

**Funding for Virginia's  
Mental Health Services**

**Senate Finance Committee  
November 15-16, 2007**

# Introduction

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- The events of April 16, 2007 cast a bright light on Virginia's mental health system, exposing weaknesses in the provision of services for people who are mentally ill.
- As reports from the Virginia Tech Review Panel, the Supreme Court's Commission on Mental Health Law Reform, and the Office of the Inspector General make clear:
  - Access to mental health services in Virginia is limited;
  - Concerns and confusion about the Commonwealth's civil commitment laws are widespread; and
  - Communication and coordination within our mental health system and between other systems needs to be improved.
- These concerns are not new; legislative commissions since 1970 have highlighted gaps in the Commonwealth's mental health system and responded with recommendations and resources.
- The General Assembly has also received 48 reports on issues related to mental disorders in the past ten years and periodically receives 13 other reports.
  - The Joint Commission on Health Care also provides oversight of mental health issues.

## Recent Investments in Mental Health

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- In the last two years \$80 million was appropriated to expand community-based mental health services across the Commonwealth including:
  - Flexible funding to the regions served by Eastern and Western State Hospitals to expand local capacity in order to reduce reliance upon state facilities;
  - Additional crisis stabilization units to serve more individuals with mental illness in the community; and
  - Funding for services to individuals with mental illness who have extraordinary barriers to discharge from state facilities but have chosen to be served in the community.
- Reports from the President’s New Freedom Commission, the Surgeon General, and the National Alliance for the Mentally Ill reinforce that the Commonwealth is investing in many of the services that contribute to a well-run mental health system.
  - Some of these “best practices” include Programs of Assertive Community Treatment (PACT), crisis stabilization, and peer-run mental health programs.

## Gaps in the Mental Health System

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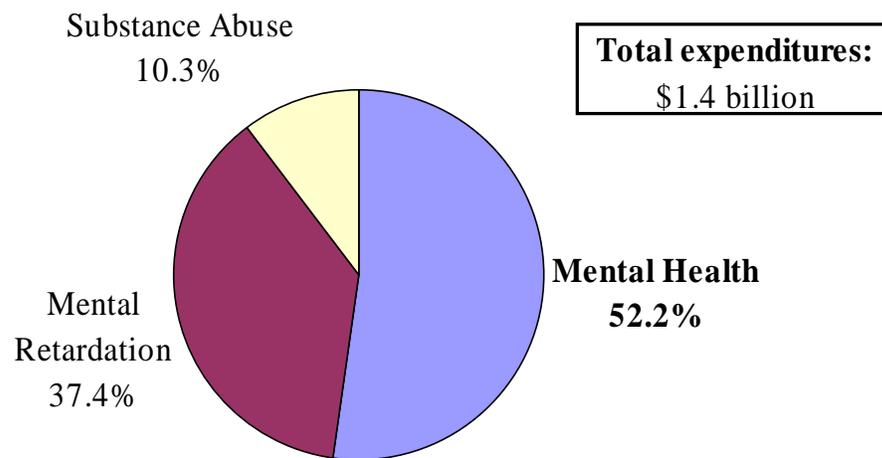
- Access to these specialized services is not available statewide and may be unavailable based on an individual's income.
- Moreover, outpatient mental health services, such as therapy, psychiatric assessments, and medication monitoring – the first line of care for individuals with mental illness – may be inadequate according to reports from the Office of the Inspector General.
- JLARC recently reported that inpatient psychiatric beds may be in short supply in some communities.
  - Additional community-based services may alleviate the need for inpatient psychiatric beds in certain localities.
- This presentation highlights recent investments in the Commonwealth's mental health system, explains the rationale behind those decisions, and lays the groundwork for possible future action.

# **Funding for Mental Disabilities**

# Mental Health Services Accounts for 52% of Current Spending on Mental Disabilities

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**FY 2007 Spending on Mental Disabilities  
by Category of Service**



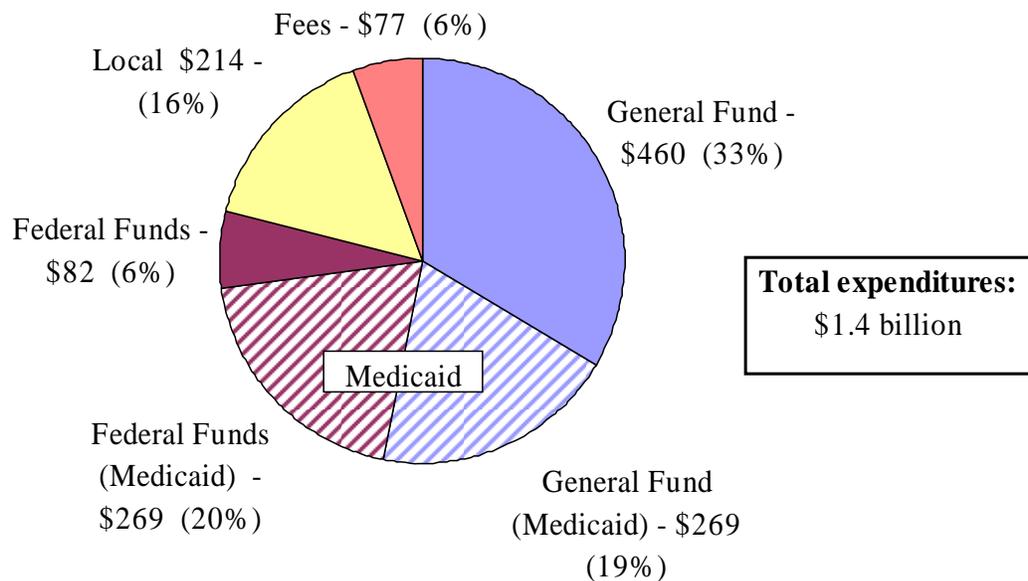
Source: Department of Mental Health, Mental Retardation, and Substance Abuse Services (September 2007)

- Spending on mental disabilities in the Commonwealth – mental health, mental retardation, and substance abuse services – totaled \$1.4 billion during the most recent fiscal year.
  - Mental health services accounted for more than one-half of all expenditures (\$717 million) in FY 2007.

