Young Adult Services

Current Status and Future Directions

Introduction and Acknowledgements

Since 1998 the Connecticut Department of Mental Health and Addiction Services (DMHAS) has received funding from the Governor and Legislature to develop and administer an interdepartmental program of services for young adults who are recovering from behavioral health disorders. Together with the Office of Policy and Management (OPM), the Department of Mental Retardation (DMR), and the Department of Children and Families (DCF), DMHAS developed processes to enable the early identification, referral, transition, and access to a range of age and developmentally appropriate clinical and support services for clients, most of whom are “aging out” of DCF care. The statewide Young Adult Services (YAS) program currently provides both inpatient and outpatient services at one state-operated psychiatric hospital, six state-operated Local Mental Health Authorities (LMHAs), and four private-not-for-profit (PNP) LMHAs. Contracts that provide funding to four additional PNP community service providers augment the primary service delivery system.

In January 2006, the Connecticut Legislature requested that the Commissioner of DMHAS, Thomas Kirk, Ph.D., provide a report to the Legislature regarding public behavioral health and support services for young adults in Connecticut. House Bill No. 7000, Public Act No. 05-280, Sec. 86, included the following language: “… On or before January 1, 2007, the Commissioner of Mental Health and Addiction Services shall report, in accordance with the provisions of section 11-4a of the general statutes, on the need for such expanded services and identify additional services needed to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services.”

Commissioner Kirk asked the Chief Executive Officers of each LMHA in Connecticut to provide their perspectives on the status of services for young adults, including services that currently are offered, gaps in services, infrastructure issues, and the need for further development of Young Adult Services. The following individuals gave generously of their time and in-depth knowledge, providing invaluable information for this report, which was drafted by William Smalley, Ph.D of DMHAS:
Sandra Wilson, Ph.D., Director of Young Adult Services, for James Pisciotta, CEO, Southwest Community Mental Health System

Karen Evertson, CEO, Western Connecticut Mental Health Network, and Collette Anderson, CEO, Northwest Mental Health Authority

Kim Beauregard, CEO, Inter-Community Mental Health Group

Ralph Depres, LCSW, for Marilyn Cormack, CEO, Birmingham Group Health Services

Christine Lidz, LCSW, Clinical Director, and Dawn Silver-DeAngelis, MA, Director of Community Support, for Barry Kasden, CEO, Bridges - A Community Support System, Inc.

Kathy Ulm, Clinical Director, and Cheryl Coleman, Travis Martin, and Louis DeStephano, Ph.D., for Jeffrey Walter, CEO, Rushford Center

Linda Filipetti, LCSW, Rich Perrone, LCSW, Mary-Ellen Leigh, LCSW, and Jennifer Fields, LCSW, for Mark Muradian, CEO, Community Mental Health Affiliates

Brenda Thorington, MSN, CEO, and Tom Pisano, MD, Chief of Professional Services, Cedarcrest Hospital

Heather Gates, CEO, Marci Neff, LCSW, Director of Operations, Genesis Center, Dottie Stawasz, LCSW, and Stan Schapiro, LCSW, Community Health Resources

Dianne Manning, CEO, and Colleen Harrington, LCSW, Clinical Director, United Services

Tony Corniello, LCSW, Director of Clinical Services, for Roberta Cook, CEO, Harbor Health Center

Kenneth Marcus, M.D., Medical Director, DMHAS

Luis Perez, LCSW, CEO, Capitol Region Mental Health Authority

Tom McMahon, Ph.D., Director of Young Adult Services, and Peg Bailey, Clinical Director, for Selby Jacobs, M.D., CEO, Connecticut Mental Health Center

Howard Reid, CEO, and Mary Rose Brogan, Ph.D., Clinical Director, River Valley Services

William Newkirk, LCSW, CEO, Cheryl Jacques, APRN, Assistant Director, and Caryl Horner, Ph.D., YAS Program Director, Southeastern Mental Health Authority
Background

In 1997, several Connecticut state agencies began a collaborative effort to address the lack of services for youth with high-risk behaviors who were aging out of the child welfare/protective service system. Although the vast majority of these adolescents had histories of neglect, abuse, and behavioral health dysfunction, at age 18 many of them did not appear to present with a major mental illness *per se*, and therefore were not eligible for services from the adult mental health agency - the Department of Mental Health and Addiction Services (DMHAS) - or from any other public agency. However, anecdotal accounts of the destiny of many of these young people suggested that a large percentage of them ended up in the criminal justice system, in DMHAS psychiatric hospital inpatient units, or homeless and bereft of services and support.

Three publicly funded agencies—the Department of Children and Families (DCF), the Department of Mental Retardation (DMR), and the Department of Mental Health and Addiction Services (DMHAS) - in conjunction with the state’s budgetary agency, the Office of Policy and Management (OPM) - sought and received state funding for a three-year interagency pilot project to develop services for two specific cohorts of high-risk youth who were “aging out” of the DCF system: 1) those with a history of sexually inappropriate or offending behaviors, and 2) those with Pervasive Developmental Disorders (excluding Autistic Disorder) and a history of significant high-risk behavior. The planners established a steering committee of individuals from the four agencies, plus those with clinical expertise from the wider community, to draft an initial model of service provision for these two seemingly disparate groups. The steering committee consulted with local, national, and international experts in the area of sexually inappropriate or offending behavior and in Pervasive Developmental Disorders (PDD) to develop a clearer understanding of the myriad issues related to such areas as risk assessment, clinical services, and siting. Project leaders hoped to identify similar models in other parts of the country that could be tapped for consultation. However, the lack of services for these high-risk populations was not unique to Connecticut, but was a gap found across the country.

