FINAL REPORT

CHILD-ADOLESCENT WORK GROUP

October 1985

Prepared for

Joseph J. Bevilacqua, Ph.D.
Commissioner

Department of Mental Health and Mental Retardation
Richmond, Virginia

Volume I of II

COMMONWEALTH of VIRGINIA

Department of
Mental Health and Mental Retardation
Virginia Treatment Center for Children

LOCATION ADDRESS
515 NORTH 10TH STREET
TELEPHONE 786-3129

ROBERT COHEN, PH.D.
DIRECTOR

MAILING ADDRESS
P.O. BOX 1797
RICHMOND, VIRGINIA 23214

November 11, 1985

Joseph Bevilacqua, Ph.D.
Commissioner
Department of Mental Health
and Mental Retardation
P. O. Box 1797
Richmond, VA 23214

Dear Dr. Bevilacqua:

On behalf of the Child/Adolescent Work Group I am pleased to submit to you our Final Report. Working with the group has been an extremely gratifying and productive experience. I have rarely had the opportunity to be involved with such a constructive group of people. The Work Group was able to sublimate its professional and territorial differences so well and devote its energy and attention to productively addressing the charge of the Work Group. This Report represents the collective hard work, knowledge and analytical ability of a group of individuals dedicated to improving mental health services for children, adolescents and families of the Commonwealth.

Through review of the existing planning material, implementation of a modest needs assessment survey, and considerable analysis and discussion the Work Group followed a logical schedule of activities. Beginning with problem identification, working through needs assessment and issue analysis, and culminating with identification and discussion of desired outcomes, the Work Group has created a series of policy/program recommendations that we believe will lead to significant improvement in the provision of mental health services to children/adolescents and their families. In developing this Report, the Work Group has tried to constantly strike a balance between describing what is really needed to achieve a comprehensive and coordinated system of quality services and recognizing the realistic resources and political constraints that currently exist. Recognizing that even if all of our recommendations are fully implemented there would still be room for improvement, the Work Group is firmly convinced that the achievement of the objectives contained within these recommendations would have a significant impact on the child/adolescent mental health system of the Commonwealth.

Members of the Work Group appreciate the opportunity you have given us to create a blueprint for change in the child/adolescent mental health system. We are hopeful that after careful review of the Report, the Department will act assertively on behalf of the many children, adolescents and their families who have a serious need for responsive and effective mental health services.

Sincerely,

Robert Cohen

RC/cs

TABLE OF CONTENTS

VOLUME I: REPORT

ACKNOWLEDGEMENTS

The Child-Adolescent Work Group set out to accomplish a great deal in a relatively short period of time. In order to fulfill this ambitious mission, the Work Group required and received considerable assistance from a number of individuals. On behalf of the Work Group, I would like to acknowledge and thank those who assisted in the development of this report.

We are indebted to John Baker and Gail Sorenson of PARENTS AND CHILDREN COPING TOGETHER (PACCT) for their faithful participation in the meetings of the Work Group. Marilyn Erickson, Ph.D., of the Psychology Department of Virginia Commonwealth University, faithfully attended and contributed to our meetings.

The Work Group is grateful to the Community Services Boards that assisted us by responding to our needs assessment survey.

The Work Group appreciates the willingness of Thomas Stage, M.D., and Jeff Nelson to discuss the issues and recommendations related to the Division of Health Planning's Technical Advisory Panel and Child and Adolescent Psychiatric Services.

We have been fortunate to have the assistance of two excellent consultants: Robert Friedman, Ph.D., of the Florida Mental Health Institute, and James Holcomb of the Children and Youth Services in Bristol.

We are grateful for the staff support provided by the Department of Mental Health and Mental Retardation throughout the course of this project. Marcia Penn assisted in identifying prevention and training issues. Mary Blackwood has provided continuous support and assistance; Ben Saunders helped to steer us through the budget process; Joseph Avellar, Ph.D., provided guidance on interagency funding issues. We extend our appreciation to David Fitch for his continuous assistance and support. The Work Group is especially grateful to Nancy Bischoff for her patience and skill in providing word processing in preparing the many drafts of this report.

Finally, we want to express a strong note of appreciation and gratitude to Leslie Tremaine, Ed.D., for her strong commitment to this project as well as her invaluable assistance in conceptualizing the issues and recommendations, understanding the system, and writing the report.

Robert Cohen, Ph.D.
Chairperson
November 8, 1985

CHILD-ADOLESCENT WORK GROUP MEMBERSHIP

Robert Cohen, Ph.D., Chair
Director, Virginia Treatment Center for Children

John B. Aycock, Ph.D.
Executive Director, Chesapeake Community Services Board

Isabel G. Brenner
Member, State Board of Mental Health and Mental Retardation

Olivia Garland
Director, Central State Hospital

Martha Norris Gilbert
Director, Division for Children

Joseph W. King, M.D.
Medical Director, Psychiatric Institute of Richmond

Robert Lassiter
Mental Health Director, Region Ten; Member, Mental Health Advisory Council

Barbara Maniha
Director, Northwest Center for Community Mental Health, Fairfax Community Services Board

Richard Merriman
Mental Health Director, Hampton-Newport News Community Services Board

Andrea Newsome
Director, Dejarnette Center

Michael D. O'Connor, LCSW
Mental Health Director, Henrico Community Services Board

David C. Pribble
Director, Eastern State Hospital

David A. Rosenquist
Director, Southwestern State Hospital

Hunter Widener
Executive Director, Highlands Community Services Board

(Continued on Next Page)

Staff:

David A. Fitch, Ph.D.
Director, Children and Youth Services, Department of Mental Health and Mental Retardation

Leslie S. Tremaine, Ed.D.
Director, Office of Mental Health, Department of Mental Health and Mental Retardation

EXECUTIVE SUMMARY

Joseph J. Bevilacqua, Ph.D., Commissioner of the Department of Mental Health and Mental Retardation, convened a broad-based Child-Adolescent Work Group in spring 1985, with the mandate to review Virginia's child-adolescent mental health system and to make policy and resource development recommendations. This group, chaired by Dr. Robert Cohen, Director of Virginia Treatment Center for Children, met over a six-month period to:

- Articulate a specialized service system model.
- Assess the current system against that model.
- Review interagency service collaboration efforts.
- Develop resource development strategies, including a proposed FY 1986-88 budget initiative for community services board program development.
- Analyze roles and functions of community services boards, state facilities, other child-serving agencies, and private sector with recommendations for policy development to improve the effectiveness of the overall system in serving young people and families.

The group's review of available data clearly showed that the current child-adolescent mental health system is seriously lacking in service capacity, particularly in the area of community-based service. Many CSBs are able to provide only general outpatient services and cannot meet critical needs for specialized intensive outpatient/day services, residential services, or prevention/early intervention programs. Capacity problems within the public inpatient system, due in part to the lack of development of community services, were also identified as a critical issue. Lack of a clear policy infrastructure for the development and management of a child-adolescent mental health system was also noted as hindering service planning and delivery, as was the lack of adequate information system/data base. The group also concluded that problems in interagency coordination in planning and funding of services led to a fragmentation and inefficiency in resource use.

The group made a series of recommendations for Department action in the areas of policy development, interagency coordination, resource development, and planning/data capacity.

These recommendations included:

- o A major budget initiative totalling $9.1 million for child and adolescent community services in FY 1986-1988. This initiative would allow for expansion of specialized child-adolesent outpatient and case coordination services as well as the development of residential treatment, day support, and specialized prevention/early intervention programs.

