FINAL REPORT OF THE
DEPARTMENT OF MENTAL HEALTH,
MENTAL RETARDATION AND
SUBSTANCE ABUSE SERVICES
ON THE

Implementation of a Comprehensive Training System for Community Services Boards and Facility Staff

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 21

COMMONWEALTH OF VIRGINIA
RICHMOND
1991

PREFACE

Senate Joint Resolution No. 138, agreed to by the 1989 Session of the General Assembly directs the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to establish and implement a system of statewide training and staff development for Community Services Boards and DMHMRSAS facility staff.

The Commissioner convened a Steering Committee to develop an orientation package for twelve key management positions in Community Services Boards and state facilities. The Steering Committee was comprised of the following members:

Constance N. Fletcher, Ph.D., Director
Southern Virginia Mental Health Institute

Martin Kline, Assistant Director, Administrative
Eastern State Hospital

Dr. Michael Connell, Medical Director
Southwestern Virginia Mental Health Institute

Leslie Gayle, Nursing Director
Southeastern Virginia Training Center

Robert Merryman, Social Work Director
Central Virginia Training Center

Anita Jackson, Employee Relations Director
Western State Hospital

C. Joseph Sharrer, Executive Director
Harrisonburg-Rockingham Community Services Board

Paul Borzellino, Emergency Services Director
Prince William Community Services Board

Alan Phillips, Director of Residential Services for the Mentally Retarded, Oakton, Virginia

Betty Burke, Mental Retardation Director
Mental Health Services of the Roanoke Valley

Linda Edwards, LCSW, Mental Health Director
Central Virginia Community Services Board

Dot Henry, Substance Abuse Director
Chesterfield Community Services Board

The Steering Committee was chaired by the Deputy Commissioner and staff assistance was provided by the Office of Human Resource Development and the Office of Employee Relations and Personnel.

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EXECUTIVE SUMMARY

Senate Joint Resolution No. 138 , agreed to by the 1989 Session of the General Assembly, directs the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to establish and implement a system of statewide training and staff development for Community Services Boards and DMHMRSAS facility staff.

The Commissioner submitted an interim report in December, 1989, on a two-phased approach to developing statewide training and development of minimum standards. This final report details the on-going development and implementation process.

The two-phased approach is in response to the differing training needs of managers and direct care staff. Individuals hired into management positions bring with them basic professional skills and experience, yet they may lack a clear understanding of the Virginia system of public mental health, mental retardation and substance abuse services. On the other hand, training for direct care staff must ensure competence in delivery of services. The methods for determining the content and implementation of training and staff development will therefore differ for the two groups.

The process followed to develop a curriculum for key management positions can be replicated for all management and supervisory positions. The major components are as follows:

1. An individual designated by the Commissioner convenes a Steering Committee of representatives of the targeted positions.

2. Each member of the Steering Committee is directed to form an ad hoc committee of his peers to identify and recommend areas that should be addressed.

3. The Steering Committee makes decisions on the recommended content and the procedures for implementing the training program.

4. The program is assigned to the appropriate unit for implementation and monitoring.

5. Support for these activities is provided by the Office of Human Resource Development and the Office of Employee Relations and Personnel.

The above process was used successfully in the first year to develop an orientation package for twelve key management positions in Community Services Boards and state facilities. Ten additional positions are targeted for the second year. The orientation training provides an introduction to the Virginia system of

community and facility services, to other human services, and information essential to function at a high level of managerial and operational capacity. Dissemination of the basic system overview and position specific knowledge will be handled through a mentor system. As with other orientation training, responsibility for implementation and monitoring this program has been given to the Office of Employee Relations and Personnel.

A six-months trial implementation period will begin January 1991. At the conclusion, the Human Resource Development Office will ask for comments and suggestions regarding the curriculum and its delivery. Recommended changes in the process will be incorporated in the implementation of phase II of the project. The Office of Human Resource Development will establish a working relationship with the Virginia Association of Community Services Boards Training Committee for the purpose of establishing Training Standards for Community Services Boards. The Office of Human Resource Development will work with the facility training directors to establish similar standards for state hospitals and training centers. The Office of Human Resource Development will recommend that these standards be incorporated in the CSB Evaluation process and facility Licensure Regulations.

A different process is being used to implement a standardized curriculum for entry level positions. In cooperation with the Virginia Department of Education, the Department has initiated a process for developing competency-based training standards for direct care personnel in state hospitals and training centers. The two agencies will study one direct care position each year to determine required duties, tasks, and proficiency levels. Currently, one position study is complete, and a second is near completion. The Vocational and Adult Education Division of the Department of Education is furnishing an extensive, competency-based curriculum guide for each position. These completed curriculum guides can be modified for training community staff who perform similar services in residential programs.

INTRODUCTION

PURPOSE: The purpose of this Orientation Packet is to help you get started in your new role. The manual is intended to serve as an introduction to persons, information, materials, and activities which may be especially helpful in your first year in this position. The packet is organized into four major sections:

* Introduction
* System Overview
* Role Specific Knowledge
* Resource Material

Orientation training has been developed in response to Senate Joint Resolution No. 138, agreed to by the 1989 Session of the General Assembly. It directs the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse services (DMHMRSAS) to establish and implement a system of statewide training and staff development for Community Services Boards and DMHMRSAS facility staff.

The first phase of training concentrates on orientation for key management positions. Each individual hired by the Department or by a Community Services Board bring to the job basic professional skills. However, the newly hired staff person may lack a clear understanding of the Virginia system of public mental health, mental retardation, and substance abuse services. In addition, knowledge of the policies and instructions of the State Board and DMHMRSAS are essential to successful functioning within the system. this orientation packet provides basic information on the Virginia system of community and facility services, information essential to functioning at a high level of managerial and operational capacity.

This packet is designed to be completed with the help of one or more staff with considerable experience (the mentor). The suggested time frames allow for flexibility in planning your orientation visits with a number of colleagues. However, it is essential that all content areas designated as "high" priority be covered within the first two weeks of assuming your position. The entire packet should be completed within the first three months of employment.

PROGRAM GOALS AND OBJECTIVES: The goal of this statewide training and staff development program is to ensure quality services in community and facility programs by providing basic orientation and training to persons entering key management positions.

The objectives of the training are to ensure that new staff will:

* Review the Virginia system of public mental health, mental retardation, and substance abuse services,

* Examine the policies and instruction of the State Board and Department of Mental Health, Mental Retardation and Substance Abuse Services,

* Identify resource persons in various setting who will assist the new staff person by acting as a sponsor or mentor.

THE MENTOR SYSTEM

Board chairmen and executive directors are busy people with little time available to devote to orienting newly hired directors and managers. One of the best methods for orienting new directors is for colleagues in similar positions and from similar organizations to act as mentors or sponsors. Sponsors can be valuable adjuncts to a traditional orientation program. They can assist the new director by answering questions, explaining why things are done as they are, and by helping the new director make the necessary contacts.

THE CSB SPONSOR: When a new executive director is employed by a CSB, the Director of the DMHMRSAS Liaison Office will arrange for an executive director from another CSB to act as a sponsor. Similarly, when a new program director is employed by a CSB, the executive director of that CSB arranges for a peer sponsor from another CSB to assist in orienting the new program director. In all cases sponsorship is voluntary and the final selection of the sponsor is left to the CSB. The CSB sponsor should be in the same or in a similar position to that of the new staff person and from a Board with a similar classification (jurisdiction served, budget size, and catchment area characteristics).

The major responsibilities of the CSB sponsor are to meet with the new staff person to discuss the position, to answer questions, and to remain a point of contact during the first months of employment. The sponsor may choose to accompany the new staff person to Richmond for all or part of the central office orientation visit or they may elect to meet afterwards to discuss the visit. The sponsor should also assist the new director to make the proper contacts at the next scheduled VACSB meeting through introductions to key participants in that organization. Finally, the sponsor may wish to accompany the new director on a visit to those state facilities utilized by the new director's CSB.

THE FACILITY SPONSOR: When a new hospital or training center director is employed by DMHMRSAS, the Assistant Commissioner for Program Support will arrange for the director of a similar facility to act as a sponsor. Similarly, when a new facility administrator or manager is employed by the Department, the director of that hospital or training center will make arrangements for a peer in a like facility to act as a sponsor to assist in orienting the new employee. The selection of the sponsor is made by joint agreement between the individual making the arrangements and the director of the facility employing the sponsor. The sponsor should be an individual in the same or similar position to that of the new employee.

The responsibilities of the sponsor are to meet with the new staff person to discuss the position and to act as a point of contact during the first months of employment. The sponsor may accompany the new employee to Richmond for all or part of the central office orientation visit. The sponsor should also assist the new director to make the proper contacts by accompanying the new director to other hospitals or training centers and introducing him/her to key staff in those organizations.

THE CENTRAL OFFICE SPONSOR: New CSB, hospital, and training center directors will be oriented to DMHMRSAS operations by a Central Office sponsor. If the new director is employed by a CSB, the executive director of that CSB or, if the new staff person is the executive director, the DMHMRSAS Assistant Commissioner for Program Support, schedules a visit for the new staff person. The Assistant Commissioner for Program Support or the appropriate disability office director will serve as the Central Office sponsor. The role of the central office sponsor is not unlike the role of the CSB sponsor, to acquaint the new director with Central Office operations, to answer questions, and to remain a point of contact in the Central Office.

Each Central Office sponsor will be provided with a work sheet (see Section IV, Role Specific Knowledge) designed to assist the sponsor to schedule the orientation visit. It is the responsibility of the sponsor to collect the necessary information in order to assess the background and knowledge base of the new staff person. Such information will normally be found in a vita or state application. If the new director comes from another state, the sponsor should discuss the structure and operation of that state's mental health, mental retardation, and substance abuse department with the new director to assess how that department differs from the Virginia DMHMRSAS. The purpose of this assessment is to identify what information is essential to the successful functioning of the new director within Virginia's system of community and facility services. Once the assessment has been completed, the Central Office sponsor will develop, with input from the new director, a schedule of meetings with key Central Office staff to take place during the Central Office orientation visit. It is the responsibility of the Central Office sponsor to provide each Central Office staff person who will be meeting with the new director with basic background information about the new staff person before the meeting takes place.

The length of the meetings will vary. They may be as brief as an introduction or they may be more lengthy informational meetings with several Central Office staff present. The objective of the meetings is to acquaint the staff person with the policies and procedures and rules and regulations of the Department. The

Central Office staff person meeting with the new director is responsible for providing the new director with an up to date operating manual for his or her area of operations and to acquaint the new staff person with those aspects of operations that are essential to the performance of his or her duties. If the new staff person is personally involved in a given area of operations, the Central Office staff person for that area will review the policies and procedures and will assist the new person to identify important areas to monitor.

Finally, it will be the responsibility of the Central Office sponsor to provide the new director with pertinent documents. The documents provided will be based on the individual's familiarity with DMHMRSAS and the service delivery system.

After the new director's Central Office orientation visit, the Central Office sponsor will send a letter to the Commissioner of DMHMRSAS to indicate that the Central Office orientation visit was satisfactorily completed. The new director and his or her immediate superiors will receive copies of this letter.

SUMMARY: One effective method of orienting new employees is to have an individual in the same or in a similar position and from a like organization act as a sponsor. The Virginia mental health, mental retardation and substance abuse service delivery system orients new administrators and managers by providing two sponsors: a CSB or facility sponsor and a Central Office sponsor. Sponsors provide the new director with information necessary to the performance of his or her duties and they introduce the new staff person to key community, facility, and Central Office staff. This approach ensures that each new manager is provided with the essential information to successfully function within the Virginia mental health, mental retardation, and substance abuse service system.

OVERVIEW OF THE VIRGINIA SYSTEM OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

The purpose of this overview is to introduce the new employee to the history, mission, and policy governing the Virginia service system. The overview summarizes the structure and capacity of the community services boards and state facilities and provides the reader with a basic understanding of the issues, needs, and future directions of the service delivery system. The overview also outlines the major characteristics and utilization patterns of each of the major components of the system. Appendix A defines the core services of the facility and community service system.

The Virginia mental health, mental retardation, and substance abuse system is a dynamic system that must continually respond to changing consumer needs, changing service delivery technologies, and changes in funding. The pages that follow are not numbered to allow for easy updating of this section as the needs, priorities, and characteristics of the service system change. However, all future updates should follow the basic outline of the overview:

History and Legislative Influence

Current Service System

Characteristics of the Virginia Service System

Community Services Utilization and Trends

Facility Utilization and Trends

System Policies, Future Directions, and Priorities

Definition of Core Services

SERVICE SYSTEM OVERVIEW

History and Legislative Influences

Prior to 1900, the provision of mental health services was considered the responsibility of the states, localities and private charities. From the mid 18th century to the 1950's, the primary setting for public mental health services was the large institution or hospital. These state operated institutions offered few services beyond basic patient maintenance and custodial care. Once patients were admitted to these institutions, they remained for extended periods - often for many years.[1] During the late 18th and 19th centuries, the four large mental hospitals in Virginia were established: Eastern State Hospital in Williamsburg, Western State Hospital in Staunton, Central State Hospital in Petersburg and Southwestern State Hospital in Marion.

Until the mid 18th century, many mentally retarded persons were housed in jails, alms-houses and mental institutions. In Virginia, mentally retarded persons were treated with epileptic and mentally ill patients at the four large state mental hospitals from 1773 to 1911. The Virginia State Epileptic Colony in Lynchburg and the Petersburg State Colony, established in 1911 and 1938 respectively, provided custodial care.[2]

The history of the Virginia community mental health system of services is a relatively short one. While the Commonwealth was promoting the development of state clinics as early as 1923, a visible system of community services did not begin to emerge until the 1940's, when the National Mental Health Act (passed in 1946) and state legislation permitting the establishment of mental hygiene clinics (passed in 1942) began to dedicate federal and state funds for such services. While the state legislation emphasized the needs of former patients, it also allowed for the treatment of those in the community who were referred for counseling, guidance and advice.

Other factors during the 1950's and 1960's which contributed to the shift in emphasis from long-term institutional care to community-based programming included:

- The increased public attention to the conditions existing in large public institutions and the recognition that these institutions served as "warehouses" for persons who had little likelihood of returning to independent community functioning;
- The increasingly widespread use of psychotropic drugs and innovative treatment approaches such as intensive activity programming, which allowed mentally ill individuals to function in community settings;

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1 Virginia State Health Plan, 1980-1984 Virginia Statewide Health Coordinating Council and Virginia Department of Health, pp. 594.

