WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH
CHARLESTON

March 22, 1977

FROM: The West Virginia Department of Mental Health

Enclosed find a copy of the final edition of the 1976 edition of The West Virginia State Plan for Comprehensive Mental Health Services for your information.

This edition incorporates both the initial document published in June, 1976 and the supplement published in September, 1976. It has been edited for appearance, typographical errors, etc.; the content and substance have not been changed.

FILED IN THE OFFICE OF
SECRETARY OF STATE OF
WEST VIRGINIA

THIS DATE 3/28/77

THE WEST VIRGINIA

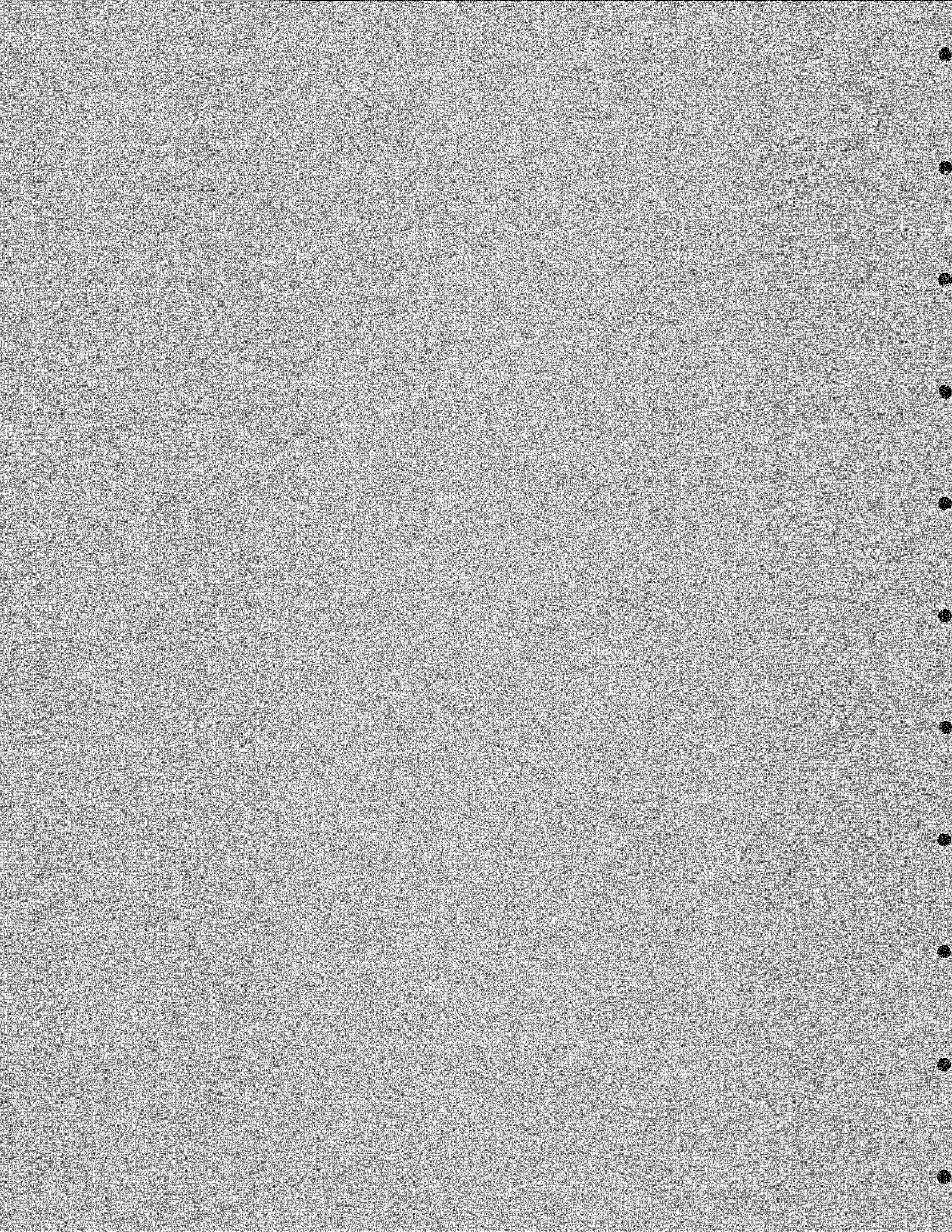
STATE PLAN FOR COMPREHENSIVE

MENTAL HEALTH SERVICES

FILED IN THE OFFICE OF
SECRETARY OF STATE OF
WEST VIRGINIA

THIS DATE 3/25/77

1976 Edition



THE WEST VIRGINIA
STATE PLAN FOR COMPREHENSIVE
MENTAL HEALTH SERVICES

West Virginia Department of Mental Health

Charleston, West Virginia

December, 1976

FOREWORD

In an effort to further assure the humanization of treatment of the mentally ill and mentally retarded of West Virginia, the following West Virginia State Plan for Comprehensive Mental Health Services has been prepared.

In actuality an update and expansion of the first plan developed in 1963, and presented here in partial fulfillment of the requirements for Public Law 94-63, this Plan will assure continuity and modernization of both outpatient and inpatient treatment.

It has taken untold hours to prepare with the hope that in future years the groundwork we have laid will be a firm foundation on which others may build.

M. Mitchell-Bateman

M. Mitchell-Bateman, M.D.
Director

PREFACE

This document was originally submitted to NIMH in June, 1976, in partial satisfaction of the requirements of Public Law 94-63. A preliminary review suggested that the plan was deficient in three areas, notably a timetable for implementation for the Advisory Council; pre-admission screening; and designation of poverty areas. A supplement, incorporating items to remove the deficiencies, as well as other supplemental materials, was submitted to NIMH in September, 1976. The plan, including the supplement, was consequently approved.

The current West Virginia State Plan for Comprehensive Mental Health Services, December, 1976, combines the two aforementioned documents. Although there has been extensive editing, there has been little or no content change.

The West Virginia State Plan for Comprehensive Mental Health Services was initially published in June, 1976, in response to federal mandate--Public Law 94-63. This legislation required the development of a written plan setting forth the goals and objectives of the Department of Mental Health for the next five years. Although the department has a previous plan, and was currently engaged in planning, a revised plan had not been formally written since 1966.

In 1973, under the direction of Dr. M. Mitchell-Bateman, director of the department, a number of citizens task forces were convened to study various vital issues, such as the mental health needs of the aged. The efforts of these task forces culminated in 1975 with a Governor's Conference on Mental Health needs. In addition to these efforts, the division directors were asked to address long-range needs and work plans for their divisions. At the same time, groups of mental health staff were asked to review the task force reports, and integrate them into departmental needs as seen by them. The Association of Mental Health/Mental Retardation Programs of West Virginia had also addressed mental health needs as they saw them, and presented them in a position paper addressed to the director.

This background information was available to the department when, in early 1976, the federal guidelines were released for developing the West Virginia State Plan for Comprehensive Mental Health Services.

Although this background information was available, it represented primarily subjective planning, unsupported by data. The department particularly required a needs assessment, and a resource inventory, both done in such a way that would allow prioritization of goals.

However, in the time allotted for formulation and publication of the plan, such surveys could not be effectively implemented. The department opted, instead, to develop a "plan for a plan". A coordinating committee, composed of members of the department, members of the Association, and an outside consultant, was given the responsibility for developing this "plan for a plan".

The 1976 plan will therefore be followed in 1977 by a more definitive five-year plan setting forth measurable, time defined goals and objectives. This in turn will be followed by annual updates and progress reports.

ACKNOWLEDGEMENTS

The West Virginia State Plan for Comprehensive Mental Health Services, established under Public Law 94-63, represents the combined efforts of many individuals and groups throughout the state of West Virginia. We would like to express our deep appreciation to Governor Arch A. Moore, Jr., and members of his staff for their support, encouragement, and suggestions.

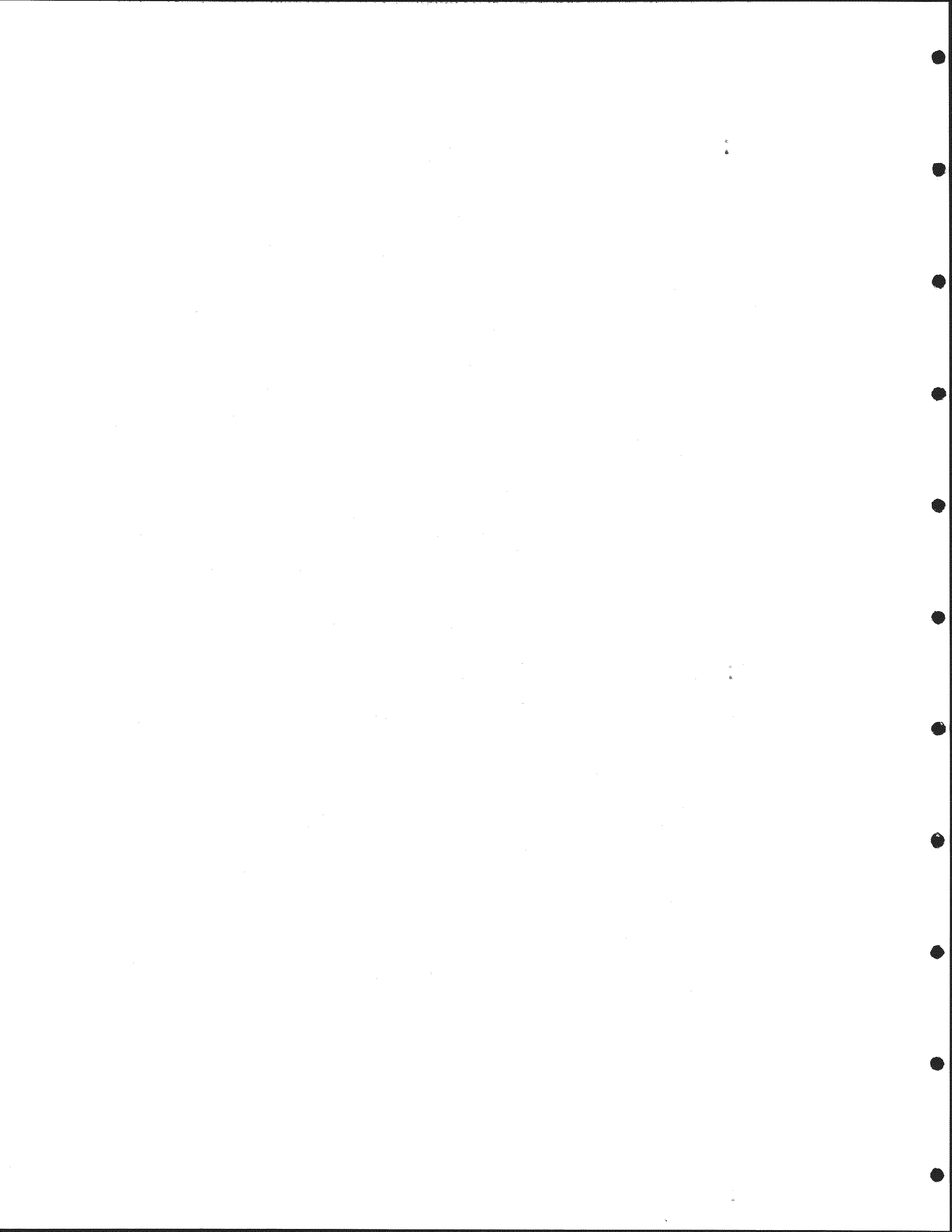
We are especially appreciative of the services and expertise provided by the statewide coordinating committee composed of Department of Mental Health staff and representatives of the Association of Community Mental Health/Mental Retardation Programs of West Virginia. Members of this committee included the following: Al Broadhead, Chris Chamberlain, Kay Howard, Randy MacDonald, John Marks, Mary Pesetsky, and Robert Marshall, Chairman, from the Department of Mental Health. The members of the Association were Michael Carey, Walter Case, and David Ogilbee. We are also indebted for the insightful and helpful consultation obtained from Robert A. Porter, Professor, Division of Social Work, West Virginia University, and Raymond Mathison, Project Director, Continuing Education Project, West Virginia Department of Mental Health.

The work accomplished by the coordinating committee has been very instrumental in setting the stage for completion of the plan and we acknowledge their dedication to the task and leadership in the planning process. In addition, during the past several years, there have been significant contributions from the various state agencies and departments, as well as from citizens who participated in the planning task forces and the Governor's Conference on Mental Health, held in January, 1975, all of which contributed greatly to the planning effort.

Our appreciation must also be extended to all the clerical and administrative staff who participated in typing and completing this document, with special thanks extended to Rachel Cassis, Barbara Rigsby, and Mary Srednicki for their dedicated leadership in this regard.

Finally by no means least, we are indebted to the directors and staff of the Divisions of Administration, Community Services, Professional Services, and Alcoholism and Drug Abuse, as well as the community mental health centers which have provided information and data as needed for the proper formulation of the West Virginia State Plan for Comprehensive Mental Health Services under Public Law 94-63.

M. Mitchell-Bateman, M.D.
Director



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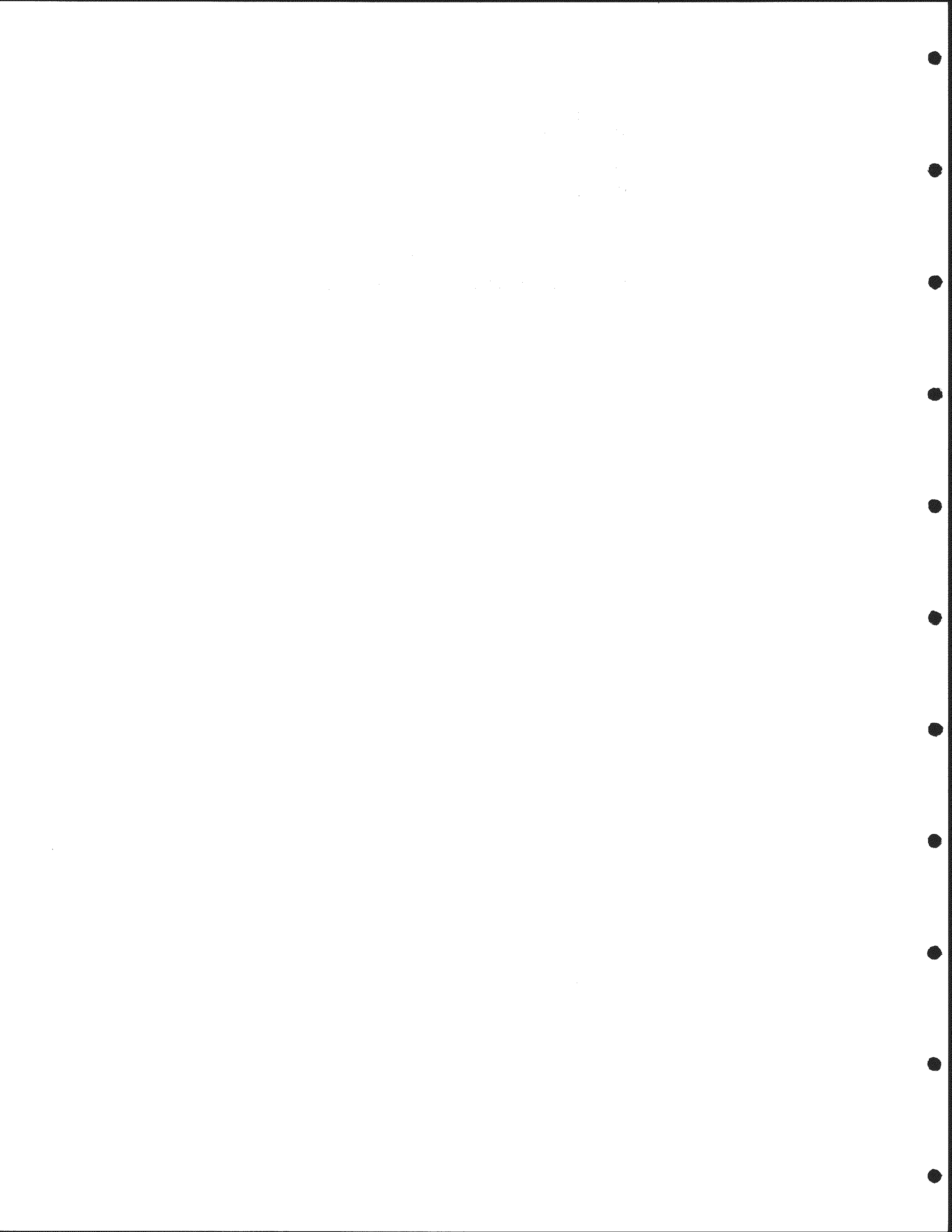


I. WEST VIRGINIA'S MENTAL HEALTH PROGRAM

A. INTRODUCTION

The year 1957 marked a milestone in the evolution of the state's mental health program when the legislature created a separate Department of Mental Health charged with developing community mental health services and having jurisdiction over the state mental hospitals.

In the 1950s, two surveys of the state's needs in mental health were made. Following the creation of the Department of Mental Health, the first Governor's Conference on Mental Health was held in 1958 -- and charged with the responsibility of formulating proposals and developing a long-range program. A series of recommendations, based on minimum acceptable standards, did emerge from this conference but were never fully implemented.

Substantial progress was made in the 1950s through creation of the department and the surveys of needs, but the strongest impetus came with initiation of the planning effort in 1963, which resulted in a widespread involvement of professional and lay citizens throughout the state, and a commitment to a realistic mental health program. For example, legislation provides subventions for approved community mental health programs, utilizing funds formerly paid by counties to the state for the support of patients in mental hospitals. These funds, and those from other state or local sources, can be used for matching federal staffing grants and for providing community facilities and services.

Communities have moved rapidly toward organizing local and regional services, and all counties are now providing some form of local mental health service. County governments are beginning to pool their resources and organize programs on a regional basis, recognizing that this must be the eventual pattern for delivering services to a population of less than two million.

Substantial increases in appropriations for the Department of Mental Health and its institutions have been approved by the legislature, enhancing the possibilities of recruiting better qualified staffs and initiating new programs.

Through funds appropriated by the legislature for matching federal programs, which were made available through the Governor's office, and additional funding from the Appalachian Regional Commission, West Virginia has been able to utilize such limited federal grants-in-aid for construction of community mental health facilities and additions to existing institutions.

Throughout the history of West Virginia and the nation, the human and financial costs of behavioral disorders have been staggering; continuing increases, which must be related to the stresses of modern life, are almost geometric. For the most part, society has resisted the idea that mental and emotional disorders are conditions susceptible to prevention. Since the turn of the century, environmental sanitation and a vast range of medical discoveries have brought about longer, more comfortable lives for people

in the area of psysical disease. Unfortunately, we are still fighting a full-scale epidemic of mental disease -- even though comparable breakthroughs have been achieved for the prevention and control of behavioral disorders.

But the picture is changing rapidly. At first, advocates of the modern approach to mental health could only enlist, for the most part, support from those persons, their families and friends, who have had experience with mental or emotional illness -- citizens who saw firsthand the tremendous gap between available knowledge and our failure to translate it into programs of service. Armed with a strong personal incentive, these citizens enlisted the support of others in their communities, and a true "grass roots" movement in mental health began to develop.

B. PHILOSOPHY

The primary goal of the West Virginia Department of Mental Health is to foster mental health and to prevent mental disabilities. While stressing the importance of prevention, it is the firm conviction of the department that when individuals need treatment for mental disabilities, they have the right to be treated as quickly and as close to home as possible, and in a setting and manner which preserves their freedom and personal dignity to the maximum degree possible. Therefore, there should be an ongoing, community-based delivery system of health, mental health, mental retardation, and other human resource programs providing both services and treatment when needed. In the event that the mental disability requires treatment in a facility located away from the home community of the individual, the Department of Mental Health has the responsibility to provide a total treatment program which recognizes and utilizes the strengths of both the recipients and providers of treatment services. The aim of every treatment program is toward rehabilitation of those served to their maximum capabilities.

Every person should have the opportunity to develop spontaneity, resiliency, and ability to cope with circumstances, which will assure him of a well-adjusted, fulfilling life. Individuals should have the chance to achieve in a manner satisfying to themselves, and should be encouraged to acquire the ability to face facts and to develop those areas wherein lie their strengths and potential capabilities. Individuals should be provided opportunities, and encouraged to search for areas of interest within the scope of their physical and mental potentials which will lead to a gratifying life.

C. GOALS AND OBJECTIVES

The various planning activities by the Department of Mental Health, its statewide affiliates, and the various citizen task forces which have been in process during the past several years, have led to the emergence of a set of goals and objectives which have guided the department in its planning efforts. While the following statement of these goals and objectives command widespread support by the planning participants, it is recognized

that the listing merits further probing and refinement in the continuing planning activity projected for the future.

GOAL 1 - TO PROVIDE COMPREHENSIVE MENTAL HEALTH SERVICES TO ALL CITIZENS OF WEST VIRGINIA

OBJECTIVES:

1. To identify the levels at which these services must be provided.
2. To assess, on a geographical basis, the availability and quality of these services now being performed, and to take actions needed to fill existing gaps in mental health services.

GOAL 2 - TO ATTAIN AND MAINTAIN A HIGH LEVEL OF QUALITY IN THE MENTAL HEALTH SERVICES DELIVERED TO THE CITIZENS OF WEST VIRGINIA

OBJECTIVES:

1. To establish and enforce, for each level within the delivery system, qualitative standards of performance evaluation.
2. To develop methods of determining, and reacting to, consumer satisfaction with the quality of mental health services being delivered.
3. To develop a unified approach to realistic assessment of qualitative and quantitative resources requirements.

GOAL 3 - TO DEVELOP AN INTEGRATED SYSTEM FOR THE DELIVERY OF MENTAL HEALTH SERVICES TO THE CITIZENS OF WEST VIRGINIA

OBJECTIVES:

1. To initiate pilot programs which will test the capability of the elements of the system to effectively communicate with each other as components of an integrated system.
2. To identify and correct obstacles to cooperation and coordination which may exist among the various elements of the delivery system.
3. To clarify the role of each element of the system in relation to its function as a component of the integrated delivery system of mental health services.
4. To activate in-service training programs and workshops which have as their goal the development of mutual understanding of the functioning of an integrated system.

GOAL 4 - TO ESTABLISH SYSTEMS FOR CONTINUOUS PLANNING AND EVALUATION OF MENTAL HEALTH SERVICES WHICH WILL PROMOTE PARTICIPATION BY REPRESENTATIVES FROM ALL ELEMENTS OF THE INTEGRATED MENTAL HEALTH DELIVERY SYSTEM

OBJECTIVES:

1. To continuously plan and evaluate methods of service delivery; the organization of the system; costs of the system in relation to system effectiveness; and the changing roles of supporting systems and organizations.

D. PLANNING PROCESS

This document sets forth a plan for implementing a needs assessment, and developing an operation schedule which we hope will ultimately lead to comprehensive mental health and community mental health programs and services for the residents of the State of West Virginia. It is the product of the widespread participation and committed efforts of many professional and lay groups, from all segments of the State of West Virginia, who are dedicated to the continued development of quality services for the mentally ill and the emotionally disturbed citizens of this state.

The West Virginia Department of Mental Health has been actively engaged in a planning process since 1963. At that time, a citizen task force was established to develop a state plan. This was a major effort, supported by a federal grant, and it culminated in 1966 with the Comprehensive Mental Health Plan for West Virginia, setting philosophy and goals.

Since that time, the various divisions of the department have been responsible for their individual program planning within the framework of the overall departmental goals. There has been no central coordination of planning vested in any one person or department.

In response to a growing feeling throughout the department that the various divisional planning efforts should be better coordinated, and progress evaluated, the director, Dr. M. Mitchell-Bateman, in conjunction with the Association of Community Mental Health/Mental Retardation Programs of West Virginia, initiated a joint statewide planning effort to update the 1966 state plan for mental health and mental retardation services.

Eight independent citizen task force committees were organized in February, 1974, and were given the mission of examining the current system of delivering mental health services in West Virginia, and following this analysis, to make recommendations for the improvement of the system. These task forces were given a target population, e.g., aging, mentally retarded citizens, general psychiatric services, alcoholism and drug abuse, emotionally disturbed children, and dangerously mentally ill; or a general area requiring study, such as organization, manpower, legislation, and research and evaluation.

The planning activity culminated in January, 1975, in a state and community level planning conference sponsored jointly by the Department of Mental Health, and Governor Arch A. Moore, Jr. The more than 300 conference participants, representing all pertinent state-level departments as well as professional and lay representatives from all segments of the statewide network of mental health and mental retardation services, reviewed, refined, and supplemented the recommendations of the various task forces.

The recommendations which emerged from these several planning efforts were tabulated in the spring of 1975. Some definite trends appeared. These fell into the following areas: community involvement; department reorganization; manpower needs; and legislation. In addition, there were repeated recommendations that the inappropriately hospitalized should be returned to the community as functioning citizens.

These recommendations, however, did not fully reflect the broad scope of the 1975 congressional amendments to the Community Mental Health Centers Act, which served to stimulate further planning activity. The Association of Community Mental Health/Mental Retardation Programs of West Virginia appointed a task group of its own members to make recommendations. These recommendations, endorsed by the full membership of the Association, were issued in the early fall of 1975, and are available for perusal by any interested party. They were studied at length by the various planning elements, and assimilated into the plan.

Meanwhile the various division directors of the Department of Mental Health, in response to the new federal legislation and in anticipation of the forthcoming guidelines, held regular meetings within the department to develop a topical outline of a comprehensive mental health plan for the state. That outline, completed in December, 1975, began to project plans to cover not only the new federal legislation related to community mental health, but also the other major components of departmental services, including the areas of mental retardation, hospital programs, and alcohol and drug abuse.

The more immediate planning activity organized within the department in anticipation of, and in response to, the publication of the guidelines relating to the 1975 congressional amendments to the Community Mental Health Centers Act (P.L. 94-63) has benefited substantially from these earlier planning efforts. The plan both assimilates the product of those earlier efforts and supplements them in its more comprehensive and detailed response to the mandates of the guidelines.

Upon receipt of the guidelines the department organized an array of task groups within the department to address each of the 19 discreet planning areas delineated in the guidelines. A coordinating committee composed of departmental staff, representatives of the Association of Community Mental Health/Mental Retardation Programs of West Virginia, and an external consultant was established to monitor and supervise the planning activity. The various task groups culled relevant material from existing documents, consulted with the personnel of local programs, and drafted segments of the present document under the guidance and supervision of the coordinating committee.

This most recent planning activity has been a monumental task performed under the pressures of a tight deadline and limited manpower. All planning participants assumed their tasks as an add-on responsibility to their current demanding schedules. In consequence, the planning process represented a compromise with the requirements of a more viable planning structure for a venture of this sort, in that time limitations

precluded the utilization of a more broadly based planning body. Secondly, the content of the plan, while addressing all essential areas specified in the guidelines, is unavoidably less than complete in many of its particulars. We anticipate a community based survey of needs during 1977 in an attempt to generate a more complete planning effort prior to submission of the 1977 progress report.

Five problem areas stood out in examining the various recommendations. These involve major decisions and subsequent programmatic thrusts. The Department of Mental Health will attempt to discuss the progress made in resolving these in our fiscal year 1977 update:

1. There is an apparent disparity between the efforts to decentralize, giving more authority to the regions; and the desire to increase the central office staff in order to provide more coordinated statewide services. This is a basic philosophical decision that must really be made before many other progammatic matters can be decided -- autonomy or strong central government?
2. Increased efforts to provide services for those institutionalized seem at conflict, given limited resources, with devoting more energies toward providing alternative care in the community.
3. On the one hand, improving the services offered in the community facility to the point where it provides all necessary services is emphasized. On the other hand, involvement of other agencies, volunteers, and various community resources, giving them the major responsibility, with the department in an advisory capacity, is stressed.
4. The ultimate goal of the department should be prevention. Almost all of the initial recommendations have to do with service delivery. There must be further specific programs developed within each division aimed at primary and secondary prevention.
5. There is an outstanding need for an Office of Planning, Evaluation, and Development. This office would be responsible for coordinating the long-range planning of each division, and of the department itself, thus allowing for consistent, systematic, continuous planning, and evaluation of the results.

These problem areas will be continually reviewed and studied in the months ahead to determine which will have an impact on the operational goals and objectives for our five year plan.

In recognition of the limitation of the current planning effort, and of the fact that the planning function of the Department of Mental Health requires continous activity, the coordinating committee projects, as a major component of the present plan, an ultimate reorganization of the department which will include an Office of Planning, Evaluation, and Development. While the department has necessarily engaged in these activities in the past, these efforts have typically been dispersed, frequently ad hoc in nature, and not always adequately coordinated. The Office of Planning, Evaluation, and Development, which would remedy these deficiencies, would have a full-time staff devoted exclusively to these interrelated functions, and would be integrally related to the director of the Department of Mental Health and all major divisions within the department.

The Office of Planning, Evaluation, and Development will be charged initially with responsibility for organizing and developing a statewide planning structure, with due attention to representativeness and process, which will further develop and refine the present plan. While details of that structure remain to be designed, it is anticipated that it will consist of a series of task groups, each to address separate areas of the plan, composed of appropriate personnel from the central office of the department, representatives of other state-level departments having a substantial interest in mental health services, and representatives from state hospital programs, local community mental health programs, and consumer/citizen groups such as mental health associations and board members of local mental health centers.

During the interim, and until the new Office of Planning, Evaluation, and Development is implemented, the coordinating committee (see page 5.) will continue to function as the primary planning vehicle within the Department of Mental Health. The committe's functions will include: coordination of all mental health system planning efforts; communication of planning progress to all planning elements; and cooperation of all segments to assure proper input to and outcome for the ultimate development of the five year plan.

E. FUNDING

If it were genuinely possible to move entirely from the "squeaky wheel gets the most grease" concept of funding, a significant void in the life style of the executive, the staff, and citizen support groups would momentarily appear. There is an increasing sophistication to planning and implementation based on needs, but a fact of life also remains that financial resources are not without limitations, and somebody's wheel always seems to be squeakier than the rest. As the planning process unfolds through the development of work plans to achieve objectives, resource allocation, including funding, becomes a part of the process, and budgets become truly meaningful.

The best that can be said of funding for programs projected in this document is that the department is concerned and hopeful. The basis? The forewords to annual reports offer one clue: 1971-72, "... acute shortage of personnel ... lack of funds ..."; 1971-72, "... an awareness of the citizens ..." as they began to experience the services of community mental health centers; and in 1974-75, an expression of thanks to the chief executive of the state for his interest and support for mental health services to the people of West Virginia. A second clue is to be found in the planning document itself -- the establishment of planning as a full-time function of the department in an effort to utilize more effectively forecasting techniques and the ever-increasing technology for assessing needs.

Finally, the allocation of budgeted funds to program areas (Figure 1) reflects percentage increases which offer a degree of reality to accompany concern and hope. Specifically, state support is moving through an encouraging upward trend for community mental health services, concomitant with department goals, and fulfilling a measure

of the demand created by citizen awareness. This same awareness encourages local support and that of third-party participation. Although our state hospitals are under staffed in terms of the recommended staff/patient ratio, the completion of capital improvements will make funds available for the necessary staff increases, yet still permit budgetary leveling.

Through all of this, the changing role of the department from being a direct provider to providing consultation, evaluation, and planning, can be expected to include furnishing the information/data to those who provide the grease to those who help "squeak the wheel" of mental health.

% ALLOCATION OF TOTAL BUDGET TO PROGRAM AREAS

Program Area	75-76	76-77 REQUEST	
CENTRAL OFFICE	3.74%	3.65%	
RESEARCH & TRAINING	0.03%	0.07%	
CIVIL SERVICE FEES	0.29%	0.37%	
COMMUNITY M. RETARDATION	3.22%	4.55%	
ALCOHOL & DRUG ABUSE	1.36%	2.29%	
COMMUNITY MENTAL HEALTH	8.13%	13.46%	
CHILDRENS' MENTAL HEALTH	0.00%	0.57%	(NEW)
EMERGENCY MEDICAL CARE	0.00%	0.34%	(NEW)
PATIENTS' PAYROLL	0.00%	0.57%	(NEW)
ALL HOSPITALS	83.24%	74.11%	

II ADMINISTRATION

A. SINGLE STATE AGENCY

The West Virginia Department of Mental Health is authorized by Chapter 27 of the Code of West Virginia as the designated state mental health authority. As such, it serves as the Single State Agency for the administration and supervision of this plan. Further, with respect to the administration of the state mental health plan for West Virginia, Chapter 27 of the Code of West Virginia sets forth a director responsible for the total operation and implementation of mental health programs for West Virginia. Reporting to the director is a deputy director for administration and a deputy director for clinical services.

The statute also mandates as separate distinct divisions: the Division of Administration; the Division of Professional Services; the Division of Community Services; and the Division on Alcoholism and Drug Abuse. Although not mandated by statute, there is a Division of Mental Health Education, as well as a rapidly developing section on licensing.

Fiscal authority and responsibility for appropriations are vested in the Division of Administration. Operating within the Division of Administration is the centralized financial managment section, the personnel section, and support service staff for other administrative functions.

Hospital operation, community mental health/mental retardation operations, alcoholism and drug abuse programs, a wide variety of federal programs, and central monitoring staff are beneficiaries of the variety of services, standards, planning, organizing, directing, and comptrollership activities of the Division of Administration.

The Division of Community Services is responsible for the program elements and related standards, planning, and monitoring of the community mental health/mental retardation facilities, programs, and activities throughout the state. Contracts for funding and approval of budgets for those facilities depend upon their adherence to prescribed rules, standards (both fiscal and programmatic), and regulations as formulated by the department, with the input and advice of the Divsion of Community Services staff.

The Division of Professional Services functions as a staff arm of the director in order to assure a core of professional and supportive services to other departmental programs. Functions within this division include the following: consulting services such as psychiatry, psychology, social work, nursing, and volunteer services; research, program evaluation, and training; statistics and data processing.

The Department of Mental Health must govern its financial operations within the statutory requirements of the state auditor's office, the treasurer's office, and the Department of Finance and Administration, and be accountable to the Governor, and the various overseer and regulatory agencies such as the legislative auditor, the state purchasing, practices and procedures commission, and various taxing authorities, as well as federal regulatory agencies when federal funding is involved.

The fulfillment of goals and adherence to standards are achieved through the implementation of policies, instructions, manuals, and regulatory directives released as numbered and classified subject matter from the department to all jurisdictional personnel of the department and its various programs. This list is on file for inspection purposes.

B. ORGANIZATIONAL CHART

The organizational chart (Figure 2) for the Department of Mental Health reflects the direct authority and consultative relationships between the various parts of the organization. The broken lines surrounding the Office of Planning, Evaluation, and Development, the positions of Deputy Director for Clinical Services, and Mental Health Licensing indicate that these parts of the organization are not yet totally established. During the past several years, the position of Deputy Director for Clinical Services has been filled by a part-time employee, and the Office of Planning, Evaluation, and Development functions have been carried by various staff in other divisions on a limited time basis.

The state operated inpatient facilities include the various state hospitals and centers operated and administered by the Department of Mental Health. The chart reflects the dual responsibility between administration and clinical services in the state operated hospitals. In addition, the Division of Administration is responsible for the administrative operations of the other divisions within the central office.

At this time there is no regional or local program under the direct supervision of the Division of Community Services. However, state laws make it possible that such programs could be operated directly by the department through the Division of Community Services, at the election of the director.

C. STATE ADVISORY COUNCIL

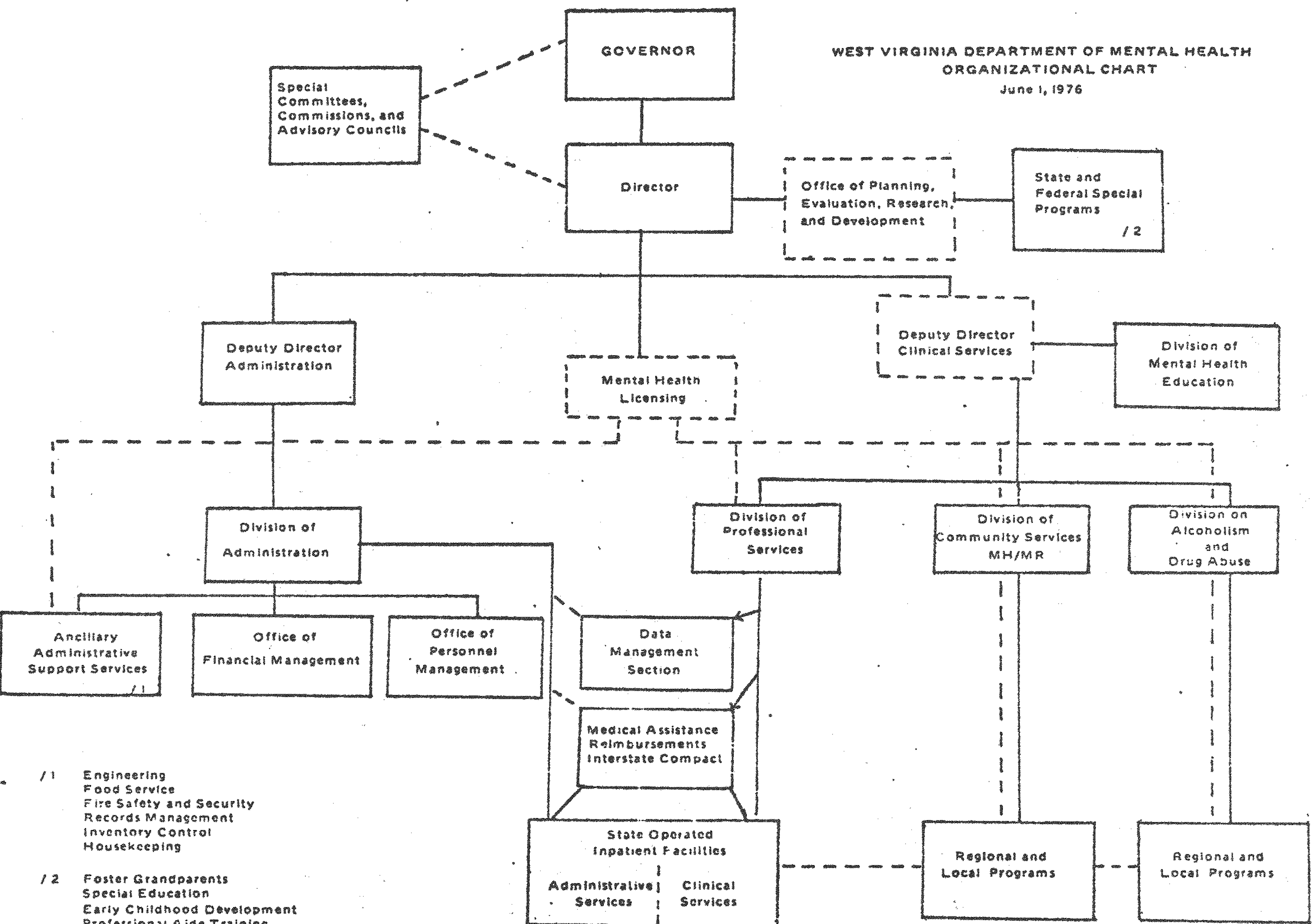
There shall be a state Mental Health Advisory Council to the West Virginia Department of Mental Health.

1. Functions and Responsibilities

a. The Advisory Council shall consult with and advise the executive and administrative personnel of the Department of Mental Health with respect to the development and implementation of the comprehensive state plan for mental health. This shall include, but not be limited to, the formal review of and comment upon any and all plans, or amendments thereto, developed by the department, and upon the annual report by the department of progress toward the achievement of the goals and objectives set forth in the plan. A written report of the Council's review and comments upon any such state plan, amendments thereto, or annual progress report shall be attached to such documents submitted to the Secretary of the Department of Health, Education and Welfare.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH ORGANIZATIONAL CHART

June 1, 1976



/1 Engineering
Food Service
Fire Safety and Security
Records Management
Inventory Control
Housekeeping

/2 Foster Grandparents
Special Education
Early Childhood Development
Professional Aide Training
Continuing Education

Broken Lines Indicate Proposed for the Future.

b. The Advisory Council shall, at the request of the department or on its own initiative, consult with and advise the department with respect to any policy issue related to the implementation of the state plan, and shall have access to departmental data relevant to its deliberations.

c. The Advisory Council shall, through the appropriate composition of its membership as set forth in regulations under the Community Mental Health Centers Act, as amended, and through other such mechanisms as it may devise, establish and maintain collaborative and coordinative relationships with other state planning bodies relevant to the implementation of the state mental health plan, to include, but not be limited to, the statewide Health Coordinating Council.

d. The Council may serve as an appellate body to receive and to review, at its discretion, complaints not satisfactorily resolved through the established grievance procedures of the department and its affiliates, and shall advise the department with reference to its findings.

2. Composition

The composition of the state Mental Health Advisory Council shall include, but not be limited to, individuals representing service providers, consumers, non-government organizations, and state agencies. A majority, but no more than 60 per cent of the membership of the Council shall be citizens who are neither direct nor indirect providers of mental health services, and no less than 40 per cent shall be direct or indirect service providers. For purposes of this paragraph the definition of "provider" will be consistent with the definition of the term in P.L. 94-63, Section 201 (c)(2). (See Appendix 1.) Members of the Advisory Council will be representative of social, economic, and racial groupings residing in the state, as well as its geographic areas.

Designation of members to the Mental Health Advisory Council will be through both public process and by appointment. Council members representing state agencies and representatives of mental health providers will be appointed to the Advisory Council by the director of the Department of Mental Health. After the initial appointment of members to the Advisory Council by the director, all subsequent appointments will require the approval of the Council. Consumer and non-government groups will be requested by the director of the Department of Mental Health to select, from their memberships, individiuals to serve on the Council.

3. Classes of Membership

The state Mental Health Advisory Council shall include, but not be limited to, four classes of membership: state agencies;

mental health providers; representatives of non-government organizations or groups; and consumer representatives.

-The category "State Agency" may include, in addition to all agencies of state government, representatives of the executive and legislative branches of government.
-The category "Mental Health Provider" shall include individuals who can meet the criteria of "provider of health care" as specified in P.L. 94-63, Section 201 (c)(2). (Appendix 1.)
- The category "Non-Government Representative" may include, but not be limited to, individuals representing the state mental health associations, professional organizations such as the state N.A.S.W., the state psychological association, and community mental health center board members.
-The category "Consumer" may include, but not be limited to, individuals representing patient organizations, patient advocacy groups, and community mental health center board members.

4. Number of Council Members

The Advisory Council shall consist of seventeen members. The number of members may be changed by vote of the Council, but at no time shall the number of Council members exceed twenty-five or be less than seventeen.

