STATE OF IDAHO

MENTAL HEALTH PLAN FOR CHILDREN AND ADULTS

FY 2004

Idaho Department of Health and Welfare

STATE OF IDAHO
MENTAL HEALTH SERVICES FOR CHILDREN AND ADULTS
FY 2004
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The Department's family-centered philosophy and resultant service organization are reflected at the regional level where children's mental health services are delivered through regional Children and Family Services offices together with child protective and adoption services. The structure of children's mental health services is such that there are few budget line items. Services are provided through a blending and pooling of child welfare and other funds to provide maximum flexibility from all funding sources.

Adult mental health services are provided through seven regional, state owned and operated community mental health centers (CMHC's). A close working relationship exists between the regional CMHC's and the two state psychiatric hospitals. The central office Mental Health and Substance Abuse program provides system coordination and leadership, technical assistance, training and consultation to support and expand an organized system of care that is consumer guided and community-based.

Beginning in July of 1996, each CMHC and Children and Family Services Program was designated as a *Regional Mental Health Authority* (RMHA) as part of the implementation of the Medicaid Rehabilitation Option by private providers. This option continues to afford private agencies the opportunity to provide psychiatric rehabilitation services through public/private partnerships with RMHA's. In these partnerships, private agencies provide direct psychiatric rehabilitation services while RMHA's perform managed care duties including service pre-authorization.

2. STATE DEMOGRAPHIC PROFILE

(a) Population Density:

Idaho is a predominantly rural state. The state population in 2000 was 1,293,953, and it is ranked 39th in the nation for population. It occupies a total land and water area of 83,574 square miles and is the thirteenth largest state in area. Idaho has a diverse geology and biology, containing large areas of alpine mountainous regions, vast desert plains, farmland valleys, and deep canyons and gorges. Many areas of the state have few roads. Some areas are vast wildernesses with *no* roads. Only five out of a total of 44 counties meet the criteria of a Metropolitan Statistical Area (MSA) as defined by the Federal Office of Management and Budget. The remaining 39 counties are classified as rural (at least 6 people per mile) or frontier (less than 6 people per square mile). Thirty-six percent of Idaho's population resides in these rural and frontier counties. Sixteen of Idaho's counties are considered frontier. These frontier areas comprise 59% of Idaho's total land area. Two thirds of Idaho's landmass consists of state and federal public lands.

The delivery of needed mental health services in such rural and frontier environments poses many challenges. Foremost among these are:

(1) Low population densities spread across immense geographic distances;

(2) Limited access to trained mental health and related professionals;

(e) Per Capita Spending
According to a study of FY1997 data (the latest year available) by the National Association of State Mental Health Program Directors- Research Institute (NASMHPD-RI), Idaho ranked 49th lowest nationally in overall public mental health services expenditures, and 47th lowest nationally on a per capita basis.

(f) Suicide Rates
Like all of the other Western States, Idaho ranks high in suicide rates. The most recent data available (1998) from the American Association of Suicidology (AAS) show that on a per capita basis Idaho ranked 8th highest nationally for completed suicides. Suicide is the 2nd leading cause of death in the 15-34 age group (Idaho Vital Statistics, 2001)

3. PUBLIC AND STAKEHOLDER PARTICIPATION

(a) Regional Mental Health Advisory Boards (RMHAB'S)

Idaho has a long history of citizen and stakeholder participation in the mental health system at the regional level. RMHAB's have been in active existence since the early 1970's (Idaho Code 39-3130) and continue to play an important role. For example, each RMHAB contributes to and monitors the State Plan, and an RMHAB member from each region has a permanent seat on the State Planning Council.

(b) State Planning Council on Mental Health

A single Council oversees the development of both P.L. 102-321 Adult and Children's Plans. The Council has the required membership with less than 50 % of the members being state employees and/or service providers (Appendix Q). Representatives from the areas of housing, law enforcement, education and vocational rehabilitation are also members. Both adult and children's mental health planning issues are addressed by the Council.

The State Planning Council on Mental Health prides itself on being very active and participatory. Consumers, family members, and advocates far outnumber state employees and providers in attendance at meetings. Council members are well informed on the issues facing the public mental health system. Council members and the two Bureaus (Bureau of Mental Health and Substance Abuse and the Bureau of Children and Family Services) have a long history of fostering a good working relationship characterized by mutual respect.

In 1999 the Planning Council established a new subcommittee, the Performance Indicators and Outcomes Committee. This decision reflects the increased importance the Council is placing on having quantitative data, including outcome data, on which to base their decisions and recommendations.

From a children's mental health perspective, the Council strives for participation from families and to identify family members from each region of the state. These are families of children with an SED who have received or are currently receiving services. The services do not necessarily need to be received from the Department of Health and Welfare. These family

(e) Idaho Federation of Families for Children's Mental Health

The Idaho Federation of Families for Children's Mental Health (Federation) is a chapter of the National Federation of Families. The Federation has played a significant role in the children's program over the last two years. The Federation is a member of the State Mental Health Planning Council, Idaho Council on Children's Mental Health and is a member of the Department's Children's Mental Health Subcommittee. All of these are policy and program development activities. In addition, the Federation has taken on the responsibility of identifying and recommending parent representatives for the State Planning Council on Mental Health, and participating on local councils when needed.

The Department has had a contract with the Federation to provide a statewide parent advocacy organization, parent participation and to develop a statewide network of family to family support. The Department is currently working on the finalization of a new contract with a family run organization. The current Federation Administrative Director is Marlyss Meyer. More information about the Idaho Federation for Children's Mental Health is available at: http://www.idffcmh.org

(f) Idaho Council on Children's Mental Health

The Governor established through Executive Order the Idaho Council on Children's Mental Health (ICCMH), (Appendix F). Lieutenant Governor Jim Risch chairs this cabinet level council with members from the Governor's Office, the judiciary, the legislature, the Directors of the Departments of Health and Welfare and Juvenile Corrections, the State Department of Education, the State Planning Council on Mental Health, a parent representative, a county commissioner and a provider of children's mental health services. This Council is responsible for overseeing a court-approved plan for implementing the recommendations of the 1999 Needs Assessment.

4. CURRENT PRIORITIES FOR THE ADULT SERVICE SYSTEM

The State Planning Council on Mental Health has established the following priorities for adult mental health:

? **Increased funding (linked to data and outcomes)**

Recommend submitting funding decision units to DHW Administration
Gather data to demonstrate service need
Get support from broad-based advocacy groups
Recognize that outcome measures are the most persuasive data

? **Fund development of data gathering and analysis systems**

? **Equitable access to care regardless of age, funding, geography**
Transition - child to adult
Transition - hospital to home (continuity of care)

? **Continue work toward full implementation of the Jeff D court ordered Plan.**

The State Planning Council considers this the top priority for Idaho's children's mental health system.

? **Transition of children from their current program to:**

- **adult mental health services**
- **juvenile and adult corrections**
- **educational, school-based program**
- **to or from more restrictive levels of care**

Transition from children's mental health services to adult mental health services continues to be an issue. It has been determined that approximately 2% of those children labeled SED will have continuity of services as they age into the adult system. The Department must continue with its plan to develop transition services for those youth who (1) need ongoing mental health services yet do not have a DSM IV diagnosis and (2) drop out of school at age sixteen and older, are still in need of mental health services yet do not have the school to help them coordinate services.

? **Enhanced community-based efforts at all levels within the community. Expand and refine collaboration, and remove barriers to coordination.**

statewide Interagency Council (ICCMH)
Regional and Local CMH councils
implementation of the recommendations addressed in the CMH Needs Assessment.

? **Increase services, increase continuous access to these services, and removal of barriers in rural areas of the state.**

? **Public education to promote awareness of mental health issues in general, access to services, available resources, knowledge of the Children's Mental Health Services Act, and recognition of a problem.**

? **Suicide prevention and education about causes suicide and at-risk populations.**

Idaho consistently ranks in the top five states for teen suicide. This alarming issue was identified as a major area of concern by the State Planning Council, participants in the Needs Assessment, school-based personnel, and the State Interagency Council. It is imperative that resources, methods, and curriculum be developed for and utilized by all child serving agencies, families and youth. A statewide suicide prevention plan is currently under construction and should be completed within the year.

? **Improve recruitment and retention of CMH professional.**

? **Continue agency/system change in philosophy and practice towards a system of care.**

under way in children's mental health. The ICCMH is functioning as the governance body for the Federal Cooperative Agreement for the development of systems of care for Idaho's children and families. The project will increase the amount of information and data regarding services provided and support training to optimize the function of Regional and Local Councils.

- We commend Mrs. Kempthorne for her ongoing support of the Red Flags Program, the Suicide Prevention Conference, the Real Choices anti-stigma campaign and the Respite Care Project. These programs have resulted in greater public awareness of mental health issues.

- We acknowledge the adjustment in the gravely disabled definitions within the Idaho Civil Commitment Code which paves the way for more timely treatment for persons with serious mental illnesses.

