INTERAGENCY PRESCRIPTION TEAM

JOINT REPORT OF

THE SECRETARY OF HUMAN RESOURCES

AND

THE SECRETARY OF PUBLIC SAFETY

TO THE GOVERNOR

AND

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This report is submitted to the House Committee on Health, Welfare and Institutions and to the Senate Committee on Rehabilitation and Social Services in the General Assembly of Virginia in response to HJR 269.

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ACKNOWLEDGEMENTS

For now, the existence of the Prescription Team is moving in the direction of the purposes set out. The tasks have been difficult, but a highly professional and competent team of men and women have made the concept a reality and have enhanced the treatment of the children referred to them. Recognition must be given the members and alternates who have served on the Prescription Team, for each has laid agency and system concerns aside to concentrate their efforts on the total being of each child.

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In 1976, an Interagency Prescription Team was created for the purpose of facilitating treatment for children committed to the Division of Youth Services who are deemed to be in need of mental health services. The General Assembly of Virginia, via HJR 269, has expressed a keen interest in this team. The following report attempts to illuminate the background, operation and impact of the Prescription Team and is respectfully submitted to the House committee on Health, Welfare and Institutions and to the Senate Committee on Rehabilitation and Social Services.

Background

For a number of years, DYS has received a substantial number of children who have been identified by courts and other community agencies as in need of mental health care. Often the courts choose to commit the child directly to DYS with the recommendation that the child is in need of mental health services. Consequently, over the years a sizable number of children have been committed to DYS' care with the hope that the children will be committed to the state mental health system or will be placed elsewhere in private mental health facilities.

Children who are committed by the courts to DYS are carefully screened and evaluated at the Reception and Diagnostic Center (RDC) prior to being placed. DYS is legally accountable for identifying each child's problems and needs, and for providing each child with the treatment he or she needs. Neither placement, treatment nor duration of either are prescribed by the courts; rather, the courts commit the child to the custody of DYS in accordance with Section 16.1-279E(10), and that system makes all decisions regarding placement and treatment.

DYS has the legal authority to place children in DYS learning centers, in community settings, and in private residential treatment facilities, and to prescribe the care and treatment each child will receive. DYS does not, however, have the legal authority to place children in public mental health and mental retardation facilities, because state law stipulates that each facility director has final authority in deciding who will be committed to and discharged from the facility he directs. In addition, the law stipulates that persons committed to mental institutions must present a danger to himself or others due to mental illness. Thus, while DYS may recommend placement of a child in a public mental health or mental retardation facility, the final decisions to admit, to treat and to discharge are legal prerogatives of the facility director.

For a number of years DYS and DMH & MR had encountered difficulties in delivering services to DYS committed youths in need of mental health services. Oftentimes, DYS would prescribe institutional mental health treatment for an individual and the child would be committed to a DMH & MR facility. However, following an evaluation in the DMH & MR facility, or a Brief treatment session, the child would be discharged to DYS with little or no significant change in the condition identified earlier. Later, the child would again be committed and discharged. Cycles of residence in DYS facilities, DMH & MR facilities and sometimes the community were not uncommon for some children and for these few it seemed neither system possessed the resources to adequately meet the child's need and that neither system was totally accountable to the child.

In August of 1976, the Secretary of Human Resources and the Secretary of Public Safety, with participation by the Secretary of Education, mandated a study of the needs of, and available resources for providing mental health services to, DYS committed youth. This work group, composed of staff from the Office of the Secretary of Human Resources, the Department of Mental Health and Mental Retardation, the Division of Youth Services, the Rehabilitative School Authority and the Department of Planning and Budget, were given responsibility for analyzing the issue and proposing alternative solutions.

During the analysis process a number of issues which caused inherent problems in coordination between the DYS and DMH & MR systems were identified. Among these were:

-The two systems operated under differing treatment philosophies and differing approaches to diagnosis which led to differing and sometimes conflicting opinions as to the child's condition and the modality of treatment needed.

-The individual's right to treatment was approached from differing vantage points. DYS saw the individual's right to treatment as providing the child with whatever treatment was identified as needed, regardless of the desire of the child. DMH & MR, on the other hand, saw the individual's right to treatment as including the right to refuse treatment, regardless of age or status.

-DYS was charged with the maintenance of a secure environment to assure that each committed child was retained in custody, while DMH & MR mandates dictated that persons voluntarily committed to institutions could not be detained against their will.

-The majority of DYS facilities were located within the DMH & MR catchmentarea served by Eastern State Hospital. As a matter of policy, catchment areas were respected with the result being that most DYS children committed for institu-

tional mental health services were committed to Eastern State Hospital regardless of whether that program was the most appropriate or not.

-Although judicial commitment to DYS custody gave the system the legal right to place that child wherever his needs could best be met, that right stopped short of public mental health facilities because the law gave admissions and discharge decisionmaking to the facility director. In addition, another judicial hearing was necessary before a child could be involuntarily committed or admitted to a mental health or mental retardation facility.