5. Selection of Council Members

There will be eight members appointed to the state Mental Health Advisory Council, four representing state agencies and four representing mental health providers. Nine members will be selected to serve on the Advisory Council by a public process. Five of these members will be selected by consumer groups and four selected by non-government organizations.

6. Term of Membership

Members shall be elected or appointed for three year terms, except initially, when one-third shall be elected or appointed for one year, one-third for two years, and the remaining third for three years. Thereafter, one-third of the membership shall be rotated off the Council and replaced by an annual process of election or appointment. Members shall serve no more than two consecutive terms. However, this rule shall in no way prohibit a member's serving in the future.

7. Vacancies

Vacancies on the Mental Health Adviory Council shall exist upon the death, resignation, or removal of any member,

or whenever the number of members authorized is increased, and shall be filled in the same manner as originally appointed or elected. A Council member will be removed if he is absent and unexcused by the Council for three consecutive Council meetings.

8. Offices of the Council

The Council shall annually elect a chairperson, a vice chairperson, and a secretary. Terms of office shall be limited to two consecutive one year terms.

9. Procedures

a. The Council shall meet as frequently as necessary, but not less than once each quarter, in accordance with an established schedule, and in appropriate quarters provided by the department. The department shall furnish such secretarial and other support services as the Council deems necessary to fulfill its responsibilities. Staff may include both professional and clerical personnel. Travel and per diem costs incurred by members shall be reimbursed by the department at established rates prevailing for state employees.

b. The Council shall establish such committees as it deems appropriate to fulfill its reponsibilities.

c. Council meetings shall be presided over by a chairperson, and in his (her) absence, a vice chairperson. Minutes of the meetings shall be maintained by a secretary who shall keep a record of the dates of Council meetings, a summary of issues considered, and a report of actions taken, including specific references to the required annual review of the plan. A report of these activities shall be submitted with the annual state plan to the Secretary of Health, Education and Welfare.

d. The meetings of the Council shall be governed by the rules of parliamentary procedure and shall be open to the public. Public notice of the time and place of each meeting, and of the agenda to be considered, shall be made in suitable public communications media at least one week in advance of the meeting. All Council meetings will be open meetings, and will be publicized as such.

10. Implementation

A proposed time table for selecting members to the Advisory Council will be found as Appendix 2. This procedure is as follows:

A letter is sent requesting names of people interested in serving on the Advisory Council.

From the affirmative replies received, the Advisory Council will be initially selected by the director, in consultation with the coordinating committee. The selection will be made in accordance with state and federal guidelines, in order to ensure adequate and proper representation from various segments of the community.

Copies of the letter sent to various people and agencies, the memorandum sent to the various community mental health center directors, and the list of people and agencies from whom we requested names is entered as Appendix 3.

The initial meeting of the Advisory Council was held December 1, 1976.

D. REPORTS

The West Virginia Department of Mental Health is currently installing a uniform accounting system, and there are plans to establish management information systems in all DMH operated and/or affiliated facilities, with common definitions for items of state-wide, and/or federal relevance. These two systems incorporate financial data, staff/personnel data, and client data and should be able to answer most questions. Provisions have been made to collect other data on an as needed basis through surveys using extra spaces on existing forms.

The West Virginia Department of Mental Health currently has a minimum retention period of two years on all original documents, as mandated by state policies.

The centralized financial management program in effect for the department is comprehensive in scope and is capable of generating any reports presently needed, or contemplated for the future. The adaptability of this system is such that the process of systematic originating, authenticating, recording, classifying, processing, analyzing, interpreting, and supplying of dependable and significant information relative to financial matters required for the operation and management of mental health activities, operates through centrally imposed standards of operation.

The all encompassing concepts of general accounting, funds accounting, cost accounting, revenue accounting, fixed assets management accounting, sub-contract reciprocal accounting, inventory accounting, budgetary accounting, and assets management accounting are all pervasive concepts at work within the theoretical framework of management operations for the mental health programs of West Virginia.

State statute and policies, instructions, manuals, and fiscal comptrollership activities by a host of state agencies with internal auditing, systems development, and central monitoring capabilities, as well as periodic staff reviews, and required outside auditing of decentralized reciprocal accounting operations, and legislative audits of centralized accounting operations assure the control of state, local,

and federal funds. The principles and practices of the American Institute of Certified Public Accountants are recognized within the theoretical foundation of the accounting system.

The entire department with its various hospital operations, community mental health and mental retardation operations, and various programs operates under a standardized, centrally imposed accounting system designed to meet all fiscal control and reporting needs at the state and local levels.

E. ANNUAL REVIEW

The Department of Mental Health shall review, at least annually, the West Virginia State Plan for Comprehensive Mental Health Services, and incorporate the results of the review in an annual submission of the plan to the Secretary of Health, Education and Welfare. In addition, a written review will be prepared by the state Mental Health Advisory Council and will be included at the time of submission of the state's comprehensive mental health plan. The Advisory Council will have access to all public documents of the department, and other public data relevant to its deliberation in the preparation of its review.

To provide the general public an opportunity to review, evaluate, and comment on the initial state mental health plan, publication of a news release concerning the proposed plan, and revisions or amendments thereto was required by the Department of Mental Health at least ninety days prior to submission of the plan to the Secretary. Such description was published in local newspapers in August, 1976. (See Appendix 4.)

A copy of the proposed state plan or any modification will be made available to the public, upon request. Requests for the proposed plan can be made by writing or calling the office of the director, Department of Mental Health. Copies of the proposed plan will be available for public inspection at all state mental hospitals and community mental health centers.

Written comments from the public regarding any aspect of the proposed state plan will be accepted by both the director, Department of Mental Health, and the Mental Health Advisory Council at any time during the year.

Prior to the annual review, public hearings will be conducted by the Department of Mental Health to accept written and verbal statements from the public, and to answer any questions regarding the plan. Comments and public reactions will be used in the state plan revisions. Prior to the annual review, public hearings will be completed 45 days prior to the date the state plan is to be submitted to the Secretary.

A description of the annual update of the plan will be published in local newspapers upon its submission to the Secretary. Copies of the final plan will be available to the public from the Department of Mental Health upon request. Additional copies of the state plan will be available for public inspection throughout the program year at the Department of Mental Health central office, state mental hospitals, community mental health centers, and centers on alcoholism and drug abuse.

F. PERSONNEL ADMINISTRATION

The West Virginia Department of Mental Health participates in the West Virginia Civil Service System which regulates personnel administration. Laws, rules, regulations, and policy statements are cited below, by reference, in the section on personnel (page 45).

Assurance is given in Section VIII (page 109) that the Department of Mental Health agrees to comply with Title VI of the Civil Rights Act of 1974 (P.L. 88-352). Assurance is also given that there shall be no discrimination on account of creed, sex, age, marital status or duration of residence. (Assurance numbers 1 & 2.) Further, assurance is given that the Department of Mental Health will forbid conflict of interest. (Assurance number 8.)

G. FUNDS FOR ADMINISTRATION OF THE STATE PLAN

There are no specific funds designated for administrative costs, and implementing and monitoring the state plan. The department commits staff time for personnel from the Divisions of Administration and Community Services to monitor the various requirements of the plan. These individuals are paid from state appropriations and have many additional responsibilities. Staff time will be used from other divisions as needed.

The department endeavors to assure that all funds available form state, local, or federal sources are utilized in a proper manner to fulfill program requirements and funding constraints.

The department anticipates and plans for the commitment of a proportion of state funds to administer the requirements of the federal law as it relates to mental health services. This commitment to the goals of Public Law 94-63 relating to the operation of comprehensive mental health and mental retardation services is reflected in our allocation of funds, and personnel for this program. The fact that a separate division is directly concerned with this program attests to the state's commitment in this regard.

1. Community Facility Financial and Fiscal Management Requirements

The Department of Mental Health utilized state general revenue appropriations for both planning and operational purposes. The administrative costs for monitoring the programs of the community mental health facilities does not consume more than 1 per cent of the budget allocated for comprehensive mental health services. The department does not utilize the allotments of 314(d) monies in excess of the 5 per cent designated from such allotments for the operation and generation of the state plan. Most of the program planning funds are carried within the general revenue state appropriated accounts for such purposes.

The department's policy with respect to the development of annual contracts with the community mental health centers

provides for the annual review of financial operations and the allocation of state operational funds to those facilities that demonstrate:

-Substantial compliance with departmental policies, standards, rules, and regulations.
-Fund allocations based upon performance as measured by financial and statistical data reflecting program development.
-Allocations of state and federal reimbursement dollars based upon demonstrated need, available resources, annual program review, and compliances with requirements that the programs provide for services -- day-care, and other partial hospitalization services; emergency services; consultation and education services; specialized services that provide for diagnostic treatment, liaison, and follow-up care for the mental health of children and the elderly.

2. <u>Annual Expenditures Needed For Administration of State Plan</u>

Table 1 describes an estimate of projected annual expenditures. In accord with that estimate, the Department of Mental Health requests that $20,900 in federal funds be made available to the department for administration of the plan during FY 1976-77. Such funds will reimburse planning personnel and provide for current expense needs pursuant to the state plan, as well as provide travel and related expenses for the state Mental Health Advisory Council.

Included in Table 1 is a statement of the expenditures incurred by the state agency, including the Department of Health expenditures, in administration of the state plan for community mental health centers during the fiscal year ending June 30, 1968. The Single State Agency during that period of time was the West Virginia Department of Health.

The Department of Mental Health agrees that not later than 60 days after the end of each fiscal year during which funds have been expended under this subsection, an officer of the state agency shall certify that any federal funds for administration of this portion of the state plan have been utilized in accordance with the Act and regulations, and shall submit a statement of the actual expenditures within each category included in the application for funds.

H. DEPARTMENT OF MENTAL HEALTH CONSTRUCTION PLANS

The Department of Mental Health has made significant strides toward completion of a network of community mental health and mental retardation facilities across the state. Center construction has been completed in eight of the 13 current planning region/catchment areas. (See Figure 3.)

TABLE 1. EXPENDITURES FOR ADMINISTRATION OF THE COMMUNITY MENTAL HEALTH PLAN OF 1968 AND PROJECTED EXPENDITURES FOR 1977

Expenditure Category	Fiscal 1968, Under P.L. 88-164			Projected 1977, Under P.L. 94-63		
	W.V. Dept. of Mental Health	W.V. Dept. of Health	Total	W.V. Dept. of Mental Health	Federal	Total
A. Personal Services						
1. Professional	$7,150.00	$2,815.00	$9,965.00	$12,150.00	$12,150.00	$24,300.00
2. Clerical	688.00	110.00	789.00	3,250.00	3,250.00	6,500.00
B. Administrative Services						
1. Supplies, Equipment Other	2,756.00	2,301.00	5,057.00	2,500.00	2,500.00	5,000.00
2. Publication of State Plan	-	-		1,000.00	1,000.00	2,000.00
C. State Advisory Council and Local Advisory Groups	-	-		2,000.00	2,000.00	4,000.00
TOTAL	$10,594.00	$5,266.00	$15,820.00	$20,900.00	$20,900.00	$41,800.00

During the past session of the legislature, surplus funds were appropriated to complete the network of facilities in those regions (Table 2.) Construction will begin in the near future in Region 2-CA1, Region 6-CA1, and 2; Regions 3 and 4 are in pre-planning stages.

Recent state legislation mandates 14 mental health centers, with the final center being developed in Region 7-8, probably in Mineral or Hampshire counties, although Grant county has also been discussed. Funds are also now available to complete approximately 40 per cent of a $21 million proposed central complex facility, which will be located 20 miles north of Charleston, the state capitol.

In addition to the mental health construction plans, two new state mental retardation facilities are also authorized, and funds appropriated, for the Moundsville (Marshall county) and Mineral/Hampshire areas to serve two of eight mandated regions. Two other regional mental retardation centers are partially completed. Four others are incorporated into a mental health facility. (It should be noted that these are plans for facilities; mental health services are available in all counties.)

Although the above construction plans will complete the basic network of facilities, it is anticipated that additional construction within the next ten years will be required for total comprehensive programming. Elsewhere in this plan the need for transitional homes in every area has been discussed in detail. In addition, several of the facilities will require new funds for renovation. More specifically, renovation probably will be needed at the following locations: Princeton, Beckley, Huntington, Lewisburg, Elkins, Martinsburg, and Wheeling. The various state hospitals are also being renovated, a process that is expected to continue indefinitely.

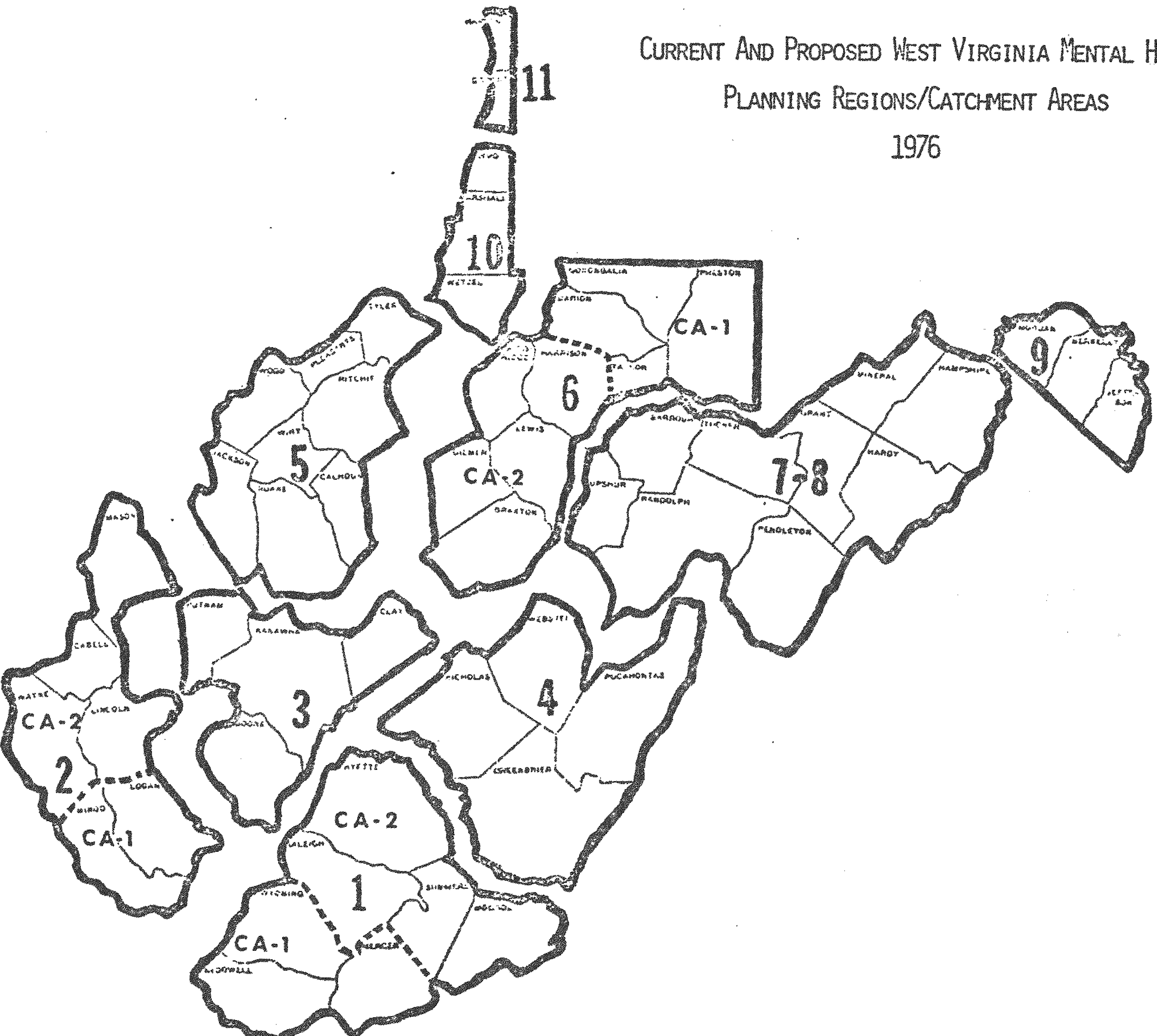
The status of the various construction projects can be reviewed by referring to the October 1976 Construction Projects Progress Report, available from the Department of Mental Health.

TABLE 2. FUNDING FOR WEST VIRGINIA MENTAL HEALTH PROGRAMS AND STATUS OF CONSTRUCTION BY CATCHMENT AREA

1975-76 Source of Funds 1/

REGION	PROGRAMS	STATUS OF CENTER CONSTRUCTION	FEDERAL STAFFING GRANT		COUNTY	STATE	FEDERAL	TOTAL
			FUNDED	EXPIRES				
1-CA1	Mercer-McDowell-Wyoming C.M.H.C., Princeton	Completed	5/72	4/80 2/	$ 75,000	$ 469,761	$ 394,764	$ 939,525
1-CA2	F.M.R.S. M.H. Council Beckley	Completed	5/72	4/80 2/	66,000	511,858	666,195	1,244,053
2-CA1	Logan-Mingo Area Mental Health, Logan	Planning	5/72	4/80	27,250	399,498	366,625	793,373
2-CA2	C.M.H.C. of Region 2 Huntington	Completed	7/69 9/72 9/74	6/77 2/ 4/ 8/80 5/ 8/77	88,500	212,776	485,729	787,005
3	C.M.H.C. of Region 3 Charleston	Pre-Planning	N/A	N/A	146,490	357,738	–0–	504,228
4	Greenbrier Valley M.H. Clinic, Lewisburg	Planning	Planning	N/A	26,300	241,404	–0–	267,704
5	Western District Guidance Center, Parkersburg	Renovation Completed	Planning	N/A	54,141	372,803	–0–	426,944
6-CA1	Valley Comprehensive C.M.H.C., Morgantown	Planning	7/74	8/82 2/	93,100	443,304	291,261	827,665
6-CA2	Central District Guidance Center, Clarksburg	Completed	Approved	Not funded 2/	145,092	320,537	26,400	492,029
7–8	Appalachian C.M.H.C. Elkins	Completed	9/66 7/70 9/71 8/72	8/74 2/ 6/ 6/73 3/ 8/79 4/ 7/80	159,833	733,657	334,129	1,227,619
8	C.M.H.C. of Region 8 (Proposed)	Pre-planning	N/A	N/A	–0–	–0–	–0–	–0–
9	Eastern Panhandle MHC Martinsburg	Completed	7/74	6/82	25,000	176,163	128,969	330,132
10	Northern Panhandle MHC Wheeling	Completed	1/74	12/82 2/	97,092	375,141	409,250	881,483
11	Hancock-Brooke MH Service, Weirton	Planning	Planning	N/A 2/	29,500	122,505	20,583	172,588
				TOTAL	$1,033,298	$4,737,145	$3,123,905	$8,894,348

1/ 1975-76 Reimbursement Budgets
2/ Initial Federal Staffing Grant
3/ Alcoholism Federal Staffing
4/ Children's Services Federal Staffing Grant
5/ Drug Abuse Federal Staffing Grant
6/ Growth Federal Staffing Grant


CURRENT AND PROPOSED WEST VIRGINIA MENTAL HEALTH
PLANNING REGIONS/CATCHMENT AREAS
1976
11
10
CA-1
6
CA-2
5
7-8
9
3
4
2
CA-2
CA-1
1
CA-2
CA-1

III. STANDARDS OF MAINTENANCE AND OPERATION

The Code of West Virginia, as amended in 1970 (Chapter 27-9-1), mandates licensing by the director of the Department of Mental Health for any hospital, center, institution, or part thereof that provides services to the mentally ill or mentally retarded. (See Appendix 5.) Also, state license is a prerequisite for accreditation by the Joint Commission on Accreditation, and/or certification by federal agencies for medicare-medicaid and other funding programs.

The intent of the West Virginia statute was to assure the availability of the best and safest service possible to all residents in each catchment area. It was one of the first mental health regulations in the country providing a comprehensive section on patients' rights. The licensing regulations were compiled with assurances to providers of mental health/ mental retardation, and alcohol and drug abuse services that the dynamics of delivering psycho-social services would be incorporated in the regulations through periodic review and update.

The West Virginia mental health licensing regulations were written to provide information to providers to aid them in reaching standards of operational excellence, ranging from minimum to optimum.

A West Virginia mental health license guarantees to the public that a facility:

-Has met safety standards applicable to the services and/or programs it provides;
-Is providing services commensurate with the declarations made to the public served; and
-Maintains records to document services actually delivered and changes in services delivered.

On August 11, 1971, the first issue of Regulations for Licensing Psychiatric and Other Related Facilities and Programs was filed with the Secretary of State, and became effective December 30, 1971. There have been numerous revisions, which have most often been necessitated by changing federal mandates related to funding grants.

The regulations call for an initial survey of a facility or program. At this time, an in-depth profile is prepared based upon the licensing regulations. The profile presents a factual picture in relation to the regulations, and is continually updated for use as a management tool. It is a vehicle providing communication between the licensing agency and the provider, enabling the license records to be kept current through feedback to the licensing agency of new developments in each licensee's program operation.

Scoring the profile provides a check list of items in violation, or in compliance, or merely flags items for discussion with the provider to set priorities for consultation services, if needed. At the first scoring, the licensing agency looks for violations of minimum standards which must be met before licensing; possible program deficiencies which

indicate a need for consultation and improvement; or simply the need for a better look at the facility's operation to determine a fair evaluation.

After an initial survey of a facility or program for license, a written report is made within 15 days to the facility, setting forth non-compliances which must be corrected before a license is granted. Copies of all reports are provided to the director of the Department of Mental Health, and deputy director or division directors as needed. As soon as the facility gives evidence of compliance with regulations, a license is issued.

Because of the wide range of program types, each program is surveyed and licensed in terms of its individual program goals. A system has been defined for applying the standards to each facility to determine compliance.

Non-compliance related to patient/client safety, general welfare, or lack of program effectiveness constitutes cause for refusal, or revocation of the license, in which case the applicant is notified, in writing, promptly.

Other areas of non-compliance call for reduction of a Class I license to Class II, with reasons therefore; or for provision of consultation services to aid the facility to come into compliance. To date, one facility has been denied license. None have had their Class I license reduced to Class II.

A provider to whom a Class I license is issued, or a Class II license with established time limits for compliance with unmet standards which do not create a hazard, should be eligible for staffing grants based on need and projected use.

Attached is a list of facilities showing license status and the regulations category, or categories, of consultation services being provided. (Appendix 6.)

After granting a license to operate, the license program provides services to assist providers in meeting optimum standards of operation.

The initial profile becomes a vital vehicle for producing data to be used to determine where consulting services are indicated, either to maintain a standard already met, or to improve from an intermediate status of operation to quality status.

In developing, keeping current, and intelligently using the sensitive and changing profile record to monitor mental health, mental retardation, and alcohol and drug abuse programs, the licensing agency is enabled to provide consultation services and education in areas where and as needed.

Those consultation services are presently focused on helping each program develop an effective program by assuring that each program has a governing board functioning through written by-laws

and policies; a written procedure of carrying out those policies; standards for handling client clinical records; a utilization review system; and an organized client clinical records system. These are all necessary support functions for the legal care and treatment of the mentally ill and mentally retarded, and at the same time they provide for appropriate development of valid and reliable client treatment, quality assurance, and program evaluation data.

This concept of an educational licensing consulting service, based on license evaluation data controlled through the facility's comprehensive profile, creates an orderly process of education to ensure maintenance of standards, whether set by licensing regulations, Joint Commission on Accreditation of Hospitals, National Institute of Mental Health, or others.

Following the initial licensing action, an annual survey is done, using the original profile as a point of departure. If the facility receives a minimum score, it must remove the conditions before the license is reissued. If, however, the conditions do not appreciably affect the health and safety of the clients, and compliance must be delayed (such as in the case of new construction), a Class II license may be issued with the conditions indicated thereon.

A provider's intermediate score on the annual survey indicates that:

1. The applicable regulations needing improvement are identified, and ongoing tasks are assigned related to defined and measurable short term goals which the provider plans to reach within an estimated time; and
2. Specific future needs are identified and long range plans are being acted upon, as evidenced by facility investigation, reports, and committee activities.

A high intermediate scoring identifies standards compliance and is deserving of increased eligibility for staffing grants.

A quality scoring indicates that the maximum level of performance of any standard can be documented by audit; the highest possible standard of service delivery is provided for residents in the facility/program, with appropriate referral procedures that can be documented by audit; and a comprehensive program providing acceptable levels of all elements of service exists, and is documented by periodic audit.

A high quality scoring indicates that the provider is ready to apply for and receive certification for medicare, medicaid and other federal funding; is ready for accreditation by the Joint Commission on Accreditation of Hospitals; and is deserving of increased eligibility for staffing grants, public and private funding for research, and accredited affiliations with colleges and universities.

The mental health licensing function is a vital function of the Department of Mental Health, mandated by West Virginia statute. Mental Health licensing is a prerequisite for accreditation by the Joint Commission on Accreditation of Hospitals. The licensing function should be released from temporary program status, fully implemented, and appropriately placed in the proposed organizational structure, with direct responsibility to the director of the Department of Mental Health. There should be an allocation of appropriate funds to operate in full force. The current skeletal staff is not large enough to meet the needs of the program, and the director faces grave professional and legal responsibilities as the time limits expire to license, relicense, and maintain the consulting services to meet the demands being made on the program.

The draft for the July, 1976, revision of the West Virginia licensing regulations includes client record mandates relating to provisions of client record staff in numbers commensurate with the volume of service provided by a facility or program; recording of all care and treatment as it is given; legality of the client records; and legal responsibility to use the recorded information of past care and treatment in determining each step in continuation of the course of treatment. The improved recording which revision of the West Virginia licensing regulations will require is not adding new information to client/patient records--it is filling gaps of illegal omissions in the care and treatment of people, the cause for conviction in most malpractice suits.

A special education and training program, by registered record administrators and accredited records technicians, to improve standards of medical record services, including the organization of client treatment records, has been partially funded under the Providers Improvement Program, Division of Long Term Care, Department of Health, Education and Welfare. A description of the program can be found in a pamphlet, Medical Record Staff Development Project, available from the Department of Mental Health. Additional funds to implement this task related activity have been provided, and eight registered or accredited medical record consultants are ready to provide eighty hours of consulting services in regions 1, 2, 3, 4, 6, 7-8, 9, 10, and 11.

The 1976 revision also proposed a requirement for governing boards to establish personnel procedures to handle changes in status of personnel, including the executive director: giving proper notice; showing cause for action in writing; and right of appeal.

The mental health licensing program is still in the developmental stage and must remain so in the absence of earmarked funds to provide manpower, space, travel, and other expenses to operate in full force. To date, only limited activity has been possible because of lack of effectiveness of the program. The needs for this service are creating an escalation of demands which require full implementation and activation without further delay.

In the beginning, the importance of the licensing program was not recognized by providers until consulting services were started on a limited scale. Now these services are in greater demand than can be provided.

The mental health licensing program, in setting the precedent of quality operation and quality standard care, has resulted in a facility being granted a Blue Cross/Blue Shield Hospital Service contract, and the establishment of a policy by the Blue Cross/Blue Shield Hospital Service of Southern West Virginia to pay for community mental health services without question upon issuance of a license by the Department of Mental Health. A recent letter from Blue Cross/Blue Shield Hospital Services of West Virginia, addressed to the director of the mental health licensing program, states in part:

> "...I would like to quote from the contract itself which states our Plan's responsibility. 'Approved outpatient psychiatric facility meaning an administratively distinct governmental, other public, private or independent unit or part of such unit that provides outpatient mental health services, and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients. The term includes centers for the care of adults or children of the nature of hospital's outpatient psychiatric clinics, day-treatment centers, night-care centers and community mental health centers as defined in the Federal Community Mental Health Act of 1963. An approved outpatient psychiatric facility shall meet the standards as may be determined by the insurance carrier from time to time.'
>
> "Our Plan policy is to rely upon state agency 'approval' of these facilities. Our plan wishes to continue this policy in cooperation with state agencies, assuring ourselves and our membership that established standards and criteria been been met...."

IV. PLANS FOR DEINSTITUTIONALIZATION

A. INTRODUCTION

Sections on alternatives to hospitalization, and follow-up care, as well as pre-admission screening, are included in this section of the plan to reflect a measure of primary emphasis on the deinstitutionalization problem. There is an attitude of shared responsibility between community mental health centers and state mental hospitals as the department strives toward a unified system.

The locus of the thrust towards deinstitutionalization has traditionally been a function of the mental hospitals. While we are neither giving up, nor casting off, the responsibility of the hospitals, it must be recognized that the community mental health centers must increasingly share this responsibility.

Currently, seven institutions serve the population of West Virginia who are mentally ill. They are Barboursville, Huntington, Lakin, Spencer, and Weston state hospitals, and Guthrie and Roney's Point centers. Fourteen community mental health facilities, and their field offices, serve the catchment areas of these hospitals (See Table 3), and are responsible for pre-admission screening of patients when admission appears necessary, and follow-up care upon their release.

This charge is outlined in the current mental health law, specifically Sections 4 and 5 of Chapter 27, Code of West Virginia. Various medical policies issued by the director of the Department of Mental Health further relate to the admission of patients to state hospitals. Copies of these policies are appended to the plan. (Appendix 7.) In addition, written agreements between the hospitals and the community facilities spell out the responsibility of each in the admission/treatment/release process. See Appendix 8 for a sample contract.

By West Virginia state law (27-5-9,) each patient is required to have a treatment plan which is to be updated no less frequently than once every three months. Planning is therefore geared toward the most appropriate utilization of our public mental health facilities to meet the needs of our mentally ill citizens, as well as toward the continuing development of appropriate alternatives to full-time hospitalization for those individuals for whom such alternatives are feasible.

As in most states, West Virginia's public mental hospitals have traditionally served a very broad range of clients, including those suffering from acute psychotic disorders, chronic mental illness, mental retardation, organic brain syndromes, senile disorders, alcoholism, drug abuse, other behavior disorders, and those who are simply dependent and neglected. Given conditions of chronic overcrowding, staff shortages , and limited community support, it has often been difficult to sort out this population to determine who needed what kind of treatment for what kind of disorder.

TABLE 3. STATE MENTAL HOSPITAL SERVICE AREAS

Hospitals	Counties
Huntington	Cabell, Fayette, Lincoln, Logan McDowell, Mercer, Mingo, Monroe, Raleigh, Summers, Wayne, Wyoming
Lakin	Jackson, Mason, Putnam
Spencer	Boone, Calhoun, Clay, Kanawha, Pleasants, Ritchie, Roane, Tyler, Wirt, Wood
Weston	Barbour, Berkeley, Braxton, Brooke, Doddridge, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jefferson, Lewis, Marion, Marshall, Mineral, Monongalia, Morgan, Nicholas, Ohio, Pendleton, Pocahontas, Preston, Randolph, Taylor, Tucker, Upshur, Webster, Wetzel

Barboursville and Colin Anderson Hospitals, because of their specialized clientele, serve the entire state.

Guthrie and Roney's Point Centers serve selected patients from Spencer and Weston respectively.

Approximately one-third of the patients in the psychiatric hospitals are diagnosed as mentally retarded. This group of patients, many of whom have been hospitalized for many years, are extremely dependent upon the hospital and are poorly motivated toward any kind of independent existence away from the protection of the hospital. Programs geared to training in social and vocational skills and habits, rather than intensive psychiatric care, are needed for this group.

A second category is the geriatric population, who represent a rather diverse population. Many of these individuals are hospitalized because of disorders associated with advancing age. Others are long-term chronically mentally ill individuals who have grown old within the hospital setting. Still others are mentally retarded persons who have been hospitalized, again for many years. The services required for this group include psychiatric services, social habilitation and rehabilitation, as well as considerable environmental manipulation.

The chronically mentally ill population, which represents perhaps 25 per cent of the total hospitalized group, can be, in many instances, appropriately treated within community settings. For most of this population, however, some general supervision and activity planning will be required. Communities are often unable to tolerate the occasionally bizarre or unusual behavior exhibited by people in this group, and there must be careful planning for placement if the patient is to be able to make adjustment and to be accepted in the community setting.

Services are also needed for such specialized groups as psychotic, emotionally disturbed, or delinquent children; the alcoholic or drug abuser; or the person suffering from acute psychiatric disorders. Each of these groups requires some specialized services which differ in many respects from the treatment resources applied to the general psychiatric population. The degree to which inpatient services of the state mental hospital are required for these groups remains an open question.

Programs developed for these groups probably will remain relatively small. It should be noted that in a state with a total population of 1.75 million people, the small specialized service unit becomes extremely expensive simply because the number of patients to be served is relatively small.

It is estimated, for example, that the cost of adequate services to that group of psychiatric patients who require close and continuing security measures will range in the neighborhood of $100.00 per day. The capital investment for a facility to meet the needs of this group probably would be in the range of $5 to $10 million.

These needs will be met, in part, by the proposed construction of the central mental health facility. The central facility has been to provide a number of relatively small model and treatment programs for several diverse groups of patients. There will be a unit for disturbed children, an adolescent unit, a treatment unit for substance abusers, a geriatrics program, and an intensive treatment unit for acute psychiatric disorders. The rationale for development of this

facility is that new and innovative programs can be developed within a facility in which, because of its location, (close to Charleston, the state capitol) we should be able to attract well-trained, sophisticated mental health workers.

These new programs, once they have been developed and shown to be effective, can then be applied within the other state hospitals. It is also anticipated that this program will provide those services which are too expensive or for which staff does not exist in adequate numbers to be able to duplicate the services throughout the state. A major role of the new facility will be a research and training component, and it is anticipated that staff from the other state hospitals, including interns from various disciplines, will receive training from either the central facility, or in their own hospitals under the supervision of central facility staff.

The rapid development and expansion of community mental health services has resulted in more patients being treated in or near their homes rather that in distant state hospitals, and has permitted early discharges to effective aftercare services for many patients who, in the past, would have remained in the hospital for longer periods. This has contributed greatly to a shift in focus of treatment from the state hospital to the community level.

Adoption of a geographic unit system within the hospitals has permitted closer liaison with community programs and a more rapid return of patients to the community treatment. A number of different models of hospital-community liaison have been tried to improve communications toward the goal of a fully unified mental health system. The most promising of these models is one in which the community mental health center has been given the authority to operate its hospital geographic unit directly. Although a one-of-a-kind example, it is illustrative of the departmental stance relative to shared responsibility for deinstitutionalization, and the rationale for including pre-admission screening, follow-up care, and alternatives to hospitalization as related component programs.

Changes in law and social policy have also resulted in a reduction of the number of patients who can be involuntarily committed to the public mental health system. Through the combination of all of these factors, state public mental facilities have reduced populations from a level of 5,200 in 1964 to approximately 2,500 in 1976, as can be seen in Tables 4 and 5. The number of discharges by region are detailed in Table 6.

B. PRE-ADMISSION SCREENING

Since the July, 1974, amendments to the Code of West Virginia, which mandated pre-admission screening, considerable progress has been made across the state in implementing such programs. Diagnostic and evaluation services are available in each catchment area. Community mental health centers have been designated as official screening agents for each region/catchment area by the Department of Mental Health. (See Appendix 9.)

TABLE 4. ADDITIONS TO 9 DMH FACILITIES BY TREATMENT GROUPING AND AGE 7/1/75 - 6/30/76
TOTAL ADDITIONS = 4,772

TREATMENT GROUPING	AGE (YRS.)	NUMBER	PERCENT
GENERAL PSYCHIATRIC	18	223	4.67
	18-64	2,288	47.95
	65	431	9.03
ALCOHOLISM, DRUG ABUSE	18	9	0.19
	18-64	1,047	21.94
	65	52	1.09
MENTAL RETARDATION	18	253	5.30
	18-64	453	9.49
	65	16	0.34

Less than
Greater than or equal to

TABLE 5. RESIDENTS OF 9 DMH FACILITIES BY TREATMENT GROUPING DURATION OF STAY, AND AGE AS OF 6/30/76
TOTAL RESIDENTS =3,080

TREATMENT GROUPING	DURATION OF STAY	AGE (YRS.)	NUMBER	PERCENT
GENERAL PSYCHIATRIC	Less than one year	18	42	1.36
		18-64	350	11.36
		65	106	3.44
	One or more years	18	44	1.43
		18-64	699	22.69
		65	513	16.66
ALCOHOLISM, DRUG ABUSE	Less than one year	18	0	0
		18-64	94	3.05
		65	7	0.23
	One or more years	18	0	0
		18-64	12	0.39
		65	11	0.36
MENTAL RETARDATION	Less than one year	18	29	0.94
		18-64	113	3.67
		65	7	0.23
	One or more years	18	174	5.65
		18-64	787	25.55
		65	92	2.99

Less than
Greater than or equal to

TABLE 6. DISCHARGES FROM STATE HOSPITALS BY COUNTY AND REGION: 7/1/75 - 6/30/76
TOTAL DISCHARGES = 2,527

REGION/ CATCHMENT AREA	COUNTY	DISCHARGES BY COUNTY	DISCHARGES BY REGION/CATCH-MENT AREA
1-CA1	McDowell	79	214
	Mercer	105	
	Wyoming	30	
1-CA2	Fayette	80	153
	Monroe	12	
	Raleigh	47	
	Summers	14	
2-CA1	Logan	74	106
	Mingo	32	
2-CA2	Cabell	236	385
	Lincoln	52	
	Mason	39	
	Wayne	58	
3	Boone	19	383
	Clay	28	
	Kanawha	307	
	Putnam	29	
4	Greenbrier	50	146
	Nicholas	60	
	Pocahontas	19	
	Webster	17	
5	Calhoun	6	202
	Jackson	22	
	Pleasants	9	
	Ritchie	5	
	Roane	27	
	Tyler	2	
	Wirt	4	
	Wood	127	
6-CA1	Marion	87	201
	Monongalia	55	
	Preston	35	
	Taylor	24	
6-CA2	Braxton	42	273
	Doddridge	17	
	Gilmer	18	
	Harrison	117	
	Lewis	79	
7-8	Barbour	26	188
	Grant	12	
	Hampshire	10	
	Hardy	11	
	Mineral	28	
	Pendleton	9	
	Randolph	53	
	Tucker	17	
	Upshur	22	
9	Berkeley	29	44
	Jefferson	14	
	Morgan	1	
10	Marshall	58	166
	Ohio	88	
	Wetzel	20	
11	Brooke	31	66
	Hancock	35	

A number of meetings have been held throughout the state between court officials, community mental health centers, and the director of the Department of Mental Health to clarify the new mental health law and discuss its implementation. These 1974 amendments, which are designed to protect the rights of the patient, provide for involuntary commitment only after a court hearing, with the appearance of a physician or licensed psychologist, and then only if there is evidence that the patient will cause harm to himself or others. Many families, faced with the problems associated with involuntary commitment as provided by law, seek out other alternatives to their crisis problems.

Voluntary admissions can be made either through the community mental health center or directly to the hospital. In either case, the community mental health center and the hospital have committed themselves to work cooperatively in planning for the patient's treatment, as described in the aforementioned agreement.

A number of problems in the process of pre-admission screening have been identified:

1. In many areas of the state there is a lack of physicians available to be a part of the pre-screening team.
2. Quite often, pre-admission services are not properly coordinated with local hospitals, physicians, protective service units of the Department of Welfare, law enforcement officials, and public health services.
3. There is a lack of alternatives to institutional care in the state.
4. The West Virginia Code establishes procedures which are cumbersome for involuntary admissions to state hospitals, and does not mandate a truly unified system of mental health service delivery.

In an effort to alleviate these problems, the Department of Mental Health has developed the following objectives:

-In an effort to improve relations with community physicians and licensed psychologists, each community mental health center, under the guidance of consultants from the Department of Mental Health, will meet during 1977 with state and county medical societies, the state psychological association, where appropriate; county health departments; and individual physicians practicing in the region. During these meetings, the involuntary commitment and hospitalization procedures will be explained, as well as the necessity of physician involvement in these procedures.

-Prevention/intervention work will be done with families of the high risk groups. If it has not already done so, each community mental health center area will identify such a group by January, 1977. During 1977, these families will be seen regularly to lessen tensions in the family; intervene before a crisis situation develops that would require inpatient treatment; foster consistency in following a treatment regime; and plan for adequate supervision of medications.

-During 1977, emphasis will be put on a public awareness campaign in each region to make the populace aware of the community mental health center and the purpose it serves. This will be followed, in 1978, by a similar campaign directed toward an understanding of mental illness, and early detection and referral. Such campaigns will vary according to the facilities in each region, but would include monthly newspaper articles, and radio/t.v. spots as appropriate. Consultation will be provided through program consultants from the Department of Mental Health, including coordination with the Division of Mental Health Education.

-Educational efforts with other agencies will be implemented to encourage early identification and referral. Such sources might be emergency rooms, physicians, Department of Welfare, schools, court officials, law enforcement officers, et cetera. It is anticipated that these efforts will lead to a 30 per cent increase in referrals per region in 1977.

-Local in patient alternatives, innovative time-out, and emergency adult family care homes will be developed in accordance with the Alternatives to Hospitalization section. Such alternatives would give time for careful pre-admission planning, often relieving pressure on the patient and giving the community mental health center an opportunity to stabilize the patient by treatment.

-The department shall work for the revision of the state's mental health laws by 1980. Some of the changes considered are: simplify the process; decrease the awkwardness caused by transportation difficulties and shortages of M.D.'s; give more credibility to mental health professionals in decisions for admission; develop special criteria to simplify readmission for the high-risk, revolving-door target group; and clarify the code to allow commitment to community mental health centers as well as hospitals.

-A unified system of service delivery with multiple intake points will be developed, consistent with the state plan. Under this system, mental health workers would be the basic case managers; i.e., a patient could be committed to a center with the locus of treatment being in a local general hospital or supervised group home. No matter what the point of entry, the community mental health center would coordinate the case, developing an individualized treatment plan in conjunction with other professionals, working with the family, doing pre-release planning, release, aftercare, et cetera. Such a system should be implemented throughout the state by July, 1978.

C. ALTERNATIVES TO HOSPITALIZATION

West Virginia has done much in recent years to reduce the number of persons in state hospitals by development of community mental health centers. At this time, it is estimated that there are approximately 1,000 individuals who could benefit from less restrictive care, if appropriate facilities were available. Many of them simply have no other place to stay. Such individuals could be cared for in Community Alternative Living Modules (CALM), which, by definition, would encompass the many categories of need levels from single placement to sizable multiple placement situations, as can be seen in Figure 4. This care alternative may also be utilized as temporary or respite care to provide breaks in social or family conditions that might precipitate need for hospitalization. Although this plan is essentially oriented towards the mental health aspect, it applies equally well to the mental retardation program.

