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Assessing Needs and Developing Programs for Children and Youth

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ASSESSING NEEDS AND DEVELOPING PROGRAMS

FOR

CHILDREN AND YOUTH

Kay Frances Greer, B.S.

A Digest Presented to the Faculty of the Graduate School of the Lindenwood Colleges in Partial Fulfillment of the Requirements for the Degree of Master of Art

1984

Thesis
G859a
1984

Digest

The Southeast region is one of six regions developed for planning purposes by the Division of Comprehensive Psychiatric Services of the Department of Mental Health in the State of Missouri. The region is comprised of 24 counties with a total population of 513,400 persons; 148,624 of those persons are under the age of 18. Concerned citizens and mental health providers have been concerned for several years about the lack of special programming for the children and youth throughout the region. Available services for this population include outpatient services in each of the four service areas, a limited day treatment program for pre-schoolers in Cape Girardeau and inpatient care at Hawthorn Childrens' Psychiatric Hospital in St. Louis. This project was designed to, 1) identify socio-economic factors in the region that may warrant need for mental health services, 2) illuminate age groups that are most-in-need, 3) identify special needs in the geographic areas and, 4) focus future programming towards the identified needs. In order to achieve these goals, an informational survey was developed and mailed to over 200 persons from the Divisions of Family Services and Youth Services, juvenile officers, school counselors and mental health providers in the 24 counties. Survey questions included information regarding referrals to mental health agencies, estimates of the number of children and youth that could

39417

benefit from mental health services, rankings of additional services/programs, and estimates of the number of children and youth exhibiting specific target behaviors. The results of the survey were tabulated and regional and service area summaries were developed on the information received in the above mentioned categories. These expressed needs of professionals from child-serving agencies were used as a basis for a model for a mental health delivery system for children and youth in Southeast Missouri.

ASSESSING NEEDS AND DEVELOPING PROGRAMS

FOR

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CHILDREN AND YOUTH

BY

Kay F. Greer

September, 1984

Submitted in partial fulfillment for

requirements of a Master of Art

COMMITTEE IN CHARGE OF CANDIDACY:

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This paper represents the culminating project for the Master of Art degree in Counseling Psychology, from Lindenwood College, St. Charles, Missouri. The project described in this document was developed for the Department of Mental Health's planning region of Southeast Missouri and was designed specifically to identify needed services for children and youth in the geographic area.

At the time of this writing, the children and youth in the region travel to Hawthorn Children's Psychiatric Hospital in St. Louis for preadmission screening and evaluation and inpatient care. Other available Department of Mental Health Services for children within the region are limited to outpatient services only.

The Department of Mental Health, mental health providers and citizens of this region have been concerned about the lack of specialized programming for this target population for several years. Those responsible for developing and implementing programs have been reluctant to do so without documentation of specific needs and prioritization of additional programs. This project, therefore, was designed to, 1) identify the expressed need of professionals who work in agencies that serve children and youth in the area and 2) develop specialized program recommendations to meet those needs.

The project was accomplished in several stages. First, a volunteer task force of consumers and mental health providers interested in children and youth services in the Southeast Region was organized. The immediate purposes of this group were to, 1) identify resource persons that could provide input for this project, and 2) develop goals that would ensure the continuation of essential advocacy for children and youth in soliciting community support in future programs. Obviously, accomplishing these goals is beyond the scope of this project and includes strategies and objectives for securing state and local funding in order to establish the programs that will be recommended.

The second stage was to develop an informational survey that was mailed to approximately 200 persons who are employed by the Divisions of Family Services and Youth Services, juvenile officers, school counselors and mental health providers (see Appendix A for sample of a survey form). The data from the returned surveys were prepared for a computer program designed to tally responses and provide a profile of the expressed needs of these professionals from each service area and the entire region. This information was used to identify target age populations and the geographic areas that demonstrated the most need for specialized programs.

Environmental factors that may also indicate needs were examined in order to identify the socio-economic

factors of the planning region of Southeast Missouri, the expressed need of the professionals who work with children and youth, and this writer's recommendations for additional programs that would fill the gap in the delivery of mental health services.

Review of Related Research and Literature

Current System

The Southeast planning region for Comprehensive Psychiatric Services of the Department of Mental Health consists of 24 counties and 513,400 persons. Of that population, 148,624 (21%) are under the age of 18. The region is approximately 150 miles long and 100 miles wide, covering 14,495 square miles. Of the state's 26 service areas, four of these are located within the Southeast Region: Service Areas, 17, 19, 20, and 21. The regional map (Figure 1) shows the counties included and the location of mental health centers that provide services for the Department of Mental Health, either directly as a department facility or indirectly through a purchase-of-service contract.

Insert Figure 1 about here

In addition to Farmington State Hospital located in St. Francois County, the Department contracts with the agencies listed in Table 1: (see Table 1)

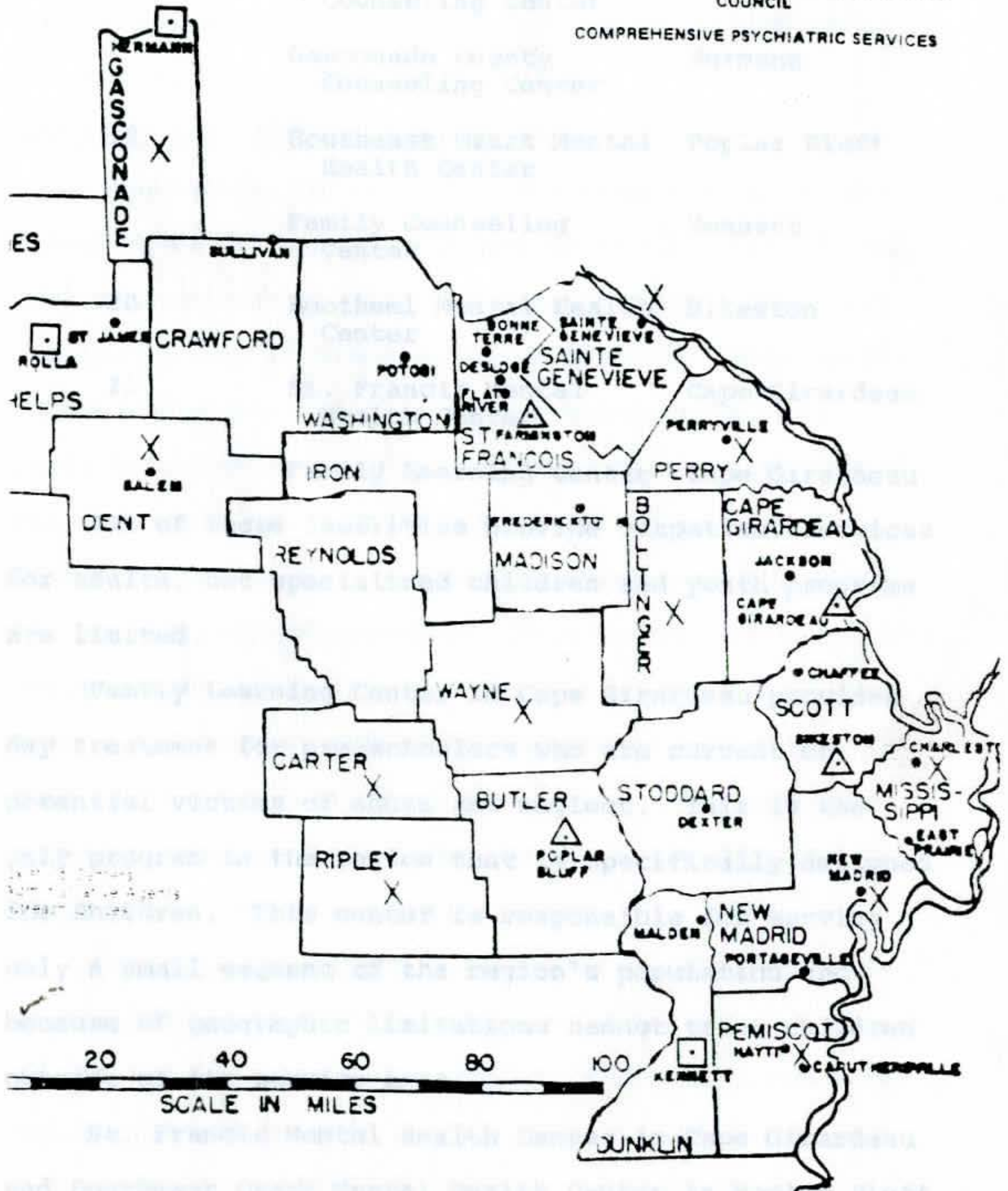

I. B. 1. Map of Southeast Region
Service Area #17
SOUTHEAST MISSOURI REGIONAL ADVISORY COUNCIL
COMPREHENSIVE PSYCHIATRIC SERVICES
HERMANN
GASCONADE
SULLIVAN
ST JAMES
CRAWFORD
ROLLA
SALEM
DENT
POTOSI
WASHINGTON
IRON
REYNOLDS
BONNE TERRE
DESLOGE
FLAT RIVER
FARMINGTON
ST FRANCOIS
SAINTE GENEVIEVE
PERRYVILLE
PERRY
FREDERICKTOWN
MADISON
BOLLINGER
CAPE GIRARDEAU
JACKSON
WAYNE
CARTER
BUTLER
RIPLEY
POPLAR BLUFF
STODDARD
DEXTER
SCOTT
CHAFFEE
SIKESTON
CHARLESTON
MISSISSIPPI
EAST PRAIRIE
NEW MADRID
MALDEN
PORTAGEVILLE
PEMISCOT
HAYTI
CARUTHERSVILLE
KENNETT
DUNKLIN
20
40
60
80
100
SCALE IN MILES

Table 1

Current Mental Health Services

Service Area	Mental Health Center	Location
17	Central Ozark Counseling Center	Rolla
	Gasconade County Counseling Center	Hermann
19	Southeast Ozark Mental Health Center	Poplar Bluff
	Family Counseling Center	Kennett
20	Bootheel Mental Health Center	Sikeston
21	St. Francis Mental Health Center	Cape Girardeau
	Family Learning Center	Cape Girardeau

All of these facilities provide outpatient services for adults, but specialized children and youth programs are limited.

Family Learning Center in Cape Girardeau provides day treatment for pre-schoolers who are current or potential victims of abuse and neglect. This is the only program in the region that is specifically designed for children. This center is responsible for serving only a small segment of the region's population and because of geographic limitations cannot treat children outside of its service area.

St. Francis Mental Health Center in Cape Girardeau and Southeast Ozark Mental Health Center in Poplar Bluff have child psychologists who offer outpatient services.

The remaining centers serve clients under the age of 18 with staff members from diverse disciplines who are trained in specialities other than child mental health.

Farmington State Hospital does provide childrens' outpatient services, but does not accept anyone under the age of 18 for inpatient services.

Regional Socio-Economic Conditions

This writer believes it is inadequate for anyone planning mental health programs to merely identify the lack of services in order to suggest need. The first responsibility of planning is to identify those socio-economic factors existing in the communities that represent unusual or unique circumstances which suggest not only need but also direct attention to specific high-risk age groups, geographic areas, and the need for specialized programming. This writer has identified several such socio-economic factors in the region that have a significant impact on the mental health of all persons, but especially on the youth. These factors include familial conditions, level of poverty and child abuse/neglect incidence rates.

Familial conditions. An unusually high marriage dissolution rate contributes heavily to the instability of the family unit, 11 counties (45.8% of the region) had a dissolution rate higher than the state rate of 5.3 per 1,000 population in 1982. (Missouri Vital Statistics, 1982). Six of the southeast counties have

the highest dissolution rate in the state as shown in Table 2: (see Table 2)

Table 2

Marriage Dissolution Rate

Counties	Service Area	Rate	Statewide Ranking
Mississippi	20	9.4	1
Dunklin	19	9.4	1
Butler	19	8.9	2
Stoddard	20	8.1	3
Pemiscot	19	7.6	4
Scott	20	7.2	5

While research has not culminated in a consensus regarding the impact divorce may have on children, several studies do indicate that children of divorced families do have more adjustment problems than children of "happy" families (Adam and Adam, 1979). Whether these problems are caused by the divorce itself, the traumatic home life before the divorce, or even from the possible lower economic status of the new family unit, is not germane at this point. Whatever the "cause" might be, the potential for adjustment problems does exist when divorce occurs.

Single parent families are an obvious result of this high dissolution rate. Available census bureau data reveal that in 1980, cities in the Southeast Region, with a population of 10,000 to 50,000, have a relatively

low number of persons under the age of 18 living with both parents. Statewide, of the 49 cities in this category,

4 cities had 90% or more living with both parents

22 cities had 80% to 89%

17 cities had 70% to 79%

6 cities had 60% to 69%

The southeast cities of this population size fall in the last two percentage groups. Table 3 reflects the converse of the above percentages by demonstrating the percentage of children and youth living in single parent families. (see Table 3)

Table 3

Percentage of Youth in Single Parent Families

City	Service Area	Percentage
Cape Girardeau	21	21%
Rolla	17	21%
Sikeston	20	29%
Kennett	19	29%
Poplar Bluff	19	31%

Poverty. The poverty level is an economic factor that not only contributes to the stress on family structures but is an indicator of clients' inability to purchase services from private practioners. Nineteen counties throughout the state are reported to have a per capita income of $4,205-$5,749, the lowest level

identified by the United States Census Bureau. Nine of those counties (47.3%) are in the Southeast Region. They are:

Service Area 17: Maries, Dent, Washington

Service Area 19: Wayne, Carter, Ripley

Service Area 20: New Madrid

Service Area 21: Madison, Bollinger

Table 4 shows the number of persons and the percentage of population below the 125% poverty level and the Southeast Service Areas' ranking within the state. (see Table 4)

Table 4

Number and Percentage of Population Below 125% Poverty Level with Statewide Ranking

Area	Number	Percentage	Ranking
State	814,055	16.56%	
Service Area			
19	47,804	35.31%	2
20	29,540	27.52%	5
17	35,389	22.28%	9
21	21,273	19.02%	12

(Note: the Southeast Region has four of the 26 service areas in the State of Missouri)

Child Abuse/Neglect Incidents. The poverty factors of the region, coupled with the high incidence of child abuse and neglect as documented by the Division of Family Services presents an apalling picture of the

socio-economic conditions in the region. (Annual Administrative Analysis, 1983). The latest figures available are used in Table 5 to reflect the rise of the number of children that were "court adjudicated with sufficient reason to believe" that abuse or neglect did actually occur in the years 1981 and 1982. (see Table 5).

It should be noted that the state rate has declined from 23.8 incidents per 1,000 children to 21.8; while the Southeast Region has increased from 28.4 to 34.6 per 1,000.

Table 5

Rate of Child Abuse/Neglect Incidents

Area	# and Rate, 1981	# and Rate, 1982
State	32,411 / 23.8	29,768 / 21.8
Southeast Region	4,217 / 28.4	5,136 / 34.6
Service Area 17	1,306 / 29.0	1,532 / 34.0
Service Area 19	1,596 / 39.8	1,991 / 49.6
Service Area 20	766 / 23.1	998 / 30.1
Service Area 21	549 / 18.1	615 / 20.3

Review of the Literature

The normal preliminary procedure of reviewing current literature and models prior to the development of this project was extremely non-productive. Numerous resources on planning provided samples of needs assessments for adults who were institutionalized. A needs

assessment that was designed specifically for children and youth could not be located. This writer believes scrutinization of mental health facilities' utilization data and admissions of diagnoses is not sufficient for <u>needs</u> assessment information for it does not indicate the type of unmet need that is currently being experienced in the communities. One alternative then is to extract the expressed need of professionals who work in child-serving organizations. Although this type of information can be construed as "opinion" it should be fairly accurate, for the survey was aimed toward professionals who have daily contact with children and youth in the communities.