The group also recommended:

- o Adoption of policy to designate a target population and model service system for children and adolescents.

- o Use of Federal block grant set-aisde funds for development this fiscal year of CSB child-adolescent services focused on interagency collaboration.

- o Policy guidelines to develop CSB-facility regional partnerships.

- o Adaptation of current department patient management guidelines for children and adolescents.

- o Thorough study of multiagency funding mechanisms with demonstration projects to test the feasibility of various options for improving state and local funding and service coordination.

Overall, the Work Group concluded that major investments in both dollars and effort are needed to remedy serious problems in the current child-adolescent mental health service system. The needs for services were seen as great, and the social-economic costs for ignoring them even greater.

VOLUME I

REPORT

BACKGROUND AND INTRODUCTION

In spring 1985, Joseph J. Bevilacqua, Commissioner of the Department of Mental Health and Mental Retardation, established a Child-Adolescent Work Group with the charge to make policy and resource development recommendations for Virginia's child-adolescent mental health services system. More specifically, the group was asked to:

- o recommend budget initiatives for the 1986-88 biennium to address identified service needs, and

- o develop strategies and policy recommendations to enhance a single system of child-adolescent mental health services with appropriate roles and responsibilities for Community Services Boards (CSBs), facilities, private providers, and other child-serving agencies.

The group was chaired by Dr. Robert Cohen, Director of Virginia Treatment Center for Children, with broad-based membership to provide input from all child-adolescent state inpatient facilities, community services boards in all five HSAs, Division for Children, advocacy groups, university programs, private sector, and the State Department of Mental Health and Mental Retardation Board. This initiative developed in part out of several earlier study and planning efforts, including the report prepared by the Commissioner on the Needs of Emotionally Disturbed Children and Youth (1981) and the Commissioner's Task Force on the Needs of Mentally Ill Children (1982), and the recent report of a Child-Adolescent Residential Services Advisory Group. The focus of all of these groups on gaps in the basic services and the need to provide multiagency alternatives to institutionalization within a coordinated system of community-based care was an important foundation to the work of the Child-Adolescent Work Group.

The Work Group met frequently over a six-month period and used an active subcommittee structure to meet its mandate. The group's approach was to focus on the following sequence of interrelated tasks:

- o Articulate a clear and comprehensive service system model.

- o Conduct a preliminary assessment of the current system against that model.

- o Review current state-level interagency service collaboration efforts to recommend Department strategies for enhancing such coordination.

- o Develop proposed FY 1986-88 budget initiatives and advocacy strategies for improving inpatient and community services based on the preliminary identification of gaps/inadequate capacity within the current system.

- o Analyze the essential roles, principles, and functions of community services boards, state facilities, other child-serving agencies, and the private sector in managing a developmentally appropriate single system of care. Provide recommendations for policy development as needed to promote such a system.

MAJOR ISSUES IN CHILD-ADOLESCENT MENTAL HEALTH SYSTEM

In basic terms, the current child/adolescent Mental Health system includes both community and inpatient services. The 40 community services boards in Virginia are intended to be the primary locus of service delivery for this as well as the general adult and geriatric population. Public inpatient services are provided in five specialized facilities/programs at Dejarnette Center, Virginia Treatment Center for Children, Eastern State Hospital, Central State Hospital, and Southwestern State Hospital.

The approach of the Child-Adolescent Work Group was founded on several important initial assumptions and identified issues regarding the current state of Virginia's child/adolescent mental health services within this system:

- o According to national standards and prevalence estimates, child and adolescent psychiatric disorders pose a major health risk which require the commitment of significant resources to provide adequate specialized prevention, treatment, and support services (see Appendix A for further information on national standards). Virginia has acknowledged but not given priority to meeting those needs, especially in the area of community-based services.

- Virginia's mental health system for children and adolescents has developed in the absence of a clear and comprehensive model of core services (see Appendix B for a description of current systems in Virginia).

- Many critical specialized child/adolescent and family mental health services are either lacking or unevenly distributed across the Commonwealth. Many community services boards are able to provide only general outpatient services; others, with basic child services, still lack specialized intensive services and/or prevention/early intervention programs. Public inpatient facilities are often unable to meet resulting bed demands or serve special populations appropriately.

- An infrastructure of policy for the development and management of a child-adolescent mental health system has not, to date, been systematically articulated. As a result, the definition of appropriate roles among public providers, between public and private providers, and with other agencies has been dysfunctionally vague and requires clarification.

- The absence of a specialized needs assessment methodology, service planning process, and management information system hampers the development of needed resources, policies and services.

PRINCIPLES AND SERVICE MODEL

The Child-Adolescent Work Group outlined the following basic principles as the foundation for a model of comprehensive services:

(1) The children and adolescent population include individuals from birth to age 18. The needs of this group and their families are unique and a specific system of services should be developed to meet their special needs, safeguard their rights, and maximize their involvement in the decision-making process.

(2) All children/adolescents with equivalent functional disability and their families should have equal access to required services regardless of their race, color, creed,

nationality, involvement with other service systems, legal or custody status, current placement, or ability to pay.

(3) An individual child, adolescent, or family's need for mental health services should be identified as early as possible.

(4) Children and adolescents in need of mental health services should receive the most clinically and culturally appropriate, least intrusive, and least restrictive intervention necessary. Every reasonable attempt should be made to treat the child and family within the family context, unless an out-of-family placement is necessary for the protection of the youth or others. Services should be developed and delivered as close as possible to the child's home.

) Children/adolescents and families in need of mental health services should be able to move readily from one program or service to another as their needs change.

Children's mental health services should have ongoing training, consultative, and service linkage relationships with all other systems serving youth and their families, with particular recognition being given to the role of the educational system in the development of all children.

) It is essential that mental health staff who treat children, adolescents, and their families have specialized clinical training. Ongoing staff development is critical for assuring effective service delivery.

) The mental health system should have ongoing planning and evaluation processes which are coordinated with all other systems serving youth; e.g., county/city social services, local school divisions and local health departments.

(9) Applied research into effective service delivery models is critical to the development of the mental health system.

Based on these principles, the Work Group outlined a mental health service model for children and adolescents and their families in Virginia. This model, described in detail in Appendix C, includes a continuum of the following core services:

- o prevention
- o case management
- o identification and early intervention
- o outpatient
- o day treatment programs
- o respite care
- o crisis intervention
- o therapeutic foster care
- o therapeutic group care
- o residential treatment
- o inpatient hospitalization

Within each service component, a range of service intensities (acute, intermediate, long-term treatment) should be available. Essential support functions needed at all levels to integrate these services include advocacy, assessment, consultation, and case management. Such a model presumes continuity of care linking inpatient and community services in a single system. As with the current guidelines for patient management in the adult mental health system, the locus of responsibility for service management should lie with the community. Child and adolescent state hospitals in this context should provide a mix of acute, intermediate, and extended treatment services (including services for specialized populations). These state facilities should also serve as a focal point for regional planning, training, research and staff development for children's services. Additionally, they should link with CSBs to serve the following supportive functions:

(1) Ensuring equal access to treatment services regardless of economic circumstance or geographic location.

(2) Taking a leadership role with CSBs in bringing about interagency cooperation for service delivery.

(3) Working cooperatively with those systems responsible for meeting other human services needs of children and families.

SERVICE SYSTEM ASSESSMENT

The Work Group then used these principles and service model descriptions to assess the current child-adolescent mental health system in Virginia. This assessment of necessity needs to be seen as preliminary, given the short time frame and lack of adequate existing data sources.