In addition to these significant accomplishments, we wish to acknowledge, on a state level, the following activities:

- Training for law enforcement regarding mental health issues.
- Telehealth activities that increase access to mental health services.
- Efforts by the Suicide Prevention Action Network and statewide community members to develop a statewide suicide prevention plan.
- The development of a mental health court in District VII.
- Reinstatement of some adult dental services in Medicaid.
- Availability of drug settlement funds to purchase high cost psychotropic medications for uninsured consumers.

CHALLENGES

Unfortunately, some of the notable accomplishments listed above pale in comparison to the many challenges Idaho continues to face. We are listing the most important challenges below in the hope that you will give the support of your office in addressing them:

- The population of the state continues to grow, yet resources for publicly funded mental health services have been reduced. Funding affects the amount of community based services and impacts at the personal level the individuals in need of recovery and treatment. We endorse full funding and staffing of Assertive Community Teams throughout the state as a method of reducing hospitalization and maintaining individuals in their communities.

- Quality assurance of publicly funded mental health services that includes knowledgeable, educated, involved consumers, provider participation, focus of services on recovery and outcomes and timely implementation of sanctions when needed is not yet in place in Idaho. We strongly recommend the direct involvement of family members and consumers in the development and monitoring of performance standards and service outcomes. More specifically, we recommend that an automated solution be developed to provide

us at our meetings. Our next meeting is scheduled for August 6-7, 2003, Boise Holiday Inn Airport.

Respectfully submitted,

STATE PLANNING COUNCIL ON MENTAL HEALTH

Rick Huber
Chair

dp

B. FUTURE VISION FOR THE MENTAL HEALTH SERVICE SYSTEM

The Idaho State Planning Council on Mental Health has established the following vision for our state's mental health system:

Idaho's public mental health system vision for service planning, development, and delivery is to promote a comprehensive, integrated, consumer and family-guided system of care. The system of care will (1) emphasize early intervention, (2) promote a normalized life, (3) cultivate natural supports, (4) encourage self-reliance, (5) enhance functional ability, and (6) recognize and support the diversity of individuals and families through:

- **IMPROVED ACCESS TO SERVICES**

Assuring consistency of services across regional boundaries

Facilitating access to services nearest a person's residence

Maintaining and expanding a continuum of care from most to least restrictive and across all ages (including 18-21 and 65 or older) and socioeconomic levels regardless of funding/resources.

Providing mental health services that focus on outreach, early detection and early intervention

Defining the roles of institutions, such as state hospitals, in a community-based system

Improving access to and availability of community-based crisis services

Addressing unique needs of rural communities for service delivery

Streamlining access to public mental health services

Facilitating information sharing between both internal and external stakeholders to coordinate and expedite service integration

↓ INCREASED RESOURCES

Pursuing increased public mental health system funding. (Current funding is insufficient for even basic core services.)

Exploring managed care initiatives, such as single stream funding and gatekeeping to extend limited resources

Augmenting the mental health provider network, including recruitment of mental health professionals in rural and frontier areas.

C. NEW DEVELOPMENTS AND ISSUES

1. State Economy and Budget Reductions.

Idaho, like much of the nation, suffered a lagging state economy and lower than expected state revenues during SFY 2002 and 2003. As a result, all state agencies were subject to a series of budget holdbacks totaling a cumulative 6% over the two years. The SFY 2004 budget did not include any increases for Division of Family and Community Services programs. These budget reductions are permanent, and cuts that have been made are not expected to be replaced in the future. Indeed, further cuts may be necessary.

2. Care Management for Adults with Developmental Disabilities

Health and Welfare is implementing a process called "care management" for adults with developmental disabilities. It is intended to provide Medicaid clients more choices in their care, provide them with quality services, and through this process, better control the state's growing Medicaid costs. Care management will allow for the delivery of better, more efficient, and cost-effective services to customers right in their communities. The plan consists of an independent assessment provider to identify needs and authorize services, a quality improvement plan to evaluate and improve the service delivery process and implementation of care management techniques to review how well services are actually delivered to our clients.

The Department conducted a pilot managed care program in Region 2 in SFY 2002, and is now moving ahead with implementation of a statewide program for adults with developmental disabilities. Implementation will require combining some Adult DD ACCESS Unit staff with Regional Medicaid Services staff, contracting with an independent assessment provider (IAP) and prior authorizing all adult DD services. The new business process is scheduled to begin in October 2003.

5. Children's Mental Health System of Care

In December of 1998, a contract was developed between the Department of Health and Welfare and the Human Service Collaborative to conduct a needs assessment of Idaho's children with serious emotional disturbance and their families. On June 29, 1999 the completed assessment was presented to the Department of Health and Welfare, the Idaho Federation of Families for Children's Mental Health, the State Department of Education, the Department of Juvenile Corrections, the Governor's office, and various service providers. Added to the Needs Assessment was a cover letter signed by each of the Directors of the above named agencies. This letter states the commitment of each of these agencies to build a collaborative entity that will fulfill the recommendations of the Needs Assessment on behalf of Idaho families and their children with an emotional, behavioral, or mental disorder.

A plan for implementing the 50 recommendations of the 1999 Needs Assessment was negotiated between the State and Plaintiff attorneys in the Jeff D. lawsuit. The plan was filed with the court on February 9, 2001. The Federal Court approved the plan on June 4, 2001. This plan has major implications for the mental health delivery system for children. It sets forth a framework for community collaboration and has implications for service delivery for the Department of Health and Welfare, Department of Juvenile Corrections and Department of Education. The plan has specific action items with associated implementation dates.

As part of the court approved plan, the Governor established through Executive Order, the Idaho Council on Children's Mental Health (ICCMH), (Appendix F). Lieutenant Governor Jim Risch chairs this cabinet level council. Some of the responsibilities of the ICCMH are to oversee the implementation of the plan and inter agency coordination.

Regional and Local Councils are being developed in the seven regions within the state. Councils will be comprised of child serving agencies, providers and parents. These councils will assist in the development and delivery of coordinated, community-based services. The Regional Councils will report to the ICCMH on services, outcomes and service gaps.

The ICCMH is guiding the Department's implementation of the court-approved plan. The council provides a structured method for implementation and completion of the action items in the plan. The ultimate outcome of the plan will be the development of a coordinated community based system of care for publicly funded children's mental health services. The plan has specific action items with associated timelines for completion. The majority of the action items have been implemented as of the writing of this plan. These action items are consistent with the Block Grant Criterion and will form the basis of the objectives for the next year.

The Governor requested additional funding and personnel for children's mental health in two of the last three years. In 2001 the Legislature approved the governor's request and added another 15 staff and nearly $3.2 million in the Children and Family Services budget for children's mental health services and in the 2002 session the legislature approved funds for 10 new children's mental health positions and additional children's mental health services.

SECTION II

STATE MENTAL HEALTH PLANS

FISCAL PLANNING ASSUMPTIONS

For planning purposes, the State of Idaho is assuming a Federal Community Mental Health Block Grant (CMHBG) allocation of $1,801,576 in FY 2004. A summary of Federal CMHBG funding for the period 1999 – 2004 is detailed below.

Community Mental Health Program
History of Mental Health Block Grant

	Actual 1999	**Actual 2000***	**Actual 2001**	**Actual 2002**	**Actual 2003**	*Projected 2004*
Adult	830,684	902,534	879,648	923,947	923,947	923,947
Children's	186,636	99,384	107,086	112,298	112,298	112,298
Admin.	53,543	68,943	84,127	86,733	86,733	86,733
00 New Award $ (Adult Special Project)		154,000	154,000	154,000	154,000	154,000
00 New Award $ (Children's Special Project)		154,000	154,000	154,000	154,000	154,000
01 New Award $ (Adult Special Project)			253,677	253,677	253,677	253,677
01 New Award $ (Children's Special Project)			50,000	50,000	50,000	50,000
02 New Award $ (Adult Special Project)				45,638	45,638	45,638
02 New Award $ (Children's Special Project)				5,369	5,369	5,369
02 New Award $ (Admin.)				2,684	2,684	2,684
03 New Award $ (Adult)					12,568	12,568
03 New Award $ (Admin.)					662	662
Total Award	1,070,863	1,378,861	1,682,538	1,788,346	1,801,576	1,801,576

* Includes indirect support, regional support, and FACS Div.

The Department, through the Division of Family and Community Services' Children and Family Services program, provides children's mental health services through seven regional service centers. Appendix B shows the seven regions and service office locations throughout the state. A variety of Children and Family Services (CFS) employees staff these regional field offices. Appendix H shows the distribution of CFS mental health clinicians available to children and their families. This network of field offices extends into all counties providing at least minimum access to departmental services across the state.

The State of Idaho is developing, implementing, promoting and evaluating an integrated system of care that is community-based and family focused for children with SED. Improving care requires Building on Each Other's Strengths. Idaho is combining family members, communities, and public agencies into lasting partnerships for care. Building on Each Other's Strengths is just beginning. Governor Kempthorne established the Idaho Council on Children's Mental Health (ICCMH) in 2001. The ICCMH is charged with the transformation of separate child serving agencies into a collaborative system of care. Under charter from the ICCMH, local community based councils join with civic leaders in each of the State's seven regions as regional councils. The regional councils provide resources, administrative oversight, and a communications link between the ICCMH and local community- based councils. The local councils provide comprehensive assessment, individualized service planning, and review for children with SED at high risk of out-of home placement.