A second pilot project, focused on prevention of chronic mental illness in young adults, was funded and initiated in 1999. Young adults with histories of behavioral health issues who were “aging out” of the DCF system, and for whom transitional clinical and support services that would help prevent the development of chronic mental illness, were included in this cohort.

Within three years these two projects were merged into the program now known as Young Adult Services (YAS). The inclusion criteria for admission into YAS also changed, with the result that YAS services became available to medically indigent individuals between the ages of 18 – 25 who met the general criteria for DMHAS services. ¹ Nine LMHAs received funding for the provision of a wide range of clinical and support services that would help prevent the development of chronic mental illness, were included in this cohort.

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¹ Individuals with PDD who were referred to YAS do not meet these general criteria for DMHAS services, so these referrals were considered on a case-by-case basis with review by the Medical Director of DMHAS.
support services for young adults, including community residential support services, assistance with accessing educational and vocational community services, skills training, support in developing recreational and leisure activities, and ongoing clinical services. In answer to needs that were identified as the YAS program developed, an inpatient Level of Care (LOC) and a specialized state-wide transitional residential treatment program also were funded and currently are part of the YAS continuum of care.

A review of the number of referrals to YAS through the DMHAS YAS Office of the Commissioner unit (YAS-OOC) illustrates the rapid growth of the program:

The spike in referrals to YAS-OOC in 2005 (see Chart 1) primarily was the result of an extensive effort in DCF to identify all individuals who might require adult mental health services and to ensure that they were referred to YAS. However, it should be noted that as the result of a reorganization of YAS services at the program level, the number of young adults who have sought services or who have been referred by families, school systems, and service agencies outside of DCF and DMR also rose substantially in the past three years. These young adults usually entered YAS programs through the LMHA.
intake process, rather than through YAS-OOC. Therefore, the total number of young adults in the YAS program at the end of SFY-06 exceeded 600. Table 2 provides a breakdown of the number of persons in each YAS program and the Levels of Care available to them:

<table>
<thead>
<tr>
<th>YAS Program Site</th>
<th>Number of Current Young Adults at Different Levels of Care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient</td>
<td>Specialized Residential</td>
</tr>
<tr>
<td>Bridges</td>
<td></td>
<td>33</td>
</tr>
<tr>
<td>CMHA</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>CRMHC</td>
<td>3</td>
<td>57</td>
</tr>
<tr>
<td>GBCMHC</td>
<td>8</td>
<td>60</td>
</tr>
<tr>
<td>NCCS</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Nicholas Drive</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>NWMHA</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>RVS</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>SMHA</td>
<td>2</td>
<td>58</td>
</tr>
<tr>
<td>Valley Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMHC</td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>Cedarcrest Hosp.</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>20</td>
<td>8</td>
</tr>
</tbody>
</table>

Staff in the YAS-OOC unit anticipates that 180 young adults who already have been referred and accepted for YAS services will be admitted to the program in SFY-07. An unknown number of additional young adults, who will require services in the same time period, will be referred by DCF and other sources, and an additional cohort will seek services or be referred for services directly to the LMHAs that have YAS programs.

Congruent with the focus on recovery from severe mental illness, young adults also leave the YAS system of intensive care. In SFY-06, 145 were discharged from YAS with a discharge plan with which the facility concurred. Thirty-four (34) moved during the same time period and were no longer enrolled in a YAS program. Only 28 dropped out of programs or left programs against medical advice. However, the number of young adults entering YAS programs far exceeds the number who are leaving, and given the increase in referrals and in those seeking services at the LMHAs it is expected that the YAS census will continue to grow for the next seven years before it stabilizes.
Request for a Status Report from the Legislature

In January 2006, House Bill No. 7000, Public Act No. 05-280, Sec. 86, included the following language:

The Commissioner of Mental Health and Addiction Services shall, within available appropriations, expand young adult services to cover additional catchment areas in the state and shall identify additional services not being provided by young adults with psychiatric disabilities. On or before January 1, 2007, the Commissioner of Mental Health and Addiction Services shall report, in accordance with the provisions of section 11-4a of the general statutes, on the need for such expanded services and identify additional services needed to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services.

Partly in response to this request for a report, the Deputy Commissioner of DMHAS and Director of Young Adult Services, Pat Rehmer, MSN, and the Director of Operations of Young Adult Services, Nikki Richer, LCSW, gathered data from a variety of sources, including YAS Program Directors and YAS-OOC staff. In addition, Commissioner Kirk asked the Chief Executive Officers (or designees) of LMHAs to provide information about the status of services for young adults in their areas, and to identify gaps in the service delivery system, needs for augmented services, and infrastructure issues. The following is a summary of that information.
## Current Status of Services for Young Adults in DMHAS Local Mental Health Authorities

<table>
<thead>
<tr>
<th>Levels of Care</th>
<th>24/7</th>
<th>Transitional Residential</th>
<th>Supported Residential</th>
<th>Clinical</th>
<th>Intensive ACT</th>
<th>Case Management</th>
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<tbody>
<tr>
<td>Region</td>
<td>LMHA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>GBCMHC</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>F.S. DuBois</td>
<td>No funded YAS program</td>
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<td></td>
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</tr>
<tr>
<td>II</td>
<td>RVS</td>
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<td>Birmingham</td>
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<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Bridges</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>CMHC</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Harbor Health</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rushford Center</td>
<td>No funded YAS program</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>III</td>
<td>SMHA</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>United Services</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>IV</td>
<td>NCCS</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
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<td>Genesis Center</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ICMHG</td>
<td>No funded YAS program</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>CRMHC</td>
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<td>Yes</td>
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<tr>
<td></td>
<td>CMHA</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>V</td>
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<td></td>
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<tr>
<td></td>
<td>NWMHA</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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</tr>
</tbody>
</table>

As noted in Table 3, only 10 of the 18 LMHAs in the DMHAS system currently receive funding for YAS programs. While every Region of the state has at least one funded YAS program, every region also has at least one LMHA that has not been funded. In fact, in Regions I (Southwest), III (East), and V (Northwest) there are at least as many LMHAs that have not received any special funding for YAS programming as there are funded LMHAs.