For the community system, a survey (see Appendix D) was disseminated to the forty community services boards to determine the types and levels of specialized services as outlined in the proposed model now available. With 23 CSBs reporting, major results were as follows:

- Fewer than half of the CSBs have a full-time specialized child-adolescent coordinator with appropriate training.

- Many CSBs provide some general child-related prevention services, but only approximately half also have early identification and intervention services.

- Child-adolescent respite day care and day treatment are rarely provided by CSBs.

- Outpatient and crisis services are available in most CSBs, but the level of specialization and adequacy of capacity are unclear.

- Only 6 of the reporting CSBs indicate they provide any type of residential services to this population.

- Across all service areas, CSBs report significant waiting lists for access to programs.

Overall, major gaps were found to exist in many key components of the service model, and specialized staffing and capacity were reported to be inadequate across the system. The lack

of child/adolescent programs and resources in the community system is identified by CSBs as a critical shortage which requires urgent action.

For the state facility system, a more accessible data base exists. The volume of admission and discharges, as well as lengths of stay at the five specialized inpatient programs for FY-85, are summarized in Appendix E, along with data on the areas of origin for patients served by these facilities. These data, along with reports of admission delays and anecdotal evidence of other system deficiencies, led the Work Group to these major observations on state inpatient services:

- The inpatient system has evolved without systematic statewide planning as a mix of specialized and regional programs. Originally, the programs that were part of larger state hospitals (Eastern State, Central State, and Southwestern State Hospitals) served the regions of these hospitals. Dejarnette and Virginia Treatment Center for Children originally developed with specialized missions but over time have become less specialized and serve a broader population. Designated or ad hoc age or other specializations at many facilities have developed. Overall, no clear design exists, however, to designate missions and catchment areas.

- Specialized services for violent offenders and moderately/severely retarded and mentally ill youth are needed, as is clarification regarding the locus of specialized services for autistic children.

- All facilities need to improve their ability to respond to the substance abuse treatment needs of mentally ill children and adolescents.

- Capacity problems have emerged across the system over the last several years due, in part, to population growth, the lack of development of community services, and changes in third party payment structures for the private sector. Demand for beds is projected to continue and, in some areas, increase. No clear system of back-up or diversion for overflow admissions now exists.

- Many child-adolescent patients are in facilities far from their home community, due in part to these capacity problems and to the lack of clarity regarding regionalization and facility missions

- Not all facilities have affiliation with teaching institutions.

- Facility services are not well distributed geographically (e.g., no state inpatient facility in Northern Virginia; no child inpatient programs in the southwest; two facilities in the central Virginia area).

The Work Group acknowledged the important role other agency and private sector providers play in the overall service system. However, due to the short time frame within which the group functioned, no focused assessment of private sector and other agency services was conducted. The group saw such an assessment as a future step needed to complete the foundation for policy and resource development decisions. The following general observations were offered as an interim basis for recommendations:

- The CON process, as acknowledged by the Health Department and the SHCC, now has no clear methodology for coordinating the development of public-private and inpatient community service resources. The Department of Mental Health and Mental Retardation has not provided clear or consistent guidance in its role in the current review and needs to develop guidelines for child-adolescent CON reviews.

- Despite the development of several mechanisms for closer interagency work, the goals set forth in earlier reports regarding the need for interagency coordination in planning, financing, and service management have not been met.

- The private sector and other agency programs also lack critical specialized and intensive residential and day services as alternatives to institutionalization for many youth, especially those with multiple disabilities and/or specialized needs.

- Coordination in funding of services is lacking so that resource use is often fragmented and inefficient.

RECOMMENDATIONS

Based on the basic model and preliminary assessments described above, the Work Group developed a series of short- and long-term policy and resource development recommendations for the improvement of child-adolescent mental health services. These recommendations are grouped in the following general areas:

I. Policy Development
II. Interagency coordination
III. Resource development
IV. Planning/data capacity

These areas must be seen as totally interdependent. It must, therefore, be recognized in reviewing these recommendations that action on resource issues is essential if policy or structural changes are to have any meaningful impact.

I. POLICY DEVELOPMENT

1. Children and adolescents at risk or experiencing acute or severe mental illness should be designated by the State Board as a priority population for resource and service development.

2. Related policy statements should be developed to include descriptions of target populations and service system model (as outlined in this report), as well as an overall approach to the development of core services needed to serve these populations. These statements should be based on the guiding principles outlined above and should particularly articulate clearly a family and community-based services focus as part of the treatment planning process.

3. Policy development is also needed for the configuration of CSB and facilities roles and responsibilities. In general, these roles should parallel those in the current adult system, with CSBs as the locus of service management and state facilities providing general in-patient services on a regional basis. Limited

specialized inpatient and community programs, particularly in the area of services for violent offenders, autistic, and severely retarded/mentally ill children, should be designated to serve a statewide area. For this population, it is also appropriate for state facilities to serve as focal points and resource centers for planning and training.

4. The long-term development of such regional CSB-facility partnerships to meet nearly all service needs not appropriately met on a local basis would require several key changes in facility service configurations by HSA. Current and projected plans for inpatient services should be developed for each HSA which will, in turn, determine current and future roles for each of the five existing facilities and the need, if any, for new capacity.

5. The development of these regional service systems would also be strengthened by the administration of current child-adolescent inpatient programs independent of larger adult facilities. Options for eventual separate locations should be developed and reviewed for long-term implementation. (Note: Although this represents a majority view, at least two members did not concur with this recommendation.)

6. By policy, child-adolescent state facilities and CSBs should seek university affiliation with professional academic/medical schools to strengthen staffing and human resource development. Appropriate child-adolescent staff in the Department of Mental Health and Mental Retardation (DMHMR) should work with the Galt Scholar and the Training Office to ensure the attention to these human resource development issues. Linkages should be established with universities to promote appropriate curriculum development and pre-professional/in-service training for child-adolescent mental health professionals.

7. The revision of current patient management guidelines should include consideration of adapting these guidelines to special issues in the child-adolescent service system. The Office of Mental Health should also work with CSBs to ensure that

revisions on current court plans are made as needed to reflect any special issues for this population. Upcoming case management guidelines should also include a special section on children.

8. Staffing and organization of child/adolescent services in DMHMR should be examined and strengthened to reflect the policy designation of this group as a priority population within the mental health system. Staff responsibility for the development of policies outlined here as needed should be clearly identified.

I. INTERAGENCY AND PUBLIC/PRIVATE COORDINATION

1. Resources should be identified to do a thorough study of current multiagency funding sources for children's services with recommendations regarding possible new mechanisms for resource utilization to be more efficient in the use of these complex funding streams.

2. Results of this study should be the basis for the work of an interagency child-adolescent work group which follows up on this report by outlining specific demonstration projects to show the feasibility of various options for improved state and local interagency coordination. This work should be done in conjunction with the current efforts of the various interagency groups now charged with coordination of children's general services.

3. The Department of Mental Health and Mental Retardation should develop a clear policy statement on the Department's role in Certificate of Need processes. This would necessitate continued work with the Department of Health on the development of an appropriate bed need methodology for child-adolescent services to include public and private beds as well as community services resources.

4. Further effort is needed to facilitate coordination with the private sector. The Department of Mental Health and Mental Retardation should take the initiative to promote the needed planning and service linkages at both the state and local levels.