# Source of Current Spending on Mental Disabilities

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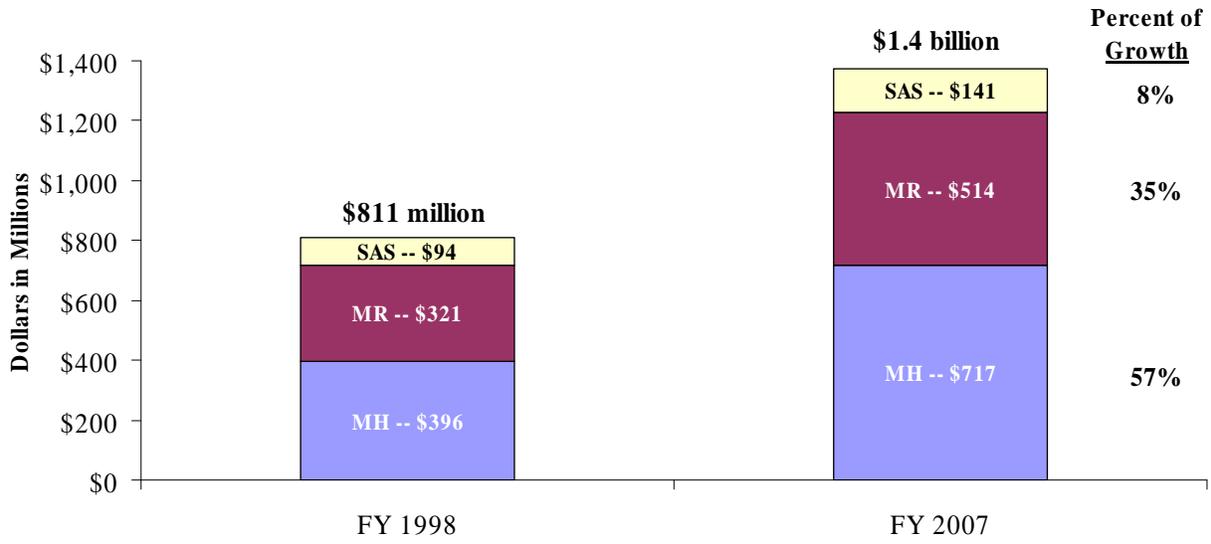
**FY 2007 Spending on Mental Disabilities  
by Fund Source (Dollars in Millions)**



- General fund resources, including the state share of Medicaid funding, account for more than one-half of current expenditures for individuals with mental disabilities.
  - 39 percent of current funding for persons with mental disabilities comes from Medicaid.
  - Federal, local, and fee revenues account for the balance of funding.

# How has Spending on Mental Disabilities Changed During the Past Decade?

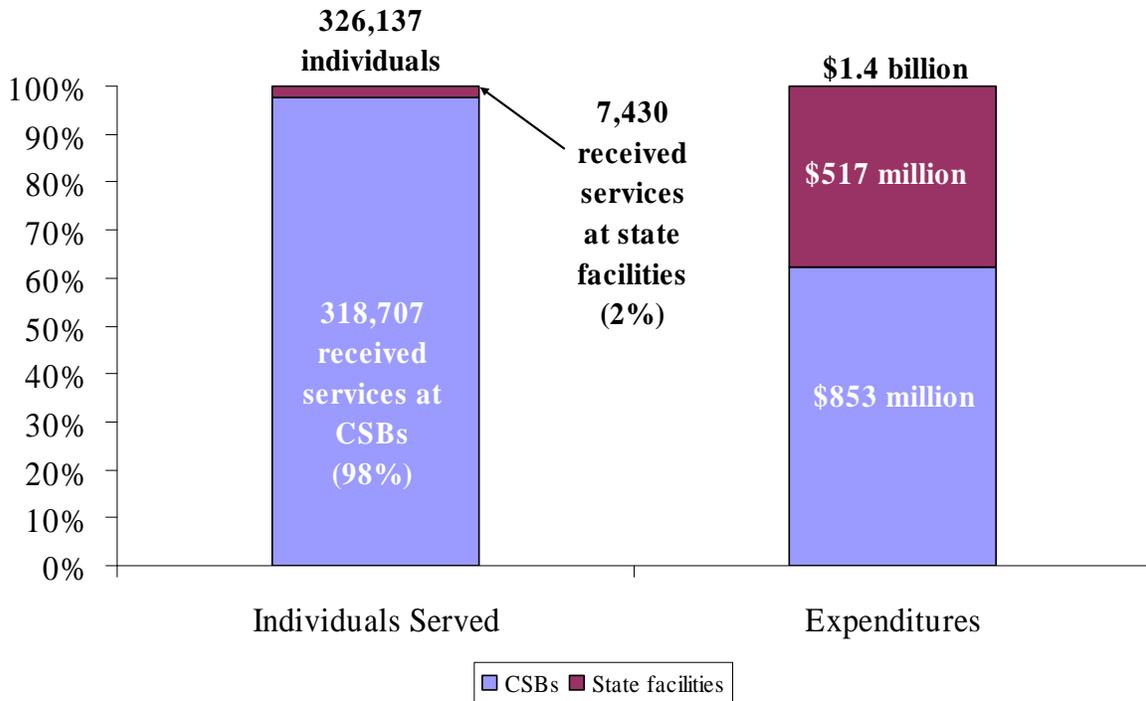
## Expenditures for People With Mental Disabilities



- Total spending on individuals with mental disabilities increased by 69 percent from \$811 million to \$1.4 billion during the past decade.
  - While considerable attention has been paid in recent years to the mental retardation (MR) waiver program – more than 2,100 waiver slots have been added in the last five years – spending on mental health outpaced mental retardation services since FY 1998.

# Where do Individuals with Mental Disabilities Receive Services in Virginia?

## State Facilities and Community Services Boards



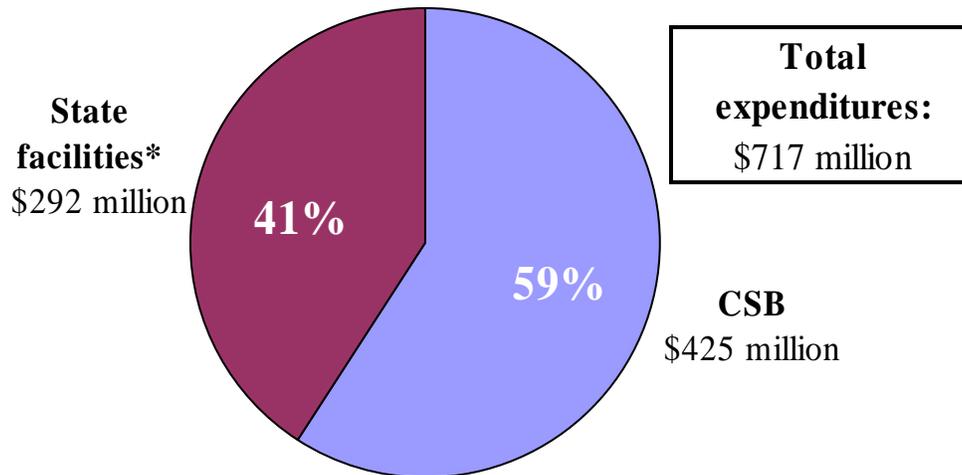
- Individuals with mental disabilities almost exclusively receive services (98 percent) through CSBs.
  - State mental health facilities provide acute and long-term treatment services for adults, children, and the elderly as well as individuals involved with the criminal justice system (i.e., forensic patients).
  - State mental retardation training centers provide care and treatment for people who have very complex medical needs.

