Rose Isabel Williams Mental Health Reform Act of 2011 Strategic Planning and Best Practices Committee Report to the Legislature June 30, 2013

Committee History

During the 2011 Regular Legislative Session, the Rose Isabel Williams Mental Health Reform Act of 2011 (Senate Bill 2836) was sponsored by Senator Hob Bryan and became law. Under the powers and duties of the Board of Mental Health (Section 41-4-7), authorization was given to establish a 15-member Strategic Planning and Best Practices Committee (see Section 41-4-7 (c)) which would be repealed after July 1, 2013. **For a list of original Committee appointments, see Attachment A**. The Committee met for the first time on September 15, 2011 and concluded its work with its last meeting held on June 20, 2013. During 2011, 2012 and 2013, the Committee held 16 meetings (4 in 2011, 7 in 2012, 5 in 2013) and performed the following functions as outlined in Section 41-4-7 (d):

- (d)(i) Established measures for determining the efficiency and effectiveness of core services;
- (d)(v) Implemented by July 1, 2012, a system of performance measures for core services; and,
- (d)(vii) Conducted other activities necessary to the evaluation and study of core services.

In addition, the Committee made progress toward the following functions, also outlined in Section 41-4-7 (d):

- (d)(iv) Recommending to the Legislature by January 1, 2014, any necessary additions, deletions or other changes necessary to core services; and,
- (d)(vi) Recommending to the Legislature any changes that the department believes are necessary to the current laws addressing civil commitment

Core Services Performance Measures

The Committee began discussions regarding establishment of meaningful performance measures for Core Services in October 2011. In November 2011, the Committee divided itself into four Subcommittees and continued their efforts. Identified Subcommittees were:

- Children and Youth Mental Health Services Subcommittee chaired by Mr. Dave Van;
- Adult Mental Health Services Subcommittee chaired by Dr. Kea Cassada;
- Intellectual and Developmental Disabilities Services Subcommittee chaired by Dr. James Herzog; and
- Alcohol and Drug Services Subcommittee chaired by Mr. Jerry Mayo.

Each Subcommittee developed a performance measure report which was submitted to the full committee by March 2012. In April 2012, a combined subcommittee report document, entitled *Core Services Performance Measures*, was presented to the State Board of Mental Health. **For a copy of the full *Core Services Performance Measures* report, see Attachment B.** Completion of this task satisfied the function listed under Section 41-4-7 (d)(i).

Implementation of Core Services Performance Measures

When the *Core Services Performance Measures* document was presented to the State Board of Mental Health in April 2012, the Board of Mental Health accepted the outcome measures and directed the Department of Mental Health to implement them statewide. Completion of this task satisfied the function listed under Section 41-4-7 (d)(v).

Accordingly, different aspects of the data collection came online at different times. Once implemented, each service area (Children and Youth Mental Health Services, Adult Mental Health Services, Intellectual and Developmental Disabilities Services and Alcohol and Drug Services) maintains its own data. In May 2013, Department of Mental Health staff presented a summary data report of 2012 Mental Health Outcome Measures specifically addressing Adult and Children's Mental Health community-based services. **For a copy of the full *Mental Health Outcome Measures* report, see Attachment C.**

Core Services Survey

In March 2013, the Committee partnered with the Department of Mental Health to develop a statewide survey of external stakeholders to identify needed or desired revisions to the Core Services that Community Mental Health Centers and other DMH approved and certified community mental health service providers are required to provide. The *Core Services Survey* was conducted in April 2013 utilizing an online survey tool, Survey Monkey®. It consisted of five sections – Demographics; Core Services designed for Adult Mental Health Services; Children and Youth Mental Health Services; Alcohol and Drug Services; and Intellectual and Developmental Disabilities Services. Survey results were presented to the Committee in May 2013. **For a copy of the *Core Services Survey Results – Summary of Findings*, see Attachment D.**

Completion of this task satisfied the function listed under Section 41-4-7 (d)(vii). Completion of the Core Services Survey in April 2013 also represented progress toward the goal in Section 41-4-7 (d)(iv).

Core Services Issues

Efforts of the Committee were complicated due to the changing service delivery landscape, especially changes to Medicaid and its effects upon core services. Remaining Issues are:

- While services may be identified as core, many individuals will not receive them because the individual has no reimbursement source for the service;
- Medicaid-eligible individuals may not receive a core service because they are subject to the prior authorization processes of Medicaid and the managed care companies; and
- Community Support Services is a Core Service for the IDD population; however, neither Medicaid nor the managed care companies will reimburse for this service. CMS deems it a rehabilitative service, although the diagnosis of IDD does not lend itself to rehabilitation.

