THE TOTAL COST OF THE ESTIMATED BASIC COMMUNITY HEALTH SERVICES BUDGETS OF ALL COUNTIES AND BALTIMORE CITY SHALL BE PAYABLE 70 PERCENT BY THE STATE AND 30 PERCENT BY THE COUNTIES AND BALTIMORE CITY.

(B) (1) (I) EACH COUNTY AND BALTIMORE CITY SHALL SHARE IN THE LOCAL COST OF ALL ESTIMATED BASIC COMMUNITY HEALTH SERVICES BUDGETS ACCORDING TO THE ABILITY OF EACH COUNTY AND BALTIMORE CITY TO PAY ITS SHARE.

(II) THE LOCAL SHARE SHALL NOT EXCEED 50 PERCENT OR NOT BE LESS THAN 10 PERCENT.

(2) (I) THE ABILITY OF EACH COUNTY AND BALTIMORE CITY TO PAY ITS SHARE SHALL BE DETERMINED BY COMPARING THE WEALTH OF EACH COUNTY OR BALTIMORE CITY TO THE WEALTH OF ALL OF THE COUNTIES AND BALTIMORE CITY AND APPLYING THIS PERCENTAGE FOR EACH COUNTY AND BALTIMORE CITY TO THE TOTAL LOCAL COST OF THE ESTIMATED BASIC COMMUNITY HEALTH SERVICES BUDGETS OF ALL COUNTIES AND BALTIMORE CITY.

(II) AS USED IN THIS SUBSECTION, THE TERM "WEALTH" IS DETERMINED ACCORDING TO THE PROVISIONS OF SECTION 5-202 OF THE EDUCATION ARTICLE OF THE CODE RELATING TO THE DISTRIBUTION OF STATE AID TO PUBLIC EDUCATION.

(C) (1) THE LOCAL SHARING FACTOR, AS DETERMINED IN SUBSECTION (B)(2) OF THIS SECTION, OF THE TOTAL LOCAL COST OF ALL ESTIMATED BASIC COMMUNITY HEALTH SERVICES BUDGETS SHALL BE APPLIED TO THE ESTIMATED BASIC COMMUNITY HEALTH SERVICES BUDGET DETERMINED FOR EACH COUNTY AND BALTIMORE CITY AND SHALL REPRESENT THE LOCAL SHARE OF THE BUDGET.

(2) (I) THE REMAINDER OF THE ESTIMATED BASIC COMMUNITY HEALTH SERVICES BUDGET FOR ANY COUNTY OR BALTIMORE CITY SHALL BE PAYABLE FROM STATE AND FEDERAL FUNDS APPROPRIATED FOR THIS PURPOSE.

(II) THE AMOUNT OF STATE AND FEDERAL FUNDING FOR ANY COUNTY AND BALTIMORE CITY UNDER THE SINGLE FINANCING FORMULA MAY NOT BE LESS IN ANY FISCAL YEAR THAN THE AMOUNT PAID IN FISCAL YEAR 1980-1981 TO THE COUNTIES OR BALTIMORE CITY FOR BASIC COMMUNITY HEALTH SERVICES FROM FUNDS APPROPRIATED TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

(III) THE INCREASED AMOUNT OF STATE AND FEDERAL FUNDING IN ANY SUCCEEDING FISCAL YEAR FOR ANY COUNTY AND BALTIMORE CITY MAY NOT BE LESS THAN THE 3 YEAR AVERAGE PERCENT INCREASE FOR BASIC COMMUNITY HEALTH SERVICES.

(IV) THE 3 YEAR AVERAGE PERCENT INCREASE SHALL BE BASED ON EACH COUNTY'S AND BALTIMORE CITY'S STATE AND FEDERAL FUND ALLOCATION FOR THE STATE FISCAL YEARS 1980, 1981, AND 1982.

(D) (1) NONE OF THE SERVICES AND PROGRAMS INCLUDED IN BASIC COMMUNITY HEALTH SERVICES IN SECTION 949, WHICH ARE DETERMINED TO BE OF CONTINUING NEED FOR THE MAINTENANCE OF HEALTH SERVICES BY THE SECRETARY OF HEALTH AND MENTAL

HYGIENE, MAY BE ALLOCATED ANY FUNDS BY THE COUNTIES AND BALTIMORE CITY AT AN AMOUNT IN FISCAL YEAR 1982 LESS THAN THE SUMS ALLOCATED IN FISCAL YEAR 1981.

(2) PARAGRAPH (1) OF THIS SUBSECTION (D) MAY NOT BE CONSTRUED TO MEAN THAT THE LEVELS OF SERVICE OF ANY PROGRAMS MUST BE MAINTAINED AT OR ABOVE THE FISCAL YEAR 1980-1981 LEVEL.

(E) (1) ANY ADDITIONAL FUNDS APPROPRIATED TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE MAY BE ALLOCATED TO COMMUNITY HEALTH SERVICES IN EXCESS OF THE BASIC COMMUNITY HEALTH SERVICES GRANT FUNDS DEVELOPED BY THE SINGLE FINANCING FORMULA.

(2) THESE ADDITIONAL FUNDS MAY BE PROVIDED AS SUPPLEMENTAL GRANTS TO INDIVIDUAL SUBDIVISIONS AT THAT INDIVIDUAL SUBDIVISION LOCAL SHARING FACTOR AS DETERMINED IN THE BASIC FORMULA.

(3) THE DEPARTMENT MAY SPECIFY THE PURPOSE OF THESE SUPPLEMENTAL GRANT FUNDS.

(F) (1) THE PROVISIONS OF THIS SUBTITLE MAY NOT BE CONSTRUED TO REQUIRE THE LOCAL GOVERNING BODY TO APPROVE THE EXPENDITURE OF ALL OF THE FUNDS SUGGESTED BY THE SINGLE FINANCING FORMULA.

(2) IF A LOCAL GOVERNING BODY APPROVES LOCAL APPROPRIATIONS LESS THAN THE LOCAL SHARE SUGGESTED BY THE SINGLE FINANCING FORMULA, THE STATE AND FEDERAL APPROPRIATIONS SHALL BE REDUCED FOR THAT FISCAL YEAR BY A PROPORTIONATE AMOUNT AS ESTABLISHED BY THE SHARING RATIO BETWEEN STATE AND FEDERAL, AND LOCAL FUNDING FOR COMMUNITY HEALTH SERVICES IN THAT FISCAL YEAR.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 1981. It shall remain effective for a period of 7 years, and, at the end of June 30, 1988, and, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

FRANK B. PESCI, SR.
LEGISLATIVE DISTRICT 23
PRINCE GEORGE'S COUNTY

ANNAPOLIS OFFICE:
203-B HOUSE OFFICE BUILDING
(301) 269-3232

DISTRICT OFFICE:
8311 FREMONT PLACE
NEW CARROLLTON, MD. 20784
(301) 577-8424

HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

COMMITTEE ON
ENVIRONMENTAL MATTERS

JOINT OVERSIGHT COMMITTEE ON
DEINSTITUTIONALIZATION
CHAIRMAN

LEGISLATIVE ADVISORY COUNCIL
SOUTHERN REGIONAL EDUCATION BOARD

JOINT BUDGET AND AUDIT
COMMITTEE

October 15, 1981

The Honorable R. Clayton Mitchell, Jr.
Chairman, House Appropriations Subcommittee
on Health and the Environment
405 Lowe House Office Building
Annapolis, Maryland 21401

Dear Clay:

I regret not being able to appear personally before the Subcommittee on Wednesday, October 14 when you discussed the subject of Single Financing Formula, but your hearing found me in Lexington, Kentucky.

The financing of public health services in the State of Maryland has been the subject of continued study and discussion since 1950. In 1955 the so-called "Case Formula" was implemented on a trial basis. It not only provided a basis for determining State assistance to local health departments, thus ending the ad hoc procedures previously in effect, but it also brought about a more equitable standard of treatment among the subdivisions.

From time to time during the 1970's the Fiscal Committees expressed concern over the Case Formula. Between 1974 and 1977, work was undertaken to develop an alternative financing mechanism to the Case Formula.

On January 11, 1978, your Subcommittee, under my chairmanship, submitted a report on "The Financing of Local Health Care Services in Maryland." The report called for legislating the establishment of a single financing formula using manpower ratios as the method of developing budgetary estimates, and incorporated the concept that distribution of funds to local subdivisions would be based on equalized assessed property value plus net taxable income.

House Bill 1276 was introduced by the Chairman of the House Committee on Appropriations during the 1978 Session. It received a favorable report in Committee, but was re-referred to the House Ways and Means Committee.

In May of 1979, in a letter from me to Governor Hughes, the Subcommittee again endorsed a single financing formula for local health services. In his response, the Governor said that the additional State support necessary under the proposed new formula gave him pause.

During the 1980 Interim, the Joint Committee on Deinstitutionalization decided to reintroduce the single financing formula bill (House Bill 465). The bill received an unfavorable report in the Appropriations Committee.

On September 22, 1981, the Joint Committee on Deinstitutionalization agreed that it would not resubmit legislation similar to House Bill 465 because this legislation addresses itself to much more than the deinstitutionalization issue. The Joint Committee feels that the House Appropriations Subcommittee on Health and the Environment might wish to consider submitting similar legislation during the 1982 Session. A copy of the 1981 bill is attached.

Sincerely,

FRANK B. PESCI, SR., Chairman
Joint Oversight Committee on
Deinstitutionalization

FBP:bjg

Attachment

cc: Members, Appropriations Subcommittee on Health and the Environment

Presented to the Joint Oversight Committee on Deinstitutionalization

August 25, 1981

Executive Plan - Mental Hygiene Administration
Fiscal Years 1983-85

(DRAFT)

Introduction

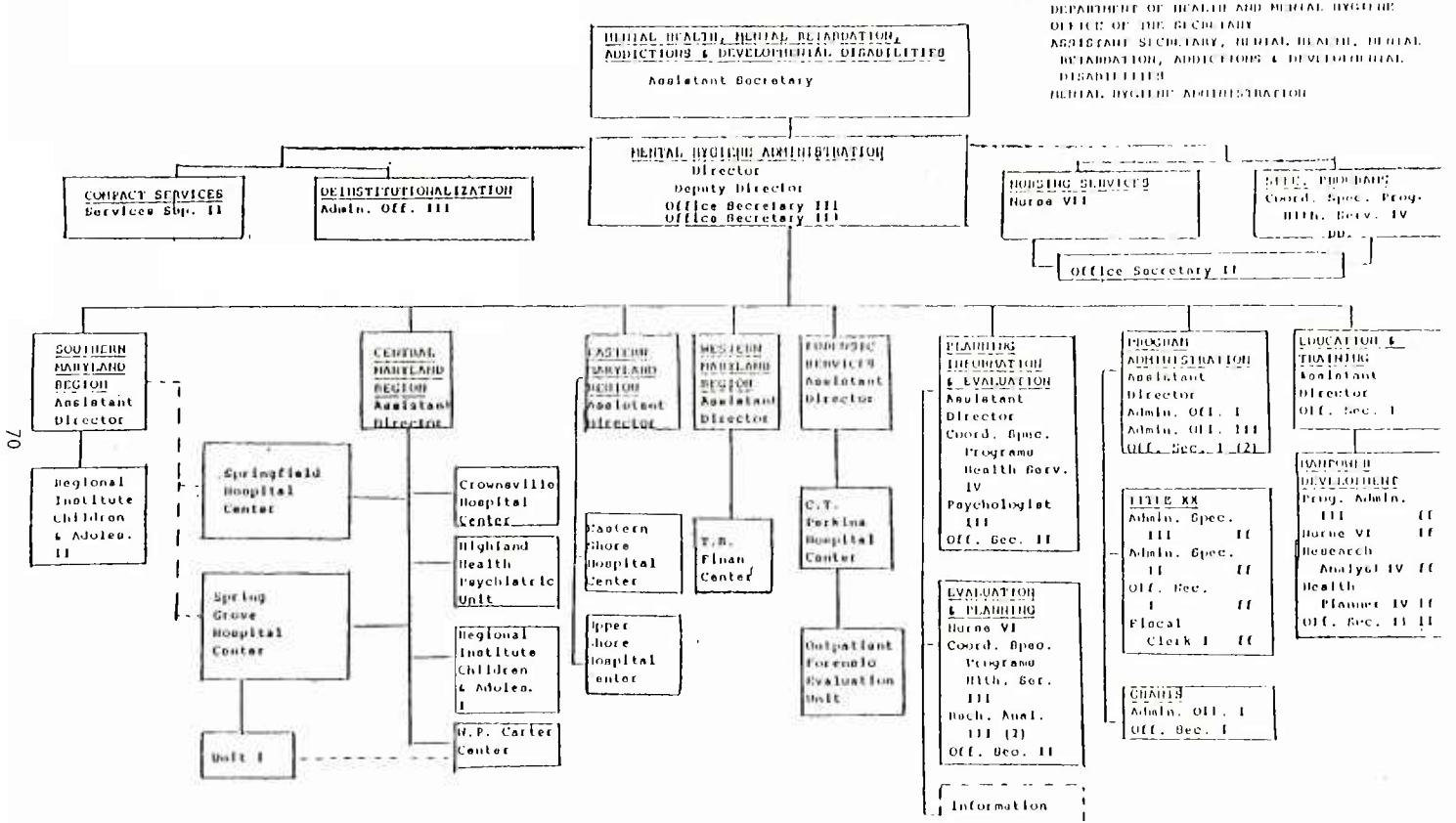
The Mental Hygiene Administration (MHA) Executive Plan for Fiscal Years 1983-85 simultaneously represents both a continuation of previous MHA Executive Plans and an innovative departure from them. It represents a continuation in that MHA will continue to emphasize deinstitutionalization--that is, keeping patients in the community to the extent practicable and returning them to the community as soon as feasible. It represents an innovative departure in that MHA proposes to follow a strategy whereby resources, including staff and funds, will be shifted from the major State hospitals to community-based programs.

Mission and Goals

MHA, a component of the Assistant Secretariat for Mental Health, Mental Retardation, Addictions, and Developmental Disabilities consists of Central Headquarters and four regions: Central Maryland, Eastern Maryland, Southern Maryland, and Western Maryland. While under the Federal Health Systems Agencies' structure, Montgomery County is a separate region, under MHA structure it is included in the Southern Maryland area. With this one exception, the MHA and HSA regions are coterminous.

MHA operates four hospital centers, two residential treatment programs for children and adolescents, one community mental health center, a forensic treatment and evaluation facility, and two community-based treatment programs. It also provides financial support to a variety of community-based treatment programs. (A copy of MHA's organizational chart is attached.)

The legal authority of MHA is derived from Articles 59, 16, 27, 31, and 43 of the Annotated Code of the State of Maryland. Under these acts, MHA's mission



March 4, 1981

Attach

is to foster and preserve the mental health of the citizens of Maryland. Under the Community Mental Health Services Act of 1966 (codified as Article 59) and amended in 1969, 1972, 1975, and 1978, MHA is authorized to provide grants to public and private nonprofit organizations to fund: (1) inpatient services; (2) outpatient services; (3) 24-hour emergency care; (4) partial hospitalization; (5) consultation and education; and (6) other forms of prevention, treatment, or rehabilitation.

Broadly speaking, the goal of MHA is to reduce the incidence and prevalence of mental illness in the State of Maryland and to restore, as quickly as possible, those persons who become mentally ill to optimal social functioning.

Trends

A number of routinely collected statistics indicate significant changes in the use of hospitals for the treatment of mental illnesses. The hospital census and hospital admissions and bed-day utilization all reflect a decrease in the numbers for the four major regional hospital centers, with a shift toward greater utilization of the community-based hospitals in the State system, particularly in the utilization of the psychiatric units in acute general hospitals.

Table I - Census of State Inpatient Facilities*

	Aug. 1978	Aug. 1979	Aug. 1980
4 Major Regional Hospitals			
Crownsville	657	621	482
Eastern Shore	327	391	333
Springfield	1552	1460	1351
Spring Grove	1101	980	887
Subtotal	3637	3380	3053
Community-Based State Facilities			
Carter	—	—	-30
Finan	—	—	105
Highland Health	—	—	—
Subtotal	—	—	155
Total	3637	3380	3208

Table II - Admissions to State Inpatient Facilities FYs 1978-1980*

	FY 1978	FY 1979	FY 1980
4 Major Regional Hospitals			
Crownsville	2265	2053	1188
Eastern Shore	882	1011	1112
Springfield	3349	3295	3011
Spring Grove	3840	3880	3577
Subtotal	10336	10239	8888
Community-Based State FAcilities			
Carter	124	488	515
Finan	—	73	272
Highland Health	—	—	270
Subtotal	124	561	1057
Total	10460	10800	9937

*These data do not include Clifton T. Perkins and the Regional Institutes for Children and Adolescents.

Trends

Table III - Admissions to Other Inpatient Facilities FYs 1978-80

	FY 1978	FY 1979	FY 1980
General Hospitals	11017	12744	15188
Private Psychiatric Hospitals	1507	1493	1433

Table IV - Bed-Day Utilization—State Inpatient Facilities

	FY 1978	FY 1979	FY 1980
4 Major Regional Hospitals			
Crownsville	240,154	228,139	208,113
Eastern Shore	122,918	112,043	117,879
Springfield	565,159	546,055	513,630
Spring Grove	395,615	374,147	333,347
Community-Based State Facilities			
Carter	—	10,457	16,062
Finan	—	8,979	33,172
Highland Health	5,051	5,258	5,884

These changes reflect the opening of new facilities which are better environments for patients because they are modern and well equipped and, most importantly, because they are in the community in which the patient lives.

As can be seen, the possibility of shifting resources from inpatient care now exists. The trend is downward in all three statistics, although there is some regional variation, notably on the Eastern Shore, where the number of bed days increased between 1979 and 1980, although overall between 1978 and 1980 a reduction has been realized. The largest reduction both in number of bed days and in percentage of change over the three-year period is in Spring Grove, where a reduction of 62,268 in the number of bed days has occurred, or almost a 16 percent reduction. Springfield experienced a decrease of 52,068 days; and Crownsville, 32,041 days.

As the table shows, some, but not all, of these days are accounted for by the community-based facilities Carter Center, Finan and Highland Health. Other factors are improved hospital-community liaison, strengthened services, community support services and the beginning of preadmission screening services.

Trends

Between fiscal year 1978 and fiscal 1980, more than 200 psychiatric beds in general hospitals were added to the overall capacity of the State with others in process of approval. With the addition of these beds, there was a 38% increase in psychiatric admissions to general hospitals. Despite the increase in admission to psychiatric patients to general hospitals, there is question as to whether this increase has contributed to a decrease in admissions to State Hospitals. The question of whether general hospitals are admitting the same populations that would otherwise be admitted to State Hospitals is unanswerable at this time and one that MHA intends to investigate.

There are two volume measures for the community programs: admissions and the Client Profile Survey. Admissions to publicly supported programs showed a slight increase from 24,443 in FY 1979 to 25,495 in FY 1980, an increase a little more than 4%. Little gain, however, is shown in the repeated Client Profile Survey which at the end of FY 1979 counted 21,668 persons on the open caseload of publicly funded outpatient programs and at the end of FY 1980 showed 21,858. Proportions of severely mentally disabled and those with a history of hospitalization have remained constant in two surveys. Neither figure includes the number of persons now enrolled in the newly established psycho-social rehabilitation programs and residential programs.

It is difficult to estimate on available information the total number of persons served in housing alternatives supported in part by MHA. In halfway houses, a total of 38 beds funded by MHA are now available. With a conservative estimate of a turnover of 6 months on the average 176 persons can be served a year. In supervised apartments, 87 beds funded by MHA are available. These alternatives permit longer stays so a conservative estimate would be 175 places for persons at any given time.

Aftercare and PreAdmission Screening. As yet no comprehensive management information system exists for these programs. Data are available from two sources, the Eastern Shore Aftercare Project and the Central Maryland Aftercare and PreAdmission Screening Pilot Reporting System.

Aftercare: The Eastern Shore Aftercare Project provides by far the most complete data comparisons for FY 1980 on the patient flow in the preliminary figures shown below:

	FY 1980		
Total Separations from Eastern Shore Hospital Center	960		
		% Total Separations	% Referrals
# of Signed Aftercare Plans	815	84.9	N/A
# of Aftercare Plan Referrals to Community MH Programs	667	69.5	100
# Persons keeping 1st Appointment	537	55.9	80.5
# of Persons Receiving MH Aftercare Services	573*	59.6	N/A

*Includes persons not referred initially to CMH Clinic.

In Central Maryland a non-automated reporting system yielded incomplete data. On the basis of two counties' and Baltimore City reports, the following information has been developed:

	FY 1980		
Total Separation from State Hospitals	702		
		% Total Separations	% Referrals
# of Aftercare Plan Referrals to CMHC	379	54.0	N/A
# Persons Keeping 1st Appointment	242	34.5	63.8

The Eastern Shore data provides a good example of how well an aftercare liaison can function: The data, from Central Maryland, though incomplete, are encouraging. The referrals rate on the Eastern Shore and in Central Maryland are

very different and reflect the complexity and variety of program alternatives in the area.

PreAdmission Screening: This program which has been in a pilot phase in Central Maryland Region nevertheless shows encouraging trends. On the basis of incomplete reporting, the following figures have been obtained:

	Jan-Dec 1980	
# Screened 3,444		
Dispositions	N	%
Referred to State Hospitals	1,091	31.7
Referred to Other Programs	2,353	68.3
# of State Hospital Admissions 2,180		
# Screened	1,091	50.0
# Admitted but not Screened	1,089	50.0

Need Plan

State hospitals, historically, have often served as the resource of last resort. When no other health, social, and support resources were available to care for needy individuals, such persons very often found themselves admitted to State hospitals. Many of these individuals were mentally ill, but some were not. After being admitted, many never returned to the community because of a lack of appropriate community resources and because of community resistance to having in their midst individuals who had been hospitalized. This situation is attested to by the fact that in the State of Maryland approximately 587 patients or 31% of all individuals residing in State hospitals for a year or more are not in need of psychiatric hospitalization.

Over the recent years, several forces have been at work to change the role of State hospitals. A body of law providing psychiatric patients with relatively new rights has evolved. Under these rights, patients cannot be admitted to psychiatric hospitals or held in them involuntarily unless it is demonstrably clear, clinically and legally, that an involuntary admission is in the patient's and society's best interest.