# **Funding for Mental Health Services**

# Current Spending on Mental Health Services

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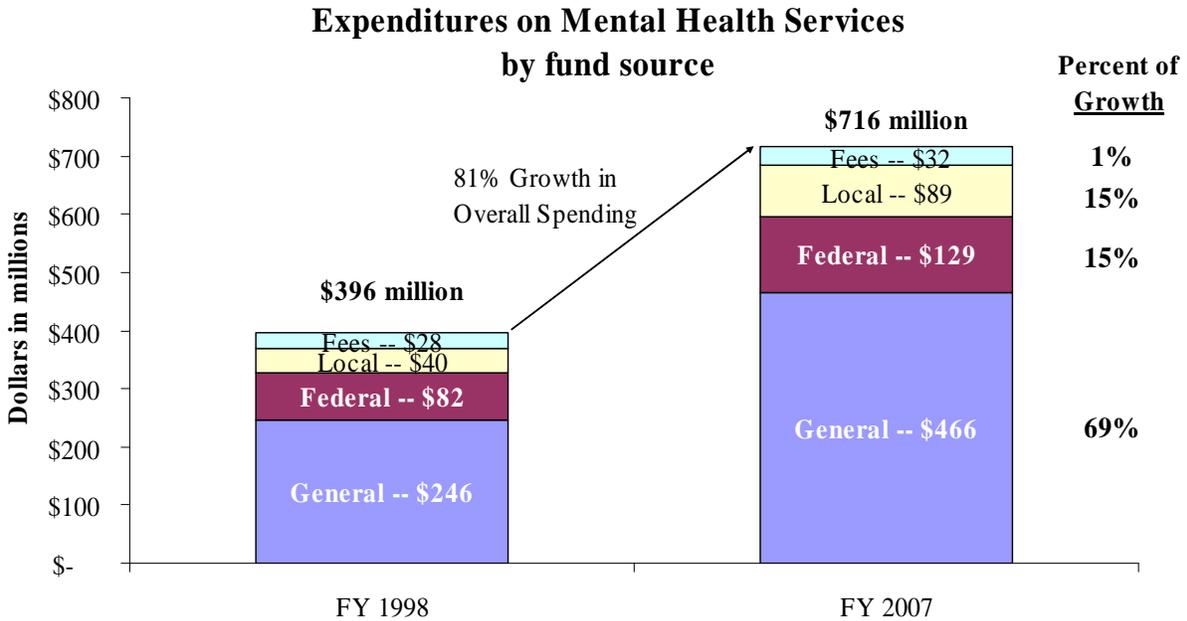
## FY 2007 Expenditures on Mental Health Services



\* Excludes the Commonwealth Center for Children & Adolescents and the Center for Behavioral Rehabilitation.

- Spending on mental health services totaled \$717 million in FY 2007.
  - Fifty-nine percent of all mental health expenditures were in the community where almost all individuals with mental illness receive treatment.
- These totals do not include all Medicaid-funded mental health services.
  - In FY 2007, Medicaid paid \$53 million for medications prescribed for recipients with a mental illness.
  - Other Medicaid and Comprehensive Services Act spending also may not be reflected in the totals above.

# Trends in Spending on Mental Health Services



- Overall spending on mental health services increased by 81 percent or \$320 million during the last ten years.

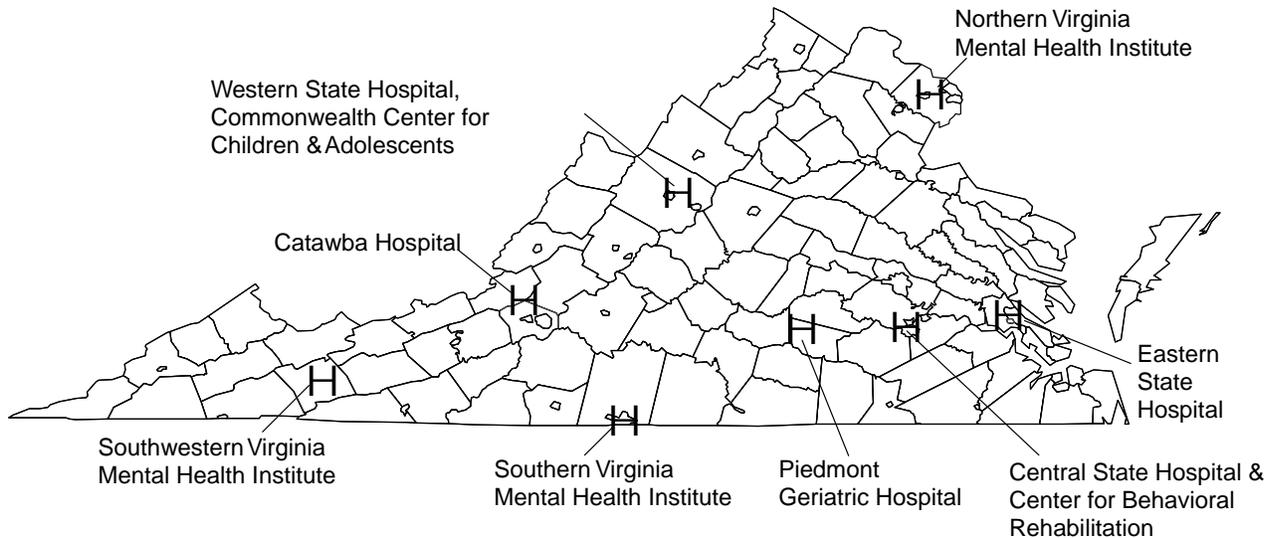
<b>Explanation of Overall Increase</b>	
Medicaid-funded services in the community*	\$99 million
State-funded initiatives in the community*	\$83 million
State mental health facilities	\$65 million
Locally-funded initiatives in the community	\$49 million
Other	\$24 million
<b>TOTAL</b>	<b>\$320 million</b>
* Categorical funding for specific individuals and services.	

- Virginia ranked 33<sup>rd</sup> in per capita spending on mental health services in FY 2005: 9<sup>th</sup> in spending on state facilities and 40<sup>th</sup> in spending on community-based services.