These issues, along with other issues, were brought to the attention of the Secretary of Human Resources and the Secretary of Public Safety. In addition, a number of strategies were presented to the Secretaries for their consideration in the selection of a mechanism to help bridge the gap between the juvenile correctional system and the institutional mental health delivery system. The Secretaries chose to develop and test an interagency prescription team. This team would serve as a neutral decision making body and would be responsible for determining the placement and treatment for children committed to DYS who were identified as being in need of mental health services.

Interagency Agreement

On November 10, 1976, an interagency agreement was signed by the Secretary of Human Resources, the Secretary of Public Safty, the Acting Commissioner of the Department of ental Health and Mental Retardation and the Director of the Division of Youth Services, Department of Corrections. This agreement established an interagency prescription team and committed the two agencies to providing the maximum available services for the treatment of emotionally disturbed juveniles committed to the care of the Division of Youth Services.

The interagency agreement established the Prescription Team as both interagency and multi-disciplinary. If further stipulated that the team would be composed of professional staff as opposed to administrative staff. It was felt that because the team would be charged with making decisions impacting the child's future, those decisions should be made by technical, professional individuals. The agencies represented on the team are Division of Youth Services, Department of Mental Health and Mental Retardation, Department of Welfare, Rehabilitative School Authority, Department of Education, and Department of Health. Professions represented on the team include Case Work Supervisor, Psychologist, Social Worker, RSA Principal, Special Education Teacher, and Medical Doctor.

Professional composition of the team and departmental representation on the team are designed to serve two purposes. First,

by having representatives from six agencies, each agency represented on the team is charged with some responsibility for that child according to his identified needs. Secondly, the diversity of professions on the team allows for the full consideration of all facets of the child's physical, social and educational needs as well as his psychological or emotional needs.

The Prescription Team was charged with making all decisions related to placement, admission, discharge, and service plan for all children referred to the team. The placement decision included the system, the facility and the program the child would enter. Authority for team decisions was made explicit; "All decisions made by majority vote of the Prescription Team will be binding upon both the Division of Youth Services and the Department of Mental Health and Mental Retardation."

It was recognized however, that all decisions made by the team might not be appropriate in all cases. For this purpose, an appeal procedure was also included in the interagency agreement. This provision allowed either agency to formally request reassessment of any team decision. This appeal procedure included re-referral to the Prescription Team, a conference between the Commissioner of Mental Health and Mental Retardation and the Director of the Division of Youth Services, and in the event the case disposition could not be resolved at the agency level, the appeal could be brought to the attention of the Secretaries of Human Resources and Public Safety.

Prescription Team Operation

On November 15, 1976, representatives from each agency on the team met to consider and develop operating procedures for the team. On November 22, 1976, the team commenced operations and reviewed their first case.

Between November 22, 1976, and June 13, 1977, the Prescription Team had been referred 74 individual cases for consideration. During the summer months, commitments to DYS had decreased significantly with the results being very few referrals to the Prescription Team (seven referrals during July and two referrals during August). Each of the 74 cases have been handled throughly and comprehensively. Typically, when a child is referred to the Prescription Team, the following sequence of events occurs. First, the team carefully reviews the written material relating to the child's case. Following the review, the child's case worker appears before the Prescription Team and verbally gives his or her personal knowledge of the case, conclusions relating to problems and needs, and usually some recommendation for the child's placement and or treatment. Following the presentation by the case worker, the team deliberates extensively on the information they have received, attempting not only to analyze the separate pieces of information but to deal with the child as a whole human being. At this point, there is usually quite a bit of delibera-

tion concerning the availability and the accessibility of the necessary resources to meet the individual child's needs. Thus, both the child's needs and the resources available to him are discussed and considered in depth. Finally, decisions are made relating to the needs which must be addressed and the treatment program most appropriate to address those needs.

Following the team's deliberation and decision making, documentation of team recommendations are prepared and sent to the Division of Youth Services. If the child is or will be a Mental Health patient, documentation of the decision is also sent to the Department of Mental Health and Mental Retardation. In order to expedite the implementation of the Prescription Team recommendations, a verbal report is given to the child's case worker immediately after the decisions are made.

The team involvement with the child continues. Each child's case is reviewed at thirty day intervals. Progress reports obtained from the treatment program are discussed, and if changes are indicated the Prescription Team may make additional recommendations regarding the individual child.

Children who are placed in ental Health and Mental Retardation facilities must be referred to the Prescription Team prior to discharge. The Prescription Team must approve the discharge and must consider recommendations for after care placement prior to the Mental Health and Mental Retardation facilities discharging the individual. The team may also decide that further institutional treatment is indicated and deny the discharge request.

Each child remains a Prescription Team case until such time as the team makes the decision they can do no more for the individual. They, by majority vote, terminate the case.

Continuation of the Prescription Team

The Prescription Team was implemented as a pilot approach which should be carefully monitored and evaluated for at least six months. During this initial test phase the Secretaries would maintain a keen interest and involvement with the concept. At the conclusion of six months, they would assess the viability of the team approach and make decisions regarding its continuation.