In addition to the legal constraints, the role of the State hospital has changed because of a plethora of evidence indicating that admission to large State hospitals may be inimical to the patient's treatment and recovery. In many instances, retention in a large institution for no clinical reason, i.e., institutionalization, exacerbates the very conditions that treatment is intended to ameliorate.

At the same time that evidence demonstrating the deleterious effects of unnecessary hospitalization has been accumulating, additional evidence has developed indicating that treatment in smaller community-based inpatient units is far more effective than treatment in large State hospitals. (One advantage of community-based inpatient treatment is that the patient remains close to his

family and natural support system, while that is rarely the case in State hospitalizations.) While inpatient treatment in a community-based facility is more effective than treatment in a State facility, alternatives to any type of inpatient treatment—day treatment, halfway houses, supervised apartments, to mention a few—often represent even more cost effective treatment for appropriate individuals than community-based inpatient treatment.

While the desirability of developing alternatives to hospitalization is widely recognized, acquiring the resources to develop such alternatives has represented a major problem for MHA. At the current time, approximately 85% of MHA's entire budget is invested in inpatient and related treatment programs. This continues to be the situation although over the past number of years, there has been a steady decline in the census of State facilities. Paradoxically, while the patient populations at the older State facilities have been declining, MHA has been subjected to constant pressure by licensing and regulatory bodies to allocate ever increasing amounts to those facilities. This is because the physical plants of the older State facilities are ancient and deteriorating and require extensive rehabilitation or complete replacement. Additional staff and other resources are also necessary. How to balance the conflicting demands for increased resources for State facilities while expanding alternatives to hospitalization has represented a major and nagging problem for MHA.

MHA has chosen to solve this problem by pursuing a strategy whereby a proportion of resources, both personnel and financial, will be shifted from State facilities to community-based alternatives to hospitalization. (Specialized treatment facilities such as Clifton T. Perkins, Regional Institutes for Children and Adolescents will not be affected by this strategy.) Simply put, as the populations of the older State hospitals decline, buildings will be closed, a proportion of personnel and finances will be shifted to community-based treatment programs that will be established or expanded to serve as alternatives to hospitalization.

Simultaneously, a proportion of the funds will be retained to upgrade the quality of care in the hospitals.

Although this plan encompasses Fiscal Years 1983-85, much of the planning that will be necessary to assure the success of this new approach will take place during FY 1982. Therefore, MHA's plan for FY 1982, as the antecedent to the plan for FY 1983, is reported here.

Fiscal Year 1982

June 1981

1. Identification of community needs by June, 1981. (Part of Needs Assessment now in progress as part of the requirements of Federal Legislation).
2. Regional Directors prioritize community needs. (Part of Needs Assessment now in progress as part of the requirements of Federal Legislation).

July 1981

3. Acquire gubernatorial support and commitment to shifting of funds from hospitals to community programs by July, 1981.
4. Identification of existing community resources . (Part of Needs Assessment now in progress as part of the requirements of Federal Legislation.)
5. Determination of basis of allocation to community programs.
6. Clarification of status of State employees affected by building closings and transfer of funds.

September 1981

1. Develop organizational structure defining relative roles and responsibilitiy of the Director and Deputy Director of MHA, assistant directors, hospital superintendents, local health officers, and others in planning and decision making.
2. Identification of loci of accountability.
3. Development of financial, administrative, and management structure.

January 1982

1. Development of performance standards.

April 1982

2. Identification of recipients and development of basis for determining amount of resources to be transferred from State hospitals to community programs.

Basis for determining amount to be transferred to community programs will consist of: (a) the hospital's and the community's success in reducing inpatient days (excluding days utilized by patients with the primary diagnosis of alcoholism); (b) patient day charge; (c) community need; (d) the extent to which the hospital is above or below the average patient day charge; and (e) maintaining a portion of any savings for hospital enrichment.

Fiscal Year 1983

1. Conduct pilot grant program(s) to test the efficacy and efficency of the organizational structure, reallocation basis, management and decision making processes.
2. Make appropriate budget modifications for FY 1984 based on FY 1981-82 utilization rates by August, 1983.
3. Continue coordination of calculations for FY 1984 in Master Facility Plan with the transfer of funds from hospital to community programs. (Refer to Master Facility Plan for futher information regarding projected inpatient resources.)

Fiscal Year 1984

1. Hospitals, following reallocation basis, shift funds and personnel to Program 12, the program that provides funding for community mental health programs.
2. Hospital units/buildings are closed; reduction in fixed cost transferred.
3. Regional offices, following reallocation basis and priorities, make grants to community programs.
4. Regional offices negotiate FY 1985 contracts between MHA and provider organizations.
5. MHA tests and modifies performance standards to be used in contracts with providers.

6. MHA monitors performance of grantees to ascertain compliance with MHA requirements.

Fiscal Year 1985

1. Hospitals, following reallocation basis, continue to shift additional funds to Program 12.
2. Additional units/buildings are closed.
3. Program 12 money is used to finance signed contracts enabling local communities to continue receiving funds and personnel.
4. Regional offices award grants for needed services not provided on contractual basis.
5. MHA monitors performance of contracting and grantee organizations.

The end result of this process will be a transfer of Hospital Program 12 funds to MHA Central Office grants (Program 12). Awarding of these funds will continue to be done by the Regional offices based on continuing analysis of community needs and the impact of services funded through grants on hospital admissions. Increases in hospital admissions will result in a reallocation of Program 12 funds to the facilities.

There is the possibility that during the period of FY 1983-85, MHA will receive funds from the Federal Alcoholism, Drug Abuse, and Mental Health Administration to fund Maryland's Community Support Program. There is also the possibility that MHA, as the exclusive agent, will receive funds under PL 96-398. All such monies, if received, as well as reallocated funds, will be used to develop alternatives to hospitalization and to finance programs for priority populations and non-reimbursable services.

Summary of Functions of Each Organizational Sub-Unit

Clifton T. Perkins Hospital Center

Clifton T. Perkins Hospital Center, located in Howard County near Jessup, is the State's forensic treatment and pre-trial evaluation facility. Community evaluations of forensic patients and the Hamilton House are components of services offered by Perkins to the forensic population. An 80-bed unit is in the process of being added to this facility.

Crownsville Hospital Center

Crownsville Hospital Center, located approximately six miles northwest of Annapolis, provides inpatient, outpatient, and day treatment to residents of Anne Arundel, Calvert, Charles, and St. Mary's Counties and the eastern portion of Baltimore City.

Eastern Shore Hospital Center

Eastern Shore Hospital Center is a regional hospital providing inpatient and outpatient services to the mentally ill and aged residents of Caroline, Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico and Worcester Counties.

Highland Health Facility

Highland Health Facility provides pre-admission screening and inpatient treatment to the residents of East Baltimore.

Maryland Psychiatric Research Center

The purpose of the Maryland Psychiatric Research Center, operated on a contractual basis with the University of Maryland, is to increase the fund of knowledge related to the etiology and treatment of schizophrenia and major affective disorders. Patients participating in inpatient and outpatient studies come primarily from Spring Grove and represent chronic, treatment resistent patients with serious long-lasting complications of drug treatments and early

and mildly schizophrenic patients with whom innovations can be tested. The Center is expected to continue conducting service related research with inpatient and outpatient populations.

Regional Institute for Children and Adolescents - Baltimore

The Regional Institute for Children and Adolescents - Baltimore, provides treatment and educational services for emotionally disturbed children and adolescents on an inpatient, outpatient, and day treatment basis.

Regional Institute for Children and Adolescents - Rockville

The Regional Institute for Children and Adolescents - Rockville, provides treatment and educational services for emotionally disturbed children and adolescents on an inpatient and outpatient basis.

Spring Grove Hospital Center

Spring Grove Hospital Center, located in Catonsville, is a multipurpose facility providing inpatient care and treatment to patients from Southwestern Baltimore City and Baltimore, Cecil, Harford, and Prince George's Counties. It also provides intermediate nursing care to aged and chronically ill patients who do not require psychiatric hospitalization.

Springfield Hospital Center

Springfield Hospital Center, located in Carroll County, serves mentally ill patients who live in Carroll, Howard, Frederick, and Montgomery Counties and the Northern portion of Baltimore City.

Thomas B. Finan Hospital Center

The mental health component of the Thomas B. Finan Hospital Center, located in Cumberland, provides inpatient and outpatient mental health services for the citizens of Allegany, Washington, Garrett, and Frederick Counties.

Walter P. Carter Community Mental Health and Retardation Center

The Walter P. Carter Community Mental Health and Retardation Center is a multidisciplinary facility located in Baltimore City. The mental health component provides inpatient, outpatient, day treatment services, consultation and education, and emergency and pre-admission services to individuals of all ages.

Director, Deputy Director, Mental Hygiene Administration

The Director is responsible for the overall direction and management of the Mental Hygiene Administration. The Deputy Director serves as the Director's chief lieutenant.

Assistant Director, Eastern Maryland Region

The Assistant Director, Eastern Maryland, is responsible for the Eastern Maryland region and also serves as a superintendent of Eastern Shore Hospital Center. The Eastern Shore Regional Office is responsible for grant awards, program consultation, planning, and development.

Assistant Director, Mental Hygiene Administration, Southern Maryland Region

The Assistant Director, Southern Maryland, coordinates the activities of the Regional Institute for Children and Adolescents-Rockville and Spring Grove Hospital Center I, and local programs. The Regional Office is also responsible for grant awards and program consultation, planning, and development.

Assistant Director, Mental Hygiene Administration, Central Maryland Region

The Directors of Crownsville Hospital Center and the Walter P. Carter Mental Health and Mental Retardation Center, Regional Institute for Children and Adolescents Baltimore, Highland Health Facility, Spring Grove and Springfield Hospital Centers report to the Assistant Director, Central Maryland. In addition, the Central Maryland Regional Office is responsible for making grant awards and providing program consultation, planning, and development.

Assistant Director, Mental Hygiene Administration, Western Maryland Region

The Assistant Director, Western Maryland, is also the superintendent of the Thomas B. Finan Hospital Center. The Western Maryland region is responsible for making grant awards and providing program consultation, planning, and development.

Assistant Director, Mental Hygiene Administration, Planning, Information, and Evaluation Unit

This unit is responsible for making all of the long-range and short-range plans for MHA. In addition, it evaluates all MHA-funded programs. PIE Unit also writes standards and regulations for mental health programs subject to MHA review and approval.

Program Administration

The Assistant Director for Program Administration is responsible for developing and monitoring MHA's budget. Title XX expenditures and requirements are monitored through this office.

Assistant Director, Education and Training

This office is responsible for reviewing the educational and manpower needs of MHA. It is also responsible for developing and coordinating appropriate educational programs for public mental health personnel.

Maryland Mental Health Manpower Development Project.

The Mental Health Manpower Development Project (MHMDP) is concerned with clarifying how mental health services are delivered and the manpower utilized to deliver these services in the State of Maryland. The goal of MHMDP is to advise MHA regarding the development of human resources necessary to implement an efficient and effective mental health care delivery system for the citizens of Maryland that is congruent with the State mental health plan, and the plan submitted to comply with the Mental Health Systems Act of the Federal government.

Director of Deinstitutionalization

The Director of Deinstitutionalization is involved in the development and implementation of policies and programs to achieve deinstitutionalization, community support systems, and psychosocial rehabilitation. This office reports to the Director of the Mental Hygiene Administration and represents the Administration on all issues related to deinstitutionalization. The Director of Deinstitutionalizatic also functions as Director of the Community Support System Project, as Coordinator of the HUD Demonstration Project for the Deinstitutionalization of the Chronically Mentally Ill.

PIE:et
3/81

		Current Modern Available Psychiatric Inpatient Beds	Special* Beds	Funded Projects Psychiatric Inpatient Beds	Special* Beds	FY '01 Requests Psychiatric Inpatient Beds	Special* Beds	Future Requests Psychiatric Inpatient Beds	Special Beds	MHP GOAL FY 1991	
	Approx Census:										
Cheltenham	18		0								0
RICA I	56		60							Special Beds	60
RICA-II	47		00							Special Beds	80
Upper Shore	0	Unit I 28 Unit II 36	2 2							Inpatient Psy. Beds Special Beds	64 4 68
	3424	64	4	*MHA projects a programmatic need for 64 inpatient beds at USHC, 36 beds will be for an alternative use.							
SUMMARY:											
Census:	3424	756	801	461	137	510	29	131	49	Inpatient Psy. Beds	1858
		1557		590		539		180		Special Beds	1016 2874

MHP Functional Breakdown: Inpatient Psychiatric Beds:

Acute Chronic	1858
Special Beds:	
Forensic	310
C/A	256
Holding	104
Trans. Living	40
Med/Surg.	256
Struct. Sheltered Care	25
Alcoholism	25
	2074

	Approx. Census	Current Modern Available Psychiatric Inpatient Beds	Special* Beds	Funded Projects Psychiatric Inpatient Beds	Special* Beds	FY '81 Requests Psychiatric Inpatient Beds	Special* Beds	Future Requests Psychiatric Inpatient Beds	Special* Beds	MHP GOAL FY 1991
Carter	58	7 East 10 7 Center 10 6 East 10 4 East 14 ETU 9 77	2 2 7 West 20 (Adoles) 2 2 2 30			6 West 16 16	2 2			Inpatient Psy. Beds 93 Special Beds 32 125
T.D. Finan	111	Cot. A 10 1 24 2 24 5 24 6 25 7 25 8 25 165	4 Cot. BC 26 1 1 1 Cot. B3 25 B4 25 83							Inpatient Psy. Beds 165 Special Beds 83 248
C.P. Perkins	214		Max. Sec. Bldg. 235* (Includes 9 seclusion rooms)*		Cent. 84* Foren-sic					Special Beds 319
Highland	42	40	4							Inpatient Psy. Beds 40 Special Beds 4

	Approx. Census	Current Modern Available Psychiatric Inpatient Beds	Special* Beds	Funded Projects Psychiatric Inpatient Beds	Special* Beds	FY '83 Requests Psychiatric Inpatient Beds	Special* Beds	Future Requests Psychiatric Inpatient Beds	Special* Beds	MFP GOAL FY 1991
Crownsville	411		Med/Sur 68	Col. II 39	1	Col. I3 39	1	Col. I5 19	1	Inpatient Psy. Beds 156
				" I2 0	40	" I4 39	1		Col. I6 40 (Transitional Living)	Special Beds 152
		0	68	39	41	78	2	19	41	308
Eastern Shore	257	Carey 48	4	Tawes I04						Inpatient Psy. Beds 210
			Meyer 40							Special 47
		Agnew 50	3							
		I06	47	I84						257
Springfield	I323	Hitch- 96	4	Col. I 40	1	D&T #2 92	8	D&T #3 92	8	Inpatient Psy. Beds 516
		man	Med/Sur I08	II 40	1	Martin 76	8			Special Beds I62
		(D & I)	Muncie 30	III 48	1	Gross				
				IV 40	1	"I."				
		96	I34	I60	4	I60	I6	92	8	678
Spring Grove	067		Smith (MS) 40	Red Brk.		Hill 58	1			Inpatient Psy. Beds 606
				#2 39	2	Mitchell 58	1			Special Beds 73
		Dix 6I	2	" "#4 39	2	Sullivan 58	1			
		Noyes 6I	2	White 00	4	Dayhoff 74	6			
		Red Brk.								
		#I 39	2							
		" "#3 39	2							
		288	56	I58	8	248	9			679

*Special Beds: Beds that are licensed for specific services, see page 3 Functional Summary.

ACCELERATED DEINSTITUTIONALIZATION (D/I) PLAN FOR MENTAL HYGIENE ADMINISTRATION

I. Purpose of Plan: To show how the addition of new funds can D/I 325 patients by FY '86 instead of FY '91 as currently planned.

II. Advantages of the Plan

1. Will obviate need for 175 modern beds thus saving approximately 7 million dollars (FY '82 dollars) in capital costs.

2. Will provide services to patients currently living in the community thus reducing the rehospitalization rate and the rise of the "street people" population.

3. Will increase the staff/patient ratio in the large hospitals thus removing one barrier to accreditation.

III. Mechanics of the Plan

In order to successfully D/I patients, MHA will complete and expand the Community Support System (C.S.S.) through the utilization of new funds and dollars reallocated from State facilities.

	Services Needed	
Basic Components of C.S.S.	Current Patient Placements	New Patient Placements
Housing Services[1]	No	Yes
Psychosocial programs	Yes	Yes
Clinical treatment services	Yes	Yes
Consultation and treatment services linkage with nursing homes		
Emergency treatment capability at designated emergency evaluation facilities	Yes	Yes

IV. Obstacles to Reallocation of State Facilities Funds to Community Programs

1. Current budgetary practices allow:

--funds to be removed from MHA budget based on the reduction in patients in State facilities (A.D.P. decrease). This also applies to fixed costs.

--salary fringe benefits to revert to State general funds consequently causing community programs to absorb these costs. Currently these funds are in the D.O.P. budget.

[1] Project HOME placements will be utilized whenever possible.

--assignment of a salary turnover factor which is higher than actual experience.

--inconsistent annual adjustment of the budget for inflation.

2. Current legislative process allows:

The "Whipsaw Effect"--positions which are held vacant in order to meet the salary turnover factor are subsequently cut by the Legislature.

FY '83-FY '86
SUMMARY OF COMMUNITY SUPPORT SYSTEM NEEDS
(FY '82 DOLLARS)

	Projected Annual Costs	Annualized Projected Available Funds	Additional Needs
382 patients placed in the community[1]	$ 477,691 (cl.treatment) 1,294,980 (psych-soc.) 1,260,600 (housing)		
subtotal	$3,033,271	$1,491,765[2]	$1,541,506
325 additional patients to be placed in the community	$ 465,400 (cl.treatment) 1,101,750 (psych-soc.) 3,185,000 (housing)		
subtotal	$4,752,150	$2,439,889[3]	$2,312,261
Emergency treatment capacity[4]	$ 625,000	-0-	$ 625,000
Consultation and treatment services linkage with nursing homes	$ 49,000	-0-	$ 49,000
TOTAL	$8,459,421	$3,931,654	$4,527,767

1. See Attachment #I
2. Includes $200,000 in Federal funds as noted in Attachment #II
3. Reallocation dollars--see Attachment #III
4. This component will generate additional patients who will utilize the psychosocial center.

PHASE-IN SCHEDULE
(FY '82 DOLLARS)

Fiscal Year	Total of New Patient Placements	Total Cost[1]	Current Available Funds	Gross Additional Needs	Amount Available for Reallocation	Net Need	Amount of New Funds Needed
'83	50	$4,563,371	$1,491,765	$3,071,606	$ 43,025	$3,028,581	$3,028,581
'84	187	6,691,585	1,491,765	5,199,820	843,424	4,356,396	1,327,815
'85	325	8,584,421	1,491,765	7,092,656	1,500,253	5,592,403	1,236,007
'86	X	8,459,421	1,491,765	6,967,656	2,439,889	4,527,767	(1,064,636)[2]
						TOTAL	$4,527,767

[1] Total Cost is based on 12 months capacity for all patients in community programs.

[2] In FY '86 and succeeding years, MHA will continue to D/I patients using the available $1,064,636.

Attachment # I

Community Living Alternatives

For Adults

Central Maryland Region	Supervised Apt. Beds	Halfway House Beds
Carroll County		
. Granite House, Inc.	16	
Howard County		
. Growth Center	6	
. Vantage Place	12	
Anne Arundel County		
. Arundel Lodge		12
. Arundel Living	8	
Baltimore County		
. Changing Directions Johns Hopkins Community Psychiatry Program (Planning Stage)		
Baltimore City		
. Project PLASE	58	16
. St. Paul House		16
. Charles Village House		13
. Glen Manor		8
. Fellowship House		20
. Hamilton House		15
. Sinai Hospital Apartment Program	12	
. Phoenix House (Planning Stage)		

	Supervised Apt. Beds	Halfway House Beds
Eastern Shore Region		
Wicomico County		
. Go Getters, Inc. (Full Psychosocial Program - 8 Supervised Apts.) P.O. Box 2581 Salisbury, MD Contact Person: Jacqui Luck	8	
. Go Getters, Inc. (Planning Stage) Talbot County Easton, MD		
Southern Region		
Montgomery County		
. Rock Creek Foundation Silver Spring	12	
. St. Luke's House		27
. Silver Spring . Bethesda . Rockville		
. Montgomery House	13	
Prince George's County		
. Family Service of Prince George's County	20	
Calvert County		
. BLESS, Inc. (Planning Stage)		
St. Mary's County		
. Freedom Landing, Inc. (Planning Stage)		

[1] plus 13 beds for Sachs population funded by MPA

	Supervised Apt. Beds	Halfway House Beds
Western Region		
Allegheny County		
. Archway Station	6	
Washington County		
. Turning Point, Inc.	7	
Frederick County		
. The Way Station, Inc.	12	
Totals:	190	132

TOTAL COMMUNITY ALTERNATIVE BEDS: 322**

Project HOME has an additional group of 60 patients in foster care (322 + 60 = 382)

Community Alternatives Cost Model

(FY 1982 Dollars)

	Daily	Annual
I. Housing: (Average cost for all levels of supervision)	$ 9.04	$3,300
II. Housing (24 hour supervision)	$26.85	$9,800

**as of September, 1981.

ATTACHMENT # II

MHA AWARDS
COMMUNITY RESIDENCE AND PSYCHOSOCIAL PROGRAMS

Program	FY '80 Award	FY '81 Award To Date	General Funds and Title XX (As of 11/4/81) FY '82 Award	Federal Dollars
Baltimore City Program				$50,000
Arundel Lodge (Halfway House; Supervised Apartment)	$93,994	$98,769	$108,766	
St. Luke's House (Halfway House)	80,200	111,616	175,000	
Project PLASE (Halfway House; Supervised Apartment)	101,531	114,386	139,386	
Family Services of Prince George's County (All Programs)	112,707	114,224	506,372	
Sinai Hospital (Supervised Apartment; Psychosocial)	14,629	16,796	17,636	
Montgomery House (Supervised Apartment; Psychosocial)	87,002	54,912	100,248	
Way Station (Supervised Apartment; Psychosocial)	23,923	22,345	28,233	50,000
Turning Point (Supervised Apartment; Psychosocial)	---	22,279	31,567	
Archway Station (Psychosocial)	---	10,422	21,354	
Go Getters, Inc. (Psychosocial)	15,333	16,406	19,737	50,000
Rock Creek Foundation (Psychosocial)	37,500	35,100	70,960	
St. Mary's and Charles Counties	---	---	---	50,000
Granite House	---	---	25,000	
PEP	---	---	27,825	
Care for Friends	---	---	19,681	
TOTAL	$566,819	$617,255	$1,291,765	$200,000

HS/KEM:mm
11/4/81

TOTAL MHA FUNDS AS OF 11/4/81 = $1,491,765 ($1,291,765 + $200,000)

ATTACHMENT # III

FORMULA FOR THE REALLOCATION OF HOSPITAL RESOURCES TO COMMUNITY MENTAL HEALTH PROGRAMS

(1)		(2)		(3)		(4)		(5)
Decrease in Patient Days	x	Daily Cost Avoidance	=	Annual Cost Avoidance	x	Understaffing Correction Factor	=	Amount to be Reallocated

legend:

(1) The length of stay in the hospital is expected to decrease. In addition, this figure will be adjusted to reflect Sachs', Project HOME, ACA patients, etc.