# **State Mental Health Facilities: Funding, Populations and Current Issues**

# State Mental Health Facilities

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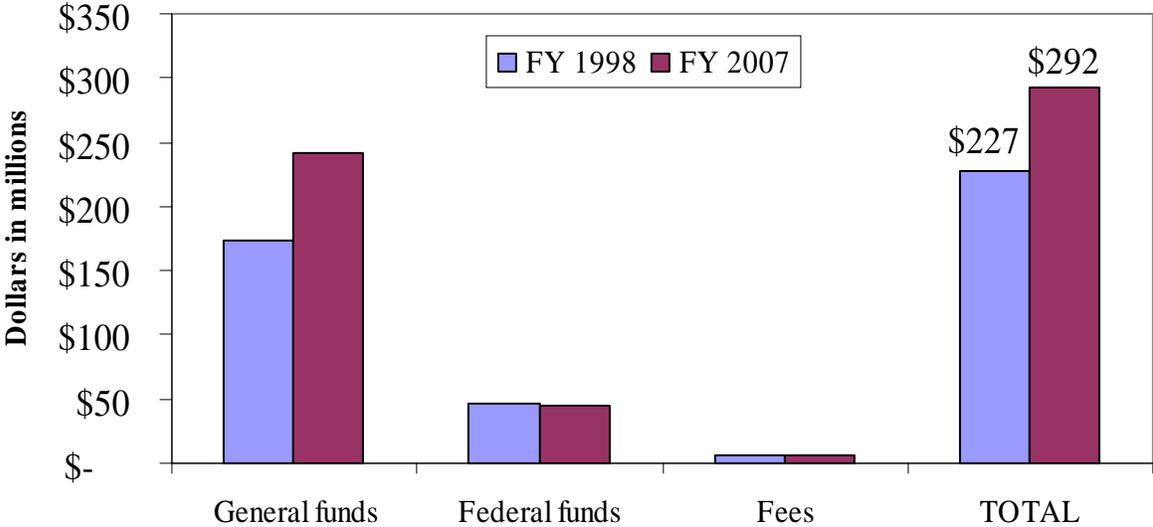


- The Commonwealth operated 10 mental health facilities at a cost of \$290 million in FY 2007.\*
  - Last year, the Department of Mental Health, Mental Retardation and Substance Abuse Services budgeted \$29.6 million to maintain 3.4 million square feet in 182 buildings that average 51 years of age.
- Since 2005, funding was approved to construct 300 adult and geriatric beds at Eastern State Hospital (\$88 million) and build a 300-bed facility to serve individuals who are civilly committed as sex offenders (\$62 million).

\* Excludes Hiram W. Davis Medical Center.

# Facility-based Mental Health Services

**State Mental Health Facility Spending\***  
by Fund Source



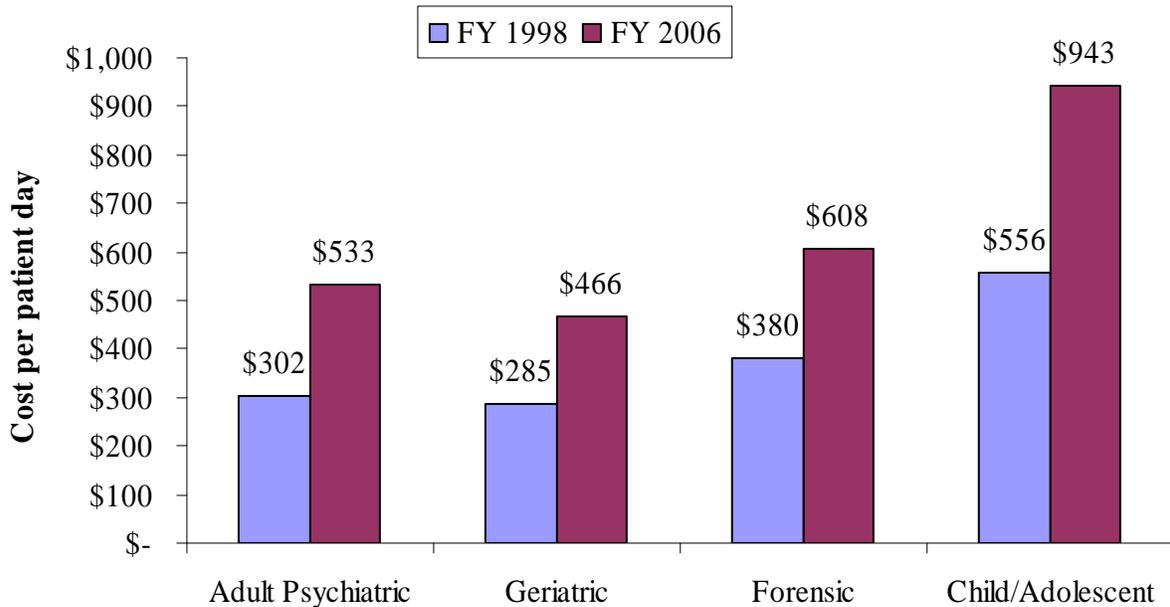
\* Excludes the Commonwealth Center for Children & Adolescents and the Center for Behavioral Rehabilitation.

- Facility-based mental health spending increased by 28 percent over the last decade from \$227 million to \$292 million.
  - Personnel and pharmacy costs account for most of the growth in spending.
- State mental health facilities provide highly-structured, intensive inpatient services for individuals who cannot otherwise be treated in the community or where local services are not available.

# Treatment Costs by Population Served

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**Treatment Costs in State Mental Health Facilities**



- The cost per patient day to treat individuals with mental illness in state facilities varies considerably.
  - Increases in the cost per patient day can be attributed to better staffing, more intensive treatment, higher costs for medication as well as overhead costs (e.g., fuel and maintenance).
- As community-based alternatives have developed and individuals with mental illness are discharged or diverted from state hospitals, the patients treated in state facilities are more difficult to care for and increasingly require costly medical interventions in addition to psychiatric treatment.

## Inpatient Mental Health Treatment

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- The average daily census (ADC) at state mental health facilities was 1,511 in FY 2007 but more than 5,900 individuals received services during the year.
  - In FY 1998, the ADC was 2,044 in FY 1998 and the number of individuals served 7,566.
- Increasingly, state facilities are discharging individuals who can be treated in the community, allowing inpatient treatment beds to be used for forensic patients (e.g., jail transfers) and temporary detention orders, where community alternatives are lacking.
- An additional 3,641 individuals received short-term mental health treatment in community-based, private psychiatric hospitals at a cost of \$11.8 million in FY 2006.