Civil Commitment

In March 2013, the Committee began a discussion on the topic of civil commitment and a representative of the Mississippi Chancery Clerk Association was invited to meet with the Committee at their next meeting. At the May 16, 2013 meeting, the Committee was joined by Mr. Kevin Rayborn, Chancery Clerk of Lawrence County, for further discussion on this topic. The group's discussions included the following concerns:

- The need for meaningful data
- The need for a uniform commitment process
- The need for consistency in fees charged
- The need to involve other groups in the conversation

Dr. James Herzog, Committee Chair, concluded the discussion by recommending that the next Strategic Planning and Best Practices Committee (as defined by SB 2670 in the 2013 Legislative Session) take up the issue of civil commitment. These initial discussions represented progress toward the goal in Section 41-4-7 (d)(vi).

Attachment A

Appointments to the Strategic Planning and Best Practices Committee As Per SB 2836, 2011 Regular Session	
Appointee:	**Appointed By:**
Sherman Blackwell, II, Ed. D., Executive Director Singing River Services Gautier, MS	Attorney General
Mary T. Buchanan Jackson, MS	Governor
Margaret Kea Cassada, M.D. Leland, MS	Chair, Board of Mental Health
Glenda Crump, CEO DREAM, Inc. Jackson, MS	Governor
Richard Duggin, COO/CFO Community Counseling Services Starkville, MS	Attorney General
Dr. David Dzielak, Executive Director Mississippi Division of Medicaid Jackson, MS	SB 2836, lines 110-111
James D. Herzog, Ph.D. Jackson, MS	Chair, Board of Mental Health
Jerry Mayo, Executive Director Pine Belt Mental Healthcare Resources Hattiesburg, MS	Attorney General
Grayson Norquist, M.D., MSPH Chairman, Department of Psychiatry UMC Department of Psychiatry Jackson, MS	SB 2836, lines 108-109
Rose D. Roberts, LCSW Pontotoc, MS	Chair, Board of Mental Health
Dr. Sandy Rogers, Executive Director Communicare Oxford, MS	Attorney General
Cy Rosenblatt Jackson, MS	Governor
Katja Russell, Director of Programs Youth Villages Ridgeland, MS	Governor
Tessie B. Schweitzer, MSW, Executive Director Emerita MS Families As Allies for Children's Mental Health, Inc. Jackson, MS	Governor
Dave Van, Executive Director Region 8 MH Services Brandon, MS	Attorney General

Attachment B

Core Services Performance Measures

Children and Youth Mental Health Services				
Core Service	**Service Specific Measure**	**Client Specific Measure**	**Data Collection**	**Best Practices or Evidence-Based Practices**
1) Day Treatment Service	Services are designed to reduce symptoms and improve level of functioning to include (but not limited to): a) Functioning in an appropriate educational setting; b) Maintaining residence with a family or community based non-institutional setting; and c) Maintaining appropriate role functioning in community settings d)Acquisition of social skills in identified deficit areas	a) Number of suspensions or expulsions b) Number of out-of-home or institutional placements c) Number and/or frequency of juvenile justice involvements d) Number/type of social skills deficits	JIFF Interviewer® Youth and Caregiver Versions Individual Service Plans Weekly progress notes	Skillstreaming, Prepare Curriculum, Second Step Incredible Years
2) Outpatient Therapy	Services are designed to reduce symptoms and improve level of functioning to include (but not limited to): a) Emotional and behavioral functioning improvement (proportion of individuals who report improved functioning in major life domains)	a) Number/type of reported major life domain deficits b) Number of unexcused school absences c) Number of grades and/or classes failed	JIFF Interviewer®, Child and Adolescent Functional Assessment Scale (CAFAS®)	EBP include Cognitive Behavioral Therapy (CBT), Trauma-focused CBT (TF-CBT), Combined Child & Parent CBT, Structured Psychotherapy for Adolescents responding to chronic stress

	b) School attendance improvement c) School performance improvement			(SPARCS), The 7 Challenges, Prepare Curriculum TeenScreen
3) Case Management *Note: Case management becomes Community Support Services under New Medicaid Rules*	Services are designed to reduce symptoms and improve level of functioning to include (but not limited to): a) Access to needed supports/services (proportion of individuals reporting case managers helping them access resources and supports) b) Maintaining residence with a family or community based non-institutional setting	a) Number/type of services needed but not accessed b) Number of out-of-home or institutional placements	JIFF Interviewer® and CAFAS® Wraparound Facilitation Plan Community Support Activity Plan	Wraparound Facilitation
4) Psychiatric/ Physician Services	Services are designed to reduce symptoms and improve level of functioning to include (but not limited to): a) Timely access to medical services to include medication management b) Proportion of individuals who are satisfied with the frequency and quality of psychiatric services	a) Time lapse between request for services and service completion b) Number of individuals not satisfied with services	JIFF Interviewer® Physician Contact Notes	
5) Intake/ Functional Assessment	Services are designed to reduce symptoms and improve level of functioning to include (but not limited to):	a) Number of individuals seeking services b) Time lapse between completion	JIFF Interviewer® CAFAS® Individual Service Plans	JIFF Interviewer® CAFAS® TeenScreen