III. RESOURCE DEVELOPMENT

1. The Department should submit and strongly support an addendum budget package to provide a minimum of $9.2 million in new appropriations for child-adolescent CSB program development in mental health in FY 1986-88. Details of this package are provided in Appendix F. The focus of the request is on the expansion of community capacity, particularly in the areas of specialized child-adolescent basic outpatient services and program development, intensive day support, residential and prevention/early intervention services.

2. The Department of Mental Health and Mental Retardation should address serious problems of periodic overcrowding in the state hospital system by developing immediate and long-term plans to meet the increased demand for inpatient beds.

3. Federal Block Grant set-asides should be used for the development of CSB child-adolescent services focused on interagency program development. A Request for Proposals (RFP) for this purpose is included in Appendix G. Future Block Grant resources should continue to be targeted to this critical area.

4. Adequate training and technical assistance capacity should be developed within DMHMR and the CSB system to assure effective use of any newly appropriated resources. As with the development of adult services, this may involve the designation and support of special training sites.

5. Options for renewed application for NIMH funds should be actively explored as should other avenues for federal support.

6. Study should continue as to possible future needs for resources in the state inpatient system so that appropriation requests can be developed as needed for FY 1988-90.

7. Potential advocacy groups and coalitions interested in child-adolescent resource development should be identified and assisted as appropriate by DMHMR. The

newly-developed Parents and Children Coping Together (PACCT) parent group is an example.

IV. PLANNING AND DATA CAPACITY

1. The Department, in cooperation with the Virginia Association of Community Services Boards Data Task Force, needs to develop over the next 18 months a pilot data system common to facilities and CSBs to allow for a child-adolescent service system MIS. These data are needed overall for more refined needs assessment against the model proposed here and specifically to determine needed services in communities and facilities.

2. An ongoing comprehensive planning process in the area of children and adolescent mental health services needs to be strengthened/developed within DMHMR and across relevant child-serving agencies. This Work Group has served to identify a number of relevant issues and to recommend areas for policy analysis and development as well as resource development. This type of activity needs to be an ongoing function within the agency. In supporting this, a permanent child-adolescent mental health planning and advisory group should be established with representatives from the CSBs, facilities, other agencies, private sector, universities, and advocacy groups.

3. Plans should be developed to strengthen applied research into effective service delivery models for child-adolescent mental health needs. Affiliation agreements between facilities, CSBs, and universities should address this critical need.

CONCLUSIONS

Clearly, the child-adolescent mental health service system lags behind the adult system in both policy and resource development. Investments in both dollars and effort are needed in the key areas of policy development, interagency coordination, resource development, and planning/data capacity. The needs for services are great, and the social and economical costs for ignoring them are even greater. This Work Group strongly recommends that

Virginia pay now rather than later to develop adequate service capacity and appropriate policy guidelines in support of a comprehensive single system. Delays in funding such critical service needs in this instance mean a geometric increase in the eventual resource requirements rather than simply being a way to put off equivalent expenditures. Immediate and longer-term actions are required within both the facility and community system to meet the needs of the persons they serve. This report has outlined a number of these actions and lays the foundation for future state-local efforts to achieve a model children's service system in Virginia.

FINAL REPORT

CHILD-ADOLESCENT WORK GROUP

October 1985

Prepared for

Joseph J. Bevilacqua, Ph.D.
Commissioner

Department of Mental Health and Mental Retardation
Richmond, Virginia

Volume II of II

VOLUME II

APPENDICES

TABLE OF CONTENTS

VOLUME II: APPENDICES

APPENDIX A

PREVALENCE RATES FOR VIRGINIA
ON CHILD-ADOLESCENT MENTAL HEALTH NEEDS

PREVALENCE RATES FOR VIRGINIA ON CHILD-ADOLESCENT MENTAL HEALTH NEEDS

A prevalence estimate of 11.8% for children requiring mental health services has been recommended by Gould, Wunsch-Hitzig and Dohrenewend; 1981. The estimated size of subcategories for this disabled population in Virginia in Figure 1 are derived from a study conducted by Ohio Mental Health Agencies in 1978 (NASMHPD, 1983).* These extrapolations are applied to Virginia's present estimated child population of 1.5 million to determine subcategory prevalence rates.

FIGURE 1

	Ohio Prevalence Rates 0-17 Age Group	Estimate Derived for Virginia Population of 1.5 Million Children
Psychosis	.23%	3,450
Anxiety Affect Disorders	4.5%	67,500
Conduct Disorder	3.5%	52,500
Developmentally Disabled	.3%	4,500
Multiple Handicapped	.8%	12,000
At Risk	2.4%	37,050
Total		177,000

These figures represent an estimate of children in Virginia with a general mental health problem as well as specific categories of dysfunction. This graphic picture of the most severely disturbed child population presents a strong challenge to a service system which is presently not structured to meet their need.

*National Association of Mental Health Program Directors

APPENDIX B

CURRENT INPATIENT AND COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS

CURRENT INPATIENT AND COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS

Inpatient

The Department of Mental Health and Mental Retardation operates five inpatient programs with a total of 174 beds which provide specialized treatment services for children and adolescents.

The Dejarnette Center in Staunton, Virginia, serves both mentally ill and autistic children as well as mentally ill adolescents. The behaviorally-based program for the mentally disabled child includes psychological, psychiatric, recreational, social skills, and educational services. The autistic children receive intense behavioral training designed to increase appropriate behavior with psychiatric and psychological services tailored to individual needs. The adolescent program is based on a behavioral model using psychiatric consultation. Services include individual and group therapy, recreational, vocational, and educational services.

The Virginia Treatment Center for Children in Richmond, Virginia, provides medically-based inpatient psychiatric care and treatment services for youths experiencing severe emotional problems. Psychiatric, psychological, recreational, and educational programs are tailored to the children's needs. Partial hospitalization services are also available for children who can function in the community with therapeutic support. Outpatient treatment services are provided, and children receive family intervention, group and individual psychotherapy, and educational services.

The large state institutions also provide services to children and adolescents. The facilities at Central State Hospital and Eastern State Hospital operate as self-contained units within the larger hospital. General psychiatric adolescent inpatient services are provided. Eastern State Hospital provides services to both autistic and mentally ill children as well as mentally ill adolescents. Southwestern State Hospital operates an adolescent program providing a therapeutic milieu in which the youth learns to accept self-responsibility and to strengthen

self-concept. The programs in these larger facilities have several components such as medical, social, recreational, psychological, educational, and occupational services. Staff members are specifically assigned to the units with their sole responsibility being the management and further development of child-adolescent programs.

Community Services Boards

Public mental health, substance abuse, and mental retardation services in Virginia are provided either directly or contractually under the administration of community services boards. The forty community services boards offer generic core services, which include emergency, outpatient, inpatient, residential, and prevention/early intervention. Although local CSBs also provide services to both children and adolescents through this approach, no specialized services model has been developed at a state level. Some CSBs are able to provide specialized services while in other instances, children and adolescents are serviced through the CSBs general programs.

The specialized programs offered through the community services board are primarily prevention, outpatient, and residential core services. Without a specific model to guide the development of the forty CSBs in the development of statewide system of child and adolescent services, major service gaps remain. The community services boards offer various services across the state which include 15 prevention programs, 14 early intervention programs, 11 early identification programs, 2 respite day care centers, 26 outpatient services, 3 day treatment/partial hospitalization programs, 20 crisis intervention services, and 12 residential group homes (92 slots). Seven of the CSBs have a specialized interagency team process. Therapeutic foster care and therapeutic group care are not offered by any of the services boards.