- MENTAL HEALTH SERVICES

The system of care for children and youth with serious emotional disturbance encompasses those services provided through the Department of Health and Welfare and services provided by other public agencies, non-profit agencies and the private service sector. Appendix I illustrates the variety and scope of mental health related treatment facilities/programs throughout the state, including private sector treatment resources.

Private providers of mental health services exist throughout the state. Private provider services range from outpatient clinic services and psychosocial rehabilitation services to residential and inpatient care. Services may be paid through Medicaid, private insurance, self-pay, and contracts. Comprehensive services exist within the state, but not in all areas of the state or in sufficient quantity.

The Department has developed service definitions and measures for the following services within the comprehensive system of care (Appendix G):

- Assessment
- Case management
- Respite Care
- Family Support
- Therapeutic foster care
- Crisis response
- School Mental Health Services
- Outpatient treatment

- REHABILITATION SERVICES

In 1997, Idaho implemented the Rehabilitation Option as part of its Medicaid Plan. The intent of Idaho's Rehabilitation Option is to provide community-based services to children with serious emotional disturbance and to adults with serious and persistent mental illness. The SED definition used to determine Rehabilitation Option service eligibility is consistent with the federal definition pursuant to section 1913 (c) of the Public Health Service Act as amended by Public Law 102-321.

One key feature of Idaho's Rehabilitation Option is the recognition that Medicaid Rehabilitation Option funding is a public resource and should be expended on that population for which the public has service responsibility, the child with a serious emotional disturbance. The Rehabilitation Option is a vehicle through which public Medicaid resources can flow to the private sector enabling them to assist in serving the target population. The Regional Mental Health Authorities (RMHA), through their service provider system, accomplishes this. Each RMHA continues to build provider networks by forming public-private partnerships with providers who want to access Medicaid funds under the Rehabilitation Option. Interested providers negotiate and sign provider agreements with their RMHA. It is important to note that not all children are Medicaid eligible and therefore, the Department provides these same services through other funding sources to ensure equal access.

- EMPLOYMENT SERVICES

Employment services and transition services are a major responsibility of the State Department of Education (SDE). SDE was recently awarded a federal grant to improve secondary transition services by increasing the ability to gather data regarding performance indicators of post secondary school students. Additionally, the Department of Health and Welfare has in place a requirement of transition planning for any child receiving services by their 16th birthday. This includes both transition to adult mental health services and transition to adulthood and employment.

Youth in transition additionally have access to vocational rehabilitation services through Idaho Vocational Rehabilitation (IVR). This is accessed through their school or through direct referrals. IVR has its own eligibility criteria for services. Children that have been in placement for 90 consecutive days through a voluntary placement agreement also have access to Independent Living funds.

- HOUSING SERVICES

Idaho Code identifies services to children and youth as only being delivered to children whose parents have provided informed consent to the services. Typically the parents of the child have the responsibility to provide housing to children receiving community based services. However, every child whose parents have provided informed consent and apply for CMH service, receives a comprehensive assessment. The child's clinical case manager has a responsibility to assist the family in finding appropriate housing to care for their family needs.

More children would be served in schools with the development of more local resources. The Bureau of Special Education of the State Department of Education utilizes an advisory board, called the Special Education Advisory Committee, to provide guidance to education professionals as they work towards meeting the requirements of the No Child Left Behind Act.

School mental health services to students with SED are delivered through a partnership between local school districts and the Department of Health and Welfare. These services range from school companion services to intensive day treatment services. The State Department of Education and the Department of Health and Welfare have collaborated to create Student Support Standards that can be used to ensure that children with emotional and behavioral disturbance have the necessary supports to allow them academic success.

- SUBSTANCE ABUSE SERVICES

The Department's Substance Abuse services are delivered by contractors located across the state and range from preventative services to outpatient and intensive inpatient services. The following are the guiding principles expected of each substance abuse treatment provider.

- Are based on consumer needs;
- Involve communities in program development and oversight;
- Have measurable outcomes;
- Provide easy access and facilitate smooth transitions from service to service and provider to provider;
- Provide for a full continuum of services;
- Are managed by leaders who create a culture of quality, effectiveness and efficiency;
- Are staffed by qualified people committed to providing quality services in the most cost-effective and efficient manner possible; and
- Have fair and objective systems to manage consumer complaints and concerns and assess responsibility for those problems and concerns.

The Department maintains one statewide contract for substance abuse services with Business Psychology Associates (BPA). BPA then subcontracts in each region for individual services providers. Outpatient and inpatient services are available to every region in the state, but not necessarily located in every region of the state. Youth 15 years and under are required to have parental consent for services, while 16 and older can access services without parental consent.

- CASE MANAGEMENT SERVICES

Stroul and Friedman (1986) refer to case management as the "back bone of the system of care" and as the cohesive element that holds the system of care together. Case management plays a key role in the coordination of services to children and families in the system of care. The children and families encountering the Department demonstrate a multiplicity of needs. These multiple needs, in turn, result in multiple service/agency involvement. Since no one type of service or program element is sufficient to meet all needs of the child and family, case management is essential and includes several functions:

The ability of a system of care to reduce restrictive inpatient placements is dependent upon that system's ability to provide alternative intensive community-based services. One strategy that the Division employs to help expand community-based service and reduce inpatient placements is to continue channeling financial resources from traditional out-of-home contracts to community-based contract services. Current efforts by the Department, the ICCMH and local councils will be strengthening community-based services.

The Children's Mental Health Services Act provides guidelines for accessing community-based services. The Act, in the purpose and legislative intent language, emphasizes that the mental health system be community-based. The law requires that services occur when the child is in the home whenever possible. It limits out-of-home placement to circumstances in which safety may be jeopardized or there is risk of substantial mental or physical deterioration without treatment out of the home. The law also prescribes guidelines for least restrictive treatment principles and safeguards and review processes to determine the necessity for initial and continued out-of home care. The continued expectation is that this comprehensive Act, passed in 1997, will be fully implemented.

In 1998, the Department instituted Medicaid Reform for children by allowing Medicaid payments for services in all licensed inpatient psychiatric hospitals. Previously, only psychiatric units attached to general medical and surgical centers could receive Medicaid reimbursement. Services in "free standing" psychiatric facilities or Institutes for Mental Disease (IMD's) were not Medicaid-reimbursable. Often the lack of available local acute intensive services in the community has contributed to a commitment and placement in the state hospital facility -- a facility often located hundreds of miles from the youth's home. In some instances, it has been necessary to make a voluntary inpatient placement away from the child's home and community. In rare cases, placement has been made out of state in a Medicaid-reimbursable unit. By making, all inpatient psychiatric hospital services Medicaid reimbursable, more children and youth have access to shorter-term, acute inpatient services closer to their homes and families. This feature of the state's Medicaid plan fills a gap in several local systems of care by providing emergency stabilization and averting penetration into "deeper end" levels of care. Implementation of a prior authorization and concurrent review process ensures there is a need for all admissions and continued stays.

The Division is committed to reduction of out-of-home placements while taking into account issues of risk/safety. Children are placed outside the home only when necessary as indicated by risk factors and/or the inability of the community-based service system to provide adequate services to assure safety. The Division uses regional placement review teams including the child and their parent(s)/guardian(s) as a mechanism for quality assurance, placement gate keeping, and intensive screening. All out-of-home placements (except for traditional foster care services) are reviewed to ensure that (a) out-of-home services are needed and (b) reasonable efforts have been made to prevent such placement. Following placement, a review process is used which focuses on (1) progress towards goal attainment while tracking determined measurable outcomes, (2) further planning (3) continued need for placement services, and (4) planning toward return to home or other less restrictive care. It is expected that this review process, as well as all treatment and transition plans, be done in conjunction with the child and his/her

Criterion:	**Comprehensive community based mental health services.**
Brief Name:	Family satisfaction
Indicators:	? Percent of reporting families who rate access to services positively. ? Percent of reporting families who rate appropriateness of services positively. ? Percent of reporting families who rate involvement in service decision making positively. ? Percent of reporting families who rate effectiveness of services positively.
Measure:	
Numerator	Number of families reporting positively for each indicator.
Denominator	Total number of families reporting.
Sources of Information:	Family satisfaction surveys received and database used to record responses.
Special Issues:	Families will be given the opportunity to fill out a family satisfaction survey every 120 days and upon completion of services. Only those surveys returned will be recorded in the database. Of the 2282 families receiving ongoing services, 639 or 28% have responded to the survey. The input will provide the baseline of service satisfaction for which quality improvement will be measured in the coming years.
Significance:	Parental input is essential to the development, design and improvement of a comprehensive system of care. This objective relates to the State Planning Council's CMH priority: *Continue work towards full implementation of the Jeff D court ordered plan.*

	FY 2002 Actual	**FY 2003 Projected**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: 1. Percent of reporting families who rate access to service positively. 2. Percent of reporting families who rate appropriateness of services positively. 3. Percent of reporting families who rate involvement in service decision making positively. 4. Percent of reporting families who rate effectiveness of services positively.	93.1 % 97.3 % 93.8 % 97.2 %			
Value:				
Numerator: Number of families reporting positively for each				