	a) Completion of strengths-based and individualized assessments within timeline established by the Operational Standards/Record Guide b) Timely access to service (proportion of assessments that include the required components outlined in the Operational Standards/ Record Guide)	of Intake/Functional Assessment and inception of service		
6) Emergency/ Crisis Services	a) Immediacy of response to telephone or face-to-face emergency/ crisis service requests b) Reduction in hospitalizations (proportion of individuals that show a decrease in number of crisis situations)	a) Number of emergency/crisis services requests b) Number of crisis-driven hospitalizations	JIFF Interviewer® CAFAS® Wraparound Facilitation Plan Crisis Intervention Progress/ Contact Notes	Intensive Outpatient Psychiatric Services Wraparound Facilitation
7) Pre-Evaluation Screening for Civil Commitment	a) Percentage of clients referred to outpatient services (avoided commitment to MSH or EMSH)	a) Number of Pre-Evaluation Screening for Civil Commitments completed	CMHC database	--
8) Making A Plan (MAP) Teams	Services are designed to reduce symptoms and improve level of functioning to include (but not limited to): a) Decrease in the number of out-of-home placements (including clinically acute psychiatric placements) b) Recommendations made by Team utilize "WRAP Around"/	a) Number of pre-service out-of-home placements b) Number of WRAP Plans implemented c) Number of preventions strategies implemented	- JIFF Interviewer® - CAFAS® -Wraparound Facilitation Plan (if referred) - MAP Service Plan - Quarterly MAP reports -Annual training reports	Wraparound Facilitation

	Strengths-based principles (include parent/youth; recognize culture-specific needs of children/families) c) A system-of-care philosophy is utilized that emphasizes prevention strategies			

Adult Mental Health Services				
Core Service	**Service Specific Measure**	**Client Specific Measure**	**Data Collection**	**Best Practices or Evidence-Based Practices**
1) Outpatient Therapy	a) Availability of evidence-based psychotherapy services b) Number of clients who receive outpatient therapy during the year c) Number of clients who are employed during the year d) Number of clients who have had encounter with justice system during the year e) Overall satisfaction of clients with psychotherapy services f) Time between initial evaluation and first psychotherapy visit g) Number of psychiatric inpatient admissions per client during the year.	a) Change in individual functional status during the year b) Number of psychiatric inpatient admissions for each client during the year c) Individual client satisfaction level d) Number of encounters with justice system for client during the year e) Number of individual psychotherapy sessions during the year f) Time to first psychotherapy session	System Level Data Sources: Individual Level Data Sources: Will need to develop a survey that could be given to clients. It would cover the items listed under "client specific measure."	Cognitive Behavioral Therapy (CBT), Trauma-focused CBT (TF-CBT), Structured Psychotherapy, Interpersonal Therapy (IPT)
2) Case Management *Note: Case Management becomes Community Support Services under new*	a) Availability of case management services b) Number of clients receiving these services c) Overall satisfaction with case management services [Can also use data from other system measures listed in #1 to evaluate	Use data from individual level measures listed in #1 plus: a) Individual satisfaction with case management services b) Time until first case management service	–	–

Medicaid Rules	this service]			
3) Psychiatric/ Physician Services	a) Availability of physician services b) Number of clients who receive physician services during the year c) Number of physician visits per client during the year d) Tune before first physician visit e) Overall satisfaction with physician services [Can also use data from other system measures listed in #1 to evaluate this service]	Use data from individual level measures listed in #1 plus: a) Individual satisfaction with case management services b) Time until first case physician service	–	–
4) Emergency/ Crisis Services	a) Availability of emergency/crisis services b) Average time to response from emergency/crisis service c) Overall satisfaction with these services d) Length of stay in crisis centers e) Dispositions at discharge from crisis centers [Can also use data from other measures listed in #1 to supplement evaluation of this service]	Use data from individual level measures listed in #1 plus: a) Individual satisfaction with emergency/crisis services b) Time until response from emergency/ crisis service	–	–