(2) Daily Cost Avoidance = $\frac{\text{(adjusted* staff/patient ratio x Average direct care staff salary)}}{365}$ + (Variable) Formula Cost

*adjustment = staff Turnover Factor, Sachs', Project HOME, Program 12, ACA services costs

(3) Cost avoidance is not available until after patient leaves the hospital.

(4) Understaffing Correction Factor = This factor will be calculated at 50% and will reflect the percentage of staff which will be maintained in order to meet JCAH accreditation standards.

(5) These funds will be in addition to the resources currently assigned to the Community Mental Health programs.

ATTACHMENT # IV

Use of New Funds

A. Emergency Treatment Needs

$25,000 x 25 sites = $625,000

B. Consultation and Treatment Services Linkage

Physician E:	50% =	$21,830.50
	25% fringe =	5,457.62
		$27,288.12
Nurse V:	100% =	$17,000
	25% fringe =	4,250
		$21,250
Travel:		$462

TOTAL: $49,000

C. Clinical Treatment Services Linkage

	Minimum Services	Maximum Services
Psychiatrist ($27/hour)	12 visits/year = $324	16 visits/year = $432
Other Professional Services (Psychologist, S.W., R.N., Rehab. Spec., etc.)	745	1,000
	Total $1,069	$1,432

325 new x $1,432 = $465,400
191 current x $1,432 = 273,512
191 current x $1,069 = 204,179
$943,091

D. Community Alternative Treatment Units

1. Psychosocial (Based on 50 patients per program)

Salary + Fringe

1 Director	$18,825	
5 Staff (1 to 10 ratio)	62,750	
		$81,575

Supplies

Admin/Office	$ 1,000	
Dietary: Cleaning ($50/day/patient x 133 days)	7,825	
		$ 8,825

Rent/Utilities			
	2,000 sq. feet		$14,000
Insurance			
	Car	$ 500	
	Liability	3,500	
			$ 4,000
Food			
	$2/day/patient x 313 days		$31,300
Transportation			
	1 Van	$10,000	
	40,000 miles @ $.15 = oper. cost	$6,000	
			$16,000
Contracts			
	Xerox	$2,500	
	Equip. Serv. Contracts	1,000	
	Exterminating	300	
	Trash Removal	1,000	
			$ 4,800
Equipment Replacement			
	Estimated		$ 2,000
Secretarial/Accounting Services			
	Estimated		$ 7,000
	Total		$169,500
Operating cost per patient			$3,390
Start-up cost			
	Equipment, deposits, alterations -- 4 units		$125,000

2. Housing

- Average per patient for all levels of supervision $3,300
- Average 24-hour supervision $ 9,800

Reallocation from MH Institutions based on:

50	FY '83
137	FY '84
138	FY '85
325	D/I Patients

A. FY '83 Reallocation

50 D/I Patients (6 months average)

Positions	-0-
Formula Cost($1,721 x 25)	$43,025
Fuel	-0-
	$43,025

B. FY '84 Reallocation

187 D/I Patients (50 - 12 months
137 - 6 months average)

Positions (50 x 4,300	
137 x 4,300 x 6 months)	$509,550
Formula (50 x 1,721	
137 x 1,721 x 6 months)	203,939
Fuel	-0-
	$713,489
Fringe @ 25.5%	129,935
	$843,424

C. FY '85 Reallocation

325 D/I Patients (187 - 12 months
138 - 6 months average)

Positions (187 x 4,300	
138 x 4,300 x 6 months)	$1,100,800
Formula Cost	
(187 x 1,721	
138 x 1,721 x 6 months)	118,749
Fuel	-0-
	$1,219,549
Fringe @ 25.5%	280,704
	$1,500,253

D. FY '86 Reallocation

325 D/I Patients (12 months)

Positions	
(325 x 4,300)	$1,397,500
Formula Cost	
(325 x 1,721)	559,325
Fuel	
(325 x 345 sq.ft./patient x $1.13)	126,701
	$2,083,526
Fringe @ 25.5%	356,363
	$2,439,889

(Square footage based upon Buildings E, I, and L2 at Springfield. 69,000 sq. ft. for 200 patients)

TOTAL COST

A. FY '83

382 current patients	$3,033,271
50 new patients	
Clinical Treatment (50 x 1,432)	71,600
Psychosocial (50 x 3,390)	169,500
Housing (50 x 9,800)	490,000
Emergency Treatment Capacity	625,000
Consultation and Treatment Linkage	49,000
Start-up Cost--50 Patient/Psychosocial	125,000
	$4,563,371

B. FY '84

382 current patients	$3,033,271
187 new patients	
Clinical Treatment (187 x 1,432)	267,784
Psychosocial (187 x 3,390)	633,930
Housing (187 x 9,800)	1,832,600
Emergency Treatment Capacity	625,000
Consultation and Treatment Linkage	49,000
Start-up Cost--100 Patient Psychosocial	250,000
	$6,691,585

C. FY '85

382 current patients	$3,033,271
325 new patients	
Clinical Treatment (325 x 1,432)	465,400
Psychosocial (325 x 3,390)	1,101,750
Housing (325 x 9,800)	3,185,000
Emergency Treatment Capacity	625,000
Consultation and Treatment Linkage	49,000
Start-up Cost--50 Patient/Psychosocial	125,000
	$8,584,421
Less Start-up	-125,000
FY '86 Operating Cost	$8,459,421

PROPOSED UTILIZATION OF $700,000 IN NEW FUNDS IN FY '83

I. Plan--to partially implement the activities designated for FY '83 in the Accelerated D/I Plan. Specifically, MHA will fund psychosocial programs for the chronic patients previously placed in the community and for 50 chronic patients currently residing in State facilities.

II. Rationale

The psychosocial program is a crucial component of the community support system because:

1. it provides the services and activities necessary to teach the patient how to function in the community, and
2. it provides the support structure to enable the patient to function to the maximum of his/her potential.

Currently, this component of the system is not addressed by any other service provider. MHA has provided limited funds to establish an initiative in this area, however, most of the existing psychosocial programs currently do not meet the minimum criteria for programmatic quality or sufficiency in services. Even the programs which were operational in the past have been devastated by the loss of C.E.T.A. funds and cannot provide adequate services to the patients previously placed in the community. Needless to say, the programs need to be expanded in order to provide services to additional patients.

III. Mechanics of Plan

1. Will provide funds to establish new psychosocial center slots for 50 currently hospitalized patients.[1]

   a.) $2,675 start-up costs (FY '83 dollars: 7% inflation factor)
   b.) $3,490 operational costs (FY '83 dollars: 7% inflation factor)
   $6,165 total annual cost per slot

   $6,165 x 50 patients = $308,250

2. Will bring existing center programs in line with minimum criteria for operation, enhancing psychosocial services for some 382 persons currently identified as in the community.

   = $391,750

   TOTAL $700,000

---

1. This is only one part of the network of services and the other components of the community support system need to be in place to assure the success of the D/I Plan.

BSH:mm
11/13/81

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MASTER FACILITIES PLAN
FY 1982-1991

MASTER FACILITIES PLAN SUMMARIES

Mental Retardation and Developmental Disabilities Administration (MRDDA). The current MRDDA plan reflects several important changes from last year's plan. First, an attempt has been made to classify clients according to residential needs along the service continuum from inpatient to community placement, based on estimates of the number of hours of residential supervision required by each client per day. Second, fiscal assumptions used in previous plans have been revised to be consistent with Departmental guidelines. Third, incidence and prevalence data extrapolated from a study done on the Eastern Shore has been used, in conjunction with the residential supervision criteria, to estimate the total number of residential beds needed in the system. This data was also used to provide an estimate of the number of State residential center beds vs. community beds projected through the period.

Using this new data and new assumptions, the plan projects a need for 5,787 residential beds, of which it is estimated, 1,815 will be intensive beds (State residential center) and 3,972 community residential beds. Because of fiscal limitations the plan projects the average daily population within the facilities to remain relatively constant at 2,549, a significant change from the 1,100 projected in last year's facilities. It should be emphasized that this change does not represent a change in philosophy but rather a reflection of the economic realities. However, if additional funds should become available, the rate of progress in reaching the 1,815 bed level will be accelerated. The first step in any move to accelerate the process will be to phase out the operation of Henryton. During this planning period fully federally certified beds are projected to increase to 1,504 by 1991, however, it should be noted that this number is below the estimated 1,815 beds needed using the service criteria for State residential centers. The MRDDA is not proposing an increase in certified beds beyond the 1,504 number because of the significant capital outlays required to fully certify 1,815 beds.

Although the projected 1991 population is estimated to be 2,549, the Department has not proposed plans to develop 2,549 federally certified beds with or without waivers based on the hope that sources other than State tax dollars, notibly Title XIX (Medicaid), can be used to accelerate the State's deinstitutionalization effort. The State of Maryland currently does not claim reimbursement for community based residential programs. However, under plans presently being proposed by the MRDDA some of these programs could become eligible for Title XIX reimbursement. This plan, if accepted, may provide the stimulus for development of new community based programs and obviate the need for maintaining institutional beds beyond the 1,815 number projected by the needs survey. Therefore, until the Medicaid decision is clear, a final decision cannot be made with regard to the number of certified beds needed within the institutional category. Absent Medicaid dollars, the small growth expected in community beds based on current financial projections will not have a significant impact on the problem, therefore, the resolution of the Title XIX issue is crucial to future MRDDA planning. It is anticipated that this issue will be clarified by the time the next plan is developed.

Mental Hygiene Administration (MHA). The MHA has a current ADP of 3,460 and s licensed bed capacity of 4,583. The MHA projects an ADP of 2,582 by 1991, with a targeted bed goal of 2,874. Bed reductions will take place in the four major hospital centers (Spring Grove, Springfield, Eastern Shore, and Crownsville) while the smaller hospitals will experience further growth and expansion. This projection is based on the continuation of the historical drop accounting for part of the decrease. Special initiatives such as the transfer of the remaining Sachs population patients to MRDDA facilities, and the continued placements in Project HOME and PLASE will also help to further the decrease in census. A resource reallocation plan would transfer funds from the hospitals to community beds as the census declines. This would allow a further reduction in the ADP needed to achieve the 1991 projection of 2,582.

The MHA currently has 1,557 modern beds. The goal of 2,874 modern beds by 1991 will be reached through completion of 598 bed renovations already approved, the 539 beds planned for renovation and requested in the FY 1983 capital budget, and 1 80 beds projected for renovation after FY 1983. Of this 2,874 bed goal, 1,858 will be utilized for chronic and acute psychiatric care and 1,016 will be specialized beds, including forensic, children and adolescent, holding, medical/surgical, structured shelter care, and addictions beds.

A major policy decision made by the MHA during FY 1981 was to transfer the City Division of Springfield Hospital Center to Spring Grove Hospital Center. This will consolidate the catchment area for Baltimore City by decreasing the number of State facilities now treating City patients. Furthermore, this policy will enable both Springfield and Spring Grove to reach a relatively smaller and manageable size (about 670 residents each) by 1991. In addition, this will allow the Springfield campus to be consolidated with one segment of it no longer being utilized.

Another significant policy change has been in the area of mental health services to children and adolescents. Specifically, the MHA's policy is to have all beds for children and adolescents available regionally. The current residential treatment bed allocations vary considerably by region. Furthermore, there is currently an adequate supply of residential treatment beds statewide. Therefore, the MHA will promote the development of local group homes and other community placements and not the construction of more residential treatment beds.

The Administration expects no new federal funds. This will increase the difficulty of placing the already very difficult and disabled patient in the community. Further federal cutbacks could hinder prescreening and aftercare programs currently provided in the community. This could cause a serious ripple effect by increasing State hospital admissions. If this occurs, MHA will reevaluate its projected ADP and shift program funds if necessary. The 20 day cap for Medicaid reimbursement for care in acute general hospital psychiatric beds may also have an impact on the future ADP.

GEORGE A. NILSON
Deputy Attorney General
659-4003

ELEANOR M. CAREY
Assistant Deputy Attorney General
659-4039

J. MILLEMANN
Counsel and
vision

AVERY ADENSTARK
Principal Counsel
Opinions and Advice
659-4019

JAMES G. KLAIR
Principal Counsel
Administration
659-4017

PAUL F. STRAIN
Chief of Litigation
659-4010

DENNIS M. SWEENEY
Special Counsel
Administrative Matters
659-4018

DEBORAH K. HANDEL, Chief
Criminal Appeals and
Correctional Litigation Division
659-4022

STEPHEN B. CAPLIS, Chief
Correctional Litigation
659-4083

OFFICES OF THE ATTORNEY GENERAL
One South Calvert Building Baltimore, Maryland 21202

STEPHEN H. SACHS
Attorney General

(301) 659-4000

TTY for Deaf
Balto. Area 383-7555
D.C. Metro 565-0451

June 16, 1981

GARY P. JORDAN, Chief
Criminal Investigations Division
659-4132

H. ROBERT ERWIN, JR., Chief
Consumer Protection Division
26 S. Calvert Street—8th Floor
Baltimore, Maryland 21202
659-4230

K. HOUSTON MATNEY, Commissioner
Securities Division
26 S. Calvert Street—Room 602
Baltimore, Maryland 21202
659-4141

CHARLES O. MONK, II, Chief
Antitrust Division
131 E. Redwood Street—Suite 771
Baltimore, Maryland 21202
659-4222

ANDREW C. TARTAGLINO, Chief
Medicaid Fraud Control Unit
15 Charles Plaza—Suite 301
Baltimore, Maryland 21201
659-6100

ROBERT A. ZARNOCH, Counsel
General Assembly
104 Legislative Services Bldg.
Annapolis, Maryland 21401
841-3589
856-3589 D.C. Metro

Charles R. Buck, Jr., Sc.D.
Secretary, Department of Health
and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Dear Secretary Buck:

Because the FY 83 budgetary process has begun, I am writing to update you on recent decisions, including the Supreme Court's very recent decision in Pennhurst v. Halderman, 49 L.W. 4363 (April 21, 1981) and its decision to review Romeo v. Youngberg, 644 F. 2d 147 (3rd Cir. 1980), that are relevant to the State's legal obligations to deinstitutionalize mentally reterded patients. These decisions should provide some guidance to you in your planning efforts for FY 83.

The primary holding of the Supreme Court in Pennhurst was that the "Bill of Rights" Section of the D.D. Act did not create a congressional mandate that mentally retarded patients be deinstitutionalized and treated in the "least restrictive environment". Specifically, the Court found that, in enacting the Bill of Rights Section of the D.D. Act, Congress did not intend to impose "massive financial obligations on the States" without the consent of the States. On the contrary, the Court found that the "explicit purposes of the Act are simply to assist the State through the use of federal grants to improve the care and treatment of the mentally retarded." Accordingly, the Court held that the Third Circuit erred in finding that the "Bill of Rights" Section of the Act mandated that "least restrictive alternative" placements be created for almost all patients in Pennhurst. What Congress intended to do when it enacted the Bill

of Rights Section was to "express a congressional preference for certain kinds of treatment", i.e., treatment in the community.

The Court also rejected the argument that Congress intended to condition the receipt of federal (D.D. Act) funds upon compliance with the "Bill of Rights Section". Simply put, the Court could find in the Act no contractual language--language that would put the states on notice that if they accepted federal (D.D. Act) funds they would also accept the obligation to virtually close all large-scale institutions for the mentally retarded. The Court supported this conclusion by noting that Congress had granted to Pennsylvania only $1.6 million in 1976, "a sum woefully inadequate to meet the enormous financial burden of providing 'appropriate' treatment in the 'least restrictive' setting" to all of Pennsylvania's institutionalized population.

While the Court, thus, ruled that the D. D. Act's Bill of Rights did not support the plaintiff-patients' contentions, it did not decide--but instead asked the Third Circuit to initially decide--whether deinstitutionalization was mandated by other congressional, State law and federal constitutional provisions. Specifically, the Court asked the Third Circuit to consider:

> (1) Whether mentally retarded persons residing in mental retardation facilities have a federal constitutional right to minimally adequate habilitation in the least restrictive environment;
>
> (2) Whether mentally retarded persons residing in mental retardation facilities have a federal constitutional right to be protected from harm as a result of the Eighth Amendment's proscription of "cruel and unusual punishment";
>
> (3) Whether mentally retarded persons residing in mental retardation facilities have a right to minimally adequate habilitation in the least restrictive environment as result of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794; and
>
> (4) Whether mentally retarded persons residing in mental retardation facilities have a right under State law to minimally adequate habilitation in the least restrictive environment.

Thus, it is apparent that a number of other "deinstitutionalization" issues will be litigated for some time. While I don't mean to minimize the Pennhurst decision, it would be a mistake to assume that Pennhurst provides a carte blanche "legal blessing"

of the status quo. It does not.

That it does not is evidenced not only by the Court'a remand in Pennhurst of the four issues noted above, but also by the Court's very recent grant of certiorari in Romeo v. Youngberg, 644 F. 2d 147 (3rd Cir. 1980), a case involving a mentally retarded man who was confined at Pennhurst Hospital.

The uncontested facts cited by the Third Circuit in Romeo are dramatic:

> "It is not contested that, while confined at Pennhurst, Romeo was injured on over seventy occasions. These injuries were both self-inflicted and the result of attacks by other residents, some in retaliation against Romeo's aggressive behavior. The injuries included a broken arm, a fractured finger, injuries to sexual organs, human bite marks, lacerations, black eyes, and scratches. Moreover, some of plaintiff's injuries became infected, either from inadequate medical attention or from contact with human excrement that the Pennhurst staff failed to clean up."

A damage action was filed by the patient's mother for injuries suffered as a result of these attacks and this action was subsequently amended to include allegations (that were never contested) that plaintiff was shackled to a bed or chair for long periods of time beginning immediately after he filed the complaint in federal court. The complaint alleged violations of the Eighth Amendment (prohibition against cruel and unusual punishment) and the Fourteenth Amendment.

The jury decided against the plaintiff and for the defendants (the superintendent and two lower echelon managers), applying the Eighth Amendment standard utilized in prisoner rights damage actions: did the defendant's acts constitute "deliberate indifference to the serious medical needs of the resident?"

The Third Circuit reversed, holding:

> 1. The appropriate legal test in this case (a case involving involuntary civil commitment) is not the Eighth Amendment test, but a due process test: did defendant's acts deny plaintiff a liberty interest protected by the Fourteenth Amendment?
>
> 2. The shackling of plaintiff was presumptively punitive and could only be justified by "compelling necessity". (In addition, it was also apparently

violative of State law).

3. The alleged failure to protect plaintiff from personal harm could only be justified by "substantial necessity".

4. Plaintiff has a right to treatment, which means: "a form of treatment that is regarded as acceptable for him in light of present medical or other scientific knowledge."

In short, the Third Circuit's resolution in Romeo of the constitutional issues in favor of the patient provides some indication how the Third Circuit may rule on the remanded Pennhurst v. Halderman constitutional issues. And, the dramatic nature of the Romeo facts makes Romeo a more likely candidate for affirmance by the Supreme Court than was Pennhurst v. Halderman.

Romeo is not the only case that makes it increasingly apparent that the potential legal liability of confining mentally retarded persons in large-scale facilities is expanding significantly. The developing legal rights of institutionalized mentally retarded persons include:

1. The right to legal services;
2. The right to habilitation;
3. The right to be protected from assaults by other patients; and
4. The right to refuse medication. See, Romeo v. Youngberg, Civil No. 76-3429 (3rd Cir., Nov. 24, 1980); Renie v. Klein, 476 F. Supp. 1294 (D.N.J. 1979); Wyatt v. Aderholt, 503 F. 2d 1305 (5th Cir. 1974); Izary W. v. Louisiana, 437 F. Supp. 1209 (E.D. La. 1976); Evans v. Washington, 459 F. Supp. 483 (D.D.C. 1978); Davis v. Watkins, 384 F. Supp. 1196 (N.D. Ohio 1974).

The development of the above rights for institutionalized mentally retarded persons has resulted during the last decade, and the most realistic prediction is that institutionalized mentally retarded persons will receive at least as solicitous attention from the courts in the future. The Court in Romeo v. Youngberg, supra indicated why this is likely to be so:

> "The mentally retarded may well be a paradigmatic example of a discrete and insular minority for whom the judiciary should exercise special solicitude. (citation omitted). The retarded cannot vote in most states and, with few community ties, sponsors or friends, have minimal impact on the

political process." (citation omitted).

The special judicial "solicitude" for institutionalized mentally retarded persons is not only the result of their politically powerless position, but is also a consequence of the recent "discovery" by the judiciary of the fact that mentally retarded persons are developmentally disabled, not diseased. As the court in Romeo noted:

> "Such a view stresses that all developmentally disabled individuals have potential for learning and growth. From this developmental model, it follows that custodial care--which is predicated on the assumption that certain individuals are essentially incapable of development--must be rejected. The newer developmental model emphasizes concrete program goals for individuals and therefore encourages evaluation based on specific outcomes.

In short, one consequence of the development of new rights for institutionalized mentally retarded persons is that additional resources will have to be invested in mental retardation institutions if significant numbers of mentally retarded persons are not deinstitutionalized. This is so because increased staff is the critical means to implement the various rights discussed above, e.g., the right to habilitation, the right to protection, and the right to refuse medication. An enhanced staff/patient ratio can be accomplished by either deinstitutionalizing significant numbers of mentally retarded persons or by adding greater numbers of staff to institutions where the patient populations are not reduced.