For those LMHAs that do have YAS programs, funding has not kept pace with the increase in referrals and active participants. Two of the 4 funded programs in Region II have been unable to provide residential support services due to minimal funding. Every YAS program is over “capacity” (defined as the cost of providing services for every person at an appropriate LOC), with the result that the service system is forced to place individuals in LOCs that do not fully meet their needs or is forced to cut back on the adequacy of services that should be provided at particular LOCs. The YAS budget has not been increased substantially for the past three years, and currently is estimated to be under funded by more than $11,000,000.00 (see Appendix 1) given the numbers of young adults in current LOCs. For SFY-07, the cost of providing the appropriate LOC and services for the projected number of clients in YAS would require a funding increase of $26.6 million over the current budget (see Appendix 2).
Services for Young Adults in LMHAs With Funded YAS Programs

Region I:

Greater Bridgeport Community Mental Health Center is the only LMHA in Region I that has a funded YAS program. It is one of the largest programs in the DMHAS YAS system, both in terms of number of active participants and in terms of budget. The YAS program at GBCMHC provides a continuum of LOCs (see Table 3) and a range of clinical services (including assessment and evaluation, individual and group therapies, families and couples counseling, prescription of psychotropic medications). Congruent with the recovery needs of young adults, many of whom are living in the community for the first time in years, YAS program staff (who are called “Recovery Facilitators”) also provide residential support services, including 24/7 staff supported transitional living homes and in-home support at “scattered site” apartments. Staff assist the young adults to access programs and services that are available in the community, including educational opportunities, employment training, medical and dental services, and, for those who become parents, programs for young parents. Social and recreational needs are addressed via social skills training and assistance with accessing recreational opportunities in the community. All of these services are provided in the context of an understanding of the age and developmentally appropriate, culturally nuanced needs of young adults who, in the vast majority of cases, were victims of neglect and abuse by their parents or other “caregivers,” were removed from their homes of origin, had multiple placements in the DCF system of care, suffered from learning disabilities exacerbated by frequent changes in their school programs, developed behavioral and emotional disorders, and had few, if any, opportunities to experience the normal developmental successes of late adolescence and early adulthood.

Region II:

River Valley Services in Middletown operates a YAS program with one of the smaller budgets in the YAS system. Rather than creating a separate YAS team to provide services, the agency has used existing clinical teams to which young adults are assigned based on LOC and clinical needs. At present, approximately 20 young adults are served on the Transitional Treatment and Evaluation Team, the Lower County Team, the Assertive Community Treatment Team, and on two Community Support teams. Six YAS participants receive residential support services in a congregate living site in Portland, CT, where staff are available 24/7. An additional two or three may be able to live at the same site. One young adult receives 24/7 1:1 staff support. All YAS participants have access to a range of clinical and support services.

The Valley Mental Health Center (Birmingham Group) has the smallest YAS budget of the LMHAs with YAS programs. Initially, it was funded through the Community Mental Health Strategy Board to develop an Assertive Community Treatment (ACT) team for young adults. In SFY-06 it became funded by YAS with funds appropriated for this service. The program provides ACT services to 48 young adults (out of a total of
approximately 150 registered in the 18 – 25 year-old age range). The program focuses on outreach and engagement with young adults, some clinical services, support and skills training for young mothers, and has developed a “drop-in” center for YAS participants.

Bridges – A Community Support System, Inc., provides services for approximately 46 YAS participants in the Milford/West Haven area. Many served by Bridges have neurocognitive and/or developmental disorders, and need a relatively high level of care and support. Bridges has developed a YAS team that is integrated with the rest of the agency for clinical services and has its own staff to provide community support and residential support services. In terms of clinical services, Bridges provides a range of individual and group therapies, medication education and prescription, substance abuse services, and crisis services. Many live in apartment complexes that are within walking distance of community staff offices maintained by the program, and receive residential support and counseling, case management, and social/recreational services. A relatively small number of young adult participants are able to access employment education and support services.

Connecticut Mental Health Center operates one of the newest YAS programs in the state through its West Haven clinic. Initially, the CMHC YAS program was funded only for ACT and case management services. In SFY-06 the program received additional funding to develop residential support services, and has contracted with Marrakech, a PNP provider, to open a 10 bed transitional residential support program. The CMHC YAS program currently serves approximately 40 individuals. (Other young adults who are not in the YAS program receive services from the non-YAS outpatient teams at CMHC.) Staff see their young adults in the community 1 – 3 times per week to provide counseling, case management, and community support. The YAS program also provides some group therapy and skills building group experiences at the West Haven clinic.

Region III:

The Southeastern Mental Health Authority is the only agency in Region III with a funded YAS program. It provides a range of services for approximately 65 young adults at present, with clinical services (including a variety of individual and group therapies, trauma informed treatment, and family treatment), residential and community support services, employment education and support (more than 50% are employed), assistance in finding medical and dental services (each YAS participant has a primary nurse at the agency who coordinates medical/dental care), case management, and education in areas such as prevention of substance abuse, healthy lifestyles, understanding psychiatric medications and diagnoses, and developing social and recreational interests. The program has a full-time staff person who attends to housing needs, including developing relationships with landlords, helping to find affordable housing in decent neighborhoods, and providing support and assistance when issues arise with utility companies or landlords. Each young adult is involved on an ongoing basis with a multidisciplinary treatment team (comprised of staff from Occupational Therapy, Psychiatry, Nursing, and Social Work disciplines) to develop and maintain a Recovery Plan based on the needs and desires of the young adult. The staff outreach efforts and contacts with young adults
in their communities is crucial to the success of these Recovery Plans, and staff provide *in vivo* support and skills training based on the needs of the participants.