## Questions That Have Been Raised About State Mental Health Facilities

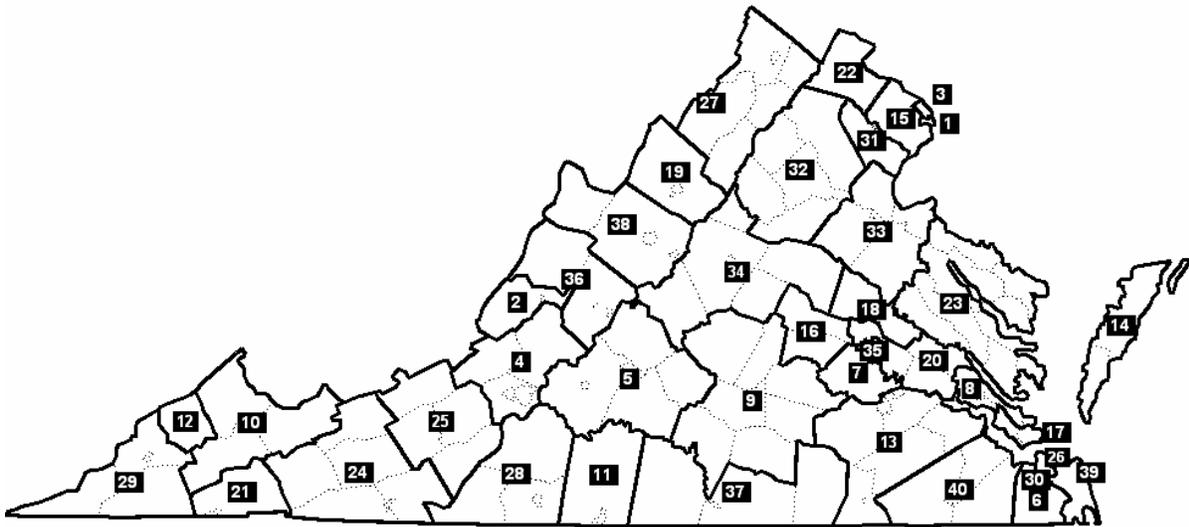
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- Is the care provided in state facilities uniform across the Commonwealth?
- Is there a shortage of inpatient treatment beds at state mental health facilities?
  - What community-based alternatives might diminish the need for more expensive and intensive, facility-based services?
- Why are individuals with mental illness increasingly showing up in our jails and prisons?
  - What is the role of entities outside the mental health system?
- Should the Commonwealth be spending 41 percent of its mental health funding on 3 percent of the population?

## **Community Services Boards: Funding, Populations and Current Issues**

# Community Services Boards (CSBs)

- In addition to mental retardation and substance abuse services, 40 CSBs provide community-based mental health services.



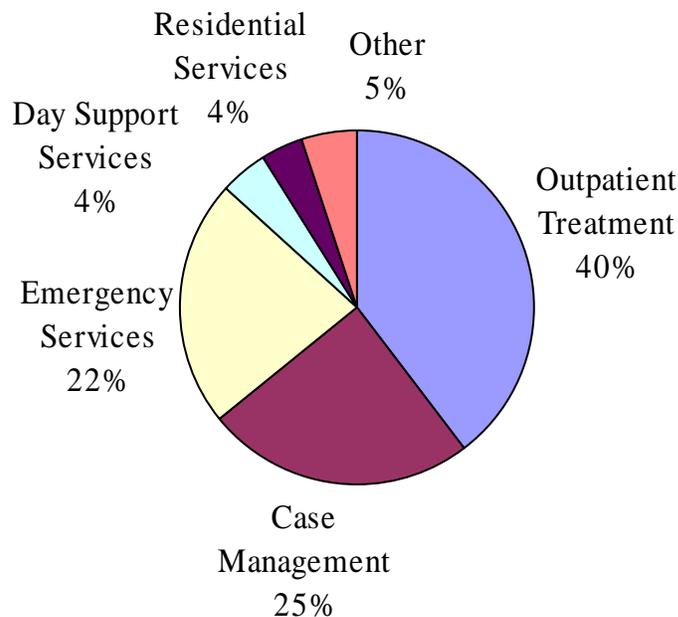
- |                           |                                   |                            |
|---------------------------|-----------------------------------|----------------------------|
| 1) Alexandria             | 15) Fairfax–Falls Church          | 29) Planning District 1    |
| 2) Alleghany Highlands    | 16) Goochland-Powhatan            | 30) Portsmouth             |
| 3) Arlington              | 17) Hampton-Newport News          | 31) Prince William         |
| 4) Blue Ridge             | 18) Hanover                       | 32) Rappahannock – Rapidan |
| 5) Central Virginia       | 19) Harrisonburg-Rockingham       | 33) Rappahannock Area      |
| 6) Chesapeake             | 20) Henrico Area                  | 34) Region Ten             |
| 7) Chesterfield           | 21) Highlands                     | 35) Richmond               |
| 8) Colonial               | 22) Loudoun                       | 36) Rockbridge Area        |
| 9) Crossroads             | 23) Mid-Peninsula – Northern Neck | 37) Southside              |
| 10) Cumberland Mountain   | 24) Mount Rogers                  | 38) Valley                 |
| 11) Danville–Pittsylvania | 25) New River Valley              | 39) Virginia Beach         |
| 12) Dickenson             | 26) Norfolk                       | 40) Western Tidewater      |
| 13) District 19           | 27) Northwestern                  |                            |
| 14) Eastern Shore         | 28) Piedmont                      |                            |

# What is the role of CSBs in Virginia?

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- CSBs are the single entry-point to the Commonwealth's publicly-funded mental health system.
- According to the *Code of Virginia*, CSBs are required to provide emergency services and, subject to appropriation, case management services.
- In FY 2006, 118,732 individuals received mental health treatment through a CSB.
- The most frequently utilized mental health services provided by CSBs include:

**CSB Mental Health Treatment  
by Core Services\* (FY 2006)**

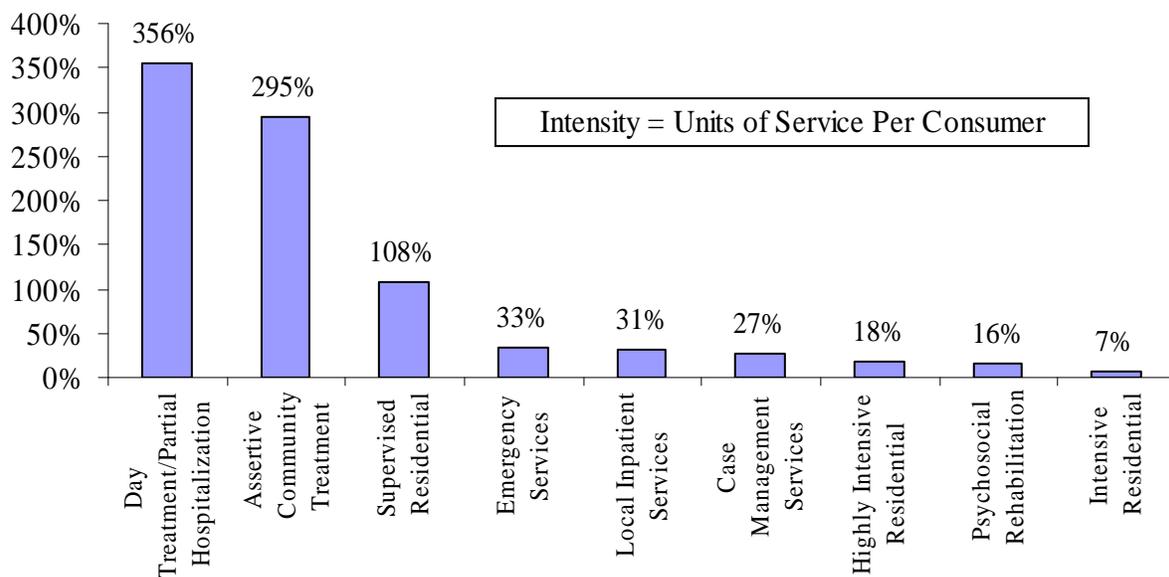


\* See Appendix II  
for more detail

## Populations Served by CSBs

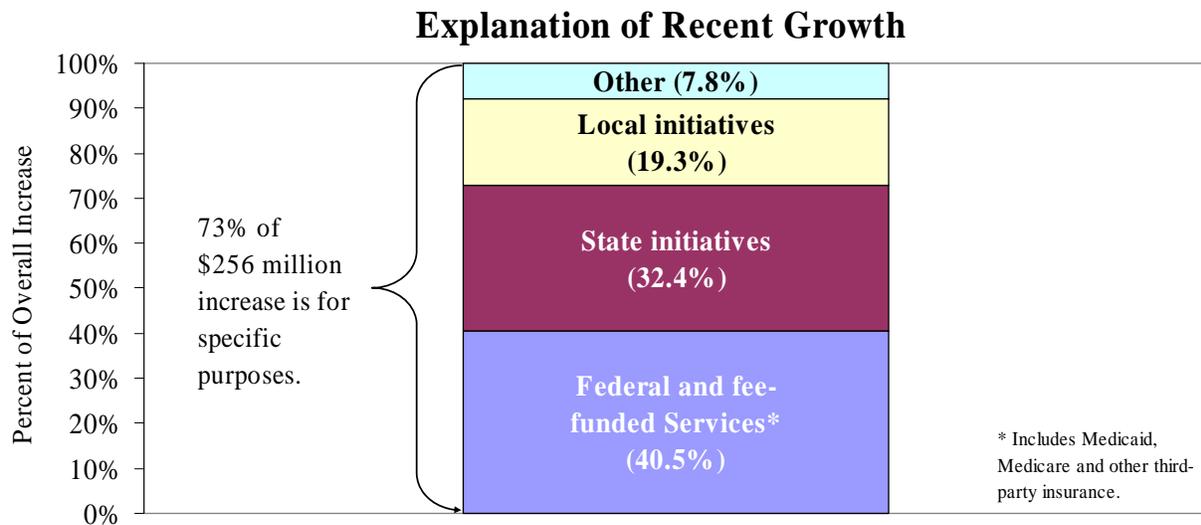
- Over the past ten years, CSBs have increasingly been asked to serve more individuals with more severe mental illnesses.
  - 49 percent of the adults served by CSBs have a serious mental illness whereas 66 percent of children have or are at-risk of having a serious emotional disturbance.
  - The acuity of CSB consumers increased by 21 percent for adults and 51 percent for children since FY 1998.
  - The intensity of services provided to individuals receiving treatment through CSBs has increased considerably in ten years. At the same time, more individuals are receiving these intense services.

### Intensity of Community-based Mental Health Services (FY 1997 through FY 2006)



# Recent Mental Health Spending by CSBs

- Spending on mental health services provided by CSBs increased from \$169 million to \$425 million or 151 percent from FY 1998 through FY 2007.
  - Specific Medicaid or legislative initiatives account for almost three-quarters of the increase.
  - Medicaid has been used to expand services in the community to eligible individuals and also generate additional federal dollars; the latter has often come at the expense of flexible funding for CSBs to serve non-Medicaid recipients.
  - Examples of legislative initiatives include PACT teams, discharge assistance, children’s mental health, crisis stabilization and flexible regional funding.



## Questions That Have Been Raised About Community Services Boards

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- Is the care provided at CSBs uniform across the Commonwealth?
- What are the treatment needs of the 5,709 people with mental illness who were on waiting lists in FY 2007?
- Why don't CSBs have a comprehensive array of crisis intervention services? What would the array look like?
- Why does it take 14 days for an outpatient clinical or psychiatric appointment following an emergency intervention?
- What are the benefits of reducing case management caseloads from 39 to 25 – the national standard?
- Why are individuals with mental illness increasingly showing up in our jails and prisons?

## **Recent Mental Health Funding Decisions and Future Actions**

## Factors That Guided Recent Investments in Mental Health Services

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- The most significant changes to the Commonwealth's system of mental health care began with the U.S. Department of Justice's investigation of care at Eastern State Hospital, Northern Virginia Mental Health Institute and Central State Hospital in the mid-1990s.
  - Virginia was compelled to improve active treatment and increase staffing levels in state facilities, lower facility censuses, aggressively discharge eligible clients to the community, and develop individualized treatment plans.
- The Supreme Court's 1999 Olmstead decision reinforced the notion that people with mental illness should be served in the least restrictive environment.
- Budgetary shortfalls in 2002 resulted in the downsizing of beds at Central and Eastern State Hospitals and the simultaneous reinvestment of general fund resources into the community.
- Collectively, these decisions shifted the focus of community-based mental health services to the most seriously mentally ill with the ultimate goal of reducing unnecessary utilization of inpatient treatment beds and hospital emergency rooms.

# Legislative Initiatives to Expand and Enhance Community-based Mental Health Services

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- The Commonwealth has made substantial investments in community-based mental health services in recent years.
  - **Flexible Regional Funding.** Flexible mental health funding was made available to CSBs in regions served by Eastern and Western State Hospitals (\$20.5 million) to address a range of local issues including housing, intensive supervision, co-occurring disorders, gaps in psychiatric services, and crisis services in order to discharge and divert individuals from state facilities;
  - **Crisis Stabilization Programs.** Additional funding for crisis stabilization units (\$16.4 million) was added to provide residential treatment for individuals with mental illness who are in crisis, act as “stepdown” placements from state facilities, and provide respite care for some residents; and
  - **Children’s Mental Health Services.** Resources were appropriated to expand mental health services to children and adolescents involved with the Comprehensive Services Act as well as develop community-based, wraparound services using the “Systems of Care” model for youth and their families (\$7.5 million).

## Legislative Initiatives to Reduce Reliance on State Hospitals

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- In recent years, efforts have been made to reduce demand at state facilities by providing community-based services such as:
  - **Discharge assistance planning (DAP).** DAP funds have been provided to develop unique service packages that allow hard to place individuals to be served in the community as opposed to state facilities (\$15.9 million);
  - **Private Psychiatric Hospitals.** Funding was allocated to preserve access to short-term, private psychiatric beds through bed purchase agreements and Medicaid rate increases (\$8.7 million); and
  - **Programs of Assertive Community Treatment (PACT).** More resources were included for PACT teams (\$4.6 million) that provide access to round-the-clock, community-based treatment for people with serious and persistent mental illnesses who tend to resist or avoid traditional treatment programs.