5) **Psychosocial Rehabilitation**	a) Availability of psychosocial rehabilitation services b) Average time until first rehabilitation service appointment c) Overall satisfaction with this service [Can also use data from other measures listed in #1 to supplement evaluation of this service]	Use data from individual level measures listed in #1 plus: a) Individual satisfaction with psychosocial rehabilitation services b) Time until first rehabilitation service appointment	–	–
6) **Inpatient Referral**	a) Inpatient psychiatric services are available within reasonable distance from home b) Overall satisfaction with inpatient services [Can also use data from other measures listed in #1 to supplement evaluation of this service]	Use data from individual level measures listed in #1 plus: a) Distance from home to inpatient service b)Individual satisfaction with inpatient services c)Time spent in inpatient services during the year	–	–
7) **Support for Family Education Services**	a) Availability of family education services b) Overall satisfaction with these services [Can also use data from other measures listed in #1 to supplement evaluation of this service]	Use data from individual level measures listed in #1 plus: a) Individual satisfaction with family education services b) Time until first family education session	–	–

8) Support for Consumer Education Services	a) Availability of consumer education services b) Overall satisfaction with these services [Can also use data from other measures listed in #1 to supplement evaluation of this service]	Use data from individual level measures listed in #1 plus: a) Individual satisfaction with consumer education services b) Time until first consumer education session	–	–
9) Pre-Evaluation Screening for Civil Commitment	a) Number of inpatient involuntary commitments during year b) Percentage of clients referred to outpatient services c) Percentage of clients who avoided commitment to one of the state inpatient institutions	a) Number of inpatient involuntary commitments for individual during the year b) Number of pre-evaluation screens for civil commitment c) Reason for commitment	CMHC Database	–
10) Other Potential Measures: I. Medical status of clients II.	–	–	–	–

IDD Services				
Core Service	**Service Specific Measure**	**Client Specific Measure**	**Data Collection**	**Best Practices or Evidence-Based Practices**
1) Case Management/ Community Support Services	a) **Subdomain: Service Coordination** Proportion of people who the Case manager/ community support provider helps individual get what they need (i.e. physical healthcare, mental healthcare, educational services, linkage to natural supports). b) **Subdomain: Service Coordination** Proportion of people involved in creating their service plans. c) **Subdomain: Service Coordination** Proportion of people who have met their case managers/community support provider. d) **Subdomain: Service Coordination** Proportion of people who report that their case managers/community support providers call them back right away. e) **Subdomain: Community Inclusion** Proportion of people who regularly participate in everyday integrated activities in their communities	–	National Core Indicators-Consumer Survey	Person-Centered Planning

2) Emergency/ Crisis Services	a) **Subdomain: Safety** Proportion of people who report having someone to contact when they need help. b) **Subdomain: Access & Support Delivery** Proportion of people who report that services/ supports are available when needed, even in a crisis. c) **Subdomain: Access** Proportion of people who feel their support staff has been appropriately trained to meet their needs. d) **Subdomain: Access** Rate at which people report they do not get the services they need.		National Core Indicators- Consumer Survey	Not presently defined

Alcohol and Drugs Services				
Core Service	**Service Specific Measure**	**Client Specific Measure**	**Data Collection**	**Best Practices or Evidence-Based Practices**
1) Outpatient Therapy	a) Increase in employment status post-discharge b) Increase in stable living situation c) Percentage not arrested post-discharge d) Decrease in number reporting alcohol usage e) Decrease in number reporting drug usage f) Percentage participating in self-help groups	a) Are clients employed (full-time or part-time) or enrolled as students 30 days after discharge? b) Are clients in stable living situation (not homeless) 30 days after discharge? c) Have clients been arrested since discharge? d) Have clients used alcohol in the past 30 days? e) Have clients used drugs other than alcohol in the past 30 days? f) Are clients participating in self-help groups (AA, NA, etc.)?	Intake and post-discharge surveys	SAMSHSA approved or published in peer reviewed journal article
2) Primary Residential	a) Increase in employment status post-discharge b)Increase in stable living situation c) Percentage not arrested post-discharge d) Decrease in number reporting alcohol	a) Are clients employed (full-time or part-time) or enrolled as students 30 days after discharge? b) Are clients in stable living situation (not homeless) 30 days after discharge?	Intake and post-discharge surveys	SAMSHSA approved or published in peer reviewed journal article

	usage e)Decrease in number reporting drug usage f) Percentage participating in self-help groups	c) Have clients been arrested since discharge? d) Have clients used alcohol in the past 30 days? e) Have clients used drugs other than alcohol in the past 30 days? f) Are clients participating in self-help groups (AA, NA, etc.)?		
3) DUI Assessment/Treatment	a) Increase in employment status post-discharge b) Increase in stable living situation c) Percentage not arrested post-discharge d) Decrease in number reporting alcohol usage e) Decrease in number reporting drug usage f) Percentage participating in self-help groups	a) Are clients employed (full-time or part-time) or enrolled as students 30 days after discharge? b) Are clients in stable living situation (not homeless) 30 days after discharge? c) Have clients been arrested since discharge? d) Have clients used alcohol in the past 30 days? e) Have clients used drugs other than alcohol in the past 30 days? f) Are clients participating in self-	Intake and post-discharge surveys	SAMSHSA approved or published in peer reviewed journal article