Region IV:

Community Health Resources, through its North-Central Counseling Services agency, operates a relatively small YAS program in the Windsor area. It has a 10 bed residential support program and capacity to serve 40 individuals in an ACT level of care. They have access to a range of clinical services, case management, and a Respite program at (dependent on vacancies among the Respite beds). In addition, staff provides informal employment, educational, and social counseling.

Capitol Region Mental Health Center in Hartford provides YAS services for approximately 110 young adults. The program offers a range of services including clinical (individual and group therapies; trauma treatment; medication education and prescription; treatment for co-occurring mental illness and substance abuse problems), case management, and residential and community support (supported housing and a 6 bed 24/7 staffed congregate living program). Assistance with accessing opportunities for vocational training and continued education also is stressed.

Community Mental Health Affiliates provides YAS services for approximately 26 persons in the New Britain area. There is a 20 bed supported apartment program, with participants living in their own apartments in the same apartment complex. A staff office also is located at the complex, so individuals have access to staff 24/7. The YAS program provides clinical services (individual therapy; medication education and prescription; family treatment; a special women’s group; substance abuse treatment), case management, residential and community support services, employment education, assistance with accessing education programs in the community, and some social/recreational opportunities. In addition, an ACT team funded by YAS provides services to 35 young adults who are not in the residential support program.

Region V:

The Northwest Mental Health Authority, located in Torrington, is the only LMHA in Region V that has a funded YAS program. Approximately 80 young adults receive a range of services, some of which are provided by YAS staff and some of which are provided by other programs within the agency. There is a Transitional Residence program that provides 24/7 staff assistance for six young adults. All others live in scattered-site apartments in the community, where YAS staff, members of a Community Support team, and two peer mentors provide *in vivo* support, skills training, and psychoeducation. The agency has a Recovery and Wellness program, which holds classes in which many YAS participants are enrolled. A core team of YAS staff provides clinical and case management services.
As noted above, eight LMHAs in the DMHAS system do not have funded YAS programs. Each of them, however, does provide clinical and case management services for young adults, and many of them have other programs (e.g., crisis services; supported apartment programs; Assertive Community Treatment) that a limited number of young adults can access. The primary issues with the services provided to young adults in the unfunded agencies have to do with the lack of specificity of services and the lack of capacity to meet the demand for services. General clinical, case management, and community support services that were developed primarily for older clients may not address all of the specific age-related and developmental needs of young adults. In addition, the increasing numbers of young adults who are entering the system of care put new stresses on the ability of the system to provide the right LOC and services for all YAS participants.

Region I:

The F.S. DuBois Center provides services for persons in the Stamford area. The agency has the advantage of being a sister agency with GBCMHC in the Southwest Mental Health System, so there is some opportunity for young adults who normally would be served at F.S. DuBois Center to receive services from the YAS program in Bridgeport. However, this arrangement adds to the stress on the YAS program and results in individuals having to make a choice about relocating to an area of the state that is more distant from their area of origin in order to receive appropriate services.

Region II:

Harbor Health Center reports an increase in the number of young adults seeking services, but has no funding for a YAS program at present. There is a population of approximately 130 young adults who do receive clinical services and case management at Harbor Health. They also have access to social rehabilitation, crisis, and a new Intensive Outpatient Program (IOP), but these services must meet the needs of all of the adults of the agency and there often are issues related to capacity and specificity for young adults. Harbor Health has a 19 bed residential support program and an eight bed group home, along with a three bed respite program, but there are waiting lists for these residential supports, and the mix of young adults with older program participants does not always provide the best fit for either group.

Rushford Center in Meriden provides services for more than 100 young adults, and reports that the young adult census would be approximately 250 if there were no barriers to services. Rushford Center does not have funding for a YAS program, but has begun to develop some age and developmentally focused services, including a young adult therapy group that meets once per week and a Dialectical Behavior Therapy program for adolescent females. Other clinical services (including addiction treatment, outpatient therapy, a Partial Hospital Program (PHP) and IOP, and medication education and prescription) are provided to young adults, but do not have a specific age and
developmental focus. Community supports, include case management, limited employment services, and social/recreational services also are available.

Region III:

United Services serves DMHAS individuals in the northeast region of the state. Like other agencies, it reports a surge in young adults who are referred for or are seeking services for mental health and substance abuse treatment. United Services currently has approximately 160 persons in active treatment who are in the 18 – 25 year-old age range, and between 30% - 50% of all new persons seeking treatment are in this age range. Many of these have a combination of substance and mental health issues, and a majority has psychotic illnesses. Service options include access to clinical services, case management, ACT services, employment services, medication education and prescription, and limited residential support services, but as in other agencies without funding for YAS programs, these services are not focused on the age and developmental needs of young adults.

Region IV:

Genesis Center in Manchester is operated by Community Health Resources (CHR), which does have a small funded YAS program in Windsor. As in the case with F.S. DuBois, in principle this provides limited ability for young adults to access services through the YAS program at the sister agency, but barriers include the limited capacity of the YAS program and the issue of geographic dislocation. Young adults at Genesis Center have access to a range of clinical, case management, and residential support services, but the same issues of capacity and specificity of services are endemic.