Performance Indicator: 1. Number of local councils established	7		30	
Value: Number of local council agreements that meet the standards established by ICCMH and the geographic area covered.	7		30	
Numerator: **Denominator:**	_____ _____	_____ _____	_____ _____	_____ _____

Objective 1.3 **The Department will implement a system of evaluating outcomes for youth served by Children and Family Services. The outcomes will be measured using the Child and Adolescent Functional Assessment Scale (CAFAS).**

Population:	Children with SED
Criterion:	Comprehensive community based mental health services
Brief Name:	CAFAS outcome data
Indicators:	Percent of children with a positive change in the CAFAS score over time. The CAFAS score will serve as the basis for determining functional impairment for this indicator. A CAFAS will be recorded upon initiation of services, at 120 day intervals and upon completion of services.
Measure:	
Numerator	Number of children receiving services with an improved CAFAS score.
Denominator	Total number of children receiving an initial CAFAS and an additional CAFAS following services.
Sources of Information:	Database used to record CAFAS scores.
Special Issues:	CAFAS is a method to measure a child's overall functional impairment. While the overall score may improve, a child may still experience difficulties in specific functional areas. Families and children may drop out of services prior to 120 days making a second CAFAS score difficult to accomplish.
Significance:	Improved functioning demonstrates the effectiveness of service interventions and leads to successful community integration of children with SED. This objective relates to the State Planning Council's CMH priority: *Continue work towards full implementation of the Jeff D court ordered plan.*

	time will indicate service enhancement.
Significance:	An array of community based services is essential for a comprehensive system of care to serve children with SED and their families. This objective relates to the State Planning Council's CMH priority: *Continue work towards full implementation of the Jeff D court ordered plan.*

	FY 2002 Actual	**FY 2003 Projection**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: Number of children with SED who receive a specific community based service. The Department will establish a method for tracking and reporting utilization of an array of community based services.	See Below			
Value: Number of children receiving the specific service within the year. Assessment: Outpatient Services: School Mental Health: Respite Care: Therapeutic Foster Care: Case Management Services: Family Support Services: Crisis Response Services: Residential Treatment Services:	 1802 1714 1059 53 42 2282 149 295 120			
Numerator: **Denominator:**	_____ _____	_____ _____	_____ _____	_____ _____

includes, as one element of its SED definition, that the disorder "requires sustained treatment interventions" (Idaho Code, Title 16, Chapter 24, sections 2403).

The estimated number of children under 18 years with an SED in Idaho is 18,452.1 (see table below). This estimate is based on the 2000 census data and uses a conservative estimate of 5.0% of Idaho's children under the age of 18 years.

Projected Population of Children with Serious Emotional Disturbance
By DHW Region, FY2004

	Regions							
	I	**II**	**III**	**IV**	**V**	**VI**	**VII**	**TOTAL**
2000 Estimated 0 to 17 Population (2000 Census Data)	47,405	22,853	58,196	93,799	47,619	48,362	50,796	**369,030**
Estimated 0 to 17 Population with Serious Emotional Disturbance (5%)	2,370.7	1,142.7	2,909.8	4,690	2,381	2,418.1	2,539.8	**18,452.1**

The public mental health system's capacity and resources are limited. Some children with emotional disturbance will receive services from the private service sector. Others will receive services from the education system, the five Idaho Tribes, and from the juvenile corrections system. Most agree the public sector's legitimate role in mental health service delivery is limited to the most seriously mentally ill.

Because of the service system's limited capacity, the target population (18,452) must be differentiated from the state's service goal -- those children who actually will receive public services. The target population (18,452) is the "pool" of youth estimated to have a serious emotional disorder with extreme impairment from which those receiving services will originate. It is estimated that 40% will need publicly funded mental health services and therefore, Idaho's service goal is 40% of the target population or 7,381 children and youth. This number is Idaho's target planning goal that, in turn, will drive public service system capacity development. This service goal includes children and youth with serious emotional disturbance served by Medicaid and/or the Mental Health Authority.

For purposes of service prioritization, a serious disorder is operationalized in order of priority:

I. The child is an imminent danger (risk to safety) to self or others (suicide/homicide) due to a substantial disorder of thought, mood or perception. This additionally includes the child who evidences an inability to meet basic needs for safety or evidences gross

capacity to include dually diagnosed. Additionally, Medicaid and Family and Community services working together have developed an intensive community-based service called Intensive Behavioral Interventions (IBI). IBI is designed to provide skill-based rehabilitative type services to children/youth that have a developmental disorder and for the dually diagnosed. See Criterion 1 for information on services to children with co-existing substance abuse and serious emotional disturbance.

4. ETHNIC AND MINORITY POPULATIONS

Idaho is predominately a Caucasian state. According to Year 2000 census data, 91% of Idaho's population is white. The racial composition of the remaining 9% of Idaho's population is as follows:

AFRICAN AMERICAN	NATIVE AMERICAN	ASIAN/ PACIFIC ISLANDER	LATINO/ HISPANIC
0.4%	1%	1%	7.6%

Idaho's largest ethnic minority, representing 7.6% of the state's total population, is of Hispanic heritage. Region III and V especially have large concentrations of people who are Hispanic. (Appendix D)

Given that only 9% of the population is non-Caucasian, the system tends to be ethnocentric. This results in a general lack of development of services that are relevant to any group other than the dominant culture.

Planning for mental health services must more fully address access to culturally relevant services for this minority population. The Children and Family Services program has an Indian Child Welfare Program Specialist. Seventy-five percent of this permanent FTE position is allocated to network and coordinate activities with the six Idaho tribes to enhance Indian Child Welfare services (Appendix E). The Children and Family Services program has ongoing networking activities with the six Idaho Indian tribes through the Idaho State and Indian Tribal Child Welfare Committee that meets quarterly. Additionally, the Department continues to allocate $200,000 in Social Service Block Grant funds to the six Idaho tribes for the enhancement of tribal child welfare services.

In 2002, Idaho was awarded a Community System of Care Cooperative Agreement from SAMHSA, which Idaho titled "Building on Each Others Strengths." The primary purpose of Idaho's use of this Cooperative Agreement is the building of an infrastructure for Idaho's ongoing effort to build a System of Care. A major objective of Building on Each Other's Strengths is the development of a culturally competent system of care. Idaho is currently working on a technical assistance plan that has established cultural competence as a priority. Idaho has recently amended the Governor's Executive Order to include a tribal representative and a member from the Hispanic community.

	serious emotional disorder receiving services in the private sector not utilizing public resources.
Significance:	Service capacity should increase over time with the development of more community based services. Increased capacity allows for more children to be served. Measurement of capacity and services is essential to the development of an adequate system of care to meet the needs of youth with SED and their families. This objective relates to the State Planning Council's CMH priority: *Increase services, increase continuous access to these services, and removal of barriers in rural areas of the state.*

	FY 2002 Actual	**FY 2003 Projection**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: 1. Percentage of the total population of children with that receive publicly funded mental health services.	63.3 %		66.5 %	
Value:				
Numerator: Number of children receiving services utilizing public monies for the year.	_11,687__	_____	_12,271__	_____
Denominator: The number of youth estimated to have a serious emotional disorder using prevalence figures this past year.	_18,452__	_____	_18,452__	_____

Objective 2.2 **Maintain local agreements or contracts to facilitate special population access to services.**

Population:	Children with SED.
Criterion:	Prevalence and number served
Brief Name:	Special Populations Served
Indicators:	Number of agreements or contracts.
Measure:	Number of agreements or contracts.
Numerator	
Denominator	
Sources of Information:	Regional Program Managers or contract officers
Special Issues:	Culturally relevant access to and delivery of services is necessary to increase services to special populations. Having contractors or state staff able to provide this is challenging given Idaho's demographic

total system of care. That model is function-specific rather than agency-specific and includes the following dimensions:

1. Mental health services
2. Social services
3. Educational services
4. Health services
5. Vocational services
6. Recreational services
7. Family Support services

Idaho's system of care model views these same dimensions, in addition to family organizations, juvenile corrections and substance abuse, as the important service components comprising a system of care. Idaho has organized its service delivery model according to the philosophy of integrated services. Children with serious emotional disturbance have multiple service needs. Their multiple needs cross traditional agency boundaries. Because of cross-agency involvement, coordination of services is a major issue for the family who has a child with a serious emotional disorder. Without such coordination, the potential for fragmentation of services is great. This occurs as gaps form between the boundaries of the separate programs. Families fall through these service gaps unless special bridges are formed to join the service functions. The integrated service model is an attempt to reduce the separation and resultant fragmentation between the services. Case management is the mechanism for coordinating and integrating the various services and service providers.

Since most service functions are provided by different child-serving agencies, both public and private, the Department seeks to develop interdepartmental agreements that provide for jointly operated and funded mental health services. The Department of Health and Welfare has developed, with the State Department of Education, the Department of Juvenile Corrections and the Department of Correction a Children's Mental Health Interagency Agreement. The purpose of this agreement is to foster collaboration in planning, developing and providing services to children whom are eligible for mental health services and to clarify financial responsibilities and develop methods to collaboratively use existing resources. The goal is to provide services that meet the child's need in the least restrictive setting without compromising the safety of the family or community.