		help groups (AA, NA, etc.)?		
4) Outreach/Aftercare	a) Percentage participating in self-help groups	a) Are clients participating in self-help groups (AA, NA, etc.)?	Intake and post-discharge surveys	SAMSHSA approved or published in peer reviewed journal article
5) Prevention	a) Decrease in number reporting alcohol usage b) Decrease in number reporting marijuana usage c) Decrease in number reporting other illegal drug usage d) Increase in number reporting disapproval of alcohol usage (1-2 drinks per day) e) Decrease in number reporting no risk of harm from alcohol usage (5 or more drinks once or twice per week) f) Decrease in number reporting driving while under the influence of alcohol or drugs	a) Have clients used alcohol in the past 30 days? b) Have clients used marijuana in the past 30 days? c) Have clients used illegal drugs (other than alcohol or marijuana) in the past 30 days? d) How do clients feel about others their age having 1-2 alcoholic drinks per day? e) How much do clients think people risk harming themselves physically and in other ways by having 5 or more drinks once or twice per week? f) Have clients driven while under the influence of alcohol or drugs during the past year?	Mississippi Participant-Level Instrument (PLI) (program pretest post-test survey)	National Registry of Evidence-Based Programs and Practices (NREPP) or state-approved evidence-based program (e.g., supported by published, peer-reviewed study)

Attachment C

Mental Health Outcome Measures

2012 At A Glance...

Measures

- Consumer Profile – Utilization
  - Numbers served
  - Service settings
  - Funding
  - Employment Status
  - Living Situation
- Appropriateness
  - Admissions
  - Length of stay
  - Readmissions

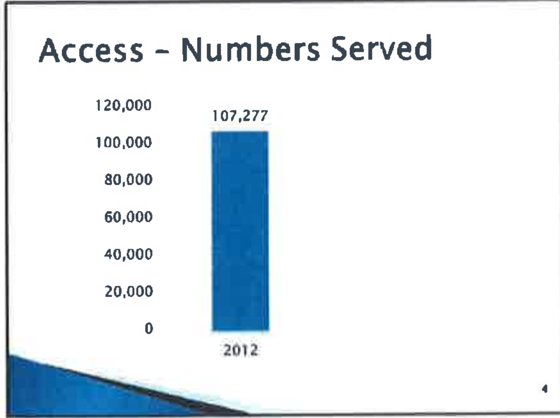
2

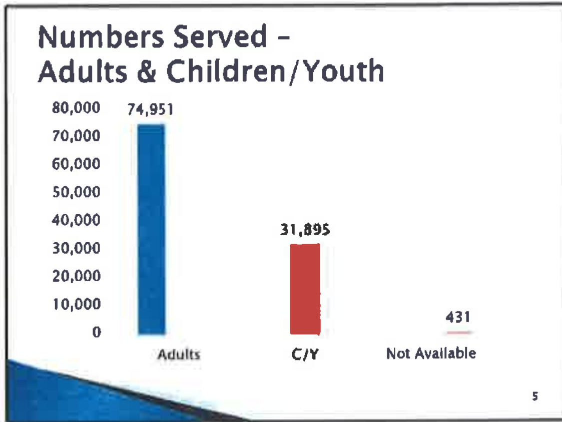
Measures

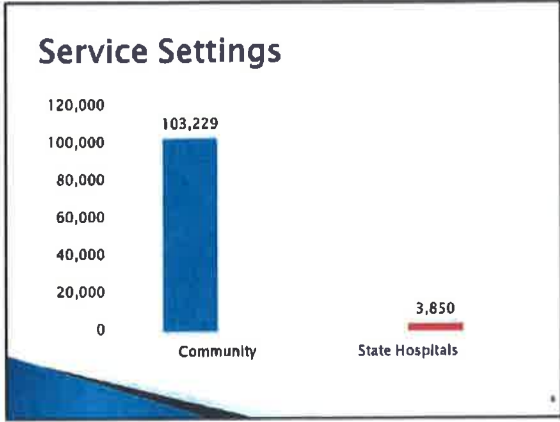
- Evaluation of Care
  - Adult
  - Children/Youth
- Changes in Social Connectedness
- Changes in Functioning

3

Access – Numbers Served




Numbers Served -
Adults & Children/Youth
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
74,951
31,895
431
Adults
C/Y
Not Available
5