APPENDIX C

CHILD-ADOLESCENT WORK GROUP SERVICES MODEL

SERVICE MODEL FOR CHILDREN, ADOLESCENTS AND THEIR FAMILIES

Service Components

1. Prevention
2. Case Management
3. Early Identification and Intervention
4. Outpatient
5. Day Treatment Programs
6. Respite Care
7. Crisis Intervention
8. Therapeutic Foster Care
9. Therapeutic Group Care
10. Residential Treatment
11. Inpatient Hospitalization

Within this service model, there are certain essential elements which support and are vital to each component of the service continuum. These essential elements are assessment consultation, case management, and advocacy. Assessment is a progressive process. There are different stages of assessment which range from screening to intensive evaluation. Children/adolescents and their families should be evaluated through an interdisciplinary process with physical health, education, and social needs being assessed as well as specific mental health strength and problems. While there may be an overall assessment and evaluation process for children, it is important that each component contain an assessment and evaluation element to assure that services are responsive to the specific needs of the child and family.

Consultation may be directed to the individual or agency providing service as well as to the child and family. In addition to serving in the communication and formation-sharing function, consultation enables individuals to increase their understanding of problems and alternative strategies for alleviating problems and increasing functional ability of the child and family. Consultation should be available throughout the entire range of services. Consultation services may be provided on-site or within the formal setting in which the consultant works.

In order to ensure that all services continue to be responsive to the client/patient needs, child and family advocacy must be an integral component of the service system. Effective advocacy encourages linkage of between the child and family and the service delivery system, facilitates coordination among various services, promotes continuity and integration of services, and assures appropriateness and quality of service. Because of the importance of other human service systems upon the child and family's development (e.g., Social Services and Juvenile Justice), these activities occur not only within the mental health system but between the mental health system and other human service systems.

While all individuals working with children and families should advocate on behalf of their clients/patients, it is important, especially for individuals with severe and persistent mental illness, that a single agency and, if possible, a single individual have continued responsibility for liaison and management.

Definition of Service Components

1. Prevention -- Services are directed at reducing the incidence of emotional disturbance and mental illness and minimizing associated functional disabilities. Activities are aimed at specifically identified high-risk groups within a community who have not been labeled yet as psychiatrically disabled. Prevention activities include direct service intervention with at-risk individuals and indirect service intervention with significant others who have an impact on children/adolescents and their families. Prevention services are generally provided to children/adolescents who have not yet become involved in the formal mental health system although other members of their family may have received mental health services. Competence-building and social support services are utilized to assist in managing, avoiding, and resisting stress.

2. Case Management -- Provides planning and direction for the delivery of services to a child and his/her family or custodian. Activities include assessment of client/patient needs, planning for services to address those needs, linking and coordinating the services to the client/child/adolescent and family, monitoring the service provided, and advocating for the child and his/her family. Case management is directed toward moving the individual through the system of mental health services as well as other important support services such as Education, Health, Social Services, and Juvenile Justice.

3. Identification and Early Intervention -- Through screening and assessment tools, efforts are made to identify children/adolescents and their families who exhibit early warning signs indicating initial stages or potential onset of mental health problems. Once identified, a primary level of treatment is offered to ameliorate the problem or minimize the degree of functional disability associated with serious mental disorder. This service component is almost always provided on an out-patient basis and often involves active out-reach services. Identification and early intervention services are often provided in conjunction with other major human service systems such as Education and Health.

4. Out-Patient Treatment -- Encompasses a broad range of services including individual and group treatment for children with mild to severe problems, and counseling, training, and support for parents and family members. For children/adolescents with mild to moderate problems who can otherwise function in a natural environment, this component is used as the primary treatment modality. Children/adolescents with moderate to severe problems often receive outpatient treatment in conjunction with other services of a more intensive nature (e.g., Day Treatment, Therapeutic Group Care). In addition to providing screening, evaluation, diagnosis and treatment, outpatient services also include follow-up work with families and case consultation to schools, Social Services, courts, and other service providers. Outpatient services can be provided either in a formal office setting or in the home and are scheduled by frequency during the week, depending on a client's/patient's needs. These services are directed toward helping the child to understand and cope with problems, improve social and behavioral functioning, and to remain or return to the family setting or the least restrictive alternative.

5. Day Treatment Program -- Services are offered during the normal working day, usually Monday through Friday, and are directed toward children who have difficulty participating in partial or full-day public school programs because of the severity of their problems. This component includes both education and mental health services, and services are generally provided four to eight hours per day. In addition to full educational/vocational services, diagnostic and treatment services, recreation, social skills development, group counseling, and services to parents are offered. Day treatment services are often provided in conjunction with residential treatment. Children served by this modality generally have moderate to severe problems.

6. Respite Care -- This component provides services for the families of mentally disabled youngsters who need periodic relief from the constant and often stressful care of their child. Services may be provided either on a planned or an emergency basis. Respite care may range from several hours up to 30 days and can be provided through a center-based model or on a contractual basis with citizens to use their homes for the provision of respite or to provide respite services in the home of the child. A child receives supervised care with the provision for meeting his/her basic health, nutritional, and daily living needs.

7. Crisis Intervention -- Provided for children in acute crisis or who require immediate mental health evaluation and/or treatment. Services are directed at crisis stabilization and may include evaluation, diagnosis, short-term treatment, follow up and case management. Crisis services may be provided on a non-residential or residential basis and are sometimes provided in the child's home. These services are directed to children in crisis who do not need the full range of medical staff and facilities as provided in in-patient services. Medical back-up, however, should be available. Crisis intervention services may be directed at alleviating the problem or achieving stabilization needed so that child/adolescent and family may become involved in longer-term services required to meet the needs of the child/adolescent and family. This component may include services directed toward both child and family.

8. Therapeutic Foster Care -- Directed toward children with mild to severe mental health problems who either do not have a family setting or cannot be maintained at home at the time of treatment. Children are placed individually or with another child in community foster care homes with specially trained and supportive foster parents. Foster parents receive a monthly subsidy for services to meet the special needs of these children. Professional mental health workers provide back-up training, case management, and treatment services.