2 Ibid. p. 779.

- The increased availability of public funds for the construction an operation of community facilities; and

- The articulation of the legal concept of the "right to treatment" which is appropriate to the needs of individuals and the philosophy that treatment should be provided in the least restrictive alternative possible.[3]

By 1959, 48 of the 98 Virginia counties were contributing to the mental hygiene clinics.[4] These mental hygiene clinics continued to operate under the auspices of the State until they were transferred to Community Services Boards, beginning in 1972. The last State clinic, Goochland-Powhatan, was transferred in the Spring of 1984.

During the development and operational stages of the Virginia Mental Hygiene Clinic System, a significant national movement was taking place which would have a profound impact on the development of the Virginia community system. In 1955, the Federal Mental Health Study Act established a Joint Commission on Mental Illness and Mental Health. This Commission analyzed national mental health service needs and recommended programs. Its 1961 report became the basis for a 1963 administration proposal for the establishment of comprehensive community mental health centers, the improvement of care in state mental hospitals and the increased support for research and training.

The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) provided construction and staffing grants t localities to build and operate nonprofit community facilities for mental patient. These centers were required to provide the five essential mental health services, including: inpatient services, outpatient services, partial hospitalization, 24 hour emergency services and consultation and educational services.[5] With the availability of this funding, Virginia began to move away from its traditional inpatient treatment setting in large state hospitals to a more community-based system of services.

The 1960's provided significant changes in the development of mental retardation services. These included the availability of federal funds for mental retardation program planning, the training of special education teachers, the development of sheltered workshops and the construction of community residences for mentally retarded persons in rehabilitation programs. Funding to improve public school programs for mentally retarded children was authorized.

In Virginia, the report of the Willey Commission in 1963 recognized mentally retarded persons as a separate client group from the mentally ill and encouraged the

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3 Ibid., p 594.

4 Funkhouser, James B., M.D., "The Present Organization and Future Plans for Mental Hygiene Clinics in Virginia", Mental Health in Virginia, Autumn, 1959, Volume 10, Number 1, pp.10-12.

5 Brink, Gerald R., M.H.A., "Financing a Mental Health Center", Ment Health in Virginia. Winter, 1969-70, Volume 20, Number, 2, pp. 9-13.

development of community based outpatient services. The report further identified substance abuse as a problem-related to mental health. This was a forward thinking concept during the period.

The Virginia Mental Health Study Commission of 1965 began an extensive assessment to needed statutory revisions in the mental health sections of the Virginia Code. It was not until 1968, however, that the Commonwealth experienced a major turning point in the development of the community-based system of services. In October, 1968, the newly created Chapter 10 of the Code of Virginia, Section 37.1-194, outlined the permissive legislation allowing cities and counties to establish Community Mental Health and Mental Retardation Services Boards. This statute addressed specific services, board membership, funding and staffing issues.[6] Arlington County became the first community to establish a Community Mental Health and Mental Retardation Board in 1968. Concurrently, a number of communities had begun work on Community Mental Health Center grant applications and center construction. In late 1968, the first of fifteen Virginia CMHC's was dedicated at the Riverside Hospital in Newport News.[7] In addition to these initiatives, there were 32 State Mental Hygiene Clinic serving approximately 19,449 persons.[8]

During the late 1960's and early 1970's the Commonwealth, through the State Health Department's Bureau of Alcohol Studies and Virginia Division of Drug Abuse Control initiated development of community alcohol and drug abuse treatment services in a number of Virginia localities. Community drug abuse services also were supported through the Department of Mental Health and Mental Retardation's Bureau of Drug Rehabilitation. Funds available through the National Institute of Alcoholism and Alcohol Abuse, the National Institute on Drug Abuse and thee Law Enforcement Assistance Administration were instrumental in the development of these services.

By 1970, Virginia had 5 approved CMHC's, 37 State clinics funded by $3,819,295 in state funds, 20 Community Mental Health and Mental Retardation Boards funded by $1,800,000 in state funds, 6 large state hospitals and training centers and plans to develop and build 3 new training centers for the mentally retarded.[9] The 1970s continued as a growth and development decade for the Commonwealth's mental health and mental retardation system. During the early 1970's, increased concern was given to the development of community alcoholism and drug abuse treatment services; and by the mid 1970's, most metropolitan areas in Virginia had established some substance abuse service capacity.

In the area of mental retardation, the 1970's saw increased availability of resources, such as those provided by the Education for All Handicapped Children's Act of 1975 (P.L. 94-142) which called for educational opportunities in the least

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6 "A Progress Report on the State Plan on Mental Services," Mental Health in Virginia, Spring, 1969, Volume 19, Number 3, pp. 16-17.

7 Wharton, Claude A., Jr., "Mental Health Center in Newport News," Mental Health in Virginia, Fall, 1969, Volume 18, Number 5, pp. 9-10.

8 "The New Mental Health Laws in Virginia," Mental Health in Virginia, Spring, 1968, Volume 18, Number 3, pp. 43-45.

restrictive environment. More disabled and retarded children were remaining at home and parents were demanding more and better program services for their children.

Additionally, there were several major legislative studies in Virginia which set the future direction of mental health, mental retardation and substance abuse services. The Commission on Mental, Indigent and Geriatric Patients, through its Report to the 1970 General Assembly and Governor, was a major contributor to the identification and recognition that a community system of care, in concert with quality hospital services, is essential to meet the needs of the mentally disabled in Virginia. The Hirst Commission, as it was called, described a "coordinated system of care" with equal care emphasis given to communities and facilities. It conceded the need for long term care and separated the issues of mental health and mental retardation. The Commission clearly recognized that additional funds had to be committed to support the many changes it recommended.[9]

The second report of the Hirst Commission in 1972 reiterated some of these same themes, while identifying several key components in successful community program development. These included: recognition of childrens' needs, interagency concepts of coordination, regional approaches to services delivery both in community and hospital care, and funding needed to greatly enhance the services network.

In 1976, the Virginia General Assembly enacted legislation which reorganized the State level administration of drug abuse and alcoholism treatment services. The Virginia Department of Mental Health and Mental Retardation became the responsible agency for the care, treatment and maintenance of persons involved with substance abuse. This consolidated the responsibilities of three separate programs, administered by separate state agencies, and provided statewide structure through the Community Mental Health and Mental Retardation Services Boards for the delivery of services.

In July, 1977, the Commission on Mental Health and Mental Retardation (the Bagley Commission) was formulated to again review the system of services in place and recommend a course of action to the Legislature for dealing with the mentally ill, mentally retarded, and substance abusing citizens of Virginia. The Bagley Commission, in 1980, issued a comprehensive report on the services network in Virginia, including administrative, funding, and program issues. With the report came extensive legislation and funding for implementing its recommendations, among them: the reiteration of the need for a "coordinated system of statewide services"; emphasis on case management and clients' rights issues such as guardianship; major focus on the community system of care including the role, responsibilities and program needs of community services boards; funding for a more balanced system of care and services; and recognition of substance abuse services by changing the name of the Community Services Boards, dropping the mental health and mental retardation titles.[10]

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9 "Mental Hygiene and Hospital Budget Reaches All-time High," Mental Health in Virginia, Spring, 1970, Volume 20, Number 3, p. 5.

10 Report of the Commission on Mental Health and Mental Retardation, to the Governor and General Assembly of Virginia, House Document 8, 1980.

To ensure the implementation of the framework outlined by the Bagley Commission, the Joint Subcommittee on Mental Health and Mental Retardation, chaired by Delegate Frank Slayton, was established in 1980. This Subcommittee worked with the Department until 1982 in order to assure that the initial phases of the Commission's work were in place.

By 1980, the number of Community Services Boards had expanded to 37 and the state hospitals and training centers had grown to 16, with the addition of two regional mental health institutes, two geriatric hospitals, two centers for children and adolescents and a medical center. Even with these new, smaller institutes and training centers, the census in state operated facilities has declined from a FY 1966 peak 15,000 average daily census to a 7,177 average daily census in FY 1983.

With the establishment, in 1984, of the 40th Community Services Board, virtually all areas of the State are covered. This statewide coverage is an essential factor in the Commonwealth's delineation of a system of care concept in which the community is responsible for the individual client without regard for the location of service delivery.

In 1984, the General Assembly established a joint legislative Commission on Deinstitutionalization (the Emick Commission). The Commission's charge was to review the status of Virginia's deinstitutionalized citizens and to examine the roles and responsibilities of state institutions and community services boards. The Commission's report and recommendations, issued in 1986, offered guidance for continuing to strive toward a community-based system of care, while recognizing major setbacks of the deinstitutionalization movement. The report called for additional community housing alternatives; additional capacity in day-treatment, psychosocial rehabilitation and transitional employment programs; quality enhancements for state facilities; and improved fiscal accountability for the community system.

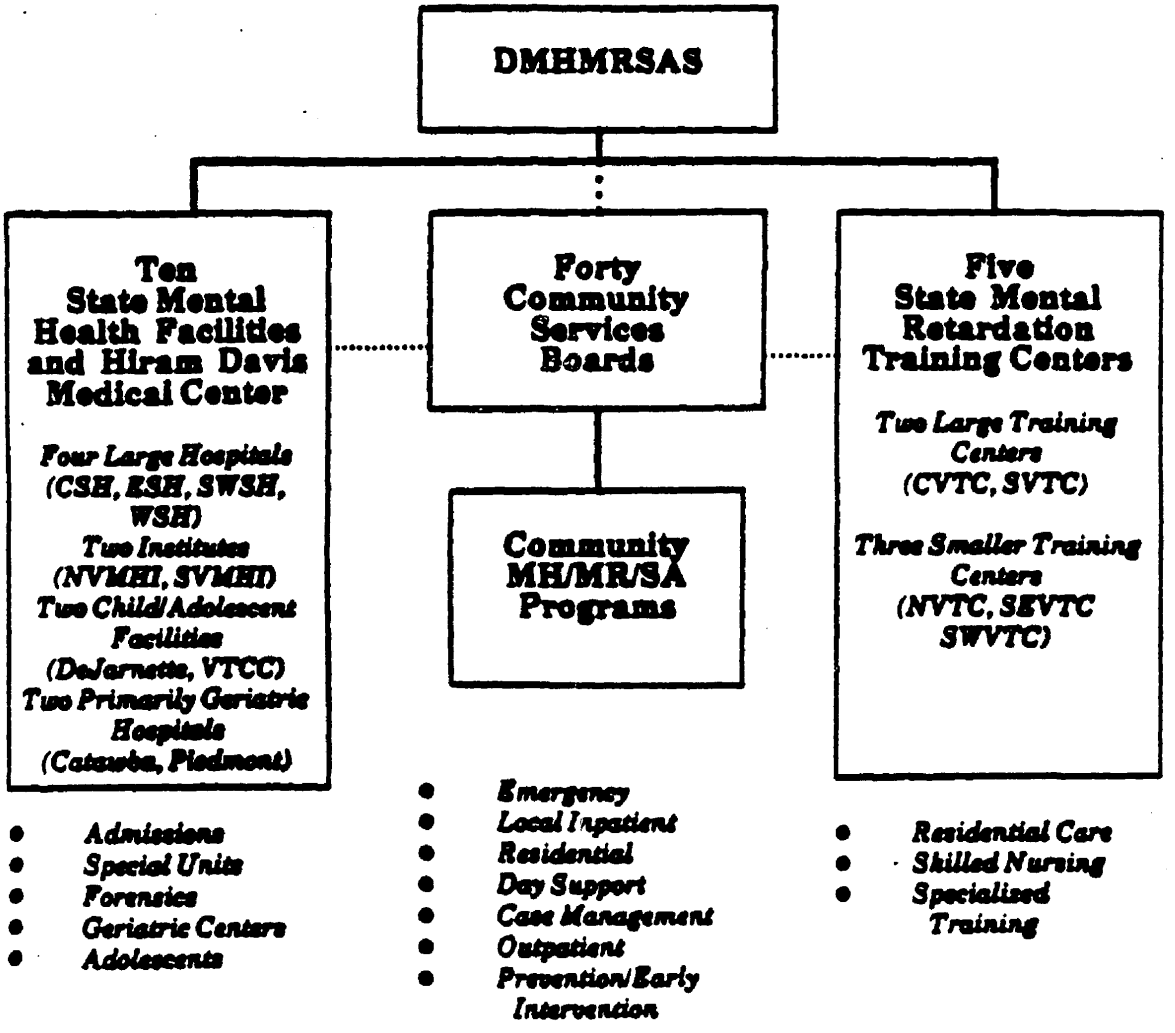
In 1987, the General Assembly passed legislation changing the name of the Department of Mental Health and Mental Retardation to the Department of Mental Health, Mental Retardation and Substance Abuse Services. The name of the State Board was changed also to reflect the increased emphasis statewide on the provision of services for persons with substance abuse problems.

The Department initiated an ongoing evaluation system in 1988 in order to enhance the Department's monitoring of community services, to serve as a vehicle for targeting and enhancing technical assistance to CSBs and to provide valid data about service needs and services delivered through the boards. This year also was important in the fiscal history of the Department because the 1988-1990 Appropriations Act included a total proposed operating budget of $958.9 million which represented an increase of $155.4 million or 19.3% over the 1986-1988 operating budget. Community service funding included an increase of 51.4% in State funded support. The 1989 General Assembly increased the total Departmental budget figure to $962.1 million.

Current Service System:

In Virginia, the public mental health, mental retardation and substance abuse service system is comprised of 40 Community Services Boards (CSBs), ten state mental health facilities, one medical center and five training centers serving persons with mental retardation. The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services provides leadership in the direction and development of public services.

The 40 CSBs provide, directly or under contract, an array of community based services. The ten mental hospitals provide a range of psychiatric,psychological, nursing, support and ancillary services. Also, Central State Hospital in Petersburg maintains a forensics unit. The five training centers provide residential care and training in areas such as language, self-care, independent living, socialization, academic skills and motor development. The Hiram Davis Medical Center in Petersburg serves patients and residents of state mental health and mental retardation facilities. A diagram illustrating service system relationships follows:



The Department has continued to use the core services as the basic framework for defining the Virginia service system. These core services are emergency services; inpatient services; outpatient/case management services; day support services; residential services; and prevention/early intervention services (see Appendix A).

The following tables summarize FY 1988 information about the service system: static capacities of the 40 CSBs and 16 state facilities, numbers of clients served by the 40 CSBs and units of services provided by the Boards and State facilities. This information is based on the fourth quarter CSB Performance Reports for FY 1988, the Weekly Census Summary for June 30, 1988 and the Comparative Direct Care Cost Report for FY 1988.