In the current Children and Family Services program, within the Division of Family and Community Services, children's mental health is integrated with child protective services, adoption/foster care services, Indian Child Welfare, and other child welfare functions. Within these programs, unlike more traditional programs, there are few boundaries and little separation of programs. Integration of services for children involved in the child protection system and who present with serious emotional disturbance can more easily occur.

The Rehabilitation Option represents a first step in the establishment of a single, fixed point of responsibility for client care and treatment for all Medicaid clients receiving services under the Rehabilitation Option. This function resides in the Regional Mental Health Authority (RMHA). The RMHA's ensure an integrated and coordinated service system for children with serious emotional disturbance through their ability to form public-private partnerships with multiple Medicaid service providers. Additionally, the RMHA's have the role of 1) assessing and

- Developmental Disabilities
- Infant and Toddler Program
- Child Welfare
- Children's Mental Health

2. REGIONAL AND LOCAL COUNCIL DEVELOPMENT

The 1999 Needs Assessment of Idaho's Children's Mental Health System recommended the development of local children's mental health councils to bring the system of care to the local level. In order to achieve this, Idaho Governor Dirk Kempthorne created through executive order (see Appendix F for Executive Order and membership list) the Idaho Council on Children Mental Health (ICCMH). The ICCMH provides for interagency collaboration at the state level and interagency collaboration through the development of Regional and Local councils.

Regional children's metal health councils are administrative in function and mirror the ICCMH in membership on a regional and local basis. Regional councils are responsible for reporting to the ICCMH on common data elements, fiscal management of local councils, monitoring local councils, assessing and identifying gaps and system planning/development. Local children's mental health councils are currently under development. There will not be any restriction on the number of local councils that are developed, assuming they meet the requirements for membership. At the time of this report there are approximately 30 local councils under development. Local councils will serve children with serious emotional disturbance that impact multiple children serving systems. Local councils will serve many purposes, but primary duties include staffing and case planning for children and families as well as serving as the local locus of collaboration. Membership on the regional and local councils may include Health and Welfare, education, juvenile probation, Juvenile Corrections, parents, parent advocates, private providers, and other interested community members. The ICCMH has developed the standards for regional and local councils. The ICCMH has the responsibility to charter the regional councils (which has been completed), and the regional councils charter the local councils (which is taking place at the time of this plan). The ICCMH will also lead the effort in the development of an annual children's mental health community report card that will make the data on gaps in service, utilization of services and may include indicators on performance, available to stakeholders and the community. The first draft of the Community Report Card was completed in December of 2002 and was distributed to the Governor, the Legislative and other stakeholders of the system of care.

3. Building on Each Other's Strengths: Cooperative Agreement with SAMHSA

As previously mentioned, Idaho has been awarded a Cooperative Agreement from SAMHSA for building community based systems of care. Idaho has titled the Cooperative Agreement project "Building on Each Other's Strengths." Idaho has determined that the best use of the Cooperative Agreement funds is towards building a system of care for the entire state, not a single community, county or region. The funds will be used to build the infrastructure for a statewide system of care, but will not be used to temporarily inflate services offered by the system. A priority of the project is to create a single vision around children's mental health, including: the need of the system to be child-centered and family-focused, to ensure that providers that serve

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 1. Percentage of children receiving services from the Department that were staffed at a Local Children's Mental Health Council.	2 %			
Value:				
Numerator: Number of children for whom a local council held a staffing. **Denominator:** Total number of children served by CFS.	___94____ __3870___	_____ _____	_____ _____	_____ _____

CRITERION 4

TARGETED SERVICES TO HOMELESS AND RURAL POPULATIONS: The plan provides for the establishment and implementation of a program of outreach to and services for individuals with SMI or SED who are homeless; and additionally describes the manner in which mental health services will be provided to individuals residing in rural areas (previously Criteria 8 and 10).

A. NARRATIVE

1. SERVICES FOR HOMELESS RUNAWAY YOUTH

A survey of Idaho's primary homeless and runaway youth programs identified the following as the major mental health needs of runaway and homeless youth:

- Family conflict situations;
- Depression;
- Suicide ideation;
- Substance abuse; and
- Trauma associated with history of physical and/or sexual abuse.

Children who are homeless and youth with serious emotional disturbance comprise two broad groups: (1) those who have no family, including runaways or those discarded from their families; and (2) those youth that have families but whose parents are themselves homeless.

d. Community Action Program (CAP) offices exist throughout the state in all seven Health and Welfare regions. The State Economic Opportunity Office allocates federally derived funds to each CAP for identified homeless clients.

e. Community-based hospital emergency rooms are a frequent point of access for crisis services for the homeless youth and his/her family. The public emergency mental health system, Children and Family Services, networks and links with this hospital resource. Community hospitals work in conjunction with their local Children and Family Services' office to provide mental health services when they have identified homeless youth with mental health needs.

f. County Social Services refer identified homeless clients to their local regional Children and Family Services' offices for children's mental health services.

g. The Department of Health and Welfare has statutory responsibility to provide child protective services for the state. As previously mentioned, the Department delivers child protective services through the Children and Family Services Program, the program that also delivers children's mental health services. When a child protective services worker identifies a homeless youth with mental health needs, mental health services are offered within the same program.

The Department of Health and Welfare co-locates eligibility offices with its regional Children and Family Services offices in all regions of the state. When families apply for services and assistance for their family/children and it is determined that they are homeless and that a child in the family has a mental health need, a referral for child mental health services is made in-house.

h. Churches may identify homeless families who have children experiencing mental health difficulties. Church authorities know how to refer and access their local Children and Family Services' office for screening and service need.

i. Community House Program

In Boise, all the major community agencies serving the needs of the homeless population have formed The Homeless Coalition. The Department of Health and Welfare, through its Region IV service center, has been an essential member of this group. This lead group helped to create Community House. Community House is designed to be the central access point for homeless families in the Treasure Valley and provides a full service program. Community House offers shelter to homeless families as well as having on site treatment and case management is provided as part of the program. Case managers help coordinate and access other identified services as part of a client's plan. The services may include job training, childcare, social services, mental health services, and medical services to homeless families. With the development of Community House, services for the homeless population are more easily accessed. Community House is an example of a locally based partnership that is funded by a blending of private and public resources. Included are on-site mental health screenings for clients in the shelter and availability of mental health services as indicated by the screening.

j. Region III contracts with the Idaho Commission on Hispanic Affairs to provide information and assistance to Hispanic families about accessing services provided though the

B. GOALS, OBJECTIVES, PERFORMANCE INDICATORS

GOAL #4: **ENSURE THAT FAMILIES RESIDING IN RURAL AREAS HAVE ACCESS TO SERVICES FOR THEIR CHILDREN WITH A SERIOUS EMOTIONAL DISTURBANCE.**

Objective 4.1 **Twenty five percent of children served by Department programs are from rural areas.**

Population:	Children with SED
Criterion:	Services to rural and homeless populations
Brief Name:	Services to rural and homeless populations
Indicators:	The percentage of children receiving publicly funded services that reside in rural areas. The number of children served in a rural service area is defined as those children served from counties and field offices other than the county in which the primary regional service center is located. This is determined by factoring out from the total of children served within the system, the number of children served in Idaho's seven most populated counties: Kootenai, Nez Perce, Canyon, Ada, Twin Falls, Bannock, and Bonneville.
Measure:	
Numerator	The number of children/youth served from rural areas.
Denominator	The total number of children/youth served across all counties/field offices.
Sources of Information:	Divisional information systems and Medicaid database.
Special Issues:	The figures reflecting numbers of children served represent both those youth receiving community-based services through DHW's regional programs and youth receiving Medicaid-funded services through the private provider service sector. Children receiving PSR services are SED. The percentage youth included in the above figures who are served by Medicaid clinic option in the private sector and who meet serious emotional disorder eligibility criteria are not known. The most that the Medicaid data system can provide is a diagnosis, and diagnosis alone is not sufficient to determine serious emotional disorder.
Significance:	Idaho is a very rural state. A large percentage of Idaho citizens reside in rural areas. It is important for citizens that they have access to services in rural areas. Rural service delivery is a requirement of federal law if states are to receive federal block grant monies. This objective relates to the State Planning Council's CMH priority: *Increasing services, increase continuous access to these services and removal of barriers in rural areas of the state.*

1. FINANCING AND RESOURCE SUPPORT

Current efforts to provide children's mental health services are fiscally integrated with other FACS programming. Whenever feasible, non-dedicated funds are pooled. The resulting social service cost pool is used to fund a variety of needed services, including children's mental health services. Within the FACS budget, there are few line items specific to children's mental health. Consequently, it is exceedingly difficult to identify and track funds specifically targeted at children and adolescents with serious emotional disorders and their families. In the Department's present configuration, the target population can be served by entering the system through several referral pathways. Therefore, children who meet the target population definition can receive services that focus on their needs and the needs of their family. Providing services in this way enables a more flexible use of available funding, reducing gaps and overlaps in the process and providing the opportunity to serve more of Idaho's population in need of service.