ALTERNATIVES TO HOSPITALIZATION: THE PRECARE/AFTERCARE CONTINUUM

The Individual's Psycho-Social Status	Maximum Independence 100% ←	Partial Independence	Total Dependence → 0%
The Individual's Life Situation	Home Life Independent Living	Close to homelike environment provided by Community Alternative Living Modules (CALM)	State Hospital Inpatient Unit of General Hospital Psychiatric Hospital Geriatric and Chronic Disease Hospital Nursing Homes
Community Mental Health System Responsibilities in Coordination with Other Programs and Services within the Community	Prevention, Precare through Consultation Education Counseling Cooperative Apartments Roommate Arrangements Arrangements	Halfway Houses Transitional Residences Long-term Residents Cooperative Apartments Personal Care Homes Vocational Rehabilitation Facilities Roommate Arrangements Foster care Placements Respite Care Partial Day or Night Hosptials or Care Programs Out-reach Programs	Consultation Education Outreach Programs Appropriate follow-up

The CALM concept would provide for appropriate care on an individual basis, and can be utilized for several aspects of care - precare, transitional care, and long-term care, as well as post-hospital or aftercare. It provides individual attention to assist a person in adjustment and readjustment to individual and community living.

The CALM facility can be private or publicly owned, although under the licensing purview of the West Virginia Department of Mental Health, and under the supervision of the local community mental health center. A CALM may be rented, leased, purchased, or constructed but must satisfy the needs of the individual, and comply with necessary legal codes for health and safety.

Along with the actual physical development of the CALM facilities, the community mental health centers will provide specific programs aimed at returning patients to the community. The goal of the program will be individual independence. This will be approached by pre-planning and training for release from the hospital into the CALM system, and a continuation of the hospital pre-release rehabilitation program while the patient is in the system.

It is the goal of the West Virginia Department of Mental Health to reduce the present state hospital population by 1,000 persons over the next five years. State hospital beds in West Virginia should be limited to only one per 1,000 of the general population by the year 1980, with further reduction by 1985.

It is estimated that there is an immediate need for appropriate placement of approximately 900 people, which, on the basis of 55 counties in the state, amounts to slightly over 16 persons per county, or one placement being needed for each 2,000 persons in the general population. CALM residences should be based on the following ratios:

-One halfway house should be associated with each state hospital based on one bed available for each 10,000 of the general population of the area.

-Other alternative care residences, such as foster care, room-mate arrangements, cooperative apartments, etc., should be based on availability of one bed per 1,000 persons, and located in each of the 55 counties of the state.

Each of the above units is planned to provide for not more than 8 to 12 persons in a homelike atmosphere. The buildings should be homelike, and not resemble institutional facilities in any way. State and local legislative changes might be necessary to assure establishment of these facilities. Changes in zoning laws may be one of the necessary measures. Continued cooperation with the authorities is planned to provide the required incentive for individuals or families in a community to become involved in this program. Continued dialogue with the Department of Welfare is planned to bring about, within the next year, an equitable distribution of supportive funding to assist the individuals involved, as work progresses towards independent living for those with capabilities.

Concurrent with this program for those with the most potential for readjustment to normal living, concern will be exercised for the other 1,800 persons who are hospitalized, either with long-term problems of retardation or ailments of the aged. Many of this group may eventually be returned to home communities.

An education program aimed at families will focus on the desirablity of caring for their family members at home, rather than resorting to terminal type custodial care in hospitals. Families should be assisted financially to provide for this necessary care, and supervised or monitored in whatever manner is most appropriate for the situation.

Several groups within the state are involved in developing community facilities. Several studies relating to alternatives to hospitalization are available but not included in this plan, and are on file with the West Virginia Department of Mental Health.

The Department of Mental Health makes the following recommendations concerning the development of Community Alternative Living Modules:

-Responsibility for planning, coordination, construction, and maintenance should be mutually determined between the community mental health/mental retardation centers and the Department of Mental Health, with technical assistance and support being the responsibility of the latter.

-Primary responsibility for monitoring, supervision, and evaluation of the CALM programs should rest with the community mental health/mental retardation centers, with accountability to the Department of Mental Health through continuing contracts.

-Each facility must meet all licensing regulations, both those of the Department of Mental Health, and those of other significant agencies such as the Department of Health and Welfare, and the Fire Marshall's office.

-Paraprofessionals and volunteers should be used wherever practicable.

-Funding should be sought at all levels to implement a coordinated program of alternatives to hospitalization.

D. FOLLOW-UP CARE

Every discharged mental health patient has a right to receive a plan of care upon discharge which, if followed, will enable him to maintain treatment gains, maximize his independent functioning, assure the availability of needed residential and supportive services; assure that he does not suffer social isolation or exploitation; and increase the probability that he will not need to return to inpatient care. In order to assure that these services are available, the hospital and community mental health center must work very closely together to assess what the patient's needs are, what services are available in terms of these needs, and who will provide what to the patient when, how, and where. Therefore, when the patient is released from the hospital, this information is available to assist in the follow-up care of the patient.

Theoretically, the hospital and community mental heath center are in weekly touch with each other so that each can be kept apprised of the status of a patient referral. As a means of carrying out this joint responsibility for patient care, the Department of Mental Health has encouraged the development of written contractual agreements between the Department of Mental Health, state hospitals, community mental health centers, and other public and private agencies, which state specifically the services each can and will provide.

A cooperative agreement is in effect between the Department of Mental Health and the Department of Welfare, to establish an orderly, effective system for returning individuals to the community and for providing supportive services once the individuals are back in the community. Hospital staffs have been advised of the procedure for referral on an individual for Supplemental Security Income so that eligible clients can receive an income within 30 days of hospital discharge.

The community mental health centers provide the traditional kinds of services, i.e., diagnosis and evaluation, psychotherapy, medication, etc., which are indeed vital services for discharged patients. In addition to these traditional services, the core of a good aftercare program is the outreach ability of the center. The community mental health programs have field workers who have the responsibility of going out to where the patient is, and assisting him and his family in securing needed services. The field worker is frequently the first person in the community who knows the patient is home. He can trigger the various medical, social, and financial agencies to the patient's needs. Since transportation is a major problem for many West Virginians, there is a need to increase the number of positions for field workers in community mental health services.

The community mental health centers also attempt to educate communities so that they will understand the need for a total network of services to provide the necessary supports for patients returning to the community. Areas of support can be categorized under the following headings: housing; income; vocational and educational opportunities; recreational outlets; health care; spiritual guidance; transportation; and general counseling. Although most communities have some element of these services, they do not generally make them available except in cases where the breakdown of the client is complete. Then help comes all too often in the form of crisis services, emergency wards, police, and the courts.

It is the responsibility of the Department of Mental Health to try and gain the cooperation of all mental health facilities and programs, and to assist in the coordination of these services to assure that they are available to patients and their families. As a means of getting agency workers together to discuss common problems, and to enhance community understanding of mental health needs, the Department of Mental Health sponsored aftercare workshops which were held in each hospital region. Representatives from community mental health centers, state hospitals, state and local welfare departments, regional social security offices, and local vocational offices participated in the workshops.

Similar workshops are scheduled to be held four times a year in each hospital region. The content of the workshops will respond to expressed needs of the participants, but will be aimed toward alleviating the problems associated with assuming continuity of care between the hospital and the community.

V. PERSONNEL

A. SUMMARY OF CURRENT PERSONNEL CAPABILITY

Table 7 shows current employee resources of the department and of community affiliates, and projections of resources needed by 1980, expressed in full-time equivalent positions. Data for the department includes Central Office; state hospitals at Barboursville, Huntington, Lakin, Spencer, and Weston; Colin Anderson, Greenbrier, Guthrie, and Roney's Point centers; and the proposed central mental health complex.

B. FIVE YEAR PROJECTION OF PERSONNEL NEEDS

The major areas of growth and expansion of the Department of Mental Health are anticipated to occur at three facilities -- Colin Anderson Center, Greenbrier Center, and the proposed central mental health complex, 20 miles north of Charleston. A modest increase in the size of staffs is anticipated, as seen in Table 7. Construction of community mental health centers will be completed, and additional programs implemented during the next five year period, requiring increased staff. Projected department needs are based on the minimum staffing ratio criteria determined in conjunction with Wyatt V. Stickney, U.S. District Court, Middle District Court of Alabama, 1972. Projections for community mental health centers assume a 45 per cent increase in programming by 1980 over that of 1976.

C. EFFORTS TO DEVELOP AND MAINTAIN AN ADEQUATE NUMBER OF MENTAL HEALTH PERSONNEL

1. Salary and Fringe Benefits

The West Virginia Department of Mental Health has been a civil service agency since 1958. As such, the great majority of salary and fringe benefits available to its employees are subject to jurisdiction of the West Virginia Civil Service System and other state agencies. The current compensation plan for the Department of Mental Health is on file in its central personnel office, as well as in the Civil Service Commission. A new compensation schedule has been prepared by the civil service staff, and has recently been approved.

Salaries and fringe benefits for employees of community mental health centers closely parallel those enjoyed by state employees; salaries generally remain competitive with those in neighboring states.

Leave benefits for civil service employees, as well as other employee benefits, are described in West Virginia Civil Service System - Employees' Handbook - July, 1975. Additional fringe benefits have been summarized in a pamphlet entitled Fringe Benefits for Employees of the State of West Virginia, from the West Virginia Civil Service System, July 1, 1975.

TABLE 7. CURRENT AND PROJECTED MENTAL HEALTH MANPOWER, STATE AND COMMUNITY, AS OF MARCH, 1976

CATEGORIES[1]	DEPARTMENT OF MENTAL HEALTH				COMMUNITY MENTAL HEALTH CENTERS			
	March 1976	Projected 1980	Increase	Percent Increase	Fiscal 1976	Projected 1980	Increase	Percent Increase
DIRECT CARE[2]	1669	2082	413	24.8	388	564	176	45.4
ADMINIS-TRATIVE[3]	355	398	43	12.1	158	234	76	48.1
SUPPORT AND MAINTENANCE[4]	997	1117	120	12.0	29	41	12	41.4
ALL CATEGORIES	3021	3597	576	19.1	575	839	264	45.9

1. The data given are number of full-time positions or their equivalent.
2. Includes all personnel having direct contact with patients and clients, such as physicians and aides.
3. Includes all administrative staff, such as all secretaries and fiscal office staff.
4. Includes maintenance personnel, housekeeping staff, food service staff and similar occupations.

Insurance benefits are summarized in a booklet, entitled State of West Virginia Group Benefits Plan, prepared by the Public Employees' Insurance Board of the State of West Virginia, April 1, 1975.

Retirement benefits are described in detail in a handbook furnished by the West Virginia Public Employees' Retirement System, November, 1974, entitled, Your Retirement System.

All of the above publications are available from the Department of Mental Health.

2. Career Development

The West Virginia Department of Mental Health published a hospital staff development manual in 1970, which is in use for inservice training of selected employees. There is, in addition, a general orientation program for all new employees. Copies of this manual are on file in the department.

A Social Seminar is available through the Division of Mental Health Education to meet specific needs for further training of mental health personnel.

3. Academic Training

The West Virginia Department of Mental Health receives a modest appropriation from the legislature for research and training purposes. These funds are administered by the stipend committee in the central office of the department, and are used primarily to assist deserving eligible employees throughout the department in further academic training.

4. Continuing Education

The West Virginia Department of Mental Health has made significant headway in the development of a continuing education program. The National Institute of Mental Health funded a three-year continuing education project to provide graduate level experience as an interim between professional preparation and actual on-the-job training. Throughout the project, the participants have been encouraged to make suggestions. Resulting program designs include a field training experience in two cooperating community mental health centers; a summer seminar program; two short courses; and an annual conference. Continued funding of this program remains a high priority objective.

5. Recruiting Activities

Contracts are maintained with placement offices at the West Virginia Insititue of Technology, West Virginia State College, Marshall University, West Virginia University, and other state colleges. On-campus recruiting is also conducted on the respective campuses. Inquiries from in- and out-of-state mental health

professionals are answered, filed, and frequently forwarded to civil service.

6. Employee Rights

The West Virginia Department of Mental Health historically has been understaffed in all job categories. Even with a significant decline in patient population over the past eight years, our hospitals do not yet meet minimum staffing requirements to qualify for certification or accreditation.

During the next five year period, the rate of decline in patient population in our hospitals will decrease because those patients remaining hospitalized tend to be those for whom rehabilitation efforts are substantially less successful. It is anticipated that during this period there will be a modest increase in the total number of personnel employed by the department.

Because of the foregoing considerations, it is deemed unlikely that any Department of Mental Health employees will be displaced by deinstitutionalization. Nevertheless, the department recognizes the remote possibility that it might be necessary at some future date to assist in the relocation or transfer of a certain number of employees. It is therefore desirable to specify procedures by which recourse can be made, if and when circumstances should so dictate.

Employees with permanent civil service status are afforded substantial job security. Thus, for example, they will not be subject to separation except for cause, curtailment of work, or lack of funds. These employees' rights are described in the following documents, available from the department: Civil Service System Law, Code of West Virginia, Chapter 29, Article 6, Section 8, Paragraphs 10 and 11; Federal Standards for a Merit System of Personnel Administration, "Layoffs and Separations"; West Virginia Civil Service Rules and Regulations, Article XI, Section 2, "Dismissals"; ibid, Section 4, "Reduction of Force"; ibid, Appendix C, "Reduction in Force Formula"; and a memorandum dated May 21, 1973 from James R. Clowser, Deputy Director, West Virginia Department of Mental Health, to hospital superintendents on the subject "Layoff Procedures."

Transfers of employees with permanent civil service status may be effected on an intra-agency and inter-agency basis. (West Virginia Civil Service Rules and Regulations, Article X, Section 7.) The department pledges to implement such transfers, where appropriate and applicable, on behalf of any employee affected by deinstitutionalization activities. The department further pledges to assist employees in various training and retraining programs.

For a number of years, this department successfully conducted a "Professional Aide Training Program." Many of the staff, and all of the materials utilized in this program, are still available to

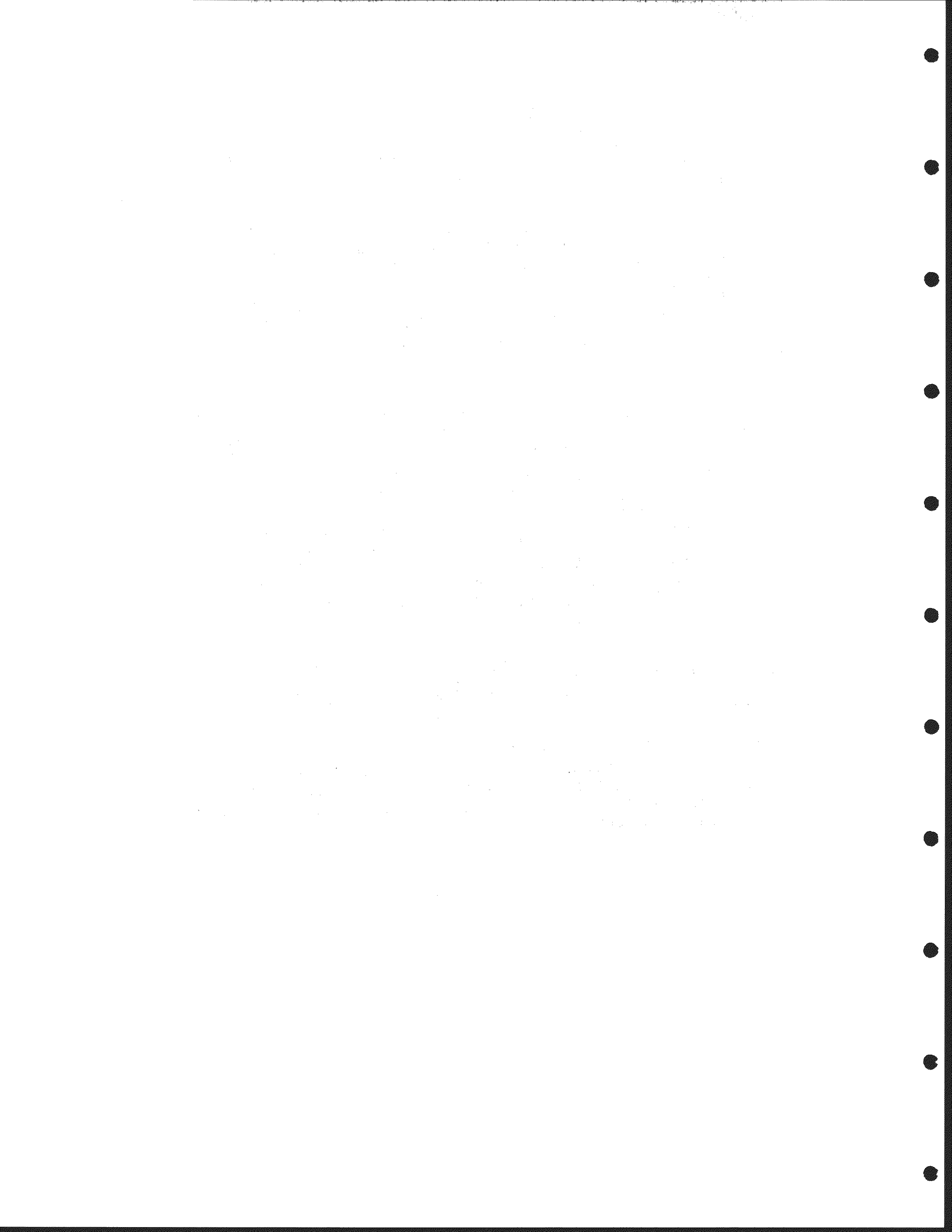
to the department for a resumption of the original program, or a modification thereof. Guidelines have been developed for the implementation of such a training program directed toward teaching precare and aftercare workers in the field of community mental health. The guidelines were published in March, 1976, and are filed in the department.

This department further pledges its assistance to affected employees by working in full cooperation with the state's employment services and vocational and technical training schools to meet their educational, training, and employment needs. Funds appropriated to the stipend committee will be reserved for use by employees needing assistance in training and retraining. Here again, efforts will be continued to secure new funding sources, as well as to maximize existing sources.

In view of the fact that it is not anticipated that any employees will be displaced by deinstitutionalization activities, it is unlikely that statistical data during the next five years will include any layoffs or separations as a result of the expansion of the community mental health center program. In the event such a situation does arise, this department will provide an annual summary of efforts to meet the employee needs identified in the previous year. These efforts will be concentrated on three major groups of employees: those for whom assignments will be available at comparable levels using existing skills; those who will need additional training; and those for whom placement will be a problem because of relocation or skill factors.

This department pledges to exert maximum effort, consistent with applicable West Virginia Civil Service rules and regulations, to guarantee the employment of employees affected by actions designed to comply with the provisions of Public Law 94-63.

It is a further objective of the West Virginia Department of Mental Health to establish throughout the entire mental health service delivery system a set of uniform standards for personnel administration, salary administration, job specifications and titles, and employee fringe benefits.



PLANNING ACTIVITIES

A. INVENTORY OF EXISTING FACILITIES

The West Virginia Department of Mental Health currently has available the NIMH Inventory of Mental Health Facilities. However, there are two associated problems:

- The NIMH Inventory does not totally correspond with the information requirements of the state plan guidelines.
- The NIMH Inventory almost certainly has not identified all of the mental health resources which are in existence in West Virginia.

Therefore, the West Virginia Department of Mental Health will conduct an annual inventory under provisions of its licensing program, with the responsibility for identifying mental health resources placed at the regional (or catchment area) level. The content of the inventory will be determined by the director of the licensing program, and will encompass at least the requirements of the state plan guidelines.

B. ASSESSMENT OF CATCHMENT AREA NEEDS

1. General Introduction

The focus of the section is the systematic assessment of needs of catchment areas for general mental health services. Needs for specific programs within regions are addressed in Chapter VII, "Community Programs", beginning on page 57. The results of this needs assessment will be incorporated in the prioritization of regions discussed in section C of that chapter, page 63.

2. Methods of Procedure

The Division of Community Services will have responsibility for carrying out the needs assessment procedures, and has designated an individual to serve as the project director for needs assessment. This individual will receive consultation and technical assistance from the Data Management Section of the department. Other staff and affiliated personnel will be given the opportunity to review and comment on the methods and procedures. The tasks for the project director will include, but not be limited to, the following:

a. Conceptualize, define, and clearly state the goals of the needs assessment program.

b. Review existing efforts, materials, and proposals for needs assessment for potential use.

c. Locate and use resources such as data, people, and relevant efforts of various government agencies and other organizations.

This will include a survey of data and resources available from community mental health centers.

d. Review, select, and carry out the selected needs assessment procedures.

e. Report to and make recommendations to the Division of Community Services, the director, and the Advisory Council on use of information in planning, and on actual plans as indicated by interpretation of project results.

f. In general, assist the department to maintain responsiveness to fluctuations and transition in the community.

3. Technical Considerations

The procedures, data collection, and data analysis techniques used will be chosen so as to be suitable for use in the prioritization of regions, as described in section C. The project director will determine costs of various approaches and recommend to the director of Community Services methodologies of choice. Techniques to be considered are:

a. Key Informant. Information obtained from individuals who are in a good position to know what the needs and service utilization patterns of their regions are, using interviews, questionnaires, or conferences.

b. Community Forum. Similar to the Key Informant, but involves a series of meetings which are open to all. Residents of the community are invited.

c. Utilization Rates. Enumeration of persons using existing services within the community.

d. Social Indicators. Inference of need from various descriptive statistics found in public records and reports such as national census data, vital statistics.

e. Field Survey. Utilization of data collected by interview or questionnaire from a sample of, or the entire population within the community.

Cost and feasibility are important issues, as department resources are severely limited. Every effort will be made to use the resources of other organizations and state agencies with related interests. The project director will particularly investigate the possibility of using West Virginia University, Marshall University, and Morris Harvey College students and professors as resources for conducting community forums or field surveys.

Existing community mental health center needs assessments are inappropriate for use as they have not been conducted according to

federal standards of systematic procedures statewide. It is planned, however, to develop methods of utilizing the resources of community affiliates for estimating the comparative needs of the various catchment areas for facilities and services.

4. Present Status/Previous Efforts

The department has utilized the Key Informant approach in the form of Governor's Conferences on Mental Health Planning, such as the one held in January, 1975, which resulted in recommendations contributing to this plan, and ongoing planning efforts. The department regularly collects admission and case load statistics from all affiliate organizations which receive state funds for mental health services, and is in the process of improving its data base (utilization rates), as well as maintaining statistics for the state-operated mental health facilities.

The department does have the NIMH Demographic Profile data output; however, the data was aggregated using a regional structure which is no longer in effect. We will request data from NIMH based on our current regional structure as seen in Figure 3, page 22 At this time, we do not have the clerical support to hand aggregate the data, nor the support necessary to do or hire programming to use the raw data tape.

The Division of Community Services has, with commentary by community programs, developed and is testing a preliminary formula for allocation of new state funds, which incorporates, among others, certain social indicator factors selected for their potential applicability for West Virginia. These social indicator factors are:

- Unemployment rate;
- A dependency ratio (number of persons under 18 plus number of persons 65 and over divided by number of persons in the work force);
- School dropouts; and
- Isolation factor (population density).

This formula is discussed in more detail in the section on prioritization of regions, page 54, and in Appendix 10.

The department also has on hand a design for a field survey project, compiled during 1972 and 1973, in conjunction with the Department of Health, under the direction of the director of the licensing program. Although it requires some design modification, it will serve well as a basis for a field survey, if such is determined feasible and necessary.

5. Developmental Plans

The most economically feasible approaches to needs assessment involve the use of utilization rates and social indicators as measures of needs. In order to implement any other approaches, it

will be necessary to secure resources beyond those which have historically been made available, particularly in view of the need for systematic reliable data collection on a statewide basis.

Current planning envisions a developmental approach in which needs assessment procedures can be extended and refined as resources can be secured, to the extent necessary. As a first approximation, the Division of Community Services has used a combination of a few social indicators and utilization rates to estimate general regional needs for mental health services.

The model suggested in the NIMH guidelines for Public Law 94-63 will be studied in more detail; however, certain of the recommended factors appear to be of little value in estimating differential needs for services in the state of West Virginia. A more specific model will be examined, using systematic procedures for selecting factors and possibly weights. More detailed developmental plans with specific time lines will be developed by the project director.

C. PRIORITIZATION OF REGIONS

The Department of Mental Health is at present using a formula for allocation of funds, which does not meet federal requirements, in that it does not take into account the extent of existing facilities. This formula approach is described in Appendix 10.

The project director for needs assessment, in conjunction with the Data Management Section, will determine a method of combining the data from the survey of mental health facilities and the needs assessment program to determine a ranked priority of needs according to federal guidelines. The completion date for a first set of priorities is dependent on the completion date for the survey of facilities, which has not been determined.

These priority rankings, along with any special consideration which might suggest departing from this ranking in terms of completion of comprehensive center programs, will be incorporated into the annual review of the state plan. As needs assessment techniques evolve, the method of priority ranking will be evaluated and modified.

D. COORDINATION OF PLANNING

The staff of the Department of Mental Health continually reviews and monitors the West Virginia Comprehensive Health Plan and other state and regional plans; the state comprehensive mental health centers' plans, and the plans for the Division on Alcoholism and Drug Abuse. The department has effective relations with other 7 state agencies such as the Division Vocational Rehabilitation, and the Departments of Welfare, Health, and Education.

Close cooperation is also maintained with the Governor's Committee on Crime, Delinquency, and Corrections, the Commission on Mental Retardation,

and with the West Virginia Department of Public Safety. Coordination is maintained with Comprehensive Health Planning. Table 8 outlines inter-agency cooperation and the department's concern and participation in such cooperative efforts.

Within local communities, the community mental health centers and the centers on alcoholism and drug abuse provide guidelines, general assistance, and training for the staff of other agencies and community organizations which are developing prevention, treatment, and rehabilitation programs for both the mentally disabled and the general population. A great emphasis is placed on coordination of services and inter-agency referrals for the client and/or his family.

Contracts are developed by the department for purchase of services provided through the community mental health centers. (See Appendix 11 for a sample contract.) The Division of Community Services, the Division on Alcoholism and Drug Abuse, and other departmental units, have a coordinated approach providing guidelines and support for the community mental health centers and the affiliated centers on alcoholism and drug abuse.

A liaison committee comprised of the director and four leadership level staff members from the department, and five appointed members from the West Virginia Association of Mental Health/Mental Retardation Programs of West Virginia meets regularly to address such issues as mutually developed accountability and responsibility; management information systems; program evaluation; research; etc.

TABLE 8. WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH
PLANNING COORDINATION
June, 1976

PROGRAM	GROUP	DEPARTMENT OF MENTAL HEALTH ASSIGNMENT	FUNCTION
Health Planning	State Comprehensive Health Planning Agency	Director, Division of Community Services	Coordination
	Health Systems Agency	Director, Division of Community Services	Coordination
Developmental Disabilities Program	Commission on Mental Retardation	Director	Advisory
Alcoholism/Drug Abuse	Department of Mental Health	Division of Alcoholism and Drug Abuse	Planning/ Implementation
Special Education	Department of Education	Mental Health/Education Joint Committee	Coordination
Welfare Programs a. Title XVIII, XIX (Medicaid, Medicare) b. Title XX (Social Services)	Department of Welfare	Division of Professional Services	Coordination/ Planning
		Division of Community Services	Coordination/ Planning
Vocational Rehabilitation Act	Division of Vocational Rehabilitation	Division of Professional Services	Coordination
Older Americans Act	Commission on Aging	Director	Advisory/ Coordination
Housing and Community Development Act	Office of Federal/State Relations	Not Assigned	------
Law Enforcement Agency Act	Governor's Committee on Crime, Delinquency, and Corrections	Director, Division of Professional Services	Advisory/ Planning
Citizens for Mental Health	W. Va. Assn. for Mental Health	Director, Executive Division	Advisory
Citizens for Mental Retardation	W. Va. Assn. for Retarded Citizens, Inc.	Director, Division of Community Services	Advisory
Regional Economic Development	Department of Commerce	Not Assigned	------

VII. COMMUNITY PROGRAMS

A. MENTAL HEALTH REGIONS/CATCHMENT AREAS

1. Review of Regional/Catchment Area Designation

To meet the requirements of P.L. 94-63, the Department of Mental Health was asked to examine its present regional/ catchment area structure, and make changes as necessary to bring it into compliance with federal guidelines. Prior to making this determination, the department conducted an open meeting to discuss issues relative to the designation of mental health regions/catchment areas. A memorandum was sent to all community mental health administrators, the State Comprehensive Health Planning "A" agency, and the Governor's Office of Federal-State Relations advising them of such a meeting, and requesting recommendations. (Appendix 12.)

Ten of the 13 responses received by the department recommended that the present regions/catchment areas remain the same. However, there were responses that recommended the department consider alternatives to the current configuration of mental health regions/catchment areas. Various alternatives were analyzed, with the three most feasible being considered and discussed at the Department of Mental Health planning meeting relative to this issue.

Alternative #1 - That the Department of Mental Health's community mental health regions would continue to be consistent with the current West Virginia State Plan for Construction of Community Mental Health Centers, as approved by the Department of Health, Education and Welfare, June 14, 1973. (A map of these regions can be found on page 24, Figure 3; the letter of approval from HEW is entered as Appendix 13.)

Alternative #2 - That the Department of Mental Health's community mental health regions be consistent with the planning and development regions of the state of West Virginia, as seen in Appendix 14.

Alternative #3 - That the Department of Mental Health's community mental health regions align with current or apparently logical medical and social service areas.

During the discussion it was pointed out that all but three of the present regions were in compliance with federal guidelines. Letters from the directors of the community

mental health centers in these regions were read, requesting that no changes be made (Appendix 15.) At the conclusion of the meeting, a motion was made and approved by the group to recommend to the director of the Department of Mental Health that the mental health regions/catchment areas remain consistent with the current West Virginia State Plan for Construction of Community Mental Health Centers. (See Appendix 16.) The director of the Department of Mental Health took this recommendation, considered it and other alternatives, and made the decision to maintain the current mental health regions/catchment areas.

The Department of Mental Health will utilize essentially this same procedure in reviewing the state's mental health regions/catchment areas every five years. The criteria that will be used in this evaluation will be in accord with federal guidelines. State agencies and community mental health centers will continue to be consulted in an attempt by this department to involve those organizations that would be most affected by the redesignation of regions/catchment areas. Any determination the Department of Mental Health will make regarding the designation of mental health regions/catchment areas will be made only when the department is convinced that a redesignation would enhance the delivery of community mental health services.

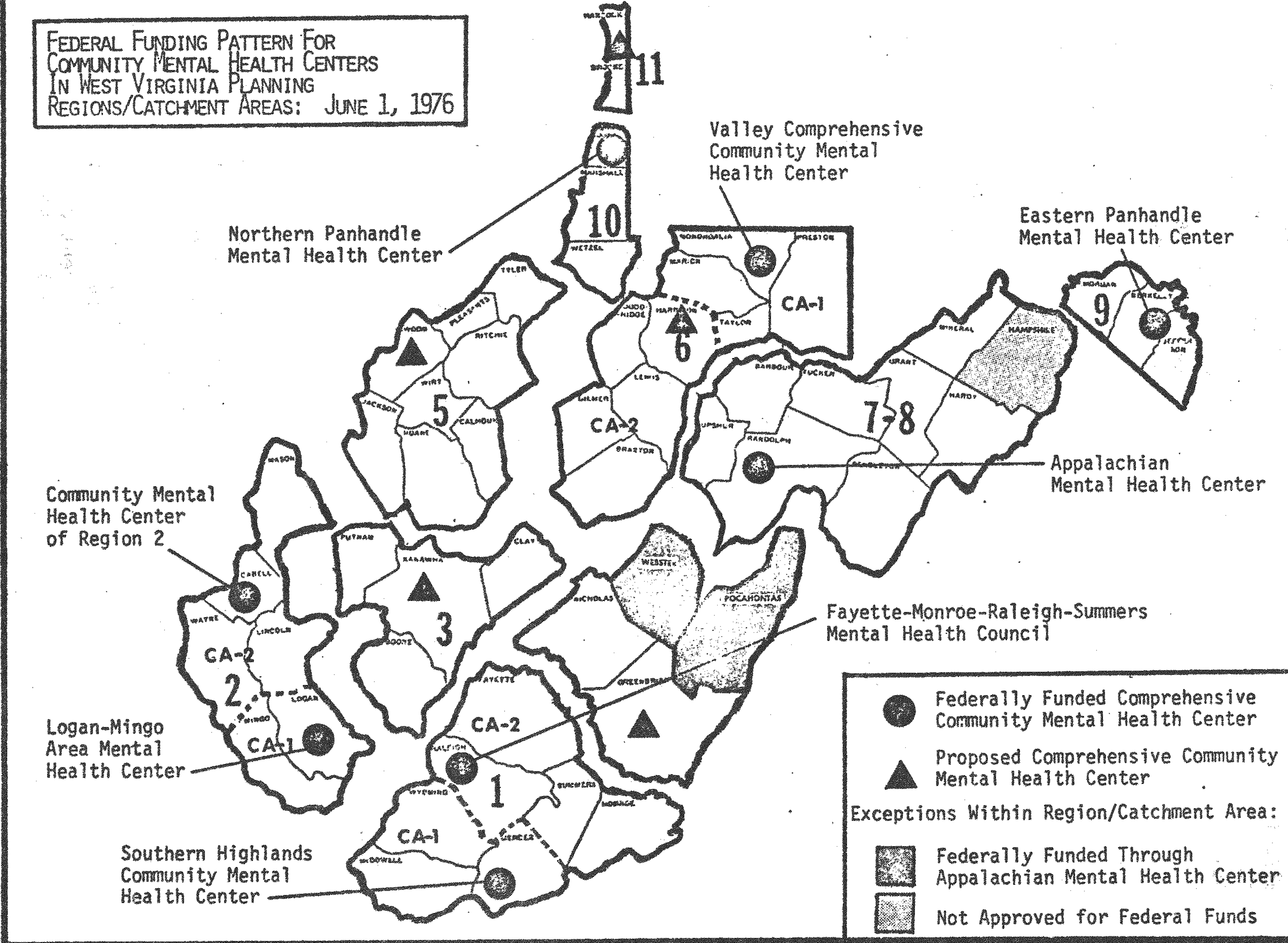
2. Description of Current Regions/Catchment Areas

A description of the current regions/catchment areas according to the most current population estimates may be found in Table 9.

3. Justification of Current Catchment Areas

Program effectiveness was the priority concern of the Department of Mental Health and the community mental health program administrators in establishing community mental health regions/catchment areas. In addition to federal guidelines, department criteria were utilized in the decision to maintain the current mental health regions/catchment areas. However, three of the current mental health regions failed to meet the population range specified in federal guidelines.

The West Virginia Department of Mental Health is satisfied that there is sufficient justification to warrant these three exceptions. Since the proposed configuation of mental health catchment areas would continue to be consistent with the West Virginia State Plan for Construction of Community Mental Health Centers, the many years of planning that have gone into the development of community mental health programs in these and other regions will not be destroyed, as would happen if the regions were realigned. (That these programs are already well established can be seen by the pattern of federal funding, Figure 5.)



FEDERAL FUNDING PATTERN FOR COMMUNITY MENTAL HEALTH CENTERS IN WEST VIRGINIA PLANNING REGIONS/CATCHMENT AREAS: JUNE 1, 1976
Northern Panhandle Mental Health Center
Valley Comprehensive Community Mental Health Center
Eastern Panhandle Mental Health Center
Appalachian Mental Health Center
Community Mental Health Center of Region 2
Fayette-Monroe-Raleigh-Summers Mental Health Council
Logan-Mingo Area Mental Health Center
Southern Highlands Community Mental Health Center
11
10
9
7-8
6
5
3
2
1
CA-1
CA-2
Federally Funded Comprehensive Community Mental Health Center
Proposed Comprehensive Community Mental Health Center
Exceptions Within Region/Catchment Area:
Federally Funded Through Appalachian Mental Health Center
Not Approved for Federal Funds

Proceeding on the federal approval granted West Virginia in 1973, (Appendix 13), the Department of Mental Health approved, encouraged, and supplemented community mental health programs in all of the state's 13 catchment areas. Contracts have been written, facilities planned, and commitments made by both state and local authorities. The ramification of a redesignation would not only have a devastating impact on those catchment areas not now in compliance, but the effect would most assuredly have negative consequences on already overloaded neighboring catchment areas. Simply, the planning, effort, and commitment that has gone into development of this proposed network of 13 mental health regions/catchment areas is such that any substantial changes would drastically curtail community mental health programming in West Virginia.

In order to make this determination, it was necessary for the Department of Mental Health to scrutinize the unique problems and assets peculiar to rural areas in general, and particularly to West Virginia. Factors such as established health and social service patterns utilized by citizens of catchment areas; cultural characteristics of the population which dictate how people perceive <u>their</u> community; the services they require, when, where, and how; and a realization of just where West Virginia is in the development of a state network of community mental health programs were considered by the staff of the Department of Mental Health in making this determination.

The Department of Mental Health, in recommending this configuration of catchment areas, is responding to community and state needs within the framework of federal guidelines. It is felt that these 13 catchment areas are most appropriate for the continuing delivery and development of community mental health programs.

Note that Region 9 has a population less than the minimum allowed by guidelines. However, it is a prior existing approved center with less than 25 per cent deviation from the 75,000 base population.

The Department of Mental Health received local justification for maintaining Regions 3 and 11 which, along with the reasons previously discussed, were accepted as sufficient justification for not changing these areas. (See Appendix 15.)

B. DESIGNATION OF POVERTY AREAS.

In West Virginia, 12 of the 13 currently designated region/ areas meet these poverty criteria, in that the income of 15 or more per cent of the entire region/catchment area falls below the poverty level, as can be seen in Table 10. Data for Region 11 does not support a poverty designation in any way.

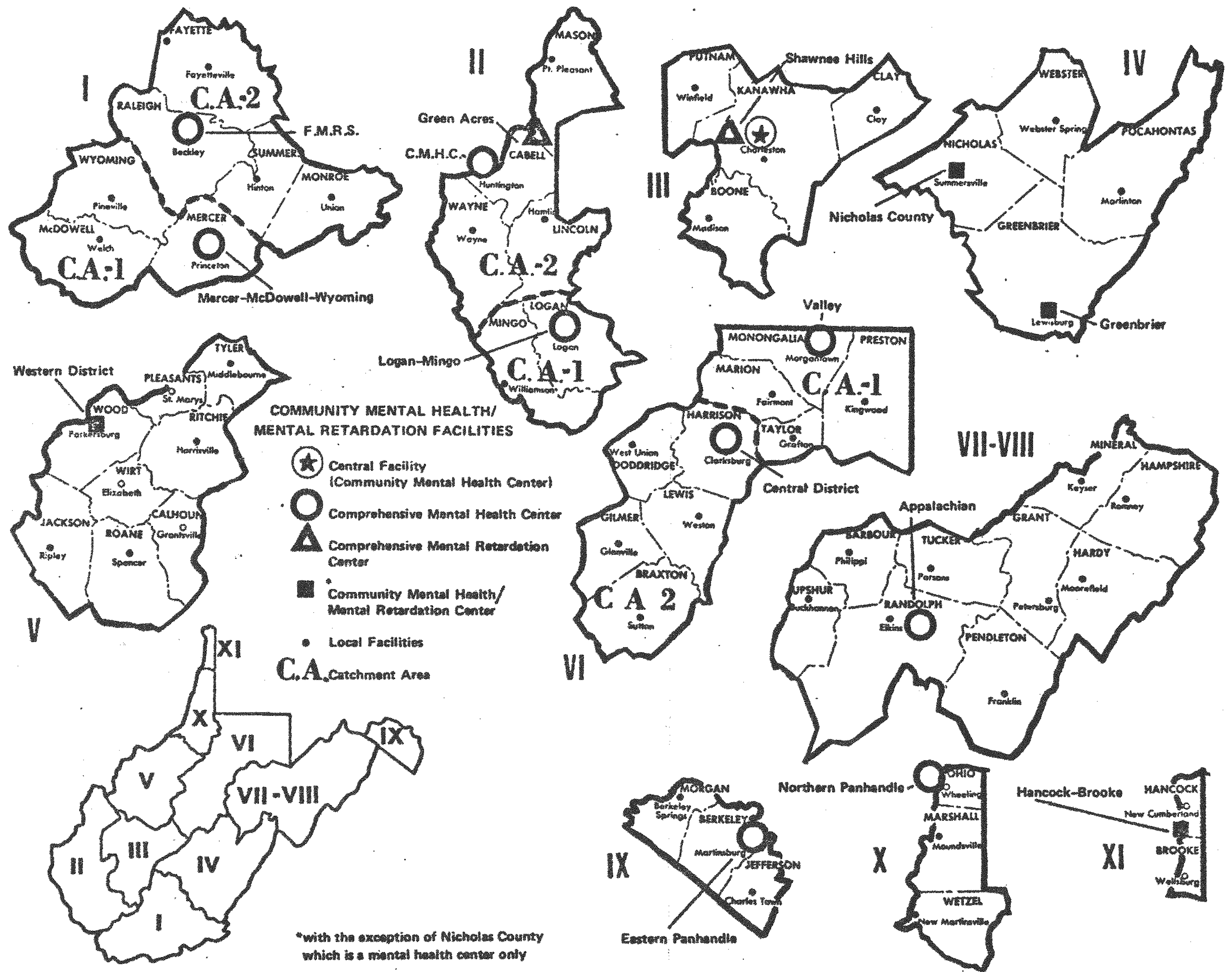
Public Law 94-63 states that there must be "one or more subareas which are characterized as subareas of poverty." The criterion for a "subarea of poverty" (6-30-76) is that 15 per cent or more of the population have incomes below the poverty level as specified by the

TABLE 9. POPULATION OF STATE MENTAL HEALTH REGION/CATCHMENT AREAS

REGION/ CATCHMENT AREA	COUNTY	POPULATION OF COUNTY[1]	POPULATION OF REGION/CATCH-MENT AREA
1-CA1	McDowell	50,100	148,200
	Mercer	65,900	
	Wyoming	32,200	
1-CA2	Fayette	52,500	153,000
	Monroe	11,500	
	Raleigh	75,500	
	Summers	13,500	
2-CA1	Logan	46,100	79,600
	Mingo	33,500	
2-CA2	Cabell	105,700	189,800
	Lincoln	20,100	
	Mason	25,800	
	Wayne	38,200	
3	Boone	27,300	290,800[2]
	Clay	9,700	
	Kanawha	223,700	
	Putnam	30,100	
4	Greenbrier	82,900	75,500
	Nicholas	24,000	
	Pocahontas	8,500	
	Webster	10,100	
5	Calhoun	7,400	162,600
	Jackson	21,900	
	Pleasants	7,600	
	Ritchie	10,300	
	Roane	14,800	
	Tyler	9,800	
	Wirt	4,400	
	Wood	86,400	
6-CA1	Marion	63,600	174,100
	Monongalia	68,800	
	Preston	26,700	
	Taylor	15,000	
6-CA2	Braxton	13,200	120,300
	Doddridge	6,600	
	Gilmer	8,000	
	Harrison	74,800	
	Lewis	17,700	
7-8	Barbour	15,300	132,600
	Grant	8,900	
	Hampshire	13,000	
	Hardy	9,100	
	Mineral	24,500	
	Pendleton	7,400	
	Randolph	25,900	
	Tucker	7,400	
	Upshur	21,100	
9	Berkley	40,200	72,500[2]
	Jefferson	23,800	
	Morgan	8,500	
10	Marshall	38,500	121,100
	Ohio	61,800	
	Wetzel	20,800	
11	Brooke	30,200	70,600[2]
	Hancock	40,400	

[1] Current Population Reports, Federal-State Cooperative Program for Population Estimates. U.S. Department of Commerce, June, 1975. Estimated as of July 1, 1974.