Statewide Summary of Static Capacity Provided in FY 1988
Community Services Boards and State Facilities

Core Service	MH	MR	SA	TOTAL
Inpatient Services				
a. Medical/Surgical	110.00 Beds	24.00 Beds		134.00 Beds
b. Skilled Nursing	159.00 Beds	148.00 Beds		307.00 Beds
c. ICF/MR		2,617.00 Beds		2,617.00 Beds
d. ICF/Geriatric	1,044.00 Beds	219.00 Beds		1,263.00 Beds
e. Acute/Intensive*	761.85 Beds		4.42 Beds	766.27 Beds
f. Extended Rehabilitation	1,283.00 Beds			1,283.00Beds
TOTAL	3,357.85 Beds	3,008.00 Beds	4.42 Beds	6,370.27 Beds
Day Support				
a. Day/Partial Hospital.	215.00 Slots		75.00 Slots	290.00 Slots
b. Psychosocial Rehabil.	1,585.00 Slots		30.00 Slots	1,615.00 Slots
c. Sheltered Employment	20.00 Slots	1,786.11 Slots		1,806.11 Slots
d. Adult Development/Day		795.00 Slots		795.00 Slots
TOTAL	1,820.00 Slots	2,581.11 Slots	105.00 Slots	4,506.11 Slots
Residential				
a. Intensive Treatment	57.00 Beds	137.00 Beds	140.85 Beds	334.85 Beds
b. Primary Care			181.67 Beds	181.67 Beds
c. Therapeutic Community			228.18 Beds	228.18 Beds
d. Group Homes	128.00 Beds	504.00 Beds	97.00 Beds	729.00 Beds
e. Supervised Apartments	287.00 Beds	185.00 Beds	12.00 Beds	484.00 Beds
f. Domiciliary Care	15.00 Beds	48.00 Beds		63.00 Beds
g. Em. Shelt./Resid. Respite	65.95 Beds	18.00 Beds	15.00 Beds	98.95 Beds
h. Sponsored Placement	117.58 Beds	56.16 Beds	0.23 Beds	173.97 Beds
TOTAL	670.53 Beds	948.16 Beds	674.93 Beds	2,293.62 Beds

* Includes 17.85 Local Inpatient (IP) Beds for MH and 4.42 Beds for SA.

Fractional bed and slot numbers in the preceding table result from the conversion of Purchase of Service (POS) contracts for bed days to beds and days of service to slots and the conversion of part year to annualized static capacity for new and/or closing programs. In certain instances, such as the addition of services during FY 1988, the static capacity figures in the Contracts have been revised.

Numbers of Clients Served By Community Services Boards in FY 1988*

Core Service	MH Svs.	MR Svs.	SA Svs.	TOTAL
Emergency	49,917	53	9,667	59,637
Local Inpatient	1,285	NA	220	1,505
Outpatient	62,466	1,032	41,510	105,008
Case Management	14,085	8,652	2,948	25,685
Day Support				
a. Day/Partial Hospital.	829	NA	1,310	2,139
b. Psychosocial Rehabil.	4,940	NA	164	5,104
c. Sheltered Employment	185	2,473	0	2,658
d. Adult Development/Day	NA	943	NA	943
e. Education/Recreation	72	2,788	0	2,860
f. Supptd/Trans. Employment	445	1,076	0	1,521
g. Alternative Day Support	27	358	333	718
TOTAL	6,498	7,638	1,807	15,943
Residential				
a. Intensive Treatment	168	152	6,360	6,680
b. Primary Care	NA	NA	1,866	1,866
c. Therapeutic Community	NA	NA	1,083	1,083
d. Group Homes	231	640	430	1,301
e. Supervised Apartments	511	200	81	792
f. Domiciliary Care	20	52	0	72
g. Emgen. Shelt./Resid. Respite	2,165	193	186	2,544
h. Sponsored Placement	227	67	6	300
i. Supported Living Arrangemt.	3,819	1,196	335	5,349
TOTAL	7,141	2,499	10,347	19,987
Early Intervention	18,808	2,964	13,353	35,115
TOTAL	160,200	22,828	79,852	262,880

* These figures do not represent unduplicated counts of clients receiving more than one service.

CSB & Facility Units of Service By Disability Area and Core Service FY 1988*

Core Service		MH Svs.	MR Svs.	SA Svs.	TOTAL
Emergency	Hours of Service	251,011	800	26,160	277,971
Inpatient	Bed Days	1,145,699	1,032,185	1,572	2,179,456
Outpatient	Hours of Service	808,054	21,989	491,674	1,321,717
Case Management	Hours of Service	153,863	118,869	26,968	299,700
Day Support	Days of Service	366,328	571,976	28,434	966,738
	Hours of Service	22,256	364,349	6,243	392,848
Residential	Bed Days	210,671	324,347	235,723	770,741
	Hours of Service	62,109	163,129	8,377	233,615
Prevention	Hours of Service	63,338	11,040	60,847	135,225
Early Intervention	Hours of Service	30,128	156,144	48,926	235,198

* Inpatient includes 10,131 bed days in MH local inpatient and 1,572 bed days in SA local inpatient.

Characteristics of the Virginia Service System

Title 37.1, Chapters 1 and 11, of the Code of Virginia, as amended, designates the Department of Mental Health, Mental Retardation and Substance Abuse Services as the State Authority for alcoholism, drug abuse, mental health, and mental retardation services. The State Mental Health, Mental Retardation and Substance Abuse Services Board has the statutory authority for the establishment of policy for the Department. Nine members, appointed by the Governor and confirmed by the General Assembly, comprise this board. The Commissioner is the chief executive of the Department. Under State statute, the Commissioner is appointed by the Governor and confirmed by the General Assembly. The Department is one of the major agencies in the Office of the Secretary of Health and Human Resources and is the largest state agency in Virginia.

Mental health, mental retardation and substance abuse services are provided in Virginia through a network of community services boards and state-operated facilities, hospitals and training centers. Increasingly, the emphasis is shifting from an institutional to a community orientation, in terms of numbers of clients served, units of service delivered, allocation of resources, and responsibility for identifying, monitoring, and tracking clients.

Community Services Boards

Community Services Boards (CSBs) are the local governmental agencies which are responsible for delivering mental health, mental retardation and substance abuse services. Boards were established to provide these services in the most accessible and responsive and least restrictive setting possible, drawing upon all available community resources and the clients' natural support system (families, friends, work, etc.).

In order to accomplish this goal, CSBs must function not only as services providers, but also as client advocates, community educators, program developers and planners, advisors to their local governments and as the focal point for fiscal and programmatic accountability. Additionally, CSBs provide clients' access to and use of state facility services through such mechanisms as preadmission screening, case and client services management, and predischarge planning.

The enabling legislation for CSBs, Chapter 10 of Title 37.1 of the Code of Virginia, was enacted in 1968. The first two Boards were established then in Arlington and Prince William Counties. Since then, 38 additional CSBs have been created. The original statute and subsequent amendments prescribe the requirements for Boards, define their characteristics, and establish certain responsibilities for CSBs. Section 37.1-194 requires every jurisdiction to join a CSB. Today, some services are available in every city and county in Virginia, although four jurisdictions have not formally joined a CSB.

The Department first funded local services through CSBs in FY 1971, distributing $480,078 to 14 Boards. In FY 1989, the Department distributed more than $121 million of state and federal funds to the 40 CSBs. The total budgets of the 40 CSBs ranged from less than $700,000 to more than $40 million in FY 1989.

The CSBs exhibit tremendous variety, reflecting Virginia's diversity in their composition, organizational structure, services and relationships. Boards can classified in several ways: number of localities served, budget size, population density, and services delivery modalities. In FY 1989, eleven (11) CSBs served a single city or county while twenty-nine (29) served between two and ten localities, as indicated below:

Table 7
Multi-Jurisdictional Community Services Boards -- 1989

Number of CSBs	Number of Localities Served	Number of CSBs	Number of Localities Served
6	2	4	6
5	3	1	7
8	4	1	9
3	5	1	10

Many of the single-jurisdiction CSBs function as actual or quasi city or county departments. Two of the multi-jurisdictional CSBs also function as quasi county departments. A number of other multi-jurisdictional CSBs rely on the local government which acts as the Board's Fiscal Agent to keep books and do the payroll.

Another indication of the diversity of the CSB system involves budget size, rural/urban population, and direct/contractual service delivery modes. Small Boards are classified as having a total budget of less than $2 million; medium Boards have a total budget of between $2 and $5 million; and large Boards have a total budget of over $5 million.

Rural CSBs are defined as having a population density of less than 120 per square mile, while the population density in urban CSBs exceeds 120 per square mile. Direct service delivery means that either (a) more programs and more dollars or (b) less programs but more dollars are expended in direct services.

Contracting service delivery means that either (a) more programs but less dollars are spent in direct services or (b) less programs and less dollars are expended for direct services. A summary of the number of CSBs, classified by these characteristics, follows:

Table 8
Characteristics of Community Services Boards -- 1989

Characteristics of CSBs	Number of CSBs
Small, Urban, Direct	1
Small, Rural, Contracting	1
Small, Rural, Direct	9
Medium, Rural, Direct	12
Medium, Rural, Contracting	2
Medium, Urban, Direct	6
Large, Urban, Contracting	3
Large, Urban, Direct	6

Section 37.1-194 of the Code of Virginia also lists the types of services which a Community Services Board may provide. These are emergency (mandatory), local inpatient, outpatient, day support, residential, and prevention and early intervention services. Boards offer varying combinations of these services through more than 450 separate directly-operated or contractual programs. Eight CSBs provide all services directly, one Board contracts all of its services, and the remaining thirty-one CSBs use both modes.

Section 37.1-195 and 196 contain Board membership provisions. Each CSB consists of between five and sixteen individuals who are appointed by city councils or boards of supervisors for up to two, three-year terms. Currently, 494 citizens serve on the 40 established Boards. Individual Boards display marked differences in member characteristics.

The following tables summarize the characteristics of Board members. The Department conducted a survey of members' gender and occupations in 1978. CSBs submitted age, race, gender and occupational characteristics for members this year as part of the Plan Update.

Table 9
Board Membership - Age (1989)

Age of Members	Number	Percent
18 - 35	51	10.45
35 - 55	290	59.42
46 - 64	93	19.06
65 +	54	11.07
Total	488	100.00

Table 10
Board Membership - Race (1989)

Race/Ethnic Origin of Members	Number	Percent
American Indian	1	.20
Asian/Pacific Islander	1	.20
Black	71	14.52
White	416	85.07
Total	489	99.99

Table 11
Board Membership - Gender (1978 and 1989)

Gender	1978 Profile	Percent	1989 Update	Percent
Female	218	47.9	225	46.0
Male	237	52.1	264	54.0
Total	455	100.0	489	100.0

Table 12
Board Membership - Occupations (1978 and 1989)

Occupational Category	1978 Profile	Percent	1989 Update	Percent
Businessmen/women	92	20.2	115	22.5
Educators	64	14.1	70	13.7
Human Service Professionals	54	11.9	61	12.0
Homemakers	87	19.1	41	8.0
Medical Professionals	51	11.2	39	7.6
Lawyers	17	3.7	33	6.5
Elected Government Officials	4	.9	26	5.1
Appointed Government Officials	24	5.3	20	3.9
Ministers	27	5.9	15	3.0
Clerical/Blue Collar	9	2.0	6	1.2
Retired	18	3.9	79	15.5
No Response/Vacancies	8	1.8	5	1.0
Total	455	100.0	510	100.0

Note: The 1989 figures reflect some duplication between the elected and appointed government officials and other categories. Twelve elected officials were also listed with other occupations, as were four appointed officials. The unduplicated number of Board members is 494.

Section 37.1-197 and 197.1 prescribe other CSB duties, including:

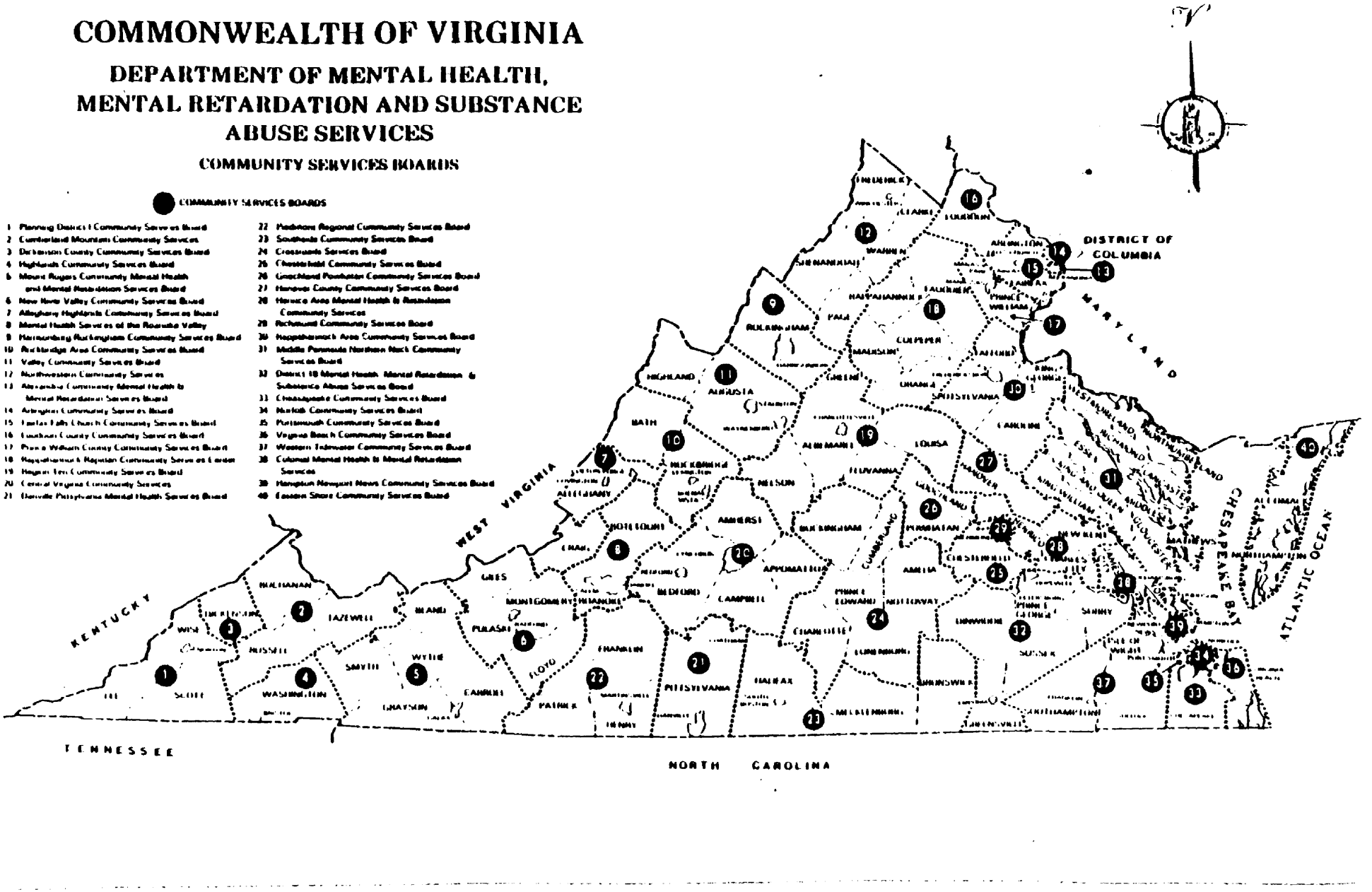
- review and evaluate mental health, mental retardation and substance abuse services and facilities and advise local governments as to the findings;
- institute a reimbursement system to maximize the collection of fees;
- accept gifts, donations, requests, and grants;
- disburse funds and apply for and accept loans;
- develop joint annual written agreements with other local human service agencies about service provision;
- establish and coordinate the operation of a prescription team;
- provide prescreening services and participate in predischarge planning.