The Division has received annual legislative funding of $6,757,100 in general funds, as dictated by the Jeff D. lawsuit settlement. These funds are specifically intended for development of community-based services for children and youth with serious emotional disorders. The Division's total projected funding for children's services programs for SFY2004 is $54,531,600. This amount can be broken down into funding sources as follows:

Social Services Block	$ 5,471,700
State General Funds	$21,097,300
Receipts	$ 556,500
IV-B CWS (Child Welfare Services)	$ 1,764,720
IV-E Funds (Foster care)	$ 5,215,300
IV-E Adoption	$ 2,219,400
TANF/Emergency Assistance	$11,944,700
MH Block Grant (10%)	$ 321,667
Child Abuse Prevention (NCCAN)	$ 13,500
IV-B Promoting Safe & Stable Families	$ 1,108,900
Independent Living	$ 561,200
Children's Justice Act	$ 83,500
Children's Mental Health Initiative	$ 972,200
Miscellaneous	$ 3,201,013
Total	$54,531,600

This level of funding provides for personnel, operating, and other expenses to support residential care systems, foster care services, and community-based services by the Department. The above information does not include the budgetary expenditures of the State Hospital South Adolescent Unit, which is an additional $2,408,300.

The estimate of the amount of funds to be spent on children's clinical services (including direct charged Jeff D. and Trustee/Benefits) in SFY2004 is as follows:

- The previously mentioned Building on Each Other's Strengths cooperative agreement provides Idaho with an opportunity to receive technical assistance from nationally recognized experts in a variety of areas including cooperative service planning, cultural competence, family-centered practice, etc.
- Individuals from the Department, the State Planning Council on Mental Health, and NAMI have provided training to the police academy on issues that pertain to mental health law and respective treatment of individuals with mental illness among others.
- Private providers of mental health services were provided training on assessment and services planning and trained on the CAFAS in every region of the state.
- Training has been delivered to emergency mental health responders on how to assess for needs, safety planning, and community referrals. Training also includes how to conduct Designated Exams for determining if involuntary treatment is necessary.
- Idaho has been sending a team of parents, advocates, juvenile justice staff, legislators, clinicians, leaders and a researcher to the system of care conferences to gather and share information on current treatment and research on children's mental health issues.

4. DATA AND INFORMATION SYSTEM DEVELOPMENT

The Division has completed implementation of its Family Oriented Community User System (FOCUS) information system. The first phase of this implementation began July 1, 1998, in Region V. Staff training and conversion of cases from the old data system took place region by region. The system was fully implemented October 1, 2000. The FOCUS information system is an electronic system including an electronic clinical record. This system encompasses child protective services, child mental health services, foster care and licensing, adoptions, interstate compacts, as well as invoicing and payment for child welfare and children's mental health services. This system will provide the information on the number of children and the resources used through the CFS program. The FOCUS system has the capability to report on a number of data elements reported in this plan. Idaho is working to enhance this system to report on all of the elements required for the implementation plan and has received the Data Infrastructure Grant to assist in this enhancement. The FOCUS system is anticipated to have the ability to report the Uniform Data requirements as the MH Block Grant becomes a Performance Partnership. The only required element that is currently not tracked is the rate of homelessness. However, prior to the start of FY2004, the system will be modified and homelessness will be recorded ongoing.

Additional data is gathered through the Medicaid fiscal system (AIMS) and a database that contains service evaluation information (the Service Evaluation Database). The AIMS system was developed for fiscal purposes and is also used to extract data on utilization and expenditures. The service evaluation database will be integrated into the FOCUS system, but was created separately to ensure its timely completion. The Service Evaluation Database contains data on the Family Satisfaction Surveys gathered every 120-days from families and the CAFAS outcomes information.

5. QUALITY ASSURANCE AND PROGRAM ACCOUNTABILITY

A number of efforts and activities are occurring to help initiate and continue assuring program accountability, outcomes and quality assurance/improvement. FACS is currently implementing a

recognizes that this outcome and service evaluation data is needed for all children and families receiving publicly funded services, not just those receiving services under the Rehabilitation Option. Client evaluation will focus on the 8-scales of client functioning specifically identified on the CAFAS.

6. SAMHSA BLOCK GRANT EXPENDITURE FOR CHILDREN

The Children's and Family Services budget contains very few specific children's mental health line items. The funding for community-based mental health services is consolidated into a social service cost pool. This includes Child Welfare funds, Social Service Block Grant Funds, TANF funds, Title IV-E funds, Medicaid funds, and state general funds. No institutional, residential care or group care expenditures are included as part of this budget. Costs are charged to the budget based on the Division's Random Moment Time Study (RMTS) completed by staff in the field. The following information represents children's mental health expenditures for SFY2003.

TOTAL RMTS COSTS FOR SFY2003:

SFY2003	ALLOCATED EXPENDITURES
Total	$2,776,400

CMH RMTS COSTS BY FUNDING SOURCES:

Mental Health Block Grant	$ 112,298
Medicaid Receipts	$ 157,200
Federal/General Funds	$2,506,902
Total	$2,776,400

TOTAL EXPENDITURES FOR CMH FOR SFY2003:

Mental Health Block Grant – Cost Pool	$ 112,298
Mental Health Block Grant	$ 21,236
Child Clinical Receipts	$ 157,200
Federal/General Funds	$10,492,666
Total	$10,783,400

The above information shows how the state loaded the 2002 SAMHSA block grant funds into its budget structure. This assures that all block grant funds pertaining to children's mental health obtained through SAMHSA and in accordance with PL 102-321 was expended for community-based programming. Loading the SAMHSA block grant funding into the social service cost pool ensures that the dollars will be used across all service regions to help fund the community-based system of care. Specifically, these dollars will go toward funding a small percentage of case management staffing and outpatient treatment services. The Department will continue to

	service effectiveness measures. This objective relates to the State Planning Council's CMH priority: *Enhancing community-based efforts at all levels within the community.* .

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 1. Percentage of total children's mental health funding, including block grant funds, expended for community based services.	82 %		75 %	
Value:				
Numerator: Amount of children's mental health funding for community based programs (non-hospital care and expenditures).	$32,851,186	_____	_____	_____
Denominator: Total funds spent on all children's mental services including State Hospital South and other hospitalizations funded by Medicaid or contracts.	$39,646,470	_____	_____	_____

Objective 5.2 **The Adult and Children's Mental Health Programs will develop and provide joint training on the provision of mental health services to children with SED and adults with SPMI for Healthy Connections primary care physicians during FY 04.**

Population:	Children with SED
Criterion:	Management Systems
Brief Name:	Training for primary care physicians
Indicators:	Training is developed and provided
Measure:	
Numerator	
Denominator	
Sources of Information:	Self Report
Special Issues:	
Significance:	This objective corresponds with the New Freedom Commission Recommendation 1.2 which recommends addressing mental health with the same urgency as physical health. This objective relates to the State Planning Council's CMH priority: *Public education to promote awareness.*

ADULT PLAN FY 2004

PLEASE NOTE:

1. Any data in the Adult Plan represents our best estimates based on available data and reflects the limitations of our reporting and information systems. In some cases it is not possible to guarantee unduplicated counts. We are currently in the process of changing to a new data collection system in order to meet the MHSIP requirements. Due to this change, we will be required to establish new baseline measures for most performance indicators during this FY as our existing data is not comparable or transferable to the new data system. Idaho will begin collecting all required MHSIP data elements beginning October 1, 2003.

2. We used 7/1/03 as the effective date in listing data, providers, resources and facilities in operation. Data reported in the plan is based on the state fiscal year.

3. We have generally adopted an approach of "maintain effort rather than expect to increase effort." We believe this to be a realistic approach based on our available financial resources, the growing state population and corresponding increase in demand for services, and projected major service delivery system changes in FY2004.

4. In Idaho, Due to funding constraints, the target population is *serious and persistent mental illness*, a narrower subset of serious mental illness.

NARRATIVE, GOALS, OBJECTIVES AND INDICATORS

CRITERION 1

COMPREHENSIVE COMMUNITY BASED MENTAL HEALTH SERVICE SYSTEMS: Establishment and implementation of a community-based system of care for adults with serious mental illness (SMI) and children with a serious emotional disorder (SED), describing all available services including health (medical and dental), mental health, rehabilitation, case management, employment, housing, educational, other support services, and activities to reduce the rate of hospitalization of individuals with SMI or SED.

A. NARRATIVE

1. ORGANIZATIONAL FRAMEWORK

- **Service Model for Adults**

Public services to adults with serious mental illness in the State of Idaho are provided primarily through a network of seven state operated regional community mental health centers and two state hospitals, State Hospital South in Blackfoot and State Hospital North in Orofino. System support is provided by the Division of Family and Community Services. A developing private sector throughout the state is also serving the state's target population.

- **Family and Children's Services Mental Health/ Developmental Disabilities Field Operations Team**

New structure was put in place as part of the overall realignment and consolidation of the Department of Health and Welfare to improve accountability, consistency and efficiency in lines of authority and responsibility for the Division of Family and Community Services (FACS). Lines of authority have been realigned to directly connect the regional programs with the FACS Division Administrators. Responsibility for program budgets, policy development and implementation and quality assurance has been shifted from the Regional Directors to the Division Administrators. The seven regional Mental Health/ Developmental Disability Program Managers now report to the Division Administrator. In addition to the Division Administrator, there are two Deputy Administrators, one responsible for Field Operations dealing with the regional programs and one responsible for Program Operations over the central office programs in the Division.