[2] See text for explanation of deviation from Federal guidelines for catchment area population.


COMMUNITY MENTAL HEALTH/
MENTAL RETARDATION FACILITIES
Central Facility
(Community Mental Health Center)
Comprehensive Mental Health Center
Comprehensive Mental Retardation Center
Community Mental Health/
Mental Retardation Center
Local Facilities
C.A. Catchment Area
I
FAYETTE
Fayetteville
C.A.-2
RALEIGH
Beckley
F.M.R.S.
SUMMERS
Hinton
MONROE
Union
WYOMING
Pineville
McDOWELL
Welch
MERCER
Princeton
C.A.-1
Mercer-McDowell-Wyoming
II
MASON
Pt. Pleasant
Green Acres
C.M.H.C.
CABELL
Huntington
WAYNE
Wayne
LINCOLN
C.A.-2
LOGAN
Logan
MINGO
Williamson
C.A.-1
Logan-Mingo
III
PUTNAM
Winfield
KANAWHA
Charleston
Shawnee Hills
CLAY
Clay
BOONE
Madison
IV
WEBSTER
Webster Springs
NICHOLAS
Summersville
POCAHONTAS
Marlinton
GREENBRIER
Lewisburg
Nicholas County
Greenbrier
V
Western District
PLEASANTS
St. Marys
TYLER
Middlebourne
WOOD
Parkersburg
RITCHIE
Harrisville
WIRT
Elizabeth
JACKSON
Ripley
ROANE
Spencer
CALHOUN
Grantsville
VI
Valley
MONONGALIA
Morgantown
PRESTON
Kingwood
MARION
Fairmont
C.A.-1
HARRISON
Clarksburg
TAYLOR
Grafton
Central District
West Union
DODDRIDGE
LEWIS
Weston
GILMER
Glenville
BRAXTON
Sutton
C A 2
VII-VIII
MINERAL
Keyser
HAMPSHIRE
Romney
Appalachian
GRANT
HARDY
Moorefield
BARBOUR
Philippi
TUCKER
Parsons
UPSHUR
Buckhannon
RANDOLPH
Elkins
Petersburg
PENDLETON
Franklin
IX
MORGAN
Berkeley Springs
BERKELEY
Martinsburg
JEFFERSON
Charles Town
Eastern Panhandle
X
Northern Panhandle
OHIO
Wheeling
MARSHALL
Moundsville
WETZEL
New Martinsville
XI
Hancock-Brooke
HANCOCK
New Cumberland
BROOKE
Wellsburg
I
II
III
IV
V
VI
VII-VIII
IX
X
XI
*with the exception of Nicholas County
which is a mental health center only

interim regulations (U.S. Commerce, weighted average thresholds, 1969.) The act further states that these subareas should "constitute (s) a substantial portion of the population" of the catchment area. This has been defined (by interim regulation) as 35 per cent or more of the catchment area population.

Prior to the passage of P.L. 94-63, using the previous criteria, which specified "families in poverty" rather than total population, only five region/catchment areas received poverty designation (see Table 11.) The implication of revisions in status from non-poverty to poverty for those region/catchment areas already receiving federal funds (see Figure 6, page 61) is being investigated; a request for revision of status is being prepared to be submitted to the appropriate office.

C. PROGRAMS OF COMMUNITY MENTAL HEALTH CENTERS BY REGION/CATCHMENT AREA

The following pages set forth the area programs for community mental health centers. It should be noted that all centers have programs consistent with the programmatic state plan which was issued in 1966, and the <u>State Plan for Construction of Mental Health Facilities</u> authorized by Public Law 88-164. For descriptive data concerning the varous region/catchment areas, refer to Tables 9, 10, 11, and Figures 5 and 6.

The descriptions of the various programs are, of necessity, at times inconsistent and incomplete. The data for this plan was gathered under strict time constraints which did not allow for more precise and controlled information. The regions/catchment areas are presently conducting needs assessments and resource inventories, to be followed by community forums addressing the needs of the public. This information will then be used in determining program priorities, both inter- and intra-regionally.

In collecting the following information, a standardized series of questions was asked of the director of each community mental health center. (See Appendix 17.) The following program and service recommendations are keyed to these questions. Although the recommendations were developed in close collaboration with the corresponding center staff, and reflect stated local needs, they were in some instances, edited or modified by the Department of Mental Health staff for inclusion in this state plan. The questions asked were:

a. The need for specialized services for children and youth, the aged, physically and mentally handicapped, or other special population groups.

b. The need for specialized services for certain special mental health problems including alcoholism, drug abuse, crime and deliquency, suicide and any others of special significance to that catchment area.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

TABLE 10. DESIGNATION OF POVERTY AREAS IN WEST VIRGINIA
AS OF JULY, 1976

RANK	REGION/ CATCHMENT AREA	PERCENT POPULATION IN POVERTY*	POVERTY LEVEL	COUNTIES
1	2-CA1	33.8	YES	Logan, Mingo
2	4	30.2	YES	Greenbrier, Nicholas, Pocahontas, Webster
3	7 & 8	28.0	YES	Barbour, Grant, Hampshire, Hardy, Mineral, Pendleton, Randolph, Tucker, Upshur
4	1-CA2	27.8	YES	Fayette, Monroe, Raleigh, Summers
5	1-CA1	27.6	YES	McDowell, Mercer, Wyoming
6	6-CA2	23.7	YES	Braxton, Doddridge, Gilmer, Harrison, Lewis
7	2-CA2	23.1	YES	Cabell, Lincoln, Mason, Wayne
8	6-CA1	20.2	YES	Marion, Monongalia, Preston, Taylor
9.5	3	18.6	YES	Boone, Clay, Kanawha, Putnam
9.5	5	18.6	YES	Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt, Wood
11	9	17.5	YES	Berkeley, Jefferson, Morgan
12	10	15.1	YES	Marshall, Ohio, Wetzel
13	11	9.0	NO	Brooke, Hancock

* Data Sources:

1. NIMH Demographic Profile System based on 1970 census data.
2. Census Data from U.S. Bureau of the Census, Census of Population: 1970, General Social and Economic Characteristics, Final Report PC(1) - C50 West Virginia

TABLE 11. DESIGNATION OF POVERTY AREAS IN WEST VIRGINIA AS OF JULY, 1973

RANK	REGION/ CATCHMENT AREA	PERCENT FAMILIES IN POVERTY *	POVERTY LEVEL	COUNTIES
1	2-CA1	28.52	YES	Logan, Mingo
2	4	25.47	YES	Greenbrier, Nicholas, Pocahontas, Webster
3	7 & 8	23.18	YES	Barbour, Grant, Hampshire, Hardy, Mineral, Pendleton, Randolph, Tucker, Upshur
4	1-CA2	22.96	YES	Fayette, Monroe, Raleigh, Summers
5	1-CA1	22.66	YES	McDowell, Mercer, Wyoming
6	6-CA2	19.00	NO	Braxton, Doddridge, Gilmer, Harrison, Lewis
7	2-CA2	18.45	NO	Cabell, Lincoln, Mason, Wayne
8	5	15.65	NO	Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt, Wood
9	6-CA1	15.57	NO	Marion, Monongalia, Preston, Taylor
10	3	14.94	NO	Boone, Clay, Kanawha, Putnam
11	9	12.79	NO	Berkeley, Jefferson, Morgan
12	10	11.48	NO	Marshall, Ohio, Wetzel
13	11	7.06	NO	Brooke, Hancock

* 1970 Census Data.

d. How and where the above might be provided.

e. The extent to which free or part pay services are expected to be needed for the medically indigent, and possible sources of financing

f. The possibility of combining existing facilities and services into a community mental health center.

g. The probable location of planned community mental health facilities.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs (e.g., child and maternal health, community health centers, HMO's, etc.), and of working with the courts and other public agencies relative to screening and aftercare programs.

i. The desirability and possibility of timing proposed facility development to take advantage of multiple sources of funding.

j. The need for mental health manpower, possibilities of joint recruitment, training and sharing of staff, and development of new categories of personnel.

k. Wherever necessary, a brief narrative description concerning unusual area characteristics such as:

Military bases and dependents
Indian reservations
Barriers to travel and communication

l. Whether there are facilities which do not meet accepted standards and what steps are being taken to meet those standards.

1. Region 1, Catchment Area 1 -- Southern Highlands Community Mental Health Center

a. The need for specialized services...

(1). Service Needs for Children and Adolescents

Available services for children and adolescents within the catchment area include day care, Head Start, special education, and Windy Mountain School for high school dropouts. At present the only specialized program for children at Southern Highlands is a humanistic skills class, accommodating not over ten children at one time. It is designed for those children who cannot function adequately in the regular classroom, due to emotional and/or behavioral disorders. There is a waiting list for this service. Treatment for the children is more generally in the form of individual therapy, family therapy, or "peer group" counseling.

One of the most obvious needs in this center is for a specialist in child psychiatry, psychology, or neurology. The two psychiatrists employed by this center do not have specialized training in this area. Another need is for the development of a specific program for children, to include the expansion of treatment modalities; increased inservice training of the staff; and a greater effort in consultation and education with the referring agents, agencies, and general public.

According to 1970 census information, 36 per cent of the total population of the catchment area were under the age of 18. In March, 1976, only 12 per cent of the caseload, or 104 persons were under the age of 18, (and 0.2% of the population.) If the need for services is conservatively estimated at only five per cent, the caseload of children at Southern Highlands would be 2,644.

(2). Service Needs for the Developmentally Disabled

Service delivery gaps in the catchment area were presented in Across Borders, Final Report, the final report of some 1975 research funded by Virginia and West Virginia Developmental Disabilities. A summary of this report and other observations and information pinpoint the following needs:

(a) Cooperation of the medical profession in early identification of mentally handicapped children.

(b) Home stimulation programs for mentally handicapped children ages 0-5, as well as pre-school and day care programs.

(c) More concentration of time of Vocational Rehabilitation staff on actual job placement and follow-up.

(d) Expansion of sheltered workshops to include a variety of job training skills.

(e) Expansion of sheltered workshops to serve the severely mentally ill; in other words, terminal sheltered employment as well as transitional training.

(f) The following direct services for the mentally handicapped are nonexistent in our catchment area.

- Terminal Sheltered Workshop employment
- Adult Activity Day Programs
- Foster Homes
- Residential Group Homes...short term and long term
- Respite Homes
- Recreation Programs
- Advocacy Programs
- Parent Training Programs

(3). Service Needs for the Aged

Services for the aged currently existing in the catchment area include the Community Action program, where lunch is served every weekday, followed by arts and crafts; a recreational program; preventive care exercises; and blood pressure clinics. Centers for the aged are located in Princeton, Bluefield, Matoaka, and Bramwell, all in Mercer County. Transportation is provided by TRIP buses, currently serving around 200 people.

The Golden Age Club in Bluefield provides arts and crafts, a recreational program, work service programs, and makes cancer pads and lap throws for nursing homes. They also dress dolls and make Christmas decorations. The "Meals on Wheels" program serves people one meal a day in their homes. The RSVP program makes phone calls and visits to check on the elderly.

Center physicians express some resistance to prescribing medication for the elderly due to possible physical complications. In addition, with the exception of partial hospitalization, staff is also somewhat resistive to engaging in individual psychotherapy with aged people.

Our main need for the aged in our area is personal care and nursing home care. There is a good extended care facility for post-hospital patients, but we need more homes for the elderly who have no acute medical problems. There is also a need to provide a specializes adult therapeutic activity program within the center.

b. The need for specialized services for certain special mental health problems...

(1). Alcoholism and Drug Abuse

Existing services for alcohol and drug abusers include outpatient counseling; limited detoxification (both inpatient and outpatient); group counseling; Fellowship Home services; 24-hour emergency services (Mercer County only); an alcohol countermeasures school for DWI offenders; educational groups for the abuser and family; consultation and education services to agencies and industry; Alcoholics Anonymous and Alanon. There is a need for more adequate detoxification and medical services for both inpatients and outpatients, especially drug abusers; more adequate residential treatment programs; and an Alateen chapter.

(2). Crime and Delinquency

Throughout the catchment area there is a well established problem in the area of crime and delinquency, both for adults and children, as shown by the number of referrals from courts requesting mental health services relevant to evaluations and disposition recommendations. Psychological and psychiatric evaluations are

frequently requested prior to jury trials and to assist circuit court judges in developing appropriate dispositions. The community reponded to the problem of juvenile delinquency by working toward the development of a regional detention center in Mercer County, soon to be opened under the auspices of the West Virginia Department of Welfare. Both evaluative and treatment services will be needed by that facility.

(3). Suicide

The center operates a 24-hour emergency services program to meet the needs of persons in the catchment area. The program in Mercer County has been functioning continuously since January, 1974, but it has been difficult to maintain a similar operation in McDowell and Wyoming Counties. Special emphasis is given to the suicidal person although the program is designed to meet a wide range of crises. Outside of this program, no specialized services are offered for suicidal individuals within the community. At present the Princeton Community Hospital and the sheriffs' offices in Mercer, McDowell, and Wyoming counties are the only community agencies involved in our emergency program. The program has been discussed at length, but as yet, community support and cooperation has not been secured.

Once a suicidal person is brought to our attention, immediate service is delivered, but the service gap is in bringing him to our attention. In an effort to overcome this problem, periodic announcements are made in radio, television, and newspapers. In the not-too-distant future, it is hoped that a 911 emergency telephone number will be established throughout the various communities in the catchment area.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

We have realized the need for these mandated services and have only to move into programs for children, the elderly, and the transitional halfway house service area to be providing the 12 essential services.

d. How and where the above might be provided.

The use of the center's existing staff and programs will fulfill the requirements to provide the services, with the present exception of a transitional halfway house. We recognize, however, that our resources are, and will be, scarce, and thus our comprehensiveness will be comparatively limited. The possibility of developing alternative community-based residential facilities needs to be explored and developed to meet the halfway house program mandate.

e. The extent to which free or part-pay services are expected...

Southern Highlands Community Mental Health Center is funded thru federal, local, and state sources. Title XX Social Security

funding, and alcohol and drug abuse funding are also available. There is also a pending fee-for-service contract with the UMWA. We anticipate approximately $30,000 this year in earned income. This $30,000 represents a very small fraction of the necessary cost of operating the center. However, we have found that patients who pay regularly will always pay, and those who do not pay will never pay.

The recent survey of the caseload in Mercer County showed that of 585 current accounts receivable, 330 of these clients, or 56%, have incomes less than $5,000 a year. Of another 220 clients, 30% fall within the range of $5,000 - $12,000 a year. Mercer County has the highest median income of the catchment area. In view of this information, it would be fairly reasonable to assume that the center cannot in the foreseeable future become totally or even partially self-sufficient without a heavy concentration of government funding.

Contracts, such as the Title XX contract, probably will not increase our income much in the next few years. The UMWA contract will generate an estimated $20,000 a year. Other fee income (insurance, and government sources, such as Disability Determination, and Vocational Rehabilitation) will increase as our client referral from these agencies increases.

In conclusion, the center expects that federal funding past the 1980 termination of our current staffing grant is going to be vital to the continuation of services in the Southern Highlands catchment area. To presume that this center could be financially self-sufficient at that time would grossly affect the quality to grow. The need for these services will also have grown, and the potential for more services will increase.

f. The possibility of combining existing facilities and services into a community mental health center...

Existing facilities and services are already contained within a community mental health center.

g. The probable location...

Community mental health facilities are located in the county seat of each county.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs...

Community mental health services have been planned in conjunction with other government supported programs, courts, and state and local agencies.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

Facility development or expansion is not planned at this time.

j. The need for mental health manpower.

With the ever increasing diversity of endeavors mandated by the needs of the community, an increasing reserve of mental health manpower is a necessity. There are a number of ways of meeting this need without taxing the center unduly. For example, schools having a need for psychological services, and at the same time experiencing budgetary problems, could be potential resources for joint recruitment and sharing of a psychologist on some type of a salary splitting basis.

This same mechanism might be possible with local hospitals; the Southern West Virginia Regional Health Council; our newly built Juvenile Detention Center; the local Developmental Disabilities Home; and such other agencies as OEO and the Department of Welfare. Joint ventures in the recruitment of such professional staff as psychologists and psychiatrists could be considered, together with recruitment of other mental health workers as aides, nurses, social workers, specialized workers in juvenile care, and case finding specialists.

While there appears to be an ever increasing need for the development of new categories of personnel, there should be a re-emphasis on an old category, the mental health paraprofessional. Such an individual, when adequately trained and supervised, could greatly relieve the professional of routine responsibilities and have significant impact upon outreach of mental health efforts.

k. Description concerning unusual area characteristics...

This catchment area is not served by adequate transportation systems, and thus consumers find it difficult to travel into the service locations. Furthermore, 22.7 per cent of the families in the area are in poverty (90th percentile compared to the U.S.A.) This area is at the 90th percentile for the per cent of males in low status occupations; 91st percentile in median school years completed; and 98th percentile in the per cent of the population disabled or handicapped. These few high risk factors indicate a definite need for mental health services in this area.

l. Facilities which do not meet accepted standards.

The rented facility in Wyoming County is the least adequate of the three service locations. Steps are underway to acquire more space in a ground level facility. As we move toward compliance with the mandated 12 essential services, the center will experience space and facility shortages. At this time no plans have been made to remedy this situation.

2. Region 1, Catchment Area 2 -- Fayette-Monroe-Raleigh-Summers Mental Health Council, Inc.

a. The need for specialized services...

(See below.)

b. The need for specialized services for certain special mental health problems...

Our first deficiency is in the provision of specialized services for children and youth; and our number two deficiency is in the provision of services for the chronically mentally ill. There is a need for development of mental health education programs in the schools. There is also a need to develop alternative living facilities in this area.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

Some of the 12 required services are being provided presently. However, for some services, a significant increase in funding is going to be required. In the latter category, specifically, are the areas of transitional homes, children's services, and consultation and education services.

d. How and where the above might be provided...

The 12 required services will be provided by the existing community mental health center located in Beckley, West Virginia, with a field office in each of the other three counties.

e. The extent to which free or part pay services are expected...

At the present time the center is reimbursed from private or third-party contracts for only 10 per cent of the cost of providing services. There is no way in the foreseeable future that clincial services can be self-supporting. It will be up to the state and federal governments to provide funds for free or part pay services.

f. The possibility of combining existing facilities and services into a community mental health center.

In two of the counties, plans are being made to relate the county clinics more closely to existing service facilities such as the Monroe County Health Department and the Summers County General Hospital. In Fayette County, a relationship has begun with one public clinic in Ansted, but elsewhere in the county there does not seem to be any strong public group with whom the center could associate. In Raleigh County, the center is housed in its own building, but a plan is under study for expanding services into the Mountaineer Family Health Plan.

g. The probable location...

F-M-R-S is a federally funded community mental health center with the main facility located in Beckley, Raleigh County, West Virginia.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs...

At least 50 per cent of the patients going to Huntington State Hospital from this catchment area go directly and are not seen by the center staff. Presumably, had they been seen prior to their going to the hospital, many might have been taken care of locally. Therefore, a concentrated effort must be made to bring these two units closer together in their care of patients. This will require some change in the admission procedures of the state hospitals, as well as an expanded public education program from this agency.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

The center's programs are planned to take advantage of all state, federal, and other sources of funds.

j. The need for mental health manpower...

There is a need for additional staff training in specialized interventions. There also need to be workshops aimed at special categories of workers, e.g., the staff involved in aftercare or follow-up programs. Such workshops could include staff from state hospitals and the community, and be held quarterly. Sharing of recruitment efforts for physicians is another need that should be coordinated through the Department of Mental Health.

k. Description concerning unusual area characteristics...

This catchment area contains federal and state prisons for women, and the state home for the elderly at Sweet Springs. In addition, there is the West Virginia Institute of Technology, located at Montgomery, Fayette County. The center has developed a working relationship with these state institutions and has a written contract with them.

l. Facilities which do not meet accepted standards...

The facilities in which the center's programs are housed meet acceptable standards of the state.

3. <u>Region 2, Catchment Area 1</u> -- <u>Logan-Mingo Area Mental Health, Inc.</u>

a. The need for specialized services...

Specialized services are available for a small portion of the physically and mentally handicapped. The center is servicing approximately 45-50 children with these handicaps. There are no specialized services for the aged. Therefore, the following specialized services are needed:

(1). Service Needs for Children

Diagnostic and treatment services are needed for disturbed children who are having problems adjusting to our changing society. In addition, ancillary services should be expanded for the physically and mentally handicapped. Educational services for these children are the responsibility of the board of education, but need to be supported by, and coordinated with, our center.

(2). Service Needs for Youth

The basic deficit in this area is the lack of therapeutic recreational services and basic vocational training opportunities for those unable to succeed in the academics.

(3). Service Needs for the Elderly

A small program for the elderly is needed in the area of therapeutic recreation, entertainment, and assistance in securing medical and financial assistance. The programs should be coordinated with the Commission on Aging.

b. The need for specialized services for certain special mental health problems...

(1). Alcoholism and Drug Abuse

Approximately 20 per cent of our present caseload have a problem with alcohol. This is the result of many factors, such as lack of cultural and recreational opportunities, and geographic isolation. Consultation and education programs are particularly needed, directed toward the school age children, preventive in scope. A more inclusive program for alcoholics and drug abusers needs to be developed in conjunction with the Division on Alcohol and Drug Abuse.

(2). Crime and Delinquency

Crime and delinquency are widespread among the youth population. Most crimes are minor and relate to the social and economic situation.

(3). Suicide and Homicide

Data is not specifically available at this time. However, the center does not believe suicide or homicide to be significant, inasmuch as most of the catchment area is rural.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

At the present time, the construction of a residential facility will enable the center to provide halfway services for hospitalized clients. Programs for children and the elderly are needed as previously mentioned. The center is now providing inpatient, outpatient, emergency, partial care, consultation and education, screening, aftercare, and alcohol and drug abuse services.

d. How and where the above might be provided.

The present and planned facilities in Logan and Mingo Counties, and their affiliate facilities will be adequate for the immediate future.

e. The extent to which free or part pay services are expected...

Approximately 50 per cent of the present caseload is eligible for support through medicare-medicaid, Welfare, and Title XX funding. It is estimated another 25-35 per cent are medically indigent, without eligilility for any of the above programs. The center would recommend that the state provide support for a large portion of the program cost until National Health Insurance becomes effective; that available funds to states at the federal level be increased; and that state funding for other services be shared and coordinated among mental health agencies on a more equal basis.

f. The possibility of combining existing facilities and services into a community mental health center.

This is not applicable for the catchment area.

g. The probable location...

Community mental health facilities are located in the county seats of both counties. At present, three new facilities are planned, two in Mingo County, at Chattaroy and Lando; and one at Three Mile Curve, Logan County.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs...

There is no other government supported agency providing mental health services. At present, the center does plan with, and provide services for, the circuit courts, Department of Welfare, county courts, hospitals, Vocational Rehabilitation, etc.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

The three proposed new facilities have utilized available federal, state, and local funding. The state legislature has appropriated total funding for the Logan County facility and the Lando residential facility. The Chattaroy facility utilized NIMH mental health construction funds, Hill-Burton funds, and state funds.

j. The need for mental health manpower...

The Department of Mental Health needs a staff recruitment and referral program from which centers could secure staff. In addition, a specialized training division should be available to centers. The Logan-Mingo program has specific manpower needs which include a psychiatrist; a psychologist; development specialists; and counselors. The psychiatrist can perhaps be recruited from the Public Health Service Corps, as the center has been approved for such appointments. A psychologist is needed for the children's diagnostic and treatment programs. Developmental specialists are needed to work with the partial hospitalization programs, and also do group and family psychotherapy. Counselors are specifically needed to provide mid-career counseling, alcoholism counseling, and marriage counseling.

k. Description concerning unusual area characteristics...

There are no military bases or Indian reservations. However, this area provided a great deal of difficulty in traveling, because of its mountainous terrain and lack of adequate roads. In addition, sparsely populated counties limit the economic feasibility of providing satellite services, and a lack of public transportation makes it difficult for many to avail themselves of existing services.

l. Facilities which do not meet accepted standards...

Our new facilities are being constructed to meet licensing standards. Plans are to construct each facility on the basis of programs and services to be carried out there, rather than to try and fit programs and services into the building.

4. <u>Region 2, Catchment 2</u> -- <u>Community Mental Health Center, Inc.</u>

a. The need for specialized services...

(1). Service Needs for School Age and Preschool Children

Special programs for the emotionally or socially handicapped school age child are minimal in Cabell County, and non-existent in other counties of the catchment area. Consultation with the school systems and provision of support services is needed. Programs for emotionally and socially handicapped preschoolers are non-existent. Presently, the center is working with Headstart and the Early Childhood Interagency Council attempting to develop day care and supportive services for this population.

(2). Service Needs for the Aged

Demographic research has indicated a high percentage of elderly in the catchment area. It further indicates a high number of single family units, many of whom are elderly. An identified geriatrics program is part of the program development mandated to comply with Public Law 94-63. Present resources do not allow the center to meet this problem need.

b. The need for specialized services for certain special mental health problems...

Statistics on alcoholism indicate that the catchment area shows a high rate of alcoholism, as do most Appalachian coal mining areas. The percentage of alcohol and related offenses is high. The area is lacking in detoxification and halfway house facilities.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

As stated above, funding for identified children's and geriatric services is very difficult to obtain. Third party billing for additional resources is being developed, but few insurance companies operating in West Virginia pay for outpatient mental health services.

d. How and where the above might be provided.

All services can be provided by the community mental health center, except for transitional care facilities. At this time, the center does not have funds to develop independent programs. The center is attempting to develop affiliate relationships with Vocational Rehabilitation which operates two halfway houses, and a community group which is attempting to establish a halfway house for alcoholics.

Another major problem in the catchment area is the lack of sufficient short-term inpatient services. A total of fifty beds is available at a local private hospital for psychiatric care. These beds serve both private caregivers and the community mental health center, and the number is inadequate to meet the need. Future development of inpatient facilities is a priority. The use of three state hospitals within the catchment area may be the only feasible answer in meeting this need.

e. The extent to which free or part pay services are expected...

At present, approximately 80 per cent of the patient load is considered medically indigent, a fact which makes it difficult to collect direct or third party fees. Although payments from Title XX for services are very limited, the center is collecting the total amount allotted to it. If the center should bill for all persons that are entitled to Title XX, the billing would be three or four times above the allotted ceiling.

f. The possibility of combining existing facilities and services into a community mental health center.

There is already an existing community mental health center.

g. The probable location...

Recently, effort has been placed in the development of a satellite clinic in each of the rural counties of the catchment area. A fourth satellite office is needed in the Cabell County community of Ceredo-Kenova.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs...

Presently, the center is planning joint programs of mental health service delivery in conjunction with medical primary care centers which are being developed in the rural areas. Personnel provided from the National Health Service Corps will be used to provide these services.

Recent efforts to screen, where appropriate, referrals from the court for hospital admission, and provide alternative care, have been implemented. Further development of the screening process is necessary. The lack of staff psychiatrists to provide the screening process is the greatest drawback to these efforts.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

Possibilities of multiple sources of funding have not been explored at this time.

j. The need for mental health manpower...

The development of joint agreements with the three state hospitals in the catchment area in order to share staff may be a possible future direction. Special attention is being given to the recruitment of psychiatrists in conjunction with the state hospitals and the primary medical care centers.

k. Description concerning unusual area characteristics...

Transportation is one of the greatest barriers to developing a mental health service delivery system. Public transportation is not available and the mental health center has been able to provide transportation for patients in strictly limited amounts. Either the providing of transportation, or the further development of a large number of satellite clinics, is necessary to overcome the geographical barriers to transportation and communication.

l. Facilities which do not meet accepted standards...

Upgrading of patient records, utilization review, evaluation techniques, accounting systems, and unaffiliate agreements are in progress to upgrade the center's standards. Compliance with regulations for accreditation is a distant goal at this time.

5. Region 3 -- Community Mental Health Center of Region 3

a. The need for specialized services...

The number of persons under age 18 being hospitalized from this region has been steadily decreasing since 1972-73, but a substantial ratio of male to female patients persists--not unlike the ratio found in the occurrence of school/learning problems; districts exist where there are high concentrations of children or elderly persons. It must also be hypothesized that factors such as hazardous employment, as well as unemployment for men, and the scarcity of role choices for women, contribute to differential hospitalization rates among men and women in different age groups.

b. The need for specialized services for certain special mental health problems...

Alcoholism is frequently mentioned as a priority problem, particularly in areas of the region where unemployment is high, or disability results in enforced idleness. Of special concern to the catchment area are social pressures for conformity to a narrow range of acceptable behavior, which are seen as resulting in early marriages, marital and child rearing problems, and of course, the familiar problem of stigmatization of individuals with mental health problems. Various areas of the region show a high incidence of small households, of widowhood, and other earmarks of conditions relating to isolation and loneliness.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

In the summer of 1975, task forces involving providers and interested members of the public at large, met and deliberated over a period of several months. At the end of that time, these groups compiled a list of 124 recommendations. The "12 essential services" were not all inclusive as seen by the recommendations of the task forces, nor are they all viewed as equally relevant to the needs and resources of Region 3.

d. How and where the above might be provided.

Services are concentrated in the Charleston metropolitan area through affiliation. Adequate distribution at a feasible cost represents a major dilemma. Partial hospitalization on a weekend basis, and out-stationed emergency services available on an as-needed basis should probably receive special priority status. Encouragement of innovative response rather than "12 essentials" would be welcomed.

e. The extent to which free or part pay services are expected...

The extent is seen as large and variable; the probable sources as Title XX, Title XIX, private philanthropy, third-party payers and a revised fee schedule. Urgently needed is a stable source of funding at the local or regional level, encouraging flexibility in providing services to those who need them.

While in some areas inpatient services are expected to provide income surplus for the support of other services, there are indicators that this is probably not a realistic expectation for this locale. Support by means of other services, which can carry their own costs plus, (e.g., industrial mental health services consultation) however, may be a potential source of support.

f. The possibility of combining existing facilities and services into a community mental health center.

Services are being affiliated; combining facilities would probably require new construction.

g. The probable location...

At present, the administrative offices are housed in a temporary facility, located in downtown Charleston. Evaluation and diagnosis are handled by the Charleston Guidance Clinic, approximately five miles away. A central facility needs to be provided, somewhere in downtown Charleston, to house the evaluation and diagnostic unit, adult day care, and the administrative offices for the region.

In addition, studies of the region have indicated pockets of high risk population in Kanawha County. Mobile units should be located in these areas, to provide services where the need is greatest. These areas are: downtown Nitro; the North Charleston, Route 21 area; Belle-Marmet; and Elkview-Clendenin. Also, adequate physical plants are needed in Clay and Putnam Counties, and an approvable site needs to be found in Boone County.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs...

Some of this activity is now taking place through affiliations and other types of cooperative agreements, both those in effect and those under study.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

Clearly, such timing would be desirable; the level of possibility or probability would be distinctly unlikely.

j. The need for mental health manpower...

Possible recruitment and sharing of staff with Shawnee Hills is currently under study. Also under consideration is the development of a mental health technician category, with various training aspects to be carried out by Morris Harvey College. Beginning July 1, 1976, increased opportunities for the training of psychiatric residents are being provided in cooperation with the Behavioral Medicine Unit of WVU/CAMC.

k. Description concerning unusual area characteristics...

While there are no military bases, or Indian reservations located in the region, unusual barriers to travel and communication exist in terms of geography, notably mountainous terrain, and unusual patterns of population distribution related to those conditions. It should be noted that a highly uneven distribution of the non-white population exists within the region. Other area characteristics that should be noted include hazardous extractive and chemical industries which provide a major sector of the regional economic base, and many individuals and families who live in isolation as a result of social, economic, or geographic factors.

l. Facilities which do not meet accepted standards...

A matter of particular concern is that of physical facilities which do not meet Life Safety Code standards in a state where building codes are frequently non-existent or ignored as an invasion of personal prerogative. The alternatives range between legitimization of the safest available facility in a given county, and housing programs in facilities only of our own construction.

6. Region 4 -- Seneca Mental Health Council, Inc.

(Two of the counties in this region, Pocahontas and Webster, are temporarily served by Appalachian Mental Health Center based in Region 7-8.)

a. The need for specialized services...

(1). Service Needs for Children and Youth

There is a need for a comprehensive county and regional approach for needs assessment; program development; and maximum utilization of community resources for management and prevention. Present services are fragmented and very limited, e.g., approximately one-fifth of the students in Nicholas County have been or are potential referrals to the mental health center.

In addition to the mental and emotional needs of children that the mental health centers can directly meet, additional special programs for children and youth need to be developed:

(a) Programs for marginally functioning youth to prevent delinquency and school dropouts. Program design should include job orientation, work experience, recreation, etc.

(b) Infant screening and infant stimulation programs.

(c) Group homes for delinquents and runaways.

(d) Expanded day care facilities for young children, and children of working mothers.

(2). Service Needs for the Aged

Services are currently being provided throughout the region by Senior Citizen Programs; however, these services are not reaching the many elderly residing in the outlying areas. Expansion of services to this population is essential, e.g., transportation is a must. Transition homes, personal care homes, adult day care services, and partial hospitalization need to be provided. Social and recreational programs need to be expanded.

(3) Service Needs for the Physically and Mentally Handicapped

Sheltered workshops are needed for this group. Educational programs for handicapped children need to be developed in conjunction with the school system. Specialized mental retardation services for adults need to be provided. Currently, only limited services are being provided the mentally retarded in adult day care programs.

(4) Service Needs for Special Population Groups

The center needs to provide a coordinated services program for young mothers exhibiting the "young mother syndrome" sometimes know as the "cabin fever syndrome"). It is estimated that as high as 25 per cent of the female population in this area experience this syndrome. We also need programs to meet the needs of single parents.

b. The need for specialized services for certain special mental health problems...

Additional services are particularly needed in regard to alcoholism and drug abuse. We particularly need a detoxification facility in the region, as well as a general emergency inpatient facility. Residential facilities for the alcoholic are needed, such as group homes, personal care homes, and transitional homes, as well as adult day care and partial hospitalization facilities. There must be an expansion of youth services as a way to reduce the extent of alcoholism and drug abuse among youth. There must also be special programs for over-dose cases among the adolescents and young adults.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

Currently, Region 4 has submitted a "Planning Application" to facilitate the development of a comprehensive community mental health program.

d. How and where the above might be provided.

The Region 4 board is still considering this question. One of the most practical alternatives would indicate a decentralized service arrangement, with sub-centers headquartered in Lewisburg and Summersville (Greenbrier and Nicholas Counties), and clinics in each of the other two counties of the region. This configuration would maximize the current service delivery system.

e. The extent to which free or part pay services are expected...

Free or part pay services are expected to be needed for the medically indigent. The medically indigent make up a substantial portion of the caseload in all centers within the region. There is a need to encourage a greater number of middle and upper class clientele now presently seeking private care to use the facilities. Third party payments are now a greater source of income than are individual fees, partially due to the fact that Nicholas County Mental Health Center has been able to generate more third party payments and fees than any other center in the state. As a regional program develops, additional funds from special grants and foundations will be more available.

f. The possibility of combining existing facilities and services into a community mental health center.

The possibility is excellent. Current status of program development throughout the region reflects much cooperation among service agencies.

g. The probable location...

One alternative would designate main facilities in Lewisburg (Greenbrier County) and Summersville (Nicholas County) for clinical services, with outreach clinics in Rainelle, Greenbrier County; Richwood, Nicholas County; Marlinton, Pocahontas County; and Webster Springs, Webster County. The Greenbrier Training Center provides regional mental retardation services.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs...

Due to the nature of the rural service delivery system, lack of resources, and the acknowledgment of the need for program coordination, agreements and contracts with other agencies have been, and will continue to be, developed.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

This would be the only practical method of constructing the facility. It is doubtful whether either the state or county would be able to provide funds for the construction of additional facilities.

j. The need for mental health manpower...

There is an immediate need for individuals with specialized service skills in this region. With the development of a regional comprehensive mental health program, the need will be that much greater. However, with regional programming, specialists can be shared and used throughout the region. Joint staff training would save time and money, as well as allow for a greater variety of inservice workshops, and continuing education.

k. Description concerning unusual area characteristics...

In this region, several different local phone systems create barriers to communications. A lack of public transportation complicates the travel problems caused by the mountainous terrain, and travel in bad weather is almost non-existent. A high degree of poverty in the region creates its own set of problems.

l. Facilities which do not meet accepted standards...

Current facilities are inadequate and may not meet accepted standards. Regional alternatives are being explored for solutions.

7. <u>Region 5</u> -- <u>Western District Guidance Center</u>

a. The need for specialized services...

(1). Service Needs for Children

The greatest need and present deficiency is in the area of children's services. Children 14 and under make up 23 per cent of the region's population. To adequately serve this age group the region needs a child psychiatrist and psychologist, as well as access to a children's psychiatric hospital. There is also a need for a transitional facility for adolescents.

(2). Service Needs for the Aged

Region 5, according to information available from Health, Incorporated, is above the national average in the percentage of people 65 and over, with 13 per cent of the region's population falling in this category. Therefore, it is essential that

comprehensive geriatric services be made available. Perhaps the most pressing immediate need is the development of alternatives to state institutionalization for the aged.

(3). Service Needs for the Isolated and Dependent

Roughly 60 per cent of the region's population resides in a rural setting, creating a problem in terms of service delivery. Our aftercare program is hampered by transportation difficulties both in terms of the road network, and also by increasing overhead costs that make it difficult for the center to provide transportation.

Unemployment presents an especially acute problem in Region 5, where the rate of unemployment is well above the state average. This is attested by an increase in marriage and family problems. Public assistance (Welfare) supports a very significant portion of the families in Calhoun, Ritchie, Roane, and Wirt Counties. Isolation and dependency are extremely critical issues in the rural communities.

b. The need for specialized services for certain special mental health problems...

Suicide prevention is a program area in Region 5 which needs particular focus. This catchment area is above the state and national averages in rates of suicide.

Local industries need training to assist them in spotting troubled employees and getting these troubled employees into the mental health delivery system.

If resources become available, a court screening program needs to be developed, so that mentally ill individuals arrested for crimes can be detected and treated.

There is also an urgent need for comprehensive alcohol-drug detoxification services in Region 5.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

During 1974, the center, in developing a Federal staffing application, recognized and documented the needed services through a community oriented task force. The non-discrete 12 essential services are generally not significantly available in this predominently rural area. Priorities are placed on developing emergency, screening, transitional, and consultation and education services.

d. How and where the above might be provided.

Fifty per cent of the region's population is in Wood County, and most of the existing mental health services are in the Parkersburg area. Existing services must be affiliated and

coordinated into an effective force. From that strength, bases must be developed in Jackson and Roane Counties, the next most populous. Then outposts can be designated in the remaining area. Accessibility will be a serious problem because of the geographic isolation of the counties.

e. The extent to which free or part pay services are expected...

The isolated rural areas have a preponderance of families supported by governmental sources. The economic capabilities are at poverty level. These factors contribute to high risk needs for human services. Payment for mental health and related services will need to come from the various funding categories of Welfare and Social Security.

f. The possibility of combining existing facilities and services into a community mental health center.

Recent center construction has enabled combining of some of the facilities and services. More integration will probably occur. Facilities in the back counties share available inelegant space with other agencies.

g. The probable location...

The regional center is newly constructed and is reasonably accessible to the immediate areas. The site of the remaining facilities will be considered carefully as to accessibility, but at best the selection will be arbitrary, depending on space available.

h. The possibility of planning or developing community mental health services in conjuction with other government supported programs...

The need of services for individuals on public assistance, if the present Title XX funding trend continues, will outstrip the resources to provide reimbursement for these services. Associated with this difficulty is the obligation to provide medication for the medically indigent who do not qualify for public assistance health services.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

Multiple funding will be necessary, and is planned for.

j. The need for mental health manpower...

In terms of manpower needs and program integration, an immediate need is the development of a cooperative and integrated working agreement with the inpatient mental health unit at St. Joseph's Hospital in Parkersburg.

k. Description concerning unusual area characteristics...

Travel and communication barriers are huge considerations in planning service delivery. There is negligible public transportation. The mountainous terrain and uneven patterns of population further deny efficient and effective service delivery.

l. Facilities which do not meet accepted standards...

All mental health facilities will be licensed and therefore must meet acceptable standards. Rural counties present problems in professional staff retention and meeting fire, safety, and sanitary standards. Satisfactory solutions are still being sought.

8. Region 6, Catchment Area 1 -- Valley Comprehensive Community Mental Health Center, Inc.

a. The need for specialized services...

(1). Service Needs for Children and Youth

We need a program of specialized services for the mental health of children and youth. The areas to be covered include diagnostic, treatment, liaison, and follow-up services. These services need to be offered from the infant through age 18. Programs geared to target groups within this age category should include such programs as those which presently exist in this center as well as others. Suggestions for future planning for children's services include:

(a) Infant stimulation. A grant proposal has been submitted to the Department of Health, Education and Welfare. The goal is to offer the first steps to a fully developed children's "prevention of problems" model in mental health services delivery. The program will involve high-risk parents and children in parent training, pre-parenthood training, and promotion of optimal opportunities for infant growth and development. Such a project necessitates close coordination with other agencies in the community.

(b) A crisis team to deal with juvenile disturbances, runaways, drug use, etc.

(c) Juvenile court-center teams to deal with adolescents over 16 years of age who have broken the law.

(d) Recreational and personal growth experience services in the community for adolescents.

(e) Expansion of the parent training program.

(f) More adequate inpatient treatment facilities for children, as well as aftercare programs.

(g) Development of mental health curricula in the schools, and more extensive consultation programs.