Inter-Community Mental Health Group in East Hartford has proposed to develop a YAS program that would provide age and developmentally appropriate clinical and residential supports services for 75 young adults, and an ACT service LOC for an additional 30 persons, contingent on YAS funding. The agency currently provides clinical, case management, residential support, ACT, peer to peer support, skills training for young parents, and family support services for young adults, but of necessity these services are components of its general outpatient services rather than being specialized, age and developmentally focused services.

Region V:

Greater Waterbury Mental Health Authority and Greater Danbury Mental Health Authority are two of the three LMHAs that make up the Western Connecticut Mental Health Network. Neither of them has funding for a YAS program. Both agencies have seen an increase in the number of young adults seeking services, and both provide a range of clinical, case management, and support services for their young adults. As in the case of F.S. DuBois and Genesis Center, because of the network system some young adults at both agencies may be able to access the services provided at the funded YAS program at Northwest Mental Health Authority. However, this arrangement has the same inherent
drawbacks of further stressing the capacity of the YAS program and causing geographical dislocation and the loss of community treatment in a participant’s area of origin.

Special Programs and Services for Young Adults

In addition to the funded YAS programs at some LMHAs, the statewide DMHAS YAS system provides a number of special programs and services for young adults and the local YAS programs.

The YAS OOC team begins the process of service planning and support for the local programs. Referrals from DCF, currently averaging about 25 every two weeks, along with referrals from families, schools, DMHAS LMHAs, hospitals, public defender offices, and other sources, all are reviewed for clinical information pertaining to eligibility for DMHAS YAS services. In cases where there is insufficient information to determine eligibility, YAS OOC staff make every effort to obtain up-to-date, relevant clinical information by requesting records, arranging for evaluations, and conducting clinical interviews. Once a determination has been made that a person is eligible for YAS services, YAS OOC staff meet with the individual and other stakeholders and begin a process of engagement and transition planning. Depending on the age of the person and other factors, the transition period may be very short or may take two years or more. At the appropriate time, YAS OOC staff convenes a Transition Action Planning meeting. Various stakeholders, including the prospective case, his/her parents or guardians, current treatment providers, DCF workers, and staff from the YAS program that the client will be entering, are invited to collaborate in planning the myriad details of a successful transition to a new locale and program. YAS OOC staff then continue to provide oversight and support during the transition process. YAS OOC staff also provide consultation on clinical issues that pertain to an individual (whether that person is transitioning or is an active participant in a local YAS program); consultation on program planning and development; access to specialized evaluations and clinical consultation; and staff training. Some of these latter activities, however, have been impeded by the lack of staff to handle the enormous increase in the number of referrals, with the consequent increase in eligibility determinations and transition work.

Cedarcrest Hospital in Newington operates a YAS-funded 15 bed inpatient unit for young adults, most of whom either are transitioning into a YAS program or are in need of an inpatient LOC after a period of outpatient treatment in a YAS program. The unit was developed to provide crisis treatment and stabilization with age and developmentally appropriate services for young adults, and the maximum census was purposely kept lower than that of other adult inpatient units at Cedarcrest to enable the staff to provide a high degree of treatment and support to participants. However, lengths of stay on the unit have been higher than those on other units of the hospital, primarily because of two factors:

- The clinical presentation and needs of most of the participants admitted to the unit are far more complex than was anticipated when the unit was established, and far less amenable to crisis management, stabilization, and rapid discharge to
community-based YAS programs. The types of specialized evaluations that many require for detailed treatment planning are not readily available, and some types of specialized treatment are not within the areas of competence of the staff. To its credit, the hospital has attempted to develop contracts with experts in various fields to provide evaluation, conduct training for staff, and provide some specialized treatment, but without in-house expertise there are inevitable delays and a kind of dilution of the intensity of services that some individuals require. The complex behavioral and mental disorders that afflict many participants may not be amenable to crisis-oriented treatment, which is the kind of treatment that the unit was designed to provide.

• Gaps in the YAS system of Levels of Care (see below) preclude the possibility that some participants, who no longer need a hospital level of care, could be discharged to lower levels of care. This is particularly true for those who are assessed to be at-risk for inappropriate sexual behavior, violence, and other kinds of dangerous behavior that might put themselves or others in the way of harm. It also is true of some with Pervasive Developmental Disorders or other disorders that affect the ability for them to function in socially acceptable ways in the community. Because YAS does not have the resources to develop the capacity to provide the high levels of support and supervision that such individuals may need in the community, they become trapped at an unduly restrictive hospital level of care and contribute to a gridlock on the active use of hospital beds.

A number of young adults with particular needs have been able to access specialized services and programs that have staff with the expertise to meet those needs. YAS OOC staff have developed contracts with providers who conduct evaluations of participants with histories of fire-setting and sexual behavior problems; with two different programs that treat those with eating disorders; with a program that provides residential supervision (in addition to clinical services) at a level of intensity that is higher than that generally available in YAS programs; with a residential program that is based on the clinical model embodied in Dialectical Behavior Therapy (DBT); with a specialized behavioral program in California that is providing services for one person with a history of extreme violence; and with a program in Utah that provides services for those with histories of sexual behavior problems. YAS OOC staff have identified other programs that may be tapped to provide services to meet the special needs of some individuals, but even more importantly may provide YAS with clinical models to be used in the development of specialized programs within the YAS continuum of care.