The seven regional adult mental health/ developmental disability program managers, the administrative directors of the two state hospitals, the FACS Division Administrators, the Mental Health Program Manager, Substance Abuse Program Manager, and two Developmental Disabilities Program Mangers constitute the newly reorganized FACS MH/DD Field Operations Team. The team meets on a monthly basis and is a primary vehicle for system coordination, policy development and system improvement.

- **Adult Mental Health Program**

The FACS Division Adult Mental Health Program consists of one program manager, two program specialists and one administrative assistant. The program was previously located in the Bureau of Mental Health and Substance abuse in the Division of Family and Community Services. In conjunction with the realignment activities of the Department the FACS bureaus were separated into individual programs. There is also a Substance Abuse Program within FACS. The Division programs provide system leadership, consultation, technical assistance, and training. The Adult Mental Health Program supports system improvement (including the areas of system coordination, consumer and family member empowerment) the development of policies and best practice procedures, overseeing federal grant applications and contract development and monitoring. Contracts administered by the Division include those with NAMI-Idaho, the Office of Consumer Affairs and the Division of Vocational Rehabilitation.

problem. Several regional community programs, most notably Regions III, V, VI and VII, continue to offer services targeted to those individuals with a dual diagnosis.

- In an ongoing effort to provide alternatives to psychiatric inpatient hospitalization in Idaho's largest metropolitan region (Region IV, headquartered in Boise) has developed Franklin House, an 8-bed community-based crisis residential facility. This facility provides a safe, secure, and supportive environment for individuals experiencing psychiatric crisis but not requiring extended hospitalization. Other DHW regions are exploring ways to implement crisis residential programs using similar program models.

- Another recent innovation has been the establishment of a Mental Health Court in Region VII. The Idaho mental health court is a voluntary program for persons who have a severe and persistent mental illness and have pleaded guilty to crimes, both misdemeanor and felonies. In, order to participate in the program the consumer must be accepted and must agree to participate in active treatment for the mental illness. While engaged in active treatment the jail sentence is suspended. The program is set up in four phases lasting a minimum of 40 weeks. The court is an intensive and collaborative effort between the judges, prosecutors' office, public defenders office, probation officers, substance abuse treatment providers, jail representatives, NAMI, and the CMHC's Assertive Community Treatment team and Crisis Team.

3. SYSTEM COORDINATION

- **Consumer and Family Member Empowerment**

We are committed to providing quality systems of care to adults with a serious mental illness in the state of Idaho. To this end, the Division of Family and Community Services and the CMHC's maximize opportunities for input from:

- The Idaho State Planning Council on Mental Health
- Regional Mental Health Advisory Boards (RMHAB's)
- The National Alliance for the Mentally Ill, Idaho Chapter
- The Mental Health Association of Idaho (MHAI)
- The Idaho Office of Consumer Affairs and Technical Assistance
- Local consumer and family member self-help groups

- **Collaboration with Community Providers and Other Agencies**

In an effort to provide the best quality services in a climate of limited resources, staff in the regional CMHC's recognize the need to work collaboratively with other agencies. Regional CMHC's offer education and consultation services regarding mental health issues and services. They also work to develop multi-agency task forces and partnerships with law enforcement, hospitals, counties, housing providers and other agencies to resolve concerns and maximize resources. The Medicaid Psychosocial Rehabilitation Option continues to provide opportunities for partnerships between the regions and private sector providers.

The following is a description of the "core" adult mental health services that are provided by all seven regional community mental health centers. Please see Appendix B for a map of Idaho showing the regional CMHC's and their field offices.

a. Population Served:
We serve any individual 18 years of age or older who has a severe and persistent mental illness and who meets the following two criteria:

(1) The individual must have a diagnosis under DSM-III R or DSM-IV of schizophrenia, schizo affective disorder, major affective disorder, delusional disorder or a borderline personality disorder; and,

(2) This psychiatric disorder must be of sufficient severity to cause a disturbance in role performance or coping skills in at least two of these areas on either a continuous or an intermittent (at least once per year) basis: Vocational/academic, financial, social/interpersonal, family, basic living skills, housing, community or health.

In addition to the above population, we also serve:

Any individual 18 years of age or older who is experiencing an acute psychiatric crisis, including suicidal and/or homicidal behavior and who may end up in an inpatient psychiatric facility if mental health intervention is not provided promptly. Only short-term treatment or intervention, not to exceed 120 days, is provided to this population.

b. Core Mental Health Services:

(1) Screening
(2) Targeted Case Management
(3) Crisis Intervention
(4) Psychiatric Rehabilitation
(5) Assertive Community Treatment
(6) Psychiatric Services
(7) Short-Term Mental Health Intervention

c. Description of Core Services:
(1) Screening: Screening for eligibility of services through Regional Mental Health Programs based on the above criteria. If an individual meets population criteria as defined above, he or she is accepted for services either on an ongoing basis or for short-term intervention. Individuals not meeting above criteria are referred out to appropriate community agencies.

(2) Targeted Case Management Services: Targeted case management services are provided to severely and persistently mentally ill clients who meet our first criteria outlined above. Services include:

(a) Comprehensive psychosocial assessment

(6) Psychiatric Services: These services include:

(a) Psychiatric evaluation
(b) Medication prescription
(c) Medication monitoring
(d) Consultation and education
(e) Psychiatric nursing

(7) Short-Term Mental Health Intervention: Short-Term mental health treatment is provided to an individual 18 and above who may not have a severe and persistent mental illness but nevertheless is in acute psychiatric crisis, including suicidal and/or homicidal behavior. Without an immediate mental health intervention, these individuals are at high risk of hospitalization. Such interventions are time limited and not to exceed 120 days. Services include:
(a) Short-term therapy
(b) Medication prescription and monitoring
(c) Referral to community agencies
(d) Designated examinations and dispositions

- **State Hospital Services**

Idaho's two state hospitals are located in Orofino (State Hospital North) and Blackfoot (State Hospital South). State Hospital North is a psychiatric hospital that is licensed for 60 beds. When the building was constructed in 1995 it was designed to have 30 beds to accommodate the acute psychiatric patients and 30 beds to be used for the residential Chemical Dependency Program. The thirty acute beds were located on Quad 3 and the 30 beds for the Chemical Dependency Program were on Quad 4.

During the last several years there has been a steady increase in the number of patients who have been involuntarily committed under Idaho Code 66-329. That increase has created a greater need for psychiatric inpatient beds. In order to try to accommodate those needs the space that was originally designed to house the Chemical Dependency Program (Quad Four) has been used to house and treat the committed patients who have more acute psychiatric problems and require a higher level of care than those that would be in a residential care facility. Because of the increased acuity, it has been necessary to limit the number of patients who are served on Quad Four to 20 in order to assure the safety of the patients and staff on that unit.

With some of the above mentioned changes the focus on programs has also changed. As a part of that, SHN has moved away from being program based and is working more on a service based model. With the change in focus, while SHN no longer has a voluntary residential Chemical Dependency Program, they do still provide substance abuse treatment to approximately 65% of the patients that they serve.

State Hospital South has a total of 90 beds. Acute, intensive, inpatient psychiatric services are provided around the clock to stabilize symptoms of acute mental illness and prepare an individual to return to community-based care.

	Counseling, Daybreak Mental Wellness Center, Opportunities Inc., New Directions Counseling Center, Integrity Therapeutic Services, St. Alphonsus Dual Recovery Center, Sufficiency Advocates, Western Idaho Training Co.
IV	Ada Family services, Advocates for Inclusion, Affinity Inc., All Seasons Mental Health, All Together Now, Inc., Alta Counseling and Rehab, Alternative Counseling and Rehab, BHC Intermountain Hospital, Cerebral at Solutions, Community Partnerships of Idaho, Community Support, Inc., Daybreak Mental Wellness Center, Idaho Easter Seals, Franklin House – St. Alphonsus Regional Medical Center, HFC dba Basin Community Health Center, Human Supports of Idaho, Inc., Rehab, Mountain States Group, The ARC, Inc., Sufficiency Advocates, WITCO, Inc.
V	A+ Solutions Center, Alliance Family Services, Community Partnerships of Idaho, Harmony PSR Services, Liberty Care Services, Magic Valley Rehabilitation Services, Pathways, Inc., Positive Connections, Pro Active Advantage, Psychiatric Services, Syringa Support Services, Valley Community Counseling
VI	Academy of Family Services, Access Point Family Services, Aid For Friends, Advocacy & Learning Association, Apex Professional Services, Community Wellness Center, Consumer Care, The Coping Connection, The Children's Center, Family Care Center, Family Pathways Cooperative, Family Services Alliance, Health Works, J & M Mental Health, Joshua D. Smith & Associates, Life Choices, Mental Wellness Center, New Beginnings, Mountain River Mental Health, New Outlook Counseling, Opportunities Inc., PC Mental Health, Reddoor Rehabilitation Services, Rehab Inc., Reliance Mental Health, Road to Recovery, Summit Counseling Services, Teton Family Services, Vista Family Services
VII	Alpine Counseling, Aspen Center Rehabilitation and Counseling, Children's Supportive Services, CLUB, Inc., Counseling Center of Southeast Idaho, Family Care Center, Family Resource Center, Innovative Health Care Concepts, Innovative Health Care Concepts, J&M Mental Health, Inc., Joshua D. Smith and Associates, Lemhi Valley Social Services, Mental Wellness Center, Northfork Developmental Services, Reddoor Rehabilitation Services, Rehabilitative Health Services, Reliance Mental Health Services, Salmon River Industries, The Children's Center, Upper Valley Resource and Counseling Center, Vista Family Services, Youth and Family Renewal Center

5. DESCRIPTION OF HEALTH AND MENTAL HEALTH SERVICES, HOUSING SERVICES, EDUCATIONAL SERVICES AND OTHER SUPPORT SERVICES TO BE PROVIDED TO THE SERIOUSLY MENTALLY ILL.