The southeast area's problems regarding lack of programming for children and youth are not unique to this region or even to the State of Missouri. A limited amount of literature on state-wide models could be found. Apparently only a few states have systematically addressed this target population. In a paper entitled <u>Defining and Counting Mentally Ill Children and Adolescents</u> (1983), Michael Gilmore, Ph.D., presented the challenge facing mental health professionals of identifying and diagnosing mentally ill children and adolescents. Dr. Gilmore maintains that the diagnoses presented in DSM III are not relevant to children's disorders and therefore further complicate the task of counting mentally ill children. As in other litera-

ture, this paper addressed the diagnostic groupings of children and youth that had been admitted to state mental health hospitals. Identification of youth that are not currently being treated was not discussed. In 1975, the State of Ohio implemented several programs for children and youth within specific geographic areas with the use of 314d grants from the federal government. As in other states, these projects were centered around parochial needs in small geographic areas and did not present an overall model for the children and youth population throughout the state or within a region of significant size. (Ohio Department of Mental Health and Mental Retardation, 1975).

North Carolina has developed an integrated system for mental health services for "seriously emotionally, mentally, and neurologically handicapped children and adolescents who are violent or assaulative" (North Carolina, 1980). This system was developed as an outcome of the "Willie M." lawsuit that was filed in the United States District Court in Charlotte, North Carolina, October, 1979, against James B. Hunt, Jr., Governor of North Carolina, Sarah T. Morrow, Secretary of Human Resources, and Craig Phillips, Superintendent of Public Instruction and other state officials. Although this program is a comprehensive model for children and youth on a state-wide basis, it addresses only a small segment of the population, i.e., violent or aggressive children

with a dual diagnosis. Again, this model does not address the overall needs of the children and youth population.

METHODOLOGY

Informational Survey

Data regarding environmental conditions may indicate an overall need for mental health services for children and youth, but do not illuminate age groups that are most-in-need or indicate the focus of needed programs. Therefore, the second step necessary in this project was to construct an instrument (see Appendix A) that could collect information from individuals who have daily contact with children in Southeast Missouri. The informational survey asked professionals who work in the child-serving fields to consider their caseloads/ contacts and make recommendations regarding the types of programs they would utilize if available.

Two hundred and three surveys were sent to representatives of the Divisions of Family Services and Youth Services, juvenile officers, school counselors and mental health providers in all four service areas:

28 surveys were sent to the county offices of the Division of Family Services

6 were sent to local offices of the Division of Youth Services

15 were sent to juvenile officers in judicial districts throughout the region

14 were sent to private and public mental health providers

140 were sent to counselors in area schools

Section I. This section of the survey merely gathered information regarding the responding agency. The responder was asked to estimate the number of children and youth being served by that particular agency/organization and to estimate the number of these youth that were currently being served by other agencies.

Question 5, was included in order to provide referral information for state affiliated mental health providers. Another purpose of this question was to determine if the agencies surveyed are currently utilizing existing mental heatlh services. Additional space was provided, question 9, to allow for comments as to whether or not the available services are adequate.

Question 7, Section I, asked the responder to estimate the percentage of children and youth served that may benefit from some type of mental health services. The overall percentage as reported by this group of professionals will later be generalized to the entire population in order to establish as estimated number of children and youth in need of services throughout the region.

Section II. This section asked the reader to rank services needed, assigning number one to the service

with the highest priority, number two to the second highest, etc. Section II and the following Section III (which asks the reader to identify the number of children seen that are exhibiting certain behaviors) were included in the survey in order to provide a check and balance. Section II is used to determine the responders expressed need of additional programs. However, since most of the persons responding to the survey are not mental health professionals, their expressed opinions of needed programs may not in fact be congruent with the type of children they are actually serving. Many non-mental health professionals may indicate a need for programs in "popular" therapeutic modes. It was believed that these professionals should have an opportunity to, 1) identify the types of programs they believe are needed, and, 2) have the opportunity to identify the number of children they see that are exhibiting specific behaviors.

<u>Section III</u>. This section of the survey was included in order to provide needed information on behaviors. The responder was asked to estimate the number of children seen that are exhibiting mild, moderate or severe symptoms in seven different categories. Although each of these categories is a description that could fall under a mental health diagnosis, the survey did not actually label these behavioral descriptions with

a DSM III diagnosis. It was believed that non-mental health professionals may be hesitant to mark certain categories with an official diagnosis heading.

Section IV. The last section was included in order to gather information regarding services the responding agency provides.

Results

Rate of Return

Eighty three of the 203 surveys mailed were returned. Of these, 76 had useable data (four surveys were duplicates and three were incomplete). The number of surveys returned from each agency were as follows:

19 from the Division of Family Services, (23 were returned, four had duplicate data), 82% of the surveys sent to the Division were returned,

3 from the Division of Youth Services, 50% were returned,

9 from juvenile officers, 60% were returned

8 from mental health providers, 57% were returned,

37 from school counselors, 27% were returned.

Obviously, a low percentage of surveys were returned by the school counselors. Surveys were sent to many small, rural schools. There was a concern these counselors might not be aware of the need and consequently may not return the surveys, but it was decided to offer them the opportunity to respond if they so wished.

Section I

The returned surveys represented a combined caseload of 17,820 persons under the age of 18. The number of children that were represented by the returned surveys from each geographic area was as follows:

Service Area 17	3,507
Service Area 19	4,936
Service Area 20	4,053
Service Area 21	5,324
	17,820

The returned surveys represent the following number of children served by these agencies:

Division of Family Services	2,588
Division of Youth Services	205
Juvenile officers	708
Mental health providers	369
School counselors	13,950
	17,820

(See Appendix B for more specific information regarding the actual number of surveys returned from each service area and by each agency).

The survey contained several questions regarding referrals (Section I, questions 5 and 7). The purpose of question 5 was to determine if the agencies surveyed currently utilize existing mental health services. Table 6 reflects the number of referrals that were listed on

the returned surveys. (see Table 6) It appears that Service Areas 19 and 20 may have the most acceptable relationships with the agencies returning the surveys. Since most of the agencies receiving these surveys are the type that would be dealing with indigent clients, one may assume that referrals would be made to the Department of Mental Health facilities more often than private psychiatric providers. Because of this assumption, it is disturbing to see the high number of referrals to organizations that are not supported by state funding.

Table 6

Number of Agencies Referred To by Responders

Agencies	Service Areas: 17	19	20	21
DMH agencies	8	14	18	10
Private Hospitals and psychiatric agencies	10	7	4	6
Other non-mental health organizations	15	21	13	7
Totals	33	42	35	23

Additional space was provided in question 9 to allow for comments regarding whether or not available services are adequate. Those responding, did so in the following manner: (see Table 7)

Table 7

Responses Regarding Adequacy of Existing Services

Service Area	Yes	No
17	10	3
19	9	3
20	8	3
21	10	1

In Section I, question 7, responders estimated that 3,272 (18.4% of the combined caseloads) could benefit from some type of mental health service.

Of the non-mental health professionals, the Division of Youth Services reported the highest percentage of youth in need of mental health services, with an estimate of 65% of their caseload. Juvenile officers gave the second highest rating of 34%, Division of Family Services estimated that 30% of their clients under the age of 18 could benefit from mental health services, and school counselors reported 12,9%.

Responders from Service Area 17 reported the highest percentage of need in the geographic areas. They estimated 26% of their youth could benefit from mental health services. Service Area 19 estimated 23%, Service Area 21 estimated 14% and Service Area 20 estimated 11%.

Needs in each service area were fairly represented by the returned surveys. In Service Area 17, 17 surveys were returned; Service Area 19, 16 were returned; Service Area 20, 24 surveys were returned; and in Ser-

vice Area 21, 21 surveys were returned. (For further information regarding estimated need see Appendix C: Estimated number of children and youth that could benefit from mental health services).

Section II

The reader was asked to rank the additional services needed, contributing a number one to the highest priority, number two to the second highest, etc. This section was answered in two different ways. Thirty-nine responders ranked only those services that should be added, with a numerical value of one, two, three, etc. This was the desired ranking procedure but had to be tabulated by hand due to the complexity of developing two different computer programs. The remaining surveys responded with an individual ranking of those services listed under each program heading. For example, under Prevention, child abuse, alcohol/drug and mental health, each was ranked one, two, three. The computer program was written to tabulate this type of response.

The results of the hand tabulation were:

Service Area 17: Residential was given the most prominent ranking with 11 of 15 surveys assigning it a value of one or two.

Service Area 19: 10 of 14 responders ranked Residential with numerical values of one or two.

Service Area 20; Prevention, averaged more responses per service, but again, Residential received the majority of low numbers indicating the highest priority, with 14 of 29 ranking it one or two.

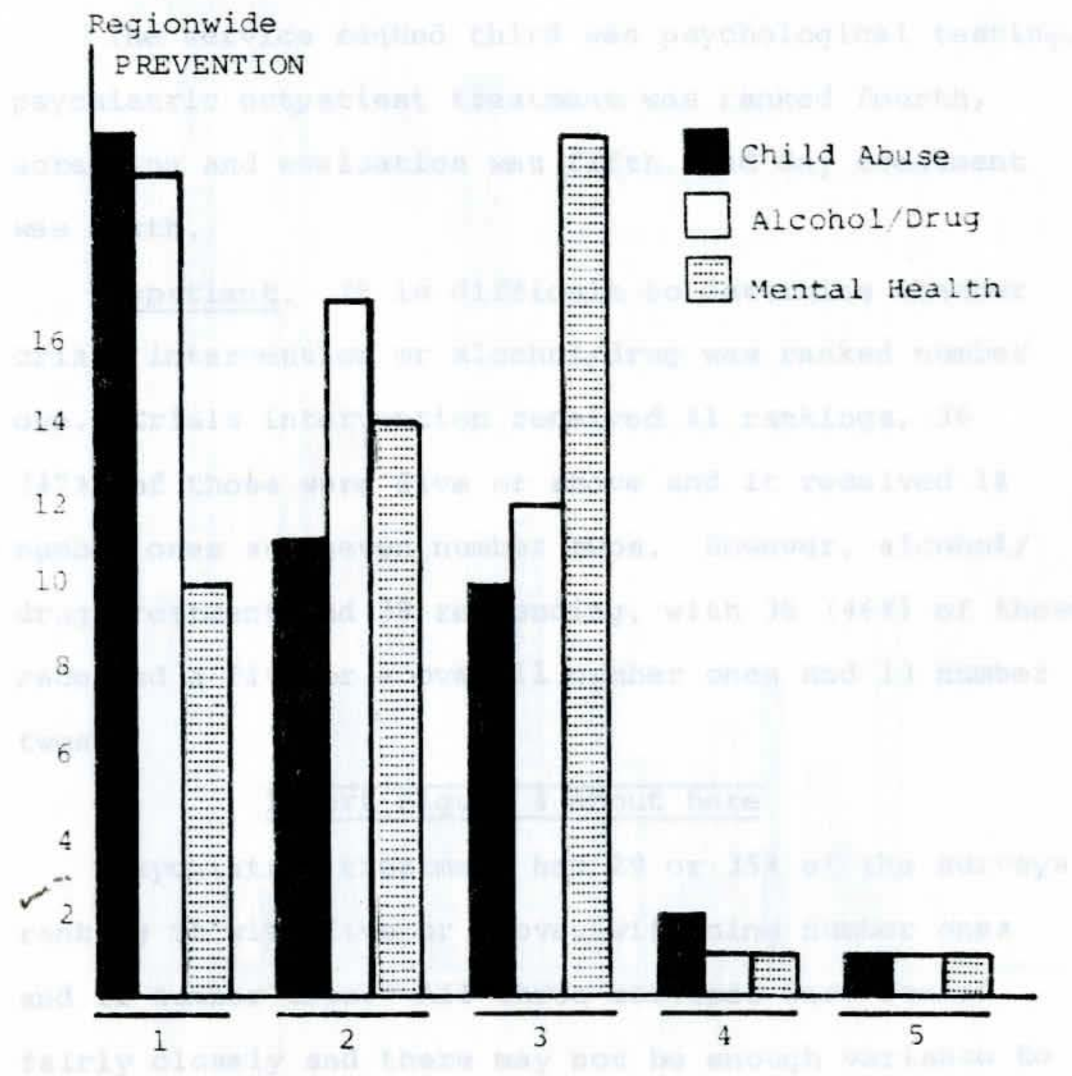
Service Area 21; Outpatient, family therapy, and Residential, crisis intervention were responded to most often but Prevention and Residential programs received more of the low numbers (one or two) than any other group (six of 14 and six of 22 respectively).

Computer Ranking of Needed Services

Prevention. Figure 2 shows that of the 76 persons/ organizations responding, 54 surveys ranked alcohol/ drug; 51 of those ranked alcohol/drug with a value of five or above. Alcohol/drug received the highest priority ranking regionwide with 67% of all of the returned surveys allotting to that service a value of five or above. Mental Health received the five or above ranking from 46 surveys or 61% of those responding; child abuse was ranked by 45 surveys or 59%. Specifically, 21 persons ranked child abuse as number one, 20 ranked alcohol/ drug as number one, and 10 ranked mental health first.

Insert Figure 2 about here

Outpatient. Family therapy was identified as the most needed outpatient service throughout the region with 62% of the surveys ranking this service with a five


Regionwide
PREVENTION
Child Abuse
Alcohol/Drug
Mental Health
16
14
12
10
8
6
4
2
1
2
3
4
5

or above and 22 persons ranking it number one. As Figure 3 shows, this is twice the number of ones given to the second highest ranked service, individual counseling, which has 11 number ones with 55% responding.

Insert Figure 3 about here

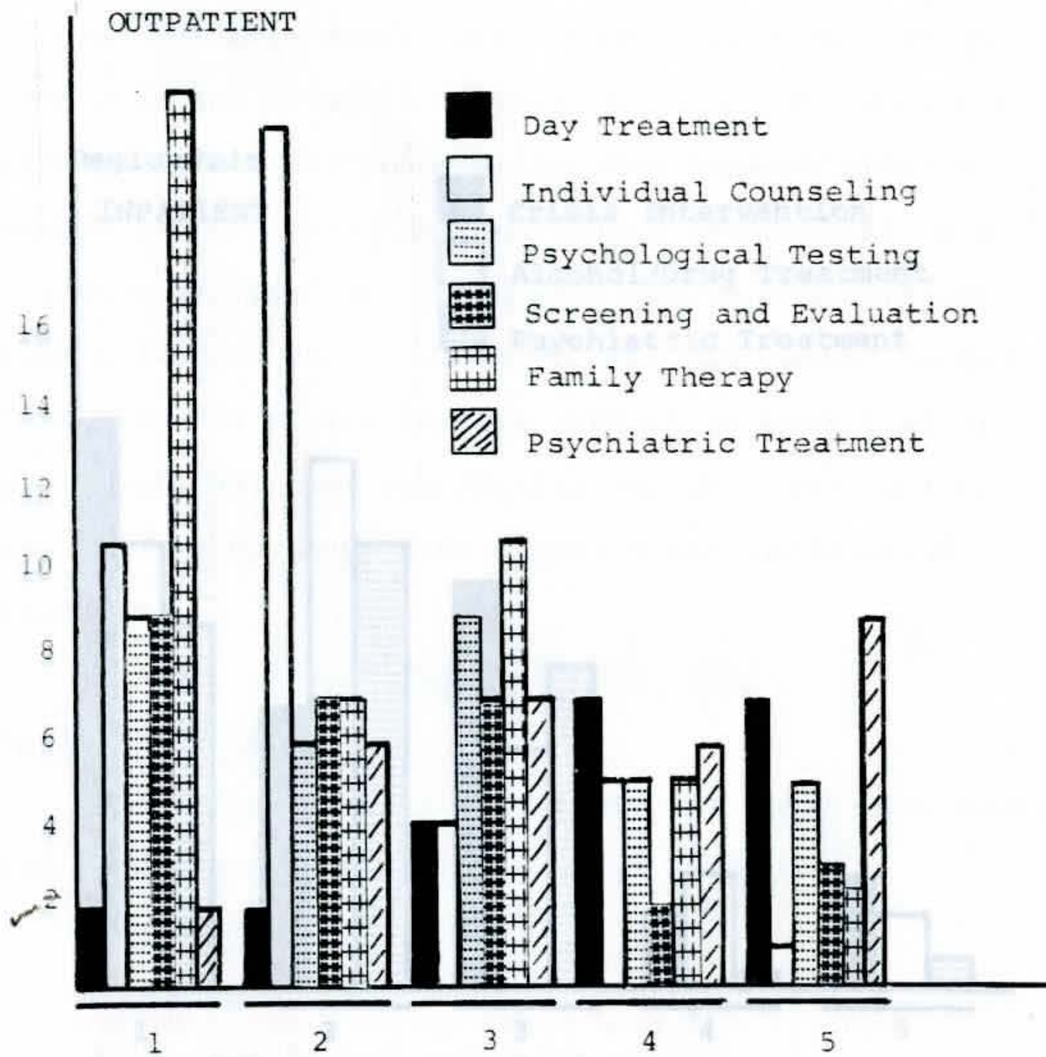
These findings were consistent in each of the service areas, i.e., family therapy and individual counseling was ranked one and two in all four areas.