(2). Service Needs for the Developmentally Disabled

A life span program should offer a spectrum of services to people of all ages who are physically or mentally handicapped. Services for this population need to be expanded to include:

(a) Consultation and education to the community at large, aimed at changing attitudes toward the developmentally disabled individual.

(b) Early detection and prevention.

(c) Transitional and halfway house services to assist patients in moving from one level of care to another.

(d) A careful assessment of licensing standards as they relate to foster homes, personal care homes, group homes, etc.

(e) An individualized treatment plan for each resident of a state hospital. This, of course, means a drastic upgrading of the hospital systems to provide adequate staff and resources.

(f) Expansion of partial care facilities and programs for both children and adults.

(g) More involvement in coordinating discharge planning with hospitals. Consultation programs could be developed in emergency rooms to improve referral services and crisis intervention programs.

(3). Service Needs for the Elderly

Services need to be expanded to include:

(a) Consultation with outpatient clinics and services at West Virginia University and other hospitals, especially designed for geriatric patients.

(b) Programs to encourage the elderly to move back into the mainstream of the community.

(c) Recruitment and training of community aides and volunteers to enable them to serve as resources in such areas as housing, medical services, recreational facilities, and legal issues.

(4). Consultation and Education Service Needs

It is imperative that consultation and education services

be recognized and viewed as an integral part of planning and delivering comprehensive mental health services. This requires sound funding which presently does not exist.

b. The need for specialized services for certain special mental health problems...

Alcoholism and drug abuse services are currently being provided in this catchment area through four CADA offices. (There is a CADA in each of the four counties which comprise the catchment area.)

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

The center is currently providing, at least minimally, the 12 elements of service required by P. L. 94-63. A conversion application has been submitted for a geriatric program. This geriatric program would further enhance the services that are currently being provided the geriatric population within Valley's catchment area.

d. How and where the above might be provided.

All services are being minimally provided throughout the catchment area. Given the current funding situation, it is difficult to plan how all these 12 services can be maintained and enhanced.

e. The extent to which free or part pay services are expected...

Presently 32 per cent of Valley's clients are in the medically indigent population. Sources of financing have included Title XX and the Department of Mental Health. Medicare is another source of funding. Funding does not seem to be a particular problem, providing that the above mentioned second party payees do, in fact, pay.

Valley is currently re-evaluating the fee scale of the center, and exploring contracting with other agencies such as schools and Headstart for services provided. The bind, of course, is how many "free" services the community does expect mental health centers to provide.

f. The possibility of combining existing facilities and services into a community mental health center.

In the existing framework of this mental health center, several services have been combined. These include the alcohol and drug program, Creative Recreation Involving Special Populations (CRISP), coordination and consultation to the group home for developmentally disabled adolescents, children's mental health services, and Unit I at Weston. In addition, a close working

relationship exists with the West Virginia University Medical Center, the local Rape Information Center, sheltered workshops in the counties, the Department of Welfare, and other social agencies.

With more appropriate facilities and funding, additional services could and should be combined into a more integrated unit in order to deliver comprehensive services that are easily accessible to the community.

g. The probable location...

The board of directors of the center has proposed a site for construction of a new mental health center in this area. The proposed location is at the junction of I-79 and U. S. Route 48, which is centrally located to the four counties. Other locations are also under consideration by the Department of Mental Health.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs...

The proposed infant stimulation grant would require close collaboration with child and maternal health. The center strongly advocates interagency relationships and works closely with the Fairmont Clinic, West Virginia University Medical Center, local hospitals, the Department of Health, courts, and schools. The possibility of planning with other government supported and other local agencies not only exists, but is mandatory in order to provide adequate and workable screening and aftercare programs.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

The state has passed funding for the construction of a regional mental health facility in this region. Therefore, equipment and staff is of a higher priority for this region.

j. The need for mental health manpower...

Joint recruitment and sharing of staff is of extreme importance. This does, in fact, exist in this region with Weston State Hospital Unit I, as well as the Creative Recreation Involving Special Populations (CRISP), Friendship Room, and others.

We have developed extensive use of the college graduate worker and the nondegree para-professional in the region. Due to the difficulty of recruiting because of the lack of funds, it appears of extreme importance that the state look to reinstituting programs such as the para-professional program. This would alleviate the shortage of manpower problem that particularly exists in the state hospital system and community after-care programs.

k. Description concerning unusual area characteristics.

Travel and transportation for clients to get to any service is prohibitive. Little or no bus service is available, rural roads are poor, and travel is generally expensive when available. From a cost benefit approach, much staff time is necessarily spent in getting the clients to the service or the service to the client. Many persons are denied services due to lack of transportation. A system very similar to the food stamp program might be a possible solution (i.e., clients could obtain transportation stamps.) This problem is perhaps one of the most significant deterrents to delivery of services.

l. Facilities which do not meet accepted standards...

The whole issue of accreditation and funding to bring centers to a uniform standard of functioning needs to be carefully scrutinized and thoroughly investigated. It is felt that quality care is mandatory; however, who makes this judgment and how this judgment is made must be studied. Presently the center is upgrading its record keeping system, as well as developing a management information system, in order to reach a level of accountability within the system that will ultimately provide a standard by which programs can be evaluated.

9. Region 6, Catchment Area 2 -- Central District Mental Health Center, Inc.

a. The need for specialized services...

(1). Service Needs for Children and Youth

This center should have a transitional living facility for youth for long term and more intensive treatment. Education groups are needed for children and their parents, to provide an encounter point without the labeling that occurs when a person comes to the comprehensive mental health center.

There should also be an advocacy staff for children whose parents or other responsible adults are mistreating them or do not have the ability to be advocate for their own children.

(2). Service Needs for the Aged

This center needs to develop close relationships with existing senior citizen centers, housing centers, and activity programs to assure that our senior citizens are maintaining good mental health. This can be accomplished through a strong consultation training role. We also need to have an advocacy staff for senior citizens. It is difficult for some senior citizens to understand the maze of paper work required to apply for various benefits.

(3). Service Needs for the Mentally Handicapped

Adequate alternative living situations should be developed as an integral part of programming to assure that common basic needs are met for those mentally handicapped being released from institutions.

b. The need for specialized services for certain special mental health problems...

(1). Alcoholism and Drug Abuse

This center should have available a detoxification team to prepare the substance abuser to take advantage of the various treatment approaches already available in the community, i.e., AA, CADA, CMHC Outpatient, ATU-Weston State Hospital, etc. Programming needs to be extended to include a special transitional living home attached to the center in order to provide an intensive support system for the substance abuser.

(2). Crime and Delinquency

This center should have a viable alternative program concept for first time offenders. For youthful offenders, an educational model needs to be developed where they can be assigned to attend a "school". This would include the parents and deal with the total environmental process that affects the youth.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

It is felt that each of the 12 services is essential to meet the mental health needs of individuals. The one crucial factor that is overlooked in the delivery of these 12 services is transportation. Mini-buses and drivers are as integral a part of delivering mental health services as therapy staff. Transportation systems outside of the cities are almost non-existent, and their lack hinders any thorough delivering of mental health services.

d. How and where the above might be provided.

One office should be available in each of the counties of the catchment area to make staff accessible to the people, and provide surroundings that would produce positive feelings.

e. The extent to which free or part pay services are expected...

Provision needs to be made for considerable free and part pay services delivery. West Virginia insurance law does not require carriers to include payment for mental health services; consequently, third party pay is erratic and unworkable in many instances. Within the catchment area, the medium income ranges from $7,717 in Harrison County to $4,485 in Gilmer County. (1970 census). The percentage of families with income less than the poverty level ranges from 13.2 per cent in Harrison County to 37.1 per cent in Braxton County. Needless to say, many uncollectable bills are written off.

Title XX coverage needs to be expanded. Medicaid coverage is inadequate. Staffing costs shared between state agencies, and between state and nonstate entities such as medical hospitals would help. This could include federal monies as well as state monies. County courts need help in understanding funding needs. Their contribution could well be increased.

f. The possibility of combining existing facilities and services into a community mental health center.

The state should support the federal concept of community mental health through a combining of efforts and programs on a local level. This can be facilitated through the development of cooperative agreements between state agencies. Such agreements would give the local program the administrative sanction to form alliances with each of the local community mental health agencies. The center has combined efforts with CADA, Vocational Rehabilitation, Headstart, Sheltered Workshop, etc., and have found these direct relationships very rewarding and beneficial to overall program delivery.

g. The probable location...

In this catchment area, with the central office building a reality, county clinics to house clinical offices and activity space should be the realistic next step. Transitional or CALM facilities are equally important. The center will construct two modest CALM facilities utilizing HUD funds. Three more are needed. CALM facilities should be in each county, not all grouped in one or two locations.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs...

Certainly, cooperative planning and implementation should be realized. It makes no sense to have duplication of funding, staffing, and housing. Most important, it makes no sense to divide service delivery for the prospective client into fragments. Endless energy is expended over who is controlling what rather than in sound planning that would eliminate the control problem and enhance competent service.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

Strong efforts should be made to develop multiple funding sources utilizing every resource. HUD/Section 202 and 8 have funding. SRS legislation contains funding. ARC funding is underutilized. Private foundations and resources are underutilized.

j. The need for mental health manpower...

The manpower need is graphically apparent. Some associated problems and solutions have been discussed in paragraphs e and h. An orientation/training school for new employees would be useful. This would be a common entry base, followed by specifics at each employment location. The curriculum and staff should be the joint responsibility of state and center personnel, and include staff from the hospitals, Department of Mental Health, and other agencies such as Vocational Rehabilitation. Funding would be provided by the state, the center, and by "special" funding earmarked for this program, secured as per item i. A specific curriculum of a universal nature could be developed, and perhaps funded under training grants to schools, such as the one under the direction of Dr. Hollister at the University of North Carolina at Chapel Hill.

k. Description concerning unusual area characteristics...

The only unusual characteristic of this catchment area is that of rural transportation difficulties. While the primary transportation system is relatively good, difficulty comes in getting persons to county clinics, especially children and geriatric citizens. (See also paragraph c.) Costs of local transportation services certainly would be addressed as part of fund development as discussed in paragraph i.

l. Facilities which do not meet accepted standards...

In this catchment area facilities are acceptable. The more stringent regulations of public health and fire marshall requirements need to be reviewed in developing CALM. Also, welfare requirements such as food stamps, living arrangements, TRIP ticket services, etc. need to be considered in planning delivery of joint services.

A major problem seems to be developing in the area of service delivery to schools and will require much work from the state level before local input will be uniformly substantial. Although understanding of school problems, and attempting to cooperate in their solutions, it appears the center seems unable to penetrate substantially at the levels where so much misunderstanding and jealousy exist.

10. Region 7-8 -- Appalachian Mental Health Center, Inc.

(As part of existing contracts with NIMH, the Department of Mental Health, and participating county governments, the Appalachian Mental Health Center serves a ten county area with a total population of 138,200. Two of these counties, Pocahontas and Webster, are actually in Region 4. An eleventh county, Hampshire, is within the region, but is temporarily served by Region 9.)

a. The need for specialized services...

(1). Service Needs for Children and Youth

(a) The level of funded staff is now inadequate to carry out the very heavy consultation load, as well as a very large demand for treatment services.

(b) The center is at a good point to launch into numerous parent-education programs, focusing on positive parenting techniques and knowledge of child development. The center has trained an experienced staff, but there are too many other demands placed on them to carry out such programs without additional staff.

(c) The program needs a supervising psychologist who can review testing, and provide clinical supervision, treatment, and consultation work.

(2). Service Needs for the Aged

Persons age 65 or more comprise approximately five per cent of the center's admissions, though they comprise 12.7 per cent of the regional population. West Virginia has a higher proportion of aged than most states due to the out-migration of young adults from a poverty area without adequate job opportunities. Many of these elderly are not receiving mental health services either directly, or as a result of consultative programs in mental health for agencies and institutions basically providing other types of services.

Center staff have been active in establishing committees on aging in several counties, and a regional Advisory Council on Aging. A conversion grant has been approved for a specialized program which will provide consultative services to every nursing home and senior center.

(3). Service Needs for the Developmentally Disabled

The center has established, or cooperated in the joint establishment, of five developmental centers in as many counties. All have now been transferred to the administration of the respective boards of education. Regional group homes and adult activity centers have been established for the developmentally disabled. Services to this population need to be expanded to include a developmental program for three and four year olds in the Mill Creek area of Randolph County; and a day training program for 20 developmentally disabled adults in the Barbour-Upshur area.

b. The need for specialized services for certain special mental health problems...

(1). Alcoholism and Drug Abuse

There is a need for the center to enter into contracts with business and industry for systematic training, evaluation of problems, and treatment of employees. The center also needs to

seek funds to place a substance abuse counselor or aide in each county, instead of one for each two counties, as is the present situation. These counselors should be provided with better educational opportunities in dealing with the substance abuser. Finally, the center should try to unify the various segments of the communities and try to fund a unified approach to the problems of substance abuse within each community, particularly in providing at least one voice of dissent in the current education patterns of the young in the region.

(2). Abused Wives

Special groups and action planning are underway in Grant County.

(3). Depressed Women

Special groups and activities are planned in Webster County to meet this prevalent problem.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

Last year the center identified eight program elements in its data collection system: emergency, inpatient, outpatient, partial care, residential, consultation and education, training, and research and evaluation. In the coming year the Appalachian Mental Health Center plans to break out, as distinct elements, two services which have been offered for some time, namely, screening and aftercare, as well as giving distinct program status to consultation and geriatric services. The community placement program element is being expanded to include a halfway house. The most specific needs are:

(1). Improvement of joint efforts in planning and screening with Weston State Hospital and the circuit courts.

(2). Realistic criteria, commitment to funding, and approval of community placement facilities of all kinds. This is a statewide deficiency and problem.

d. How and where the above might be provided.

The center is planning a central office in Elkins and a system of county field offices, so that they will be within an hour's driving time from anywhere in the region.

e. The extent to which free or part pay services are expected...

The center's general plan to cover the medically indigent is to develop third party payers; however, the center will still remain largely dependent on federal, state, and local government funding.

f. The possibility of combining existing facilities and services into a community mental health center.

The ten county Appalachian Mental Health Center service area has been stable for eight years. The current mental health state plan calls for a reduction in size of the area. The Appalachian Mental Health Center is ready to cooperate in any orderly transfer of service responsibilities according to the state plan.

g. The probable location...

In a proposed Region 8, the most logical geographical sites to locate a center are Petersburg, in Grant County, or Moorefield, in Hardy County. Petersburg has the only suitable existing hospital facility for contracting for psychiatric inpatient services.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs...

The center has working agreements with schools, children's homes, welfare agencies, Vocational Rehabilitation, Family Health Service, and correctional institutions.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

Hill-Burton, H.U.D., and foundation funding possibilities are constantly explored for assistance with facility development.

j. The need for mental health manpower...

The projected manpower needs for the Appalachian Mental Health Center are: a director of research; a deputy director in Region 8; a supervising psychologist; a resident psychiatrist in Region 3; a children's program coordinator in Region 8; a children's community worker; Mill Creek day care staff; and three secretary-receptionists in field locations. This projection is considered minimal for the provision of essential services to the region.

k. Description concerning unusual area characteristics...

The region covers 5,726 square miles with a population of only 138,200. The pattern of service delivery best adapted to the region's rural, sparsely populated area appears to be one of centering services in each county seat. A traveling team of staff from the central office in Elkins supplements the work done by the resident staff in each county.

l. Facilities which do not meet accepted standards...

Only four mental health locations have adequate physical plant equipment--Elkins, Randolph County, main facility; Buckhannon, Upshur County, satellite and adult day care facilities;

Keyser, Mineral County, satellite facilities; and Elkins, group home. All other facilities are leased and are substandard in location, space arrangement, and quality of facilities or furnishings.

11. Region 9 -- Eastern Panhandle Mental Health Center, Inc.

(General agreement has allowed temporary service to Hampshire County, part of Region 7-8, through Region 9 until an adequate program is available in Region 7-8, or a new Region 8 is established.)

a. The need for specialized services...

(1). Service Needs for Children

The mental health services rendered to children in this region are lacking in both quantity and quality. This is due to the shortages of resources within the region to provide services to those 0-18 years of age, and concentration of services toward specific target groups relating to educational deficiencies. Consultation between center staff, school personnel of Jefferson and Berkeley Counties, the West Virginia Department of Welfare, and Big Brothers of Berkeley County, revealed the following deficiencies in mental health services and facilities:

(a) Insufficient diagnostic, evaluation, and treatment services.

(b) A lack of consultation and education providers.

(c) No coordinated referral system for children's services.

(d) No system of emergency services for crisis intervention.

(e) Inadequate facilities such as respite or halfway houses for adolescents, or a child's psychiatric ward.

(2). Service Needs for the Aged

Meetings with service groups working with the aged have shown a great need for day care services for this population. Such services might combine the services of Committees on Aging, physicians, the Department of Welfare, and the Department of Mental Health to provide total care at various satellite locations in the catchment area. Jefferson County may have space available for such a program at Jefferson Memorial Hospital. In this case, a van would be needed to transport participants to the central location. In Morgan County, the Committee on Aging has small satellite programs which, in view of the population distribution and geographic situation, would require a mobile team to travel to each site.

b. The need for specialized services for certain special mental health problems...

This region appears to be in need of more, particularized

emergency services, such as a crisis intervention team to be available to deal with suicide threats, family and neighborhood crises, etc. Also, along these lines, the center should provide emergency backup and training services to local law enforcement agencies, clergy, and others in the community.

This area also needs formalized counseling services geared to deal with the problems of pregnant school-age girls, rape victims, and victims of other crimes.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

(See below.)

d. How and where the above might be provided.

The five basic services are offered in the three county catchment area. Efforts this year will be made to expand partial hospitalization services in the outlying counties, with a priority given to Jefferson County. Additional staff required to do this include two Community Mental Health I workers and one Community Mental Health II worker.

In conjunction with Public Health services, a priority for establishing aftercare programs has been set. Target areas will be Berkeley and Jefferson Counties. Volunteers will be an essential part of these programs. A volunteer coordinator will be needed to recruit, train, and support these volunteers. In addition, distance from Weston State Hospital (200 miles) makes the position of liaison between center and hospital staff essential.

A statewide M.I.S. is essential to support this program. Staff training in the area of program evaluation is greatly needed. This potentially could be offered on a statewide basis since similar programs offered by NIMH cannot accommodate a sufficient number of participants.

Research into new program needs is required in this region. No needs assessment has been done here in the past five years. At least one additional staff member is required to set up such a program.

Liaison services to courts and other public agencies are currently offered under the consultation and education program, especially in the Berkeley County area. This service needs strengthening in Morgan and Jefferson Counties. The addition of a liaison person to coordinate all services to courts and other public agencies in screening residents for referral to a state mental health facility for inpatient treatment, would greatly facilitate communications between the center, state hospital, and courts.

A transitional halfway house with facilities for 10 to 12 persons is needed within the catchment area. The approximate

cost would be $100,000. Staffing requirements for such a program would be house-parents, cook, and maintenance personnel.

Rape control is a newly required program under the consultation and education service. This catchment area needs research into the size of the problem before consultation and education services can be offered. At present, almost no referrals come through this center.

Inpatient services are being expanded. Kings Daughters Hospital has agreed to a six bed closed psychiatric unit.

e. The extent to which free or part pay services are expected...

This center serves a large percentage of free and part pay clients. To pay for these clients, different sources of funding will be sought. Most of these funds will have to come from state funds; another source will be Title XX funds.

f. The possibility of combining existing facilities and services into a community mental health center.

This region contains a federally funded comprehensive community mental health center. Plans are being made to expand services by working with various community agencies.

g. The probable location...

This center is located at Martinsburg, West Virginia, with field offices in Jefferson, Morgan, and Hampshire Counties.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs...

Jefferson Memorial Hospital is refurbishing its old hospital building to accommodate a nursing home. The bottom floor is open to the Jefferson Committee on Aging for an activity center. Space is available, potentially, to house a day treatment and aftercare program.

This center already screens patients for admission or commitment to Weston State Hosptial. Other court evaluations are performed when requested. A major difficulty in offering this service is the reluctance of Weston State Hospital to accept patients for 20 days observation. Since this hospital is 200 miles from the catchment area, law enforcement officials are reluctant to transport patients only to have them return within 24 hours.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

This center will take advantage of multiple sources of funding as they become available.

j. The need for mental health manpower...

In the past three budget requests, this center has asked for funding from the state for a clinical psychologist. In addition, the center has approached the county commissioners in Jefferson, Morgan, and Hampshire Counties concerning contributing to the salary of a social worker to work in these counties. A similar approach is being made in Morgan and Hampshire Counties regarding contributions to the salary of a psychologist.

k. Description concerning unusual area characteristics...

This catchment area includes a 600 bed Veterans Administration hospital. There is also a domiciliary unit with 550 patients.

Migrant workers are in the area from the summer months through October. Services to this population are generally emergency services, including crisis intervention.

Distances and lack of staff make delivery of comprehensive emergency services difficult. At present, twenty-four hour telephone service is available in Berkeley, Jefferson, and Morgan Counties.

l. Facilities which do not meet accepted standards...

Present facilities meet acceptable standards of the state Department of Mental Health.

12. Region 10 -- Northern Panhandle Mental Health Center, Inc.

a. The need for specialized services...

(See below.)

b. The need for specialized services for certain special mental health problems...

Due to the needs assessment reviews and two years of operating services, it is felt that two priority services loom as major hurdles to the provision of quality mental health services.

(1). The Need for an Alcohol and Drug Detoxification Unit in the Catchment Area.

Currently, approximately 25 per cent of the center's inpatients have been either alcohol or drug abuse related. This problem forces bed utilization for detoxification in our short-term crisis unit. The center currently has sixteen beds, plus three emergency beds (a total of nineteen possible beds) for inpatient care. The expansion of the inpatient unit to a minimum of twenty-five beds with at least two seclusion rooms is recommended. Also, increased state funding is needed in the areas of alcohol and drug abuse to properly reimburse the center for costs incurred in the treatment of said patients. An alternative suggestion might be the feasibility

of merging the alcohol and drug abuse program in the catchment area with the mental health center. This might be an avenue worth exploring to better utilize the resources of the state.

(2). The Need for Greatly Expanded Consultation and Education Services

Such services are vital if the center is to educate the community and strengthen the institutions within the community. More state funding must be made available to allow this basically unreimbursable service to work as it is intended. Currently, the center lacks the capability to adequately perform the consultation and education functions necessary to complement the direct services of the center. Without staff designated to perform these jobs, the center can never be expected to attain the objective of responsibility sharing in finding solutions to community problems. By not doing this, it is likely that firm, long-range funding bases will not be established in the catchment area, and the center will be forced to look elsewhere for funding.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

Currently, the center is providing ten of the twelve mandated services, at various levels of efficiency. The center intends to implement all twelve within two years. However, in order for the center to operate all twelve services at an accreditation level, the state must be prepared to provide the additional funds that will be necessary to embark upon such an ambitious program.

d. How and where the above might be provided.

Center staff suggest that many of the above stated services can be effectively coordinated and realized through the conversion of the Roney's Point facility. Center staff report it does not comply with good management practices to allow the Roney's Point Center to continue as it has; however, it does not make sense to close it. The facilities and grounds need renovation and local management to make it a viable part of the new mandated services. The center suggests that it is vital to the interests of the state to convert this facility, and merge it into a useful part of the mental health center. This proposal will be fully explored.

e. The extent to which free or part pay services are expected...

Now, as never before, with the complexities of our society and the changing times, mental health services are more demanding. The dollars to support the services, however, have become scarce. Unless national health insurance becomes a reality, with inclusions for mental health services, the center must rely on federal, state, and local support to continue services. It will be vital for this center, and other centers as well, to move as rapidly as possible in order to bring services up to accreditation standards. Accreditation will be the link to future funding from

insurance carriers and national health insurance. Those centers not prepared and non-accredited may risk extinction.

f. The possibility of combining existing facilities and services into a community mental health center.

As previously mentioned, the merging of facilities and services such as Roney's Point Center, mental retardation, alcohol and drug abuse, and children's mental health, is the most logical and manageable way to effectively provide mental health services.

g. The probable location...

This topic does not apply as this area already has a comprehensive community mental health center in Wheeling.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs...

This center works closely with other government and non-government funded health and social service agencies in order to coordinate services and avoid duplication.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

This topic does not apply as this area already has a comprehensive community mental health center. It is important to note, however, that the center has attempted to utilize all possible multiple funding sources. It is recommended that more effective measures be made at the state level in securing multiple source funding through state match dollars. This would open new avenues of funding for the centers.

j. The need for mental health manpower...

This area of concern is one which has been greatly overlooked. It is imperative that the state provide leadership and funding in the following areas, which, up to this time, have been considered as needed, but of secondary importance:

(1). There exists a need for funding to the centers to provide staff, software, and hardware for Management Information Systems (MIS). These have long been utilized in business and industry, but not thought applicable to social services.

(2). Evaluation is a necessary function in any kind of organization; however, it is a highly specialized skill that requires people with the understanding of evaluative techniques.

(3). Research is another area coupled with MIS and evaluation. It is only through the use of research that mental health will improve systems of service delivery. This too requires personnel.

(4). Staff training must also be considered as highly important to the progression of any center. This means training on a center level and on an individual level. Again, more funding is needed for mental health.

(5). Training must also occur and the state must set as its goal the accreditation of all of its facilities. The state should assume leadership in this role.

k. Description concerning unusual area characteristics...

The three county catchment area was not designated a poverty area because of the composition of Ohio and Marshall Counties; however, the third county (Wetzel County) is both poverty and rural. Because of the alleged poverty condition in Wetzel County, the center has been unable to increase its appropriation to more than $5,000. Through the resources of the state, a method of subsidizing the appropriation from Wetzel County must be found to continue the satellite office there.

l. Facilities which do not meet accepted standards...

Since the facility was built only two years ago, and meets all physical standards, and the center has been licensed by both the Department of Health and the Department of Mental Health, it is felt that this topic does not apply. It is requested that assistance be given to help this center reach full accreditation standards.

13. <u>Region 11</u> -- <u>Hancock-Brooke Mental Health Center</u>

a. The need for specialized services...

(1). Service Needs for Children, Youth, and the Elderly

It is safe to say that, despite the limited staff of the center, children, youth, and the elderly have always received mental health care at the center, either within the general grouping of its outpatient program or when hospitalized at Weirton General Hospital under the care of a family physician who may request mental health input and follow-up. However, the specialized nature of their needs, such as services geared to the needs of children and youth at different stages of development, are not at the present time provided by the center, nor does the center provide the full range of services that are needed to meet the physical and emotional needs of the elderly.

(2). Service Needs for the Mentally and Physically Handicapped

There is also a need for specialized services for the mentally and physically handicapped in the area of additional

protective living arrangements. Throughout the specialized service needs for the mentally and physically handicapped, Hancock-Brooke Mental Health Service sees the need for mental health services, as many of these individuals may exhibit symptoms of emotional maladjustment.

b. The need for specialized services for certain special mental health problems...

(1). Alcohol and Drug Abuse

The center, along with the state's Center on Alcoholism and Drug Abuse which operates an outreach office in Region 11 (the main CADA office is located in Region 10), provides drug and alcohol services to Region 11. At the present time, the CADA outreach office has one full-time secretary, one full-time case aide, and one counselor who is in the region on a part-time basis. The center itself does not have any one staff member identified as a drug or alcohol therapist. All drug and alcohol cases are seen in the center's outpatient service. The center does not have a specialized drug or alcohol program at this time.

(2). Crime, Delinquency, and Suicide

The center does not have any specialized services for these mental health problems. They are currently addressed and provided for within the framework of the center's outpatient program.

c. The need for mental health services and programs to provide the 12 essential services required in the legislation.

As one can determine from the brief review provided in topics a and b, Region 11, which does not have federal funding, is not currently able to provide specialized services to those population groups listed in topics a and b, nor provide services for certain special mental health problems listed in topic b. Thus, the center is currently unable to provide the essential 12 services and programs until such time as adequate funding for both mental health and developmental disabilities is forthcoming.

d. How and where the above might be provided.

These services should be provided by the Hancock-Brooke Mental Health Center, which is the agency in Region 11 that is designated by the West Virginia Department of Mental Health to provide mental health services to Region 11. It is clear that these services can only be provided when sufficient funding is forthcoming. At the present time, this seems possible only through joint cooperation of the center and the West Virginia Department of Mental Health in the development and application for a federal grant under P.L. 94-63.

e. The extent to which free or part pay services are expected...

This region currently has one of the state's lowest, if not the lowest, percentage of persons on welfare, as well as one of the highest income levels in the state. Therefore, it is anticipated that the center will be able to pay for many of its services through collection of fees. However, there is a percentage of the population that lacks the financial resources to pay for all or part of the services provided. It is expected that cost for services to this population will be generated from Welfare, Medicaid, etc., as well as borne by local community charities, county courts, etc.

f. The possibility of combining existing facilities and services into a community mental health center.

A new $1.6 million mental health facility for this region has been funded by the state. Funds for construction became available July 1, 1976. In discussions with state mental health officials, the center has assured that it will be able to offer space within the facility to appropriate agencies. The center plans to house all appropriate mental health - developmental disabilities services in the facility.

g. The probable location...

The probable location of the planned mental health center for Region 11 is adjacent and attached to the Weirton Medical Center, currently under construction on Weirton Heights.

h. The possibility of planning or developing community mental health services in conjunction with other government supported programs...

The mental health center will continue to be developed in conjunction with other community health services. The association with the new Weirton Medical Center and their inclusion of the center adjacent to them is a case in point. The association with the mental hygiene commissioners and the county courts is very good. The new mental health facility will enable the center to expand that relationship, and to develop more completely a program of screening and aftercare. Programs and services within the mandated responsibility of the center will continue to be carried out without duplication and in cooperation with the programs and services of existing agencies.

i. Possibility of timing proposed facility development to take advantage of multiple sources of funding.

It is always necessary to plan facility development to coincide with the availability of funds for program staffing, services, and operations of significantly expanded facilities. This region is moving rapidly into an especially critical need for new funding to supplement existing funding sources. Timing is no longer an issue to deal with as the facility, the new

mental health center, is on its way. The center must, with the assistance of the West Virginia Department of Mental Health, immediately develop new sources of revenue for this region and its programs.

j. The need for mental health manpower...

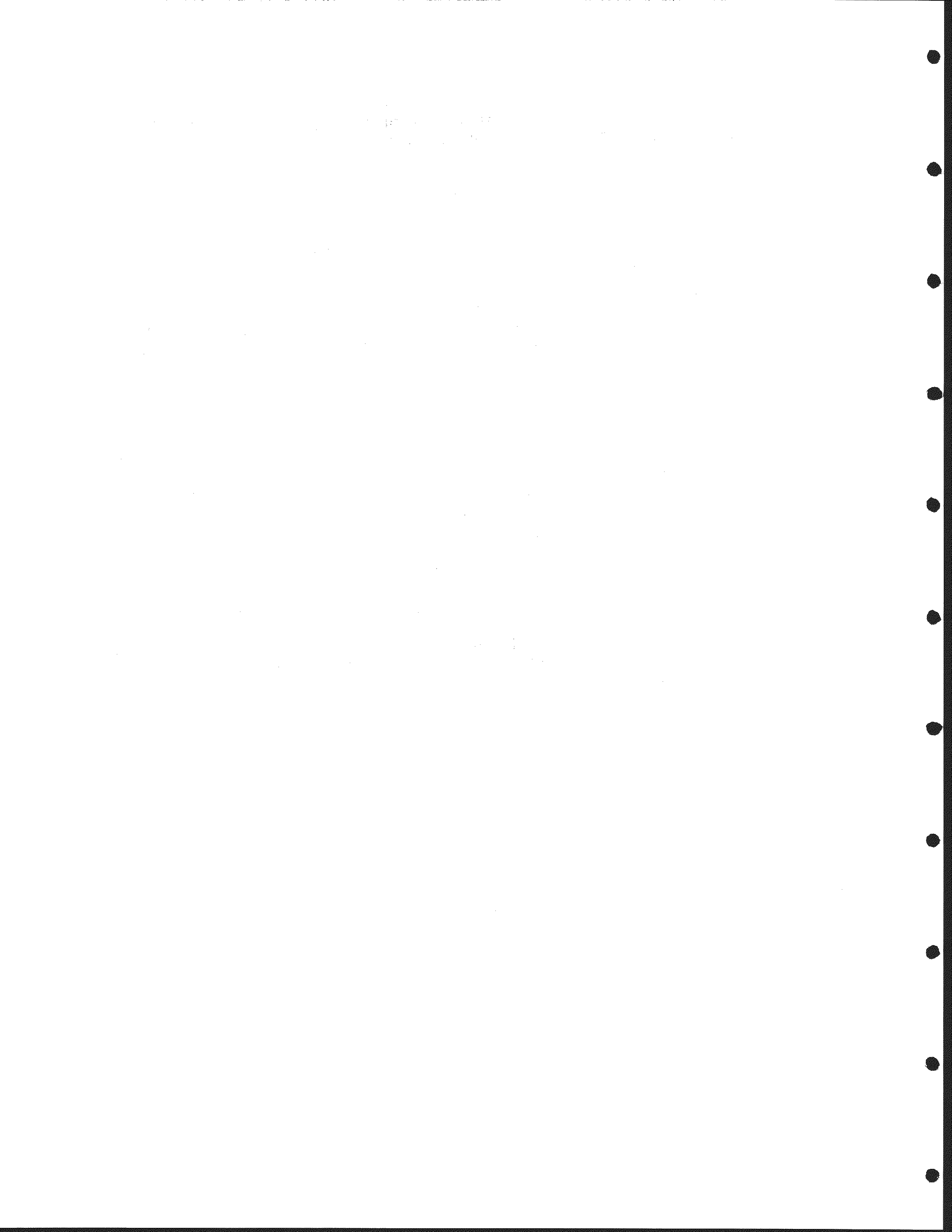
The need for mental health manpower will significantly increase over the next two years as the new physical plant for the mental health center becomes a reality, and as the mandate for services is met. Where the possibilities of sharing staff and resources of other agencies in meeting the comprehensive mental health needs of the region exist, they will be cultivated. Such cultivation can be effected through formal contractual arrangements, and through strong information and referral systems.

k. Description concerning unusual area characteristics...

Although Region 11 is smaller than others in square miles, significant transportation problems exist due to the limited availability of public transportation. This problem is certainly not unique to this region; however, it is somewhat compounded by the fact that many residents live off the main routes in the two counties and must depend on private transportation.

l. Facilities which do not meet accepted standards...

The center, which is the only facility providing mental health services to the region, is working in cooperation with the West Virginia Department of Mental Health to meet licensing standards for both its mental health and developmental disabilities services and programs.



VIII. ASSURANCES

The West Virginia Department of Mental Health agrees:

1. That all services provided under the state plan will be made available without discrimination on account of race, creed, color, sex, age, marital status, or duration of residence.

2. That the state agency or any other agency, organization, or institution administering and/or carrying out any activity under the state plan shall not discriminate in any way against any employees with respect to compensation, terms, conditions, or privileges of employment solely because of race, color, creed, sex, age, or national origin.

3. That the state agency or any other agency, organization, or institution administering and/or carrying out any activity under the state plan shall not refuse employment to any qualified applicant for a position solely on the basis of the fact that he or she has had or has not had a problem of mental or emotional disturbance.

4. That the state agency or any other agency, organization, or institution administering and/or carrying out any activity under the state plan shall maintain a hiring policy that is consistent with the state merit system regarding training, experience, and salary.

5. That federal funds will not supplant non-federal funds otherwise available for providing the services and carrying out the activities under the plan, and that such funds will, to the extent practical, be used to increase the level of funds otherwise available for such services and activities.

6. That all purchases and procurements made using federal funds will, in all ways, correspond with the state purchasing procedures regulations as set forth in Chapter 5a, Article 3, of the state code, or as otherwise defined by the Purchasing, Practices, and Procedures Commission as established in Chapter 4, Article 5 of the state code.

7. That the state agency or any other agency, organization, or institution administering and/or carrying out any activity under the state plan will establish safeguards to prohibit employees from using their positions for private gain to themselves or others, as set forth in Chapter 6b, Article 1 of the state code.

8. That no full-time officer or employee of the state agency or any firm, organization, corporation, or partnership which such officer or employee owns, controls, or directs shall receive funds from any appliant directly or indirectly for payment for services provided in connection with the planning, design, construction, equipping, or operation of any projects funded under the Community Mental Health Centers Act.

9. That all records of the identity, prognosis, or treatment of any patient which are maintained in connection with the performance of any function of the state agency or any other agency, organization, or institution administering and/or carrying out any activity under the state plan, shall be kept confidential as required by Chapter 60 a, Section 504, Article 5 of the state code and Federal Regulations 42 CFR part 2.

10. That services provided under the state plan shall be publicized as to be generally known to the population to be served, shall be available and responsive to the needs of those to be served, and shall be so located as to be readily accessible to the population to be served.

11. That the state agency or any other agency, organization, or institution administering and/or carrying out any activity under the state plan shall make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports.

12. That the state agency or any other agency, organization, or institution administering and/or carrying out any activity under the state plan shall retain on file for a period of at least one year beyond participation in the program all documents, accounting records, and control related to any expenditure, and will take such steps as are necessary to assure that sponsors retain, for a period of at least two years after final payment of federal funds, all financial records and documents related to expenditures for the project.

13. That the state agency or any other agency, organization, or institution administering and/or carrying out any activity under the state plan will comply with the Uniform Relocation Assistance and Real Property Acquisition Act of 1970, P.L. 92-646, which provides for fair and equitable treatment for persons displaced as a result of federal programs.

14. That in all ways, services provided under the state plan shall conform to all regulations pertinent to and promulgated by the State of West Virginia in general, and the Department of Mental Health in particular.

15. That the personnel practices and procedures of the West Virginia Civil Service System, as established by Article 6, Chapter 29, as amended through January 1, 1974, of the Code of West Virginia, and the Attorney General's Opinion, June 29, 1962, will be adhered to in administering the West Virginia comprehensive mental health program.

M. Mitchell-Bateman, M.D.
Director
West Virginia Department of Mental Health

ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

West Virginia Department of Mental Health (hereinafter called the "Applicant")
(Name of Applicant)

HEREBY AGREES THAT it will comply with title VI of the Civil Rights Act of 1964 (P. L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health, Education, and Welfare (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with title VI of that Act and the Regulation, no person in the United States shall on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

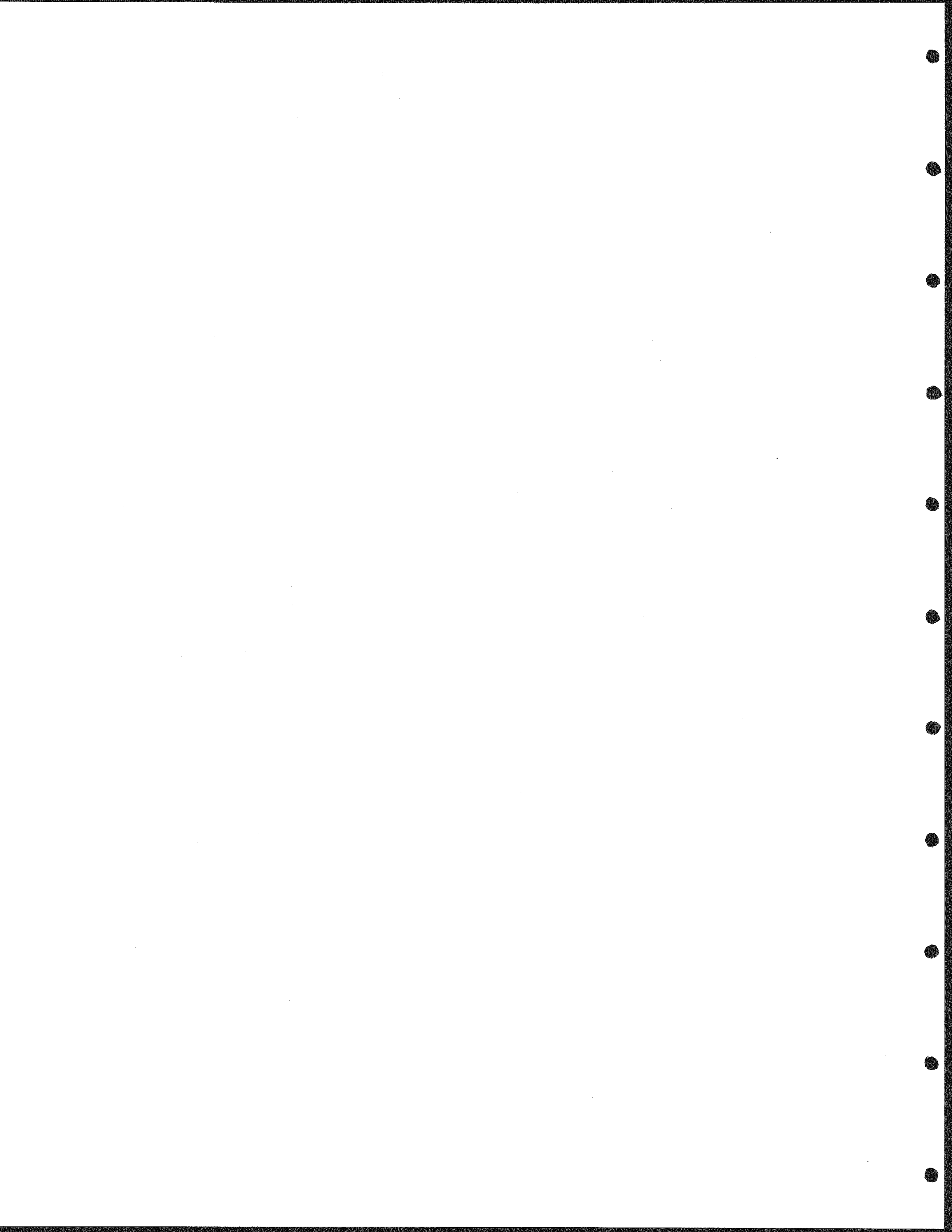
THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Applicant.