A map of the CSB service areas follows:

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

COMMUNITY SERVICES BOARDS



State Facilities

State mental health facilities and training centers serving persons with mental retardation, provide highly-structured, intensive services for mentally ill, mentally retarded, and substance abusing persons. In the evolutionary movement toward a single, integrated system of care, increased emphasis has been placed on the establishment of community services and on the more effective and efficient use of state facilities. This emphasis has defined the role of state facilities as one of several resources in an overall continuum of care.

As CSBs have assumed responsibility for the coordination of all services to clients, the development and maintenance of strong working relationships between the CSBs and state facilities has increasingly become critically important. Performance contracting, with both CSBs and facilities, which includes bed utilization monitoring for adult psychiatric services, anticipates and requires joint planning among CSBs and facilities for budgetary and service delivery activities.

The specific maximum and operating (staffed) bed capacities for the state mental health and mental retardation facilities are as follows:

Table 13
Mental Health Facility Maximum and Operating Bed Levels
April, 1989

Facility/Category	Maximum Space Capacity	Operating Space Capacity
Catawba Hospital	270	219
Central State Hospital	545	545
DeJarnette	60	60
Eastern State Hospital	986	1,013
Adult and Adolescent	603	612
Hancock Geriatric Center	383	401
Hiram Davis Medical Center	80	74
Northern Virginia Mental Health Institute		114
Piedmont	290	210
Southern Virginia Mental Health Institute	96	96
Southwestern State Hospital	295	294
Adult and Adolescent	199	198
Porterfield	96	96
Virginia Treatment Center for Children	28	28
Western State Hospital	740	703
Adult Psychiatric	580	580
Shenandoah Geriatric Center	160	123
TOTAL MH FACILITIES	3,504	3,356

A description of each MH facility follows:

Catawba Hospital in Catawba, just outside Roanoke, provides geriatric and adult psychiatric inpatient services. Geriatric services (207 beds) are available to patients 65 years of age and older. Additionally, Catawba Hospital directly admits individuals within Planning District Five who are above the age of 18 and in need of psychiatric treatment in a state facility.

Central State Hospital in Petersburg employs seven functional treatment units (patients grouped according to treatment needs and level of functioning) to serve adults in the 18- 64 year age bracket. Youth between the ages of 14 and 17 are served in the Adolescent Unit. Central State Hospital also has a forensic unit which serves the entire state.

DeJarnette Center in Staunton provides residential, day treatment and educational services to emotionally and behaviorally disturbed children ages 2 through 17. DeJarnette Center has four treatment programs to provide services to distinct populations and ages of children. Emphasis is placed on individualized treatment and programming. Affiliation with the University of Virginia Department of Behavioral Medicine and Psychiatry provides psychiatric consultation services.

Eastern State Hospital in Williamsburg has a physical plant of more than 30 buildings. Eastern State offers active treatment programs to residents of Southeastern Virginia. Three geographic units accommodate patients in the 18--64 age bracket. Young people between the ages of 7 and 18 are treated in the child and adolescent unit. The acute treatment unit, medical-surgical unit and extended care unit serve general patient populations. Hancock Geriatric Treatment Cente located on the Eastern State campus, provides psycho-geriatric treatment and serv to patients 65 years of age and older.

Hiram W. Davis Medical Center in Petersburg provides skilled nursing, infirmary and general medical care to patients and residents of state mental health and mental retardation facilities, primarily from the Southside Complex of Central State Hospital and the Southside Virginia Training Center.

Northern Virginia Mental Health Institute in Falls Church provides short-term hospital intensive treatment to persons, age 14 and above, who have acute psychiatric illness or acute exacerbation of chronic disorders. Some partial hospital and day treatment is also provided. Patients who are more behaviorally disturbed and more difficult to treat receive intensive general and specialized medical care.

Piedmont Geriatric Hospital in Burkeville provides psycho-geriatric rehabilitation services. Piedmont is a chronic disease facility with a primary treatment goal of helping patients 65 years of age and older to regain and maintain their highest level of behavioral and physical functioning. The average age of patients is 76. Emphasis at Piedmont is placed on providing a therapeutic milieu and active work activity program.

Southern Virginia Mental Health Institute in Danville provides short-term psychiatric care to persons ages 14 and over in its 18 county catchment area. The Institute maintains four treatment teams arranged on a geographic basis, allowing for close ties between each team and the Community Services Board area it serves. Patients are referred to programs based on functional level and needs. The progr

includes individual, group, family, marital, and activity therapy, as relevant, with use of a variety of community resources.

Southwestern State Hospital (soon to be Southwestern Virginia Mental Health Institute) in Marion is a regional psychiatric center with specialized services for individuals who are acutely mentally ill, chronically mentally ill, adolescent and aged. Porterfield Geriatric Treatment Center, located on the Southwestern State campus, provides psycho-geriatric services to patients 65 years of age and older.

Virginia Treatment Center for Children in Richmond serves as the Division of Child Psychiatry of the Medical College of Virginia/Virginia Commonwealth University. The Center provides intensive inpatient services and a small, day-care service for former patients, an outpatient follow-up service, a separate outpatient department for children who are not being hospitalized, consultation for the pediatric service of the Medical College of Virginia and Field Unit Clinic which visits communities to screen children and to follow-up children and families who have been treated at the Center. In addition, it serves as a research and teaching hospital.

Western State Hospital in Staunton provides psychiatric treatment to adults, 18 to 64, in five units, and to the elderly (65 years of age and older) in the Shenandoah Geriatric Treatment Center. The 301 acre facility has 22 buildings. The multi-disciplinary team approach is used in all psychiatric units. Services include: admission services and special programs for the chronically mentally ill, with emphasis on preparation for community living; special services for male admissions who are court referred with misdemeanors or non-violent felony charges; a special program for the mentally ill hearing impaired; and medical support service.

Table 14
Mental Retardation Training Center Maximum and Operating Bed Capacities -- 1989

Facility/Category	Maximum Space Capacity	Operating Space Capacity
Central Virginia Training Center	1,724	1,484
Northern Virginia Training Center	344	299
Southeastern Virginia Training Center	200	200
Southside Virginia Training Center	776	756
Southwestern Virginia Training Center	223	223
TOTAL MR BEDS	3,267	2,962

A description of each MR training center follows:

Central Virginia Training Center in Lynchburg provides four certified levels of care: acute, skilled nursing (SNF), intermediate care (ICF/MR), and intermediate care-general for elderly residents. The Center's programs are designed to improve the developmental level of all residents, who are served in accordance with Medicaid and national standards. More than 85% of the residents are severely or profoundly retarded, many with other handicapping conditions. Special programs for intensive behavioral intervention and skilled nursing serve the entire state. Other programs are designed to serve a catchment area of 16 cities and 36 counties in Central Virginia.

Northern Virginia Training Center in Fairfax provides residential care and traini. to severely mentally retarded and multi-handicapped citizens of Northern Virginia. The Center provides a spectrum of health and habilitation services to meet each resident's individual needs. Education programs are provided through contract with Fairfax County Public Schools. Also, prevocational programs are available on campus. Activity centers and sheltered workshops in the community are provided for all adults.

Southeastern Virginia Training Center in Chesapeake offers training in self-care, language, independent living, socialization, academic/cognitive skills, and motor development. Individualized assistance, professional services and education are also offered to the families of residents, as well as to individual residents.

Southside Virginia Training Center in Petersburg provides habilitative, educational and health services. Residential life services are divided into four units: skilled nursing care/severely handicapped; maladaptive; school age, and high level functioning mentally retarded persons.

Southwestern Virginia Training Center in Hillsville provides intensive, relatively short- term habilitative services, care and treatment primarily to severely and profoundly retarded citizens of far-western Virginia.

A map of the state mental health and mental retardation facility service area follows:

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

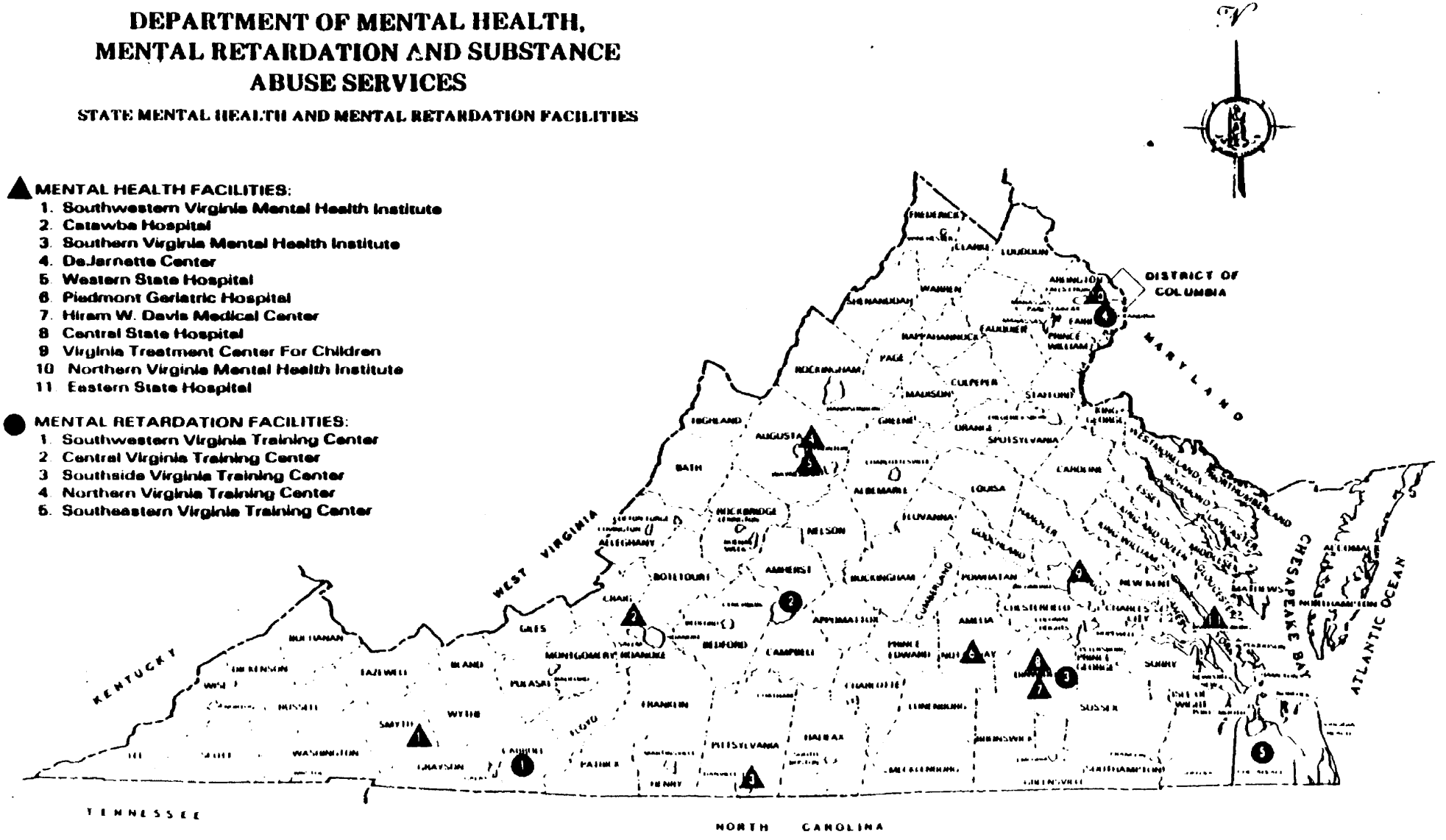
STATE MENTAL HEALTH AND MENTAL RETARDATION FACILITIES

▲ MENTAL HEALTH FACILITIES:

1. Southwestern Virginia Mental Health Institute
2. Catawba Hospital
3. Southern Virginia Mental Health Institute
4. DeJarnette Center
5. Western State Hospital
6. Piedmont Geriatric Hospital
7. Hiram W. Davis Medical Center
8. Central State Hospital
9. Virginia Treatment Center For Children
10. Northern Virginia Mental Health Institute
11. Eastern State Hospital

● MENTAL RETARDATION FACILITIES:

1. Southwestern Virginia Training Center
2. Central Virginia Training Center
3. Southside Virginia Training Center
4. Northern Virginia Training Center
5. Southeastern Virginia Training Center



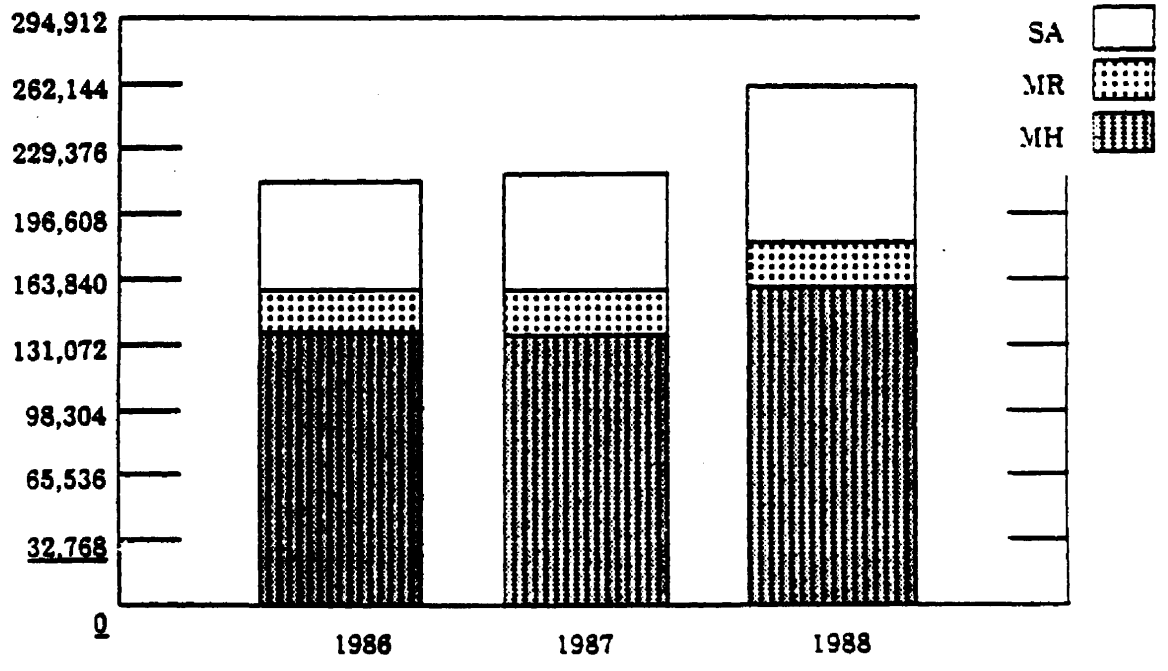
Community Services Utilization and Trends

Since 1968, when State legislation authorized the creation of Community Services Boards, a statewide system of community, mental health, mental retardation and substance abuse services has been established.