The service ranked third was psychological testing, psychiatric outpatient treatment was ranked fourth, screening and evaluation was fifth, and day treatment was sixth.

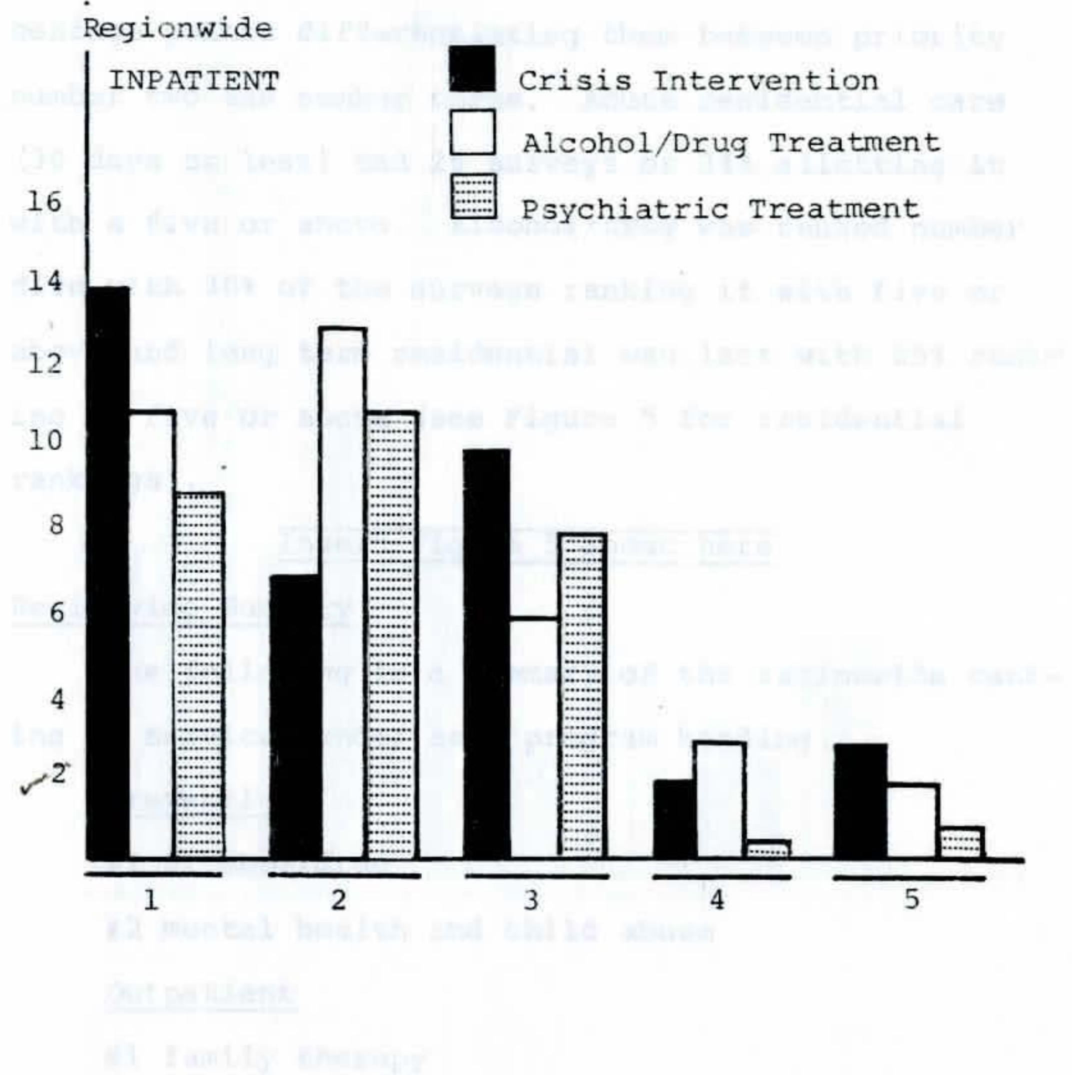
Inpatient. It is difficult to determine whether crisis intervention or alcohol/drug was ranked number one. Crisis intervention received 41 rankings, 36 (47%) of those were five or above and it received 14 number ones and seven number twos. However, alcohol/ drug treatment had 38 responding, with 35 (46%) of those received a five or above, 11 number ones and 13 number twos.

Insert Figure 4 about here

Psychiatric treatment had 29 or 35% of the surveys ranking it with five or above, with nine number ones and 11 number twos. All three services were ranked fairly closely and there may not be enough variance to



Regionwide
OUTPATIENT
Day Treatment
Individual Counseling
Psychological Testing
Screening and Evaluation
Family Therapy
Psychiatric Treatment
16
14
12
10
8
6
4
2
1
2
3
4
5



Regionwide
INPATIENT
Crisis Intervention
Alcohol/Drug Treatment
Psychiatric Treatment
16
14
12
10
8
6
4
2
1
2
3
4
5

rate any significant difference. (see Figure 4 for inpatient rankings).

Residential. Residential treatment did not receive the attention Prevention and Outpatient received except for specialized foster care. This service had 50% of the surveys ranking it with a five or above and received 21 number ones which far exceeded the second highest ranking, short term residential care. Short term care and crisis intervention have only two percentage points differentiating them between priority number two and number three. Acute residential care (30 days or less) had 26 surveys or 34% allotting it with a five or above. Alcohol/drug was ranked number five with 30% of the surveys ranking it with five or above and long term residential was last with 25% ranking it five or above (see Figure 5 for residential rankings).

Insert Figure 5 about here

Regionwide Summary

The following is a summary of the regionwide ranking of services under each program heading.

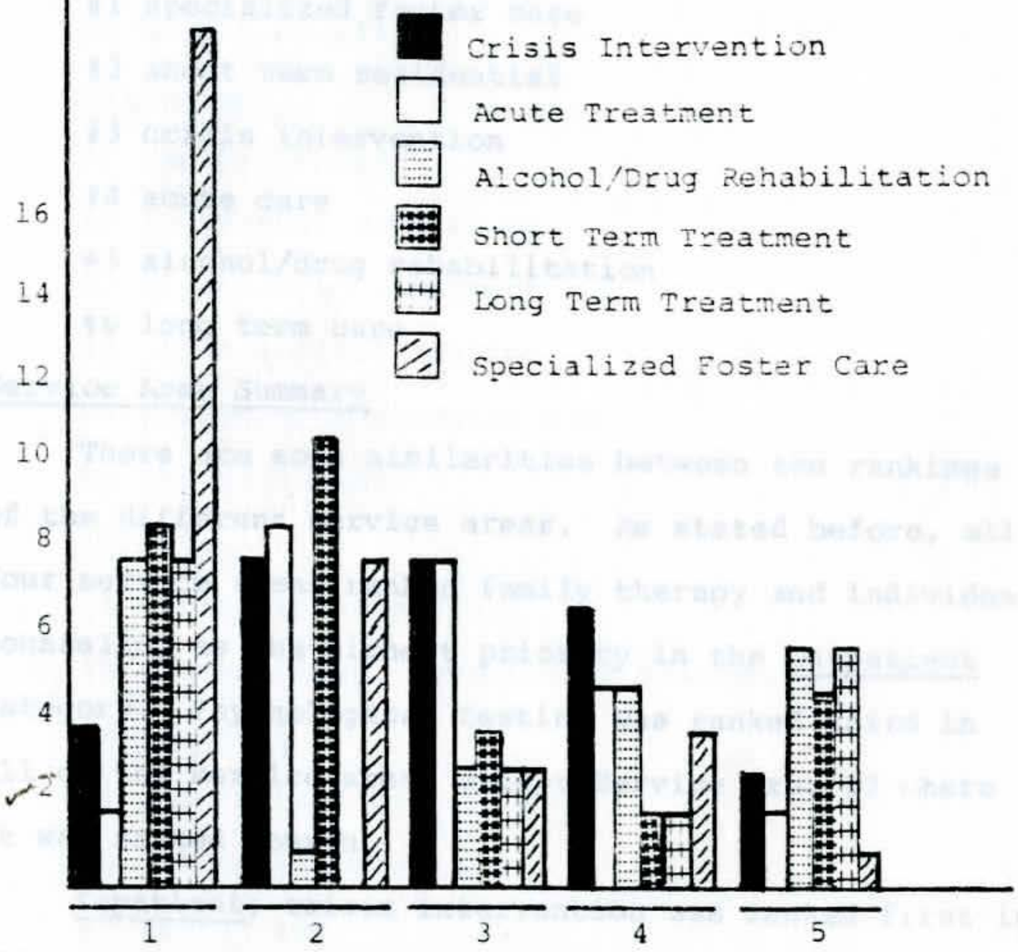
Prevention

#1 alcohol/drug

#2 mental health and child abuse

Outpatient

#1 family therapy



Regionwide
RESIDENTIAL
Crisis Intervention
Acute Treatment
Alcohol/Drug Rehabilitation
Short Term Treatment
Long Term Treatment
Specialized Foster Care
16
14
12
10
8
6
4
2
1
2
3
4
5

#2 individual counseling

#3 psychological testing

#4 psychiatric treatment

#5 screening and evaluation

#6 day treatment

Inpatient

#1 crisis intervention and alcohol/drug

#2 psychiatric treatment

Residential

#1 specialized foster care

#2 short term residential

#3 crisis intervention

#4 acute care

#5 alcohol/drug rehabilitation

#6 long term care

Service Area Summary

There are some similarities between the rankings of the different service areas. As stated before, all four service areas ranked family therapy and individual counseling as the highest priority in the Outpatient category. Psychological testing was ranked third in all of the service areas except Service Area 17 where it was ranked fourth.

Inpatient, crisis intervention was ranked first in all service areas except Service Area 19 where it was ranked second with psychiatric treatment. Also, Resid-

<u>ential</u>, specialized foster care received highest priority in three of the areas. Service Area 21 ranked it second, giving crisis intervention its highest priority.

The following is a summary of the rankings of all four service areas.

<u>Service Area 17:</u>

<u>Prevention</u>

#1 child abuse

#2 alcohol/drug

#3 mental health

<u>Outpatient</u>

#1 family therapy

#2 individual counseling

#3 psychiatric treatment

#4 psychological testing

#5 screening and evaluation

#6 day treatment

<u>Inpatient</u>

#1 crisis intervention

#2 alcohol/drug, psychiatric treatment

<u>Residential</u>

#1 specialized foster care

#2 crisis intervention

#3 acute care

#4 long term residential

#5 alcohol/drug rehabilitation

(see Figure 6 for Service Area 17 rankings)

Insert Figures 6 and 7 about here

Service Area 19:

Prevention

#1 child abuse

#2 alcohol/drug

#3 mental health

Outpatient

#1 family therapy

#2 individual counseling

#3 psychological testing

#4 screening and evaluation, day treatment

#5 psychiatric treatment

Inpatient

#1 alcohol/drug

#2 psychiatric treatment, crisis intervention

Residential

#1 specialized foster care

#2 short term residential

#3 alcohol/drug rehabilitation

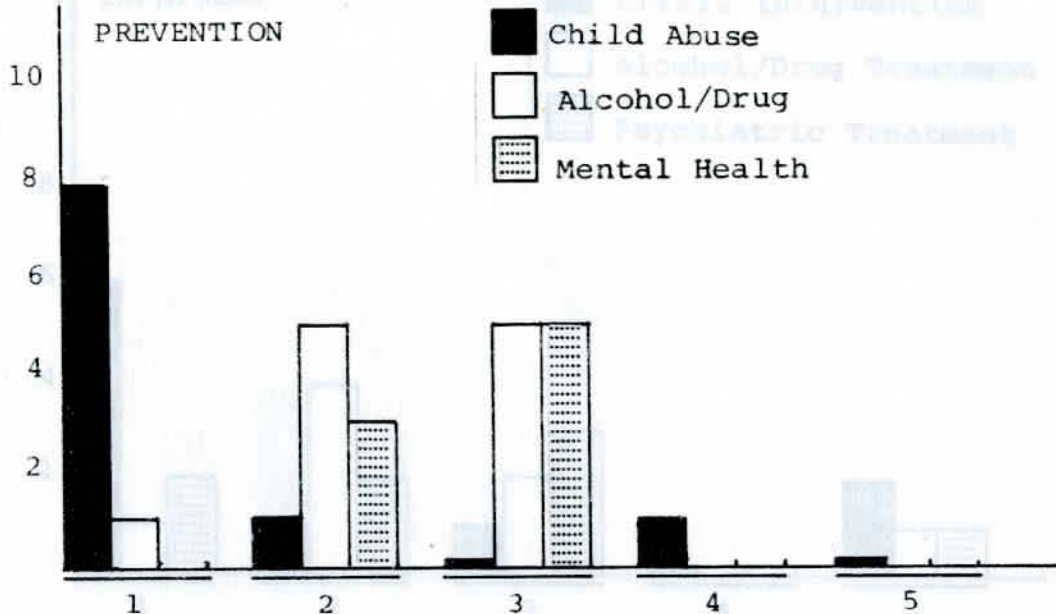
#4 acute care

#5 crisis intervention

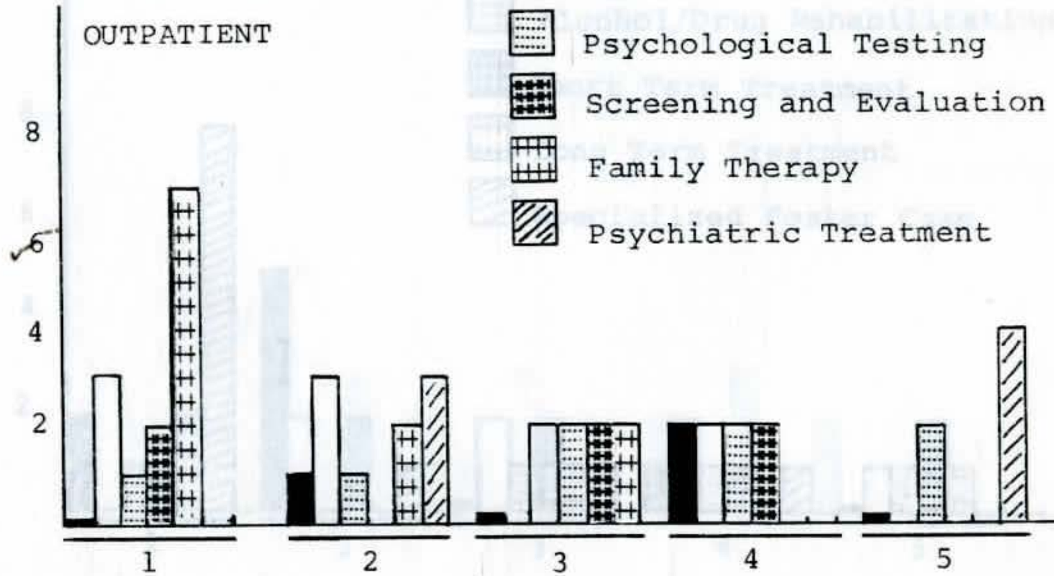
#6 long term residentail

(see Figure 7 for Service Area 19 rankings)