Dated June 7, 1976

West Virginia Department of Mental Health
(Applicant)

By [signature], M.D.
(President, Chairman of Board, or comparable authorized official)

1800 Washington Street, East
Charleston, West Virginia 25305
(Applicant's mailing address)



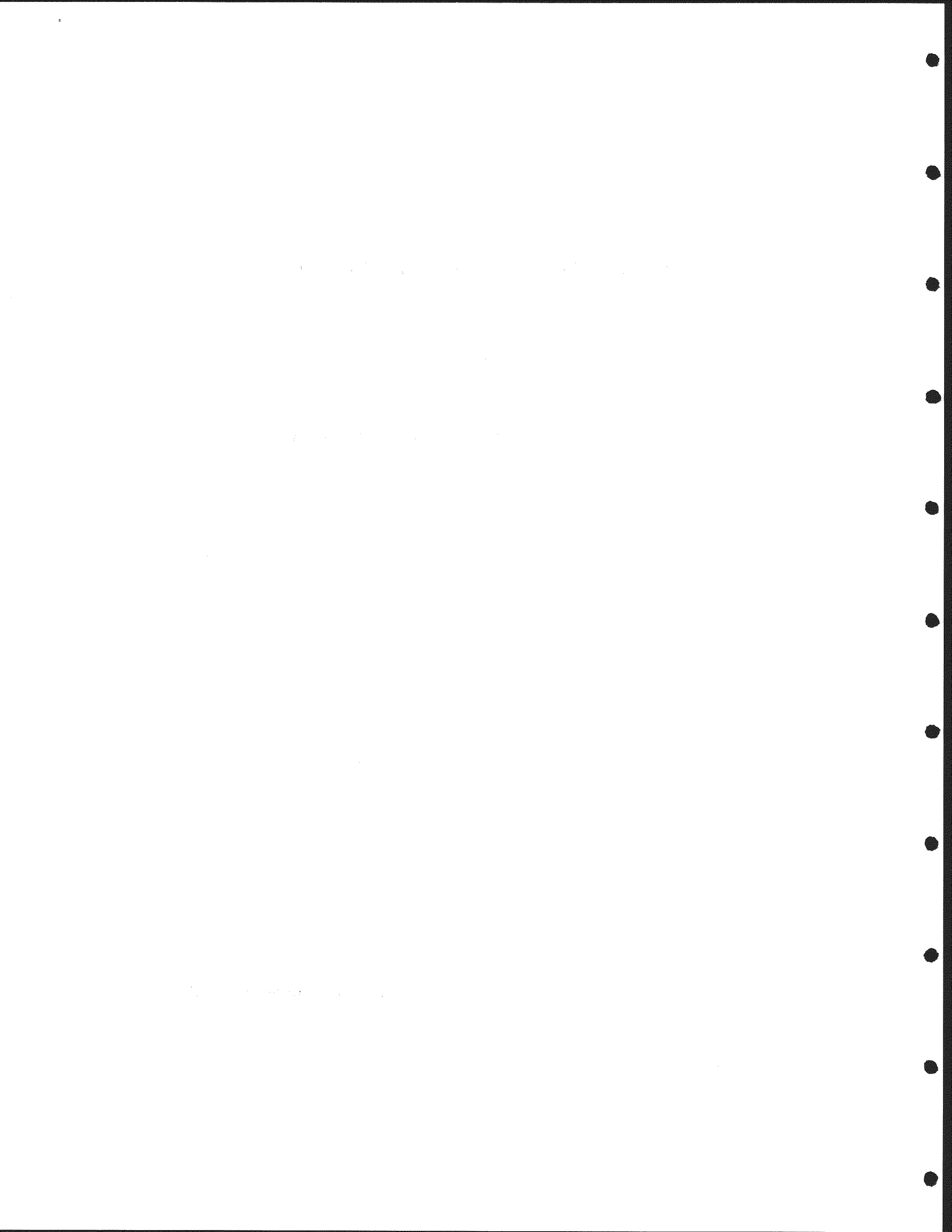
WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

AFFIRMATIVE ACTION PLAN FOR

EQUAL EMPLOYMENT OPPORTUNITY (EEO)

M. Mitchell-Bateman, M.D.
Director

July 1, 1975



I. Background-Authority: The Inter-Governmental Merit System Standards for Personnel Administration were revised in March, 1971. One of the changes requires State and local agencies to implement the merit principle of equal employment opportunity through (1) establishing an impartial and binding system for appeals in cases of alleged discrimination, and (2) planned affirmative action. The standards provision was recently supplemented by requirements from several Federal granting agencies that affirmative action plans be established by July 1, 1972. (See SRS-Program Instruction OPRT-PI-72-5 dated November 12, 1971).

II. Purpose: This affirmative Action Plan represents the commitment of the West Virginia Department of Mental Health to insure equal employment opportunity in all areas of operations affecting its employees and prospective employees. This Plan is the written document describing general and specific actions (and timetable) which will be taken by this agency in carrying out this commitment. The Plan is based on the particular needs of this agency's program relative to equal employment opportunity.

This agency, in mid 1974, employed females corresponding in number to 66.26% of all its employees. Blacks, male and female, accounted for 3.44% of the total full-time employees. The 1970 census for West Virginia showed a Black population correspomding to 3.9% of the total.

It is one of the purposes of this Plan to provide similar statistical data in the future as one of the means whereby an evaluation may be made of the effectiveness of the efforts to eliminate discrimination.

III. General Policy Statement: The West Virginia Department of Mental Health will comply with the non-discrimination provisions of all State and Federal rules and regulations including the Civil Rights Act of 1964. The Department subscribes to the proposition of equal employment opportunities for all individuals and to this end will strive in all possible ways to avoid discrimination in carrying out Department of Mental Health programs and objectives by assuring that no person shall be excluded from consideration of employment, training, retention, promotion, or any other personnel actions, or be denied any benefits on the grounds of race, religion, color, national origin, politics, age, physical and mental disability, or sex, except where a bonafide occupational qualification exists.

Area A. The Department of Mental Health is presently revising its Employee Handbook to reflect recent changes in Attendance and Leave Regulations and other Fringe Benefits.
Target Date: January 1, 1976
Responsibility: Personnel Officer

B. Recruitment Program

A representative from the Department of Mental Health will speak with the students at OIC and Job Corps in an attempt to recruit them into the Department of Mental Health.
Target Date: May 1, 1976
Responsibility: EEO Coordinator

C. Staff Development Activities

The Department of Mental Health will continue training EEO Counselors in our various facilities. They will be given assistance as needed in processing the Grievance Procedure and in the proper disposition of cases of alleged discrimination.
Target Date: Throughout the year
Responsibility: EEO Coordinator

D. Usage of Exit Interview Form

The Department of Mental Health will distribute a copy of the Civil Service pamphlet describing Fringe Benefits to all employees.
Target Date: January 1, 1976
Responsibility: Personnel Officer

E. Reporting Activities of EEO Counselors

Each EEO Counselor will be required to present a quarterly report of EEO activities in his/her facility, as well as a plan of affirmative action to be taken during the fiscal year by the local EEO Counselor, in such areas as recruitment, training, written and unwritten promotional policies.
Target Date: October 1, 1975
Responsibility: EEO Coordinator

F. Pre - employment Interview Reports

The Department of Mental Health is revising the Interview Form to be used when interviewing prospective employees.
Target Date: October 1, 1975
Responsibility: Personnel Officer

IX. DOCUMENTS OF AUTHORIZATION

This section includes excerpts from the Mental Health Laws of West Virginia, 1975, Chapter 27 of the Code of West Virginia. These excerpts will demonstrate the legislative authority under which the Department of Mental Health operates. We have also included a letter certifying that the requirements of OMB Circular A-95 have been met; and a second letter indicating review by the Comprehensive Health Planning Agency.

LEGISLATIVE EXCERPTS

§ 27-1A-1. Statement of policy.

The purpose of this article is to improve the administration of the state hospitals, raise the standards of treatment of the mentally ill and mentally retarded in the state hospitals, encourage the further development of outpatient and diagnostic clinics, establish better research and training programs, and promote the development of mental health. (1957, c. 107; 1965, c. 98.)

§ 27-1A-2. Creation; composition; control of state hospitals.

There shall be a state department of mental health, to be known as the department of mental health. It shall be a corporation and, as such, shall have a seal and may contract and be contracted with. The department shall consist of a director of mental health, supervisors of divisions of the department, and such other employees as are needed to carry out its functions. The department shall supervise and control the state hospitals. (1957, c. 107; 1965, c. 98.)

§ 27-1A-3. Appointment of director; qualifications; term; oath; bond; salary and expenses.

The governor shall appoint the director of the department of mental health by and with the consent of the senate; he shall be known as the director of mental health. Before entering upon the duties of his office, the director shall take and subscribe the oath of office prescribed by section 5, article IV of the Constitution of this State, the certificate whereof shall be filed in the office of the secretary of state, and he shall give bond in the penalty of ten thousand dollars, conditioned as required by law. The director shall serve at the will and pleasure of the governor. The salary of the director shall be the salary specified in section two-a [§ 6-7-2a], article seven, chapter six of the Code and in addition thereto he shall be reimbursed for all necessary travel and other expenses incurred in the performance of his duties. The director shall be a qualified psychiatrist with both clinical and administrative experience. (1957, c. 107; 1972, c. 97.)

§ 27-1A-4. Powers and duties of the director; power of eminent domain in department.

The director shall be the executive head of the department, and as such shall have the following powers and duties:

(1) To develop and maintain a state plan which sets forth needs of the State in the areas of mental health and mental retardation; goals and objectives for meeting those needs; plan of operation for achieving the stated goals and objectives, including organizational structure; and statement of requirements in personnel funds and authority for achieving the goals and objectives.

(2) To appoint deputies and assistants to supervise the departmental programs, including hospital and residential services, and such other assistants and employees as may be necessary for the efficient operation of the department and all its programs.

(3) To promulgate rules and regulations clearly specifying the respective duties and responsibilities of program directors and fiscal administrators, making a clear distinction between the respective functions of these officials.

(4) To delegate to any of his appointees, assistants or employees all powers and duties vested in the director, including the power to execute contracts and agreements in the name of the department as provided in this article, but the director shall be responsible for the acts of such appointees, assistants and employees.

(5) To supervise and coordinate the operation of the state hospitals named in article two [§ 27-2-1 et seq.] of this chapter and any other state hospitals, centers or institutions hereafter created for the care and treatment of the mentally ill or mentally retarded, or both.

(6) To transfer a patient from any state hospital to any other state hospital or clinic under his control and, by agreement with the state commissioner of public institutions, transfer a patient from a state hospital to an institution, other than correctional, under the supervision of the state commissioner of public institutions.

(7) To make periodic reports to the governor and to the legislature on the condition of the state hospitals, or on other matters within his authority, which shall include recommendations for improvement of the state hospitals and any other matters affecting the mental health of the people of the State.

The director of mental health shall have all of the authority vested in the divisions of the department, as hereinafter provided.

The director is hereby authorized and empowered to accept and use for the benefit of a state hospital or hospitals, or for any other mental health purpose specified in this chapter, any gift or devise of any property or thing which lawfully may be given. If such a gift or devise is for a specific purpose or for a particular state hospital or hospitals, it shall be used as specified. Any gift or devise of any property or thing which lawfully may be given and whatever profit may arise from its use or investment shall be deposited in a special revenue fund with the state treasurer, and shall be used only as specified by the donor or donors.

Whenever it shall become necessary, the department of mental health may condemn any interest, right, or privilege, land or improvement, which in its opinion may be necessary, in the manner provided by law, for the acquisition by this State of property for public purposes. (1957, c. 107; 1961, 1st Ex. Sess., c. 9; 1965, c. 98; 1966, c. 40; 1972, c. 97.)

§ 27-1A-5. Division of administration; deputy director; appointment by governor; deputy director's qualifications, powers and duties.

There shall be a division of administration in the department of mental health. The chief executive of this division shall be the deputy director for administration. The deputy director shall be a college graduate with not less than two years' experience in business administration, health services administration or hospital administration, with broad knowledge of accounting, purchasing and personnel practices as related to the rendition of health and health related services. He shall have the following duties:

(1) To keep the records in the department.

(2) To receive and disburse funds for the department as the agent of the director of the department.

(3) To assemble and analyze departmental budget estimates, review requests for transfer of funds and maintain departmental appropriation and fiscal records.

(4) To make rules and regulations governing the administration and business management of the state hospitals, formulate standard fiscal procedures, and make recommendations for improvement; to make regulations concerning any superintendent's trustee funds heretofore established by authority of section three-a [§ 25-1-3a], article one, chapter twenty-five of the Code of West Virginia, one thousand nine hundred thirty-one, as amended.

(5) To have the responsibility for the maintenance of the land, buildings and equipment of state hospitals.

(6) To review requisitions for supplies and equipment, and cooperate with the division of purchases in development and drafting specifications.

(7) To handle the personnel records of the department and to process payrolls.

(8) To enter into contracts for the department consistent with his assigned duties.

(9) To develop job classifications and standards for employees of the department.

(10) To perform any other duties assigned to the division by the director of the department. (1957, c. 107; 1965, c. 98; 1966, c. 40; 1972, c. 97.)

§ 27-1A-6. Division of professional services; powers and duties of supervisor; liaison with other state agencies.

There shall be a division of professional services in the department of mental health. The supervisor of this division shall assist the director in the operation of the programs or services of the department and shall be a qualified psychiatrist.

The supervisor of this division shall have the following powers and duties:

(1) To develop professional standards, provide supervision of State hospitals, analyze hospital programs and inspect individual hospitals.

(2) To assist in recruiting professional staff.

(3) To take primary responsibility for the education and training of professional and subprofessional personnel.

(4) To carry on or stimulate research activities related to medical and psychiatric facilities of the department, and render specialized assistance to hospital superintendents.

(5) To establish liaison with appropriate State agencies and with private groups interested in mental health, such as the State department of health, the board of probation and parole, the department of education, the board of governors of West Virginia University, and the West Virginia Association for Mental Health, Incorporated.

(6) To license, supervise and inspect any hospital, center or institution, or part thereof, maintained and operated by any political subdivision or by any person, persons, association or corporation to provide in-patient care and treatment for the mentally ill, or mentally retarded, or both.

(7) To perform any other duties assigned to the division by the director of the department. (1957, c. 107; 1965, c. 98; 1966, c. 40.)

§ 27-1A-7. Division of community services; powers and duties of supervisor.

There shall be a division of community services in the department of mental health. This division shall administer all funds made available to the State of West Virginia and any political subdivision thereof under the National Mental Health Act, and all other funds made available for use by this division. The director shall establish standards and criteria for reimbursing sponsoring groups for a portion of the cost of local mental health services which they may provide.

The supervisor of this division shall also have the following powers and duties:

1. To establish standards for and supervise the operation of community mental health clinics for adults and children and to develop new community facilities and community service programs for the overall improvement of the regional mental health facilities.

2. To develop a comprehensive and practical program of mental health education of the public, especially at the local level.

3. To work with county mental hygiene commissions and circuit courts.

4. To determine and approve schedules of reasonable cost for reimbursement by the patient or responsible relative for mental health services rendered.

5. To perform any other duties assigned to the division by the director of the department. (1957, c. 107; 1965, c. 98; 1967, c. 108.)

§ 27-1A-11. Division on alcoholism and drug abuse; powers and duties; definitions.

The division on alcoholism, heretofore established in the department of mental health, shall continue and be known as the division on alcoholism and drug abuse.

The supervisor and personnel of this division shall assist the director of the department in the establishment of a program for the care, treatment, and rehabilitation of alcoholics and drug abusers; for research into the causes, prevention, and treatment of alcoholism and drug abuse; for the training of personnel to work with alcoholics and drug abusers; and for the education of the public concerning alcoholism and drug abuse.

The department's program for the care, treatment, and rehabilitation of alcoholics and drug abusers may include, when intended for such purposes, the establishment of special clinics or wards within, attached to, or upon the grounds of one or more of the state hospitals under the control of the department of mental health; the acquisition in the name of the department of real and personal property and the construction of buildings and other facilities; the leasing of suitable clinics, hospitals, or other facilities; and the utilization, through contracts or otherwise, of the available services and assistance of any professional or nonprofessional persons, groups, organizations or institutions in the development, promotion and conduct of the department's program.

Neither the department of mental health nor the division on alcoholism and drug abuse shall be required to accept any alcoholic or drug abuser voluntarily seeking hospitalization for clinical or hospital care, treatment, or rehabilitation; but the department may accept, pursuant to its adopted and promulgated rules and regulations, responsibility for clinical or hospital care, treatment, or rehabilitation of any alcoholic or drug abuser through arrangements made voluntarily with the department by him or some person acting in his behalf: Provided, that any such person accepted by the department on a voluntary basis shall be charged a minimum fee unless he shows, to the satisfaction of the department, that he is unable to pay the fee.

The department shall accept all alcoholics and drug abusers committed by a county mental hygiene commission in accordance with the procedure of article six [§ 27-6-1 et seq.] of this chapter; but notwithstanding any provision in said article six which may be to the contrary, the supervisor of the division on alcoholism and drug abuse may, in his discretion, specify the clinic or hospital to which the alcoholic or drug abuser shall be committed.

The department's program of research into the causes, prevention, and treatment of alcoholism and drug abuse may include the utilization, through contracts or otherwise, of the available services and assistance of any professional or nonprofessional persons, groups, organizations or institutions, as well as cooperation with private and public agencies engaged in research in alcoholism or drug abuse or rehabilitation of alcoholics or drug abusers.

The department's programs shall also provide for the training of personnel to work with alcoholics and drug abusers and the informing of the public as well as interested groups and persons concerning alcoholism and drug abuse and the prevention and treatment thereof.

The department may employ such medical, psychiatric, psychological, secretarial and other assistance as may be necessary to carry out the provisions of this section.

§ 27-2-1. Establishment of a new central mental health-mental retardation facility; development, operation, location; state hospitals, the Colin Anderson center, Guthrie center, Roney's Point center; continuation; management.

In consultation with the governor, the director of mental health is hereby authorized and directed to establish, develop, operate and maintain a new central mental health mental retardation facility for the evaluation, diagnosis, treatment, research and training and rehabilitation of persons disabled by mental illness or mental retardation and to include, but not to be limited to, alcoholism and drug abuse facilities, specific residential facilities designed for diagnosis, treatment, research and training and rehabilitation of mentally ill children, adolescents and other specialized groups; such facility to be located on a site selected in accordance with the State comprehensive mental health and mental retardation plans, such facility shall also serve as a designated component as one of the fourteen regional mental health centers.

The state hospitals heretofore established at Weston, Spencer, Huntington, Barboursville, Lakin and St. Marys shall be continued and known respectively as the Weston hospital, Spencer hospital, Huntington hospital, Barboursville hospital, Lakin hospital and the Colin Anderson center. Said state hospitals shall be managed, directed and controlled by the department of mental health. The Guthries center and the Roney's Point center shall be managed, directed and controlled by the department of mental health as treatment, and rehabilitation centers for the mentally disabled, and shall be included in all references to "state hospital" in this chapter: Provided, that the Roney's Point center shall have its own budget separate and apart from any other "state hospital" referenced in this chapter.

The governor and the director of the department of mental health are hereby authorized to bring said hospitals into structural compliance with appropriate fire and health standards.

All references in this Code or elsewhere in law to the "West Virginia training school" shall be taken and construed to mean and refer to the "Colin Anderson center." (1955, c. 101; 1957, c. 107; 1965, c. 98; 1972, c. 66; 1973, c. 75.)

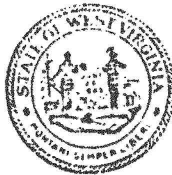
§ 27-2A-1. Comprehensive community regional mental health-mental retardation centers; establishment, operation and location.

In consultation with the governor, the director of mental health is authorized and directed to establish, maintain and operate not more than fourteen comprehensive regional mental health centers and not more than eight comprehensive mental retardation facilities, to be located at such places within the State as may be determined by the director in accordance with the comprehensive mental health plan for West Virginia and such community facilities for the mentally retarded as may be indicated in accordance with the State's comprehensive mental retardation plan. Such facilities may be operated directly by the department of mental health or by locally based nonprofit organizations under such rules and regulations as may be promulgated by the director of mental health.

The State's share of costs of operating such centers or facilities may be provided from funds appropriated for this purpose within the budget of the department of mental health. (1972, c. 66.)

OFFICE OF THE GOVERNOR
Charleston, West Virginia
FEDERAL STATE RELATIONS

Arch A. Moore, Jr.
Governor



August 2, 1976

File: PNRS-M
#76071120

M. Mitchell-Bateman, M.D.
Director
West Virginia Department of Mental Health
1800 Washington Street, East
Charleston, West Virginia 25305

Re: West Virginia State Plan for Comprehensive Mental Health Services

Dear Doctor Bateman:

The State Clearinghouse has reviewed your notification of intent to apply for Federal assistance in connection with the above referenced project, and has found the proposal to be consistent with overall State plans and objectives.

This will certify that the requirements of the U. S. Office of Management and Budget Circular No. A-95 have been met, and the State Clearinghouse is in concurrence with this project.

Sincerely,

Robert V. Barill
Deputy Director
Office of Federal-State Relations

RVB:am

cc: Dr. B. L. Coffindaffer

RWM
7-26-76

OFFICE OF THE GOVERNOR
Charleston, West Virginia
FEDERAL STATE RELATIONS

Arch A. Moore, Jr.
Governor

July 23, 1976

Mr. Robert E. Marshall
Director
Division of Community Services
W. Va. Department of Mental Health
Charleston, West Virginia 25305

Dear Mr. Marshall:

The West Virginia Comprehensive Health Planning Agency has the following comments on the draft of the West Virginia State Plan for Comprehensive Mental Health Services dated June 1976 which will be finalized for submission to the U.S. Department of Health, Education and Welfare by August 1, 1976 in partial satisfaction of the requirements of Public Law 94-63.

1) The four goals and ten objectives are endorsed and supported (pages 4-5). However, the objectives should be placed in a time frame to indicate progress being made and the overall direction of the program.

2) The linkage between the current Plan and the previous Plans should be clarified. This should indicate progress made toward achievement of goals and objectives.

3) The five areas of concern are well described (pages 9-11). The new West Virginia Health Systems Agency (HSA), Statewide Health Coordinating Council (SHCC) and State Health Planning and Development Agency (SHPDA) formed under Public Law 93-641 should each have a significant role in addressing these concerns. The roles should be mutually agreeable to these three new entities, the Department of Mental Health and the various community mental health centers.

REM

4) The concern regarding funding is well described (pages 11-13). The applicant is encouraged to develop cost/benefit ratios for various types of services so that limited funds can be directed as much as possible to support the services of greatest needs and benefits to the public.

5) The establishment of the State Advisory Council to the West Virginia Department of Mental Health as described is noteworthy (pages 15-20). This Council would have great potential to help the Department to develop programs particular for the needs expressed by the public.

6) It is noteworthy that completion of authorized construction projects will complete the network of community mental health/mental retardation facilities across the state (pages 27-28).

7) Concern is expressed about the state institutions having insufficient capability to perform prompt pre-admission screening (pages 39-43). Perhaps the professional resources of the community mental health centers could be used more to fill this need.

8) Community Alternative Living Modules (CALM) show great potential in moving as many persons as possible to a community living environment (pages 45-48).

9) The need for institutional services particular to the needs of children should be studied closely (pages 52-53). Rather than costly new facilities, conversion of present institutional space (made available at existing institutions as a result of community mental health programs) would provide the needed facilities.

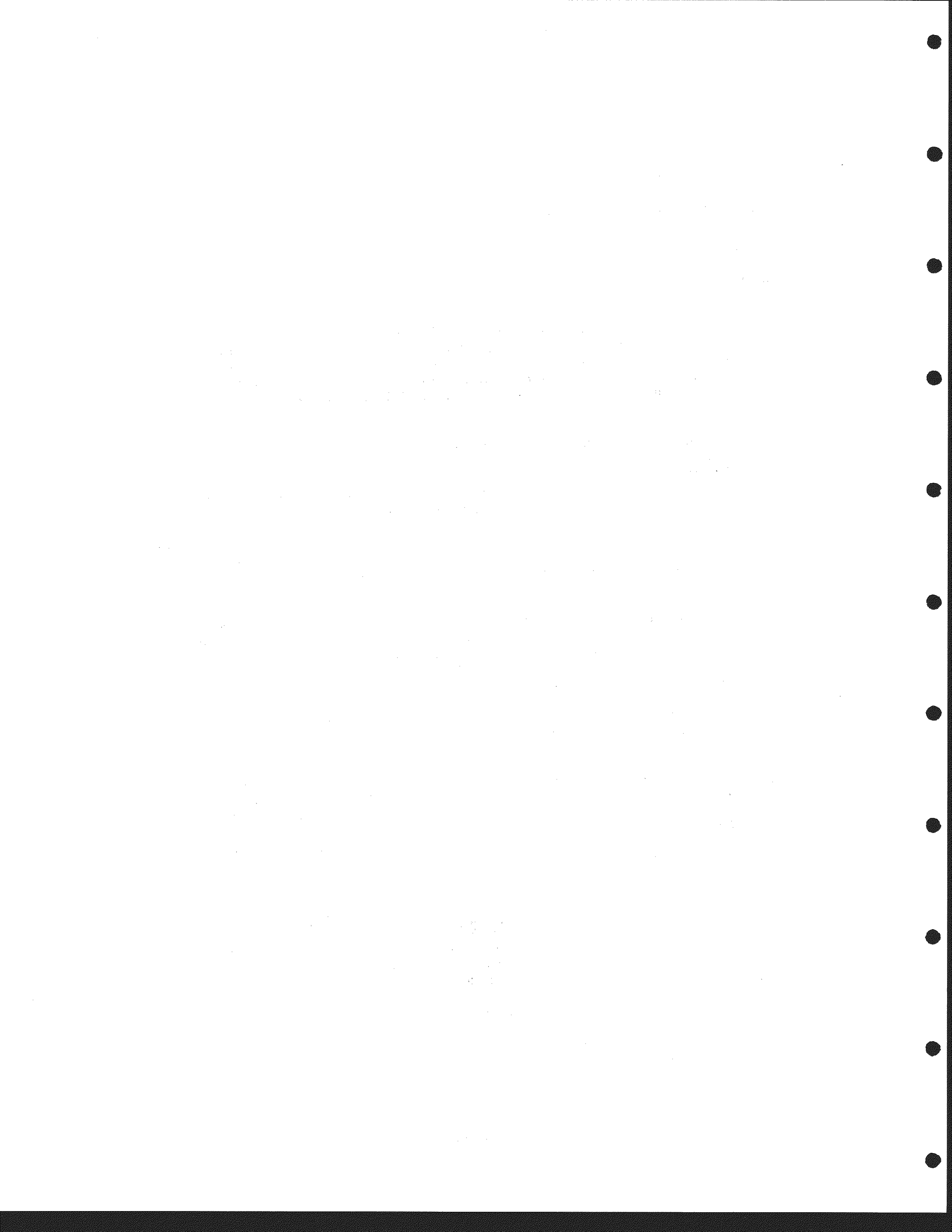
Sincerely yours,

Harry A. Stansbury

Harry A. Stansbury, Jr., Ph.D.
State Director of Comprehensive Health Planning

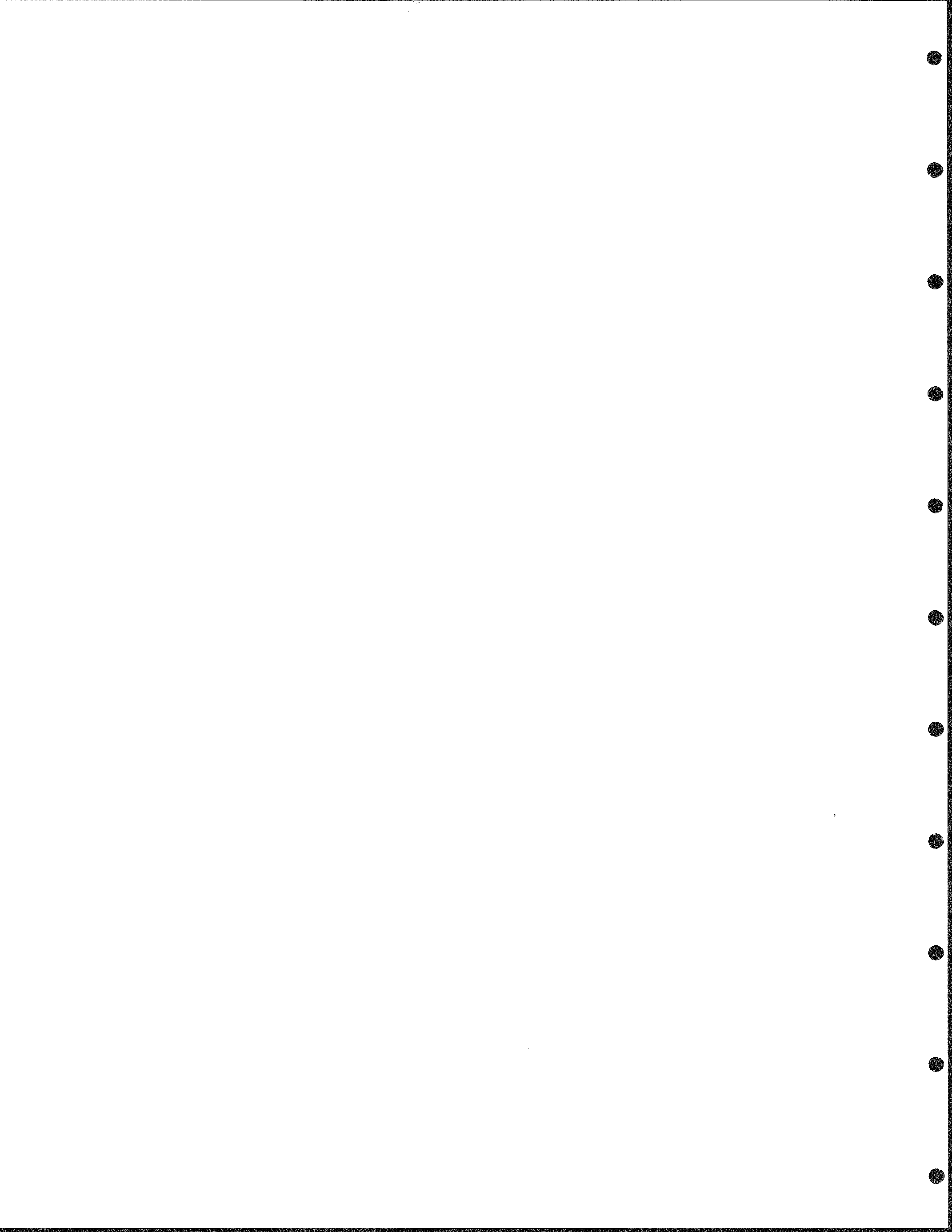
HAS:djd

cc: Dr. Mildred Mitchell-Bateman
Mr. Alfred Broadhead
Dr. B. L. Coffindaffer
Mr. Robert Barill
Mr. Robert Bugey



APPENDICES

We regret the poor quality of some materials in the Appendices. In some instances, however, orginals were not available.



Public Law 94-63, Section 201(c)(2)...."Provider of Health Care."

"Provider of health care."

"(2) For purposes of subparagraphs (A) and (B) of paragraph (1), the term 'provider of health care' means an individual—

"(A) who is a direct provider of health care (including a physician, dentist, nurse, podiatrist, or physician assistant) in that (i) the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including hospitals, long-term care facilities, outpatient facilities, and health maintenance organizations) in which such care is provided, and (ii) when required by State law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration; or

"(B) who is an indirect provider of health care in that the individual—

"(i) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subclause (II) or (IV) of clause (ii);

"(ii) receives (either directly or through his spouse) more than one-tenth of his gross annual income from any one or combination of the following:

"(I) Fees or other compensation for research into or instruction in the provision of health care.

"(II) Entities engaged in the provision of health care or in such research or instruction.

"(III) Producing or supplying drugs or other articles for individuals or entities for use in the provision of, in research into, or instruction in the provision of, health care.

"(IV) Entities engaged in producing drugs or such other articles.

"(iii) is a member of the immediate family of an individual described in subparagraph (A) or in clause (i), (ii), or (iv) of subparagraph (B); or

"(iv) is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

PROPOSED TIMETABLE FOR THE ESTABLISHMENT OF THE STATE ADVISORY COUNCIL FOR THE WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

August 1, 1976

The establishment of the State Advisory Council to the West Virginia Department of Mental Health will require a process that includes:

(1) A search for potential candidates.

(2) The development of a roster of candidates representative of the Council's four classes of membership.

(3) A means of screening candidates that will ensure the composition of the Council consistent with Federal and State guidelines.

(4) The final selection and appointment of members to the Council.

It is proposed that this process commence August 16, 1976, and conclude with the first State Advisory Council Meeting December 1, 1976.

The following is a recommended timetable which establishes deadlines for the completion of the major tasks required in the development of the State Advisory Council.

August 16 - 31	Develop a mailing list of potential candidates to serve on the State Advisory Council.
September 1 - 2	Letters to be sent to potential candidates of the State Advisory Council by the Department of Mental Health inquiring as to their interest and availability for service as a member of the State Advisory Council.
September 5 - 30	Receipt of candidates' responses to the Department of Mental Health's letter of inquiry regarding interest and availability to serve on the State Advisory Council.
October 1 - 6	The screening and selection by the Department of Mental Health of candidates to serve on the State Advisory Council, and the screening and selection of groups/organizations that will select members of the Council.
October 7	Letters sent by the Department of Mental Health advising individuals and groups of their designation to either serve, or participate in the selection of, a representative to serve on the State Advisory Council.

PROPOSED TIMETABLE FOR THE ESTABLISHMENT OF THE STATE ADVISORY COUNCIL OF THE WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

October 10 - 30	Receipt by the Department of Mental Health of candidates' notification of their acceptance to serve on the State Advisory Council.
November 5	Letters sent by the Department of Mental Health advising State Advisory Council members of the time and place of the first meeting.
December 1	First State Advisory Council meeting.
March 1	Second quarterly meeting of the State Advisory Council, time and place to be announced.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH
CHARLESTON 25305

M. MITCHELL-BATEMAN, M.D.
DIRECTOR

ADDRESS ALL REPLIES
TO THE DIRECTOR

The West Virginia Department of Mental Health has completed and submitted to the National Institute of Mental Health a State Plan for Comprehensive Mental Health Services. The Plan has been written consistent with regulations promulgated following the enactment of Public Law 94-63, the Community Mental Health Center's Federal legislation. The Plan, as submitted by the Department of Mental Health establishes a State Advisory Council. Functions and responsibilities of this Council are specified in an accompanying enclosure.

As an individual who has demonstrated concern for mental health programming in West Virginia, I am inquiring as to your interest and availability for service as a member of the Comprehensive Mental Health State Advisory Council. In addition, if there are any other individual(s) you feel may be appropriate candidates to serve on the Council, the submission of the individual's name to my office will be greatly appreciated.

Your response to this request will not commit either you or any individual you refer to this office to serve on the State Advisory Council. The final selection and appointment of members to serve on the Council will be made from a roster of candidates who have indicated their interest and availability for service. This selection process will use criteria consistent with both Federal regulations and guidelines specified in the State Plan regarding Council composition.

Please be assured that you will be advised regarding the make up of the State Advisory Council and other avenues available to insure your input concerning the provision of comprehensive community mental health services in West Virginia.

Your cooperation in this matter will be greatly appreciated.

Sincerely yours,

M. Mitchell-Bateman, M.D.
Director

DMH-OD-1

N O T I C E

September 9, 1976

TO: All Community Mental Health/Mental Retardation Center Directors

SUBJECT: Recruitment of Potential Candidates to State Advisory Council

The West Virginia Department of Mental Health has completed and submitted to the National Institute of Mental Health a State Plan for Comprehensive Mental Health Services. The Plan has been written consistent with regulations promulgated following the enactment of P.L. 94-63, the Community Mental Health Center's Legislation.

The Plan, as submitted by the Department of Mental Health establishes a State Advisory Council. The Department of Mental Health is now in the process of screening potential candidates to serve on this Council. The membership of the Council shall include, but not be limited to, four classes of membership: (1) State agencies, (2) mental health providers, (3) representation of non-governmental organizations, and (4) consumer representatives.

In order to assure as representative a make up of the Council as possible, I am requesting that you forward to me immediately the names of any individuals you feel should be considered as potential candidates to serve on the Advisory Council from your region. I would be particularly interested in the names of any consumer or consumer group that you could recommend.

Your response to this request will not commit any individual you refer to this office to serve on the State Advisory Council. The final selection and appointment of members to serve on the Council will be made from a roster of candidates who have indicated their interest and availability for service. The selection process will use criteria consistent with that specified in the State Plan regarding Council composition.

All responses to this request should be made by September 20, 1976. Your cooperation will be greatly appreciated.

Robert E Marshall

Robert E. Marshall
Director
Division of Community Services

cc: M. Mitchell-Bateman, M.D.

MENTAL HEALTH ASSOCIATION

Mr. Dave Cleland
Div. Vocational Rehabilitation
P & G Building
Charleston, W. Va. 25305

Mrs. J. C. Hunt
McDowell Co. M. H. Assoc.
121 Summers Street
Welch, W. Va. 24801

Mrs. Irene Snyder
Lewis Co. M. H. Assoc.
P. O. Box 126
Weston, W. Va. 26452

Mrs. Allen Sharp
Mong. Co. M. H. Assoc.
1413 Anderson Avenue
Morgantown, W. Va. 26505

Mrs. Sharron Hrncirik
Wetzel Co. M. H. Assoc.
259 East Thistle Court
New Martinsville, W. Va. 26155

Mrs. Shirley Crowther
Upshur Co. M. H. Assoc.
7 Hillcrest Drive
Buckhannon, W. Va. 26201

Mrs. W. A. Jefferies
Mineral Co. M. H. Assoc.
581 South Main Street
Keyser, W. Va. 27626

Mrs. R. O. Burford
W. Va. State M. H. Assoc.
5204 Noyes Avenue S. E.
Charleston, W. Va. 25304

GOVERNOR
Arch A. Moore, Jr.
State Capitol Bldg. 1
Charleston, W. Va. 25305

HEALTH & WELFARE
Mrs. W. W. Withrow (Jackie)
1301 Maxwell Hill Road
Beckley, W. Va. 25801

DEPT. OF WELFARE COMMISSIONER
Thomas R. Tinder
State Capitol Bldg. 6
Room 617
Charleston, W. Va. 25303

DEPT. OF EDUCATION STATE SUPERINTENDENT OF SCHOOLS
Daniel B. Taylor
State Capitol Bldg. 6
Room 535
Charleston, W. Va. 25305

DIVISION OF VOCATIONAL REHABILITATION DIRECTOR
Thorold S. Funk
P & G Bldg.
Washington Street East
Charleston, W. Va. 25305

COMMISSION ON AGING EXECUTIVE DIRECTOR
Louise B. Gerrard, Ph.D.
2100 Washington Street East
Charleston, W. Va. 25305

COMMUNITY MENTAL HEALTH/MENTAL RETARDATION PROGRAMS OF WEST VIRGINIA

REGION I

Fayette, Monroe, Raleigh, Summers, Mercer, McDowell, Wyoming

Catchment Area 1

Southern Highlands Community Mental Health Center
12th Street Extension
Princeton, West Virginia 24740
Danis Soylu, M.D., Clinical Director
Steve Farley, Administrator
Charles J. Langan, III, Ph.D., Executive Director

Telephone: 425-9543 or 9541

Guy Perkins, President
Board of Directors
301 Ridgecrest Road
P. O. Box 727
Bluefield, W. Va. 24
Telephone - 327-3551

Catchment Area 2

Fayette-Monroe-Raleigh-Summers Mental Health Council
101 S. Eisenhower Drive
Beckley, West Virginia 25801
David A. Ames, M.D., Executive Director
Guy H. Hensley, Jr., Administrator
Telephone: 252-8651

Charles Vickers, President
Board of Directors
Fayette County Court House
Fayetteville, W. Va. 25840
Telephone: 574-1600

REGION II

Cabell, Lincoln, Mason, Wayne, Logan, Mingo

Catchment Area 1

Logan-Mingo Area Mental Health
206 Dingess Street
Logan, West Virginia 25601
Telephone: 752-6320
June Church, Ph. D., Executive Director
George P. Kirk, Assistant Director for Research, Planning, and Development
Mrs. Norma Thompson, Secretary/Treasurer of Board

Mark S. Spurlock, M.D.
Chairman
Board of Directors
Sears Building
Logan, W. Va. 25601

Catchment Area 2

Community Mental Health Center
3375 U. S. Route 60, East
P. O. Box 8069
Huntington, West Virginia 25705
Larry Thompson, Ed.D., Director
Harry Fischer, Business Manager
Telephone: 525-7851

Bart W. Lovins, President
Board of Directors
103 Fairfax Drive
Huntington, W. Va. 25705
Telephone - 696-3246

REGION II (Continuted)

Catchment Area 2 (Continued)

Green Acres Regional Center
P. O. Box 115 - Route 2
Lesage, West Virginia 25537
David H. McGinnis, Executive Director
Telephone: 762-2521 or 762-2522

David B. Daughtery, Chairman
Board of Directors
737 - 5th Avenue
Huntington, West Virginia 25701
(Lawyer)
Telephone: 523-3427 (Office)

REGION III

Kanawha, Boone, Putnam, Clay

Community Mental Health Center of Region III
1217 Lee Street, East
Charleston, West Virginia 25301
Michael C. J. Carey, Regional Administrator
Telephone: 342-8138

Kemp Winfree, President
Board of Directors
1002 Knob Way
South Charleston, West Virginia
25309
Telephone: 768-0830 (Home)
346-0423 (Business

Shawnee Hills Regional Center
P. O. Box 338
Institute, West Virginia 25112
John Barnette, Director
Telephone: 768-3901

Mrs. Roxane (Frank)Butts
President, Board of Directors
1416 Bedford Road
Charleston, West Virginia 25314
Telephone: 342-0260

REGION IV

Nicholas, Webster, Pocahontas, Greenbrier

Greenbrier Valley Mental Health Clinic
100 Church Street
Lewisburg, West Virginia 24901
Telephone: 645-3319
Mrs. Anne Blair Alderson, Administrator

Mr. Ralph D. Keightly, President
Board of Directors
205 W. Washington Street
Lewisburg, West Virginia 24901

Nicholas County Mental Health Center
305 McKees Creek Road
Summersville, West Virginia 26651
Telephone: 872-2659
Moody J. Goff, Administrator

Mr. Edgar Kitchen, President
Board of Directors
Nicholas County Mental Health Center
Telephone: 742-5271 (Craigsville School)

REGION V

Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt, Wood

Western District Guidance Center
2121 - 7th Street
Parkersburg, West Virginia 26101
Mr. David Ogilbee, Administrator
Telephone: 485-1721

James Brammer, President
Board of Directors
Route 2
St. Marys, West Virginia 26170

REGION VI

Braxton, Doddridge, Gilmer, Lewis, Harrison, Marion, Monongalia, Taylor, Preston

Catchment Area 1

Valley Comprehensive Community Mental Health Center
603 East Brockway Avenue
Morgantown, West Virginia 26505
Telephone: 296-1731 or 296-1739
O. B. Fawley, Jr., Executive Director

Reverend Richard Bowyer
President
Board of Directors
1105 Locust Avenue
Fairmont, West Virginia 26554

Catchment Area 2

Central District Mental Health Center
#6 Hospital Plaza
Clarksburg, West Virginia 26301
James Chapman, Executive Director
Telephone: 623-5661

Mr. Jim Rommel, President
Board of Directors
150 Oliv. Street
Weston, West Virginia 26452

REGION VII-VIII

Barbour, Grant Hampshire, Hardy, Mineral, Pendleton, Randolph, Tucker, Upshur

Appalachian Mental Health Center
Yokum and Wilmoth Streets
P. O. Box 1170
Elkins, West Virginia 26241
Alex T. Portz, Ph.D., Executive Director
Telephone: 636-3232

Ashby Craft
National Weather Service
Box 349
Elkins, West Virginia 26241
Telephone: OFFICE - 636-1200
HOME - 636-1675

Hampshire County Special Services Center
c/o Hampshire County Board of Education
Romney, West Virginia 26757
Mrs. Paula Daskal, Director/Teacher
Telephone: 822-3050

Dale Rawlings, President
Board of Directors
Hampshire County Special Services Center, Inc.
Route 1 - Box 87-P
Romney, West Virginia 26757

Developmental Center
50 Clary Street
Keyser, West Virginia 26726
Robert Miller, Director
Telephone: 788-0788

David Nuzum, President
Board of Directors
Potomac State College
Keyser, West Virginia 26726

Hampshire County Mental Health Service
Hampshire County Courthouse
Romney, West Virginia 26757
Miss Isabella Miller, Director
Telephone: 833-3318

REGION IX

Berkeley, Jefferson, Morgan

Eastern Panhandle Mental Health Center
235 South Water Street - P.O. Box L
Martinsburg, West Virginia 25401
Randolph R. MacDonald, Ed.D., Executive Director
Telephone: 263-8954 - 263-8955

Charles A. Kizer, President
Board of Directors
131 West King Street
Martinsburg, West Virginia 25401

REGION X

Marshall, Ohio, Wetzel

Northern Panhandle Mental Health Center
2121 Eoff Street
Wheeling, West Virginia 26003
Ryan Beaty, Executive Director
Telephone: 233-6250

Mrs. Adelaide Allen, Vice-Pres.
Board of Directors
302 12th Street
Glen Dale, West Virginia 26038
Telephone: 845-3211

REGION X (Continued)

Children and Family Service Association
329 McLain Building
40 - 12th Street
Wheeling, West Virginia 26003
Manuel Viola, ACSW, Executive Director
Telephone: 233-2350

Charles C. Milton, President
Board of Directors
4000 Water Street
Wheeling, West Virginia 26003

MAIL FOR MANUEL VIOLA: 109 N. Main Street
Wheeling, West Virginia 26003

REGION XI

Hancock, Brooke

Hancock-Brooke Mental Health Service
Weirton General Hospital - St. John's Road
Weirton, West Virginia 26062
David O. Miller, ACSW, Administrator
Telephone: 748-7700

Mr. David Levitt, Chairman
Board of Directors
Hancock-Brooke Mental Health Service
810 Commerce Street
Wellsburg, West Virginia 26070
Telephone: (Home) 737-2746
(Office) 737-3481

Reference Page 18 Appendix 4

TO: News Media

FROM: West Virginia Department of Mental Health

SUBJECT: State Plan for Comprehensive Mental Health Services

INFORMATION: For Further Information, Contact Mr. Robert E. Marshall, Director – Division of Community Services. Phone: 348 - 2411

DATE: August 25, 1976

FOR IMMEDIATE RELEASE

The West Virginia State Plan for comprehensive mental health services should be ready for distribution by October 1, 1976, it was announced by Dr. M. Mitchell-Bateman, Director of the Department of Mental Health.