The failure to implement fully the requirement placed upon the MRA Director to provide "all necessary professional and support personnel and equipment for full implementation" of an "individualized plan of care" for every institutionalized mentally retarded person, see, Article 59A, §8A, provides just one example of the potential liability faced by the State if it fails to either deinstitutionalize significantly or commit much greater resources to institutional care. While it is arguable that the statutory requirement that adequate funding be provided for full implementation of all "individual plans of care" may exceed the power of the State General Assembly as a matter of State law, see Maryland Action For Foster Children v. State, 279 Md. 133 (1977), it is likely that a federal court would find that the federal constitutional right to habilitation imposes an obligation upon the State to implement a reasonable plan of care for each patient. As noted above, this is one of the several

issues that the Court in Pennhurst remanded for consideration.

All institutionalized mentally retarded persons in Maryland (about 2,500) have had individualized plans of care developed for them; but there has apparently been "significant" implementation (76% to 99% implementation) of such plans for only about 16% of the total population. In FY 80, the estimated annual cost of fully implementing all patient "plans of care" was in excess of $12,000,000.

This one example makes it clear that the fiscal impact of "institutional conditions" litigation against Maryland's MRA institutions could be very substantial. The fiscal impact of similar suits in other states also provides some measure of this potential liability. For example, one commentator evaluated the cost of implementing Wyatt v. Aderholt, supra, a decade-old case in which plaintiffs successfully challenged the conditions of confinement in Alabama's institutions for the mentally ill and retarded. He concluded that:

> "One of the more controversial aspects of the Wyatt litigation was the enormous amount of additional resources which would be required to bring the system in Alabama into compliance with court-ordered standards and the resulting explicit threat of judicial intervention into a state's budget. Since the introduction of the Wyatt suit, the budget of the Department of Mental Health has increased by almost 300 percent, from $26 million to over $72 million (see Table 13.5). That this amount is not considered adequate by the Department can be inferred from its request for another substantial increase, to approximately $90 million, for fiscal year 1975-1976. ...
>
> ... There is good reason to believe, however, that even this substantial increase in funding has not been enough to achieve compliance with all of the court's standards. A preliminary attempt to develop a five-year plan for Bryce Hospital indicates that a considerable amount of money is still required before the hospital will be able to comply completely with the court-ordered standards. Weisbrod, Public Interest Law at 386.

In light of the broad scope of the Wyatt decision (it involved both mentally ill and mentally retarded patients), and

the low level of funding for mentally ill and retarded persons in Alabama at the time of that decision, the costs of implementing Wyatt overstate Maryland's potential fiscal liability. But, the costs of implementing decrees against mental retardation facilities in northeastern states should be of some utility in assessing our potential liability. For example, in response to litigation against its mental retardation facilities, Ricci v. King, No. 72-469-T (D. Mass. 1972), Massachusetts has spent over $100,000,000 in capital outlays alone to upgrade institutional care and conditions since 1975 and is spending an additional $10,000,000-15,000,000 per year developing new community-based programs.

As a result of a pending case brought by the United States Department of Justice, Garritty v. Gallen, Civil No. 78-116 (D.N.H. 1978), the New Hampshire Department of Health and Welfare has spent $8,000,000 to date to create new community-based programs and to upgrade institutional care and conditions. It has also decided to reduce its institutionalized mentally retarded population from 550 to 150 over the next five years, and it has asked the State Legislature to appropriate an additional $30,000,000 over the next two years to begin to implement this five year plan. The very substantial nature of New Hampshire's response to the Justice Department's litigation--i.e., the $30,000,000 request for new community beds--is apparent from the total size of the State budget: $600,000,000.

MARC v. Smith, (E.D. Mich. 1979), has required Michigan to dramatically expand its community-based programs at an estimated cost of $30-35,000,000 over the next two years.

And, in response to a pending case, Lasimone v. Garrahy, (D.R.I. 1979), Rhode Island has placed almost a quarter of its institutionalized mentally retarded population (150 of 650) in newly created community-based programs, is continuing to create new community beds for many of the remaining patients, and will spend an additional $7-8,000,000 per year to create community beds for mentally retarded persons who are now living in the

community.[1]

The central message of these cases is clear: the implementation of a judicial decree in institutional "conditions cases" usually always requires expansion of community-based programs and can be extremely expensive.

With the exception of the considerable efforts of DHMH to deinstitutionalize mentally retarded persons who are confined inappropriately in mental institutions, the process of deinstitutionalizing mentally retarded persons has slowed considerably in Maryland in recent years because adequate funds have not been allocated to create new community-based programs. This critical absence of resources was pointed out by the General Assembly's Division of Budget Review in its 1979 publication, "Deinstitutionalization in Maryland", in which the Division concludes that:

> "The lack of sufficient community programs, primarily due to inadequate funds, results in keeping patients in large institutions who really should be treated in more humane and appropriate community-based programs." Id. at 1.

Due to this lack of community services, the Division concludes that "deinstitutionalization in Maryland appears to be at a standstill". Id. at 3.2 The jeopardy Maryland is placed in as a result of this deinstitutionalization "standstill" is given immediacy by the recent enactment by the United States Congress

1. The cost figures in the above cases were obtained from assistant attorneys general representing the defendant states. They are rough estimates and, because they measure the total increases in State budgets for improvements in the institutional care and expansion of community-based programs from the date lawsuits were filed, they include the costs of both expenditures made as a result of State policy, and those mandated, or thought to be mandated by law. However, it is clear from conversations with the respective assistant attorneys general that pending litigation and judicial decrees were a major reason for the expenditures.

2. While the population of Rosewood dropped sharply from FY 1972 (2,550) to FY 1980 (1,207), this population has "plateaued" at about 1,200. Similarly, since FY 1980, the total population of MRA institutions has remained at about 2,500.

of H.B. 10 (the act that authorizes the United States Department of Justice to investigate and, if necessary, to suc state institutions to enforce the civil rights of institutionalized persons), the Justice Department's continuing investigation of Rosewood, and the pendency in State court of Bauer v. Mandel, Equity No. 22,871 (Cir. Ct. A.A. County), a case that raises under State and federal law all the issues remanded for lower court consideration by the Supreme Court in Pennhurst.

In sum, the State's potential legal liability in this area was not completely, or even primarily resolved by the Pennhurst deeision. Legally, we should do considerably more to improve institutional conditions and increase the number of community-based programs for mentally retarded patients. If we don't, we continue to assume the real risk that we will be ordered to do so by a State or fedcral court.

Very truly yours,

Stephen H. Sachs

mpk

cc: Governor Harry R. Hughes
Ejner J. Johnson
Dr. Stanley R. Platman
Mr. Bernard A. Carpenter, Jr.
Randall M. Lutz, Esq.

MARYLAND CENTER FOR HEALTH STATISTICS
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 W. PRESTON STREET - BALTIMORE, MARYLAND 21201 - AREA CODE 301 - 383-2850
[redacted] SECRETARY
Charles R. Buck, Jr., Sc.D.

MENTAL HEALTH STATISTICAL SYSTEMS IN MARYLAND

Presently there are two routinized Mental Health Statistical information systems that are operating in the Maryland Center for Health Statistics (MCHS). In addition special studies in the Mental Health area are done on a periodic basis as well as compilation of the data from outside sources.

I. The two routinized data systems[1] pertaining to the Mental Health Service System are designed to output statistical information on patient movement (on a daily and monthly basis) within the State operated psychiatric hospital centers and patient/client characteristics at the point of admission and separation from the reporting facility (usually on a quarterly or annual basis). Reporting facilities include state operated psychiatric inpatient facilities; Mental Health outpatient facilities; private psychiatric hospitals and designated psychiatric units within general hospitals.

(A) The first system - the patient movement system - which deals exclusively with state operated psychiatric inpatient facilities, serves two main functions. Since this system is designed to operate on a daily basis, i.e., one transaction form (Attachment A) listing each patient movement is forwarded to the center each day, it allows for "timely" output for all patients entering or leaving the hospital system.

From this daily report, which is also used by the Division of Reimbursements for input to the patient master file, center staff compute the measures that appear on the monthly report (see Attachment B).

[1]The second of the routinized systems (i.e., DHMH 500) also captures information on Mental Health outpatient programs, private psychiatric hospitals and designated psychiatric units of general hospitals.

(B) The characteristics (i.e., demographic, clinical) of patients entering and leaving the hospital centers are obtained through the second routinized statistical system. This system, usually referred to as the DHMH 500 - Patient Service Record, is designed to output information on patient characteristics, both clinical and demographic, at the point of entry and separation from the hospital centers. The procedures for this system are as follows:

1. person enters or leaves hospital - hospital personnel collect data on patient's demographic characteristics, e.g., age, sex, race, etc., previous treatment history and clinical characteristics viz, diagnosis.
2. Patient Service Record (DHMH 500) is completed and forwarded to MCHS, fifteen days after the close of the month.
3. Patient Service Record is received by MCHS staff, cross checked with the patient movement sheet. This procedure is only performed for state hospital centers (see Attachment A) to make sure all cases are accounted for. Then manual edit checks are performed on the 500 document for completeness, legibility and inter-response consistency. If errors are detected, center staff contact the reporting facility to obtain correct information. Also, coding procedures are carried out on geographic residence variables (e.g., census tract), previous treatment history and diagnostic descriptions.
4. After editing and coding, forms are "batched" together and sent to data entry for transaction processing. During this phase, transactions are "fed" into an automated edit program where any response outside the "valid" range of responses is printed on the error report and sent to MCHS for correction and re-entry.
5. After the transaction data have been "cleaned up", they are added to the "Mental Master File" through the production control system of the Division of Data Processing. This file is maintained in the tape library of the Baltimore Data Center (BDC) and accessed whenever a specialized data set needs to be created, e.g., Fiscal Year 1980 admissions to state hospitals. This file is constructed such that all admissions and discharge episodes are encoded jointly. However the same individual may have more than one admission and discharge episode recorded on the master file. This type of file

structure will only yield information on "duplicate" episode (admission or discharge) counts. Efforts are underway, through the use of the unit case numbering system, to produce file structures that will provide longitudinal data as well as unduplicated counts of "persons" served.

6. After the data set in question has been created, MCHS staff access these data through the use of "canned" statistical software packages, e.g., Statistical Packages for Social Sciences (SPSS). The outputs from this system are varied. They range from general information usually compiled on an annual basis to special requests from persons inside and outside of the department.

The attached materials are representative of the various outputs that have been obtained through this system (See Attachments).

II. Special Studies are also a major source of mental health statistical information available from MCHS. These studies have focused mainly on specific issues within the Mental Health Service system, e.g., Aftercare, CSS Target Population, Outpatient Caseload Mix.

Special Studies[2] - Level of Care Studies at Psychiatric Regional Hospital Centers

Every August since 1976, the Center has conducted a "one day census" of all persons present in the hospital on the day of the census. Information on patient demographic characteristics, diagnosis, length of stay and treatment history were collected.

Results of these studies have been distributed in the statistical note series (see Attachments).

Eastern Shore Aftercare Project and Follow-up Study - This is a cooperative data collection effort between MCHS, and Eastern Shore Hospital Center and county based aftercare coordinators. Project has been operating since Fiscal Year 1978. Results for the first two years have been distributed in Statistical Notes #22 and 23 (see Attachments).

Master and Individual Facility Plans - Data from the patient movement system and the DHMH 500 were supplied for use in the master facility plan and also in some of the individual facility plans, e.g., Spring Grove.

[2]Procedures for data collection, reduction, analysis and output for special studies are basically identical to those described under the patient service record (DHMH 500) system.

Client Profile - Cooperative data collection effort between PIE unit - MHA, MCHS and reporting mental health clinics. Methods and results of this study have been circulated in Statistical Note 18- 1 & 2.

III. Mental Health Statistical Systems "Outside" of MCHS

(A) Patient Reimbursement Master File - This system is designed to accumulate patient days in hospital in order for the division of reimbursements to bill clients. There is also a sponsor record that indicates payment source. This system only operates for state inpatient facilities.

(B) Monthly Services Report - This report is maintained by the Planning Information and Evaluation Unit (PIE) of the Mental Hygiene Administration. The system compiles aggregate "services rendered" data from outpatient clinics on a quarterly basis.

(C) Maryland Health Services Cost Review Commission - Discharge abstract files are maintained on all general hospital inpatient episodes by this agency. Output from these files (selecting only those cases with a diagnosis of mental disorder) have been used in the Statistical Note Series (see Statistical Notes #13 and 19).

EXHIBIT 2

DAILY HOSPITAL REPORT

CENSUS CHANGE REPORT COUNT

EASTERN SHORE STATE HOSPITAL

BMH 750

2062

18

REGISTER OF PATIENT MOVEMENT

5 DIGIT PATIENT NUMBER	PATIENT – LAST NAME FIRST	WARD NUMBER OUT	WARD NUMBER IN	1 RECEIVED	3 ELOPED	4 ON VISIT	5 FOSTER CARE	6 CONV. LV.	7 TRANS. OUT	8 DISCHARGED	9 DIED
07056			06	81							
07057			06	01							
00860			07	41							
06960		02				14					
06445		01				14					
06920		05				14					
05929		01				14					
06534		04				14					
06685		05				14					
06915		04				14					
06789		00						46			
07025		04				14					
04527		05				14					
06966		04						16			
06963		04				14					
06716		00								68	
07038		01								18	
07055		03	04								

Attachment A

FOR THIS DAY ENDING AT MIDNIGHT	December 9, 1960
REGISTERED PATIENTS	
+ YESTERDAY	891
+ 01	1
+ 71	0
+ 81	1
– X7	0
– X8	2
– X9	0
NOW REGISTERED	891
HOSPITAL POPULATION	
+ YESTERDAY	684
+ X1	3
– 1X	12
NOW IN HOSPITAL	675
ELOPEMENT STATUS	
+ YESTERDAY	4
+ X3	0
– 3X	0
NOW ON ELOPEMENT	4
PATIENTS ON VISIT	
+ YESTERDAY	32
+ X4	10
– 4X	2
NOW ON VISIT	40
PATIENTS IN FOSTER CARE	
+ YESTERDAY	26
+ X5	0
– 5 X	0
NOW IN FOSTER CARE	26
PATIENTS ON CONV. LEAVE	
+ YESTERDAY	145
+ X6	2
– 6X	1
NOW ON CONV. LEAVE	146
PROOF OF REGISTRY	
1 POPULATION +	675
3 ELOPEMENTS +	4
4 ON VISIT +	40
5 IN FOSTER +	26
6 ON CONV. +	146
REGISTERED –	891
DIFFERENCE	0
PROOF OF POPULATION	
+ WARD COUNT	675
– COMPUTED POP.	675
DIFFERENCE	0
INTER-WARD MOVEMENT TODAY	1
PAGE 1 OF 1	

GENERAL HOSPITALS WARD CODE 99
MEDICAL RECORDS WARD CODE 00

OUT IN 1 3 4 5 6 7 8 9

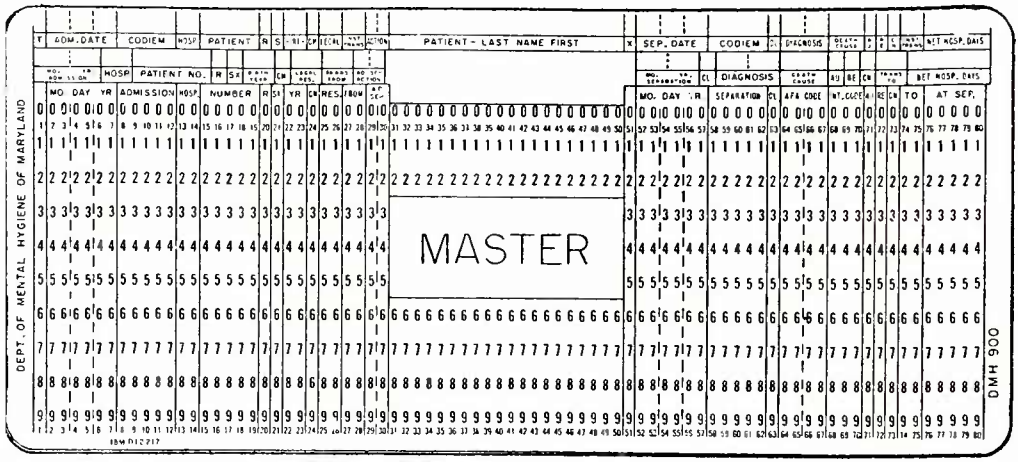
CERTIFIED BY MEDICAL RECORDS LIBRARIAN

2062 FORM L

FRIDAY DEC 09 1960

EXHIBIT 3

MASTER CARD, DMH-900



Card Column	Information
2-7	Admission Date
13-14	Facility
15-19	Patient Number
20	Race
21	Sex
22-23	Birth Year
24	Type of Commitment
25-26	Place of Residence
27-28	Transfer In From
29	Type of Admission
31-50	Name

All Other Columns Are Used For Other Than Register Purposes.

ATTACHMENT B

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

PSYCHIATRIC INPATIENT FACILITIES
STATISTICAL REPORT FOR JULY 1, 1980 - JANUARY 31, 1981

TABLE 1
MAXIMUM AND AVERAGE OCCUPANCY RATES

	TOTAL	CROWNSVILLE	EASTERN SHORE	SPRINGFIELD	SPRING GROVE	S.W. CMHC SPRING GROVE	CARTER A. UNIT ONE ***	C.T. PERKINS	HIGHLAND PSYCHIATRIC UNIT	THOMAS S. FINAN *****	WALTER P. CARTER	RICA I (BALTO.)	RICA II (MONT.CO.)
AVERAGE PATIENT POPULATION	3,492	512	309	1,335	587	28	241	234	30	107	51	38	20
MAXIMUM PATIENT POPULATION	3,788	549	352	1,387	628	37	257	242	43	124	62	59	48
RATED CAPACITY*													
LICENSED CAPACITY**	4,583	544	410	1,510	1,362	35	****	246	48	221	71	80	56**
OCCUPANCY RATES:													
FOR LICENSED CAPACITY													
BASED ON AVERAGE POP.	76.2	94.1	75.4	88.4	60.8	80.0	****	95.1	62.5	48.4	71.8	47.5	35.7
BASED ON MAXIMUM POP.	82.7	100.9	85.9	91.9	63.9	105.7	****	98.4	89.6	56.1	87.3	73.8	85.7

*EXCLUDES MEDICAL-SURGICAL BEDS
**INCLUDES ONLY 2 OF THE 3 LICENSED COTTAGES AT RICA-II
***CARTER A BEGAN REPORTING SEPTEMBER 17, 1979 (UNIT I - SPRING GROVE)
****INCLUDED IN SPRING GROVE FIGURES
*****THOMAS S. FINAN BEGAN REPORTING OCTOBER 23, 1978

PREPARED BY: MARYLAND CENTER FOR HEALTH STATISTICS

DMHH 1359

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

PSYCHIATRIC INPATIENT FACILITIES
STATISTICAL REPORT FOR JANUARY 1981

TABLE 2
AVERAGE NUMBER OF HOSPITALIZED PATIENTS

MONTH	TOTAL	CROWNS-VILLE	EASTERN SHORE	SPRING-FIELD	SPRING GROVE	S.W. CMHC SPRING GROVE	CARTER A. UNIT ONE	C.T. PERKINS	HIGHLAND PSYCHIATRIC UNIT	THOMAS B. FINAN	WALTER P. CARTER	RICA I (BALTO.)	RICA II (MONT.CO.)
JANUARY, 79	3,756	627	303	1,466	969	22	-	229	14	35	37	54	-
JANUARY, 80	3,652	541	320	1,421	626	21	279	235	13	100	53	43	-
JANUARY, 81	3,449	496	288	1,324	576	26	235	234	36	109	51	38	36
7 .....MONTH AVERAGE (FISCAL YEAR)													
1979	3,829	626	314	1,512	1,021	25	-	221	12	27	23	48	-
1980	3,783	588	319	1,417	728	25	305	230	16	80	40	35	-
1981	3,492	512	309	1,335	587	28	241	234	30	107	51	38	20
CHANGE (1981-1979)	-337	-114	-5	-177	-434	+3	+241	+13	+18	+80	+28	-10	+20

TABLE 3
TOTAL NUMBER OF PATIENTS UNDER CARE

MONTH	TOTAL	CROWNS-VILLE	EASTERN SHORE	SPRING-FIELD	SPRING GROVE	S.W. CMHC SPRING GROVE	CARTER A. UNIT ONE	C.T. PERKINS	HIGHLAND PSYCHIATRIC UNIT	THOMAS B. FINAN	WALTER P. CARTER	RICA I (BALTO.)	RICA II (MONT.CO.)
JANUARY, 79	5,586	1,170	410	1,891	1,443	42	-	371	40	39	94	86	-
JANUARY, 80	5,244	913	431	1,808	983	47	354	361	38	130	109	70	-
JANUARY, 81	4,717	628	379	1,672	889	48	305	351	76	149	105	62	53
7 .....MONTH TOTAL (FISCAL YEAR)													
1979	11,633	2,233	920	3,556	3,323	137	-	549	464	43	291	117	-
1980	11,267	1,783	994	3,484	2,824	139	605	598	188	225	320	107	-
1981	9,346	1,134	877	2,982	1,997	148	526	558	277	310	383	99	55
CHANGE (1981-1979)	-2,287	-1,099	-43	-574	-1,326	+11	+526	+9	-187	+267	+92	-18	+55

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

PSYCHIATRIC INPATIENT FACILITIES
STATISTICAL REPORT FOR JANUARY 1981

TABLE 4
AVERAGE NUMBER OF PATIENTS ON HOSPITAL BOOKS

MONTH	TOTAL	CROWNSVILLE	EASTERN SHORE	SPRINGFIELD	SPRING GROVE	S.W. CMHC SPRING GROVE	CARTER A. UNIT ONE	C.T. PERKINS	HIGHLAND PSYCHIATRIC UNIT	THOMAS B. FINAN	WALTER P. CARTER	RICA I (SALTO.)	RICA II (MONT.CO.)
JANUARY, 79	4,580	961	337	1,628	1,117	29	-	337	15	35	39	82	-
JANUARY, 80	4,374	806	346	1,556	743	32	318	329	14	109	56	65	-
JANUARY, 81	3,988	555	312	1,451	710	30	275	323	39	119	70	55	49
7 ....MONTH AVERAGE (FISCAL YEAR)													
1979	4,962	692	348	1,709	1,169	33	-	323	13	27	24	84	-
1980	4,648	916	356	1,568	872	36	349	339	17	93	44	58	-
1981	4,059	591	339	1,474	716	33	281	324	32	119	63	61	26
CHANGE (1981-1979)	-633	-371	-9	-235	-453	-	+281	+1	+19	+92	+39	-23	+26