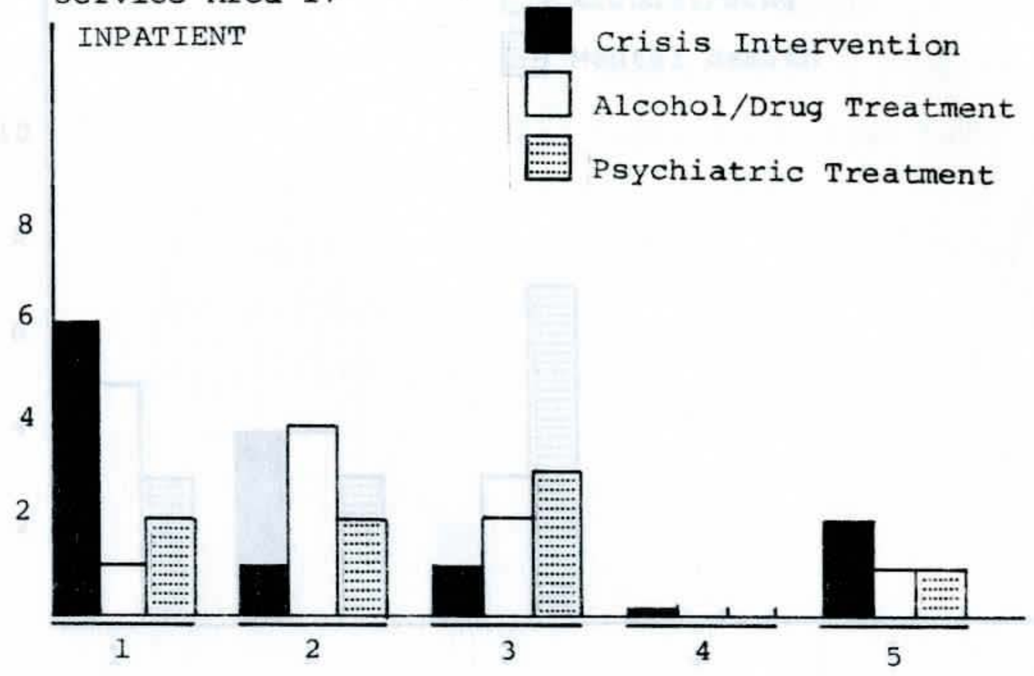
Insert Figures 8 and 9 about here



Service Area 17
PREVENTION
Child Abuse
Alcohol/Drug
Mental Health
10
8
6
4
2
1
2
3
4
5



Service Area 17
OUTPATIENT
Day Treatment
Individual Counseling
Psychological Testing
Screening and Evaluation
Family Therapy
Psychiatric Treatment
8
6
4
2
1
2
3
4
5


Service Area 17
INPATIENT
Crisis Intervention
Alcohol/Drug Treatment
Psychiatric Treatment
8
6
4
2
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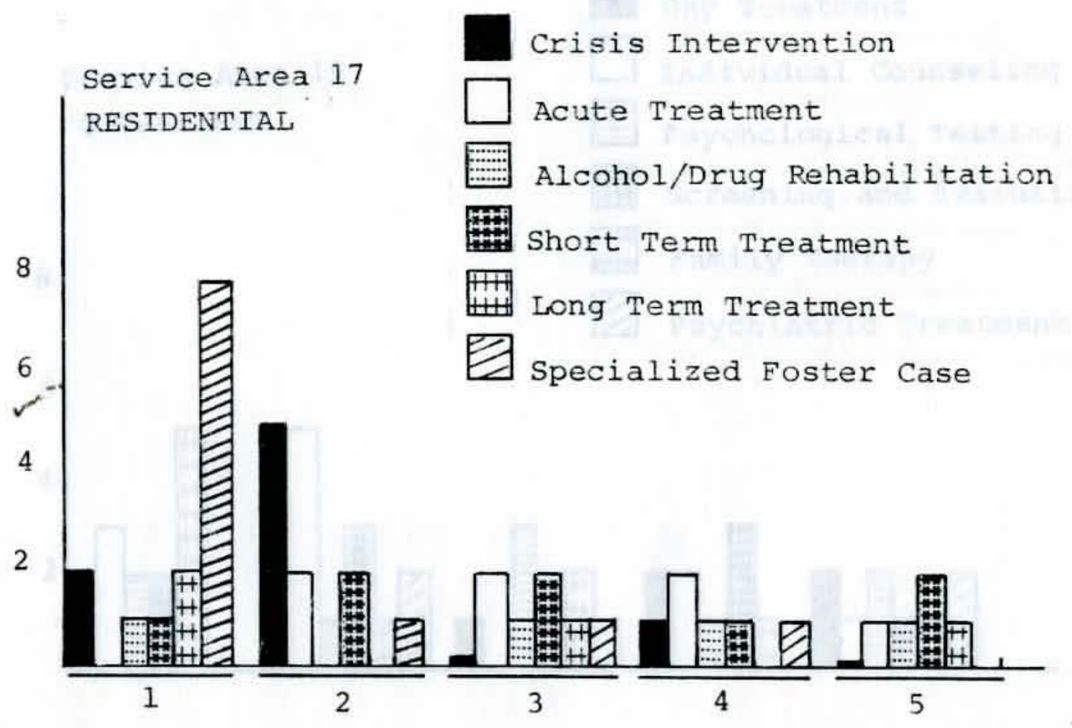
2
3
4
5


Service Area 17
RESIDENTIAL
Crisis Intervention
Acute Treatment
Alcohol/Drug Rehabilitation
Short Term Treatment
Long Term Treatment
Specialized Foster Case
8
6
4
2
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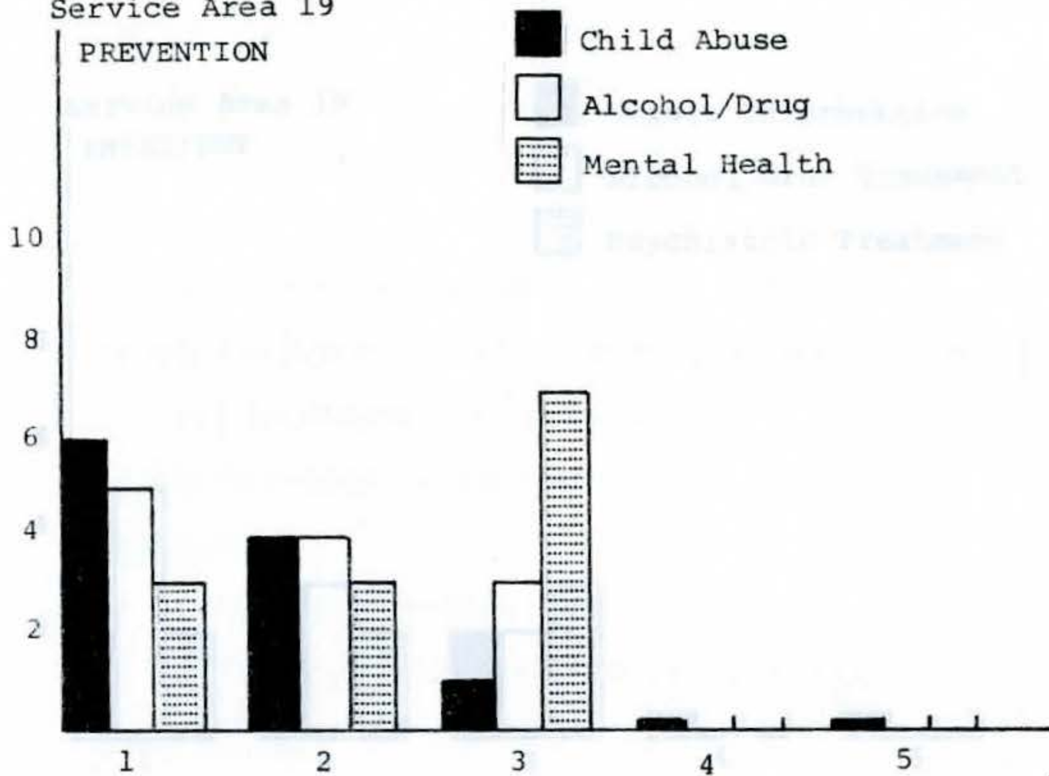
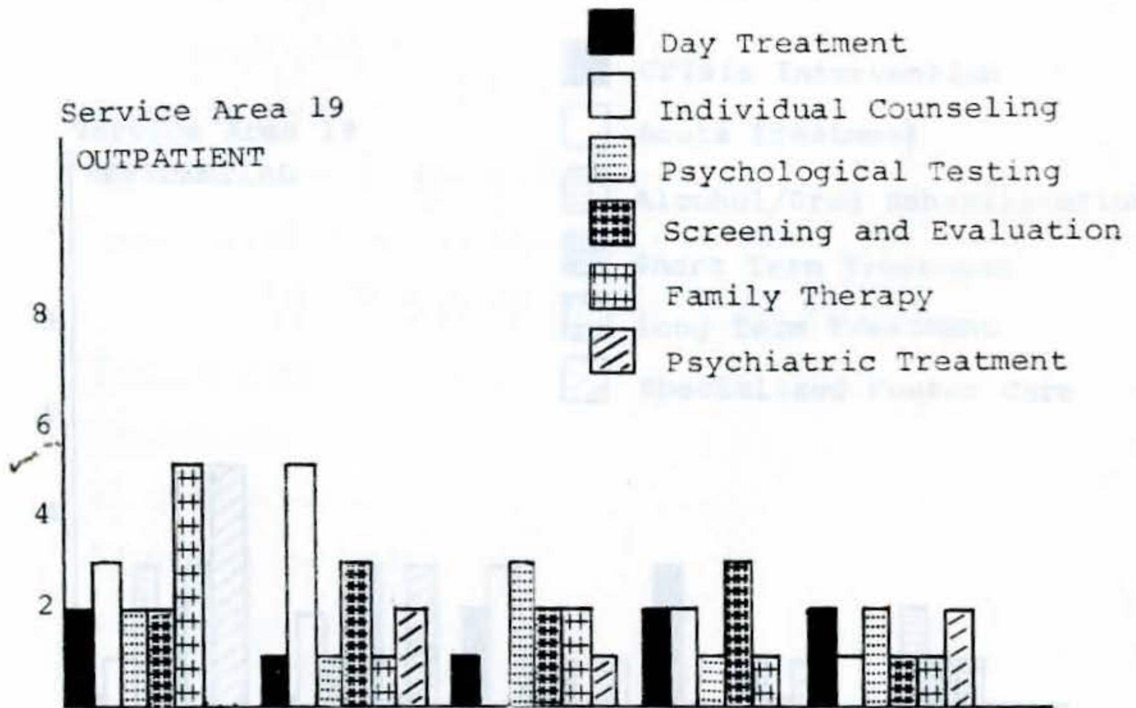
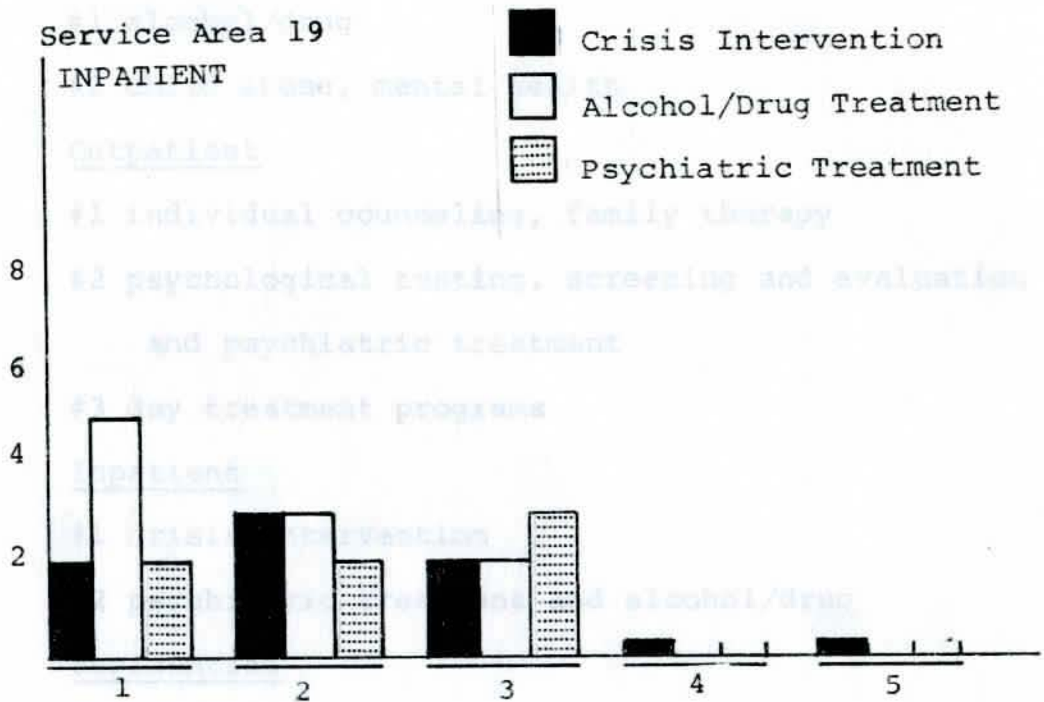
2
3
4
5


Service Area 19
PREVENTION
Child Abuse
Alcohol/Drug
Mental Health
10
8
6
4
2
1
2
3
4
5


Day Treatment
Individual Counseling
Psychological Testing
Screening and Evaluation
Family Therapy
Psychiatric Treatment
Service Area 19
OUTPATIENT
8
6
4
2


Service Area 19
INPATIENT
Crisis Intervention
Alcohol/Drug Treatment
Psychiatric Treatment
8
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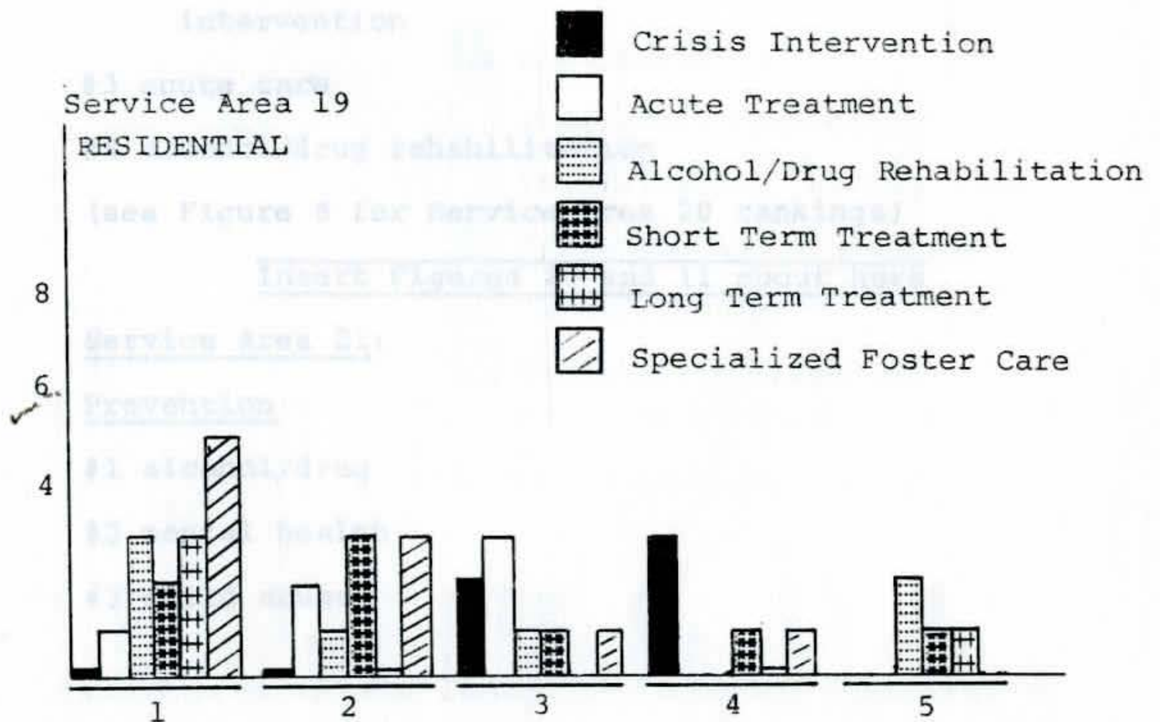
Service Area 19
RESIDENTIAL
Crisis Intervention
Acute Treatment
Alcohol/Drug Rehabilitation
Short Term Treatment
Long Term Treatment
Specialized Foster Care
8
6
4
1
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3
4
5