Service Settings
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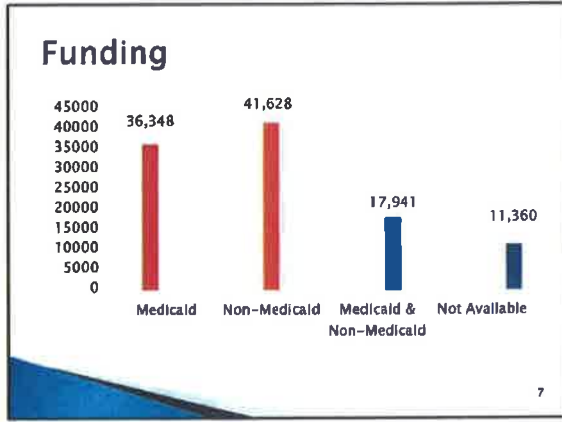
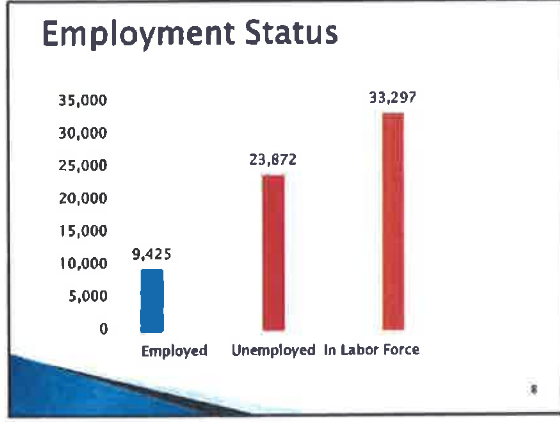
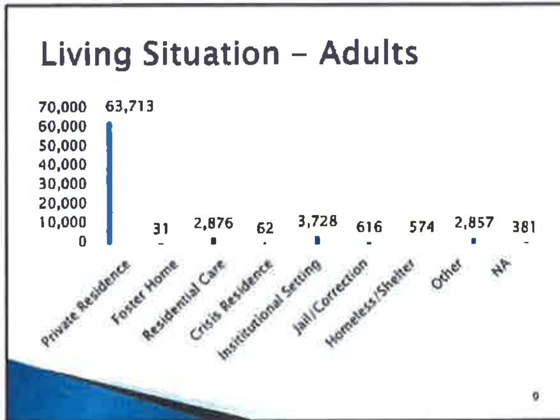
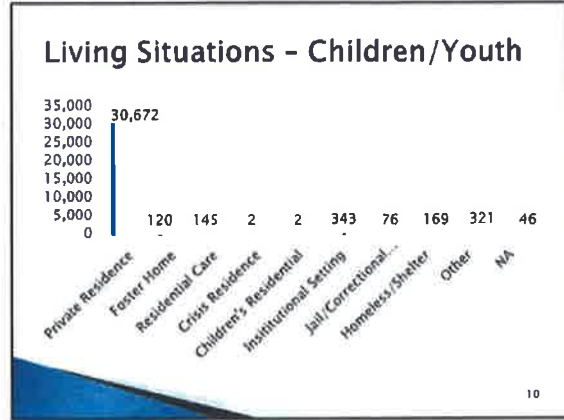
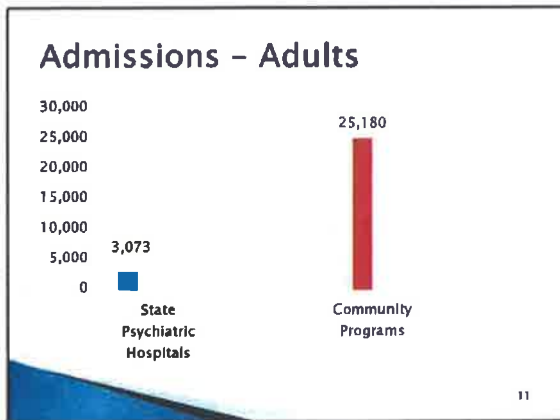
100,000
80,000
60,000
40,000
20,000
0
103,229
3,850
Community
State Hospitals

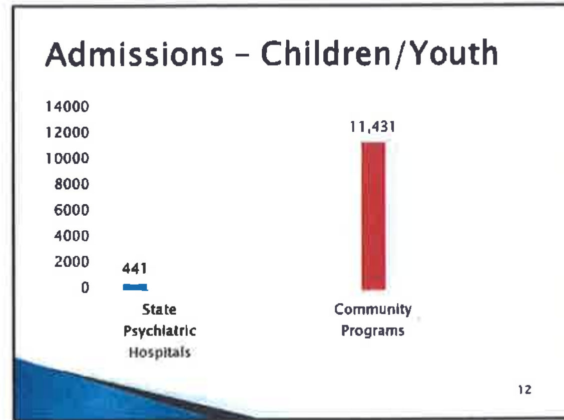

Funding
45000
40000
35000
30000
25000
20000
15000
10000
5000
0
36,348
41,628
17,941
11,360
Medicaid
Non-Medicaid
Medicaid &
Non-Medicaid
Not Available
7