TABLE 5
TOTAL NET RELEASES*

MONTH	TOTAL	CROWNSVILLE	EASTERN SHORE	SPRINGFIELD	SPRING GROVE	S.W. CMHC SPRING GROVE	CARTER A. UNIT ONE	C.T. PERKINS	HIGHLAND PSYCHIATRIC UNIT	THOMAS B. FINAN	WALTER P. CARTER	RICA I (SALTO.)	RICA II (MONT.CO.)
JANUARY, 79	942	212	64	249	295	9	-	35	23	2	51	2	-
JANUARY, 80	941	176	89	258	239	15	40	30	23	15	51	5	-
JANUARY, 81	706	74	56	221	179	17	27	27	35	27	34	8	1
7 ....MONTH TOTAL (FISCAL YEAR)													
1979	6,875	1,229	554	1,853	2,180	104	-	223	447	4	248	33	-
1980	6,801	1,009	622	1,887	2,035	108	312	246	173	105	262	42	-
1981	5,227	558	530	1,470	1,285	118	237	235	236	187	323	45	3
CHANGE (1981-1979)	-1,648	-671	-24	-383	-895	+14	+237	+12	-211	+183	+75	+12	+3

*HOSPITAL DISCHARGES PLUS PLACEMENTS ON LONG-TERM LEAVE MINUS RETURNS TO HOSPITAL FROM LONG-TERM LEAVE

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

PSYCHIATRIC INPATIENT FACILITIES
STATISTICAL REPORT FOR JANUARY 1981

TABLE 6
TOTAL ADMISSIONS

MONTH	TOTAL	CROWNS-VILLE	EASTERN SHORE	SPRING-FIELD	SPRING GROVE	S.W. CMHC SPRING GROVE	CARTER A. UNIT ONE	C.T. PERKINS	HIGHLAND PSYCHIATRIC UNIT	THOMAS B. FINAN	WALTER P. CARTER	RICA I (BALTO.)	RICA II (MONT.CO.)
JANUARY, 79	1,010	216	86	227	327	15	-	36	25	11	62	5	-
JANUARY, 80	817	56	85	240	253	15	27	33	21	28	53	6	-
JANUARY, 81	717	64	66	199	186	19	32	31	34	24	45	5	12
						TOTAL ADMISSIONS							
7 MONTH TOTAL (FISCAL YEAR)													
1979	6,902	1,237	568	1,806	2,138	100	-	241	452	43	281	36	-
1980	6,619	816	652	1,851	1,673	109	605	260	165	160	285	43	-
1981	5,222	495	525	1,476	1,276	124	237	233	253	193	325	30	55
CHANGE (1981-1979)	-1,680	-742	-43	-330	-862	+24	+237	-8	-199	+150	+44	-6	+55
						FIRST ADMISSIONS							
7 MONTH TOTAL (FISCAL YEAR)													
1979	2,357	480	201	542	577	36	-	102	263	25	95	36	-
1980	2,494	325	247	758	505	32	49	119	96	138	189	36	-
1981	2,246	218	213	653	420	36	56	118	151	115	191	25	50
CHANGE (1981-1979)	-111	-262	+12	+111	-157	-	+56	+16	-112	+90	+96	-11	+50
						READMISSIONS							
7 MONTH TOTAL (FISCAL YEAR)													
1979	4,545	757	367	1,264	1,561	64	-	139	189	18	186	-	-
1980	4,125	491	405	1,093	1,168	77	556	141	69	22	96	7	-
1981	2,976	277	312	823	856	88	181	115	102	78	134	5	5
CHANGE (1981-1979)	-1,569	-480	-55	-441	-705	+24	+181	-24	-87	+60	-52	+5	+5

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

PSYCHIATRIC INPATIENT FACILITIES
STATISTICAL REPORT FOR JANUARY 1981

TABLE 7
TOTAL LIVE DISCHARGES

MONTH	TOTAL	CROWNSVILLE	EASTERN SHORE	SPRINGFIELD	SPRING GROVE	S.W. CMHC SPRING GROVE	CARTER A. UNIT ONE	C.T. PERKINS	HIGHLAND PSYCHIATRIC UNIT	THOMAS B. FINAN	WALTER P. CARTER	RICA I (BALTO.)	RICA II (MONT.CO.)
JANUARY, 79	949	207	64	258	297	9	-	36	23	2	51	2	-
JANUARY, 80	948	177	91	258	243	15	40	32	23	14	50	5	-
JANUARY, 81	715	76	56	226	179	18	29	26	35	27	34	8	1
7 MONTH TOTAL (FISCAL YEAR)													
1979	6,866	1,245	547	1,869	2,155	104	-	214	447	4	248	33	-
1980	6,873	1,026	633	1,897	2,067	107	290	269	173	108	261	42	-
1981	5,252	573	530	1,487	1,275	118	246	233	236	187	319	45	3
CHANGE (1981-1979)	-1,614	-672	-17	-382	-880	+14	+246	+19	-211	+183	+71	+12	+3

TABLE 8
TOTAL DEATHS

MONTH	TOTAL	CROWNSVILLE	EASTERN SHORE	SPRINGFIELD	SPRING GROVE	S.W. CMHC SPRING GROVE	CARTER A. UNIT ONE	C.T. PERKINS	HIGHLAND PSYCHIATRIC UNIT	THOMAS B. FINAN	WALTER P. CARTER	RICA I (BALTO.)	RICA II (MONT.CO.)
JANUARY, 79	16	3	2	8	3	-	-	-	-	-	-	-	-
JANUARY, 00	23	3	4	7	9	-	-	-	-	-	-	-	-
JANUARY, 81	17	2	7	4	3	-	-	-	-	1	-	-	-
7 MONTH TOTAL (FISCAL YEAR)													
1979	147	20	29	62	25	1	-	-	-	2	-	-	-
1980	121	24	25	44	26	-	1	-	-	1	-	-	-
1981	115	11	31	53	14	-	3	1	-	2	-	-	-
CHANGE (1981-1979)	-32	-17	+2	-9	-11	-1	+3	+1	-	-	-	-	-

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

PSYCHIATRIC INPATIENT FACILITIES
STATISTICAL REPORT FOR JANUARY 1981

TABLE 9
MONTHLY PATIENT MOVEMENT STATISTICS (PART 1)

	TOTAL	CROWNSVILLE	EASTERN SHORE	SPRINGFIELD	SPRING GROVE	S.W. CHOIC SPRING GROVE	CARTER A. UNIT ONE	C.T. PERKINS	HIGHLAND PSYCHIATRIC UNIT	THOMAS B. FINAN	WALTER P. CARTER	RICA I (BALTO.)	RICA II (MONT.CO.)
PATIENTS ON HOSPITAL BOOKS AS OF JANUARY 1, 1981	4,000	564	313	1,473	703	29	271	320	42	125	60	57	41
IN HOSPITAL	3,279	474	282	1,297	544	20	223	233	35	108	36	15	12
MEDICAL LEAVE	29	7	1	7	7	-	4	-	-	1	1	-	1
UNAUTHORIZED LEAVE	57	3	3	23	17	-	3	3	-	1	1	1	2
VISIT	355	54	21	90	69	7	22	1	7	8	9	41	26
FOSTER CARE	76	-	-	25	30	2	16	3	-	-	-	-	-
CONVALESCENT LEAVE	204	26	6	31	36	-	5	80	-	7	13	-	-
ADMISSIONS TO HOSPITAL	717	64	66	199	186	19	32	31	34	24	45	5	12
FIRST ADMISSIONS	344	28	24	90	83	7	8	16	23	19	33	4	9
READMISSIONS	350	36	42	107	92	11	18	14	11	5	12	1	1
TRANSFERS IN	23	-	-	2	11	1	6	1	-	-	-	-	2
DISCHARGES FROM	715	76	56	226	179	18	29	26	35	27	34	8	1
HOSPITAL	523	67	40	145	138	12	13	26	32	17	29	4	-
MEDICAL LEAVE	-	-	-	-	-	-	-	-	-	-	-	-	-
UNAUTHORIZED LEAVE	37	-	4	19	4	-	2	-	2	1	4	1	-
VISIT	108	7	12	53	20	3	4	-	1	5	-	3	-
FOSTER CARE	12	-	-	4	5	1	2	-	-	-	-	-	-
CONVALESCENT LEAVE	10	2	-	3	1	-	-	-	-	4	-	-	-
TRANSFERS OUT	25	-	-	2	11	2	8	-	-	-	1	-	1
DEATHS	17	2	7	4	3	-	-	-	-	1	-	-	-
HOSPITAL	14	1	7	3	3	-	-	-	-	-	-	-	-
MEDICAL LEAVE	3	1	-	1	-	-	-	-	-	1	-	-	-
UNAUTHORIZED LEAVE	-	-	-	-	-	-	-	-	-	-	-	-	-
VISIT	-	-	-	-	-	-	-	-	-	-	-	-	-
FOSTER CARE	-	-	-	-	-	-	-	-	-	-	-	-	-
CONVALESCENT LEAVE	-	-	-	-	-	-	-	-	-	-	-	-	-

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

PSYCHIATRIC INPATIENT FACILITIES

STATISTICAL REPORT FOR JANUARY 19 81

TABLE 9

MONTHLY PATIENT MOVEMENT STATISTICS (PART 2)

	TOTAL	CROWNS-VILLE	EASTERN SHORE	SPRING-FIELD	SPRING GROVE	S.W. CMHC SPRING GROVE	CARTER A. UNIT ONE	C.T. PERKINS	HIGHLAND PSYCHIATRIC UNIT	THOMAS B. FINAN	WALTER P. CARTER	RICA I (BALTO.)	RICA II (MONT.CO.)
PLACEMENTS ON LEAVE	1,219	85	63	378	167	15	80	44	29	36	65	139	118
MEDICAL LEAVE	49	8	2	16	8	1	4	-	2	5	3	-	-
UNAUTHORIZED LEAVE	99	3	5	52	11	-	7	-	3	7	1	-	10
VISIT	1,058	74	56	308	141	14	69	43	24	21	61	139	108
FOSTER CARE	5	-	-	2	3	-	-	-	-	-	-	-	-
CONVALESCENT LEAVE	8	-	-	-	4	-	-	1	-	3	-	-	-
RETURNS TO HOSPITAL FROM	1,126	102	46	334	151	14	74	33	25	30	59	144	114
MEDICAL LEAVE	44	10	-	15	7	-	3	-	2	4	3	-	-
UNAUTHORIZED LEAVE	65	2	-	38	8	-	3	-	1	5	1	-	7
VISIT	1,005	90	46	277	132	14	68	33	22	17	55	144	107
FOSTER CARE	2	-	-	2	-	-	-	-	-	-	-	-	-
CONVALESCENT LEAVE	10	-	-	2	4	-	-	-	-	4	-	-	-
TRANSFERS TO OTHER LEAVE FROM	21	-	-	8	4	-	-	-	-	6	3	-	-
MEDICAL LEAVE	1	-	-	-	-	-	-	-	-	-	1	-	-
UNAUTHORIZED LEAVE	4	-	-	1	-	-	-	-	-	3	-	-	-
VISIT	16	-	-	7	4	-	-	-	-	3	2	-	-
FOSTER CARE	-	-	-	-	-	-	-	-	-	-	-	-	-
CONVALESCENT LEAVE	-	-	-	-	-	-	-	-	-	-	-	-	-
TRANSFERS FROM OTHER LEAVE TO	21	-	-	8	4	-	-	-	-	6	3	-	-
MEDICAL LEAVE	-	-	-	-	-	-	-	-	-	-	-	-	-
UNAUTHORIZED LEAVE	8	-	-	3	1	-	-	-	-	1	3	-	-
VISIT	1	-	-	1	-	-	-	-	-	-	-	-	-
FOSTER CARE	2	-	-	1	1	-	-	-	-	-	-	-	-
CONVALESCENT LEAVE	10	-	-	3	2	-	-	-	-	5	-	-	-
PATIENTS ON HOSPITAL BOOKS AS OF JANUARY 31, 1981	3,985	550	316	1,442	707	30	276	325	41	121	71	54	52
IN HOSPITAL	3,341	487	284	1,302	562	24	228	227	33	109	45	21	19
MEDICAL LEAVE	30	4	3	7	8	1	5	-	-	1	-	-	1
UNAUTHORIZED LEAVE	58	4	4	20	17	-	5	3	-	-	-	-	5
VISIT	205	31	19	62	54	4	19	11	8	4	13	33	27
FOSTER CARE	69	-	-	22	29	1	14	3	-	-	-	-	-
CONVALESCENT LEAVE	202	24	6	29	37	-	5	81	-	7	13	-	-

CURRENT STATUS OF DEINSTITUTIONALIZATION IN MARYLAND

Mental Retardation and Developmental Disabilities Administration (MRDDA)

The Joint Committee received a progress report on the development of a client data system for MRDDA. The lack of such a system is acknowledged as one of the impediments to deinstitutionalization.

Bernard A. Carpenter, Jr., Director, MRDDA, reported that the First Report of the Joint Committee and the Fourth Report of the Humane Practices Commission served as the impetus for MRDDA to convince the Department of Health and Mental Hygiene to allocate some money appropriated to the Office of the Secretary toward developing a data base system.

In February 1981, MRDDA formed a Data System Task Force with a budget of $47,744. Under the system, the costs of a fully implemented individualized program plan should be able to be determined. Between $50,000 to $60,DOD in F.Y. 1982 will be needed to develop a "cost overlay" to associate client service data with costs. This data system should enable MRDDA to target its dollars to the mentally retarded population in greatest need.

Once a data collection system is established, the next step is a systematic approach to develop a single point of entry into the service system so that clients can enter the system at one point. That point could be the local health department, a residential center, or some other point in a county or regional basis where needs can be assessed, programmed, and projected for the use of services.

Mr. Carpenter expressed State policy as first to survey the known retarded population and then try to deal with the unknown population. MRDDA feels that the State priority for direct services should be focused on persons with severe and profound handicapping conditions.

Between 2,500 - 2,600 clients currently are in State institutions. Another 1,015 are in community residential programs with day program components, plus approximately 1,764 in community day programs with transportation services.

Dr. James A. Brahlek, Program Director at Rosewood Center, who heads the Data System Task Force, indicated that the Rosewood client file should be in place by the end of 1981, with preliminary reports testing off the file. In early 1983, MRDDA hopes to add the financial component to the system (see Appendix M, Report On The Progress To Date Of The Development Of A Client Data System For the Mental Retardation And Developmental Disabilities Administration).

An important action of MRDDA is the contract consumated in July, 1981 with the John F. Kennedy Institute in Baltimore City. This contract involves a study of the use and feasibility of applying Title XIX funds to support community-based residential programs of 4 - 15 beds, as 23 other states have done. The results of this study should be available from MRDDA in February, 1982.

Another item of concern to the Joint Committee was expressed in its First Report as "... fragmentation of services for the mentally ill and mentally retarded, and the lack of coordination of these services within the Executive departments." Dr. Stanley R. Platman said that, with the new directors, Mr. Carpenter and Dr. Alp Karahasan, the Mental Retardation and Developmentally Disabled Administration (MRDDA) and the Mental

Hygiene Administration (MHA) now work together in terms of evaluation, placement in the community, and in transferring persons to State residential centers. The law suit brought by Attorney General Stephen H. Sachs to rectify the misplacement of emotionally disturbed mentally retarded patients in mental institutions has facilitated coordination of the two Administrations. Crownsville Hospital Center now serves both populations (the Phillips Building serves the "Sachs population"). Dollars for the Sachs population for both F.Y. 1981 and F.Y. 1982 are being transferred in the supplemental budget. MHA is moving $792,000 from its budget to MRDDA's, to follow the client either into an MRDDA institution or into the community. Extensive planning is required to follow the client in the joint budget processes. Agreements now exist to place clients in the community with back-up community mental health services. If any of these services and programs fails, the client suffers.

Dr. Platman explained that one of his functions is to seek an early resolution of problems or conflicts between Dr. Karahasan and Mr. Carpenter with, hopefully, "a correct arbitrary decision." He pointed out, however that some clients do not fit simple labels, whether mentally retarded or mentally ill. Clinical skills may determine that some people fit in the middle, or if they fit there today, they may fit some place else tomorrow.

There are clients who are inappropriate for both Administrations, but somehow got placed in one of them and are difficult to place elsewhere. Efforts are being made to resolve such situations with other external groups.

Mental Hygiene Administration (MHA)

In testimony before the Joint Committee, the Department of Health and Mental Hygiene reported that funds for each State facility are based on the per capita cost of each client. Without new funds for the under-utilized new facilities, the Department has been transferring funds from the older facilities to open and operate these new facilities.

For example, the Thomas B. Finan Center is opening its remaining empty units. Staff and clients at Spring Grove Hospital Center are being transferred to the Finan Center. However, an empty cottage remains at RICA II in Montgomery County. It cannot be opened without reallocating funds from some other place.

Two wards at the Clifton T. Perkins Hospital Center have been opened. Perkins is essential in providing forensic services. The Department of Health and Mental Hygiene reported the dilemma of not being able to afford to reduce admittances even though it cannot afford to operate Perkins at its present level. Pressure from judges, police, and the communities have required the Department to assure that Perkins will be operated at maximum bed capacity because of the individuals it serves. Funds for empty beds in other regional facilities have been reallocated to Perkins.

Any reallocation of funds to operate the Eastern Shore Hospital Center at a reduced level for a short period in order to open and operate two units (64 beds) of the now empty Upper Shore Community Mental Health Center would be counterproductive if new funds to sustain both operations are not appropriated (estimated at about $850,000 for F.Y. 1983).

Currently, approximately 85 percent of MHA's entire budget is invested in inpatient and related treatment programs, a ratio to community-based programs (15%) that has continued for a number of years, even though there has been a steady decline in the population of State facilities. The physical condition of older State facilities either have required extensive renovation or complete replacement to satisfy licensing and regulatory bodies. MHA reports that additional staff and other resources are necessary.

The problem that confronts MHA (as with MRDDA) is how to balance the demands for more resources for State facilities while concurrently expanding alternatives to hospitalization.

Excluding specialized treatment facilities such as Clifton T. Perkins and RICA I and II, MHA intends to strike at this problem by shifting a proportion of personnel and finances from older State facilities as their populations decline and buildings are closed, in order to expand alternatives to hospitalization with community-based treatment programs.

Dr. Karahasan has emphasized the importance of adequate "preadmission screening" before admission to a facility, and "aftercare" upon discharge from the facility. As yet no comprehensive management information system exists for aftercare and preadmission screening programs, although data are becoming available from the Eastern Shore Aftercare Project and the Central Maryland Aftercare and Preadmission Screening Pilot Reporting System.

INTRODUCTION

The lack of comprehensive and uniform information describing the need for mental retardation services in the State has been evident. In the November, 1980, Humane Practices Commission Study of the Mental Retardation Services System, it was pointed out that an automated information system has been recognized by the Mental Retardation Developmental Disabilities Administration as a critical component of an integrated planning and service delivery system. In your own report of December, 1980, you noted that the Secretary of the Department of Health and Mental Hygiene has given high priority to establishing an accurate data base that describes the mentally retarded population in the State. It was noted that this data base would include evaluation information, service plans and demographic information of those persons living in institutions as well as in the community. The present report describes the development, current status and future plans regarding the project that was mobilized by the Mental Retardation Developmental Disabilities Administration to address this need.

HISTORY

The Office of the Secretary of the Department of Health and Mental Hygiene made available funds in Fiscal Year 1981 for the initial development of a Mental Retardation Developmental Disabilities Administration data system. During the first half of the fiscal year, the Department conducted a nationwide search of mental retardation data systems and collected extensive information on about 15 data operations conducted in other states. These data operations were reviewed by people in the Division of Management Analysis and by people in the Mental Retardation Developmental Disabilities Administration and were found to fall into two categories. The less effective and less useful types of data systems collected some personal information, behavioral characteristics, and service needs. The second types of data systems were more refined and better developed and included extensive service information and individual behavior characteristics. Although none of these systems have update capability, it was this latter type of system that received favorable review and was chosen to be developed by the Mental Retardation Developmental Disabilities Administration.

In February, 1981, the Mental Retardation Developmental Disabilities Administration gathered a group of state-wide mental retardation professionals both from its institutional programs and from the community. It then formed a Data System Task Force by adding people to the group from Management Analysis and from the Data Processing Division. The purpose of the Task Force was to act as a resource and advisory group to the Mental Retardation Developmental Disabilities Administration, to screen other state systems and evaluate their usefulness to the State of Maryland and to lead in the development of s data system for the Mental Retardation Developmental Disabilities Administration. To the present time, the Task Force has had five full meetings and numerous meetings of sub-committees. In addition, the Chairman of the Committee, Dr. James Brahlek, has met individually with various community providers and their representatives.

The Task Force has so far accomplished the following:

1. It found that there was no data system available in another state which was completely developed, intact and able to be turned over to the State of Maryland for use.

2. The Task Force also determined that to hire a contractor to establish and maintain an appropriate data system would have been very expensive and would have ignored the large pool of talent in this area which currently exists within the State.

3. The Task Force developed a set of goals and objectives and a budget. The goals and objectives and the budget are appended to this report. The Fiscal Year 1981 budget for the project is $47,744.

4. The final draft of most of the input document has been developed and is appended to this report. It contains sections on client identifying information, general abilities, residential needs and day program and ancillary service needs. The part of the input document that records the client's adaptive behavior is still being reviewed by the community providers and will be adopted within the next two weeks.

5. A user's guide that explains all the items of information requested for the input document is in its final stages of development.

6. The decision by the Data Processing Division to help the Mental Retardation Developmental Disabilities Administration develop a data system required some additional equipment to be available to the Data Processing Division. This equipment is on order and should be received before the beginning of the new fiscal year.

7. Initial training and ongoing assistance will be provided by the Mental Retardation Developmental Disabilities Administration for user agencies. The training program has passed through its initial stages of planning and will be implemented beginning in late June or early July, 1981.