Service Area 20:

Prevention

#1 alcohol/drug

#2 child abuse, mental health

Outpatient

#1 individual counseling, family therapy

#2 psychological testing, screening and evaluation and psychiatric treatment

#3 day treatment programs

Inpatient

#1 crisis intervention

#2 psychiatric treatment and alcohol/drug

Residential

#1 spcialized foster care

#2 long term residential, short term and crisis intervention

#3 acute care

#4 alcohol/drug rehabilitation

(see Figure 8 for Service Area 20 rankings)

Insert Figures 10 and 11 about here

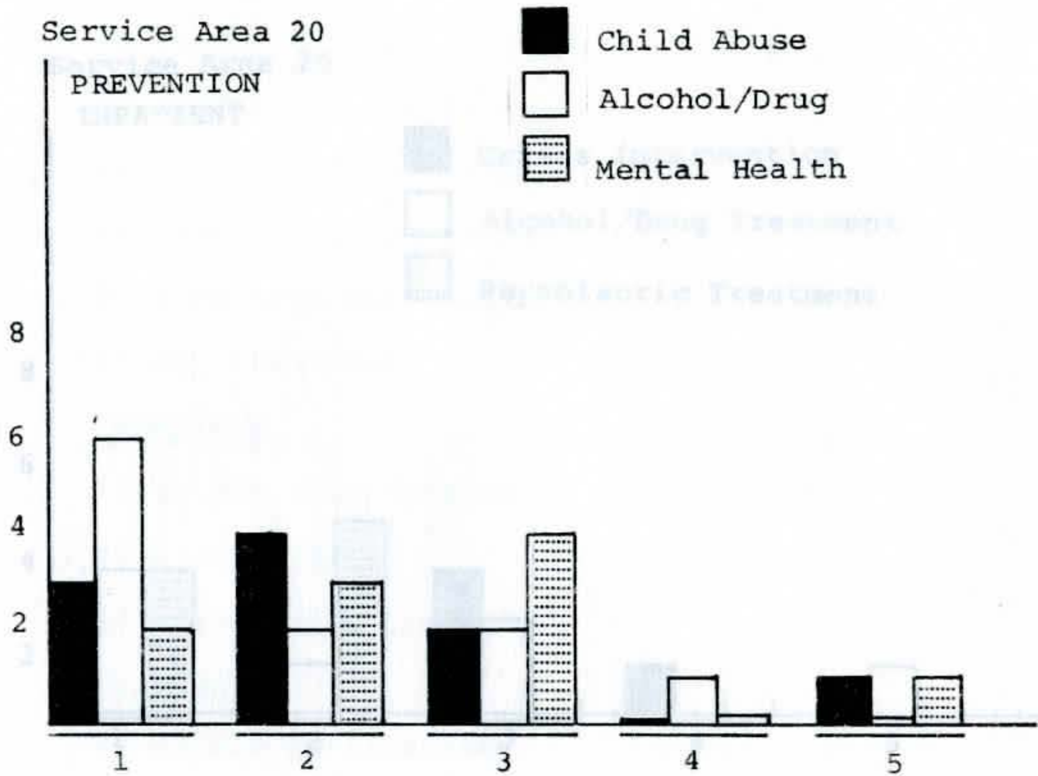
Service Area 21:

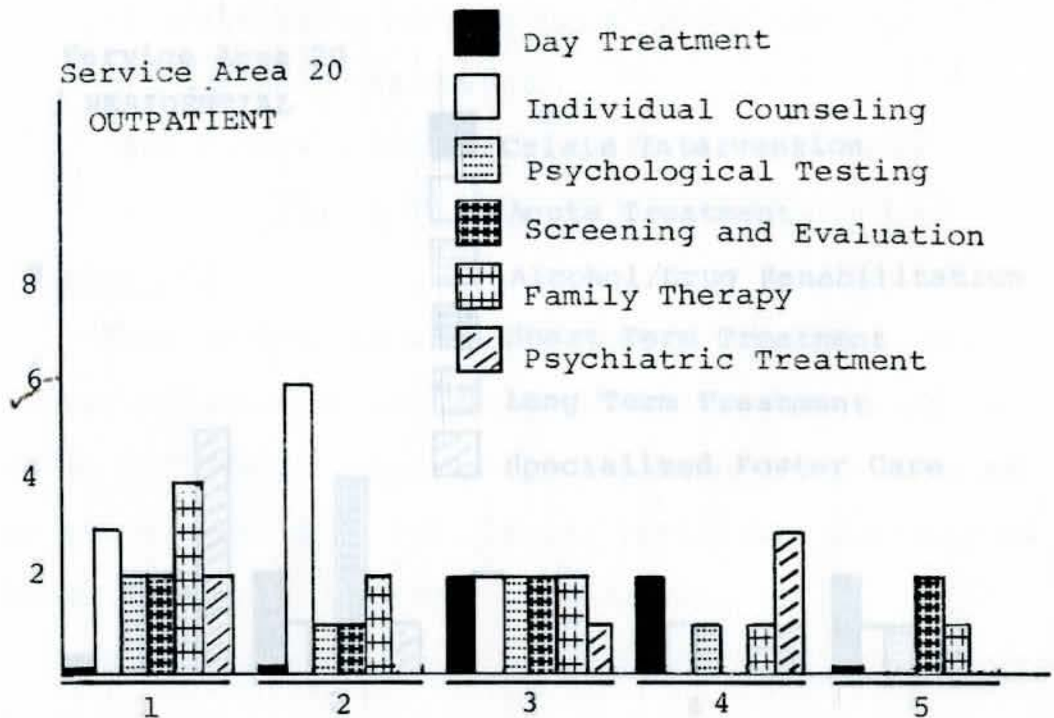
Prevention

#1 alcohol/drug

#2 mental health

#3 child abuse


Service Area 20
PREVENTION
Child Abuse
Alcohol/Drug
Mental Health
8
6
4
2
1
2
3
4
5


Service Area 20
OUTPATIENT
Day Treatment
Individual Counseling
Psychological Testing
Screening and Evaluation
Family Therapy
Psychiatric Treatment
8
6
4
2
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4
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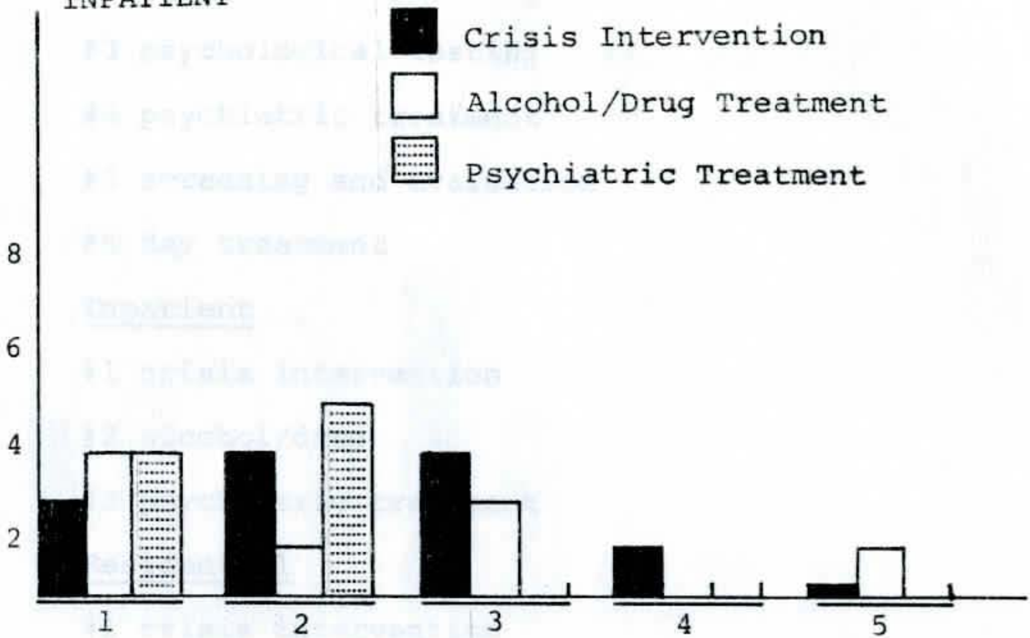

Service Area 20
INPATIENT
Crisis Intervention
Alcohol/Drug Treatment
Psychiatric Treatment
8
6
4
2
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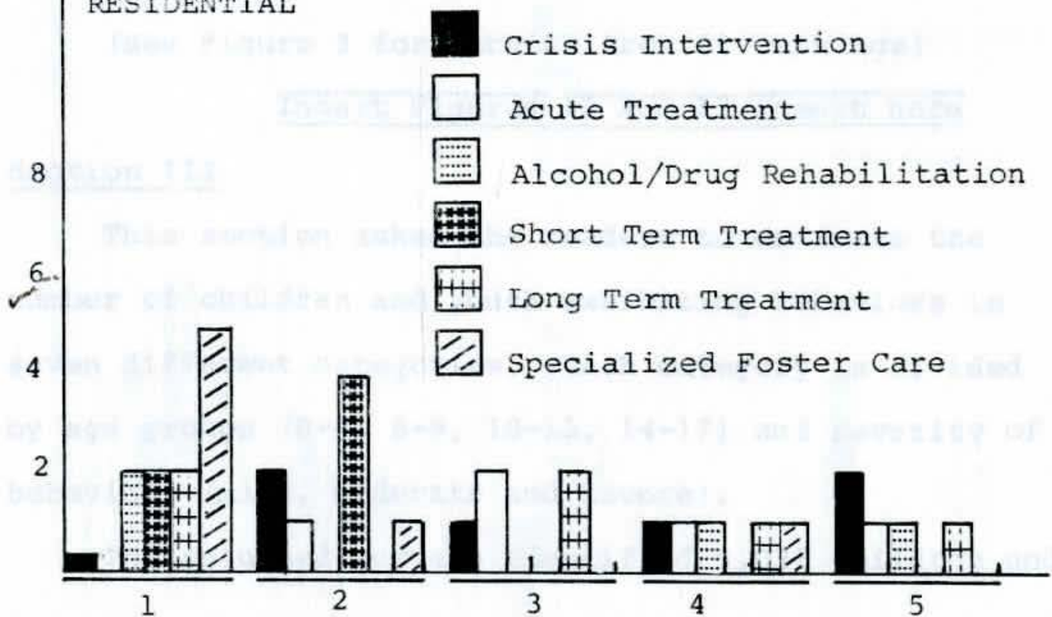


Service Area 20
RESIDENTIAL
Crisis Intervention
Acute Treatment
Alcohol/Drug Rehabilitation
Short Term Treatment
Long Term Treatment
Specialized Foster Care
8
6
4
2
1
2
3
4
5

Outpatient

#1 family therapy

#2 individual counseling

#3 psychological testing

#4 psychiatric treatment

#5 screening and evaluation

#6 day treatment

Inpatient

#1 crisis intervention

#2 alcohol/drug

#3 psychiatric treatment

Residential

#1 crisis intervention

#2 spcialized foster care

#3 short term residential

#4 acute care, alcohol/drug rehabilitation

#5 long term residential

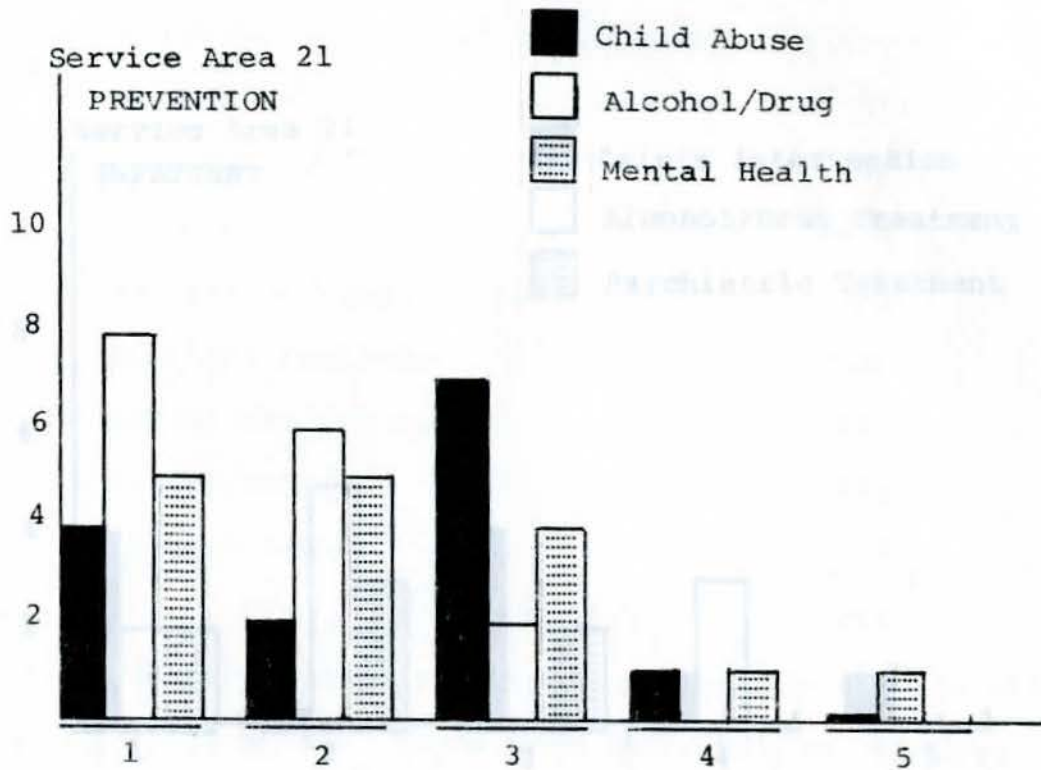
(see Figure 9 for Service Area 21 rankings)

Insert Figures 12 and 13 insert here

Section III

This section asked the readers to estimate the number of children and youth exhibiting behaviors in seven different categories. Each category is divided by age groups (0-4, 5-9, 10-13, 14-17) and severity of behaviors (mild, moderate and severe).