A draft of the plan has been submitted to the National Institute of Mental Health for review. Upon the completion of this Federal review and the review of the plan by local community mental health centers, revisions, addendums, and amendments will be made by the Department of Mental Health to the plan.

The State Plan, as required by Public Law 94–63, was developed by the West Virginia Department of Mental Health in collaboration with the Association of Community Mental Health/Mental Retardation Programs of West Virginia and all other community mental health programs in the state.

The State Plan will serve as a mechanism to assure public accountability for the expenditure of Federal and matching funds in the provision of community mental health services, and a rational basis for the utilization of all available resources in meeting the needs for provision of comprehensive mental health services for residents of the state. The plan also encourages coordination with other state and local, public and voluntary planning activities concerned with enhancing the quality of life for citizens in their communities.

Following distribution of the completed plan, comments and suggestions regarding it may be submitted to the Central Office of the West Virginia Department of Mental Health. This plan will be available for public perusal at all community mental health/mental retardation centers.

A NEWS CLIP FROM
West Virginia
Press Services, Inc.
211 Knight Bldg.
Charleston, WV

AUG 3 1 1976
MOUNDSVILLE DAILY ECHO
Moundsville, W.Va.

MENTAL HEALTH PLAN TO BE READY OCT. 1

The West Virginia State Plan for comprehensive mental health services should be ready for distribution by October 1, 1976, it was announced by Dr. M. Mitchell-Bateman, Director of the Department of Mental Health.

A draft of the plan has been submitted to the National Institute of Mental Health for review. Upon the completion of this Federal review of the plan by local community mental health centers, revisions, addendums, and amendments will be made by the Department of Mental Health to the plan.

The State Plan, as required by Public Law 94-63, was developed by the West Virginia Department of Mental Health in collaboration with the Association of Community Mental Health-Mental Retardation Programs of West Virginia and all other community mental health programs in the state.

The State Plan will serve as a mechanism to assure public accountability for the expenditure of Federal and matching funds in the provision of community mental health services, and a rational basis for the utilization of all available resources in meeting the needs for provision of comprehensive mental health services for residents of the state. The plan also encourages coordination with other state and local, public and voluntary planning activities concerned with enhancing the quality of life for citizens in their communities.

Following distribution of the completed plan, comments and suggestions regarding it may be submitted to the Central Office of the West Virginia Department of Mental Health. This plan will be available for public perusal at all community mental health-mental retardation centers.

A NEWS CLIP FROM
West Virginia
Press Services, Inc.
211 Knight Bldg.
Charleston. WV

SEP 1 1976
GAZETTE
Charleston, W.Va.

Mental Health Plan Ready by Oct. 1

The West Virginia State Plan for comprehensive mental health services will be ready for distribution by Oct. 1, according to Dr. Mildred Bateman, director of the department of mental health.

The plan will assure public accountability for the expenditure of federal and matching funds in the provision of community mental health services.

A NEWS CLIP FROM
West Virginia
Press Services, Inc.
211 Knight Bldg.
Charleston. WV.

SEP 3 1976
RALEIGH REGISTER
Beckley, W.Va.

Mental Health Plan Ready For Handout

The West Virginia State Plan for comprehensive mental health services should be ready for distribution by Oct. 1, according to Dr. M. Mitchell - Bateman, director of the department of Mental Health.

A draft of the plan has been submitted to the National Institute of Menatl Health for review. Upon completion of this federal review and the review of the plan by local community mental health centers, revisions, addendums and amendments will be made to the plan by the Depdrtment of Mental Health.

The State plan, as required by Public Law 94 - 62, was developed by the West Virginia Department of Mental Health in collaboration with the Association of Community Mental Health/Mental Retardation Programs of West Virginia and all other community mental health programs in the state.

Accordimg to Dr. Mitchell - Bateman, the state plan will serve as a mechanism to assure public accountablility for the expenditure of federal and matching funds in the provision of community mental health services, and a rational basis for the utilization of all available resources in meeting the needs for provision of comprehensive mental health services for residents of the state.

SEP 5 1976
DOMINION POST
Morgantown, W.Va.

Mental health plan is due by October

CHARLESTON—A statewide plan for comprehensive mental health services should be ready for distribution by Oct. 1 according to Dr. Mildred Mitchell-Bateman, director of the Department of Mental Health.

The plan is being designed to serve as a mechanism to assure public accountability for the expenditure of federal and matching funds in the provision of community mental health services. The plan will also be used as a basis for using all available resources in meeting the needs of mental health services for residents of the Mountain State.

A state plan is required by Public Law 94-63 and is being developed by the West Virginia Department of Mental Health in collaboration with the Association of Community Mental Health and Mental Retardation Programs of West Virginia and all other community mental health programs in the state.

A draft of the plan has been submitted to the National Institute of Mental Health for review. After the federal review and a review by local community mental health centers, revisions and amendments will be made.

After the distribution of the completed plan, comments and suggestions regarding it may be submitted to the Central Office of the West Virginia Department of Mental Health. The plan will be available for public inspection at all community mental health or mental retardation centers.

A NEWS CLIP FROM
West Virginia
Press Services, Inc.
211 Knight Bldg.
Charleston. WV

SEP 7 1976
POST HERALD
Beckley, W.Va.

State Mental Health Services Plan Ready

Dr. M. Mitchell-Bateman, director of the State Department of Mental Health, has announced that the West Virginia state plan for comprehensive mental health services should be ready for distribution by Oct. 1.

A draft of the plan has been submitted to the National Institute of Mental Health for review. Upon completion of this federal review and the review of the plan by local community mental health centers, revisions, addendums and amendments will be made to the plan by the Department of Mental Health.

The state plan, as required by Public Law 94-62, was developed by the West Virginia Department of Mental Health in collaboration with the Association of Community Mental Health/Mental Retardation Programs of West Virginia and all other community mental health programs in the state.

According to Dr. Mitchell-Bateman, the state plan will serve as a mechanism to assure public accountability for the expenditure of federal and matching funds in the provision of community mental health services.

ARTICLE 9.

LICENSING OF HOSPITALS.

Sec.
27-9-1. License from director of mental health; regulations.

§ 27-9-1. License from director of mental health; regulations.

No hospital, center or institution, or part thereof, to provide inpatient, outpatient or other service designed to contribute to the care and treatment of the mentally ill or mentally retarded, or prevention of such disorders, shall be established, maintained or operated by any political subdivision or by any person, persons, association or corporation unless a license therefor shall be first obtained from the director of mental health. The application for such license shall be accompanied by a plan of the premises to be occupied, and such other data and facts that the director may require. He may make such terms and regulations in regard to the conduct of such hospital, center or institution, or part thereof, as he may think proper and necessary. He, or any person authorized by him, shall have authority to investigate and inspect such hospital, center or institution, or part thereof; and the director of mental health may revoke the license of any such hospital, center or institution, or part thereof, for good cause after reasonable notice to the superintendent or other person in charge thereof. (1955, c. 104; 1957, c. 107; 1965, c. 98; 1970, c. 54.)

Reference Page 26 Appendix 6

West Virginia Department of Mental Health

Licensing Program Report

December 31, 1976

Licenses Denied: 1
Class I Licenses Issued: 25
Class I Licenses Reduced to Class II: 0

STATUS KEY: License No.
LOA - Letter of Authority Issued*
SFM - State Fire Marshal clearance pending
SAN - State Department of Health Division of Sanitation clearance pending
CLASS I - License Issued
CLASS II - License Issued
Pending: Indicates License Program Communicating. License will probably be issued within 60 days.

*License Program not funded and Letters of Authority were granted upon assurances of SFM and SAN.

As of November 4, 1976 2 Registered Record Administrators and 6 Accredited Record Technicians added to Licensing Staff for 80 hours each for medical records staff development in Mental Health Facilities.

Medical Record Staff Development Project, mentioned in State Plan beginning September 30, 1976. Approved.

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

BECKLEY AREA — LICENSE NO.

Fayette-Monroe-Raleigh-Summers
Mental Health Council
101 South Eisenhower Drive
Beckley, West Virginia 25801 — No. 7 Class I

Field Offices

Fayette County Mental Health Center
213 North Court Street
Fayetteville, West Virginia 25801

Monroe County Mental Health Center
Box G, Main Street
Union, West Virginia 24983

Summers County Mental Health Center
98 Union Street, P. O. Box 658
Hinton, West Virginia 25951

Fayette County Mental Health Center
Montgomery Office
210 Third Avenue
Montgomery, West Virginia 25136

Adult Programs

Fayette-Monroe-Raleigh-Summers
Adult Activity Center
Kelly Avenue
Oak Hill, West Virginia 25901

Southern West Virginia Fellowship Home
Beckley, West Virginia 25801

Day Care Centers

Fayette County Day Care Center
P. O. Box 336
Scarbro, West Virginia 25917

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

BECKLEY AREA (continued

LICENSE NO.

Day Care Centers

Summers County Day Care Center
P. O. Box 1146
616 Temple Street
Hinton, West Virginia 25951

Raleigh County Day Care Center
101 South Eisenhower Drive
Beckley, West Virginia 25801

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

CHARLESTON AREA — LICENSE NO.

Community Mental Health Center of Region III — No. 11 Class I
1217 Lee Street
Charleston, West Virginia 25301

Field Offices

Boone County Mental Health Association
(Old Post Office Building)
343½ Main Street
Madison, West Virginia 25130

Charleston Guidance Clinic
5608 MacCorkle Avenue
Charleston, West Virginia 25304

Clay County Mental Health Steering Committee
Main Street, P. O. Box 255
(Courthouse)
Clay, West Virginia 25043

Putnam County Human Problems Center
4026 Teay Valley Road
Scott Depot, West Virginia 25560

Early Childhood Diagnostic Center
Charleston Memorial Hospital
3700 MacCorkle Avenue, S. E.
Charleston, West Virginia 25304

Children's Mental Health Service
St. John's Episcopal Church
1105 Quarrier Street
Charleston, West Virginia 25301

Charleston Drug Treatment Center — No. 24 Class I
415 Brooks Street
Charleston, West Virginia 25301

Charleston General Hospital
Elmwood Avenue
Charleston, West Virginia 25301

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

CHARLESTON AREA (continued)	LICENSE NO.
Center on Alcoholism and Drug Abuse 410 Kanawha Boulevard, East Charleston, West Virginia 25301	No. 18 Class I

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

CLARKSBURG AREA	LICENSE NO.
Central District Guidance Center 6 Hospital Plaza Clarksburg, West Virginia 26301	LOA Pending

Field Offices

Braxton County Mental Health Clinic
307 Main Street, Third Floor
Sutton, West Virginia 26601

Doddridge County Mental Health Clinic
Doddridge County Courthouse
West Union, West Virginia 26456

Gilmer County Mental Health Clinic
201 North Court Street, P.O. Box 58
Glenville, West Virginia 26351

Lewis County Mental Health Clinic
145 High Street
Weston, West Virginia 26452

Day Care Center

Open Door School for Exceptional Children
6 Hospital Plaza
Clarksburg, West Virginia 26301

Center on Alcoholism and Drug Abuse #6 Hospital Plaza Clarksburg, West Virginia 26301	No. 22 Class I

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

ELKINS AREA	LICENSE NO.
Appalachian Mental Health Center Yokum and Wilmoth Streets P. O. Box 1170 Elkins, West Virginia 26241	No. 6 Class I

Field Offices

Appalachian Mental Health Center
Upshur County
29 South Kanawha Street
Buckhannon, West Virginia 26201

Appalachian Mental Health Center
Pendleton County
Main Street, P. O. Box 412
Franklin, West Virginia 26807

Appalachian Mental Health Center
Mineral County
City Building (Davis and Armstrong)
Keyser, West Virginia 26726

Appalachian Mental Health Center
Pocahontas County
Marlinton, West Virginia 24954

Appalachian Mental Health Center
Hardy County
c/o Hardy County Health Department
Hardy County Courthouse
Moorefield, West Virginia 26836

Appalachian Mental Health Center
Tucker County
220 First Street
Parsons, West Virginia 26287

Appalachian Mental Health Center
Grant County
19 Virginia Street
Petersburg, West Virginia 26847

Appalachian Mental Health Center
Barbour County
Williams Building
Philippi, West Virginia 26416

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

ELKINS AREA (continued) LICENSE NO.

Field Offices (continued)

Appalachian Mental Health Center
Webster County
Rush Auto Parts Building
Webster Springs, West Virginia 26288

Day Care Centers

Upshur County Developmental Center
22 Chancery Street
Buckhannon, West Virginia 26201

The TRY Center
Davis and Elkins College
Albert Hall
P. O. Box 1170
Elkins, West Virginia 26241

Mt. Top Developmental Center
Union High School
Mt. Storm, West Virginia 26739

Pendleton County Developmental Center
Courthouse Annex
P. O. Box 412
Franklin, West Virginia 26807

Barbour County Developmental Center
50 South Main Street (Tacy School Bldg.)
Philippi, West Virginia 26416

Adult Activity Center

AMHC-Adult Activity Center
Nurses' Residence Building
Davis Memorial Hospital
Elkins, West Virginia 26241

Group Homes

AMHC-Group Home for Developmentally
Disabled Adults
932-34 South Henry Avenue
Elkins, West Virginia 26241

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

ELKINS AREA (continued) LICENSE NO.

Affiliate Programs

Memorial General Hospital
1200 Harrison Avenue
Elkins, West Virginia 26241

Davis Memorial Hospital
Harrison Avenue
Elkins, West Virginia 2621

TRY Center
Albert Hall
Davis and Elkins College
Elkins, West Virginia 26241

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

FAIRMONT/MORGANTOWN AREA — **LICENSE NO.**

Valley Comprehensive Community Mental Health Center — No. 8 Class I
603 East Brockway
Morgantown, West Virginia 26505

Mental Health Center
1101 Fairmont Avenue
Fairmont, West Virginia 26554

Mental Health Center
Presbyterian Church
Fairmont, West Virginia 26554

Mental Health Center
111 Water Street
Mannington, West Virginia 26582

Field Offices

Mental Health Center
Preston Memorial Hospital
Kingwood, West Virginia 26537

Mental Health Center
Public Health Building
West Main Street
Grafton, West Virginia 26354

Day Care Centers

Pre-School for the Early Education of Children with Handicaps
Christ Episcopal Church
9th Street
Fairmont, West Virginia 26554

Diagnostic and Developmental Center
Presbyterian Church
Willie and Price Streets
Morgantown, West Virginia 26505

Center on Alcoholism and Drug Abuse — No. 19 Class I
300 Second Street
Fairmont, West Virginia 26554

Center on Alcoholism and Drug Abuse — No. 20 Class I
414 High Street (P.O. Box 760)
Morgantown, West Virginia 26505

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

HUNTINGTON AREA	LICENSE NO.
Community Mental Health Center, Region II 3375 U.S. Route 60, East P. O. Box 8069 Huntington, West Virginia 25705	No. 5 Class I
Community Mental Health Center, Region II 6990 State Route 3 Coffman and Hart Building West Hamlin, West Virginia 25523	
Community Mental Health Center, Region II Wayne, West Virginia 25570	
Mason County Mental Health Service 701 Viand Street Point Pleasant, West Virginia 25550	

Family Service

Family Service, Inc. 1007 Fifth Avenue Huntington, West Virginia 25701	LOA Pending

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

INSTITUTE AREA	LICENSE NO.
Shawnee Hills Regional Center, Inc. Day Training Center Academy Drive Institute, West Virginia 25112	No. 9 Class I
Shawnee Hills Regional Center Faith Sheltered Workshop 3 Carney's Commercial Court Dunbar, West Virginia 25064	
Shawnee Hills Regional Center North Charleston Workshop 2401 Washington St., West Charleston, West Virginia 25312	
Shawnee Hills Regional Center Adult Activities Center 22nd Street Dunbar, West Virginia 25064	No. 9.3 Cl. I
Shawnee Hills Regional Center Infant Stimulation 22nd Street Dunbar, West Virginia 25064	No. 9.2 Cl. I
Shawnee Hills Regional Center Transitional Training 22nd Street Dunbar, West Virginia 25064	No. 9.1. Cl. I
Shawnee Hills Regional Center North Charleston Community Living Program 423 21st Street Charleston, West Virginia 25312	

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

KEYSER AREA	LICENSE NO.
Day Care Center	
The Developmental Center, Inc. 50 Clarey Street Keyser, West Virginia 26726	No. 25 Class I

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

LESAGE AREA	LICENSE NO.
Green Acres Regional Center P. O. Box 115, Route 2 LeSage, West Virginia 25537	No. 4 Class I

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

LEWISBURG AREA	LICENSE NO.
Greenbrier Valley Mental Health Clinic 100 Church Street Lewisburg, West Virginia 24901	LOA Pending
Greenbrier Community Mental Health Center (Mental Retardation Center) 103 Church Street Lewisburg, West Virginia 24901	

Day Care Center

Greenbrier Day Care Center
103 Church Street
Lewisburg, West Virginia 24901

Center on Alcoholism and Drug Abuse 100 Church Street Lewisburg, West Virginia 24901	No. 17 Class I

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

LOGAN/WILLIAMSON AREA	LICENSE NO.
Logan-Mingo Area Mental Health Center 206 Dingess Street Logan, West Virginia 25601	LOA Pending

Logan-Mingo Area Mental Health Center
Memorial Building (P.O. Box 2357)
Williamson, West Virginia 25661

Logan-Mingo Area Mental Health Center
600 East MacDonald Avenue
Man, West Virginia 25635

Day Care Centers

Logan County Day Care Center
Holden Recreation Building
Holden, West Virginia 25625

Mingo County Day Care Center
Sprigg Grade School
Sprigg, West Virginia 25693

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

MARTINSBURG AREA	LICENSE NO.
Eastern Panhandle Mental Health Center 225 South Water Street (P.O. Box L) Martinsburg, West Virginia 25401	No. 15 Class I

Field Offices

Jefferson County Mental Health Service
114 West Washington Street
Professional Building
Charles Town, West Virginia 25414

Morgan County Mental Health Service
Morgan County Courthouse
Berkeley Springs, West Virginia 25411

Hampshire County Mental Health Service
Hampshire County Courthouse
Romney, West Virginia 26757

Center on Alcoholism and Drug Abuse 220 South Water Street Martinsburg, West Virginia	No. 16 Class I

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

PARKERSBURG AREA	LICENSE NO.
Western District Guidance Center 2121 Seventh Street Parkersburg, West Virginia 26101	No. 14 Class I

Field Offices

Jackson County Mental Health Clinic
10 Walnut Street
Ravenswood, West Virginia 26164

Roane and Calhoun Counties
Mental Health Clinic
Spencer State Hospital
Spencer, West Virginia 25276

Ritchie County Mental Health Clinic
Harrisville Health Department
Harrisville, West Virginia 26362

Tyler County Mental Health Clinic
210 Elizabeth Street
Health Department
Sistersville, West Virginia 26175

Adult Activity Center

Adult Activity Center
1701 19th Street
Parkersburg, West Virginia 26101

Center on Alcoholism and Drug Abuse 2121 East Seventh Street Parkersburg, West Virginia 26101	No. 21 Class I

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

PRINCETON AREA	LICENSE NO.
Southern Highlands Community Mental Health Center Twelfth Street Extension Princeton, West Virginia 24740	No. 1 Class I

Field Offices

Southern Highlands Community Mental Health Center Elkhorn Clinic Welch, West Virginia 24801	No. 1.1 Class I
Southern Highlands Community Mental Health Center Guyandotte Clinic Pineville, West Virginia 24874	No. 1.2 Class I

Day Care Centers

Mercer County Day Care Center
Route 1, Box 284
Glenwood Park Complex
Bluefield, West Virginia 24701

McDowell County Day Care Center
Route 2, Box 6
Havaco, West Virginia 24844

Wyoming County Day Care Center
Pineville Presbyterian Church
Pineville, West Virginia 24874

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

ROMNEY AREA	LICENSE NO.
Hampshire County Special Services Center c/o Hampshire County Board of Education Romney, West Virginia 26757	No. 26 Class I

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

SUMMERSVILLE AREA	LICENSE NO.
Nicholas County Mental Health Center 305 McKees Creek Road Summersville, West Virginia 26651	No. 12 Class I

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

WEIRTON AREA	LICENSE NO.
Hancock-Brooke Mental Health Center Weirton General Hospital Weirton, West Virginia 26062	LOA Pending

Day Care Programs

Hancock-Brooke Mental Health Center
Day Care Program
3301 West Street
Weirton, West Virginia 26062

Hancock-Brooke Mental Health Center
Mental Retardation Group Home (Adults)
2973 Elm Street
Weirton, West Virginia 26062

FACILITIES WITH LICENSE STATUS

Community Mental Health Centers

WHEELING AREA	LICENSE NO.
Northern Panhandle Mental Health Center 2121 Eoff Street Wheeling, West Virginia 26003	No. 2 Class I

Field Offices

Northern Panhandle Mental Health Center - Marshall County
Marshall County Courthouse
Moundsville, West Virginia 26041

Northern Panhandle Mental Health Center - Wetzel County
255 Main Street
New Martinsville, West Virginia 26155

Children and Family Service Assn.
329 McLain Building
40 12th Street
Wheeling, West Virginia 26003

Center on Alcoholism and Drug Abuse Room 224, McLain Building 40 12th Street Wheeling, West Virginia 26003	No. 23 Class I

FACILITIES WITH LICENSE STATUS

GENERAL HOSPITALS	LICENSE NO.
Beckley Appalachian Regional Hospital P. O. Box 1149 Beckley, West Virginia 25801	LOA Pending
Cabell-Huntington Hospital 1340 Sixteenth Street Huntington, West Virginia 25701	LOA Pending
Charleston Area Medical Center General Division Brooks Street and Elmwood Avenue Charleston, West Virginia 25301	LOA Pending
St. Joseph's Hospital of Parkersburg 19th Street and Murdoch Avenue Parkersburg, West Virginia 26101	LOA Pending
St. Mary's Hospital 2900 First Avenue Huntington, West Virginia 25701	LOA Pending
PSYCHIATRIC HOSPITALS	
Highland Hospital 300 Fifty-sixth Street, S.E. Charleston, West Virginia 25304	LOA Pending
Valley Clinic 7004 Kanawha Street St. Albans, West Virginia 25177	No. 3 Class I

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

MEDICAL SERVICE INSTRUCTION 3010

TO: HOSPITAL SUPERINTENDENTS
HOSPITAL ADMINISTRATORS
HOSPITAL PHYSICIANS
REGISTRARS
NURSING SERVICE
CENTRAL OFFICE STAFF
SOCIAL SERVICE DIRECTORS

SUBJ: ADULT STATUS FOR 18 YEAR OLDS

Effective June 9, 1972, Chapter 27 of the West Virginia Code is amended to give adult status to 18 year olds. A copy of the revision as it applies to mentally ill persons is attached.

On or before this date a survey should be made at your hospital to determine the persons this legislation will affect. These persons should be staffed to determine the course of action which will be taken.

The parent/guardian should be written and informed of the new legislation and the status under which the patient will be hospitalized.

M. Mitchell-Bateman

M. Mitchell-Bateman, M. D.
Director

CHAPTER 27. MENTALLY ILL PERSONS.

ARTICLE 4. VOLUNTARY HOSPITALIZATION.

§27-4-1. Authority to receive voluntary patients.
§27-4-3. Right to release on application.

§27-4-1. Authority to receive voluntary patients.

1 The superintendent of a state hospital, subject to the
2 availability of suitable accommodations, and subject
3 further to the rules and regulations promulgated by the
4 director of mental health, shall admit for diagnosis, care
5 and treatment any individual:

6 (1) Over eighteen years of age who is mentally ill,
7 mentally retarded or who has symptoms of mental illness
8 or mental retardation and makes application for hospi-
9 talization; or

10 (2) Under eighteen years of age who is mentally ill
11 or mentally retarded or who has symptoms of mental
12 illness or mental retardation and there is application
13 therefor in his behalf (a) by the parents of such per-
14 son, or (b) if only one parent is living, then by
15 such parent, or (c) if the parents be living separate and
16 apart, by the one to whom was awarded the custody of
17 such person, or (d) if there is a guardian entitled to
18 the custody of such person, then by such guardian.

§27-4-3. Right to release on application.

1 A voluntary patient who requests his release or whose
2 release is requested in writing, by his parents, parent,
3 guardian, spouse, or adult next of kin shall be released
4 forthwith except that:

5 (1) If the patient was admitted on his own applica-
6 tion and the request for release is made by a person
7 other than the patient, release shall be conditioned upon
8 the agreement of the patient thereto;

9 (2) If the patient is under eighteen years of age, his
10 release prior to becoming eighteen years of age may be
11 conditioned upon the consent of the person or persons
12 who applied for his admission;

13 (3) If, within ninety-six hours of the receipt of the
14 request, the superintendent of the state hospital in which
15 the patient is confined files with the clerk of the county
16 court of the county in which the patient is a resident,
17 or the clerk of the county court of the county where the
18 hospital is situated, an application for involuntary hos-
19 pitalization as provided in section four, article five of
20 this chapter, release may be postponed pending a de-
21 cision on the application by the mental hygiene com-
22 mission.

23 Notwithstanding any other provision of this chapter,
24 legal proceedings for hospitalization shall not be com-
25 menced with respect to a voluntary patient unless re-
26 lease of the patient has been requested by him or the
27 individual or individuals who applied for his admission.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

MEDICAL INSTRUCTION 3010

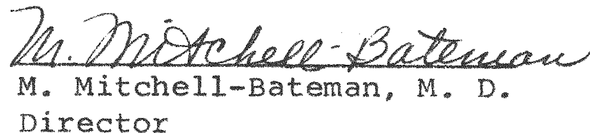
JUNE 28, 1972

TO: HOSPITAL SUPERINTENDENTS
ADMINISTRATORS
HOSPITAL DEPARTMENT HEADS
DIVISION DIRECTORS
SPECIAL PROJECT DIRECTORS

SUBJ: Eighteen Year Olds From Juvenile Courts

We call your attention to Medical Services Instruction 3010, Adult Status for 18 Year Olds. This instruction does apply to 18 year olds confined to your hospital by Juvenile Court Order.

Each case is to be staffed and the Judge of the Juvenile Court informed of the hospital staff's recommendation for the patient. The Juvenile Court Judge will be requested to release the patient from Juvenile Court Commitment, so the recommended staff action may be pursued.



M. Mitchell-Bateman, M. D.
Director

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

MEDICAL INSTRUCTION 3041

AUGUST 20, 1971

TO: HOSPITAL SUPERINTENDENTS
CLINICAL DIRECTORS, PHYSICIANS, NURSES
MEDICAL RECORD LIBRARIANS
MEDICARE CLERKS

SUBJ: PSYCHIATRIC CERTIFICATION AND
RECERTIFICATION (MEDICARE AND
MEDICAID FORM DMH-CR-127) (new 8-29-69)

NCELLATION: Administrative Instruction 3150 issued September 9, 1969.

January, 1970, Federal regulations were changed to state that rtification and recertification statements were to be obtained at the llowing intervals for patients occupying certified beds:

I. Certification: To be obtained at the time of admission or as soon thereafter as is reasonable and practicable, a physician (the admitting physician or a medical staff member with knowledge of the case) must certify the medical necessity for inpatient psychiatric hospital services.

   Inpatient psychiatric hospital services certification: In the case of inpatient psychiatric hospital services, the required physician's statement should certify that such services were required for either:

   1. Treatment which could reasonably be expected to improve the patient's condition; or

   2. Diagnostic study.

   Since the health insurance program's intent is to cover only active care and not to cover custodial care, certification is to be obtained upon admission.

II. Recertification: To be made on or before the 12th day of hospitalization.

III. Second recertification: To be made on or before the 18th day of hospitalization.

Inpatient psychiatric hospital services recertification: The recertification statement should indicate:

1. The inpatient psychiatric hospital services furnished since the previous certification and recertification were, and continue to be, required for either:

   (a) Treatment which could reasonably be expected to improve the patient's condition or

   (b) Diagnostic study; and

2. That the hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.

IV. Additional certifications:

Subsequent recertifications must be made at intervals established by the utilization review committee (on a case by case basis, but in no event may the interval between recertifications exceed thirty days.

The period covered by the physician's certification and recertification is referred to as a period during which the patient was receiving active treatment. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition, or because intensive treatment services are not being furnished), program payment can no longer be made even though the patient has not yet exhausted his benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

V. The present form DMH-CR-127 lists the 14th as the date for recertification and the 21st as the date for the second recertification. If you have a supply of these forms on

V. (continued) hand, please change the dates to read 12th for certification and 18th for recertification. All newly printed forms are to reflect this change with the following notation beside the form number (revised 9-1-71).

VI. The original copy of the DMH-CR-127 must be placed in the patient's medical record file.

M. Mitchell-Bateman

M. Mitchell-Bateman, M. D.
Director

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

MEDICAL POLICY 3110

TO: Hospital Superintendents, Clinical Directors and Registrars

FROM: M. Mitchell-Bateman, M. D.
Director

DATE: April 18, 1974

SUBJ: Notification of family on new admissions under the provisions of the emergency or medical certification procedures.

1. Discussion - The West Virginia Code, Chapter 27, Article 5, Section 3, entitled, "CUSTODY FOR MEDICAL EXAMINATION; EMERGENCY PROCEDURE; HOSPITALIZATION OR RELEASE; NOTICE OF ADMISSION TO CERTAIN PERSONS: stipulates in part the following:

   "When an individual is admitted to a State hospital or to a private facility or hospital pursuant to the provisions of this section, the superintendent of the State hospital or the head of the private facility or hospital, as the case may be, shall immediately give notice of the individual's admission to such State hospital or private facility or hospital to the following persons: His or her spouse, parents, parent or guardian, to two of the individual's next of kin. Such notice shall be in writing and shall be transmitted to such person or persons at his, her or their last known address be registered or certified mail, return receipt requested."

   The provisions of the aforesaid law require that the family be notified immediately in every instance in which a patient is admitted under the provisions of the emergency or medical certification procedures. In many instances, this is not being done and there is an apparent assumption that the referring agency has made such notification.

2. Procedures - The implementation of this law is for the attention of the registrar who should take whatever steps are necessary to assure that such notifications are made immediately in every such admission.

3. Effective Date: This policy cancels the memorandum previously issued and is effective upon receipt.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

MEDICAL SERVICE POLICY 3110

JULY 1, 1974

CRITERIA AND PROCEDURE FOR ADMISSION OF CHILDREN TO STATE HOSPITALS

A. A child may be admitted to the hospital if:

1. The psychological problem is so disturbing that the child cannot be treated on an outpatient basis, that is,

   a. The child is highly likely to be physically harmful to himself or others as a result of his mental illness, and

   b. All alternative plans for treatment have been attempted by the referring agency, and

2. The suggested treatment plan as mentioned above is impossible to carry out on an outpatient basis because of lack of staff and/or appropriate family facilities.

B. Before a request for admission to the hospital is made, the following must be done:

1. The community mental health center serving the area of this child's residence must first review the case for establishing the appropriate evaluation and treatment plan.

2. The community mental health center dealing with the child is to assist parents or guardians in obtaining a physical examination for the child (including vision and hearing).

3. The center is to arrange for the child to have a psychological and/or psychiatric evaluation.

4. The evaluation report is to be written and should contain the following:

   a. A description and analysis of the social history of the client.

   b. Diagnosis and description and analysis of the client's functional behavior symptom, and

   c. Suggested treatment plan for the child.

5. Referral to the Diagnostic Center may be made if the child is six years of age or younger and the diagnosis is questionable.

6. Private practitioners may make referrals, but the entrance point to the system must be the mental health center in the client's region.

7. The center must have identified possible post-hospital placements prior to admission to the hospital.

8. Agreement must be obtained from the parent of the child that they will participate in the client's program of treatment. This participation may vary according to a mutual decision between the parents and the referring center staff. This could include parent counseling and/or actual involvement with the hospital treatment program while the child is in the hospital.

All the provisions of the Mental Health Code, House Bill 910, are to be adhered to strictly. Special attention is drawn to the fact that admission to a mental health hospital for prospective patients sixteen to eighteen years of age is contingent upon his consent.

When children are referred for admission to state hospitals, it is the responsibility of the admissions office to contact the Director of the Children's Unit regarding authorization for admission. If the child's need does not seem to be appropriate for the particular Youth Unit, the hospital shall make the necessary arrangements with the appropriate Youth Unit. Authority for emergency admissions may be granted by contacting the following persons in the order given:

Clinical Director or Chief Medical Officer
of the receiving hospital

Mrs. Ida B. Chamberlain	Office - 348-2480 Home - 925-3625
Robert D. Kerns, Ph.D.	Office - 348-3219 Home - 343-7858
Randolph R. MacDonald, Ed.D.	Office - 348-4093
Mrs. Mary A. Hicks	Office - 348-3219
M. Mitchell-Bateman, M.D.	Office - 348-3211
Richard A. Bracco, M.D.	Office - 269-1210

While it is important that no child be permitted to remain in a damaging or inappropriate situation in the community, it is equally important that inappropriate hospitalization not occur either. It is, therefore, the responsibility of the medical officer on duty to assure that a proper decision be made relative to each child for whom admission is sought, and to make those contacts necessary to accomplish this end.

When the patient's treatment plan is revised or updated, a copy of this update is to be forwarded to the referring mental health center.

At least two weeks prior to discharge of a patient from the hospital, a discharge summary on the patient must be forwarded to the referring mental health facility. If the admission has been for short term or crisis intervention, this requirement may not be met; however, the hospital staff is expected to keep Center staff well apprised of patient progress and to jointly make release plans.

This policy supersedes Policy 3110 issued December 14, 1973, and will remain in effect until changed.

M. Mitchell-Bateman, M.D., Director

APPROPRIATE PLACEMENT OF CHILDREN

When admission of children within the catchment areas of Huntington State Hospital or Weston State Hospital is deemed necessary, the following is to be expected:

a. The child is to be admitted to the appropriate Youth Units at the respective hospital facility.

b. These hospitals are to serve as crisis intervention facilities.

c. If it is believed that prolonged hospitalization would benefit the child, plans to transfer this child to the appropriate facility are to be initiated.

d. If the child is 14 years of age or younger, he is to be transferred to Lakin State Hospital when space is available.

e. If the child is older than 14 years of age, he is to be transferred to Spencer State Hospital as soon as space is available.

f. Cases involving a primary diagnosis of severe mental retardation are to be referred to Colin Anderson Center.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

MEDICAL SERVICES INSTRUCTION 3160

APRIL 19, 1972

TO: Hospital Superintendents
Hospital Administrators
Clinical Directors
Hospital Department Heads

FROM: M. Mitchell-Bateman, M. D.
Director

SUBJ: Interstate Transfer

When a patient is transferred to another state under terms of the Interstate Compact on Mental Health, the patient is not to be discharged from West Virginia commitment until we are sure the new state has processed the legal papers for continued hospitalization in their state.

Some states will send Voluntary papers to this state to be signed by the patient before transfer. In this situation, the patient may be discharged when he is transported to the new state.

In some instances, it will be necessary to release the patient on temporary medical leave with follow up correspondence to the new state asking that you be informed at the time their legal work is completed.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

MEDICAL INSTRUCTION 3160

JUNE 9, 1971

TO: HOSPITAL SUPERINTENDENTS
HOSPITAL ADMINISTRATORS
SOCIAL SERVICE STAFF
REGISTRARS
PHYSICIANS - NURSING

FROM: M. Mitchell-Bateman, M. D. (MMB)
Director

SUBJ: Interstate Compact

West Virginia is one of the forty states who are members of the Interstate Compact on Mental Health.

The primary intent of the Compact is to give more emphasis to the welfare and clinical needs of the patient, and ease of maintenance of community contacts rather than the usual emphasis on the patient's legal place of residence. As a member of the compact, we have authorization to handle transfer matters from the point of view of the patient's best interest.

Each state keeps a statistical report on the number of transfers in and out; thus, all requests and investigations for out of state living arrangements or hospitalization are to be sent through the Compact Administrator. When requests are handled in this manner, problems between states can be worked out on a statewide basis allowing decisions and policy changes to be transmitted to all our hospitals.

If the request is sent through the Compact Administrator and the patient finds himself in need of mental health services in his new state of residence, a contact will have been set up for him which will eliminate unnecessary court procedures and undue delay in his receiving care and treatment.

Discharge planning must begin early. Adequate time must be allowed for correspondence between states.

Selection of cases for transfer may come to your attention through the following:

1. Admission (out of state address, relatives, etc.).

2. Staffing conferences.

(MMB)

3. Correspondence from interested relatives.

4. Availability of rehabilitation and training programs.

Transfers are made with the following criteria in mind:

1. Place of treatment which will be most beneficial to patient.

2. Interest of family, relatives, etc.

3. Patient's state of residence.

The following types of cases are to be processed through the Compact Administrator:

1. Requests for transfer of a patient from another state to West Virginia for the purpose of hospitalization.

2. Request for placement of patient from another state to out-patient facility or for aftercare supervision in West Virginia.

3. Request for transfer of a West Virginia state hospital patient to a hospital in another state.

4. Request for the placement of a patient in our hospital for out-patient service or aftercare supervision in another state.

5. Requests from another state for the return of a patient to that state, who is absent without leave from a hospital in that state.

6. Requests for return to West Virginia from another state of patient absent without leave from a West Virginia State Hospital.

7. West Virginia has enacted legislation which allows us to make requests for the transfer of a patient under sentence for commission of a crime to an institution in another state for the purpose of care, treatment, aftercare, auxiliary services and rehabilitation. These requests are based on the therapeutic needs of the patient.

Procedure to be followed:

A. Transfers in:

1. All requests will be directed to the Compact Administrator, Dr. Mildred Bateman, West Virginia Department of Mental Health, State Capitol Building, Charleston, West Virginia 25305.

2. The Compact Administrator or his designate, will review each individual request and assemble the necessary case information. This information will be forwarded to the proper agency to interview relatives and investigate home conditions to determine the interest in an attitude toward the patient and his proposed transfer.

3. The Compact Administrator or his designate, will review the material, including the results of and recommendations of the investigating agency and will advise the interested state of the decision rendered.

4. If the patient is coming into the state, the nearest mental health clinic will be notified of patients arrival and requested to provide aftercare services.

B. Transfers out:

The Superintendent or his designee should periodically scrutinize samples of admission records as well as inpatient records to determine if there are cases which come under the compact provisions. The Registrar at each hospital has been assigned the duty of compiling the information needed for execution of the transfer.

The Unit Team, the patient's physician, the social service staff, all may make the Superintendent aware of cases which they feel will benefit from an interstate transfer.

Material which must be included with all requests for transfers out:

1. Four copies of DMH-PS-401 dated August 1, 1970.
   Distribution: 1 copy for Hospital Medical Record
   3 copies to be forwarded to Compact Director

2. Four copies of a clinical summary which should include a resume of the patient's record, description of illness, measures of treatment, type of future treatment indicated. Same distribution.