8. Coordination of the Mental Retardation Developmental Disabilities Administration's efforts in this project with the Center for Health Statistics has been explored and is being established.

SYSTEM CHARACTERISTICS

As can be seen from the rough draft of the input document appended to this report, a great deal of service-related information will be collected on each client in the Mental Retardation Developmental Disabilities Administration service system.

1. A full range of identifying information will be stored on each client.

2. Types and degrees of handicapping conditions, functional abilities relevant to community placement, and health-related information will be collected.

3. Data regarding residential program needs, both short-term and long-term, are recorded, and obstacles are identified which might prevent future placement.

4. Similarly, information regarding day program placements and needs are recorded by the system.

5. The system collects information about ancillary services required by a client. The hours required by the client's individualized program plan and the actual hours provided to the client will both be recorded. Obstacles preventing full program implementation will be identified.

6. Finally, a full evaluation of the client's adaptive behavior will be collected and stored.

All items of information being recorded can also be updated so that a current client file can be maintained. It will therefore be possible to generate accurate monthly reports that are useful in describing the population and their needs and in forecasting future service needs. In developing this aspect of the system, both the Mental Retardation Developmental Disabilities Administration and its community providers are currently defining the nature of the reports they wish to compile from the data base. In general terms, the various agencies contributing to the data base will be receiving information which will assist them in planning programs for their clients and in measuring the progress being made by their clients. In addition, statistics will be available which will allow agencies to plan programs according to the needs of the clients they are serving. Management reports on service requirements by clients living in specified geographic districts will also be available to the Mental Retardation Developmental Disabilities Administration and will assist in projecting service costs.

Effort will be exerted by the Mental Retardation Developmental Disabilities Administration to assure reliability and accuracy of the system in the future. Ongoing training will be supplied to provider agencies in order to assure quality control of the information being sent to the

Mental Retardation Developmental Disabilities Administration. As a part of this procedure, the Mental Retardation Developmental Disabilities Administration will spot-check on a random basis the manner in which provider agencies are evaluating their clients in order to uphold a high degree of accuracy.

FUTURE PLANS

By January 1, 1983, the Mental Retardation Developmental Disabilities Administration hopes to add a financial component to the data system. The Task Force is currently working on a model and specifications of a financial reporting system which would require provider agencies to define program and other operating costs in terms that can be applied directly to an individual client. These client-related cost centers could then be used to describe and/or project with a high degree of accuracy the cost of any given client's program. With relatively little additional information, it would then be possible to determine the dollar amounts required from various funding sources including the Mental Retardation Developmental Disabilities Administration to support that client's program. By integrating this financial information with information that is already contained in the client's file, particularly with the progress in adaptive behavior made by the client, it will be possible to perform cost benefit analyses on an individual client basis. It will also be possible to identify the ramifications of changes in funding levels.

Two major issues emerged which will have to be addressed if the data system established with Fiscal Year 1981 funds is to continue in the future. The first issue is that continued funding must be available to the Mental Retardation Developmental Disabilities Administration and the Data Processing Division to support and maintain the data system. Printing costs and other material costs will be approximately $7,000 per year. Data entry could be as high as $5,000 per year. Travel for training and the checking of the system reliability will cost about $750. A second issue in maintaining the system is the allocation of personnel. Although most of the manpower requirements for establishing and maintaining the system can be absorbed by redirecting existing staff, it will nevertheless be necessary to devote one full-time position to the continued training of provider agencies and to the maintenance of system reliability. This position cannot be absorbed within existing resources and will require the addition of a position. If this position is not provided to the Mental Retardation Developmental Disabilities Administration, it will be extremely difficult if not impossible to assure the continued maintenance of the Mental Retardation Developmental Disabilities Administration data system.

TASK FORCE MEMBERS

James A. Brahlek, Ph.D., Rosewood Center

Lewis Garmize, Ph.D., Great Oaks Center

Jerry Adams, Calvert County Association for Retarded Citizens

Charles Wiggins, Data Processing Division

Charles Bures, Data Processing Division

John Kozarski, Management Analysis

John Cahill, Management Analysis

Beatrice Terl, Mental Retardation Developmental Disabilities Administration

Richard Glaser, Mental Retardation Developmental Disabilities Administration

Elmer Cerano, Maryland Association for Retarded Citizens

Michael Smull, Rock Creek Foundation

Debbie Woodall, Maryland Center for Health Statistics

GOALS AND OBJECTIVES OF THE MENTAL RETARDATION DEVELOPMENTAL DISABILITIES ADMINISTRATION DATA SYSTEM

The Task Force adopted the series of goals and objectives presented below:

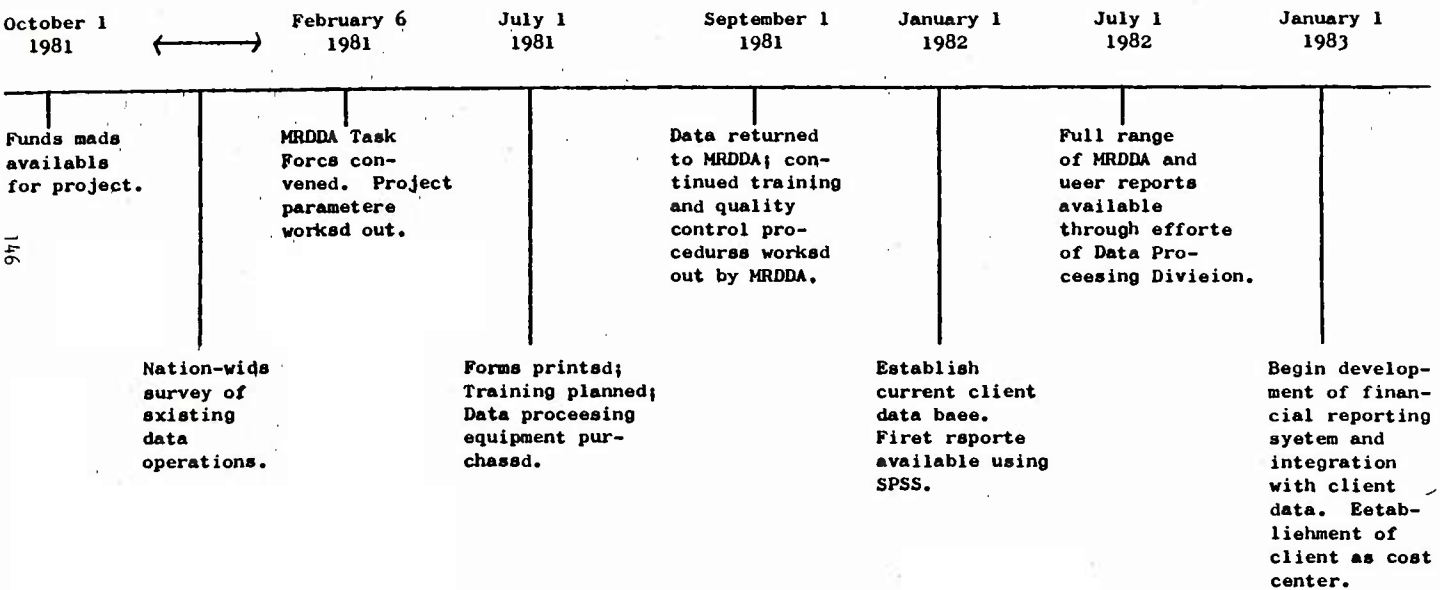
1. Establish client file.
   a. Work out final formats for client data input form and user's manual.
   b. List agencies and determine who within these agencies will fill out the forms.
   c. Provide training to agencies in supplying the data.
   d. Work out logistics of sending forms out and back.
   e. Turn forms over to Data Processing for coding on tape.
   f. Create the file update programs and implement the update system.

2. Establish a management information system on the client file.
   a. List all SPSS reports required by the Mental Retardation Developmental Disabilities Administration and by participating agencies. Determine schedule for each report.
   b. List all special reports required by the Mental Retardation Developmental Disabilities Administration and by participating agencies. Determine schedule for each report.
   c. Develop the non-SPSS computer programs to generate the require management reports.

3. Establish a management information system on the client file with refined financial data.
   a. List and define cost centers. Work out model and specifications for financial reporting system.
   b. Integrate financial reporting system with existing client file.
   c. Develop input document and user's manual to capture financial data.
   d. Provide training to agencies in supplying financial data.
   e. List all financial reports required by the Mental Retardation Developmental Disabilities Administration and by participating agencies. Determine schedule for each report.
   f. Develop computer programs to generate required management reports on combined client/financial information file.

TIMETABLE OF EVENTS

MENTAL RETARDATION DEVELOPMENTAL DISABILITIES ADMINISTRATION DATA SYSTEM



MRDDA DATA BASE

INPUT DOCUMENT

A. IDENTIFYING INFORMATION

1. Client ID Numbers.....

2. Date Completed..... month | day | year

3. Birth Date..... month | day | year

4. Sex.....
   1 = Female
   2 = Male

5. Marital Status.....
   1 = Single (Never Married)
   2 = Married
   3 = Divorced
   4 = Widowed

6. Ethnic Background.....
   1 = Black
   2 = White
   3 = Native American
   4 = Spanish Surname
   5 = Oriental
   6 = Other
   7 = Unknown

7. Residence Code.....
   (See Appendix 1)

8. Date of Admission to MRDDA Service System..... month | day | year

9. Status of Admission to MRDDA Service System.....
   1 = Juvenile Court Commitment
   2 = Other Court Commitment
   3 = Voluntary Admission
   4 = Agreement for Treatment
   5 = Agreement for Treatment of Minor Child
   6 = Interested Party
   7 = Article 59 Transfer (Sach's Population)
   8 = Other (Please Specify)_____

10. Date of Separation from MRDDA Service System... month | day | year

11. Status of Separation from MRDDA System.....
   1 = Interstate Transfer
   2 = Voluntary Transfer Out
   3 = Involuntary Transfer Out
   4 = Death
   5 = Other (Please Specify)_____

12. County of Origin (See Appendix 2)..... [ ]

13. County of Interest (See Appendix 2)..... [ ]

14. Indicate those forms of financial assistance the person receives now and those forms of financial assistance the person is eligible for but does not now receive.

1 = Yes
2 = No

	REC NOW	ELIG BUT NOT REC
Self Support.....		
Family Support.....		
No Source of Financial Assistance.....		
Supplemental Security Income.....		
Other Social Security Benefits.....		
Aid to Families with Dependent Children.....		
Genoral Public Assistance.....		
Medical Assistance.....		
Veteran's Assistance.....		
Private Medical Insurance Benefits.....		
Other Financial Assistance..... (Please Specify)_____		

B. FUNCTIONAL AND DISABILITY STATUS

1. Enter the Primary, Secondary, and Tertiary Disability from the list below (See Appendix 3).

Primary..... [ ]

Secondary..... [ ]

Tertiary..... [ ]

01 = None
02 = Alcoholism
03 = Autism
04 = Cerebral Palsy
05 = Chemical Dependency
06 = Epilepsy
07 = Impairments of Aging
08 = Mental Retardation
09 = Neurological Impairment
10 = Physical/Medical Disability
11 = Psychiatric
12 = Special Learing Disability
13 = Undetermined
14 = Other

2. If Physical/Medical Disability was coded in Item 1, Functional and Disability Status, mark all below that apply (See Appendix 4).

1 = Yes
2 = No

Growth Impairment	
Musculo-Skeletal	
Respiratory	
Cardiovascular	
Digestive	
Genito-Urinary	
Hemic/Lymphatic	
Skin	
Endocrine	
Multiple Body Systems	
Neurological	
Neoplastic Disease	
Hearing Impairment	
Vision Impairment	

3. Date of Last Cognitive Test..... month | day | year

4. Cognitive Test Score.....

5. Estimate of Cognitive Adaptive Function.....
Please use AAMD standards in determining the client's overall level of functioning (See Appendix 5).

1 = Borderline and Above
2 = Mild Retardation
3 = Moderate Retardation
4 = Severe Retardation
5 = Profound Retardation
6 = Not Determined At This Time

6. Mobility (select one response).....

1 = Walks independently
2 = Walks with supportive devices
3 = Walks unaided with difficulty
4 = Wheelchair operated by self
5 = Wheelchair - needs help
6 = No mobility

7. Hearing (select one response).....

1 = Hearing is normal (includes hearing corrected to normal with hearing aid)
2 = Hearing is impaired
3 = No functional hearing
4 = Unknown or not determined at this time

8. Vision (select one response)..... ☐
   1 = Vision is normal (includes vision corrected to normal with glasses)
   2 = Vision is impaired
   3 = Legally blind, has travel vision
   4 = No functional vision
   5 = Unknown or not determined at this time

9. Expressive Language (select one response)..... ☐
   1 = Uses appropriate speech skills
   2 = Uses simple speech (can indicate needs)
   3 = Uses manual language only (i.e. form of sign language)
   4 = Uses written symbol language only (i.e. Bliss, Rebus)
   5 = Uses written language only
   6 = Uses a combination of '2' and either '3', '4', or '5' above
   7 = No expressive skills or nonsensical speech

10. Receptive Language (select one response)..... ☐
   1 = Understands complex statements/ instructions
   2 = Understands simple statements/ instructions
   3 = Does not demonstrate understanding
   4 = For hearing impaired
   5 = Understands by lip reading or signing only

11. Independence Capacity Skills. Rate each item appropriately using the codes below.
   1 = Completely independent
   2 = Needs some supervision or training
   3 = Cannot presently do

   Uses telephone..... ☐
   Uses stove to prepare meals..... ☐
   Uses banking services..... ☐
   Uses neighborhood stores for shopping..... ☐
   Uses laundry to wash clothes..... ☐
   Uses public transportation..... ☐
   Is able to obtain medical service..... ☐
   Is able to summon police or fire dept. in emergency..... ☐
   Is able to understand public signs..... ☐

12. Self-Care Skills. Rate each item appropriately using the codes below.
   1 = Completely independent
   2 = Needs assistance or further training
   3 = Completely dependent

12. Self-Care Skills (con't)

Toileting.....
Eating.....
Dressing.....
Personal Hygiene.....

13. Impediments to Independent Functioning. Identify the major impediments from Appendix 6 and indicate their frequencies from the list below.

1 = Daily
2 = Weekly
3 = Monthly
4 = Has occurred less than 12 times in past year
5 = Has occurred but not in past year

A. Greatest Impediment (from Appendix 6).....
Frequency (from list above).....

B. Second Impediment (from Appendix 6).....
Frequency (from list above).....

C. Third Impediment (from Appendix 6).....
Frequency (from list above).....

14. Seizure History (select one response).....

1 = None (no history)
2 = History, but no seizures in past year
3 = Seizures in past year, but none in last six (6) months
4 = Has had seizures within last six months

15. Seizure Type and Frequency. If Item 14 above is marked "1", leave this item blank and go on to Item 16. If Item 14 above is marked "2", "3", or "4", indicate the frequency below for each type of seizure experienced by the client. Seizure types are defined in Appendix 7. Frequency codes appear below.

1 = Daily
2 = Weekly
3 = Monthly
4 = Less frequent than monthly

	FREQ CODE
A. Minor Motor.....	
B. Major Motor.....	
C. Psychomotor.....	
D. Other (specify) _____	

16. If no medication is used, leave this item blank and go to Item 17. If medication is used, indicate next to each type of medication how it is administered.

1 = By self
2 = By self with supervision
3 = By others

Psychotropic..... ☐
For Diabetes..... ☐
Anticonvulsant..... ☐
Other..... ☐

17. Special Dietary Needs..... ☐

1 = None
2 = Yes, Nutritional Reasons
3 = Yes, Religious Reasons
4 = Yes, Functional Reasons

PROGRAM STATUS AND NEEDS

1. Type of Current Residential Placement

A. Use Residential Alternatives List (Appendix 8) to select current type of residential placement..... ☐

B. Is a change in residential placement projected within the next six months?..... ☐

1 = Yes
2 = No

2. Type of Short-Term Residential Placement Needed in One Year

A. Select the least restrictive residential placement needed in one year. If current placement will also be adequate in one year, enter same code as used in Item 1.A. above..... ☐

B. Identify up to two obstacles preventing access to this placement (See Appendix 9). If no obstacles exist, enter code "99" in both boxes..... ☐ ☐

3. Type of Long-Term Residential Placement Needed.

A. Select the least restrictive residential placement needed in two years. If the placement projected in one year will also be adequate in two years, enter the same code as used in Item 2.A. above..... ☐

B. Identify the single greatest obstacle that might prevent access to placement (See Appendix 9). If no obstacle exists, enter code "99" in the box..... ☐

4. Type of Current Day Program
List the most important day program the person now receives and where it is provided. If applicable, list a second and third program received and their locations. (See Appendix 10 and Appendix 11).

A. Most Important (From Appendix 10)..... ☐

Location of Most Important (From Appendix 11).. ☐☐☐☐☐☐☐☐☐☐

B. Second Most Important..... ☐

Location of Second Most Important..... ☐☐☐☐☐☐☐☐☐☐

C. Third Most Important..... ☐

Location of Third Most Important..... ☐☐☐☐☐☐☐☐☐☐

If not in any Day Program, indicate the Major Obstacle (See Appendix 9)..... ☐

5. Type of Short-Term Day Program Needed

A. Select the single most important day program that the individual should receive in one year (See Appendix 10). If the current program will also be adequate in one year, enter the same code as used in Item 4.A. above..... ☐

B. Identify up to two obstacles that might prevent access to this day program. (See Appendix 9). If no obstacles exist, enter code "99" in the boxes..... ☐☐

6. Type of Long-Term Day Program Needed

A. Select the single most important day program the client should receive in two years (See Appendix 10). If the program projected in one year will also be adequate in two years, enter the same code as used in Item 5.A. above..... ☐

B. Identify the single greatest obstacle that might prevent access to this day program. (See Appendix 9). If no obstacles exists, enter code "99" in the box..... ☐

D. SUPPLEMENTAL HEALTH, THERAPY, AND COMMUNITY GENERIC SERVICES
(See Appendix J1 for definitions of services).

1. In the column "Weekly Hours Required", indicate the service hours per week required by the client's Individualized Program Plan (IPP). If a service is not required, leave the box blank.

2. In the column "Weekly Hours Provided", indicate the service hours per week provided to the client for each of the services marked in the first column. If no service is provided, enter "00".

3. If the service hours provided are less than the service hours required, mark the major specific obstacle preventing the client from receiving the hours required. (See Appendix 9).

	Weekly Hours Required	Weekly Hours Provided	Obstacle
Audiology Services.....			
Dental Services.....			
Nursing Services.....			
Nutritional Services.....			
Occupational Therapy.....			
Physical Therapy.....			
Psychological Services.....			
Recreational Therapy.....			
Routine Medical Services.....			
Specialized Medical Services.....			
Speech/Communication Therapy.....			
Social Work Services.....			
Adult Education.....			
Homemaker Services.....			
Legal Services.....			
Mental Health Counseling.....			
Pers. Care/Home Health Sys. Services..			
Parenthood Planning Services.....			
Pub. Health/ Vis. Nurse Services.....			
Religious/Pastoral Services.....			
Respite Care Services.....			
Transportation Services.....			
Voc. Rehabilitation Services.....			
Other Service (Specify).....			

APPENDIX N

PREPUBLICATION COPY. NOT FOR CITATION OR QUOTATION WITHOUT EXPLICIT PERMISSION OF AUTHOR. REVISED FEBRUARY 24, 1981

(Permission granted June 16, 1981)

ITALY'S REVOLUTIONARY MENTAL HEALTH LAW: AN ASSESSMENT

Loren R. Mosher, M.D.
Department of Psychiatry
Room C1066
Uniformed Services University
of the Health Sciences (USUHS)
4301 Jones Bridge Road
Bethesda, Maryland 20014

ACKNOWLEDGMENTS

I am deeply indebted to many persons who made this study possible, especially to those in the Department of Psychiatry at Verona. In particular I want to thank the following individuals who made such helpful comments on an earlier version of this manuscript: Drs. A. Balestieri, L. Burti and M. Tansella in Verona and Drs. G. Jervis and D. Serwer in Rome.

ITALY'S REVOLUTIONARY MENTAL HEALTH LAW: AN ASSESSMENT

I. Introduction

In May 1978 the Italian Parliament passed the most comprehensive community-oriented mental health act in the Western industrialized world. Because the Italian mental health system had been essentially unchanged since 1904 when the law which the current one replaces was passed, the changes required by the new law are particularly dramatic. The details of the Law #180, as it is called, are given in tables 1, 2 and 3. Its most radical provisions are: 1) Closing of large state hospitals by first stopping all new admissions and then, as of 1 January 1981, all admissions. 2) Involuntary commitment does not utilize dangerousness as a criterion for commitability. 3) All health and social welfare money is pooled and distributed by the federal government to each region (equivalents of states) on a per capita basis. Thus, in contrast to the U.S. system, health and social welfare dollars are not distinguished. The law's attention to community-based catchmented services is not unlike our own CMHC legislation, except that the Italian law leaves greater latitude as to the kinds of services that can be developed. It specifically provides only that no more than one 15-bed unit per general hospital may be established in each Unitá Sanitaria Locale (U.S.L.), the basic catchment area for all health services, usually containing 100- to 120,000 people.

II. Background

The question that first occurred to me during my seven-month stay in Italy to study the law's effects was how did this radical new law come to be in a country we tend to view oversimplistically as the land of wine, pasta, opera and "Kleenex" governments (i.e., rapidly disposable)? How could a society that tends to not be taken very seriously by other Western powers pass a law that converts an early 20th century mental health system into a 21st century one in the course of several years? The answer to this question is complex. To begin with, Italy is much more than pasta and wine. Its parliamentary system of government includes a large and powerful communist party (the PCI), the christian democrats who have governed Italy since 1946, and a number of smaller parties who wield power by acting as "swing" parties in coalition governments. Another critical factor in the development of the new mental health law was the widespread foment in Italian society from 1968 onward. The cultural changes that resulted from this upheaval are reflected in a number of new laws focused on social issues (e.g., abortion, workers' rights, etc.). The new mental health law ("No. 180") can be seen as one in this series of legislative initiatives.