The returned surveys identified 5,028 children and



Service Area 21
PREVENTION
Child Abuse
Alcohol/Drug
Mental Health
10
8
6
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4
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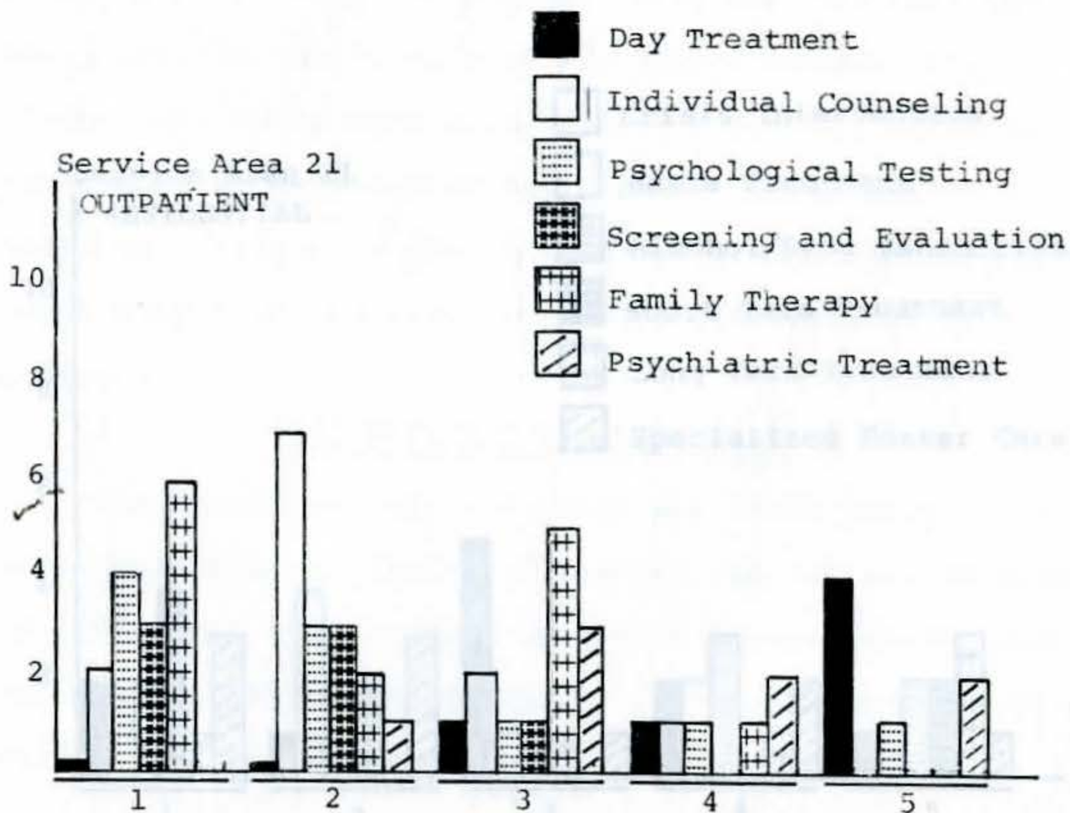

Service Area 21
OUTPATIENT
Day Treatment
Individual Counseling
Psychological Testing
Screening and Evaluation
Family Therapy
Psychiatric Treatment
10
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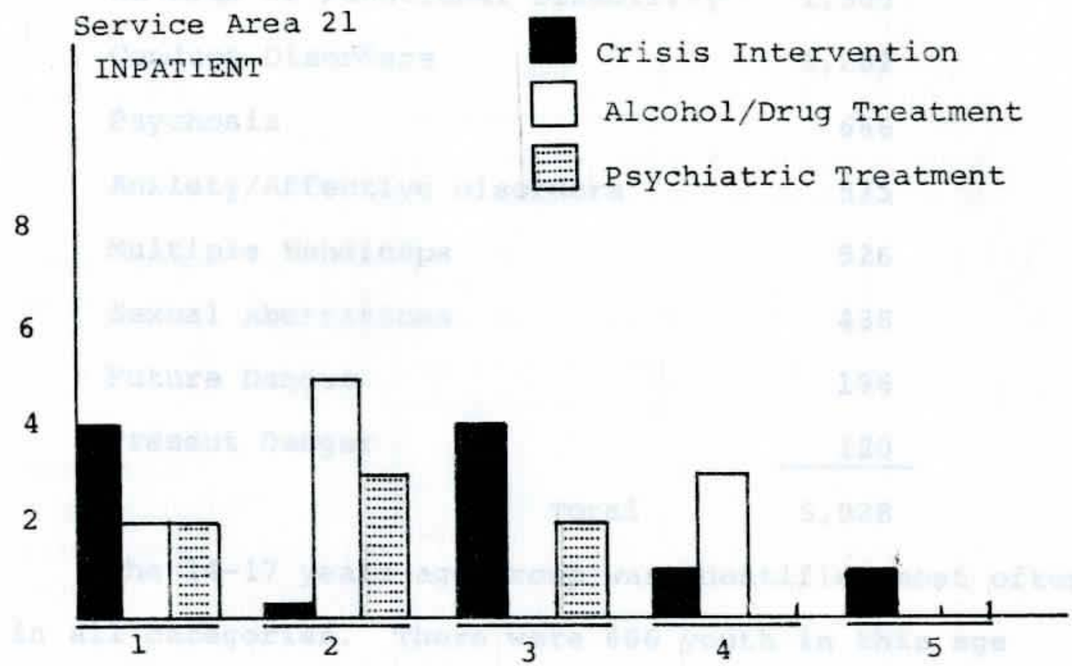
Service Area 21
INPATIENT
Crisis Intervention
Alcohol/Drug Treatment
Psychiatric Treatment
8
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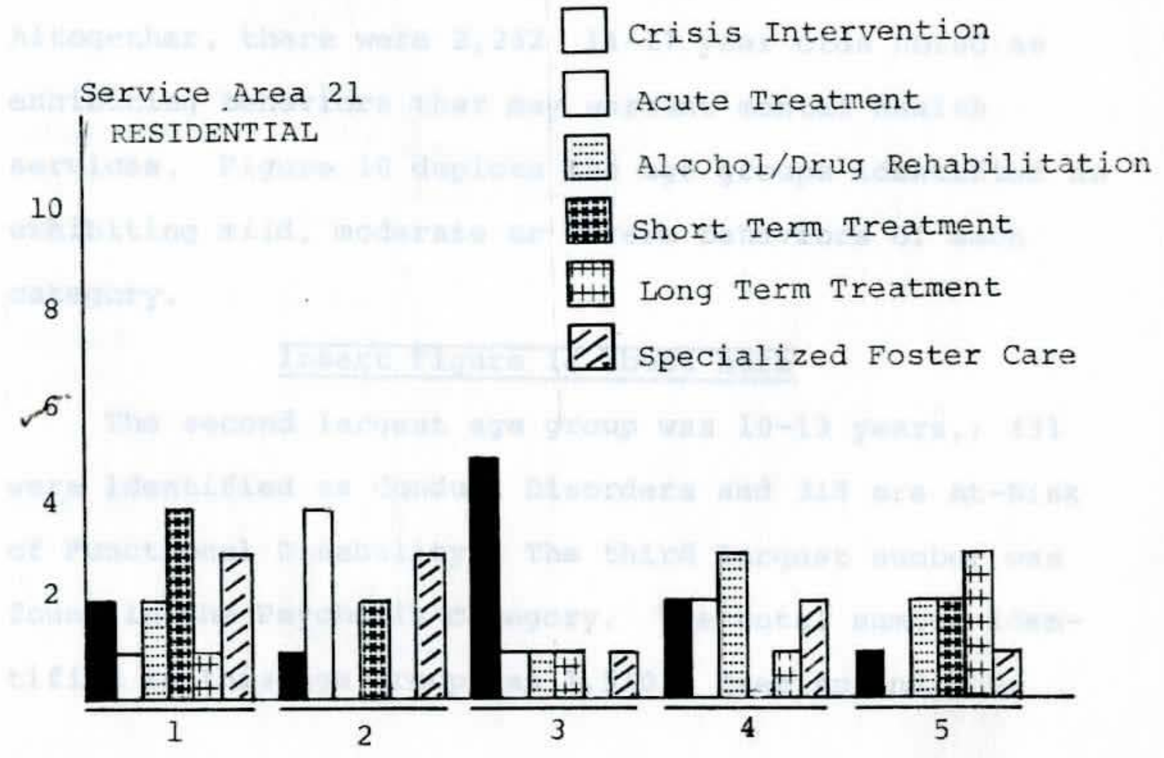
Service Area 21
RESIDENTIAL
Crisis Intervention
Acute Treatment
Alcohol/Drug Rehabilitation
Short Term Treatment
Long Term Treatment
Specialized Foster Care
10
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4
5

youth in the above mentioned categories. Below is a listing of the categories in descending order:

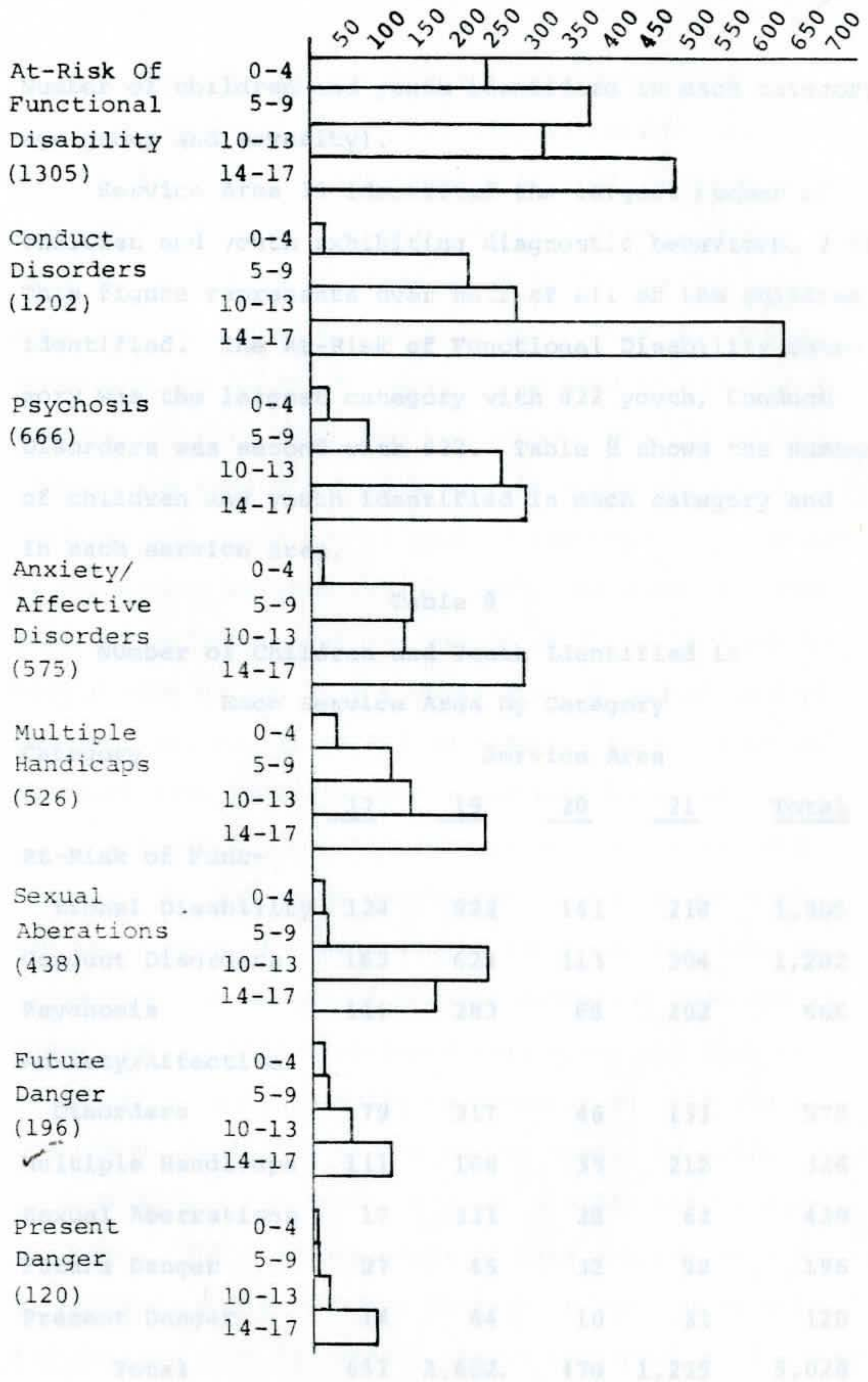
At-Risk of Functional Disability	1,305
Conduct Disorders	1,202
Psychosis	666
Anxiety/Affective Disorders	575
Multiple Handicaps	526
Sexual Aberrations	438
Future Danger	196
Present Danger	120
Total	5,028

The 14-17 years age group was identified most often in all categories. There were 666 youth in this age group identified in the Conduct Disorders category and 422 identified as At-Risk of Functional Disability. Altogether, there were 2,232 14-17 year olds noted as exhibiting behaviors that may warrant mental health services. Figure 10 depicts the age groups identified as exhibiting mild, moderate or severe behaviors of each category.

Insert Figure 14 about here

The second largest age group was 10-13 years,; 331 were identified as Conduct Disorders and 318 are At-Risk of Functional Disability. The third largest number was found in the Psychosis category. The total number identified in this age group was 1,510. (see Appendix D:

Number of Children Identified by Symptom and Age



Number of children and youth identified in each category, age group and severity).

Service Area 19 identified the largest number of children and youth exhibiting diagnostic behaviors, 2,652. This figure represents over half of all of the children identified. The At-Risk of Functional Disability category was the largest category with 822 youth; Conduct Disorders was second with 622. Table 8 shows the number of children and youth identified in each category and in each service area.

Table 8

Number of Children and Youth Identified in Each Service Area by Category

Category	Service Area 17	19	20	21	Total
At-Risk of Functional Disability	124	822	141	218	1,305
Conduct Disorders	163	622	113	304	1,202
Psychosis	116	283	65	202	666
Anxiety/Affective Disorders	79	317	46	133	575
Multiple Handicaps	111	168	35	212	526
Sexual Aberrations	17	331	28	62	438
Future Danger	27	45	32	92	196
Present Danger	14	64	10	32	120
Total	651	2,652	470	1,255	5,028

Summary, Conclusions and Recommendations

The Southeast Region has 148,624 persons under the age of 18; 17,820 (approximately 12%) of these were represented by the returned surveys. These surveys indicated that 18.4% of these youth could benefit from some type of mental health services. This percentage translates to 3,279 of the youth covered by the survey. However, if this estimated percentage could be generalized to the region's population, it would suggest 27,347 children and youth are in need of services. (It should be noted that between July 1, 1982, and June 30, 1983, only 927 persons under the age of 18 from the Southeast Region were served by the Department of Mental Health through its facilities and contracts. This number represents both inpatient and outpatient services).

Although a generalization is helpful in estimating the children and youth population of the region that may be in need of mental health services, the task of estimating the number of persons suffering from specific conditions in each geographic area would not only be astronomical but basically unnecessary at this stage. The youth identified in the survey should be sufficient in providing a framework on which a model can be constructed. The original goals of this project were to, 1) identify socio-economic factors in the region that may warrant need for mental health services, 2) illumin-

ate age groups that are most-in-need, 3) identify special needs in the geographic areas and, 4) focus future programming towards the identified needs. Conclusions regarding these goals can be drawn from the results of this project without excessive or imaginative generalizations.

Goal #1: To identify socio-economic factors in the region that may warrant mental health services.

The economic deprivations and the high rates of marriage dissolution and child abuse/neglect incidents indicate a potential for deterioration in our youth. This was specifically supported by the high number of youth (1,305) identified in the category At-Risk of Functional Disability. The 1,202 youth identified as Conduct Disorders could also be a direct product of the deprivation throughout the region.

Goal #2: To illuminate age groups that are most-in-need.

The agencies responding to the survey were clearly most concerned about the youths between the ages of 14 and 17 years. This age group had the highest number of youth (2,232) identified as At-Risk of Functional Disability, Conduct Disorders, Psychosis, Multiple Handicaps and in Present and Future Danger. The only category where this age group did not have the largest number is Sexual Aberrations. There were 242 10 to 13 year olds in this category compared to 164 14 to 17 year olds.

Goal #3: To identify special needs in the geographic areas.

Service Area 19 reported over half of the children and youth presenting diagnostic symptoms/behaviors (2,654 or 53% of the youth identified), while the returned surveys from that geographic area represented only 18% of all the children and youth covered by the survey. Again, the largest number of youth from that service area was found in the At-Risk of Functional Disability and Conduct Disorders categories.

The service area with the second largest number of youth identified (1,255) in these categories was Service Area 21. This number represents 25% of the children identified while the returned surveys from Service Area 21 represents 27% of all the youth covered. This area reported 304 youth with Conduct Disorders as the largest category. They also reported the largest number of Multiple Handicaps than any other service area (212, 40% of all the youth in this category).

Service Area 17 identified 651 or 13% of the youth as presenting diagnostic symptoms/behaviors and the surveys from that area represented 20% of the population covered. Again, the largest category was Conduct Disorders (163 youth) but there was no significant or unusual groups identified.