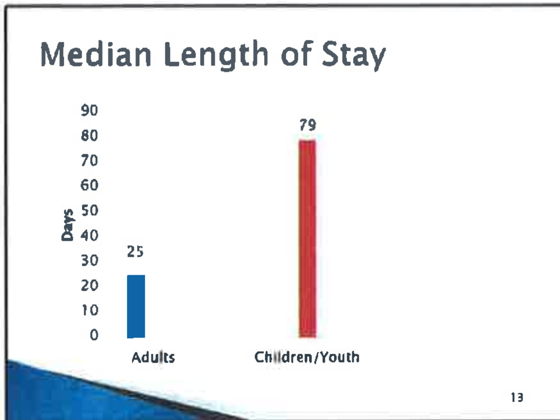

Employment Status
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
9,425
23,872
33,297
Employed
Unemployed
In Labor Force

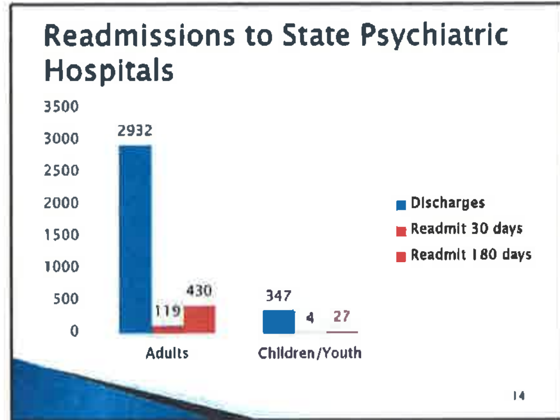

Living Situation – Adults
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
63,713
31
2,876
62
3,728
616
574
2,857
381
Private Residence
Foster Home
Residential Care
Crisis Residence
Institutional Setting
Jail/Correction
Homeless/Shelter
Other
NA
9

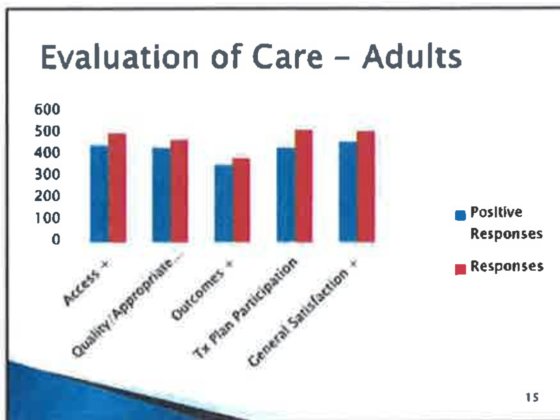

Living Situations - Children/Youth
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
30,672
120
145
2
2
343
76
169
321
46
Private Residence
Foster Home
Residential Care
Crisis Residence
Children's Residential
Institutional Setting
Jail/Correctional...
Homeless/Shelter
Other
NA
10

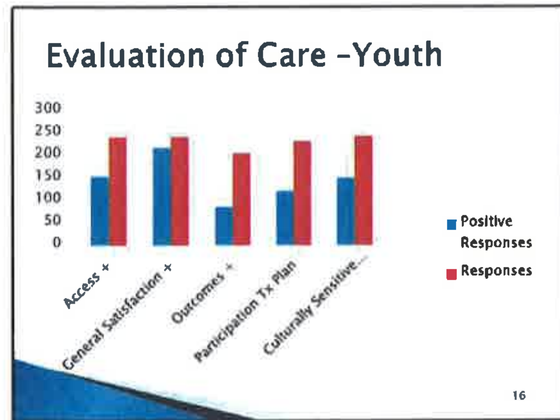

Admissions – Adults
30,000
25,000
20,000
15,000
10,000
5,000
0
3,073
25,180
State Psychiatric Hospitals
Community Programs
11

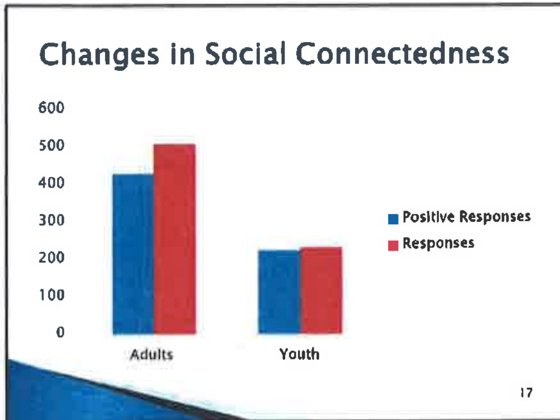

Admissions – Children/Youth
14000
12000
10000
8000
6000
4000
2000
0
441
11,431
State Psychiatric Hospitals
Community Programs
12