## Maintain Focus on the Mentally Ill Who Are Involved with the Criminal Justice System

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- In the past few years, the Senate and the Joint Commission on Health Care have focused attention on the growing problem of individuals with mental illness ending up in the criminal justice system.
- Jointly, the Health and Human Resources and Public Safety Subcommittees of Senate Finance helped to secure limited funding to:
  - **Jail Diversion Programs.** Provide intensive case management to divert individuals with mental illness from jail or provide treatment upon discharge from jail (\$1.0 million);
  - **Juvenile Detention Centers (JDC).** Permit CSBs to deploy a clinician and case manager at each JDC (\$1.9 million) to expand mental health screenings, assessments and services at these facilities; and
  - **Innovative Treatment Programs.** Continue innovative programs such as the Dual Treatment Track Program in Chesterfield County for individuals with mental illness and substance abuse problems (\$438,063) and the Crisis Intervention Team (CIT) Program located in the New River Valley to train officers responding to individuals with mental illness.

## Where Do We Go From Here?

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- The General Assembly made an ongoing, not one-time commitment, to mental health services during the 2006 session.
- For more than a year the Supreme Court's Commission on Mental Health Law Reform has been analyzing concerns about our civil commitment laws and the issue of people with mental illness in our criminal justice system.
- Members of the General Assembly need to re-examine the investments that have been made in recent years, digest information that is available in recent reports on the mental health system, request information where gaps exist and decide what policy goals to pursue in the months ahead.
- What happened on April 16<sup>th</sup>, and recently in Richmond, lends urgency to the task ahead - re-examining the operations and capacity of the Commonwealth's mental health system as well as the interaction with entities outside that system.

## A Wide Array of Policy Questions Will Confront The 2008 General Assembly

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- What is the appropriate role for state mental health facilities, CSBs and the private sector to play in the Commonwealth's mental health system?
  - How can the General Assembly foster better communication and cooperation between these and other entities?
- What level of human and financial resources do state hospitals, CSBs and private providers need to adequately care for individuals with mental illness?
- What is the role and responsibility of entities outside the mental health system that interact with people with mental illness (e.g., courts, law enforcement)?
- More specific questions include:
  - Should our civil commitment laws be changed? Who will be affected by these changes? What outcomes are desired? How much will changing our laws cost?
  - How do state and federal privacy laws affect the sharing of information on mental illness?

## Conclusion

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- While the events of April 16<sup>th</sup> brought renewed attention to the Commonwealth's system of mental health care, the design and financing of mental health services in Virginia has been examined and re-examined for more than four decades.
  - Funding for mental health services in Virginia increased significantly in the past ten years.
  - National reports confirm that the Commonwealth is investing in appropriate services.
- In spite of these initiatives, reports continue to point out shortcomings in the current system and gaps in service capacity.
- The 2008 General Assembly will wrestle with myriad questions about our system and its two primary providers – state mental health facilities and community services boards.

# Appendix I – Examples of Community-Based Services

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## Programs of Assertive Community Treatment

**What is it?** PACT teams provide access to round-the-clock, intensive, community-based treatment for people with serious and persistent mental illnesses. A multi-disciplinary team tailors services to consumers in their home or community. PACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. Services may include case management, counseling, medication administration and compliance monitoring, crisis intervention, psychiatric assessments, and life skills training.

**Who gets it?** Individuals with serious mental illness who tend to resist or avoid traditional treatment programs. In FY 2007, 77 percent of the individuals served had a diagnosis of schizophrenia. Almost one-half of the individuals served had a co-occurring substance use disorder.

**Where are they located?** There are 17 PACT teams located in the Commonwealth, primarily in areas of the state that are high utilizers of inpatient hospital beds.

CSBs That Operate PACT Teams			
Arlington	Blue Ridge (Roanoke)	Central Virginia (Lynchburg)	Chesapeake/Portsmouth
Danville-Pittsylvania	District 19 (Petersburg)*	Fairfax-Falls Church	Hampton-Newport News
Henrico (2)	Mt. Rogers (Wytheville)	New River Valley (Blacksburg)	Norfolk
Region Ten (Charlottesville)	Richmond	Valley (Staunton)	
* Also operate an Intensive Community Team or ICT.			

**How much do they cost?** On average, PACT teams cost \$1.2 million to operate. Currently, \$10.3 million from the general fund is provided for PACT teams.

**How many are served?** In FY 2007, 1,487 individuals were receiving PACT team services or an average of 94 per team.

**What outcomes have we seen?** PACT teams have reduced state hospital bed usage by 76 percent, increased stability in living situations for individuals, and reduced involvement with the criminal justice agencies (e.g., 92 percent had no arrests).

## **Local Inpatient Psychiatric Services**

**What is it?** Community services boards contract with private psychiatric hospitals to provide short-term acute treatment for individuals with mental illness. Funding is designed to serve individuals in local communities as opposed to state facilities on a short term basis.

**Who gets it?** Individuals with mental illness who need short-term acute psychiatric services.

**Where are they located?** Thirty-two locations across the Commonwealth.

**How much do they cost?** In FY 2006, the Commonwealth paid \$11.8 million to 32 private hospitals to provide short-term, psychiatric care.

**How many are served?** 3,641 individuals with mental illness were served through contracts with private hospitals in FY 2006.

**What outcomes have we seen?** Ninety-seven percent of the individuals served in FY 2006 were diverted from placement in state hospitals. The Department of Mental Health, Mental Retardation and Substance Abuse Services estimates that providing acute psychiatric care in private hospitals costs a fraction of what it would cost to serve individuals in state facilities.

## **Discharge Assistance Project**

**What is it?** The Discharge Assistance Project or DAP provides funding for individuals who are residing in state mental health facilities or mental retardation training centers that have extraordinary barriers to discharge or who have been discharged from state facilities. Funds are used to develop community service plans for individuals.

**Who get it?** Individuals with mental disabilities who are residing in state facilities or training centers, have been approved for placement in the community, and desire to do so.

**Where are they located?** N/A.

**How much do they cost?** The Department estimates that it currently spends approximately \$22.0 million using DAP funds.

**How many are served?** Currently, 964 individuals with mental illness are receiving DAP-funded services.

**What outcomes have we seen?** Individuals with mental illness or mental retardation who would otherwise be occupying a state mental facility bed are now living in the community.

## Crisis Stabilization Units

**What is it?** Crisis stabilization is a residential treatment program for individuals with mental illness. Services provided in all 12 sites include psychiatric assessment, medication evaluation and medication management, psycho-education about treatment and medication, individual and group counseling, and referrals and discharge planning. Additional services available at eight or more of the sites include nursing evaluations, medical screening and assessments, assistance with self-administration of medication, Wellness Recovery Action Planning, dual diagnosis (MH and SA) treatment, and benefits acquisition.

**Who gets it?** Individuals a) with mental illness experiencing a mental health crisis, b) “stepping down” from state facilities, c) adjudicated Not Guilty by Reason of Insanity (NGRI) who need community placements, and d) who need respite care.

**Where are they located?** Currently, there are 12 crisis stabilization units in Virginia that operate 94 inpatient treatment beds at a cost of \$12.1 million in total funds. A non-residential, 23-hour crisis stabilization unit is operated by the Hampton-Newport News CSB.