Services for Client Cohorts with Particular Neurocognitive or Developmental Conditions

Recognizing that some individuals, particularly those with neurocognitive conditions or Pervasive Developmental Disorders (PDD), have not been prepared to live successfully in the community when they first enter the YAS system, YAS OOC developed a Request for Proposals in 2004 for a specialized residential treatment program for persons with severe neuropsychiatric disorders, neurocognitive conditions, and Pervasive Developmental Disorders. Ability Beyond Disability (ABD) was awarded the contract,
and developed a nine bed residential program with a behavioral focus and extensive links to community services. The program, which is located in Bristol, began serving clients in 2005. At present, eight persons are in the program with an additional one being almost ready to transition into the program. The program uses a state-of-the-art computerized behavior and treatment tracking system (Sigmund™, developed by Supervised Life Styles) with real-time monitoring of the behavioral health status of participants. With this system the efficacy of interventions and services, including medications, behavior support plans, and contingency-based reinforcements, can be assessed both in the short term and over longer periods of time. The program places a heavy emphasis on educational opportunities, developing skills necessary for community living and a high quality of life, and decreasing dysfunctional behavior. The success of the program to date is evidenced by the fact that, although each of the persons admitted to the program would have required a hospital LOC had the program not been available, only two have required brief hospitalizations and none have required long-term hospitalization since their admission. Even more importantly, two are now at the point where they are almost ready to begin transitioning to a lower level of care, and each has been able to move forward in developing the skills and decision-making processes that will help to assure successful community living.

Gaps in Services and Infrastructure

Review of the status of behavioral health services for young adults in Connecticut reveals five (5) areas in which there are major gaps in the service delivery system or the infrastructure that supports the service delivery system.

1. As noted above, eight LMHAs (including at least one in every Region) have received no funding for the development of age and developmentally appropriate services for young adults. Each of those agencies does provide services for 100 or more persons in this age group, according to the CEOs or their designees, but with a few exceptions the services tend to be those that were developed for an older and more chronic population, and the intensity of the services does not meet the needs of many young adults, particularly those who are transitioning to adult services from DCF care.

There are two (2) primary consequences of this situation. First, the path of recovery for many young adults who are served in these agencies may be disrupted by barriers that exist almost solely due to lack of financial resources. The CEOs (or designees) of each of these agencies reported that the agency fully understands the need for age and developmentally appropriate services, provided by staff with training and expertise in assisting young adults, and that the agency would welcome the opportunity to develop such services to better meet the needs of its young adult clients. Without the funding to develop programs for young adults in every area of the state it seems likely that the long-term outcomes of treatment will be negatively affected, with consequent higher costs to the state over the course of time as recovery processes are disrupted or stalled. Secondly, the status quo ante places additional stresses on the YAS programs, as individuals
from outside the catchment areas of the YAS programs seek or are referred to such programs based on their need for higher LOCs or more intense services. It also creates disruptions in important relationships and geographical dislocations for persons who need to move to different areas of the state in order to access their needed services. This situation has reached a crisis point particularly with regard to referrals from DCF. Up until this point, YAS OOC staff have attempted to triage DCF referrals to existing YAS programs, even if the programs were not in the person’s area of origin. With all YAS programs being at or above capacity, such triage cannot continue to occur. This means that DCF referrals will *de facto* be involved in a two-tier system of adult services, with some having access to LOCs and higher intensity services based solely on the uneven assignment of funding to LMHAs. Along with the impact this may have on individuals, this will jeopardize the ability of DCF to meet one of the goals established in *Juan v. Rell* regarding the development of comprehensive, appropriate care continuation plans prior to a person leaving the DCF system of care.

2. There are serious disparities regarding funding to existing YAS programs, which also result in major gaps in services. As noted above, two YAS programs in Region II have been unable to establish higher LOCs (e.g., 24/7 transitional residential programs and intensive supported apartment programs) due to lack of funds. Another program in Region II lacks funding to develop the residential support capacity beyond a minimal level. In all of the programs, the high census and the number of persons transitioning into YAS programs have taxed the programs to the point that service components within particular LOCs are having to be cut back or curtailed altogether, staff are having to carry high case loads, program developments and enhancements cannot be implemented, and individual care may be jeopardized.

<table>
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<tr>
<th>Available LOCs</th>
<th>Inpatient</th>
<th>Specialized Residential</th>
<th>Group Home</th>
<th>Supported Apartment 24:7 Staff</th>
<th>Intensive ACT</th>
<th>ACT/Case Management</th>
<th>Total Clients</th>
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Table 4 provides information on the current distribution of YAS participants across various LOCs in all LMHAs with a YAS funded program, and on the optimum capacity within LOCs to meet the needs of current participants. (A more complete breakdown of these data for each YAS program can be found in Appendices 2 and 3.) As can be seen from the table, optimally YAS would be able to provide an additional 22 beds in Specialized Residential programs, an additional six beds in a Group Home setting, and an additional 73 beds at a Supported Apartment (24/7 staff availability) LOC. Seventy-four (74) persons
who received services at the Intensive ACT LOC and 18 who receive services at the ACT/Case Management LOC would then be able to move to more appropriate levels of care. Nine persons who are occupying hospital beds would be able to be discharged and served at appropriate LOCs in the community, thereby reducing the current state of gridlock.

Table 5 provides information regarding the anticipated need for beds at different LOCs by the end of SFY-07:

<table>
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<tr>
<th>Available LOCs</th>
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<th>Intensive ACT</th>
<th>ACT/Case Management</th>
<th>Total Persons</th>
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<td>38</td>
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<td>346</td>
<td>243</td>
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The estimated additional cost of providing the appropriate LOC for all participants in SFY-07 is approximately $26.6 million over the current YAS budget (see Appendix 2). Note that there should be no need for additional hospital beds and that some person (particularly those in a Supported Apartment LOC) would be able to move to lower (and less expensive) LOCs in this fiscal year if the full range of LOCs and the necessary capacity at each LOC were available.