For FY 1988, the CSBs reported that: mental health services were provided to 160,200, mental retardation services to 22,828, and substance abuse services were provided to 79,852. These figures include duplicate counts of clients who received more than one service. They do not, however, reflect the total number of persons who received CSB services (e.g. persons benefiting from prevention services).

The following figures illustrate trends in the number of clients reported by CSBs as being served by disability area (1986-1988); the number of beds and slots by disability area and the percent of the system total of clients, FTEs and expenditures by disability area (1988).

Figure 1
Community Services Boards Utilization
Number of Clients by Disability, 1986 - 1988



Over the past three years, the number of clients served by CSBs has increased by 24%. The number of persons served in mental health programs rose by 16%, 11% in mental retardation programs and 49% in substance abuse programs. It is important to remember that the numbers of clients shown here are not unduplicated counts, since many clients receive more than one core service.

Figure 2
Community Services Boards Capacity
Number of Residential and Local Inpatient Beds by Disability, 1986 - 1988

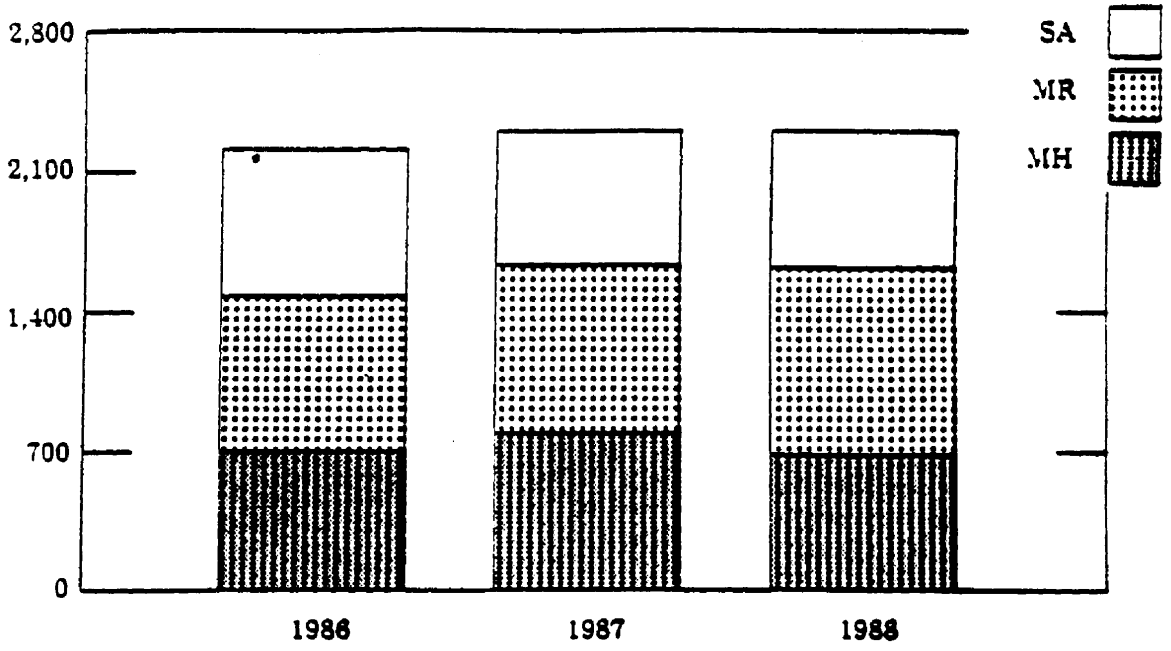
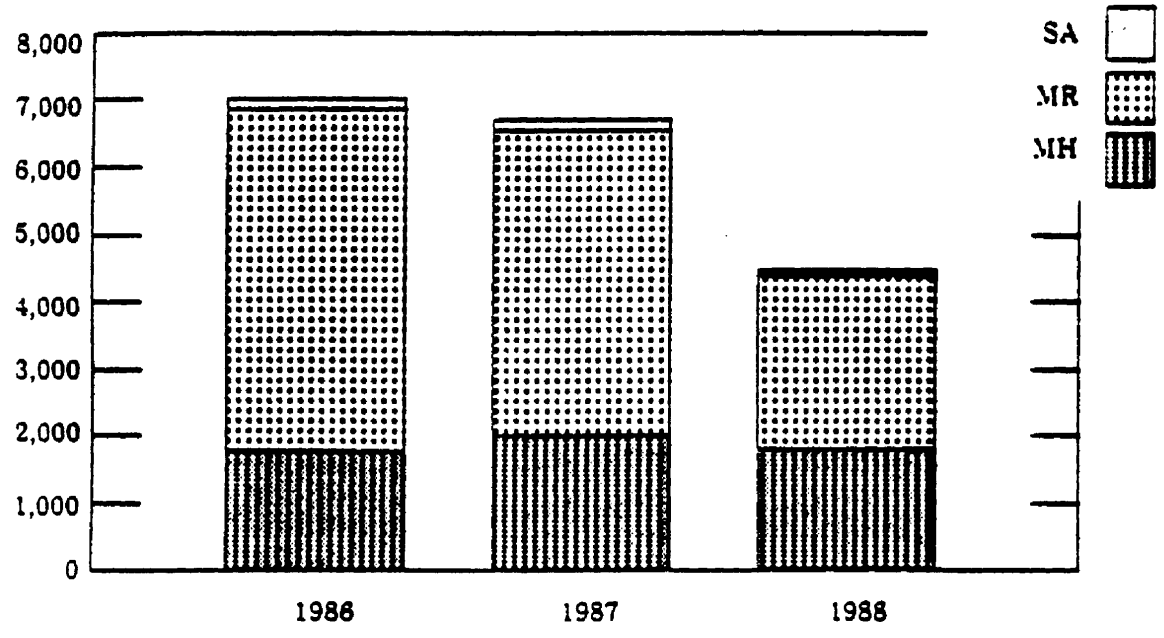
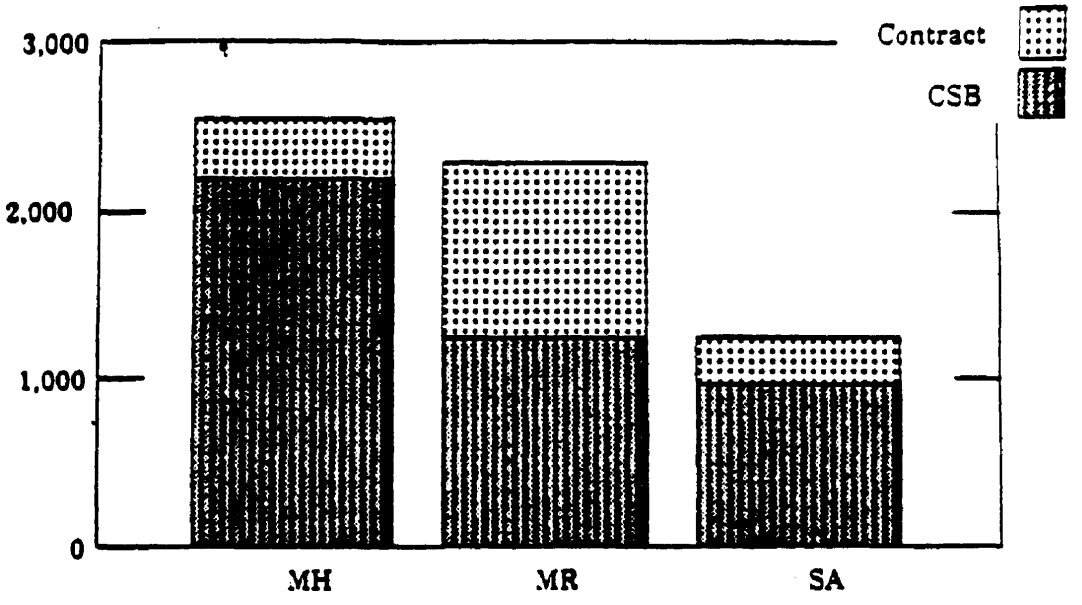


Figure 3
CSB Capacity -- Number of Day Support Slots by Disability 1986-1988



Fluctuations in numbers of beds and slots over time generally result for more accurate reporting and changes in definitions of beds and slots. The sharp decrease in mental retardation slots reflects an increasing shift of resources from sheltered employment to supported employment services, which are not measured in slots and days of service but in service hours.

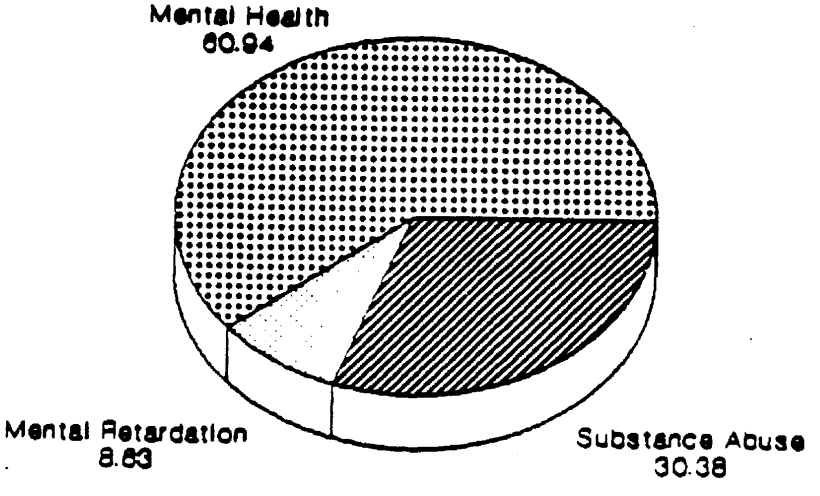
Figure 4
CSB Staffing Number of FTEs by Disability, 1988



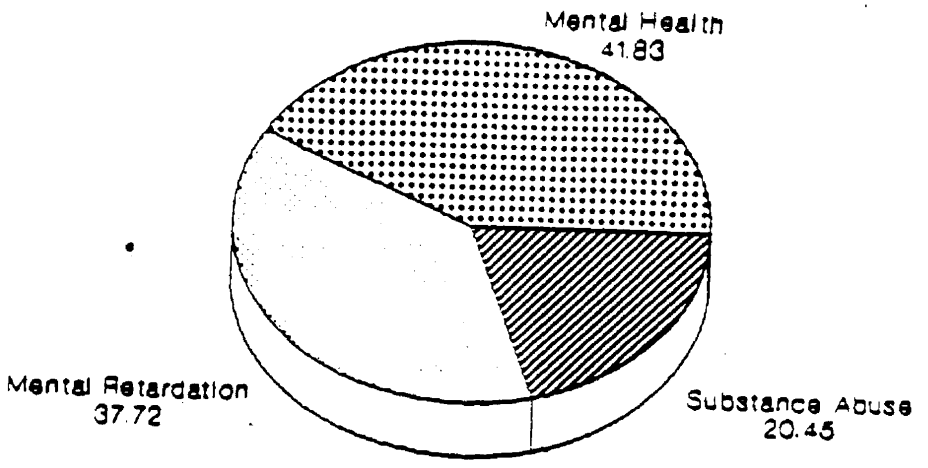
These graphs include client and support staff FTEs. Many other contractual agency staff are not included because the CSBs contract many services on a purchase of services basis, based on amount of costs, rather than a line-item grant basis.