The smallest number of youth identified was in

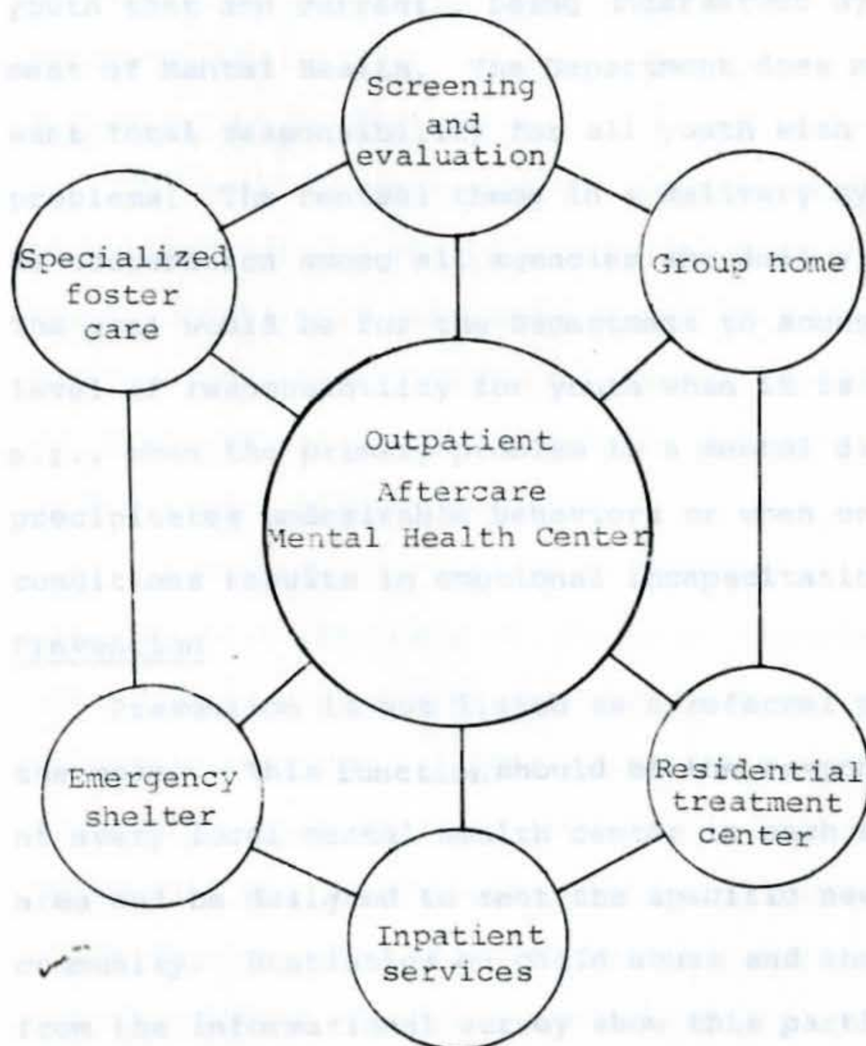
Service Area 20. This area reported 470 youth or 9% of the total and the surveys represented 23% of the youth covered by the surveys.

Goal #4: To focus future programming towards identified needs.

Regionwide model for mental health services for children and youth. The task now is to develop a model for a mental health delivery system for children and youth. Due to the geographic size of the region and the lack of specialized programming, the model should be fairly comprehensive, representing a continuum of care. This continuum should not be considered as a linear progression requiring youth to proceed from one service to another before having an opportunity to benefit from the most restrictive environment, inpatient. The basic outpatient services located in the local mental health centers should be considered as an entry/exit point allowing a child to go directly to the appropriate service. The ideal system would have local mental health centers operating as the most prominent and widely used service for youth and as a referral source to the following programs: 1) screening and evaluation or assessment program, 2) specialized foster care programs, 3) group outpatient for abused and neglected children, 4) group home or short term residential treatment, 5) residential centers for long term

treatment, 6) inpatient services, 7) emergency shelter, and 8) outpatient services and followup.

The following displays the line of referrals needed to organize available services into a mental health delivery system:



The type of program chosen for any particular child would, of course, depend on the severity and nature of the youth's problems and familial or environmental situations.

The purpose of this model is not to duplicate existing services being provided by other youth agencies, but to recommend programs that would meet the needs of youth that are currently being underserved by the Department of Mental Health. The Department does not need or want total responsibility for all youth with behavioral problems. The central theme in a delivery system should be cooperation among all agencies who deal with youth. The goal would be for the Department to accept the proper level of responsibility for youth when it is appropriate, e.g., when the primary problem is a mental disorder that precipitates undesirable behaviors or when environmental conditions results in emotional incapacitation.

Prevention

Prevention is not listed as a referral program in the model. This function should be the responsibility of every local mental health center in each service area and be designed to meet the specific needs of the community. Statistics on child abuse and the rankings from the informational survey show this particular problem as needing special and immediate attention.

Several programs are either currently providing

894/17

services or in proposal form. These programs focus on young parents and encourage bonding and teach parenting skills. Additional services could include increased cooperation between the mental health centers and the local communities, the Division of Family Services, the local medical community (doctors, nurses, maternity wards in hospitals, etc.) and community child welfare organizations.

Screening and Evaluation

The need for this program has not been specifically identified through the informational survey for any specific area, but represents a need to coordinate future programs and to supplement the restricted capabilities of rural centers. Service Area 20 did rank this service as its second highest priority.

A screening and evaluation program (S & E), in order to meet the needs of the local centers, must offer highly specialized services that may not be available to core centers. Some centers may have the capacity to provide these services, however, a regional team that would be available for contracted services would allow remote, rural areas to take advantage of this service without expensive capital outlay. The limited need for this service may not warrant a team in each service area. The program would incorporate an interdisciplinary team approach with persons qualified to

evaluate and assess youth in one or more of the following areas: psychological testing, psychiatric evaluation and assessment, neurological assessments, educational assessment, and social histories and evaluation of environmental conditions.

The local mental health center would serve as an entry/exit point for families and non-mental health organizations and would be responsible for appropriate referrals of youth that could not be evaluated on the local level. The local center may wish to refer to the screening and evaluation program if the need for residential or inpatient care is expected. If the S & E team determines that the youth can be maintained on an outpatient basis, they would be responsible for referring the youth back to the local mental health center in the youth's community and for providing consultation services to an identified staff member in that center. The local staff member would then be considered part of the S & E team and be directly involved in developing a treatment plan or further referrals for the youth. Case managers would be appointed from the S & E team for each youth to serve as the client advocate and work with all mental health and non-mental health agencies that may be involved in the youth's welfare. Along with the evaluation, one of the major tasks of the S & E team would include a recommendation for services.

As stated before, one of the major responsibilities of the S & E team would be to not only assist the local staff member in developing a treatment plan for outpatient care, but would also work as a referral source to other programs. If outpatient services are in fact appropriate, the S & E team would offer consultation to assist the staff member responsible for treatment in developing short and long term goals. Reasonable expectations of obtainable goals and length of treatment should be discussed by the S & E team and the local staff member. The team would be available to the staff member throughout the Course of Treatment for consultative services.

Criteria for referral to the S & E team would include all children and youth under the age of 18 when one of more of the following conditions exist: 1) inability to assess child with limited available resources on an outpatient basis (this may include situations where screening and evaluation is not possible with time restrictions or when the child would need to be removed from familial conditions in order to achieve a true assessment), 2) when the referral source suspects physical or biological causes or conditions that may be contributing to emotional instability, 3) when the referring counselor may suspect that a more restrictive environment and intensive treatment may be necessary,

i.e., inpatient care or residential treatment, 4) any time the counselor may want the consultative services of the screening and evaluation team.

Since this S & E team is responsible for training local mental health center staff in treatment procedures when appropriate, it would also be appropriate to have this team responsible for training potential foster parents in the specialized foster care program.

Specialized Foster Care Program

This program received top priority in the regional summary of the rankings of needed services from the informational survey. One of the reasons for the attention this program received may be the lack of alternatives to Hawthorn Childrens' Psychiatric Hospital in St. Louis. Admission to the hospital is difficult due to the geographic distance and the restrictive admission criteria the hospital must exercise. Inpatient services, by definition, should be limited to acute care because of the desire of all mental health professionals to utilize least-restrictive environments. The specialized foster care program would allow for treatment in a non-institutional setting that would simulate a "natural" environment. Specialized foster care homes should be developed in each of the four service areas.

Another part of this model will refer to group homes in which youth are treated in a family style

setting, utilizing the advantages of peer pressure. Not all children are capable or willing to accept this type of environment, especially in situations where youth are considered dangerous to peers. In these cases, it may be more appropriate for the youth to reside in a home setting in which no other children are present and they can receive constant attention from persons who have been trained to deal with these unusual and possible volatile behaviors. Currently, the Division of Family Services may place a child in foster care setting when the natural home is no longer capable of providing for that child's welfare. Specialized foster care programs are not to be confused with the current social services system. Foster care parents for this therapeutic program should undergo intensive screening, meet minimal educational or experiential requirements and undergo specialized training in order to assist them in dealing with the types of problems these youth will possess.

The Division of Family Services would continue to following the normal procedures for the initial training of regular foster parents. The Department of Mental Health, through the screening and evaluation training program, would do a second more specialized training in order to prepare these foster parents for the type of youth they would be caring for. This procedure

would be similar to a certification process currently being utilized by the Division of Family Services and the Department of Mental Health in the licensing standards for residential homes.

Since these special foster parents must meet minimal educational requirements in order to qualify for this program and since the child would require intensive supervision and treatment, the foster parents should be paid a sum comparable to that which would be received by a residential or inpatient program. Because of the severity of the youth's problem, it would be expected that the youth would remain in foster care for approximately one year or more.

Youth placed in these settings should be matched with the foster parents through a screening process allowing the parents to decline placement if they do not feel compatible with the youth or capable of handling a certain situation. This process should allow for the foster parents acceptance of children that may fit in their own personal specialty. For example, some couples may find that they work best with teenage males or withdrawn youth, etc. Therefore, youth considered for admission into this program would include along with an identifiable diagnosis, one or more of the following:

1) the youth may be impossible to place because

of past aggressions against peers or family members,

2) the parents may find it impossible to maintain the youth in the natural home setting because of acting out or sexual behaviors,

3) the youth may not respond to group settings and may not be able to handle the pressures of peers and family members,

4) the youth is not acceptable for placement in available community placement programs.

The type of youth that would be placed in these homes may exhibit severe acting out behaviors, may be episodically violent or aggressive and may be inappropriate for placement in an institutional or group residential setting. These foster parents would be expected to provide a "normal" home setting with constant supervision and 24 hour treatment.

Although treatment should always be individualized, depending on the needs, diagnosis, and situational problems, the following could constitute a normal procedure if deemed appropriate. Treatment goals should include prevention of mental health disorders at the primary, secondary, or more likely the tertiary level. The foster parents would be expected to participate in outpatient counseling with the youth on a regular basis during the entire length of stay in the home. The local

mental health center would serve as a support for the foster parents and would play a consultative and therapeutic case manager role. The foster parents would act as surrogate parents and would be responsible for medical appointments, mental health appointments, school responsibilities, recreational activities, etc.

It is possible that children of this type may not be returning to their natural homes upon release from this program. However, if family conditions are such that the child could return, the family would also be required to be involved in therapy while the child is in foster care. It is not recommended that the family and the child be involved in conjoint therapy. The child should be receiving services with the foster parents until such time that these parents and the mental health professional believe the child is ready for re-entry into the natural family. Until that time, family members would be seen on an outpatient basis in a mental health center close to their local community. The purpose of family treatment is to help parents to understand the child's situation and help rectify any existing familial conditions that perpetuated the child's incapacitation.

The foster care program of course can include children who have experienced physical or emotional abuse or neglect. However, if the child can be maintained

within the natural family structure, it is recommended that group sessions with other abused children be made available to supplement existing individual outpatient counseling.

Outpatient Group

This specific service was not addressed in the ranking of services on the informational survey. However, the socio-economic factors, the high rate of child abuse/neglect incidents and the attention prevention of child abuse received on the survey, justifies inclusion of a program to meet the apparent need of this population. These group activities should not be designed to supplant but rather complement individual therapy.

Service Area 19 has a high rate of abuse/neglect incidents (49.6 per 1,000 compared to the state rate of 21.8 per 1,000) and a high number of youth identified as presenting symptoms typical of being At-Risk of Functional Disability (63% of all the youth in this category). Socio-economic statistics indicate a need for this program in all service areas, but Service Area 19 may warrant specific, immediate action.

Outpatient group therapy can be helpful in allowing the youth to associate with others who have had similar experiences. It should be stressed that this model is not endorsing the child remaining in the home if abuse is occuring. While removal of the child from

the family can in fact convey to the child that s/he is at fault and is being punished by separation, it may also be equally damaging to the child to be forced to live in an environment that may impose a constant threat. It is not recommended that children be forced to live in fear in order to maintain them in their natural family, and therefore, group outpatient may not be appropriate in all abuse situations. If the child does remain in the family home, it is an essential requirement that the abuser, if a family member, also undergo separate therapy and treatment.

Careful consideration should be given to admission into these youth groups. Before joining the group, the youth should be aware that there may be members in the group that attend the same school or live in the same neighborhood as the other participants. Confidentiality must be stressed and insisted upon at the very beginning of the sessions. Ground rules should be formulated establishing do's and don'ts of social contact between members outside of the group setting. It is recommended that these groups be established with homogeneous participants, that is, children removed from the home should not be in a group with children who are still living in the home. This mixture may contribute to a child's feelings of punishment if the child has contact with other children who have not been extracted from their families.

Group treatment is not recommended for youths who are experiencing <u>severe</u> emotional problems or who have been diagnosed with a severe disorder for the symptoms of the disorder could be extremely detrimental to the well being of other group members. This group is for children who are experiencing emotional problems due to situational circumstances and not due to a mental disorder. Specialized foster care programs would be more appropriate for the more emotionally disturbed child rather than group therapy.

In cases of sexual abuse, the group process may be particularly helpful to allow the child to release any personal guilt feelings and the sense of responsibility for what has happened to him/her. Other treatment goals for the group would include: 1) to use the support of peers to establish a healthy self image and confidence that would allow the youth to regain control of his/her life, and 2) to allow the youth to gain insight into the roles played by "victims and abusers." The child should realize that s/he has the right to say "no" to an authority figure if they are making unreasonable demands that are harmful to the youth. These youth are often in Erickson's stage of trust vs mistrust and need to be taught skills in making accurate decisions regarding persons who can be trusted.

Group Homes

Residential care should be considered as a regional service. Due to the cost of such a program, this is not recommended for each service area but the region could be served by possibly two group home facilities designed especially for youth. Youth identified in the mild or moderate categories of Conduct Disorders, At-Risk of Functional Disability and Future Danger may be appropriate for admission to this program.

The surveys received from the Division of Youth Services workers reported that 65% of their caseloads could benefit from mental health services and juvenile officers reported 30%. These figures would indicate a significant population that is generally not being treated by the Department of Mental Health. The Division of Youth Services currently operates group home placement for youth with problems similar to those children identified as the responsibility of the Department of Mental Health. This mental health group home program would not duplicate existing Youth Services group homes, for youth in the mental health program must have a primary diagnosis of a mental disorder. The purpose of mental health group homes would be to allow the Division of Youth Services or juvenile courts to more appropriately place youth that, in fact, may have had some contact with juvenile authorities. The

behaviors that involved these other agencies should be secondary - a product of the mental condition. It is not recommended that this be the target population for a group home, but these youth should not be refused because of minor infractions of the law. It is not unusual for youth with emotional instability to have had problems in their local communities. Admission staff needs to be sensitive to the homes population and consider residents before admitting a juvenile offender.

Children that have adopted a victim or abuser self concept are not recommended for a group home setting. These youth would need to be fairly socialized so they could function in a peer setting. When severe cases of undersocialization or severe symptoms of Conduct Disorders exist, a peer setting may be too stressful.

Ideally, the child would be referred for admission to the group home through the local mental health center or through the screening and evaluation team. If the child is accepted in the group home and it is decided that the situation is more severe than previously believed or if new dangerous or psychotic behaviors occur, the child could then be referred to the residential treatment center.

The group home should be as much like a family setting as possible. For example, in a family type living

arrangement, each member has individual responsibilities and personal chores.

A group home would consist of 8 - 10 residents of the same sex and similar age groups, and would include only those children who are capable of functioning in the local school system. Admission to this type of program would include children who are unable to function in a family setting because of poor or inadequate interpersonal skills that have interferred with the family or community involvement.

Treatment goals of the program would be to help the youth become aware of the secondary gains s/he is receiving from inappropriate behaviors. The model would utilize the positive peer culture (PPC) allowing the group and the group process to operate in achieving these goals with the minimal amount of interference from the staff (Vorrath, 1974). Recreation and physical activities are extremely important in this type of setting. Outdoor recreational programs such as the ropes course may be helpful in the group process and can be utilized anytime the group is adding a new member or is experiencing a breakdown in relationships (Seattle Mountaineers, 1960).