3. Program development, training, and supervision must receive more attention in order to make YAS programs and services for young adults as efficient and as effective as possible. To date, each site has had its own internal program of staff training and each site has had the opportunity to send staff to statewide trainings on a variety of topics (e.g., PDD; trauma; psychosexual behavior problems; working with persons with behavioral dyscontrol). In addition, each site has implemented a program of supervision for all staff. However, the training programs are not uniform across all sites, different staff members have received different types and levels of training, and there has been no uniform structure to integrate training, consultation, and supervision. YAS OOC staff have provided a three-day didactic training for all YAS staff regarding the effects of neglect and abuse on the developmental path of children and adolescents, with the result that more than 300 staff that work in YAS programs have received this basic training. The feedback from participants of the training has been excellent. However, in order to move from the realm of education of staff to the realm of enhancing staff competencies, with the goal of being better able to assist young adults, additional measures are necessary.

² Because it is anticipated that hospital beds will be used primarily for YAS participants in crisis who will be discharged back to their community programs when they have stabilized, this number is not included in the total of 760 YAS participants.
YAS OOC staff have concluded that a model that integrates the overlapping spheres of training (the goal of which is information transfer), consultation (the goal of which is to promote the development of new or improved competencies that are based on increased knowledge), and supervision (the goal of which is to develop and promote the utilization of new or improved competencies and the continual “fine-tuning” of each competency to improve its quality) is essential for understanding and treating young adults with complex disorders who have suffered from the effects of traumatized development, neurocognitive and Pervasive Developmental Disorders, and other severe psychiatric illnesses.

The model of integrated training, consultation, and supervision (TCS) provides a structure for assessing the needs of staff in YAS and planning a coherent program to address those needs. If a staff member lacks knowledge, he/she should be afforded training and the early stages of consultation to develop the knowledge base and the competencies that emanate from that knowledge base. If a staff person has the information but does not know how to make use of it, she/he should be given consultation on developing and utilizing competencies, and the early stages of supervision to receive feedback on improving the quality of those competencies. If a staff person has knowledge and is using that knowledge in a competent way, he/she should continue to receive supervision focused on sustaining and improving the competencies.

Because knowledge never is static, integrated TCS implies that every staff person will move from one sphere to another repeatedly in each content area. Therefore, integrated TCS requires that staff competencies continually be monitored and that, as new knowledge or competencies are identified, the need for training, consultation, or supervision is recognized and addressed.

The major content areas of integrated TCS for YAS are informed by an understanding of who our service recipients are, what their major needs are, and the current state of “best practices” for meeting those needs. Our understanding of each of these will evolve over time. However, at present, YAS OOC staff have identified the need for additional efforts involving integrated TCS in the following five areas:

- Comprehensive, integrated assessment of YAS participants, with particular focus on the functional skills, strengths, and challenging or high-risk behaviors of each person.
- Understanding and working with those whose development during childhood and adolescence was affected by neglect, abuse, and other forms of trauma.
- Understanding and working with young adults with Pervasive Developmental Disorders (and those with similar presentations that are based on complex
neurodevelopmental issues) who exhibit high-risk behaviors or severe challenging behaviors.3

- Educational and employment planning and support.

4. Planning and developing services for individuals with developmental and neurocognitive disorders has not progressed beyond first steps. As noted above, there is a severe lack of capacity in the Specialized Residential LOC and Group Home LOC, which are the primary levels of care that meet the needs of individuals in these cohorts. There also is a lack of clinical expertise, both in the DMHAS system in general and in YAS, in assessing the complex biological, psychological, psychiatric, behavioral, and social strengths and disabilities of persons in these cohorts, and in developing positive, reward-based, person-centered programs for these young adults. Finally, it is very difficult to commit the necessary staff resources (particularly the number of staff needed for a fully developed support team and the number of hours required of each staff person) to ensure the full implementation of a positive behavior support plan.

5. Continue to develop the centralized YAS OOC Unit in order to meet the continually expanding tasks and responsibilities of the staff of that Unit. Each of the four areas delineated above depends on the work of the Unit for successful implementation. That work falls into three major areas: administration of the state-wide YAS program (including the identification of gaps in services and infrastructure needs, and developing the resources necessary to meet those needs; assisting the YAS programs in developing their program structure, human resource planning, and fiscal management; developing new or more effective partnerships with a wide range of stakeholders; and providing leadership in the ongoing development of clinical and support services); consultation and training for YAS staff (including both direct provision of consultation and training and developing additional resources to provide consultation and training); and eligibility determination and transition planning. Given the current level of staffing and the administrative structure of the Unit, staff within the Unit are unable to provide the level of attention in any of these areas that is necessary. Further expansion of the statewide YAS program, either in terms of additional individuals transitioning into existing programs or expansion of the number of program sites, is jeopardized if this area is not addressed.

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3 Although it is not a part of the mission of DMHAS to provide services for individuals with PDD, there currently are a large number of such individuals within the DMHAS system, both in YAS and in the population of older DMHAS clients. While awaiting resolution of the issue of which state agency should take on the responsibility of providing services for these clients, it is incumbent on DMHAS to develop the services and supports necessary for the effective treatment of those who already are DMHAS clients, and to provide training, consultation, and supervision for the staff who provide care.
CEO/Designee Reports on YAS Development and Needs

The informants who are acknowledged at the beginning of this report provided valuable information regarding the next stage of development of services for young adults across the state, and the needs that must be addressed in order for that development to occur. The following is a summary of that information, with emphasis on two foci: service needs and infrastructure issues.