Because of space limitations I cannot do justice to the nuances and multiple forces involved that coalesced to bring about Law #180. Therefore, for the sake of brevity and simplicity (perhaps oversimplistically), I will attempt to sketch the law's background via one of its major proponents, Dr. Franco Basaglia, whose untimely death in August 1980 was a great loss for many Italians from all parts of society. At the outset it should be made clear

that although Basaglia was an important leader and catalyst, without the Italian political system and the social context of change described above, it is much less likely that his efforts would have been successful.

In 1960 Franco Basaglia was an assistant professor in the university psychiatric clinic in Padua, a northern Italian city (near Venice) known for its excellent university. He was one of several bright young professors whose thinking had been influenced by the existential and phenomenologic philosophers and psychiatrists (e.g., Satre, Strauss, Boss, Heidigger). Because the Italian academic system was (and still is, to a large extent) strictly pyramidal, it meant the professor chose his successor and the unchosen were either relegated to a lifetime of obscurity toiling in the academic fields or leaving. Dr. Basaglia chose the latter course. Because lateral academic mobility in Italy is not easy (e.g., Padua faculty has difficulty getting positions at the university in Rome), he became the head of the mental hospital in Gorizia, a small city on the Italian-Yugoslav border. The hospital was a prototypical Italian "manicomio" (their word for large mental hospitals). There were about 800 mostly long-stay patients housed in turn-of-the-century buildings. Although this was 1961, the Italian mental hospital system had not begun to plateau or decline in numbers of resident patients, as was beginning to be the case in the United States. In fact, the Italian mental hospital system did not show a significant decline in resident patients until 1968-70.

Because Dr. Basaglia was impressed by Maxwell Jones' therapeutic community ideas, he started a number of such communities in the hospital in an attempt

to reform it. He became disillusioned with them after a couple of years in that they did not seem to be able to get patients motivated to leave. Basaglia was an extraordinarily gifted clinician, especially with groups of patients and staff. Following his negative experience with Jones-type therapeutic communities, he addressed himself again and again to the clients and the staff asking them, "What is wrong here?" "What is the problem?" It became increasingly clear to him that the problem was the institution itself--its authoritarianism, hierarchy, inflexibility and medicalization of "social" problems. With this in mind, he and his co-workers began what would be a five-year (1963-68) effort to dismantle the institution. They evolved a philosophy that includes the beliefs that psychiatry is politics, that psychiatry provides scientific support of the existing establishment, that scientific neutrality is a myth and that existing standards of normality and deviance resulted in the oppression of certain groups within society. Therefore the approach was essentially nonmedical and antitechnological. Electroshock, lobotomy and the use of mechanical restraints were forbidden. Social services necessary for community survival were developed. Community-based residential programs were implemented. Traditional barriers that distinguished the townspeople from hospital inmates and staff, and patients from staff within the hospital were broken down. Patients were now called users, staff wore no uniforms and had no keys, townspeople were invited to festivals on the hospital grounds, etc. By 1968 there were about 300 patients left in the hospital. Of that 300, roughly 100 were senile-infirm in need of constant nursing care; 100 were senile-noninfirm who just don't want or can't be gotten out of the hospital; and another 100 were chronic psychotic persons, either unable to function in the community, or for whom community housing could not

be found, or who chose to stay behind in the hospital. These last two categories of persons--those who do not need constant nursing care--are redefined as "guests" rather than users. They live in hospital buildings but are free to come and go as they wish. They use the various hospital services and staff on an individualized as-needed basis.

Needless to say, dismantling of a large, traditional state mental hospital did not meet with universal acclaim. In fact, because of a change in government in the Gorizia province, in 1968 strictures were placed on what Dr. Basaglia could do by provincial administrators. Even prior to this time Basaglia and coworkers had been criticized by a variety of groups: psychiatrists, townspeople, and some governmental officials. In fact, Dr. Basaglia's name has been in court for most of the time since he took charge in Gorizia, and when he died in August there was still a suit pending in Trieste about a patient who had run amuck after being discharged from the hospital. Because of these efforts to marginalize or criminalize their work, Dr. Basaglia and his followers decided that in order to continue their reform they needed broad-based popular support. They had been able to enlist the patients and staff in this particular mental hospital to this cause, but now they wanted to start a social movement. Although generally leftist in political philosophy, Basaglia's group had never been active politically. Beginning in 1966, but most actively after 1968, co-incidental with the great social upheaval of that time, they began regular meetings with politicans--mostly leftist in orientation. They promoted the "liberation of the mental patient" as a social reform cause that deserved official political support. Between 1968 and 1974, Basaglia and followers had a rather stormy courtship with the Italian

communist party over this "movement." Finally, in 1973-74, the liberation of the mental patient became an official party doctrine. Although the communist party was vocal in its wish to reform the mental health system, there was also widespread agreement among mental health professionals and laypersons, independent of political affiliation, with that position. This is very important to remember in trying to understand why the new law was greeted with relative aplomb.

In the early seventies the Italian communist party became increasingly powerful--a fact reflected in their increasing their share of the vote from 28% in 1972 to 34% in 1976. The christian democrats decided to be moderate and accommodating in responding to the communists (perhaps because of the first real threat to their 30-year rule). On the other hand, it appears that the communist party may have felt that should they come to power, there might be reprisals against Italy by other Western countries, and so they felt in a somewhat conciliatory mood as well. Thus, new accommodations between the two large parties were reached, including agreement that both would support legislation to reform the health and mental health systems. Although there was a great deal of discussion of this reform in the Italian Parliament between 1973 and 1977, nothing was done legislatively by the spring of 1977.

Enter a new character on the scene: the radical party. This small party (five to seven percent of the seats in parliament) is known as the party of human rights because it has promoted a number of liberal social legislative initiatives in Italy over the past decade. In this instance, it told the two large ruling parties that if a new law was not passed to reform the mental health

system, the existing laws would be subject to a referendum on the June 1978 ballot. The Italian constitution provides that a referendum may be held on any law that exists on the books if one percent of the registered voters sign petitions to that effect. The radical party had enough signatures to call to a referendum on the mental health law. The big parties were very nervous about what might happen because of their experience with the divorce referendum. That is, a referendum on the divorce law had recently passed, much to the surprise of the politicians and the Church. If the mental health law referendum passed, there would no longer be any legal basis for the operation of mental hospitals, payment for their staff, or commitment.

Faced with the possibility of anarchy, the two large parties each appointed a deputy to sit down and write a new mental health act. This act was written in the winter of 1978 and passed in the middle of May, just in time to avoid a referendum in the June elections. Although Dr. Basaglia did not actually write the law, he was in constant telephone and personal consultation with the two deputies who did. So in many respects the law is Dr. Basaglia's, although there are areas of compromise in it.

As part of the politization and popularization of the reform process, the followers of Basaglia did two other things: First, beginning in 1968, they spread out to a number of other cities in the north of Italy--Reggio Emilia, Arezzo, Parma--Basaglia first to Parma and then to Trieste in 1972, where he was until 1978. Following passage of the law, a special position was created for him in Rome where he was until his death. The second step they took (in 1972) was to create a new psychiatric society, called "democratic psychiatry."

In effect, this meant that, to be a member of the society, you were in all likelihood also leftist politically and a follower or believer in the principles of dismantling institutions as espoused by Basaglia and others. It meant also, therefore, that those pschiatrists who were christian democratic or pro-institution were left in the traditional psychiatric society which was, in a sense, forced to align itself with the christian democrats. Thus, in Italy today, psychiatry and politics are inexorably, and openly, intertwined.

III. Results

Any statement about results must be provisional at this point in time. The law has been in effect for only two and one-half years and each regional government had to pass implementing legislation along the way, so that in some regions the law did not really go into effect until as late as September of 1979. The basic, most simple results are given in table 4. Note that the one-year decrease in inpatients is not terribly dramatic. This is in large part due to the fact there had already been a nearly 40 percent decrease in resident patients, mostly after 1968. This also means that there was not a wholesale "dumping" of clients out of hospital. The vast majority of the patients discharged from hospital went either into nursing homes or to their families. In some areas they have gone into group homes or cooperative apartment programs, but these are relatively rare. It must also be remembered that a number of clients who are still in the hospital are called "guests," and are therefore no longer counted in these statistics.

As of September 1980, about 3000 beds had been opened in wards in general hospitals throughout the country. If all of the civil hospital beds that are allowed under the law were in place, there would be roughly 7500 throughout Italy. As usual, conformance with the law in Italy is not always guaranteed, regardless of the law in question. In general, as is usually the case, the North is in better conformance than the South.

IV. Discussion

In my seven months of study in Italy it became clear to me that the law was being phased in at varying speeds throughout the country. Almost everyone was at least verbally committed to trying to conform. The more conservative psychiatrists are not happy with the rate at which hospital beds are being opened and the more untraditional psychiatrists are unhappy with the slow rate at which community-based services are being developed. To some extent both are correct in that obviously not all of the general hospital beds that are allowed have been established and in many places there are essentially no community-based services at all. Places where the majority of the time, energy and personnel have been involved in developing hospital wards, there tend to be few community services.

Because of Basaglia's leadership, the best developed model for community-based services is in Trieste where there are five small mental health centers located in the various sectors of the city. Each is open from 8:00 in the morning until 11:00 at night. They are usually staffed by three to five

psychiatrists, twelve or more nurses, one or two social workers and one or two psychologists. The basic modus operandi is family crisis intervention. When phone referrals are made, either from the police, GPs or families, the personnel there determine whether or not an immediate intervention is needed and if so, where it is best given. Most often, this will be a family intervention in the home. In one mental health center there that serves a catchment area of roughly 100,000 people, they do something on the order of 8- to 10,000 home visits per year. Mental health center staff are also responsible for working on the ward in the general hospital in rotation. For this city of 350,000, there is one ward in the central general hospital of 10 beds, with an average census of three or four and an average length of stay of one to two days. Basically, the ward is used to cover the 11:00 p.m. to 8:00 a.m. shift. Each mental health center calls the ward in the morning to find out if any clients from their area have been admitted overnight. If they have clients there, they come and attempt to get them out of the hospital to the mental health center immediately. These mental health centers also have a few beds--six to eight--that are used for crisis residential care and more prolonged care when needed.

It goes without saying that there are major problems with the implementation of a law which involves such rapid, dramatic changes in the entire mental health system. The first problem, to which I have already alluded, is noncompliance. In some parts of Sicily and Sardinia, in Naples and in Bari it appears that the law is either being ignored or gotten around. A second major problem is the personnel. As you may remember, the law provides that only

existing mental health personnel will be used in the new community-based programs. This means deinstitutionalization of the mental hospital staffs. The staff are, of course, uncomfortable at the prospect of working in a community rather than in hospital. They feel unqualified and untrained for their new tasks and are quite apprehensive about what it may involve. Needless to say, there has been considerable foot-dragging and involvement of the unions in the process of trying to get the staff out. Although the law guaranteed everyone's job, it unfortunately did not make provision for retraining or early retirement, such that the nurses often feel abused by assignment to places that are less convenient to their homes and where they must learn to operate in very new ways. The same is true of hospital psychiatrists. In general, they tend to want to become the head of one of the inpatient services, but as there are limited numbers of inpatient services, the competition for these jobs is quite fierce. In fact, in several places, because of seniority, the former superintendent of the large hospital has become the head of a 15-bed general hospital ward. A third major problem is the development of community-based services. With the exception of the cities where democratic psychiatry was firmly entrenched, there are not many community-based services in place. This problem is compounded by the fact that Italy has a tremendous housing shortage, such that finding accommodations for patients and space for centers are difficult. Because of this, new facilities in the community will have to be built. Therefore, it will be some years before really adequate community-based programs are in place. The fourth major area of difficulty is the involvement of the university psychiatric departments. Traditionally, the universities have been outside of the comprehensive delivery system and have operated like private clinics with

highly selective admission policies. As of the spring of 1981 there were only three university psychiatric clincs actively involved and responsible for a catchmented segment of a community: the University of Padua Medical Branch in Verona, the University of Padua in Padua and the University of Pavia. It remains to be seen whether or not medical faculties will be forced to participate in the delivery of health care in general and in psychiatry in particular. If academic departments are not directly involved in care delivery in U.S.L.s, medical students and psychiatrists in training will not have a way of obtaining the experience they will need to enable them to work in community-based programs after graduation. A more hidden issue (but important) is one of money and power, for if they participate in the new health system, medical schools must compete with other providers for money at the regional level. Heretofore, they obtained their support directly from Rome. They do not want to lose this special power status and direct access to money. How this will all go remains to be seen. The problem gets even more complicated, though, by the political considerations; that is, for example, the Universiy of Milan Psychiatric Clinic offered to participate in the delivery of psychiatric services but was turned down by the communist administration because the clinic is run by a biologically oriented christian democrat. So even here, where there was a willingness, the politics of the regions, provinces and the communes intervened to dictate the outcome. It is not always predictable what direction it would take. For example, Basaglia's work in Trieste was strongly supported by a christian democratic provincial health minister.

One rather surprising finding is that there has not been a great deal of organized community resistance to the new law. This is so mostly because Italians protest via their political parties and neither one of the large parties objects to this law. Ergo, there is no good means for expression of discontent.

V. Conclusion

Based on seven months of study, from March to October 1980, it is my view that the new Italian law that mandates the phasing down and out of large mental hospitals is being successfully implemented. I believe it is able to be so successful because of the logical, gradual way in which the hospitals are being phased out. There is no wholesale turning out of patients from the hospital into the community as was so often the case with deinstitutionalization in the U.S. They also seem to be more comfortable with the notion that some patients are better off left in the same residential setting as they had been in for so many years. Rather than uproot them, they are allowed to stay where they are, often as "guests," a new administrative arrangement vis-a-vis those persons. Although dropping the concept of dangerousness from the involuntary commitment law may strike forensic psychiatrists and lawyers as a dramatic shift, the decrease in compulsory admissions is more related to the need for three separate signatures than the change in the grounds for commitment. In fact, one might say that the commitment law could lead to more people being committed because the basic criterion is "in urgent need of care and treatment." The problems are predictable and perhaps some of them could have been avoided. However, only

time will tell the direction of the resolution of these problems and the ultimate fate of this radical change in a country's mental health system.

TABLE 1

Italy: Law No. 180 - May 1978

Major Provisions: Inpatient Care

1. No new patients may be admitted to large "state" hospitals.

2. Until 31 December 1980 ex-hospital patients may be readmitted voluntarily. No patients may be admitted after 1 January 1981.

3. Construction of new psychiatric wards or use of "state" hospitals as general hospital psychiatric wards is prohibited.

4. Psychiatric wards in general hospitals are allowed; they can have no more than 15 beds and must be applicated with community mental health centers.

TABLE 2

Italy: Law No. 180 - May 1978

Major Provisions: Compulsory Admissions

1. Compulsory evaluation and treatment should take place in community-based facilities.

2. Compulsory admission to a general hospital ward may take place if:

   a) urgent intervention is required;
   b) the necessary treatment is refused;
   c) community treatment cannot be opportunely implemented; and
   d) two doctors and the mayor or his designate deem care and rehabilitation necessary.

3. Independent judicial review is required at 2 and 7 days.

4. Patient and relatives may appeal the decision to the mayor or the courts.

5. These standards must be applied to patients currently involuntarily in mental hospitals.

6. The constitutional rights of involuntarily admitted patients must not be violated.

TABLE 3

Italy: Law No. 180 - May 1978

Major Provisions: Other

1. Community-based facilities will be responsible for a prescribed geographical area ("U.S.L.").

2. All facilities will be staffed by existing mental health personnel.

3. As of October 1, 1980, medical and social welfare monies will be pooled and distributed on a per capita basis within each region (state).

TABLE 4

Italy: Law No. 180 - May 1978

Results: Country-wide (June 1978 - June 1979) *

1. 18% decrease in inpatients.
2. 60% decrease in compulsory admissions
3. Little evidence of "dumping."
4. No increase in suicide or violent crime by former patients.
5. No appreciable differences in admissions to private psychiatric hospitals.

* Misiti, Raffaello (1980)

JOINT OVERSIGHT COMMITTEE ON OEINSTITUTIONALIZAION

Hearing -- August 12, 1981

"Alternatives on Oeinstitutionalization Programs"

Views on service delivery concepts from:

1. Ms. Nan Ulle, Chairman
   Citizens Advisory Board, Great Oaks Center

2. Or. Lloyd Church, Chairman
   Citizens Advisory Board, Great Oaks Center

3. Mr. Robert C. Norton, Vice President
   Parents, Guardians and Friends of Holly Center, Inc.

4. Mr. Ercell S. Oove, Chairman
   Citizens Advisory Board, Holly Center

5. Ms. Loretta M. Sinclair
   Parents, Guardians and Friends of Holly Center, Inc.

6. Mental Health Association
   -- Mrs. Peggy Whyte, President
   -- Frank Oearden, Ad Hoc Committee on Psycho-Social Rehabilitation
   -- Ms. Peg McCusker, Member, "On Our Own" (formerly hospitalized patients)

7. Franklin Oouglas, House Oirector
   St. Luke's House, Inc. (Bethesda)

8. Mrs. Gracemarie M. G. Sommerhoff, RN, Chairman
   Citizens Advisory Board, Unit Two (Currently for Baltimore, Cecil and Harford Counties)
   Spring Grove Hospital Center

9. Richard G. Ounne, President
   Prince George's Coalition for the Handicapped, Inc.

10. Eileen Leaman, Oirector, Adult Services
    United Cerebral Palsy of Central Maryland

11. Harold L. Flanagan
    Great Oaks Center Legislative Chairman

12. Ms. Jane Salzano, President
    Maryland Society for Autistic Adults and Children

13. Ms. Cathleen Zeidler
    The Highland Health Center Parents Association

14. Philip C. Holmes, Director
Maryland Developmental Disabilities Council
Office of the Secretary, Department of Health and Mental Hygiene

15. Mr. Monroe Karasik
Maryland Association for Retarded Citizens

16. Richard L. Holler, Acting Chairman
Citizens' Advisory Board, Eastern Shore Hospital Center

17. Ms. Eleanor E. Merlo
Parents' Group, Rosewood Center

18. Mrs. Myrtle McCullers, Chairman
Citizens' Advisory Board, Walter P. Carter Center

19. Mr. Carl O. Shelton, President
Auxiliary of Henryton Center, Inc.

20. Ms. Mary I. Love, Director of Planning, Garrett County Health Department
and Chairman, Citizens' Advisory Board of Finan Center - Submitted Letter

21. The "Village" Concept
-- Dr. Lee Goren, President - Friends of the Retarded, Inc.
-- Dr. W. Michael Gould, Past President
Friends of the Retarded
-- Dr. John J. Barnes, Executive Director
Annandale Village, Inc., Suwanee, Georgia
-- Dr. Donald F. Klein, Chairman, Residential Committee, BCPFR

22. Maisie Wood, MAAH, Annapolis

Blue Cross
of Maryland Inc.

700 East Joppa Road, Baltimore, Maryland 21204

Comments on Deinstitutionalization

Bonnie Katz
Blue Cross of Maryland, Inc.

August 26, 1981

I would like to focus on what is Blue Cross of Maryland's corporate interaction with deinstitutionalization of psychiatric patients. In the simplest perspective, deinstitutionalization has two ends of the tunnel through which it must be approached. There is the notion of heading off new admissions to state hospital centers for those patients for whom community treatment is clinically appropriate and importantly those with third party capabilities. Then there is the other end of spectrum, which is discharging a large proportion of the chronic and inappropriately placed state hospital admissions and caring for them,transitionally and/or permanently in community resources. The buzzwords are "least restrictive treatment settings" and the fulcrum for this delicate balance is dollars. In order for deinstitutionalization to maintain a sense of equilibrium, dollars previously directed to capital facilities must, of course, be diverted to community treatment programs.

Where does Blue Cross, as a private third party payor, fit into this scheme? In this first illustration I gave, that is, diverting new state hospital admissions, the answer is clear. To the extent that our members receive inpatient psychiatric care in a psychiatric or general acute hospital, their inpatient psychiatric benefits are available to them. The Mental Hygiene Administration has, in fact, established a telephone referral mechanism, known as Syscom, to identify and arrange private sector admissions for persons with third party coverage.

The other issue, the process of moving patients back into the community, less clearly defines Blue Cross' role. I had the opportunity to participate in the MHA's Community Support System task force which, with an NIMH grant, attempted to define the model community support system for the chronically mentally disabled. There is no doubt that the deinstitutionalized can not be tossed back into society without a network of services to bridge the gap. The needs of the deinstitutionalized are many: housing, sustenance, camraderie, social protection among the most obvious. Generally, the needs of this population are in a social service vein. Less compelling, according to the literature, is the need for ongoing active therapy. The types of programs designed to deal with the needs of the deinstitutionalized are halfway houses, group living arrangements, social clubs in the Fountain House model (which is a successful group in New York in existence since post World War II), and day care programs. By and large, these are not medical care programs. They are not programs designed to provide active treatment. They are not designed to comply with meaningful licensure and accreditation standards. They are not

within the province of what are traditionally respected as health care providers.

Blue Cross benefits, in the ideal marketplace circumstances which hopefully prevail the majority of time, are developed in response to market demand and when there is appropriate provider development and credentialling. When employers tell us they are interested in a benefit, we work to make it available. The other natural impetus for new benefit design is a cost containment incentive. But alternative delivery sites are not always justifiable as cost containment measures.