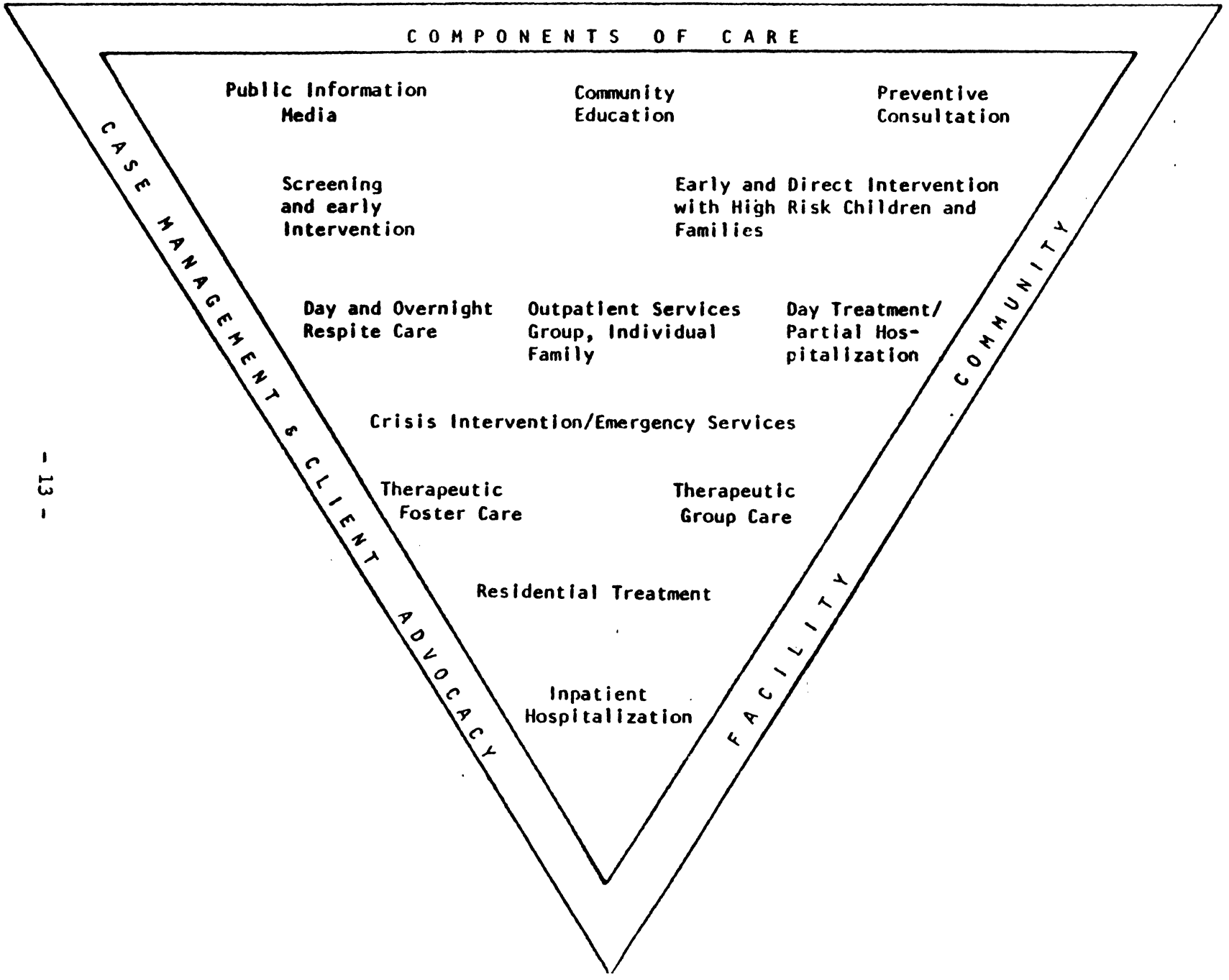
9. Therapeutic Group Care -- Serves children with moderate to severe problems and provides residential treatment to children for whom removal from home is essential to facilitate treatment. Children served in this setting generally attend public school but may use day treatment or job placement while in residence. Group homes provide healthy adult role models, group, and individual family counseling as appropriate and back-up services of mental health professionals. Staffing is sufficient to supply a moderate level of supervision. Length of stay is generally six to eight months but may vary, depending upon the child's individual needs.

10. Residential Treatment -- Provides highly structured and secure residential treatment to children with severe problems, including the multiply handicapped and highly aggressive child/adolescent. Children in residential treatment usually are too disturbed to attend public school or receive vocational training outside the residential

setting, but in some instances, children may receive services in another setting. In addition to group, individual and family counseling, liaison services are offered to mobilize community and family resources. Emergency services, education and vocational training, day treatment, and counseling may be provided by the program from other mental health center components or from another agency as indicated. Staffing patterns are generally on a shift system, employing paraprofessionals, teachers, and mental health therapists. Community and family liaison services are provided.

11. Inpatient Hospitalization -- Provided on a 24-hour-a-day basis for children with severe problems who require protective care and cannot be served appropriately in a less restrictive setting. Services include psychological and medical diagnostic procedures and observation treatment modalities, including medication, psychotherapy, group therapy, occupational therapy, industrial therapy, vocational rehabilitation, recreational therapy, and milieu treatment. Medical care and treatment are offered as needed. Room and board and supportive services are offered. Both voluntary and involuntary patients may be served in this setting. Services may be directed toward short-term evaluation and/or crisis stabilization as well as extended treatment for children with particularly intractable problems requiring intensive inpatient treatment to achieve stabilization and/or problem amelioration. Supervision is extensive and staffing includes a full range of mental health professionals and other ancillary professional and paraprofessional personnel. Interdisciplinary teams under medical leadership are utilized to provide comprehensive services.

CHILD AND ADOLESCENTS
MODEL SYSTEM



APPENDIX D

SURVEY OF COMMUNITY SERVICES BOARD
CHILD-ADOLESCENT MENTAL HEALTH SERVICES

RESULTS OF THE SURVEY OF COMMUNITY SERVICES BOARDS ON CHILD/ADOLESCENT SERVICES

Results

Twenty-four of the state's 40 CSBs responded to the survey. Although this is a significant response rate, the results presented do not provide a comprehensive picture of types of child and adolescent services provided by the network of CSBs in Virginia. However, a stable pattern of responses emerged which seem to typify CSB services for children and adolescents.

The first issue addressed by the survey was whether or not the CSBs have a staff position with a specific focus on child/adolescent services and issues (i.e., a child/adolescent coordinator). Half of the reporting CSBs indicated that they do have such a position. Further, a majority of these CSBs reported that the coordinator spends 100% of his/her time on child/adolescent services and issues.

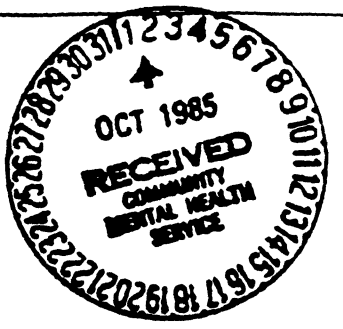
A second issue addressed by the survey was the types of child and adolescent services provided by the CSBs such as prevention, outpatient, residential, etc. The most common type of service provided by the CSBs in this general service area was "prevention" services, with about 90% of the CSBs indicated that they provide this type of service. By contrast, half of the CSBs indicated that they provide some type of early intervention service and about one-third of the CSBs indicated that they provide early identification services.

The next general area of services addressed by the survey concerned non-residential services; specifically, respite day care, outpatient, day treatment/partial hospitalization, and crisis intervention services. The preliminary results of the survey indicate that respite day care and day treatment/partial hospitalization are services that are rarely provided to the child/adolescent population by the CSBs. Only one of the CSBs reported providing respite day care and only two CSBs reported providing day treatment/partial hospitalization. On the other hand, outpatient and crisis intervention services appear to be very common components of a CSB;s child/adolescent service agenda. Twenty-three of the CSBs reported

VACSB

VIRGINIA ASSOCIATION OF COMMUNITY SERVICES BOARDS, INC.

Post Office Box 9416
Richmond, Virginia 23228



Septeaber 14, 1985

Dear Executive Director:

On June 6, 1985, a questionnaire on child/adolescent aental health services was sent to you requesting information that would assist the work group on child/adolescent services in 1) describing the nature and scope of existing services, 2) developing a service aodel which can be used statewide with all the local variations inherent in our system, and 3) proposing a budget request for the next biennium to support the developaent of needed services. The questionnaire arrived on your desk aaid the flurry of JLARC requests and end-of-year "stuff" and likely took a lower priority. The analysis of existing services has proceeded on the basis of returns to date but we have aade provisions to incorporate your response, which is important to the work group and ultimately to you. A second copy of the questionnaire is enclosed for your convenience. Even if you are unable to provide complete data, and aany CSB's were not because child and adolescent services are not statistically separate from adult services, please return what is available to:

Robert E. Lassiter
Region Ten Community Service Board
Suite 103
413 E. Market Street
Charlottesville, Va. 22901

(804) 972-1800

A budget addendua proposal has been developed by the work group and discussed with the Commissioner, and will be subaitted to the DMH/MR as part of the final report of the work group in October. Information gathered via these questionnaires is being used as supporting data for this proposal.