Figure 5
CSB Clients Served, FTEs and Expenditures Percent of System Total -- 1988

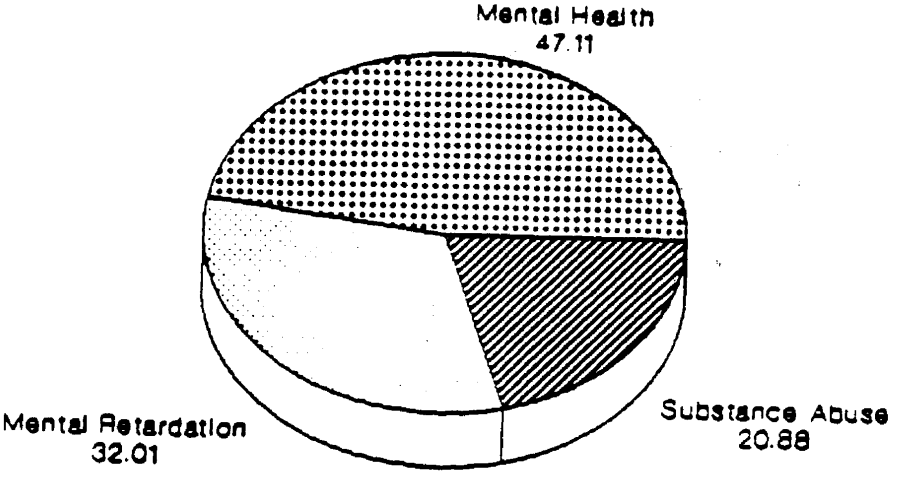
Clients Served by Disability



CSB FTE Positions by Disability



CSB Expenditures by Disability

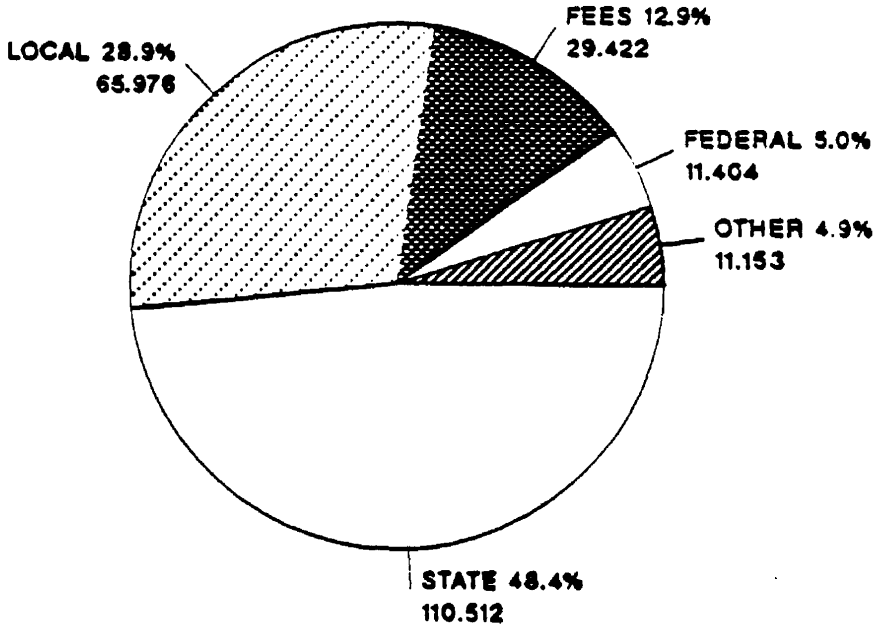


Overall CSB expenditures increased by about 26% from FY 1986 to FY 1988 (24% State funds), with mental retardation reflecting the greatest increase (31%), mental health the next largest (25%), and thirdly substance abuse with a 24% increase.

At the present time, CSB mental health programs account for 61% of the clients served, 42% of all FTEs and 47% of system expenditures. Substance abuse programs serve 30% of the clients served with 20% of all FTEs and 21% of the system budget expenditures. Mental retardation programs serve 9% of the total client served with 38% of all FTEs and 32% of expenditures.

Figure 6

COMMUNITY SERVICES BOARD
FUNDING BY SOURCE: FISCAL YEAR 1989

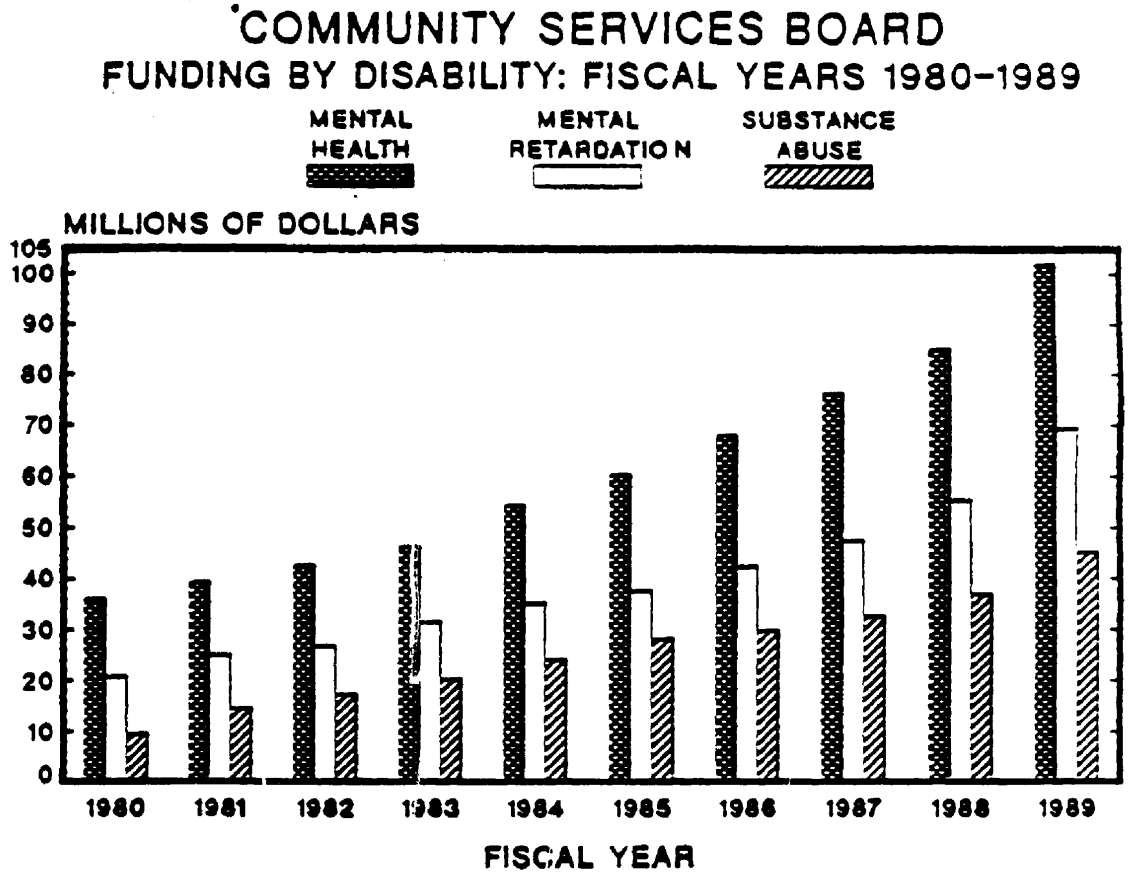


TOTAL $228,470,234

The breakout of revenues by source indicate that state and local funds continue to be the primary sources of revenue funding.

Figure 7 provides a summary of CSB revenue information for FY 1980 through FY 1989 by disability area.

Figure 7



In FY 1980, the breakout by disability was: mental health 51.9%, mental retardation 29.9%, substance abuse 13.7% and administration 4.6%. By 1986, the proportion of allocations for mental health was 46.3%, mental retardation 28.3%, substance abuse 20.3% and administration 5%.

Facility Utilization and Trends

Mental Health Facilities

The following points illustrate recent MH facility trends:

- Linkages between facilities and community services boards continue to be expanded and improved in order to better plan for services to patients.
- Facility performance agreements have been enhanced to increase accountability for fiscal, administrative and patient management.
- All Virginia mental health facilities are now JCAHO accredited.
- Increasing demands for substance abuse services requiring specialized diagnostic services, acute stabilization and detoxification.
- Facilities have an increased level of academic affiliations.
- Facilities have experienced increased costs for more specialized medical care for patients who have physical as well as psychiatric problems.
- Increasing numbers of AIDS patients have entered the system.
- A new facility in Southwest Virginia is being built and another planned at DeJarnette.
- Facilities have continued to have an increase in demand for acute psychiatric treatment services while the operating capacity have remained the same.

Table 15
Per Diem Costs for Intensive Psychiatric Services
By State Mental Health Facility -- FY 1988

Facility/Area	Per Diem Charge
Eastern State (Region V)	$ 145
Central State (Region IV)	$ 136
Southwestern State (Region III)	$ 170
Western State (Region I)	$ 191
NVMHI (Region II)	$ 182
SVMHI (Region III)	$ 165

Comparison to average private facilities charges illustrate that state facility costs are quite low:

Table 16
Per Diem Costs for Private Psychiatric Hospitals
Effective, February, 1988

Facility/Area	Average Charge Per Patient Day*
Region I	$ 504
Region II	$ 495
Region III	$ 449
Region IV	$ 482
Region V	$ 563
Statewide Per Diem Average	$ 519

* Source: Virginia Health Services Cost Review Commission.

In the future, mental health facilities are projected to focus upon:

- Sustaining JCAHO accreditation/Medicaid and Medicare certification;
- Improved client service management linkages with CSBs as well as special projects to provide support and incentives to CSBs for reduced unnecessary hospital use (e.g., transportation to off campus services, loan funds, special incentive contracts); and
- Strategies for improved staffing efficiency and increased provision of active treatment, congruent with recommendations from DPB and Departmental staffing studies.

Mental Retardation Training Centers

- The census at Virginia's five, mental retardation training facilities continues to decrease, although the rate of reduction is significantly less than what was experienced in the decade prior to 1984. Between 1978-79 and 1987-88 there was a 23.7% reduction in the average daily census. As of May 1989 the total census at the five facilities was 2,761 residents.

- Client movement into and out of the training facilities remains stable with fewer admissions (143) and fewer discharges (166) in 1987-88 than in previous years. Since 1978-79, the admission rate among the facilities has decreased by 52.2% and the discharge rate has decreased by 30.8%.

- Although in the past ten years there has been a significant reduction in average daily census there has been only a 5.1% reduction in the number of employees serving the residents of the training facilities.

- The total amount of facility expenditures between 1978-79 and 1987-88 has dramatically increased by 111%. Average per diem costs have jumped from $60 to $127 during this time period. In 1987-88, per diem costs among the five facilities ranged from a low of $97.59 at SSVTC to a high of $143.79 at NVTC. It should be noted that all five facilities are certified as Medicaid (ICF/MR) providers.

- There are 300 children currently in training centers. This combined with the percentage of children on waiting lists for mental retardation training facility admission is an alarming trend. Currently, 58% of the individuals on the facility waiting list are under 18 years of age.

- Over the past five years, the following resident population characteristics have essentially remained unchanged:

    - age
    - level of mental retardation
    - ability to ambulate
    - hearing disabilities
    - visual disabilities
    - epilepsy
    - aggression and other maladaptive behaviors.

- In order to provide more effective training to children who have been diagnosed as being autistic as well as functioning severely/profoundly mentally retarded, an 8 bed special living unit is being created at SEVTC. The intent of this new unit is to provide a comprehensive array of services to young people who were previously placed at DeJarnette Center or other mental health or mental retardation state facilities.

- The Department's continuing Commitment of providing behavior change opportunities to maintain individuals in community residential options is

evidenced by the Special Behavior Unit (SBU) at CVTC and the new behavio unit that is being developed at NVTC. These units have been created to prevent regular facility admission and have a primary goal of returning individuals back to a community (or facility) living arrangement after intensive, short term behavior management programming.

- Training facilities have begun to strengthen their outreach to communities. Community residential staff training, medication training, health and psychological consultation are all being done with increased frequency on a regional basis by facility staff. It is becoming increasingly apparent that the training facilities in Virginia are not only interested in developing expertise in resident management within institutional walls, but are also interested in better preparing community service providers to work with severely disabled individuals.

For the future, mental retardation facilities are projected to focus upon:

- Maintaining Medicaid certification.
- Submitting any required staffing improvements based on the final recommendations of the current mental retardation staffing study.
- Providing the Department and CSBs with updated information on Medicaid decertified residents and other residents who could be placed in community programs if such programs were available.
- Establishing special programs for elderly persons and individuals requiring forensic services.
- Establishing the capability to provide behavior stabilization programming for community based persons requiring short term out of residence intervention and assessment.

System Policies, Future Directions and Priorities:

Mission and Policy Governing the Virginia Service System

The mission of the Department is to assure and provide a comprehensive system of services that is responsive to the citizens of the Commonwealth. Underscoring this mission is a commitment to the provision of quality programs that are both sensitive to client needs and concerns and accountable to statutory requirements and directions established by the State Board. The following declaration of policy related to the provision of services was adopted by the General Assembly in 1980:

> *It is the policy of the Commonwealth of Virginia to establish, maintain, and support the development of an effective system of treatment, training, and care of mentally ill, mentally retarded, and substance abusing citizens. The basic principle of this statewide system is that in every instance, the appropriate treatment, training, and care shall be provided in the least restrictive environment with careful consideration of the unique needs and circumstance of each such person...*
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> *It is the policy of the Commonwealth that all human service agencies, at both the state and local levels, shall jointly and cooperatively strive to assist citizens who have mental disabilities and to reduce the numbers of individuals defined as mentally handicapped who are subsequently enrolled in the treatment and training population.*

By this policy, the Commonwealth recognized its responsibility to provide services necessary to effectively and humanely integrate persons who have mental disabilities into the community and to provide those unable to live independently, quality treatment, training, and care in the least restrictive environment.

This policy statement for the Commonwealth is the basis for the State Board policy, including "Policy Declaration on a Statewide System of Services" (1980) and "Policy Goal of the Commonwealth – Development of a Comprehensive Community-Based System for Serving Mentally Ill, Mentally Retarded and Substance Abusing Citizens," (1986, renewed in 1988). Such a statewide system of services must be planned and provided as a continuum ranging from independent community life to hospital placement and where responsibility for the continuity of all services is placed with the local CSBs. Under this system, the continuing focus of services across the continuum must be on responding to each individual's needs.

Future Directions for the Virginia Service System

The overall service goal of the Department continues to be to assure that a sufficient level of services is available throughout Virginia so that mentally ill, mentally retarded and substance abusing citizens, no matter where they live, can receive the care they need:

- in emergencies or crisis situations;
- in acute intensive inpatient treatment or training in state facilities;
- in an outpatient setting;
- in a day setting;
- in short and long term residential housing in the community; and
- in early intervention and prevention programs.

Realization of this goal requires both continued progress in the development of community based care and upgrading of the quality of care in state facilities, which serve as a vital component of a comprehensive community based system of services. Over the next decade, the operation of the service system will continue to be guided by the following major themes:

- Direct client care will be given the highest priority, with additional resources directed to support active treatment and developmental services.

- Current community care capacity provided by CSBs must be expanded, with emphasis on the provision of core services and increased services to more severely disabled and at-risk populations.

- State facilities will enhance their focus on active treatment, emphasizing acute psychiatric and extended rehabilitation services, habilitation and training and specialty programs.