During April and May of 1977, the Office of the Secretary of Human Resources conducted an opinion survey of Prescription Team members and of staffs of the Division of Youth Services and the Department of Mental Health and Mental Retardation. On June 10, 1977, the preliminary results of that evaluation were shared with the Secretaries and the two agencies. The resulting decisions were: 1) The Prescription Team should be continued; 2) The operation of the Prescription Team should be the joint responsibility of the Department of Corrections and the Department of Mental Health and Mental Retardation with involvement by the Secretaries

limited to oversight and problem resolution issues; and 3) The two agencies should review the Interagency Agreement and negotiate any changes they identified. Thus, the Prescription Team will continue and will be institutionalized under the joint direction of the Department of Corrections and the Department of Mental Health and Mental Retardation.

Conclusions

The interagency agreement between the Division of Youth Services and the Department of Mental Helath and Mental Retardation sought to accomplish two purposes. First, it sought to establish a mechanism for treating the whole child and overcome the tendency of viewing the child in terms of the resources available in any one system. Secondly, it sought to build cooperation and communication between the two systems. Although much remains to be done, progress has been made toward fulfilling both these purposes.

The results of the prescription team evaluation indicated that team members and the staff from both agencies felt that the utilization of an interdisciplinary, cross-agency, team-oriented approach does promote an exchange of ideas and an opportunity for mutual understanding among agencies of differing perspectives. Furthermore, the team approach provides for an objective screening of the child's total needs and mitigates, to a certain degree, individual agency biases regarding treatment capabilities. The most frequently identified strenth is that the team has a child orientation vis-a-vis an agency orientation.

In the opinion of 64 percent of the agency personnel surveyed, positive communication between the two agencies has increased due to the existence of the Prescription Team. Fifty percent of the team members, however, did not perceive an increase in positive communication. The differing persepctives may be due to a more distant or more objective assessment by the team, or it may be due to the fact that the team received a disproportionate share of the negative communication between the two systems. All respondents, however, indicated that communication per se had increased.

As a secondary purpose, the team was to identify gaps in available treatment services. Two major gaps exist. First, services are lacking and often non-existent in both community and institutional settings for the long-term treatment of seriously disturbed but non-psychotic adolescents. Secondly, programs for mildly and borderline mentally retarded youngsters are lacking. There are programs for children who are psychotic and for children who are severely retarded. However, those children who have needs but are not severly handicapped, do not have adequate resources to meet their needs.

In addition to the lack of some program resources, children in the custody of DYS are ineligible for two financial resources which increase the availability of existing program resources for other children. First, under an Attorney General's ruling,

children committed to DYS custody are not eligible for Medicare services. Secondly, these children are not eligible for Title XX services. The Department of Welfare and the Division of Youth Services have, however, entered into negotiations to extend Title XX coverage to certain DYS children residing in community settings. (Federal regulations prohibit Title XX expenditures for institutional services.)

The evaluation of the Prescription Team revealed that while the concept does place appropriate emphasis and concern on the whole child, it should be implemented with discretion for it is an extremely costly mechanism.

A March sample of Prescription Team meetings and activities indicate that a total of 408.5 staff hours, costing approximately $3,590, was devoted to the operation of the team for that month. The addition of support costs such as transportation to and from meetings, xerox expenditures, meeting space, etc., would probably reflect a cost approaching $4,000 per month. Furthermore, it should be noted that staff time devoted to the team represents time which would otherwise have been spent in traditional agency specific activities.

Further Action Necessary

There are, however, a number of problem areas, in the treatment of emotionally disturbed children, where the Prescription Team has not had an impact except to emphasize existing constraints. First, both systems have service gaps in the programs they provide. Significantly more mental health services and programs are needed for both residential and community based care of children and adolescents regardless of their custody status or place of residence. DMH & MR has recently placed priorities upon the expansion of children's services and a new residential program designed specifically for juvenile offenders is being developed at Central State Hospital. Nevertheless, it will require several years to upgrade and expand community and residential mental health services for children and adolescents in general.

Secondly, little impact has been made on existing relationships between the treatment systems and the judicial system. Some DYS children are excluded from treatment in public mental health facilities because they are not legally committable. A closer working relationship needs to be cultivated between the two systems (DYS and DMH & MR) and the courts in order to provide the judiciary with as much information as possible in adjudicating those cases which may result in the placement of children in the juvenile justice system or the public mental health system.

Thirdly, the two agencies appear to operate from a conflicting legal base regarding children and adolescents, their admission, their treatment and their custody. The issues which surround statutory provisions are complicated and often intertwined

with policy provisions. The Secretaries are currently working with the Attorney General's office to further define and clarify those issues which are indeed legal constraints to the delivery of mental health services to DYS children. A report on statutory provisions will be prepared in conjunction with the Attorney General's Office and transmitted to the General Assembly in time for consideration during the 1978 session of the Assembly.