M. Mitchell-Bateman

M. Mitchell-Bateman, M. D.
Director

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

ADMINISTRATIVE POLICY 5210

June 26, 1975

TO: HOSPITAL SUPERINTENDENTS
CLINICAL DIRECTORS
REGISTRARS
DIVISION SUPERVISORS

FROM: DIRECTOR
DEPARTMENT OF MENTAL HEALTH

SUBJ: REGISTRAR'S OFFICE MANUAL CHANGE LETTER #14

1. PURPOSE: The purpose of this release is to issue revised policy regarding the Registrar's Office Manual.

2. SECTIONS ADDED AND/OR DELETED:

   Deletion: Section III, page 2 dated December 29, 1970

   Addition: Section III, page 2 dated June 26, 1975

3. DISCUSSION: Effective July 1, 1975, the listing of counties served by each of the state mantal hospitals under the jurisdiction of the West Virginia Department of Mental Health, has been revised according to this new listing. After that date, no patient will be admitted to a hospital other than that designated as serving his home county without the espress approval of the office of the Director of Mental Health.

4. PROCEDURES: As with previous R. O. Change Letters, this letter will be transmitted to Registrars, who in turn will distribute the letter to all Registrar's Office Manual holders in each hospital. Each manual holder is instructed to review these pages and insert them in the proper place in his manual. If any hospital staff needs help in inserting the pages in his manual in the proper place, aid should be requested from the Registrar.

5. EFFECTIVE DATE: This Policy is effective July 1, 1975.

M. Mitchell-Bateman

M. Mitchell-Bateman, M. D.
Director

ADMISSION OF PATIENTS:

A. POLICY:

2. STATE MENTAL HOSPITAL DISTRICTS: As noted below admissions to West Virginia State Mental Hospitals as based on districts.

Barboursville

No direct admissions

Huntington

Cabell	McDowell	Raleigh
Fayette	Mercer	Summers
Lincoln	Mingo	Wayne
Logan	Monroe	Wyoming

Lakin 1/

Jackson	Mason	Putnam

Spencer

Boone	Pleasants	Wirt
Calhoun	Ritchie	Wood
Clay	Roane	
Kanawha	Tyler	

Weston

Barbour	Harrison	Pocahontas
Berkeley	Jefferson	Preston
Braxton	Lewis	Randolph
Brooke	Marion	Taylor
Doddridge	Marshall	Tucker
Gilmer	Mineral	Upshur
Grant	Monongalia	Webster
Greenbrier	Morgan	Wetzel
Hampshire	Nicholas	
Hancock	Ohio	
Hardy	Pendleton	

Colin Anderson Center - St. Marys

Statewide admissions as space is available

1/ Statewide admissions to children age 15 and under who enter the "Children's Unit"

R. O. Change letter #14

Cooperative Agreement *
between
Central District Mental Health Center, Inc.
and
Weston State Hospital

I. Weston State Hospital, hereinafter called the "Hospital", and the Central District Mental Health Center, Inc., hereinafter called the "Center", hereby enter into a cooperative agreement to provide mental health services to precare and aftercare patients of a common geographic catchment area - (Braxton, Doddridge, Gilmer, Harrison and Lewis Counties). The term "Patient" as hereinafter used is understood to refer only to the mentally ill patients of the five counties jointly served by the Hospital and the Center.

The intent of this compact is to insure within the limits of existing resources of the "Center" and the "Hospital" via joint planning, continuity of care to the mentally ill person and his family in his transition between his community of residence and the "Hospital".

II. The "Center" Agrees:

A. To provide to the patient upon release from the "Hospital" outpatient care, supervision of medication, home visits, day care, and consultation services as required.

B. To provide to the "Hospital" case records or a summary of psychiatric, psychological, social and other information on patients admitted to the "Hospital" who have previously been evaluated or treated by the "Center".

C. To work with families of patients referred or admitted to the "Hosptial" upon request from the "Hospital" by:

1. Providing to the "Hospital" an admission social history for all patients admitted to the "Hospital" upon request from the "Hospital", within existing staff resources.

2. Making home visits and obtaining information helpful to the "Hospital" in the pre-release planning for patients.

3. Helping the family work through problems which are contributing to the patient's illness.

4. Cooperating with the "Hospital" staff in preparation of the family to receive the patient upon release from the "Hospital".

5. Working with Welfare, Vocational Rehabilitation and the "Hospital" in efforts to place and supervise patients whose primary resources (family) is non-existant or uninterested.

D. To provide without charge to the family, services defined in this agreement while the individual patient is a resident of the "Hospital". The "Center" further agrees that fees to be billed for any precare and aftercare services will be determined according to the family ability to pay prior to the referral or rendering of services.

* Original unavailable. This is a retyped copy.

E. To invite participation of Weston State Hospital Staff in the planning activities for additional mental health services.

III. The "Hospital" Agrees:

A. To provide to the "Center" regular listings of patients admitted to or returning from the "Hospital" so that the names of all patients who are hospitalized from the "Center's" region will be on file in the "Center".

B. To make referrals to the "Center" of patients who need aftercare and so that a medication check and other follow-up reviews may be made within two weeks after return to the community from the "Hospital".

C. To send a "Notification of Release" to the "Center" at the time a patient is returned to the community so that the "Center's" Staff is aware of the patient's presence in the community, the medication used and the name of his family physician or referring physician.

D. To send the "Center" a discharge summary or other information pertinent to aftercare planning within two weeks of the patient's return to the community.

IV. Projected Goals - to be reviewed jointly by the "Hospital" and the "Center" within one year following the date of this agreement.

1. The "Hospital" agrees to work toward:

A. The establishment of a geographic unit within Weston State Hospital to include counties served by the "Center".

B. Send progress notes as appropriate to the "Center" and the family physician while the patient is in the "Hospital".

C. Invite "Center" participation in staffings of patients on a scheduled basis.

D. Require that all patients referred for admission be referred to the "Center" for preliminary screening within the "Center's" resources.

2. The "Center" Agrees to work toward:

A. The further stated use of the "Center" cooperating with County Clerks, Sheriffs, County Health Officers, and others, in order to provide appropriate screening of the mentally ill prior to admission to the "Hospital".

B. To become involved in joint planning with the five counties of its common catchment area with a view towards total comprehensive Mental Health coverage as outlined in the Community Health Centers act (Public Law 88-164 as amended).

V. Terms of the Agreement:

This agreement is intended to assure continuity of care and services to emotionally disabled persons of the "Center" catchment area.

This agreement will take effect on January 17, 1974, and may be terminated by either party by written notice thirty (30) days prior to termination or by adoption of a different agreement between "Hospital" and "Center.

DATE________________________ DATE________________________

________________________ ________________________

Richard Bracco, M.D.
Deputy Director
Clinical Services
Department of Mental Health

W. Obed Poling
Superintendent
Weston State Hospital

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M. Mitchell-Bateman, M.D., Director
West Virginia Department of Mental Health

________________________ ________________________

James C. Chapman
Executive Director
Central District Guidance Center, Inc.

Allen L. Tibbs
President
Board of Directors
Central District Guidance Center, Inc.

DISTRIBUTION OF MENTAL HEALTH FACILITIES BY REGION AND COUNTY

as required by

THE WEST VIRGINIA CODE, 1931, as AMENDED
(Chapter 27-1-9; 27-5-1)

In order to assure a community-based approach, the following listing of mental health facilities, as required by the West Virginia Code, designates the primary community mental health facilities to which patients and clients requiring mental health or mental retardation services should be referred for evaluation, diagnosis, and treatment. Whether or not the patient needs inpatient services requiring hospitalization, the designated mental health center will be responsible for evaluating the situation, determining the most appropriate service needed, and following through with the client until no further services are required.

It is understood that in some areas where 24-hour emergency service may not be available, that the state hospital serving that area may be utilized as the point of initial contact in an emergency situation.

COUNTY	REGION/ CATCHMENT AREA	DESIGNATED MENTAL HEALTH SERVICE FACILITY
Barbour	7&8	Appalachian Mental Health Center, Inc. Williams Building Philippi, West Virginia 26416 Telephone: 457-2580
Berkeley	9	Eastern Panhandle Mental Health Center, Inc. 212 S. College Street Martinsburg, West Virginia 25401 Telephone: 263-8954
Boone *	3	Boone Human Services Center Community Mental Health Center of Region 3 62 Avenue C Madison, West Virginia 25130 Telephone: 369-1930
Braxton	6-CA2	Braxton County Mental Health Center Sutton Business and Professional Building 307 Main Street Sutton, West Virginia 26601 Telephone: 765-7447
Brooke **	11	Hancock-Brooke Mental Health Service Salvation Army Building Wellsburg, West Virginia 26070 Telephone:
Cabell	2-CA2	Community Mental Health Center, Inc. 3375 U.S. Route 60, East P. O. Box 8069 Huntington, West Virginia 25705 Telephone: 525-7851
Calhoun	5	Roane and Calhoun Counties Mental Health Clinic Western District Guidance Clinic Spencer State Hospital Spencer, West Virginia 25276 Telephone: 927-2110
Clay *	3	Clay County Human Services Center Community Mental Health Center of Region 3 P. O. Box 355 Clay, West Virginia 25053 Telephone: 587-4205
Doddridge	6-CA2	Doddridge County Mental Health Clinic Central District CMHC, Inc. Doddridge County Courthouse West Union, West Virginia 26456 Telephone: 873-1288

Fayette	1-CA2	Fayette County MHC FMRS Mental Health Council 213 N. Court Street Fayetteville, West Virginia 25840 Telephone: 574-2100 or 878-3600 and Fayette County Community MHC FMRS Mental Health Council 210 Third Avenue Montogmery, West Virginia 25136 Telephone: 442-5266
Gilmer *	6-CA2	Gilmer County Mental Health Clinic Central District Mental Health Center 201 N. Court Street P. O. Box 58 Glenville, West Virginia 26351 Telephone: 462-8226
Grant	7&8	Appalachian Mental Health Center 19 Virginia Street Petersburg, West Virginia 26847 Telephone: 257-8323
Greenbier **	4	Greenbrier County MH/MR Center 103 Church Street Lewisburg, West Virginia 24901 Telephone: 645-3319
Hampshire **	7&8	Hampshire County Mental Health Service Eastern Panhandle Mental Health Center Courthouse Romney, West Virginia 26757 Telephone: 822-3318
Hancock **	11	Hancock-Brooke Mental Health Service Weirton General Hospital Weirton, West Virginia 26062 Telephone: 748-3232
Hardy	7&8	Appalachian Mental Health Center Hardy County Courthouse Moorefield, West Virginia 26836 Telephone: 538-6420
Harrison	6-CA2	Central District Mental Health Center #6 Hospital Plaza Clarksburg, West Virginia 26301 Telephone: 623-5661
Jackson *	5	Western District Guidance Center 210 Walnut Street Ravenswood, West Virginia 26164 Telephone: 273-3302

Jefferson	9	Jefferson County Mental Health Service Eastern Panhandle Mental Health Center Professional Building 114 West Washington Street Charles Town, West Virginia 25414 Telephone: 725-9685
Kanawha *	3	Charleston Guidance Clinic Community Mental Health Center of Region 3 5608 MacCorkle Avenue, S.E. Charleston, West Virginia 25034 Telephone: 925-4926
Lewis	6-CA2	Lewis County Mental Health Center Central District Mental Health Center 145 High Street Weston, West Virginia 26452 Telephone: 269-5220
Lincoln	2-CA2	Lincoln County Mental Health Office Community Mental Health Center of Region 2 6990 State Route 3 West Hamlin, West Virginia 25571 Telephone: 924:5790
Logan	2-CA1	Logan-Mingo Area Mental Health 206 Dingess Street Logan, West Virginia 25601 Telephone: 752-6320 or 752-4357
McDowell	1-CA1	Elkhorn Mental Health Clinic Southern Highlands CMHC 57 Elkhorn Street P. O. Box 164 Welch, West Virginia 24801 Telephone: 436-2106
Marion	6-CA1	Valley Comprehensive Community Mental Health Center 1101 Fairmont Avenue Fairmont, West Virginia 26554 Telephone: 366-7174
Marshall	10	Northern Panhandle Mental Health Center Courthouse Moundsville, West Virginia 26041 Telephone: 845-8660
Mason	2-CA2	Mason County Mental Health Service Community Mental Health Center of Region 2 701 Viand Street Point Pleasant, West Virginia 25550 Telephone: 675-2361

Mercer	1-CA1	Bluestone Clinic of Southern Highlands Community Mental Health Center 12th St. Extension Princeton, West Virginia 24720 Telephone: 425-9543
Mineral	7&8	Appalachian Mental Health Center Public Health Building Route 4, Box 15A Keyser, West Virginia 26726 Telephone: 788-2241
Mingo	2-CA1	Logan-Mingo Area Mental Health, Inc. Memorial Building Williamson, West Virginia 25661 Telephone: 235-2954
Monongalia	6-CA1	Valley Comprehensive Community Mental Health Center 603 E. Brockway Avenue Morgantown, West Virginia 26505 Telephone: 296-1731
Monroe	1-CA2	Monroe County Mental Health Center FMRS Mental Health Council P. O. Box G Main Street Union, West Virginia 24983 Telephone: 772-5452
Morgan	9	Morgan County Mental Health Service Eastern Panhandle Mental Health Center Morgan County Courthouse Berkeley Springs, West Virginia 25411 Telephone: 258-2889
Nicholas **	4	Nicholas County Mental Health Center 305 McKees Creek Road Summersville, West Virginia 26651 Telephone: 872-4207
Ohio	10	Northern Panhandle Mental Health Center 2121 Eoff Street Wheeling, West Virginia 26003 Telephone: 234-8671
Pendleton	7&8	Appalachian Mental Health Center High Street P. O. Box 412 Franklin, West Virginia 26807 Telephone: 358-2554

County	Region	Center
Pleasants *	5	Western District Guidance Center 1100 Market Street Parkersburg, West Virginia 26101 Telephone:
Pocahontas	7&8	Appalachian Mental Health Center, Inc. Pocahontas County Courthouse Marlinton, West Virginia 24954 Telephone: 799-4678
Preston	6-CA1	Valley Comprehensive Community Mental Health Center Kingwood Shopping Plaza Kingwood, West Virginia 26537 Telephone: 329-1059
Putnam *	3	Putnam County Human Problems Center CMHC of Region 3 3769-A Teays Valley Hurricane, West Virginia 25526 Telephone: 562-3711 or 755-4871
Raleigh	1-CA2	FMRS Mental Health Council 101 South Eisenhower Drive Beckley, West Virginia 25801 Telephone: 252-8651
Randolph	7&8	Appalachian Mental Health Center Yokum and Wilmoth Streets P. O. Box 1170 Elkins, West Virginia 26241 Telephone: 636-3232
Ritchie *	5	Western District Guidance Center 2121 E. Seventh Street Parkersburg, West Virginia 26164 Telephone:
Roane *	5	Roane and Calhoun Counties Mental Health Clinic Western District Guidance Center Spencer State Hospital Spencer, West Virginia 25276 Telephone: 927-2110
Summers	1-CA2	FMRS Mental Health Council 98 Union Street P. O. Box 658 Hinton, West Virginia 25951 Telephone: 466-3899
Taylor	6-CA1	Valley Comprehensive Community Mental Health Center Public Health Building W. Main Street Grafton, West Virginia 26354 Telephone: 265-3947

Tucker	7&8	Appalachian Mental Health Center 220 First Street Parsons, West Virginia 26287 Telephone: 478-2764
Tyler *	5	Tyler County Mental Health Clinic Health Department 210 Elizabeth Street Sistersville, West Virginia 26175 Telephone: 657-2350
Upshur	7&8	Appalachian Mental Health Center 29 South Kanawha Street Buckhannon, West Virginia 26201 Telephone: 472-2022
Wayne	2-CA2	Wayne County Mental Health Office CMHC of Region 2 c/o Wayne County Health Department Wayne, West Virginia 25570 Telephone: 272-3466
Webster	7&8	Appalachian Mental Health Center Rush Auto Parts Building Webster Springs, West Virginia 26288 Telephone: 847-5425
Wetzel	10	Northern Panhandle Mental Health Center 255 Main Street P. O. Box 609 New Martinsville, West Virginia 26255 Telephone: 455-3622
Wirt *	5	Western District Guidance Center 1100 Market Street Parkersburg, West Virginia 26164 Telephone:
Wood *	5	Western District Guidance Center 2121 E. Seventh Street Parkersburg, West Virginia 26101 Telephone:
Wyoming	1-CA1	Guyandotte Mental Health Clinic Southern Highlands CMHC Daniels Building - Main Street Pineville, West Virginia 24874 Telephone: 732-7402

* Twenty-four hour emergency service is not available. Spencer State Hospital, Spencer, West Virginia, may be utilized as the point of initial contact in an emergency situation.

** Twenty-four hour emergency service is not available. Weston State Hospital, Weston, West Virginia, may be utilized as the point of initial contact in an emergency situation.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

CHARLESTON 25305

M. MITCHELL-BATEMAN, M.D.
DIRECTOR

ADDRESS ALL REPLIES
TO THE DIRECTOR

MEMORANDUM

TO: All Community Mental Health/Mental Retardation Program Directors

FROM: M. Mitchell-Bateman, M.D.
Director

DATE: June 4, 1976

RE: Funding Allocation Formula

This memorandum is to advise you that through the cooperative efforts of the staff of the Community Services Division and members of the Association a proposal has been advanced and accepted for the allocation of State appropriated funds for the 1976-77 fiscal year.

State reimbursement and S.B. 56 funds, contingent upon availability of dollars, will be approved as follows:

(1) Maintenance funding or the continuation budget will be based on the same state (accounts 4100-23 and 4100-25) and county (S.B. 56) funding as Fiscal Year 1975-76.

(2) Deficit funding - replacement funding for deficit incurred by loss of prior approved Federal staffing grants.

(3) Request funding - for loss of other Federal funds, expansion of programs, new programs and cost of living increases.

The formula that has been conceived for more equitable allocation based on equality of funds for equality of care for the population in need of services will be applied only to part 3 above and will be applicable to supplemental funding.

In the event that the legislature in subsequent special session appropriates the total amount as originally requested for Community Mental Health/Mental Retardation programs the original requests will be honored as far as is practicable in accordance with the motion made to that effect during the April meeting of the Association.

If the legislature's appropriation is less than the original request and if funds are available after categories 1 and 2 above are satisfied, the formula will then be applied to 3.

If the formula exceeds the original request, such funds may probably be redistributed to other programs on an equitable basis where the original request was greater than allowed by the formula.

The formula to be used will be based on the following three components:

Component	Part	Factor	Weight	Total
Basic Population and Economics	(1) (a)	Population	50%	= 70%
	(b)	Median per capita income	20%	
Environmental Stresses	(2) (a)	Unemployment rate	3%	= 10%
	(b)	Dependency ratio	3%	
	(c)	Education factor	3%	
	(d)	Isolation factor	1%	
Evaluation	(3) (a)	Ratio between in-patients and 4.5%	5%	= 20%
	(b)	Ratio between out-patients and 4.5%	5%	
	(c)	Score from licensing profile	10%	

All data used will be from the most recent information available.

In parts (1)(b), (2)(d), and (3)(a) above a reciprocal factor is applied.

The formula is not to be interpreted as any attempt to penalize but rather to bring about an equalization of services available to all.

In subsequent years the percentages in parts (1), (2), and (3) above will be adjusted as below:

Part (1) will be reduced proportionately next year to total 60%, the following year to 50% with maintenance at that level.

Part (2) will be adjusted to meet the needs of programs after further study.

Part (3) the ratios are in relation to an arbitrary 4.5% of the general population which is a minimum level of the general population considered likely to benefit from mental health/mental retardation services availability and accessibility.

The reductions in percentages as mentioned in Part (1) would be compensated by increases in Part (3) on a proportional basis. In following years Part (3)(c) would be based upon a program review which will most probably be combined with the federal site review where applicable.

In these trying times of uncertainty about funding the application of this formula seems to be an appropriate method for assuring continuation and strengthening of our total program of service.

cc: James R. Clowser
Robert E. Marshall

PURCHASE OF SERVICE

THIS AGREEMENT, made this _______ day of ___________________, 19_______ by and between the WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH, as authorized by Section 7, Article 1-A, Chapter 27, West Virginia Code, first party, and

____

____

a local governmental unit, a non-profit organization, second party (use appropriate term).

WITNESSETH:

(1) For and in consideration of the mutual benefits therein contained, the parties hereto mutually agree to enter into and abide by the terms and provisions setforth herein.

(2) As provided by the West Virginia Legislature for this purpose, the first party agrees to reimburse to the second party a sum not to exceed $__________________________for the fiscal year ending June 30, 19_____, said sum to be released in monthly installments after the beginning of the new fiscal year on the basis of actual reimbursable expenditures as submitted on forms prescribed by the West Virginia Department of Mental Health. These approved plans for programs and expenditures shall thereafter be attached to and considered a part of this agreement.

(3) It is mutually agreed by the parties of the first part and the parties of the second part that any equipment and unused supplies purchased under the terms of this contract for the local mental health service will revert to the party of the first part in the event the party of the second part fails to carry out the responsibilities as stated in the contract or dissolution of the program provided by the party of the second part. It is herein agreed that the party of the second part shall keep an inventory of all equipment and supplies purchased under this agreement and submit annual inventory reports to the first party.

(4) It is also agreed that the party of the second part shall utilize the standard DMH - chart of accounts and procedures in maintaining accounting records. It is also agreed that the accounting records shall be open for inspection or audit to the administration of the department and that standards for independent audits and required time tables shall be followed to the fullest extent possible. It is further agreed that the state properties used by the party of the second part shall be properly maintained to avoid the risks of rapid deterioration or undue wear.

(5) It is mutually agreed that the second party shall serve as the designated mental health facility within its service area as provided in Chapter 27, Articles 4 and 5, West Virginia Code, and shall abide by rules and regulations established by the first party relating thereto, which shall include compliance with standards of (a) eligibility, (b) treatment, (c) audit and accounting, and (d) invoicing and reporting. The first party agrees to accept, within State hospitals under its control and direction, individuals referred for in-patient treatment by the second party, and to provide free access to such patients and their records by the second party and its agents according to the terms of written agreements negotiated between the second party and the respective State hospitals. Such agreements must be in accord with West Virginia Statutes and DMH regulations regarding confidentiality.

(6) All parties shall abide by the provisions of Title VI of the Civil Rights Act.

(7) The parties hereto adopt by reference all of the terms and conditions set out in this Agreement.

IN WITNESS WHEREOF, the parties by their duly authorized agents, have subscribed this Agreement, the day, month, and year first written above.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

BY______________________________
As to First Party

______________________________ ______________________________
ATTEST As to Second Party

DMH-CS-16-a (Revised 3/1/76)

PURCHASE OF SERVICE AGREEMENT

I. AUTHORIZATION Chapter 27, Article 1-A, Section 7, and Article 8, Section 2-a, of the West Virginia Code, 1931, as amended.

II. PURPOSE

Since it is the intent and purpose of the West Virginia Department of Mental Health to provide a comprehensive program for the care, treatment, and prevention of mental illness and mental retardation in the State of West Virginia and since it is believed that many problems of the mentally ill and mentally retarded can be more appropriately and effectively treated at the community level, it is concluded that the State of West Virginia should share with the local communities in the financing of such programs.

To accomplish this goal, the West Virginia Department of Mental Health, subject to the availability of funds, intends to reimburse local sponsoring groups for reimbursable costs, payment shall be made to those appropriate entities which meet the following requirements of eligibility.

III. ELIGIBILITY

A. Organizations

To be eligible for reimbursement, organizations must be public or non-profit. Non-profit organizations shall be incorporated in accordance with Chapter 27, West Virginia Code, and in addition, have an administrative board of directors.

B. Services

To be eligible for reimbursement by the State, the community mental health services provided herein shall consist of at least one of the following: (1) partial hospitalization, must include at least day care services, (2) emergency services, (3) inpatient services, (4) outpatient services, (5) consultation and education, (6) alcoholism services, (7) drug abuse services, (8) special services for children, (9) special services for elderly, (10) precare (screening for state hospitalization), (11) aftercare (follow-up care), (12) transitional half-way house services. Other types of services may be reimbursed, if approved by the Director. Priority would be given those programs which show a definite relationship with the comprehensive mental health program for its specific region.

C. Financial

To be eligible for reimbursement by the State, the following conditions must be conformed with:

1. The organization shall submit to the West Virginia Department of Mental Health for approval an annual plan for program and expenditures. The approved plan shall thereafter be attached to and considered a part of this Agreement. That plan and this Agreement may be amended by the second party hereto only upon prior written approval of the Director.

PURCHASE OF SERVICE AGREEMENT

2. Disbursements will be on a monthly basis, subject to availability of funds.

3. To use these funds only for expenses set forth to the annual expenditure plan (see item No. 1)

4. Salaries shall be consistent with rules and regulations promulgated by the West Virginia Department of Mental Health.

5. That state reimbursement funds are not intended to supplant local community funds.

D. Standards

To be eligible for reimbursement by the State, the organizations shall conform to the standards, rules, and regulations promulgated by the West Virginia Department of Mental Health in all functions including but not limited to the following: (1) Program Standards (2) Licensing Standards (3) Administrative Standards, and (4) Fiscal and Program Accountability and Internal Control Standards.

This Agreement shall continue in force from ______________________,
19____, to ______________________________, 19___, provided the Department reserves the right to terminate this Agreement if any of the aforementioned conditions are not met.

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH
CHARLESTON 25305

M. MITCHELL-BATEMAN, M.D.
DIRECTOR

ADDRESS ALL REPLIES
TO THE DIRECTOR

MEMORANDUM

TO: All Community Mental Health/Mental Retardation Program Directors and Administrators

FROM: Robert E. Marshall, Director Division of Community Services

DATE: February 5, 1976

RE: Designation of Catchment Areas

The subject of designation or redesignation of Catchment Areas was briefly discussed at the P.L. 94-63 Workshop held in Charleston on February 3rd, your thoughts on the matter were invited.

It is essential to the completion of the State Comprehensive Mental Health Plan to have your comments on the present Catchment Areas and any changes that you may believe to be necessary to provide more effective delivery of services.

Federal guidelines define the term "catchment area" as a geographic area for delivery of community mental health services designed to maximize the accessibility of such services to the population served. Further, the population of each catchment area shall not be less than 75,000 nor more than 200,000 except that in particular cases modifications may be made if it can be justified on the basis that the program effectiveness of a community mental health center will be improved. Once a grant has been awarded population variations of 25 percent above or below the population at the time of center establishment will be allowed. However, when the population number deviates from the established range by 25 percent a waiver must be requested for a determination by the Secretary of Health, Education, and Welfare as to the adequacy and accessibility of services that can still be provided by the Center.

Criteria to be considered in an evaluation of present catchment area boundaries are:

(a) sociological and psychological accessibility, to insure that residents of each area have few attitudinal and emotional barriers to services;

(b) geographic accessibility, to insure that residents of each area have few physical and environmental barriers to services;

(c) human services utilization and referral patterns;

(d) functional economic areas;

(e) political subdivisions which are relevant to the financing of services;

(f) health service areas as designated under section 1511 of the Public Health Service Act.

The guidelines require that the established catchment areas should be reveiwed and redrawn, to the extent practicable, to achieve consistency between groupings of multiple catchment areas and health services areas required by P.L. 93-641, the National Health Planning and Resources Development Act of 1974. (Only one Health Systems Agency has been designated for the State of West Virginia under this legislation.)

The catchment areas for the State Comprehensive Mental Health Plan should be drawn so that:

(1) the population size is within the 75,000 to 200,000 range,

(2) services provided, or to be provided by a center, (including satellites) serving the catchment area are available and accessible to the residents of the area promptly, as appropriate,

(3) the boundaries of catchment areas conform, to the extent practicable with relevant boundaries of political subdivisions, school districts, and Federal and State health and social service program areas, (particular attention must be paid to the new health service area boundaries under Public Law 93-641),

(4) the boundaries of the catchment areas eliminate, to the extent possible, barriers to access to the services of the center serving the areas, including barriers resulting from an area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation.

(5) catchment areas should be described in terms of census units, such as census tracts, county civil divisions, minor civil divisions, or other statewide geographic subdivisions on which demographic data about the population residing in such units is systematically aggregated on a regular basis and is available to the State mental health authority and the United States Public Health Service.

Your early response to this memorandum will be appreciated so that your thoughts can be incorporated into the planning efforts of Department of Mental Health staff who are working on this project.

If you have questions generated by this request, please address them to your program consultant for early reply.

Many thanks for your cooperative effort in furtherance of planning for delivery of better community mental health services.

cc: M. Mitchell-Bateman, M. D.
Billy Coffindaffer, Ph.D.
Harry A. Stansbury, Ph.D.

June 14, 1973

N. H. Dyer, M.D., MPH
Director
State Department of Health
State Capitol Building
Charleston, West Virginia

RE: Revision of West Virginia State Plan for Construction of Community Mental Health Center - P. L. 88-164

Dear Dr. Dyer:

This letter constitutes full approval of the West Virginia request dated April 30, 1973 to change certain regional and catchment area boundaries; also the renumbering of the regions and/or catchment areas. The request and supporting material submitted now becomes an amendment to the State Plan.

National Institute Mental Health Region III staff indicate that this revision not only brings mental health regions into closer compliance with the new economic and other planning regions developed in the state but it will significantly enhance the on-going planning process necessary to the continuing development of community mental health programs. This is especially true of those regions and/or catchment areas where the five basics of the comprehensive community mental health programs have not yet been established.

Sincerely,

George C. Gardiner, M.D.
Regional Health Director

cc: Mildred Mitchell-Batemen, M.D. - DMH, W. Va.
Robert Marshall - Div CMH Services - DMH, W. Va.
Alex Portz, Ph.D. - Elkins, W. Va.
West Virginia Federal State Relations
Office of the Governor - State Capitol, Charleston, W. Va.
Harold Goldstien, Ph.D. - NIMH

NIMH:RTMURPHY:jcp:6-14-73

OUTLINE MAP

WEST VIRGINIA

PLANNING AND DEVELOPMENT REGIONS OF THE STATE OF WEST VIRGINIA

CERTIFIED: MAY 3, 1972

SCALE OF MILES
10 5 0 10 20 30 40

N

1 MONROE SUMMERS MERCER RALEIGH WYOMING McDOWELL

2 LINCOLN LOGAN MINGO CABELL WAYNE

3 KANAWHA PUTNAM BOONE CLAY

4 FAYETTE NICHOLAS GREENBRIER POCAHONTAS WEBSTER

5 WOOD WIRT ROANE JACKSON CALHOUN RITCHIE PLEASANTS TYLER

6 MONONGALIA MARION TAYLOR HARRISON DODDRIDGE PRESTON

7 UPSHUR LEWIS BARBOUR TUCKER RANDOLPH BRAXTON GILMER

8 MINERAL HAMPSHIRE HARDY GRANT PENDLETON

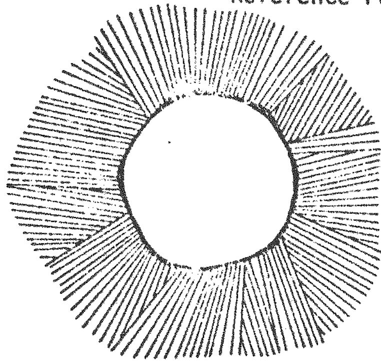
9 MORGAN BERKELEY JEFFERSON

10 MARSHALL WETZEL

11 HANCOCK BROOKE OHIO

MASON

Reference Page 58 & 60 Appendix 15



community mental health center

serving Boone, Clay, Kanawha & Putnam Counties

February 17, 1976

Robert E. Marshall/ Director
Division of Community Services
WVa Dept.of Mental Health
State Capitol Bldg. #3
Charleston WV 25305

Dear Bob,

We have received your memo of February 5 concerning the designation of catchment areas. This topic has been under discussion off and on throughout this and the past year by Fritz Maine and myself, as well as by the two of us with Gayle Auchenbach--with correspondence. It is my opinion, reinforced by my staff in general and by various advisory-board members in our county centers that redesignation of our single, relatively enormous catchment area would not contribute to a more effective delivery of service. (I assume that a like statement might be forthcoming from the Shawnee Hills regional mental-retardation center.)

I realize thatour region is a dual catchment area: it holds close to 295,000 people. But these are distributed in such a way that the establishment of two separate areas is impossible, partly because they would overload neighboring catchment areas in other regions if transferred to these regions, partly because Kanawha County would have to be dismembered in some fashion if the 295,000 had to remain within the region (and knowing the temper and temperament of West Virginians, I cannot visualize any kind of splitting-up of the Capitol county), and partly because the patterns for marketing, entertainment, schooling, transportation, highway networks, health delivery, etc., are centered upon the Charleston/ South Charleston core with all four counties as the periphery dependent upon this core.

(I recall the halving of Erie County PA into two catchment areas, with the dividing line through the very middle of the city of Erie, and the 2 community mental-health centers located in two hospitals just a few blocks away from one another. Patients/ clients paid no attention to the artificial dividing line but went to the hospital of their choice, following a pattern that they and their relatives had established long before the catchment area had been contrived.)

The counties of Boone, Clay, and Putnam have very few resources and hold only 25% of the Region's population; Kanawha is the giant with almost all the manpower, facilities, etc., and 75% of the people, almost all of whom are strung along the river valley. All roads led to Rome; all roads lead to Charleston/ South Charleston, except in the westernmost part of Putnam County--which neverthess relates to C/SC. People in Boone, Clay, and Putnam either work in their respective counties or travel every day to Kanawha in order to earn (and spend) their income. There is even a portion of Fayette County that uses Charleston as its core city.

REM

Regional Office 1217 Lee St, East Charleston WV 25304 (304) 342-8138

Each of our four counties is served by the Center generally and by a satellite specifically. (Kanawha will have several satellites eventually--the Charleston Guidance Clinic will be phased out to become a satellite and the nucleus of the Regional Center. This will take some time, of course.) The sharing of services from the Center and the progressive improvement of the individual satellites as dollars become available is apparently going to be the solution for our Region. What we need is not two catchment areas but an increase in the quantity and quality of services in each of the satellites.

If the core city of Charleston/ South Charleston were to be severed from the Region and set up as a catchment area of their own (65,252 + 16,333 = 81,585 population) the Region's remaining population within the remainder of Kanawha and the entirety of the other three counties would be 10,000 above the set maximum for a catchment area. Such a solution, furthermore, is simply the emasculation of the Region. If one were to consider setting up the three non-metropolitan counties as a catchment area separate from Kanawha County, the combined populations are still less than the minimum and Kanawha alone is beyond the maximum.

I am sure that the 75,000 to 200,000 range for areas is an excellent standard based on principles that must work well in such places as Los Angeles and a host of SMSAs throughout the nation. But the mountains and the hollows defy most principles and their people will fight to determine who owns a creek and who owns a barbecued pig....

It took ten years and more to establish the one community mental health center that now exists for the Region called Three; and this Region is gasping for its financial life. Can you imagine what would happen if another Center were planned for? All the other agencies and institutions that have regionalism as part of their structure have all established these four counties as their region--generally. One outstanding exception is Welfare, who have made of Kanawha County a single "area" within their own system and have assigned the three other counties of our Region among other "areas." However, Welfare in no way intended to regionalize according to the basic 14 now established for the State. At any rate, Kanawha's population is well above the 200,000 MH maximum.

I could go on and on, as you know, with reasons not to have the Region sundered. To do so now would be to kill it, for it might not recover from the blow until many years had passed and much money wasted. Follow the example of Solomon and leave the baby whole.

Fritz can speak with you about these matters more eloquently than I, for we have shared conversations about our dual catchment area for many hours.

Sincerely,

Mike Carey

Michael C.J. Carey
Regional Administrator

cc Travis E. Wells, Jr.
Fritz Maine
Mildred Mitchell-Bateman MD
Gayle Auchenbach

HANCOCK-BROOKE MENTAL HEALTH SERVICE
WEIRTON GENERAL HOSPITAL
WEIRTON, WEST VIRGINIA 26062

TELEPHONE LOCAL 748-7700
CHESTER AREA 387-3595
WELLSBURG AREA 737-2551

February 20, 1976

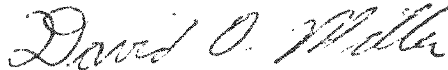
Mr. Robert E. Marshall, ACSW
Director
Division of Community Services
West Virginia Department of Mental Health
1800 Washington Street, East
Charleston, West Virginia 25305

Dear Mr. Marshall:

In response to your memoranda of 2-5-76 and 2-18-76, I would like to express, on behalf of the Service Board, which is the planning Board for mental health/mental retardation services in Region 11, Hancock and Brooke counties, that we feel that an effective delivery of mental health/mental retardation services to the residents, of this most northern panhandle arc of the state of West Virginia can only be accomplished through the continuation of Hancock and Brooke counties as a designated and separate planning region. We do not see any reason to revise or change the Region 11 service area.

Residents of this region have identified with the Service and look to it for the planning, development and provision of mental health/mental retardation services. Services are within easy access of residents as is determined by our referral patterns. Politically, the Region has identified with the Service and continually increases local financial support.

Sincerely,



David O. Miller, ACSW
Executive Director

DOM/w

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH
CHARLESTON 25305

M. MITCHELL-BATEMAN, M.D.
DIRECTOR

ADDRESS ALL REPLIES
TO THE DIRECTOR

MEMORANDUM

TO: M. Mitchell-Bateman, M. D.
Director

FROM: Robert E. Marshall, Director
Division of Community Services *Robert E. Marshall*

DATE: March 3, 1976

RE: Planning Meeting: Designation of Mental Health Regions/
Catchment Areas

PRESENT:

Anne B. Alderson - Greenbrier Valley Mental Health Clinic
Judith Beatty - Community Mental Health Center - Region III
Al Broadhead - Department of Mental Health
Chris Chamberlain - Department of Mental Health
Blaine Dowler - Department of Mental Health
Moody J. Goff - Department of Mental Health
Julia Hawkins - Department of Mental Health
Kay Howard - Department of Mental Health
John Marks - Department of Mental Health
Robert Marshall - Department of Mental Health
Jim McCullough - Department of Mental Health
Mary Pesetsky - Department of Mental Health
Robert Porter - Consultant, Department of Mental Health

The Division of Community Services conducted a meeting Friday, February 27, 1976, to discuss issues relative to the designation of Mental Health regions/catchment areas. Prior to the meeting, a memorandum was sent to all community mental health/mental retardation program directors advising them of such a meeting and requesting any recommendations directors felt should be made to the Department of Mental Health regarding this issue.

Of the 13 (thirteen) responses received by this Division, 10 (ten) directors recommended no redesignation of regions/catchment areas. There were 3 (three) responses that recommended the Department consider alternatives to the current configuration of Mental Health regions/catchment areas.

Discussion at the meeting centered on the examination of three alternatives proposed by the Division of Community Services for the designation of Mental Health regions/catchment areas. These alternatives were representative of the response of program directors, their centers, and boards.

Alternative #1 - That the Department of Mental Health's Community Mental Health Regions be consistent with the West Virginia Planning and Development Regions.

Alternative #2 - That the Department of Mental Health's Community Mental Health Regions be consistent with the West Virginia State Plan for Construction of Community Mental Health Centers, 3/73 (Current catchment area configuration).

Alternative #3 - That the Department of Mental Health Community Mental Health Regions align with current or apparently logical medical and social service areas.

Options

(1) That Region IX expand to include Hampshire County and Appalachian Mental Health Center continue servicing Grant, Hardy, Pendleton, and Mineral Counties.

(2) a. That Region IV be comprised of Nicholas, Pocahontas, Greenbrier, and Monroe Counties and that Webster County remain being served by Appalachian.

b. That Region IV be comprised of Monroe, Pocahontas, and Greenbrier Counties, Webster County remain being served by Appalachian, and Nicholas County affiliating with Region VI - C.A. 2, Central District.

c. That Region IV be eliminated, i.e., that Nicholas affiliate with Region VI - C.A. 2 (Central District); that Webster and Pocahontas remain in Region VII-VIII and the Appalachian Mental Health Center; and that Greenbrier be included in the current F.M.R.S. catchment area.

The discussion which followed relative to each alternative and option posed arguments both pro and con for the consideration of the group.

After the presentation of alternatives and all relevant discussion, motions were made that would represent the group's recommendation to the Director of the Department of Mental Health for consideration prior to any final decision regarding the redesignation of Mental Health regions/catchment areas.

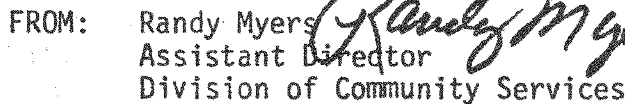
The motion was made and approved that the group recommend to the Director the second alternative, that the Department of Mental Health Mental Health regions/catchment areas be consistent with The West Virginia State Plan for Construction of Community Mental Health Centers, 3/73.

cc: Al Broadhead
John Marks

M E M O R A N D U M

TO: Community Mental Health Program Directors

FROM: Randy Myers
Assistant Director
Division of Community Services



DATE: April 27, 1976

RE: Survey of Catchment Area Needs for Preparation of P.L. 94-63 State Plan for Comprehensive Mental Health Services

I have been given the responsibility of writing the narrative description of the Catchment Areas for the P.L. 94-63 State Plan. A part of the narrative description must include recommendations concerning twelve topics that are listed in the Guidelines For The Preparation Of State Plans For Comprehensive Mental Health Services.

The twelve topics are listed below and I am asking your assistance in making whatever recommendations you feel are appropriate about each topic as it applies to your catchment area. These recommendations will be incorporated in the narrative description of each catchment area in the State Plan.

The twelve topics are:

1. The need for specialized services for children and youth, the aged, physically and mentally handicapped, or other special population groups.

2. The need for specialized services for certain special menta health problems including alcoholism, drug abuse, crime and delinquency, suicide and any others of special significance to that catchment area.

3. The need for mental health services and programs to provide the 12 essential services required in the legislation.

4. How and where the above might be provided.

5. The extent to which free or part pay services are expected to be needed for the medically indigent, and possible sources of financing.

6. The possibility of combining existing facilities and services into a community mental health center.

7. The probable location of planned community mental health facilities.

8. The possibility of planning or developing community mental health services in conjunction with other government supported programs (e.g., child and maternal health, community health center, HMO's, etc.), and of working with the courts and other public agencies relative to screening and aftercare programs.

9. The desirability and possibility of timing proposed facility development to take advantage of multiple sources of funding.

10. The need for mental health manpower, possibilities of joint recruitment, training and sharing of staff, and development of new categories of personnel.

11. Wherever necessary, a brief narrative description concerning unusual area characteristics such as:

    Military bases and dependents
    Indian reservations
    Barriers to travel and communication

12. Whether there are facilities which do not meet accepted standards and what steps are being taken to meet those standards.

Please return your recommendations to me no later than May 14, 1976.

cc: Robert E. Marshall