- Interagency efforts which support service providers at the state and local levels will be enhanced to meet basic needs such as food, shelter, income maintenance, vocational rehabilitation and protection along with treatment and training needs.

- Existing affiliations between the public mental health, mental retardation and substance abuse service system and the state college and university system will be enhanced.

- CSBs, facilities and the central office will continue to strengthen their administrative capability in order to ensure that accountability requirements are met and that their operations are effective.

Mental Health Service Development Priorities

Mental health service development priorities continue to focus on the needs of persons -- adults and children -- with serious mental illness. The philosophy upon which Virginia's system of mental health services for persons with serious mental illness is based can be summarized in these four values statements developed in conjunction with the Mental Health Planning Council:

- The system of services must be consumer/family-oriented, emphasizing dignity, choice, and individualization for those needing services.

- The system of services must be community-centered,maximizing opportunities for integration into a full community life and providing services in the most natural, least restrictive environment.

- The system of services must be accessible, coordinated, and comprehensive; basic needs for housing, income supports, meaningful activity or employment, and social supports must be met in a manner compatible with diverse cultural and special need groups.

- The system of services must provide care and supports of the highest quality.

Services for seriously emotionally disturbed children and adolescents should reflect similar core values, in being community-based and child-centered and in ensuring that the needs of the child and family dictate the type and mix of services provided.

General service areas targeted for development include:

- Housing, with emphasis on supported living and non-congregate services;
- Face-to-face emergency services and active involvement in detention and commitment proceedings;
- Non-residential and individualized residential treatment services for seriously emotionally disturbed children and adolescents (with emphasis on interagency service linkages);
- Local inpatient and crisis stabilization services as alternatives to state hospitalization;
- Client service management functions (e.g., case management, hospital liaison, outreach); and
- Increased capacity as needed in medication management and day support.

Major priorities for the 1990-92 biennium include meeting the housing and associated support needs of seriously mentally ill persons now on waiting lists or otherwise identified as needing service; developing services which reduce frequent readmissions or extended lengths of stay for persons with a history of state hospitalization; and developing community services for children which reduce the need for inpatient beds.

Target populations for service development include: persons in state psychiatric facilities; persons with serious mental illness; persons with multiple annual admissions to state psychiatric facilities; seriously emotionally disturbed children and adolescents; and persons with concurrent serious mental illness and mental retardation or substance abuse problems.

Priorities for state mental health facilities include sustaining JCAHO accreditation/Medicaid and Medicare certification; improved client service management linkages with CSBs; and improved staffing efficiency and increased provision of active treatment.

Mental Retardation Service Development Priorities

The development of services for persons with mental retardation is shifting away from the concept of specific service models to one in which services are structured around individualized, flexible supports that respond to the needs of clients and their families. This approach requires that adaptations and accommodations be made to ensure the effective use of natural and community resources and places, such as: schools, work place, health services, and the home. This "client" focus is to be emphasized rather than simply trying to fit clients into existing program models.

It is critical that resources be directed at support services that are technologically current and that build on the concept of expanding choices. Such efforts need to be directed at serving the most severely disabled persons in their own communities. The system's focus must be on:

- Developing placements for persons who have the potential to live in less restrictive, but individually appropriate, residential alternatives.
- Furnishing the needed types and levels, respectively, of day support and case management.
- Continuing reassessments of client needs and existing service patterns to ensure programmatically sound and cost effective options are utilized.

Waiting lists for residential and day services -- of persons living in communities and in training centers -- must be addressed and priority attention given to persons residing in training centers who have been Medicaid decertified due to level of care, persons with the most severe disabilities and those who are at risk of out-of-home placement.

There are three primary areas requiring attention -- living, working and community support coordination. These areas are represented in four core services: residential; day support; case management; and early intervention.

Residential -- Residential support services need to be located in natural homes or family-like settings with access to other support services. All families should have the option to choose to have their family member with a disability remain at home and be provided with the necessary supports and principles of providing support should be the same whether or not the persons live at home or in a family-like setting with trained, paid staff. The development of large group homes or ICF/MRs is not encouraged and are not priorities for development. Rather, development of residential services that are small scale, community integrated and in family-like settings is encouraged:

- Additional sponsored placements, e.g., specialized foster homes with care provided by trained staff.
- Additional supervised apartment options.
- Additional supported living, i.e., support provided directly to the individual and/or family in the natural home as well as expanding independent living alternatives, and "living with others" and "boarding in" options for less disabled persons.
- Additional small group homes.
- Expanded support services such as in-home and out-of-home respite and short term stabilization.

Day Support -- Persons with mental retardation require a range of work and educational opportunities. Perhaps more than any single area, holding a job or doing productive work is the most visible means by which persons who are disabled can feel like full participants in the culture and society. Service

priorities include more supported employment opportunities and center-based day support programs for persons whose health or needs for supervision preclude less restrictive options.

Case Management/Community Support Coordination -- The range and variety of services that persons with mental retardation require must be coordinated. It is the responsibility of the support coordinator to assist clients and family members in developing the needed package of services. Special focus should be on the transition from early intervention services to school services and from school to adult services. Service priorities include an adequate number of case managers focused on serving the most severely disabled and persons at risk of out-of-home placements.

Early Intervention and Prevention -- Early intervention is a critically important service that CSBs have had, and will continue to have, a major role in furnishing. Increasingly, the interagency nature of services to this group requires coordination of limited resources across agencies with mutual responsibilities. Service priorities include adequate in-home or center based infant stimulation capacity including family/parent support.

Training centers continue to provide many vital and important services to a large number of Virginians. As the service technology has evolved, it has been demonstrated that many persons can be served in their home communities, even persons with severe disabilities and complex needs. For those who are served in training centers, priorities include:

- Maintaining Medicaid certification.
- Staffing improvements based on the final recommendations of the current mental retardation staffing study.
- Continuing work with CSBs to arrange appropriate services for Medicaid decertified residents and other residents who could be placed in community programs if such programs were available.
- Establishing the capability to provide behavior stabilization programming for community-based persons requiring short term out-of-residence intervention and assessment.

Substance Abuse Service Development Priorities

Substance abuse services system development has included work toward the establishment of an array of community-based services that will provide outreach, stabilization, ongoing treatment in a variety of modalities, and integration into the community. Future program development and design must include components for changing client populations who present unique needs. There are increasing demands to serve people who have problems with combinations of abused substances, including alcohol. Also, people who abuse and use drugs intravenously (IV) will require specialized approaches and expanded treatment availability in order to continue efforts to prevent the spread of AIDS.

Future substance abuse services in Virginia must be increasingly community-based and must be prepared to utilize recent advances in the state-of-the-art of treatment to provide services to an increasingly complex client population. Program

planning and development must include a variety of community agencies, organizations, and citizens at large. Program design must address changing client populations, including people with polydrug abuse problems; those who are at risk of having AIDS, are HIV positive, or have ARC or AIDS; and those who have concomitant mental health problems, are resistant, or are young (adolescents). General service areas targeted for development include the following:

- Implementation of community-based services for those people who have substance abuse problems and who present a "backlog" at discharge from state facilities. These persons too often remain on an inpatient basis longer than is clinically appropriate because of their limited access to appropriate community-based programming.

- Development of community-based detoxification services for clients who require social-setting management during the withdrawal phase of treatment.

- Development of adequate day treatment and residential treatment services for people who require a service level more intensive than outpatient services.

- Development of adequate half-way house or other transitional arrangements in the CSB catchment area which will provide housing and basic support services to those who have completed intensive treatment services and who require supported living until they can gain independent living status.

- Provision of specialized outreach, prevention and other needed services to underserved and previously unidentified populations in need of substance abuse services.

Target populations for new state-funded services include persons with substance abuse problems waiting for discharge from state facilities; people who have substance abuse problems and are involved in the criminal justice system in the community (recent releases and those on probation); people who have both mental health and substance abuse problems; and special populations, including adolescents, members of cultural or ethnic minorities, women and elderly persons who have substance abuse problems.

State psychiatric facilities need to provide increased attention to the identification and stabilization of admissions with substance abuse problems through comprehensive assessment, integration of substance abuse specific components in the regular treatment protocol, and coordinated discharge planning with respect to substance abuse service needs. Additionally, they need to develop acute stabilization and diagnostic capability for people who require facility care.

Definitions of Core Services
Core Service Taxonomy III - December, 1988

Emergency: Unscheduled mental health, mental retardation or substance abuse services, available 24 hours per day and seven days per week, which provide crisis intervention, stabilization, and referral assistance over the telephone or face-to-face, if indicated, to individuals seeking such services for themselves or others. These emergency services may include walk-ins, home visits, jail interventions, and pre-admission screenings and other activities for the prevention of institutionalization or associated with the judicial commitment process and the certification process for admission to mental retardation facilities.

Inpatient: Mental health, mental retardation, or substance abuse services which are delivered on a 24 hour per day basis in a hospital or training center setting.

a. Medical/Surgical - Acute medical treatment and/or surgical services provided in state facilities. Such services may include medical detoxification, orthopedics, oral surgery, urology, care for pneumonias, post-operative care, ophthalmology, ear, nose and throat, and other intensive medical services.

b. Skilled Nursing - Nursing services for mentally disabled individuals in state facilities who require nursing as well as other care. Skilled nursing services are most often required by acutely ill or severely/profoundly mentally retarded individuals and those elderly mentally ill individuals who suffer from chronic physical illnesses and loss of mobility. These services are provided by professional nurses, licensed practical nurses and qualified paramedical personnel under the general direction and supervision of a physician.

c. Intermediate Care Facility/Mentally Retarded - Services provided in state training centers for mentally retarded individuals who require active habilitative and training services, including respite and emergency care, but not the degree of care and treatment provided in a hospital or skilled nursing home.

d. Intermediate Care Facility/Geriatric - Services provided in State geriatric facilities which may include psychiatric treatment, therapeutic programs, medical and personal care. These services are provided by an interdisciplinary team to patients 65 years of age and older.

e. Acute/Intensive Psychiatric or Substance Abuse Services - Intensive short term psychiatric or substance abuse services provided in state mental health facilities and intensive short term psychiatric or substance abuse services provided in local hospitals which are supported by CSBs through contractual arrangements. These services may include intensive stabilization, evaluation, chemotherapy, hospital-based medical detoxification, psychiatric and psychological services and other supportive therapies provided in a highly structured and supervised setting.

f. Extended Rehabilitation - Intermediate or long term treatment provided in a state facility for individuals with severe psychiatric impairments and emotional disturbances, multiple handicaps (e.g. persons who are mentally ill

and deaf) and severe/profound mental retardation. These services may include rehabilitation training, skills building and behavioral management for those who are beyond the crisis stabilization and acute treatment stages.

Outpatient and Case Management Services: Mental health, mental retardation, or substance abuse services generally provided in sessions of less than three hours to clients in a non-residential setting.

a. Outpatient - Scheduled outpatient mental health, mental retardation, or substance abuse services generally provided on an individual, group, or family basis, and usually in a clinic, similar facility, or other location. These services may include diagnosis and evaluation, counseling, psychotherapy, behavior management, psychological testing, ambulatory detoxification and chemotherapye.

b. Methadone Detoxification - Outpatient services coupled with the use of methadone as a means to detoxify a person with a narcotic addiction.

c. Methadone Maintenance - Outpatient services coupled with the use of methadone as a means to treat narcotic addiction and promote ongoing stability.

d. Case Management - Services to assure identification of and outreach to potential clients and continuity of care for mentally ill, mentally retarded, and substance abusing clients by assessing, planning with, linking, monitoring and advocating for clients in response to their changing needs.

Day Support: A planned program of mental health, mental retardation, or substance abuse treatment or training services generally provided in sessions of three or more hours to groups of clients in a non-residential setting.

a. Day Treatment/Partial Hospitalization - A treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for patients with serious mental disorders or substance abuse who require coordinated, intensive, comprehensive, and multidisciplinary treatment of pathological conditions not provided in an outpatient clinic setting.

b. Psychosocial Rehabilitation - Programs for mentally ill or substance abusing clients that provide certain basic opportunities and services - socialization, evaluation, training, vocational and educational opportunities, and advocacy - in the context of a supportive environment in the community focusing on normalization. Psychosocial rehabilitation programs emphasize strengthening client abilities to deal with everyday life instead of focusing on the treatment of pathological conditions.

c. Extended Sheltered Employment or Work Activity - Programs which provide remunerative employment for mentally ill, mentally retarded, and substance abusing clients as one option in the rehabilitation process for those who cannot be readily absorbed in the competitive labor market. These programs may include sheltered employment and specialized vocational training services.

d. Adult Developmental/Activity Center/Developmental Day Programs For Adults - Programs providing instruction and training for mentally retarded/ developmentally disabled adults (age eighteen or older) in order that they may progress toward independent functioning.

e. Education/Recreation - Programs designed to provide education, recreation, enrichment, and leisure activities. Programs can consist of daily, weekly, monthly activities which are carried out during the summer or throughout the year.

f. Transitional/Supported Employment - Three different types of programs providing paid employment.

Transitional Employment Programs (TEP) provide time-limited services including job-related support and paid work experience placement in competitive-setting jobs intended as temporary employment for mentally ill or substance abusing individuals.

Supported Employment (SE) programs provide on-going services including supervision, periodic training, counseling, advocacy and other supports needed to maintain mentally ill, mentally retarded or substance abusing individuals in paid employment for an average of 20 or more hours per week in an integrated setting.

In the Supported Employment-Individual Placement Model (SE-IPM), an integrated setting means most co-workers are not handicapped or opportunities exist in the immediate work setting for regular contact with non-handicapped individuals who are not providing support services. To be considered appropriate for this model, clients must receive at least two SE service contacts per month to maintain employment.

In the Supported Employment-Group Models (SE-GRP), an integrated setting means clients are part of a small work group of not mores than eight co-workers with handicapps and opportunities exist in the immediate work setting for regular contact with non-handicapped individuals who are not providing support services. SE-GRP models include mobile and stationary crews, enclaves, and small businesses.

g. Alternative Day Support Arrangements - Day support alternatives not included in preceding subcategories which assist clients in locating day support settings and may provide program staff, follow along, or assistance to the clients. The focus may be on assistance to the client to maintain the independent day support arrangement.