You will also be receiving soon fraa the DMH/MR a request for proposals for developaent of child and adolescent services to be funded from block grant funds.

Sincerely,

Bob

Robert E. Lassiter

SURVEY OF
COMMUNITY SERVICES BOARD
CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

CSB Name_____
Contact person for this questionnaire_____
Telephone_____

1. Please identify by title and name the individual with your CSB who is the designated coordinator of child and adolescent services.

_____

2. Please list the following information for the designated child/adolescent coordinator. Attach their job description if you wish.

a. Duties of the position:

b. Qualifications for the position: (Are these met by the current incumbent? Y N)

c. Experience required for entry into the position: (Is this met by the current coordinator? Y N)

d. What percentage of the coordinator's time is spent on child/adolescent services or issues? ____

3. By position title, please indicate the qualifications, i.e. degrees, credentials, special training, etc., and experience required of other (than coordinator) staff providing child/adolescent mental health services.

4. What are the current training needs of staff providing child/adolescent mental health services?

5. Please enclose any policy statements of your organization directed to the establishment and operation of child/adolescent mental health services. Include any information or procedural guidelines which describe access of children and adolescents to services throughout your system. However, exclude program level policy/procedure/operations manuals which are lengthy. Please list the name of documents you have but did not send.

6. Please enclose a comprehensive organizational chart which depicts child/adolescent mental health services and the relationship of these services to the total organization.

7. Please indicate the extent to which children and adolescents are provided services in the context of "family" counseling or therapy.

8. For your catchment area, please give:
   a. census _____
   b. size, in square miles _____

Following is a series of questions (#9 -#16) that relate to the components of the outlined continuum of mental health care for children, adolescents and their families. In responding, include programs or services for clients ages 0 to 18 years, showing where there are exceptions to 21 years old, when appropriate. Please elaborate as you wish in describing your programs/services. Use additional sheets as necessary.

SERVICE CONTINUUM

I. Prevention/Early Identification/Early Intervention
   a. Prevention
      i. Public Information (Media)
      ii. Community Education
      iii. Consultation and Training with Other Service Providers
      iv. Direct Intervention with High Risk Children/Adolescents/ Families
   b. Screening and Early Identification
   c. Early Intervention
      i. Direct Service
      ii. Consultation

II. Case Management and Client/Family Advocacy (where provided as a separate service)

(SERVICE CONTINUUM continued)

III. Non-Residential (Includes assessment and evaluation; treatment and discharge planning; direct service; case specific consultation; with appropriate variations in intensity)
   a. Respite Day Care
   b. Outpatient
   c. Day Treatment/Partial Hospitalization
   d. Crisis Intervention

IV. Residential (Includes assessment and evaluation; treatment and discharge planning; direct service; consultation; emergency, acute, intermediate, and long-term care)
   a. Respite Care Overnight
   b. Therapeutic Foster Care
   c. Therapeutic Group Care
   d. Residential Treatment
   e. Inpatient Hospitalization

Please answer questions #9. through #16. for each service area. Although lengthy, this set of questions is repeated for each service area for ease in answering and analyzing the responses.

SERVICE: I. Prevention/Early Identification/Early Intervention
   a. Prevention
      i. Public Information (Media)

9. Is this servic available in your area? Y N
10. Does your CSB provide these services? Y N
   If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) ____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
   How and why?

SERVICE: ii. Community Education

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
    How and why?

SERVICE: iii. Consultation and Training with Other Service Providers

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
    How and why?

SERVICE: iv. Direct Intervention with High Risk Children/Adolescents/ Families

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N How and why?

SERVICE: b. Screening and Early Identification

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N How and why?

SERVICE: c. Early Intervention
i. Direct Service

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
How and why?

SERVICE: ii. Consultation

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients _____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
How and why?

SERVICE: II. Case Management and Client/Family Advocacy (where provided as a separate service)

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
    How and why?

SERVICE: III. Non-Residential (Includes assessment and evaluation; treatment and discharge planning; direct service; case specific consultation; with appropriate variations in intensity)
a. Respite Day Care

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
    How and why?

SERVICE: b. Outpatient

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
    How and why?

SERVICE: c. Day Treatment/Partial Hospitalization

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
    How and why?

SERVICE: d. Crisis Intervention

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
    How and why?

SERVICE: IV. Residential (Includes assessment and evaluation; treatment and discharge planning; direct service; consultation; emergency, acute, intermedate, and long-term care)
a. Respite Care Overnight

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
    How and why?

SERVICE: b. Therapeutic Foster Care

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
    How and why?

SERVICE:
c. Therapeutic Group Care

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
    How and why?

SERVICE: d. Residential Treatment

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
    How and why?

SERVICE: e. Inpatient Hospitalization

9. Is this service available in your area? Y N
10. Does your CSB provide these services? Y N
    If Y, please check ___contract, ___directly operate, ___both.
11. Name other non-CSB providers of this service in your area.

12. If CSB provided, estimate services that will be provided this fiscal year: units of service_____; # of clients_____; where applicable, # of slots_____.
13. Where applicable, waiting list for service as of the end of May, 1985: # requests unserved_____; estimate ratio of requests to service capacity_____.
14. Approximate cost of existing CSB services, give the annual budget for FY 85 including all revenue sources:_____.
15. Considering your CSB area's needs for new or expanded services, rank this service in order of priority relative to the other services in this continuum. 1 (high) to 17 (low) _____. If this number is 1, 2, or 3, provide brief narrative details for new or expanded services on a separate sheet and estimate the revenues required to develop these first three priorities.
16. If your CSB has a program in this service area, is it at risk? Y N
    How and why?

APPENDIX E

ADMISSIONS TO CHILD-ADOLESCENT MENTAL HEALTH INPATIENT UNITS BY HSA

ADMISSIONS TO CHILD-ADOLESCENT MENTAL HEALTH
INPATIENT UNITS BY HSA

(September 1984 - August 1985)

FACILITY	HSA I	HSA II	HSA III	HSA IV	HSA V	TOTAL
Eastern State	8	10	11	24	72	125
Central State	6	5	16	52	5	84
Southwestern State	5	1	58	2	1	67
Dejarnette Center*	43	32	27	4	4	110
Virginia Treatment Center	3	5	9	54	9	91
TOTAL	65	53	121	147	91	477

*Includes outpatient and day treatment

CLIENTS UNDER THE AGE OF 18

DISCHARGED IN FY 1984-85 PER MONTH

Hospital	Sept. 1984	Oct. 1984	Nov. 1984	Dec. 1984	Jan. 1985	Feb. 1985	Mar. 1985	April 1985	May 1985	June 1985	July 1985	Aug. 1985	ROW TOTAL
Eastern State Hospital	3	2	5	2	6	10	7	12	8	6	9	10	80 18.4
Central State Hospital	8	9	5	11	5	4	5	2	4	14	3	4	74 17.0
Southwestern State Hospital	3	4	4	5	3	5	7	9	7	4	6	3	60 13.8
Dejarnette Center	7	8	6	7	11	9	14	10	5	5	6	18	106 24.4
Va. Treatment Center	3	1	21	20	45	3	2	12	2	2	3	1	115 26.4
COLUMN TOTAL	24 5.5	24 5.5	41 9.4	45 10.3	70 16.1	31 7.1	35 8.0	45 10.3	26 6.0	31 7.1	27 6.2	36 8.3	435 100.0

CLIENTS UNDER THE AGE OF 18
DISCHARGE IN FY 1984-85 PER MONTH
(Average Length of Stay)

HOSPITAL	MEAN
For Entire Population	192.7724
Eastern State Hospital	106.7724
Central State Hospital	101.6757
Southwestern State Hospital	77.9000
Dejarnette Center	207.8585
Virginia Treatment Center for Children	357.5217

TOTAL CASES: 435

APPENDIX F

PROPOSED COMMUNITY SERVICES BOARD
CHILD-ADOLESCENT SERVICES
BIENNIUM BUDGET REQUEST
1986 - 1988

BUDGET REQUEST

COMMUNITY SERVICES BOARD
CHILD AND ADOLESCENT SERVICES

Objectives: Biennium Budget 1986-1988

In the first year of the biennium, the community services boards will seek to expand the continuum of care for children and adolescents through the implementation of a local/regional network of services based on need.