Let me highlight some of the available Blue Cross benefit programs which a deinstitutionalized population may utilize as they receive active treatment:

> Outpatient mental health counselling under Blue Cross basic, Blue Shield and Major Medical programs; services may be performed in a doctor's office, hospital outpatient department or a community mental health center
>
> Alcoholism Rehabilitation - Outpatient and Inpatient (now mandated)
>
> Drug Abuse Rehabilitation - Outpatient and Inpatient
>
> Psychiatric Day Treatment

Finally, I would like to call your attention very briefly to an article that appeared in the August 6 issue of New England Journal of Medicine. It crossed my desk late yesterday afternoon after I had compiled these remarks. At the risk of offending anyone who is a staunch supporter of untempered deinstitutionalization, which I hope not to do, let me share with you another side of the coin. This article is by Dr. Jonathan Borris, Massachusetts General Hospital entitled "Deinstitutionalization of the Chronically Mentally Ill."

ce

Abstracts in the advertising sections

The New England Journal of Medicine

Established in 1812 as The NEW ENGLAND JOURNAL OF MEDICINE AND SURGERY

VOLUME 305 AUGUST 6, 1981 NUMBER 6

Original Articles

Special Article

Seminars in Medicine of the Beth Israel Hospital, Boston

Case Records of the Massachusetts General Hospital

Editorial

Sounding Board

Massachusetts Medical Society ... 342

Correspondence

The New England Journal of Medicine (ISSN 0028-4793) is published weekly from editorial offices at 10 Shattuck Street, Boston, MA 02115
Subscription price: $35 per year. Second-class postage paid at Boston and at additional mailing offices.
POSTMASTER: Send address changes to 1172 Commonwealth Avenue, Boston, MA 02134

NEJMAG 305(6) 297-356 (1981)

SOUNDING BOARD

DEINSTITUTIONALIZATION OF THE CHRONICALLY MENTALLY ILL

DEINSTITUTIONALIZATION of the mentally ill has be-
e the predominant public mental-health policy in
states. This policy has been supported by a cu-
s political marriage of liberals, who decry the cus-
al-level care in state mental hospitals, and con-
atives, who see the closing of expensive public
itutions as an easy way to save tax dollars. Dein-
itionalization has been effected by discharging
g-term inpatients from state hospitals and making
ncreasingly difficult to admit new patients. Over
past decade, it has resulted in the shift of the pri-
ary locus of clinical care in the public sector from
ditional inpatient settings to community-based
patient facilities.

The peculiar historical intertwining of mental-
alth care and government accounts for the fact that
s major change in the delivery of care resulted from
opolitical as well as clinical considerations. Since
olonial times, the care of the mentally ill and the pro-
tion of the community from disturbance by them
ve been responsibilities of the state and local gov-
nments. Successively located over the years in jails
d almshouses, state hospitals, and outpatient com-
unity-mental-health centers (CMHCs), a separate
blic delivery system dependent on the political
ocess has been maintained for mental-health care.
The persistence of this separate system to the present
lay stems not only from the paucity of insurance cov-
rage for private treatment but also from the chron-
and often debilitating nature of severe mental ill-
nesses such as schizophrenia, affective disorders, and
rganic mental syndromes.

It is the nature of the political process to foster over-
implification of complex issues so that a single solu-
on can be advocated that will overcome the inertia
nhibiting major change in governmental policy or
practice. Deinstitutionalization was the political so-
ution proposed in response to professional requests in
the 1960s for major improvements in state-hospital
care and for the development of public treatment
facilities for the mentally ill in the community.[1] In
support of this solution, a number of unproved and
often conflicting wishful assumptions or fantasies
about deinstitutionalization have been presented to
the public as facts. This paper discusses five of these
fantasies and contrasts them with the clinical realities
of deinstitutionalization during the past decade.

FANTASIES AND FACTS

Mental Hospitals Are Harmful and Are Not Needed

Some advocates of deinstitutionalization espouse the wishful assumption that severe mental illnesses do not exist and that the so-called chronically mentally ill primarily have iatrogenic disabilities secondary to confinement in a mental hospital.[2,3] The difficulty with this fantasy is that it disregards the evidence that genetic linkages, differential responses to pharmacologic agents, or organic disorders can define discrete types of disabling mental illness.[4] In addition, it ignores the fact that although a regressive, custodial inpatient milieu can further debilitate these patients, the affective and cognitive symptoms associated with psychotic illness are usually evident before hospitalization and are often the cause for it.

Despite these contradictory facts, this assumption has been used to justify plans to phase out state hospitals. In support of such plans, two factors are cited: the success in cutting the public-mental-hospital census in the past 25 years by over 70 per cent (from 559,000 patients in 1955 to approximately 150,000 today)[5] and the clinical observation that many patients who were previously kept in mental hospitals can be effectively treated as outpatients with psychoactive medication, with or without brief stabilizing hospitalization in general hospitals or CMHCs. However, such plans falsely assume that important societal functions now undertaken by public mental institutions — specifically, care and asylum for the most severely ill and protection of the public from them — can be shifted to community facilities.[6] Experience over the past decade has shown that some patients continue to need mental-hospital settings because of the severity of their behavioral disorders. Such violent, incompetent, or suicidal patients cannot survive in the community and are unsuited for inpatient units in a general hospital or CMHC because they require long-term care in a secure facility for their own protection and that of society.[7] In addition, less severely disturbed patients who are admitted to general-hospital or CMHC inpatient units and who require the temporary security of a locked unit or an extended stay beyond the usual 30-day limit for stabilization are often discharged back to the community before improvement occurs. Without the availability of mental hospitals as backup for public-sector patients, the pressure on acute-care units to free up beds causes a revolving-door syndrome of repeated hospitalizations, each of which is too brief to bring the patient's illness under control.[8]

The political motive underlying the notion that mental hospitals are necessarily harmful is revealed by the lack of opposition to private hospitals that are not dependent on public funding. Many private mental hospitals have locked and long-term units. Neither politicians nor the public view them as harmful or custodial facilities because, unlike state hospitals, they have adequate resources to provide active treatment. The rush to close "harmful" institutions also ignores the growing evidence that many patients discharged from state hospitals have been "transinstitutionalized" to nursing homes and penal institutions.[9,10] It has yet to be demonstrated that either of these settings offers better treatment or custodial care for the mentally ill than do state hospitals.

Outpatient Treatment Is What the Chronically Mentally Ill Really Need

Deinstitutionalization has also been promoted under the assumption that state-hospital care for the less fortunate can be replaced by outpatient psychiatric care that is similar to the private therapy available to patients of means. Unfortunately, differences in resources, scale, and mandate prevent this extrapolation from rich to poor. CMHCs, today's publicly subsidized alternative to private outpatient care, suffer from inadequate funding and unstable staffing (especially of psychiatrists), too large a service responsibility (75,000 to 200,000 citizens per service area), and a mandate that prohibits refusal to treat anyone from their area.[11] Although appropriate outpatient treatment in CMHCs has decreased the need of many patients for institutional care,[12] the marginal funding given CMHCs reinforces the reality that the public will not support the same quality of services for poor patients as the rich can purchase.

This fantasy also assumes that the numerous needs for care that are met by a residential institution can be satisfied solely by outpatient psychiatric treatment. The state hospital took responsibility not only for mental-health care but also for the patient's housing, food, finances, medical care, medications, work activities, and social relations.[13] The deinstitutionalized patient's limited abilities to cope are often overwhelmed when he or she is forced to seek these types of care from multiple, uncoordinated community agencies.[14] Many CMHCs have devoted their limited resources to helping the chronically ill obtain such needed treatment and supportive services. Other CMHCs have ignored this costly task and have preferred to use their resources to treat a much larger group of less severely ill people. The wishful notion that these patients will require such supportive services only for a transitional period as they move from the hospital to independent community life is not supported by the data, which show that the chronically mentally ill need ongoing care to maintain a reasonable level of function.[15,16] Without continuously available services, most of these patients' conditions deteriorate, and they either require rehospitalization or lead isolated, marginal lives in the community that are similar to life in state hospitals' "back wards."[15-17]

The Public Wants Deinstitutionalization

This fantasy hinges on the assumption that the patient and the patient's family and neighbors prefer that treatment take place in the community. In fact, some patients in state hospitals resist leaving the institution that has taken care of them, albeit at a substandard level, for many years. Life in the community requires patients to struggle to get basic needs met, and with the scarcity of low-cost housing, the number of homeless patients carrying their worlds around in shopping bags has noticeably increased. Emergency-room clinicians witness daily the desperate attempts of the chronically ill to circumvent the restrictive admissions policies of public hospitals with repeated and often increasingly destructive demonstrations of their need to be admitted when they cannot cope in the community.

Families have often had considerable difficulties with the patient before hospitalization, and thus they hesitate to reassume the psychological and financial burdens of living with their disturbed relative. This stressful task for the family appears to be better tolerated when mental-health professionals provide them with direct support[18]; however, studies to determine the long-term effects on the lives of family members, specifically on the development of young children living with a psychotic relative, have not been reported.

Finally, communities often fear that increased violence and socially disruptive behavior will result from the deinstitutionalization of the mentally ill. Although some exceptional communities have organized impressive efforts to reintegrate these patients, others have used restrictive zoning and legal measures to attempt to prevent large numbers of the chronically ill from living in the area. Citizens may abstractly agree that it is a good idea to return the patient to the community, but few want any to live on their own block. As a result of such sentiment, most group-living facilities for deinstitutionalized patients end up in a community's least attractive neighborhoods to avoid arousing citizens' resistance.[19]

Deinstitutionalization Will Cost Less

The pivotal political assumption that appears to have motivated deinstitutionalization is that state tax dollars would be saved by closing state hospitals and by the resultant decreased cost of providing mental-health services for the chronically ill patients in the community. The fact is that state mental-health budgets have increased over the past decade with inflation and with the continued need to fund both institutional and community care. Although antiquated state hospitals are expensive to heat and maintain, they have proved to be politically difficult to close. Government workers' unions and rural towns whose economies depend on their state hospitals have fought the loss of jobs and the changes that are required to close hospitals and to shift staff to community settings.[20,21] Since deinstitutionalization has been advocated as a cost-saving measure, politicians have been reluctant to allocate sufficient additional resources to improve the institutions and to ensure that adequate community-based programs are in place when patients arrive.

Even though studies to date have not demonstrated direct savings from treating the chronically ill in the community,[19,22] state governments have continued to push deinstitutionalization because it yields them relative savings by shifting some of the fiscal burden onto the federal and local governments. The states

have "passed the buck" to the federal government, which provides Supplemental Security Income and Medicaid payments to the severely ill when they are not institutionalized, and to local governments, which must bear the costs of providing additional community services (e.g., those of police, emergency medical workers, and mental-health professionals) to handle the needs of disorganized patients.[5,9,22]

"Someone Else" Is Ultimately Responsible (to Blame) for the Care of These Patients

In the past, state and local governments were held responsible for their hospitals' dismal conditions, which, despite geographic isolation, were intermittently brought to the public's attention by the media, causing great political embarrassment. Although the unmet needs of the chronically ill living in the community are more visible with deinstitutionalization, their care has become diffused among so many agencies that it is unclear whom to hold responsible.[8]

As it has become apparent that the political act of deinstitutionalization alone will not solve the multiple problems of these patients, the states have tried to assign the responsibility (and blame) for community care to the federal government and the CMHC program that it initiated in 1963. In this political shell game, the federal government reminds the states that federal CMHC funding was always designated as "seed money" to stimulate the development of community-based services and was never intended to replace the states' historic responsibility for the mentally ill.[23] Private insurers claim that their subscribers will not support the costs of extended mental-health coverage, and a national health insurance that might support services for the chronically ill remains a distant possibility.

New Initiatives

Two new political initiatives are aimed at clarifying responsibility for the conduct and costs of care of deinstitutionalized patients. Stemming from the findings of the President's Commission on Mental Health, the recently passed Mental Health Systems Act (P.L. 96-398) will provide federal grants to help the chronically mentally ill function outside institutions. The act authorizes appropriation of $48 million for the 1982 fiscal year to state mental-health authorities and CMHCs, which will take responsibility for coordinating services for the chronically ill and upgrading the skills of the staff who work with them.

Considering the size of the problem, the authorized funding for this initiative seems minuscule: the Massachusetts Department of Mental Health alone spends over four times that amount annually on the chronically ill. In addition, it appears doubtful that the conservative new administration and Congress will support even that inadequate funding level. Like past federal mental-health initiatives, this act offers only time-limited seed money to the states, without assuming long-term programmatic or fiscal responsibility. The Mental Health Systems Act, therefore, represents an incremental step that could bolster current services and improve the quality of community-based care systems; it is so limited in size and scope, however, that it cannot solve the vast and expensive problems of the chronically ill.

A second initiative, occurring at the state level, has been the effort to "privatize" the care of the mentally ill. In Massachusetts, for example, both inpatient and outpatient care are being contracted to private nonprofit providers, who are not bound to the state delivery system's fiscal inflexibility, civil-service regulations, and union demands. It is hypothesized that private agencies can deliver better and more efficient clinical care than the state can. In addition, these agencies are eligible to recoup third-party reimbursements — less readily available to public providers — which can help support the costs of care. Although this plan inventively aims to create a one-class care system that can better support itself, the basic responsibility for financing this system will remain with the state. Since many of the services required to support the chronically ill are not reimbursable by insurers, the success or failure of privatization will be determined by the willingness of the state to underwrite these final costs. It is questionable whether political administrators and legislators are likely to be any more reliable in funding the increasing costs of care under contract to private providers than they were in funding the state's own delivery system directly.

Politics and Patient Care

The political process has condensed the complex issues of caring for the chronically mentally ill into a single problem, the state hospital, with a single solution, the policy of deinstitutionalization. This policy has replaced the prior political solution, under which institutional care of the mentally ill in the state hospitals was the predominant approach for over a century. To clinicians, it is obvious that patients with chronic mental disorders have substantive illnesses requiring diverse treatment and supportive services in both the hospital and the community. Predictably, deinstitutionalization has helped patients for whom prolonged hospitalization was inappropriate treatment and has hurt patients whose needs for care cannot be met in the community. Clearly, the choice of care should be determined by the clinicians' treatment decisions about individual patients rather than by political policy that indiscriminately dictates any single alternative.

The decade of deinstitutionalization has provided many positive byproducts. In their attempts to help very sick patients, mental-health professionals have learned much about the clinical care of the chronically mentally ill in the community. Innovative model programs, most of which have been supported by special funding from the National Institute of Mental Health, have demonstrated that with discriminate evaluation of the strengths and needs of the individ-

ual patient, adequate resources, designated responsibility for care, long-term provision of services, professional flexibility, and public support, many patients can lead reasonable lives outside institutions.[12,15,24]

The limited ability to generalize and reproduce these model programs nationwide is in large part due to the public's enduring unwillingness to pay for high-quality care for the mentally ill. The custodial-level funding that politicians allocated to state hospitals over the years accurately reflected this limited public support; deinstitutionalization has shown that without sufficient resources, simply changing the locus of bad care will not create good care. Since provision of the many high-quality treatment alternatives that the severely ill require is an expensive proposition, it is even less likely to receive broad support in these times of fiscal restraint. Without adequate treatment resources, mental patients can be expected to become more disturbingly visible and bothersome to our communities. It is to be hoped that reinstitutionalization will not be the next "new" political solution, for no single "inexpensive" remedy will alleviate the suffering or adequately serve the complex needs of the chronically mentally ill.

Massachusetts General Hospital
Boston, MA 02114

JONATHAN F. BORUS, M.D.

REFERENCES

1. Joint Commission on Mental Illness and Health. Action for mental health. New York: Basic Books, 1961.
2. Szasz TS. The myth of mental illness. Am Psychol. 1960; 15:113-8.
3. Rosenhan DL. On being sane in insane places. Science. 1973; 179:250-8.
4. Snyder SH. Biological aspects of mental disorder. New York: Oxford University Press, 1980.
5. Toward a national plan for the chronically mentally ill: report to the Secretary by the Department of Health and Human Services Steering Committee on the Chronically Mentally Ill, December 1980. Rockville, Md.: Department of Health and Human Services, 1981. (DHHS publication no. (ADM)81-1077).
6. Bachrach LL. Deinstitutionalization: an analytical review and sociological perspective. Washington, D.C.: Government Printing Office, 1976. (DHEW publication no. (ADM)76-351).
7. Lamb HR, Goertzel V. The demise of the state hospital — a premature obituary? Arch Gen Psychiatry. 1972; 26:489-95.
8. Rieder RO. Hospitals, patients, and politics. Schizophrenia Bull. 1974; 11:9-15.
9. Shurfstein SS, Turner JEC, Clark HW. Financing issues in the delivery of services to the chronically mentally ill and disabled. In: Talbott JA, ed. The chronic mental patient: problems, solutions, and recommendations for a public policy. Washington, D.C.: American Psychiatric Association, 1978:137-50.
10. Swank GE, Winer D. Occurrence of psychiatric disorder in a county jail population. Am J Psychiatry. 1976; 133:1331-3.
11. Borus JF. Issues critical to the survival of community mental health. Am J Psychiatry. 1978; 135:1029-35.
12. Hunsell N, Willis GL. Outpatient treatment of schizophrenia. Am J Psychiatry. 1977; 134:1082-6.
13. Borus JF, Hatow E. The patient and the community. In: Shershow JC, ed. Schizophrenia: science and practice. Cambridge: Harvard University Press, 1978:171-96.
14. Returning the mentally disabled to the community: government needs to do more (report to Congress by the Comptroller General of the United States, January 7, 1977). Washington, D.C.: General Accounting Office, 1977.
15. Stein LI, Test MA. Alternative to mental hospital treatment. I. Conceptual model, treatment program, and clinical evaluation. Arch Gen Psychiatry. 1980; 37:392-7.
16. Davis A, Dinitz S, Pasumanick B. Schizophrenics in the new custodial community. Columbus, Ohio: Ohio State University Press, 1974.
17. Lamb HR, Goertzel V. The long-term patient in the era of community treatment. Arch Gen Psychiatry. 1977; 34:679-82.
18. Creer C, Wing J. Living with a schizophrenic patient. Br J Husp Med. 1975; 14:73-82.
19. Kirk SA, Therrien ME. Community mental health myths and the fate of former hospitalized patients. Psychiatry. 1975; 38:209-17.
20. Greenblatt M, Glazier E. The phasing out of mental hospitals in the United States. Am J Psychiatry. 1975; 132:1135-40.
21. Becker A, Schulberg HC. Phasing out state hospitals — a psychiatric dilemma. N Engl J Med. 1976; 294:255-61.
22. Weisbrod BA, Test MA, Stein LI. Alternative to mental hospital treatment. II. Economic benefit-cost analysis. Arch Gen Psychiatry. 1980; 37:400-5.
23. Weiner RS, Woy JR, Sharfstein SS, Bass RD. Community mental health centers and the "seed money" concept: effects of terminating federal funds. Community Mental Health J. 1979; 15:129-38.
24. Turner JEC, TenHoor WJ. The NIMH community support program: pilot approach to a needed social reform. Schizophr Bull. 1978; 4:319-44.

MASSACHUSETTS MEDICAL SOCIETY

DEATHS

SMITH — Charles David Smith, M.D., of Chestnut Hill, died on April 5. He was in his 86th year.

Dr. Smith received his degree from Tufts College Medical School in 1923. He was a member of the American Medical Association and a 50-year member of the Massachusetts Medical Society.

He is survived by two brothers and three sisters.

TAIT — Arthur Alfred Tait, M.D., of West Dennis, died on April 6. He was in his 81st year.

Dr. Tait received his degree from the University of Illinois College of Medicine in 1930. He was a member of the American Medical Association and the American College of Surgeons.

CORRESPONDENCE

Letters to the Editor are considered for publication (subject to editing and abridgment), provided that they are submitted in duplicate, signed by all authors, typewritten in double spacing, and do not exceed 1½ pages of text. They should not duplicate similar material being submitted or published elsewhere. Letters referring to a recent *Journal* article should be received within six weeks of the article's publication. We are unable to provide pre-publication proofs, and unpublished material will not be returned to authors unless a stamped, self-addressed envelope is enclosed.

ACUTE LEUKEMIA IN POLYCYTHEMIA VERA

To the Editor: Berk and his coauthors from the Polycythemia Vera Study Group reported convincing evidence of a leukemogenic potential of chlorambucil in polycythemia vera (February 19 issue).[1] Similar results were reported previously regarding single-agent chemotherapy with other alkylating drugs, such as busulfan in lung cancer[2] and dihydroxybusolfan in ovarian carcinoma.[3] In the polycythemia vera study, the cases of leukemia that developed in ^{32}P-treated patients were dispersed between the third and the ninth year after the patients' randomization to treatment groups, where-

APPENDIX Q

General Assembly of Maryland

JOINT OVERSIGHT COMMITTEE ON DEINSTITUTIONALIZATION

AGENDA

September 8, 1981

Views of officials of the Counties and Baltimore City on Deinstitutionalization for persons with mental illness, mental retardation, and other handicapping disabilities, including:

-- group homes in the neighborhood
-- scattered site housing units
-- network of local services needed
-- ideas on financing
-- role institutions may serve

1. Howard County

   Rochell Brown, Community Development Coordinator for Howard County

2. Prince George's County

   Ella E. Ennis, Legislative Liaison for the County Executive

3. Carroll County

   Louis B. Scharon, President, Board of County Commissioners

4. Montgomery County

   Harvey R. McConnell, Director, Department of Family Resources

   Edward R. Bloom, Special Assistant to the Director, Department of Family Resources

   Rosalynd Garfinkel, Coordinator, Health Group Homes

   Peter Ziebell, Montgomery County Health Department

5. Other local government responses by mail.

   - Allegany County - County Commissioners, John J. Coyle, President
   - Allegany County Department of Social Services - Bertram G. Lazarus, LCSW, Secretary to Mental Health Advisory Committee
   - Carroll County Health Department - Howard M. Held, M.S.W., Director Bureau of Mental Health
   - Dorchester County - Thomas A. Flowers, County Commissioner
   - Garrett County - Charlotte S. Griffith, Acting Director, Appalachian Center
     - Daniel J. Elmlinger, Acting Director, Garrett Crossroads
   - Montomgery County Council - Ruth Spector, President

AGENDA

September 9, 1981

Views of officials of the Counties and Baltimore City on Deinstitutionalization for persons with mental illness, mental retardation, and other handicapping disabilities, including:

-- group homes in the neighborhood

-- scattered site housing units

-- network of local services needed

-- ideas on financing

-- role institutions may serve

1. Harford County

   Virginia O'Rourke, Director of Community Services

2. Frederick County

   John W. Gray, Administrative Officer,
   Health Services Division, Frederick County

   Daniel Roff, Director, Frederick County Health Department

3. Baltimore County

   Vincent J. Klimas, Baltimore County Coordinator of the Coalition
   for Handicapped Persons

4. Washington County

   Robert E. DeHaven, Executive Director, Washington County
   Association for Retarded Citizens

5. Baltimore City

   Marc B. Lipton, Ph.D., M.P.A., Assistant Commissioner of Health,
   Mental Health, Mental Retardation and Addictions

   Iris Gordon, Chief, Mental Retardation and Disability Services

6. Charles County

   Mrs. Lynn Rees Finn, Charles County Mental Health Coordinator

7. St. Mary's County - Mail Response

   Departemnt of Health and Mental Hygiene
   William J. Marek, M.D., M.P.H., Health Officer