<b>Crisis Stabilization Units by CSB</b>		
Blue Ridge (Roanoke)	Central Virginia (Lynchburg)	Chesterfield
Cumberland Mountain (Cedar Bluff)	Fairfax-Falls Church	Mt. Rogers (Wytheville)
New River Valley (Blacksburg)	Prince William	Rappahannock Area (Fredericksburg)
Region Ten (Charlottesville)	Richmond	Virginia Beach

**How much do they cost?** On average, an eight-bed facility will cost approximately \$900,000 a year to operate.

**How many are served?** In FY 2007, 2,562 individuals received treatment services.

**What outcomes have we seen?** Fairfax-Falls Church CSB reports that more than one-half of its admissions were diverted from hospital placements. In addition, 25 percent of admissions were “stepped down” from state hospitals.

## Appendix II – CSB Services By Frequency of Use

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**Outpatient Treatment Services (40% of consumers)** include clinical treatment services such as outpatient services and assertive community treatment. *Outpatient Services* may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services (e.g., psychiatric, medical, and nursing services) and medication services (e.g., prescribing and dispensing medications, medication management, and pharmacy services). Outpatient Services include *Intensive In-home Services* for children and families including crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24 hour per day emergency response. *Assertive Community Treatment* includes an array of services on a 24-hour per day basis to individuals with serious mental illness in their natural environments to help them achieve and maintain effective levels of functioning and participation in their communities. Services may include case management; supportive counseling; symptom management; medication administration and compliance monitoring; crisis intervention; developing individualized community supports; psychiatric assessment and other services; and teaching daily living, life, social, and communication skills.

**Case Management Services (25% of consumers)** assist individuals and their family members to access needed services that are responsive to the person's individual needs. Services include: identifying and reaching out to potential consumers; assessing needs and planning services; linking the individual to services and supports; assisting the person directly to locate, develop or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; and advocating for people in response to their changing needs.

**Emergency Services (22% of consumers)** include unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, 24 hours per day and seven days per week, to people seeking such services for themselves or others. Services also may include walk-ins, home visits, and jail interventions. Emergency Services include preadmission screening or other activities that prevent admission to a mental health hospital or are associated with the judicial admission process.

**Day Support Services (4% of consumers)** provide structured programs of treatment, activity, or training services to groups or individuals in non-residential settings that may include a) ***Day Treatment/Partial Hospitalization***, a treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for adults with serious mental illnesses or substance use disorders who require coordinated, intensive, comprehensive, and multi-disciplinary treatment of pathological conditions that is not provided in outpatient services or b) ***Rehabilitation/Habilitation*** that includes *Psychosocial Rehabilitation*, which provides assessment, medication education, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support and education, vocational and educational opportunities, and advocacy in a supportive community environment focusing on normalization.

**Residential Services (4% of consumers)** provide overnight care with an intensive treatment or training program in a setting other than a hospital or training center, overnight care with supervised living, or other supportive residential services. Residential services include: a) ***Highly Intensive Residential Services*** provide overnight care with intensive treatment or training services, b) ***Intensive Residential Services*** provide overnight care with treatment or training that is less intense than highly intensive residential services, c) ***Supervised Residential Services*** offer overnight care with supervision and services, and d) ***Supportive Residential Services*** are unstructured services that support individuals in their own housing arrangements.

**Limited Services (3% of consumers)** include the following activities that typically are short term, that is less than 30 days or four to eight sessions in duration, or infrequent or low-intensity services and do not require collection of as many data elements or as much consumer service record information as other core services. ***Consumer Monitoring Services*** are provided to consumers who have been admitted to a CSB but will not be receiving any other services immediately. This includes individuals who have been admitted to a CSB and assigned case managers but have not been enrolled in other services; instead, they have been placed on waiting lists for other services. These individuals receive no interventions or face-to-face contact in more than 180 days, but they receive Consumer Monitoring Services, which typically consist of service coordination or intermittent emergency contacts, at least once every 360 days. This also includes individuals who receive only outreach services, such as outreach contacts through Projects for Assistance in Transition from Homelessness (PATH). ***Assessment and Evaluation Services*** include court-ordered or psychological evaluations; initial assessments for screening, triage, and referral for individuals who probably will not continue in services; and initial evaluations or assessments that result in placement on waiting lists without receiving other services. An abbreviated individualized services plan and consumer record may be required.

**Inpatient Services (1% of consumers)** deliver services on a 24-hour-per-day basis in a hospital or training center setting. They include *Acute Psychiatric or Substance Abuse Inpatient Services* that provide intensive short-term psychiatric treatment in state hospitals or intensive short-term psychiatric treatment, including services to persons with mental retardation, or substance abuse treatment, except detoxification, in local hospitals. Services include intensive stabilization, evaluation, psychotropic medications, psychiatric and psychological services, and other supportive therapies provided in a highly structured and supervised setting.

**Employment Services (<1% of consumers)** provide work and support services to groups or individuals in non-residential settings. Employment services include: *Sheltered Employment* programs provide work in a non-integrated setting that is compensated in accordance with the Fair Labor Standards Act for individuals with disabilities who are not ready, are unable, or choose not to enter into competitive employment in an integrated setting. This service includes the development of social, personal, and work-related skills based on an individualized consumer service plan. *Group Supported Employment* provides work to small groups of three to eight individuals at job sites in the community or at dispersed sites within an integrated setting. Integrated setting means opportunities exist for consumers in the immediate work setting to have regular contact with non-disabled individuals who are not providing support services. The employer or the vendor of supported employment services employs the consumers. An employment specialist, who may be employed by the employer or the vendor, provides ongoing support services. Support services are provided in accordance with the consumer's individual written rehabilitation plan. *Individual Supported Employment* provides paid employment to a consumer placed in an integrated work setting in the community. The employer employs the consumer. On-going support services that may include transportation, job-site training, counseling, advocacy, and any other supports needed to achieve and to maintain the consumer in the supported placement are provided by an employment specialist, co-workers of the supported employee, or other qualified individuals. Support services are provided in accordance with the consumer's individual written rehabilitation plan.

**Prevention and Early Intervention Services (<1% of consumers)** are designed to prevent or intervene early in the process of mental illness, mental retardation, or substance use disorder. Prevention and early intervention services include: *Prevention Services* involve people, families, communities, and systems working together to promote their strengths and potentials. Prevention is aimed at substantially reducing the incidence of mental illness, mental retardation and other developmental disabilities, and substance use disorders. Emphasis is on enhancement of protective factors and reduction of risk factors. *Early Intervention Services* are intended to improve functioning or change behavior in those individuals identified as beginning to experience problems, symptoms, or behaviors that, without intervention, are likely to result in the need for treatment. Services are generally targeted to identified individuals or groups. Early Intervention Services include: case consultation, groups for adolescents who have been suspended for use of alcohol or tobacco, and programs for children or adults exhibiting behavior changes following loss such as divorce, death of a loved one, and job loss.