When possible, the youth's family members should be involved in therapy in their local mental health centers while the children are residents in the group home. The

progress of the natural family in therapy should be considered before releasing the child back into the previous environment. The family counselor should be in contact on a regular basis with the staff at the group home regarding the child's progress and in order to share any information that may be helpful in the therapeutic situation. An average length of stay for group home residents should be around three to six months. Youth requiring more intensive treatment would be more appropriate for placement in residential treatment.

Residential Treatment Center

This type of care should be considered more restrictive than a group home but less restrictive than inpatient care. Residential treatment is too expensive for each service area so this type of program would be strictly regional. One residential treatment center should be sufficient for the entire region.

The hand tabulation of the ranking of needed services on the survey reflected priorities chosen by responders when comparing program-to-program rather than services under a program heading. The results of this type of prioritization was all four service areas ranking residential with a high priority.

The number of children and youth identified in Section III of the survey also constitutes a need for this program. Five hundred two (502) youth were identified as presenting severe behaviors. Of that number,

266 were 14 - 17 years old and 147 were 10-13 years old. Of course not all of these would be appropriate for a residential program. The severe cases of Psychosis and Anxiety/Affective Disorder alone amount to 154 youth. A number of these youth could be stabilized in an inpatient setting and then be transferred to a residential program. It is impossible to predict the actual number of youth who could be released to residential, but 40 beds could easily be utilized.

The residentialtreatment center would be an institutional type setting, providing a secure environment for approximately 40 residents who would have a length of stay in excess of one year. These children would be difficult or impossible to place in a community program but would no longer require inpatient services. The staff/resident ratio would need to be fairly high considering the type of youth that would be placed in this program. It is recommended that the residents be clustered according to age and sex. Direct attention should be paid to co-mingling and mixing children with aggressive behaviors with those who are withdrawn and potential victims.

In order to avoid the appearance of an institution, it is recommended that the center be based on the cottage system with approximately eight children in each cottage with "parents" for each home. For

security reasons, the cottages would not be physically separate, but designed more as a wheel structure with common areas serving as a hub. The children should have individual bedrooms in order to allow them the privacy and safety needed. Since most of the children will be in school during the day (either on the grounds or in a public school) the most important part of the day would be the evening. This is when the majority of the staff and the most highly trained staff would be on duty.

Some of the behaviors youth may be exhibiting would include sexual acting out, a mental disorder that would necessitate a restrictive environment or possess a past history of dangerousness to self or others. These children would be currently unable to function in community or family settings.

Individual therapy would be part of each child's treatment program. Drug therapy may also be needed as an adjunctive measure. Although group therapy would not be stressed in a residential treatment center as it would be in a group home setting, the grouping of the homogeneous residents in the cottages would offer a structure for addressing housekeeping problems. The group would not be important in treatment, but would facilitate the children's activities and movements.

The majority of the residents of the treatment center would in all likelihood be transferring from an

inpatient program.

Inpatient Care

Inpatient programs are considered the most restrictive environment and the most expensive service on the continuum. These programs ideally would be utilized primarily for short term or acute care on a limited basis. Potential referrals to this type program would include children and youth exhibiting severe behaviors in any of the seven categories but especially in Psychosis (84 severe cases reported), Multiple Handicaps (51 severe cases), Anxiety/Affective Disorders (70 severe cases) and Present Danger (19 severe cases).

Inpatient programs are used to stabilize children who are potentially dangerous to themselves or others or those who are experiencing acute severe mental disorders. Inpatient treatment may also be used when attempting to diagnosis, or in the preliminary stages of evaluating the efficacy of medication and proper dosage. The majority of the children will remain in inpatient care for not longer than six months. Long term inpatient may be the responsibility of statewide programs.

Currently, inpatient programs receive referrals from mental health professionals to assist in removing a child from the home when dangerous situations exist in their home environment. This is an inappropriate use of inpatient treatment but has become common because of the lack of alternatives. Appropriate placement in these situations would be in an emergency shelter that

would provide room and board and crisis intervention therapy until more permanent placement could be found.

Emergency Shelters

Emergency shelters would provide housing and care for a child until necessary arrangements for placement or evaluations are completed. This type of care can be expected to last for as little as several hours or until placement papers and procedures are completed. Shelters could house children from the ages of 0 to 18 and would not adhere to the usual strict mental health admission criteria. Staff at these shelters would be responsible for transportation of the child to school if the placement is longer than 96 hours.

Crisis intervention is the only type of therapy the shelter would provide, any long term therapy would be the responsibility of the permanent placement. If proper screening and evaluation has not been done, this process can be completed while the child resides in the emergency shelter. It is extremely important in these situations that the mental health providers work closely with local juvenile courts. Also, these shelters should have professional mental health back up in case of a mental health emergency.

Conclusions

The Southeast Region has an obvious lack of specialized programs for children and youth. Outpatient services

are the only available services in the loacl mental health centers, but only two of the seven centers have trained child psychologists.

This project was designed to assess the mental health needs of this population and identify specific behaviors and ages of those who are currently untreated by the Department of Mental Health. Data from a survey sent to child-serving agencies were compiled in order to develop a model system for the delivery of mental health services for the entire region. This model will be used as a guide for a group of interested persons who are responsible for advising the Department of Mental Health of the regional and local needs.

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Appendix A: Informational Survey

INFORMATIONAL SURVEY REGARDING CHILDREN AND YOUTH IN SOUTHEAST MISSOURI

The Regional Advisory Council for Psychiatric Services is attempting to determine the mental health needs of youth (the term youth will refer to all persons under the age of 18) in the Southeast region. The purpose of this questionnaire is to identify the most prevalent mental health problems, the largest at-risk age group, and the need to prioritize requests to the Department of Mental Health for mental health services for youth. The Council appreciates your assistance in this project. Please complete and return the following questionnaire to this office by April 20th. Enclosed is a current list of members of the Council for your information. If you have any questions or comments, please feel free to contact the Council's staff member, Kay Greer, 686-1123, or your local representative on the Council. If the questionnaire has not been returned by the above date, a Council member from your area will contact you to offer assistance in completing the form. Thank you for your cooperation.

Name of Agency/Organization____________________

Address______________________________

City______________________________

Name of Person Completing Form____________________

Title or Position______________________________

Telephone Number______________________________

Does the following information reflect total organization?____________________

I. 1. Please check the age group your organization primarily serves:

0-4_____ males_____

5-9_____ females_____

10-13_____ both_____

14-17_____

all of the above_____

2. The approximate number of youth you or your organization serves on a monthly basis?______

3. Of this group, can you estimate the number of youth that are currently receiving services from the following agencies?

   Division of Family Services__________

   Juvenile Court/Officer__________

   Division of Youth Services__________

   School Counselor__________

   Mental Health Provider__________

   Other (please specify)__________

4. Could you give a brief description of the types of services your organization offers youth?

____

5. Other youth organizations you currently refer to and the types of services they provide:

   Agency/Organizations   Services

   ____________________   ____________________

6. Other agencies that may refer to your organization:

____

7. Can you estimate the percentage of youth you serve that you believe could benefit from some type of mental health services?__________

____

8. If your organization does not provide these services, what agency/s would you refer to?

____

9. Do these mental health organizations provide the type of services you need for the youth you serve?__________ Remarks:__________

____

II. 1. In our effort to work cooperatively with existing agencies and to search for identification of additional, needed services, we have identified the following list of potential mental health services.* Please rank only those services you feel could benefit your youth population. Types of services should be ranked with #1 reflecting the highest priority, #2 second, etc. Also, please check if there is a specific need for a particular age group or sex.

Services	Ranking	Age Group 0-4	5-9	10-13	14-17	Sex M	F
PREVENTION							
child abuse							
alcohol/drug							
mental health							
OUTPATIENT							
day treatment							
individual counseling							
psychological testing							
screening and evaluation							
family therapy							
psychiatric treatment							
INPATIENT							
crisis intervention							
alcohol/drug treatment							
psychiatric treatment							

*If these services are currently being provided but you feel they should be expanded or improved, please include them in your ranking.

Services	Rank-ing	Age Group 0-4	5-9	10-13	14-17	Sex M	F
RESIDENTIAL							
crisis intervention							
acute treatment (30 days or less)							
alcohol/drug rehabilitation							
short term treatment (1-3 months)							
long term treatment (up to 1 year)							
specialized foster care (for youth with extreme behaviors/trained parents)							

III. 1. Can you estimate the number of children you see a month that you believe are exhibiting the following symptoms/behaviors?

Symptoms/Behaviors	Severity Mild	Mod.	Severe	Age Groups
Youth who exhibit impaired contact with reality and impaired social, academic and self-care functioning. Thinking may be confused, behavior may be grossly inappropriate and bizarre. Emotional reactions are frequently inappropriate to the situation				0-4
				5-9
				10-13
				14-17
Youth who may have another disorder in addition to a mental health condition, such as mental retardation, severe neurological disorder or sensory impairment or physical handicap.				0-4
				5-9
				10-13
				14-17

Symptoms/Behaviors	Severity: Mild	Severity: Mod.	Severity: Severe	Age Groups
Youth with behaviors that may include impulsiveness, aggressiveness, anti-social acts, refusal to accept limits, suicidal gestures or substance abuse. Functional deficits may include impaired academic and social functioning.				0-4
				5-9
				10-13
				14-17
Youth who are suffering from a serious discomfort from anxiety, depression, irrational fears and concerns. Symptoms may include serious eating or sleeping disturbances, extreme sadness or depression or suicidal proportions, maladaptive dependence on parents, persistent refusal to attend school. Deficits include impaired social, academic and emotional functioning.				0-4
				5-9
				10-13
				14-17
Youth who demonstrate traits associated with demographic factors that may include but are not limited to : 1. failure in infancy and early development to secure basic nurturance, 2. environmental stresses that precipitate social breakdown, 3. families who have experienced mental illness, 4. youth who have been subject to child abuse, neglect or sexual abuse, 5. youth suffering chronic physical illnesses to such an extreme that mental illness may be precipitated.				0-4
				5-9
				10-13
				14-17
Youth who you fear may become dangerous or assaultive in the future if intervention does not occur.				0-4
				5-9
				10-13
				14-17

Symptoms/Behaviors	Severity			Age Groups
	Mild	Mod.	Severe	
Youth who are dangerous and assaultive presently to the extent that you are concerned about immediate harm to others.				0-4
				5-9
				10-13
				14-17
Youth who are exhibiting sexual aberations that are impairing family, social or academic environments.				0-4
				5-9
				10-13
				14-17

IV. 1. Please answer the following questions that pertain to your organization:

School Personnel:

a. Please check the grade levels of your school:

1-4 ____ 5-6 ____ 7-8 ____ 9-10 ____ 11-12 ____

all of the above ____

b. Does your school have a school counselor? If so, could you give a general description of job responsibility? ____________________

____

c. Does your school counselor refer to a mental health agency? If so, what agency and under what conditions? ____________________

____

d. Does your school currently operate behavior disorder classrooms? If so, are there any services that mental health could offer that would be helpful to assist your classroom teacher? ____________

____

Division of Family Services:

a. Does your local agency have a multi-disciplinary contract with a mental health provider? ______

Name of Mental Health Center ______

Are the services you currently receiving adequate for your needs? ______

Comments: ______

______

Juvenile Courts/Officers:

a. Does your local court have a contract with a mental health provider? If so, the name of the center you currently refer or contract with. ______

______

b. Are there any additional services that would be helpful to assist you with the juveniles you serve? ______

Mental Health Providers:

a. Please list the services you currently have available to youth and identify the staff who are responsible for providing these services. (Please include staff credentials) ______

______

b. Please list those agencies or organizations that you refer to for further mental health treatment and the services they provide. ______

______

c. If you have any additional requests (other than the ranking of additional services on pages 3 and 4), please feel free to comment in the following space.

______

______

Division of Youth Services:

a. Please list the services you currently have available to youth and identify the staff who are responsible for providing these services. (Please include staff credentials)____________________

____

b. Please list those agencies or organizations that you refer to for further mental health treatment and the services they provide.____________________

____

c. Can you identify the number of youth that have delinquent behaviors in conjunction with emotional disturbances such as suicidal or agressive gestures or mental retardation, etc.____________________

____

d. What recommendations would you make to the Department of Mental Health regarding needed services for the youth mentioned above?____________________

____

The Council would be willing to provide survey participants with the information gathered as a result of this survey. If you wish to receive followup information, please check, yes_____

The Southeast Council wishes to express its sincere appreciation for your cooperation on this project.

Appendix B: Population represented by surveys: by service area and by agency

Agency	Service Areas				
	17	19	20	21	Total
DFS	685* 5**	975 3	596 7	332 4	2588 19
DYS	-	186 2	-	19 1	205 3
JO	290 3	100 1	160 1	158 4	708 9
MHP	82 3	110 2	132 2	45 1	369 8
SC	2450 6	3565 10	3165 8	4770 13	13950 37
Total	3507 17	4936 18	4053 18	5324 23	17820 76

*The top number represents the children and youth being served by that agency on a monthly basis (Note: school personnel reported school census).

**The second number represents the amount of surveys returned by each agency in the service area.

Appendix C: Estimated number of children and youth that could benefit from mental health services

(Percent of number covered by survey)

Agency	Service Areas				
	17	19	20	21	Total
DFS	158 (23.0%)*	381 (39.1%)	150 (25.2%)	91 (27.4%)	780 (30.1%)
DYS	0	132 (71.0%)	0	1 (5.3%)	133 (64.9%)
JO	136 (47.0%)	5 (5.0%)	64 (40.0%)	37 (23.4%)	242 (34.2%)
MHP	82 (100.0%)	110 (100.0%)	87 (65.9%)	45 (100.0%)	324 (87.8%)
SC	545 (22.2%)	514 (14.4%)	156 (4.9%)	579 (12.1%)	1794 (12.9%)
Totals	921 (26.3%)	1142 (23.1%)	457 (11.3%)	753 (14.1%)	3273 (18.4%)

*The first number is the actual number of children and youth that could benefit from mental health services. The number in parenthesis is the percentage of the agency's caseload that could benefit from mental health services.

Appendix D: Number of children and youth identified in each category, age group and severity

At-Risk of Functional Disability

	0-4	5-9	10-13	14-17	Total
Mild	22	69	81	76	248
Moderate	155	299	221	307	982
Severe	11	9	16	39	75
Total	188	377	318	422	1305

Conduct Disorders

	0-4	5-9	10-13	14-17	Total
Mild	7	46	70	152	275
Moderate	12	157	222	404	795
Severe	2	11	39	80	132
Total	21	214	331	636	1202

Psychosis

	0-4	5-9	10-13	14-17	Total
Mild	3	39	91	116	249
Moderate	19	38	135	141	333
Severe	3	10	34	37	84
Total	25	87	260	294	666

Anxiety/Affective Disorders

	0-4	5-9	10-13	14-17	Total
Mild	5	15	26	62	108
Moderate	10	119	96	172	397
Severe	2	7	15	46	70
Total	17	141	137	280	575

Multiple Handicaps

	0-4	5-9	10-13	14-17	Total
Mild	7	47	55	100	209
Moderate	29	52	75	110	266
Severe	5	13	13	20	51
Total	41	112	143	230	526

Sexual Aberrations

	0-4	5-9	10-13	14-17	Total
Mild	4	8	14	34	60
Moderate	5	7	216	116	344
Severe	2	6	12	14	34
Total	11	21	242	164	438

Future Danger

	0-4	5-9	10-13	14-17	Total
Mild	3	7	20	32	62
Moderate	5	5	21	66	97
Severe	3	5	14	15	37
Total	11	17	55	113	196

Present Danger

	0-4	5-9	10-13	14-17	Total
Mild	0	2	8	43	53
Moderate	1	0	12	35	48
Severe	0	0	4	15	19
Total	1	2	24	93	120

(See Table 8 for number of children and youth in each service area by diagnosis)