In the second year of the biennium, there will be a continuing expansion of the child-adolescent local and regional network of services as community services boards apply for funds to develop other needed services.

Strategies: Biennium Budget 1986-1988

1. To ensure that each community services board offers specialized child and adolescent services with at least one FTE of coordination and treatment provided for a total of 60 FTEs. These FTEs will provide services to 3,000 families each year.

2. To develop a statewide community or regionally based system of residential (to include respite and therapeutic foster care) and day treatment services. A total of 135 new slots will be available to serve 1985 additional clients annually.

3. To implement specialized prevention/early intervention services in each CSB for a total of 22 FTEs statewide. Services for an additional 1500 clients will be provided by each of these FTEs for a total of 33,000 additional clients.

Justification

The Division for Children's publication, **Virginia's Children: A Statistical Summary**, estimated that of 1.5 million children in Virginia, 172,500 have some level of mental health needs that require specialized services. A 1985 departmental survey found that there is a significant lack of specialized community-based services to treat these children and adolescents. Of these, the juvenile offenders, dually diagnosed, and autistic are priority target populations.

The requested funds will initiate the development of a model mental health service system for children and adolescents in the community. The services most urgently needed are specialized coordination and outpatient treatment, residential (including respite care and therapeutic foster care), day treatment programs, and prevention. This budget proposal is requesting funding for these services that are basic to the provision of sufficient community-based mental health treatment and care of children and adolescents.

If funds are not provided to build these critically-needed services, most of the estimated 172,500 children and adolescents will remain unserved. Others will continue to be referred to the court system for services and overcrowd the correctional system, while others receive more expensive services in the public and private psychiatric services. The costs of serving these youths in institutions will be far greater than providing services in the community, and the child will be more likely to be institutionalized in the future rather than to remain in the community as a healthy, productive citizen.

Estimated Costs

First Tier
FY-87

20 FTE @ $45,000 = $ 900,000 (includes support expenditures)
40 FTE @ $35,000 = $1,400,000 (includes support expenditures)

FY-88

Continuation of $2,300,000 from FY-87

Second Tier
FY-87

$ 900,000	60 residential slots (includes respite and therapeutic foster care)
$ 600,000	75 day treatment slots
$1,500,000	**Subtotal**

FY-88

Continuation of $1,500,00 for established residential program

Third Tier
FY-87

22 FTE Prevention Specialists x $35,000 = $770,000

FY-88

Continuation of $770,000 budget for 22 FTE Specialists

Subtotal, FY-87:	$4,570,000
Subtotal, FY-88:	$4,570,000
TOTAL	$9,140,000

APPENDIX G

FEDERAL BLOCK GRANT RFP
COMMUNITY CHILD-ADOLESCENT SERVICES

RFP BLOCK GRANTS
COMMUNITY SERVICES BOARDS - CHILD AND ADOLESCENT

INTENT:

The Department of Mental Health and Mental Retardation has received federal block grant funds for FY-85, including a special allocation set aside for the development of community-based child and adolescent services. The Department will use these funds to support CSB projects which focus on the development and delivery of interagency services for this population. The funding of interagency programs through the block grant funds will extend the capability of the CSBs to provide child and adolescent mental health services together with local networks of local child-serving agencies. The funds will support projects which provide services such as group homes, day treatment, therapeutic foster care, and outpatient services.

TARGET POPULATION:

Children and adolescents whose mental health needs range from early intervention and preventive care to intensive residential/day treatment may be served through these projects.

APPLICATION PROCESS:

In applying for these funds, the community services board should develop proposals including description of need, program narrative (including goals/objectives), a plan of action with time tables, evidence of interagency collaboration, budget, and evaluation. Proposals should be a maximum of 10 pages. The funding request should not exceed $90,000.

Need

The request must cite statistical and documented sources which support the need for the proposed program within that CSB's service area. These additional sources may be

the findings of work groups/task forces as well as the identification of key incidents that document a problem that will be addressed by the requested program.

Program Narrative

The request must include a description of the program to be implemented including the relevant details regarding staffing, services,cooperating agencies, and the relationship to present services available to the children and adolescents within the CSB and other local public/private child-serving agencies. It should also include goals and objectives. The goals must directly relate to the stated need and must state the major end-term results arising from the implementation of the program. These should become the basis for specific statements of objectives which should include specific activities and time frames for completing these activities. The goals and objectives must be achievable both in terms of the locally available resources, requested funds, and the time period during which the project will operate.

Action Plan

The plan of action should briefly describe the way in which the community services board will implement the goals and objectives within stated time frames. In instances where conceivable issues will arise which may interfere with the completion of a goal (i.e., locating program site), alternative actions for completing the goal should be described. With the plan of action should be a time table which displays major activities and the timeline for completion.

Interagency Collaboration

These demonstration projects must clearly involve other local public/private child-serving agencies in the delivery of support services such as education, medical, welfare, recreational, etc., as deemed necessary by the child's needs. Therefore, included in the application must be documentation as to the support and cooperation of other involved child-serving agencies. This documentation can be either letters of support and/or interagency agreement (proposed or active).

Budget

The application must include the completion of the attached budget form.

Evaluation

The final section of the proposal shall state the means by which the success of the demonstration project will be demonstrated. The description of evaluation should include but may not be limited to the degree to which stated goals and objectives are completed. The evaluation should be designed to allow the community services boards and other participating agencies to determine through self-study the degree of the project's success.

SUBMISSION AND SELECTION:

The deadline for submission will be November 29, 1985. The notification as to awards will take place by December 15, 1985. The funds will be awarded by January 1, 1986. Each project will be evaluated by a panel who will judge the merits of the program in terms of impact, innovation, feasibility, and cost effectiveness.

Impact: To what degree does the program address the stated need? Will the quantity and quality of interagency services for children and adolescents be increased as a result of the implementation of this program? Will current or future reliance on institutionalization be reduced?

Innovation: The degree to which the program is able to use its resources and to incorporate new approaches to providing local interagency services will be important since these projects are intended to demonstrate locally and on a state-wide basis interagency collaboration for improved community-based child/adolescent services.

Feasibility: Can the proposed program be successfully implemented? Will the expected results be clearly identifiable so that the CSB and other involved local agencies can evaluate the degree of success?

Cost Effectiveness: Does the project increase both the level and quality of services available to children and adolescents at a cost below episode costs for inpatient hospitalization? Also, does the project reduce the cost over the provision of services by individual agencies?