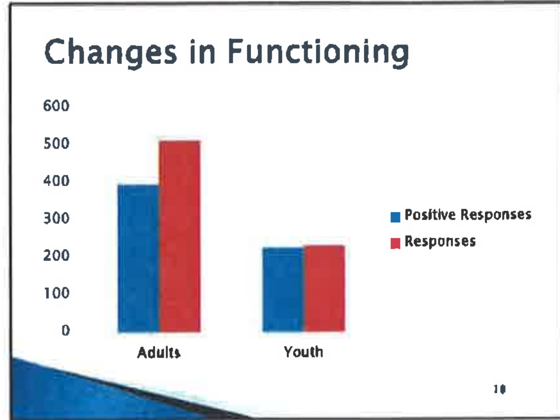

Median Length of Stay
Days
90
80
70
60
50
40
30
20
10
0
25
79
Adults
Children/Youth
13


Readmissions to State Psychiatric Hospitals
3500
3000
2500
2000
1500
1000
500
0
2932
119
430
347
4
27
Adults
Children/Youth
Discharges
Readmit 30 days
Readmit 180 days
14


Evaluation of Care – Adults
600
500
400
300
200
100
0
Access +
Quality/Appropriate...
Outcomes +
Tx Plan Participation
General Satisfaction +
Positive Responses
Responses
15


Evaluation of Care -Youth
300
250
200
150
100
50
0
Access +
General Satisfaction +
Outcomes +
Participation Tx Plan
Culturally Sensitive...
Positive Responses
Responses
16


Changes in Social Connectedness
600
500
400
300
200
100
0
Adults
Youth
Positive Responses
Responses
17


Changes in Functioning
600
500
400
300
200
100
0
Adults
Youth
Positive Responses
Responses

Attachment D

Core Services Survey - Summary of Findings

Overview

The Department of Mental Health and the Strategic Planning and Best Practices Committee partnered in April 2013 to conduct a survey of external stakeholders to identify needed or desired revisions to the Core Services that Community Mental Health Centers (CMHCs) and other DMH approved and certified community mental health service providers are required to provide. The survey was conducted utilizing an online survey tool, Survey Monkey®. The survey consisted of five sections – demographics, Core Services designed for adults with serious mental illness (SMI), Core Services designed for for children/youth with serious emotional disturbance (SED), Core Services designed for individuals with substance abuse disorders, and Core Services designed for individuals with intellectual/developmental disabilities (IDD).

Respondents

A total of 87 surveys were completed during the survey period. Almost 50% of the respondents identified themselves as service providers from throughout MS. Approximately 11.5% of the respondents identified themselves as consumers, or former consumers, of the public mental health system. Approximately 16.5% of the respondents identified themselves as family members of a person who currently or formerly has received services through the public mental health system.

Results

Overwhelmingly, the survey confirmed that the current DMH required Core Services should remain intact as they are included in the current 2012 DMH Operational Standards for Community Service Providers of Mental Health, Intellectual/ Developmental Disabilities and Substance Abuse Disorders.

Services for Adults with SMI

Respondents confirmed that the Core Services designed for adults with SMI should continue to include: Outpatient Therapy Services, Community Support Services, Emergency/Crisis Services, Psychosocial Rehabilitation Services, Inpatient Referral, Peer Support Services, and Targeted Case Management.

Recommendations for additional Core Services included the following: employment related services, transportation, supportive housing, expanded crisis services (Crisis Intervention Teams, additional beds), supportive housing, increased PACT teams, and supportive services (i.e. money management, peer services, family education and respite).

Services for children/youth with SED

Respondents confirmed that the Core Services designed for children/youth with SED should continue to include those stated above for adults with SMI with the additional services of Day Treatment, Psychiatric/Physician Services, Intake/ Functional Assessment, and Making A Plan (MAP) Teams.

Recommendations for additional Core Services included the following: respite care, family support, supportive housing options, prevention services, and creative therapies such as art and music therapies.

Services for individuals with substance abuse disorders

Respondents confirmed that the Core Services designed for individuals with substance abuse disorders should continue to include: Outpatient Services, Prevention Services, Primary Residential Services, DUI Assessment Services, and Recovery Support Services.

Recommendations for additional Core Services included the following: integrated substance abuse and mental health services, increased prevention services, supportive services (i.e. family education, recovery support), and community support services for this population.

Services for individuals with intellectual/developmental disabilities
Respondents confirmed that the Core Services designed for individuals with IDD should continue to include Community Support Services and Emergency/Crisis Response Services.

Recommendations for additional Core Services for individuals with intellectual/developmental disabilities included the following: employment related services, transition services for adolescents, behavioral intervention, and personal care services.

Limitations
Any future study related to the Core Services should address two possible limitations of this survey. The first possible limitation is the low number of total respondents. The second possible limitation is underrepresentation of family members and individuals receiving services as respondents.