Service Needs

1. Continue to develop a comprehensive system to assess the strengths and needs of young adults across a range of domains to ensure that transition planning and engagement in treatment are meeting the needs of individuals. Current and complete information in the domains of a person’s functional skills and adaptive functioning, personal interests, personal strengths, psychiatric history and current status, developmental history and disorders, history of trauma, family involvement, history of high-risk and challenging behaviors, neurocognitive status, medical history and current status, learning style and disabilities, employment readiness, social history and current interests, substance use and abuse, behavioral control, and educational status and interests is necessary to inform the planning that needs to occur before a young adult enters the system.

2. Develop a full continuum of Levels of Care that is accessible to young adults in each LMHA. At a minimum, YAS should increase capacity in Specialized Residential, Group Home, and Supported Apartment LOCs. There also is a need for increased capacity for short-term support for young adults in Respite programs. Developing this continuum actually would decrease the demand for inpatient beds by providing the necessary capacity in appropriate LOCs in the community, thereby relieving gridlock within the inpatient system and allowing inpatient units to focus on short-term treatment and stabilization of YAS participants.

3. Continue to develop a full continuum of recovery-based YAS programs at LMHAs that are trauma sensitive, phase-based, person-centered, and domain-driven. The informants listed the following domains as crucial to the recovery of young adults:
   - Complete and comprehensive individual assessments, with a focus on functional skill levels as well as clinical status.
   - Positive behavior support programs to address high-risk and challenging behaviors that will result either in psychiatric hospitalization or incarceration if not addressed.
   - Preparation and assistance that promotes independent or semi-independent employment readiness.
   - Community living skills development.
   - Access to appropriate educational opportunities.
   - Substance use education and abuse treatment.
   - Ongoing trauma treatment.
• Psychiatry services from psychiatrists who have training/experience in working with adolescents and young adults.
• Programs and support for young adults who are going to become or have become parents themselves.
• Peer support and mentoring.
• Crisis services to prevent hospitalization.

4. Develop statewide, highly structured Specialized Residential programs that have staff with expertise and training to provide services for young adults with particular behavioral needs, such as those with Pervasive Developmental Disorders and those with sexual behavior problems.

5. Streamline access to inpatient beds, and improve the capacity for individuals to move from one LOC to another as needs dictate.

Infrastructure Issues

1. Establish parity among the LMHAs in Connecticut in terms of funding to develop the infrastructure and service delivery system for young adults.
   • Ensure that funding is available to every LMHA for YAS programs.
   • Ensure that funding is based on a formula that includes the number of young adults served (regardless of the source of the referral for services) and the LOCs and programs required to meet the needs of the population.

2. Provide access to consultants with expertise in various areas pertaining to the young adult population to assist in the planning and development of service delivery systems.

3. Fund YAS programs in such a way that the following infrastructure resources are available:
   • Physical space for drop-in centers, social clubs, and other places where YAS participants can congregate.
   • Vans and automobiles, and program-funded drivers where necessary, to provide transportation for staff and YAS participants.
   • Transportation vouchers or other means to assist in accessing public transportation systems, where such exist.
   • Computer systems for staff documentation and other work, and computers for skills training classes for participants.
   • Clerical assistance.
   • Professional accountancy assistance to help maintain oversight of YAS program budget issues and to help teach money management skills to participants.
   • Maintenance staff that will clean and maintain the buildings and space occupied by the program and will work with participants on maintaining their living spaces and repairing damage.

4. Work with landlord associations, local Housing Bureaus, DSS, and other agencies to develop the stock of affordable housing for young adults in each area. Make rental assistance for young adults both universal and easily accessed.
5. Hire additional clinical staff at all levels in order to reduce case loads and provide
the intensity of therapeutic contact, engagement, relationship development,
treatment, and support that is necessary with the young adult population.
6. Develop statewide staff training programs with core curricula, standards for
knowledge acquisition, competency development, and ongoing supervision.
7. Evaluate and prepare for the impact that the current burgeoning population of
young adults will have on the DMHAS system as they “age out” of the YAS
programs into the adult outpatient programs.
8. Continue to work with other state agencies (including DCF, DMR, OPM, DSS,
and CSSD) to establish collaborative initiatives that will support the needs of
young adults.

Conclusions

In the past decade, the collaborative efforts of DMHAS, DCF, DMR, and OPM have
produced a service system for young adults that is nationally recognized as a model for
public behavioral health care and support for this age group.

However, fiscal and other resources for the YAS OOC Unit and YAS programs across
the state have not kept pace with the number of referrals, the growing participant
population, the increased demand for services, and the need for developing the
infrastructure that supports Young Adult Services, resulting in a situation that threatens to
dismantle the system of care.

In addition, almost half of the Local Mental Health Authorities in the state have received
no special funding for YAS programs and are unable to develop the kind of age and
developmentally appropriate LOCs and programs necessary to provide adequate support
and behavioral health interventions.

Remediation of this situation requires an infusion of funding for current YAS participants
in existing programs in the amount of $11.2 million, approximately $16 million to
develop YAS programs in those LMHAs that have not been funded to date, and an
additional increase in funding of approximately $26.6 million by the end of the fiscal
year.
### Census and Budget Figures - FY 2005-2006

<table>
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<tr>
<th>YAS Program Site</th>
<th>Inpatient</th>
<th>Specialized Residential</th>
<th>Group Home</th>
<th>Supported Apartment 24:7 Staff</th>
<th>Intensive ACT</th>
<th>ACT/Case Management</th>
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Current Projected Shortfall: $11,197,448
Appendix 2

Projected YAS Budget Shortfall for Persons Projected to be In Service At the End of SFY-07

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<tr>
<th>YAS Program Site</th>
<th>Inpatient</th>
<th>Specialized Residential</th>
<th>Group Home</th>
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Projected Shortfall: $26,608,118