Residential: Overnight care in conjunction with an intensive treatment or training program in a setting other than a hospital or training center; or overnight care in conjunction with supervised living and other supportive services.

a. Intensive Treatment or Intermediate Care Programs: Mental Health Residential Treatment Centers, such as adolescent treatment, residential alternatives to hsopitalization, and dually diagnosed programs where intensive treatment rather than just supervision occurs; Intermediate Care Facilities for the Mentally Retarded (ICF/MR), which deliver active habilitative and training services in a community setting; and Medical/Social

Detoxification Programs, which are non-hospital based and normally last from 3-7 days.

b. Primary Care - Substance abuse rehabilitation services which normally last no more than four months, with three to four weeks as the expected length of stay.

c. Therapeutic Community - A substance abuse psychosocial therapeutic milieu with an expected stay exceeding four months.

d. Group Homes/Halfway Houses - Facilities which provide identified beds, supported or controlled by CSBs, and 24 hour supervision for individuals who may require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and budgeting.

e. Supervised Apartments - Programs which provide identified beds, supported or controlled by CSBs, for individuals who have achieved a limited capacity for independent living but who also require varying degrees of assistance, support, supervision, and staff intervention in order to function in the community.

f. Domiciliary Care - Provision of food, shelter, and assistance in routine daily living but not training; this is primarily a long-term setting but the expected stay can be brief. This is a less intensive program than a group home or supervised apartment; an example would be a licensed home for adults funded by a community services board.

g. Residential Respite/Emergency Shelter - Programs which provide identified beds, supported or controlled by CSBs, in a variety of settings reserved for short term stays, usually several days to no more than several weeks. This includes residential respite services for mentally retarded individuals and crisis stabilization, emergency shelter, or public inebriate shelter services for mentally ill or substance dependent individuals.

h. Sponsored Placements - Programs which place clients in residential settings and provide substantial amounts of financial, programmatic, or service support. Examples include specialized foster care, family sponsor homes, and residential services contracts for specified individuals. The focus is on individual client residential placements rather than on organizational entities with structured staff support and set numbers of beds described in preceding subcategories.

i. Supported Living Arrangements - Innovative residential alternatives not included in preceding subcategories which assist clients in locating or maintaining residential settings where access to beds is not controlled by CSBs and may provide program staff, follow along, or assistance to the clients. The focus may be on assistance to the client to maintain the independent residential arrangement. Examples include family support programs, intensive in-home services (such as Homebuilders) and other programs established to avoid out of home placements of mentally ill children and adolescents, homemaker services, public-private partnerships and non-CSB subsidized apartments. This subcategory also includes respite care

provided in a home setting or a setting other than that described in subcategory 5.g.

Prevention Services and Early Intervention Services: Activities which seek to prevent, or ameliorate the effects of, mental illness, mental retardation, and substance abuse.

a. Prevention - This is a proactive process which involves interacting with people, communities, and systems to promote the strengths and potential of those currently not in need of treatment and which is aimed at substantially reducing the occurrence of mental illness, mental retardation, and alcohol and other drug dependency and abuse. Essentially, prevention services are provided to well populations to keep them from ever needing mental health, mental retardation or substance abuse services. Prevention interventions, thus, involve a variety of techniques generally applied to groups, which may be the population at large or specific groups identified as high-risk for developing the condition to be prevented. The following kinds of activities comprise prevention interventions: general competency building, specific coping skills training, support system interventions, strengthening caregivers, ecological interventions social-political change strategies and community organization.

b. Early Intervention - These activities are intended to improve functioning in those people identified as beginning to experience problems or circumstances which are likely to result in mental illness, mental retardation, or substance abuse. Such activities provide services to identified individuals. Examples of early intervention services may include: client-based case consultations, education groups, and parent-infant education or infant intervention programs.

ROLE SPECIFIC KNOWLEDGE

The work sheets that follow outline the specific knowledge requirements for community service board administrators, facility administrators, and facility directors of human resources included in phase I implementation of Senate Joint Resolution No. 138. The work sheets are to be used by the Central Office sponsor to assess the new director's background and knowledge base and to schedule the orientation visit. Priorities have been established for facility staff, as indicated on the outline. Priorities for community services board staff will be established jointly by the community services board sponsor and the new staff person.

COMMUNITY SERVICE BOARD ADMINISTRATOR

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
I. Legal authority and obligations of Community Service Boards			
A. CSB table of organization, mission statement, bylaws			
B. Chapter 10 (state law)			
C. Civil commitment (state, law, federal regulations)			
D. Confidentiality (state law, federal regulations)			
E. Conflict of interest (state law)			
F. Freedom of Information (state law)			
G. Procurement and Purchasing (state law)			
H. Professional licensing, certification, or registration			
I. Forensic Services			
II. Overview of state government in Virginia			
A. Organizational Structure			
1. State table of organization (handout)			
2. Overview of legislative process			
B. Key agencies cooperative agrements			
1. Department of Planning and Budget (DPB)			

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
2. Department of Personnel and Training (DPT)			
3. Department of Social Services (DSS)			
4. Department of Rehabilitative Services (DRS)			
5. Department of Medical Assistance (DMS)			
6. Court system, Department of Corrections, and Department of Criminal Justice			
7. Department of Mental Health, Mental Retardation and Substance Abuse Service (DMHMRSAS)			
III. Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)			
A. Table of organization, mission and goals			
B. Disability issues			
1. Mental Health			
2. Mental Retardation			
3. Substance Abuse			
4. Prevention			
5. Geriatric Services			

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
C. Administrative Support			
1. Financial management			
2. Personnel			
3. Purchasing			
4. Automated data processing			
5. Planning process			
6. Technical or legal advice and consultation			
7. Staff training resource			
D. Institutional Relationships			
1. State mental health facilities			
2. State mental retardation facilities			
3. Site visits to programs and facilities serving that CSB			
IV. Performance contracting and budgeting process for Community Service Boards			
A. Schedule of annual events			
B. State agency decision-making authority			
C. Required documents			
D. Budget revision process			
E. CSB reporting requirements and schedules			
F. Local authority and discretion			

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
V. Licensing Regulations			
A. Authority			
B. Content			
C. Process			
VI. State oversight of community service boards			
A. Regional representatives' functions			
B. Disability directors' functions			
C. Inspector General functions			
D. Program evaluations process			
E. Fiscal audit			
F. State Human Rights Committee and Regional Advocate, process			
VII. Risk Management			
A. Financial			
B. Occupational			
C. Legal Liability			
VIII. State advocacy, State and national organizations			
A. Overview and identification			
B. Linkage with Department of Mental Health, Mental Retardation and Substance Abuse Services			

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
C. Pitfalls and opportunities			
D. Virginia Association of Community Service Boards (VACSB)			
IX. Funding			
A. Medicaid Reimbursement System			
1. Eligibility			
2. Fees			
3. Allocating Funds			
4. Services			
B. Block Grants all CSBs get			
C. Competitive grants			

FACILITY ADMINISTRATORS

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
I. Regulations governing various facilities and court processes.	High		
A. Medicare			
B. Medicaid			
C. JCAHO			
D. Code of VA			
E. Attorney General's Office			
II. Personnel Practices	High		
A. Performance Evaluations			
B. Classification/Comp.			
C. Reallocation			
D. Abolishment of position			
E. Fair Labor Standards Acts			
F. Grievances			
G. Role of Employee Relations Counselors & DMHMRSAS Personnel Office			
H. Employment of wage staff			
I. Facility specific personnel issues, problems, etc.			
J. Standards of Conduct			
III. Facility/CSB Relationships	High		
A. "The Scoop" B. Where the Buck stops C. VIPs			

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
IV. Press Relations	High		
A. Briefing on press/media relationships			
B. Central Office expectations regarding incidents			
C. How to work with reporters			
V. "Inner Working"?	High		
A. Limits of Central Office in provision of guidance			
B. Where the Buck stops			
C. Availability of various resources			
D. Networking			
E. Central Office organization and lines of communication			
F. Local VIPs			
VI: Orientation to State Government	Med.		
A. Descriptions of secretariats			
1. Size of each division, budget, FTEs, etc.			
2. Names, tenure of current Secretaries, and Commissioner			
3. Roles and responsibilities of key departments (DPT, DPB, DOA, DOE, DOC as relevant)			

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
4. Structure of General Assembly			
5. Key committees of General Assembly			
6. Names, tenure, and committee memberships of local legislators supportive of Department issues			
7. Biennial legislative process			
8. Dynamics of how ideas become bills then laws			
9. Key political groups in region and state			
10. Court structure			
11. Introduction to Code of Virginia statutes applicable to facilities			
II. Orientation to Standard/Important Current Documents/Concepts	Med.		
A. Standard Administrative Practices and Procedures Manual (key chapters)			
B. Departmental Instructions (key)			
C. Rules and Regulations to Assure the Rights of Residents in Facilities Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services			

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
D. Patient Management Guidelines			
E. State Board Policies and Procedures			
F. Comprehensive State Plan			
G. Departmental activity summaries (past year)			
H. Nursing shortage document			
I. Facility Performance Agreement			
J. Staffing studies			
K. Routine reporting requirements of Central Office			
L. Facility Enhancement Plan			
M. Role of the Inspector General			
N. Role of the Galt Scholar			
O. Moving and relocation			
P. Other: _____ _____			
VIII. Money Related Issues	Med.		
A. Procurement and contracting			
B. Reimbursement process			
C. Budget cycle process - M&O and capital outlay			

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
D. Do's and Don'ts/Central Office expectations			
E. Handling resident funds			
F. Insurance coverage and terms			
IX. Orientation to Mental Health (Advocacy Groups/Persons-Roles)			
A. Coalition for the Mentally Ill			
B. Department for the Rights of the Disabled			
C. Local Human Rights Committee			
D. State Human Rights Committee			
E. Mental Health Association			
F. Parent's Organizaitons (in MR Facilities)			
G. Persons with specific interest/issues vis a vis the facility			
X. Orientation to Management/Supervision of Facilities:	Low		
A. Importance of and methods of supervision			
B. Importance of communication formal, informal, and grapevine			
C. Program organization of facility			
D. Handling requests for admission			
E. Handling request for consent			

FACILITY HUMAN RESOURCE DIRECTOR

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
I. Orientation to the Facility	High		
A. Organizational structure			
B. Policies & Procedures			
II. To familiarize individual with appropriate parts of State Government that impact, guide or influence Human Resource Manager in the Commonwealth	High		
A. Structure of the Commonwealth and the Secretariat of Health and Human Resources			
B. Department of Personnel and Training (DPT)			
C. Virginia Retirement System (VRS)			
D. Department of Employee Relations Counselors			
E. Department of General Services/Risk Management			
F. Consolidated Risk Management Services			
G. Industrial Commission			
H. Office of the Attorney General			
I. Central Office			
J. Virginia Employment Commission			
III. Review DPT Policies	High		
A. DPT Policy and Procedure Manual			
B. Employee Handbook			

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
B. Departmental Instruction #26 - Educational Grant Funds			
C. Departmental Instruction #71 - Educational Assistance			
D. Departmental Instruction #33 - Policy of Reporting Abused Patients and Residents			
E. Departmental Instruction #105 - Equal Employment Opportunity			
F. Departmental Instruction #78 - Pre-employment Verification			
G. Departmental Instruction #92 - Aids Policy			
H. Chapter 35 - Worker's Compensation Mgmt. Program			
I. Departmental Instruction Manual			
J. Administrative Policies and Procedure Manual			
IX. Visitation to the Central Office Human Resource Office	High		
X. Visitation of Other Facility Human Resource Office	Low		
A. One large facility B. One small facility C. One comparable facility			
XI. Training Required	High		
A. Employee Relations and the Grievance Procedure			

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
C. FLSA Manual			
D. Compensation Manual			
E. Compensation Plan			
F. Employee Suggestion Award Program			
G. State Employee Assistance Service			
H. Health Benefits			
I. Agency Affirmative Action Plan & Affirmative Action Plan Assessment Manual			
IV. Department of Employee Relations Counselor's Policies	High		
A. Employee Grievance procedure and brochure			
B. Mediation program			
V. Department of General Services - Risk Management Policies	High		
A. Workers' Compensation Act			
B. Consolidated Risk Mgmt. Policies			
VI. Virginia Industrial Commission policies and services	Med.		
VII. Virginia Employment Commission Policies and Services	Med.		
VIII. Central Office Policies	High		
A. Departmental Instruction #72 - Attendance			

CONTENT	PRIORITY	RESOURCE PERSON LOCATION	TIME REQUIRED
B. Standards of Conduct and Performance			
C. Performance evaluation			
D. EEO and sexual harrassment			
E. Recruitment and selection			
F. Classification and compensation processing			
G. Transactions - PMIS - CIPPS - BES - Personnel Data Base			
H. Worker's compensation			
I. Health benefits			
XII. DMHMRSAS	Med.		
A. Central Office structure and expectations			
B. Department structure			
C. Relationship to CSBs			
XIII. Orientation to the legislative process	Low		

SENATE JOINT RESOLUTION NO. 138

Directing the Department of Mental Health, Mental Retardation and Substance Abuse Services to develop and implement standards and training for community services facilities and staff.

Agreed to by the Senate, February 6, 1989
Agreed to by the House of Delegates, February 17, 1989

WHEREAS, Virginia has taken a significant first step in the 1988-1990 biennium to upgrade and expand its community programs for the mentally disabled and substance abusers of the Commonwealth; and

WHEREAS, the legislature is committed to continuing improvements in the quality of care to clients with mental disabilities and substance abuse problems in both community and state facility settings; and

WHEREAS, the requirement to have well-trained staff at all levels of the community and state public mental health, mental retardation and substance abuse systems is a key factor in providing quality treatment and care; and

WHEREAS, Virginia's system of local community services boards has great diversity in staffing levels and in the professional training and expertise of staff; and

WHEREAS, the Department of Mental Health, Mental Retardation and Substance Abuse Services has now initiated an evaluation system for community services boards and has expanded its licensing of community programs, and both of these activities have identified the need for continuous staff training; and

WHEREAS, the Commonwealth's goal of quality care is linked to the level of training and skills of staff providing and managing services; and

WHEREAS, state leadership is needed to ensure that community and facility staff are adequately trained to deliver and manage services; now, therefore, be it

RESOLVED by the Senate of Virginia, the House of Delegates concurring, That the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services be directed to establish and implement a system of statewide training and staff development for community and facility staff and that these training requirements meet certain minimum standards as established by the Commissioner; and, be it

RESOLVED FURTHER, That the Commissioner shall submit an interim report to the Secretary of Health and Human Services, the Governor and the General Assembly on the status of this training requirement and its implementation by December 1, 1989, and a final report on implementation of a comprehensive training system by October 1, 1990, as provided in procedures of the Division of Legislative Automated Systems for processing legislative documents.