- **Housing Services**

The Idaho Department of Health and Welfare, Division of Family and Community Services (FACS) contracts with Supportive Housing and Innovative Partnerships, Inc. to provide housing consultation services for FACS personnel, community-based groups, advocacy groups and Community Housing Development Organizations to increase the capacity of all of these organizations to ultimately increase the availability and affordability of housing for persons who have special needs and are served by FACS programs. SHIP, Inc. is a nonprofit organization that was developed by the Boise City Ada County Housing Authority. SHIP provides the following services throughout the state of Idaho:

- Develop, distribute and maintain a Housing Development Guide
- Monitor and disburse information regarding housing funding opportunities
- Acting as a liaison and building collaborative partnerships between the Department and other organizations interested in special needs housing
- Technical Assistance with funding applications
- Providing training and technical assistance

SHIP is also spearheading an effort to develop Oxford Houses throughout Idaho upon request from the Regions. Oxford Houses are group homes for persons who are in recovery from alcohol and/or substance abuse. To date there is one house in Region I, two houses in Region III, five

a nursing home to hold clients until they can be placed at State Hospital North. These beds are not considered crisis diversion placements as they are intended to provide temporary safe holding placements until a state hospital admission is available.

Region III has secured one crisis bed in Nampa. The bed is affiliated with the Touchstone consumer drop in center which is governed by a consumer board. Access to the crisis bed is arranged through the CMHC crisis team. The bed is fund by the regional CMHC program budget. Crisis support services are provided by the CMHC clinicians and contracted psychiatrist and can be delivered for up to 120 days.

Region IV has an 8 bed 24 hour crisis residential facility known as Franklin House, previously described, which opened in October of 1998.

Region V has arranged for a crisis bed at Woodstone Retirement Center.

Region VI has contracted with Road to Recovery for three crisis beds. The beds are available for individuals who are experiencing acute psychiatric crisis but are not in need of inpatient treatment. These are voluntary placements and are intended to be for short term stays only. The contract provides for 24 hour supervision, medication distribution, food and shelter.

Region VII has developed a number of community resources for the provision of crisis beds. The CMHC has agreements with the ARA substance abuse facility for the use of one male crisis bed and one female crisis bed and agreements with three residential and assisted living facilities for crisis beds. The program also pays for one home with four crisis beds for men and one home with four crisis beds for women. The regional CMHC also utilizes crisis housing available through CLUB Inc. which includes four men's crisis beds, six transitional beds for men, four crisis beds for women, four transitional beds for women and one transitional bed for either a male or female. They also regularly access the services of the Haven Homeless Shelter for women and children and the City if Refuge for Homeless Men.

- **Lodge/Semi-Independent homes**

The following lodge/semi-independent homes are available to the seriously mentally ill in Idaho. Additionally, supportive housing options such as Residential and Assisted Living Facilities and Certified Family Homes are available throughout the state.

STATEWIDE LODGE/SEMI-INDEPENDENT HOMES

REGION	LODGE	CAPACITY
I	Trinity Group Homes 1601 Gilbert Ave., Coeur d' Alene, ID 83814	12
II	Latah Alliance for the Mentally Ill, 123 N Lillie, Moscow, ID 83843	6
III	Touchstone Starlight House, 3421 Starlight, Caldwell ID 83605 (Semi-independent)	5
	St. Germaine, 903 E Amity, Nampa ID 43686 (Semi-independent)	5

IV		Recovery Treehouse
V	Harmony Club CSC Burley CSC Twin Falls	
VI	Activity Center	
VII	CLUB, Inc.	

STATEWIDE CONSUMER AND FAMILY MEMBER SELF-HELP GROUPS

REGION	CONSUMER GROUPS	FAMILY MEMBER GROUPS
I	Idaho Consumer Advocacy Network (Umbrella organization for four separate groups) Consumer Connection	NAMI of Coeur d' Alene NAMI of Benawah NAMI Silver Valley
II	Confluence Club	NAMI of Latah County NAMI of Lewis/Clark Valley
III	Touchstone Schizophrenics Anonymous Mental Health Association of Idaho	NAMI of Quad Counties NAMI of Canyon County
IV	Schizophrenics Anonymous	NAMI of Boise NAMI of McCall
V	Community Support Center, Inc. Twin Falls and Burley Harmony Club	NAMI of Mini-Cassia NAMI of Magic Valley NAMI of Wood River Valley
VI	People of Pocatello Consumer Works Inc. Peer Companion Group Consumer Advocates of Pocatello	NAMI of Southeast Idaho
VII	CLUB Inc. COMFORT Tri-County Manic Depressive Support Group	NAMI of Upper Valley, Idaho Falls
Statewide	Mental Health Association of Idaho Idaho Office of Consumer Affairs and Technical Assistance Idaho Leadership Academy	NAMI, Idaho Chapter, Albion Family to Family- NAMI sponsored Red Flags Idaho

- **Medical and Dental Services**

Medical and dental needs for consumers in the public mental health system are identified during the assessment process. The assessment is used to address the individual's medical history and current health problems and identify needs. Medical/Health is an area that can be included in the PSR service plan to assist a consumer with learning to access needed medical and dental

evidenced based, technologically improved program for prior authorizing classes of medications. The program consists of two new features:

1. An automated system to receive and review PA request to speed service and promote convenience to the pharmacy, prescriber and patient.
2. A new procedure for reviewing classes of medications to aid in determining prior authorization guidelines.

The program will utilize evidence based data to develop criteria that will aid in the decision to choose the most appropriate medication for the client. The enhanced prior authorization program will enable the prior authorization of more medications within a therapeutic class. Recommendation on prior authorization guidelines will come from a Pharmacy and Therapeutics (P&T) Committee made up of Idaho physicians, pharmacist and other healthcare professionals. The Enhanced Prior Authorization Program is planned to go into effect in December 2003.

Service limits were also implemented in Targeted Case Management, which previously had no service limitations. A limit of 5 hours for ongoing case management services and 3 hours for emergency case management service was implemented. A procedure was developed for prior authorizing any additional service hour requests beyond the established limits.

Idaho also has seven public health districts that are the primary outlets for public health services. These districts work in close cooperation with the Department of Health and Welfare and numerous other state and local agencies. Each district has a board of health appointed by the county commissioners within that region. The districts are not part of any state agency. Each district responds to local needs to provide an array of services that may vary from district to district. Services range from community health nursing and home health nursing to environmental health, dental hygiene and nutrition programs. Many services are provided through contracts with the Department of Health and Welfare.

6. ACTIVITIES TO REDUCE THE RATE OF HOSPITALIZATION OF THE SERIOUSLY MENTALLY ILL.

The state of Idaho is committed to activities designed to increase the effectiveness of community-based services, while at the same time seeking opportunities to reduce the rate of hospitalization of adults with serious mental illness.

In Idaho, a variety of strategies are in use (and receive the strong support of both the regional community mental health programs and the state hospitals) as multiple ways to reduce the rate of hospitalization of adults with serious mental illness

a. An increased emphasis on **communication and cooperation** between the state hospitals and the community mental health programs in order to make timely decisions about admissions and discharges, identify at an early stage potential barriers to timely discharge, and promote the sense of teamwork between hospital and community staff and administrators.

8. SERVICES TO PERSONS WHO ARE DUALLY DIAGNOSED (CO-OCCURING MENTAL ILLNESS AND SUBSTANCE ABUSE)

During this past year there have been greater efforts placed on coordination between the regional CMHC's and Drug Courts. More detailed information on services for persons who are dually diagnosed being offered by the regional programs is as follows:

REGION I- Currently the substance abuse treatment needs of the dually diagnosed are primarily being referred to treatment facilities outside of the CMHC. The Crisis Response Team (CRT) performs a mental health screening at the CMHC and if a dually diagnosed client is identified an appropriate referral will be made to better meet the needs of the individual. Consumers screened who have a documented mental illness or prior mental health symptoms that preceded their substance abuse will be opened for CMHC services. Referrals are made to outside agencies to meet the substance abuse treatment needs. Referrals are usually made to North Idaho Behavioral Health, Port of Hope and Powder Basin. However, there often are waiting lists for clients to be seen, or they do not have insurance or the funds to pay for treatment. It has become increasingly important for the CRT to make referrals for the client to access support services such as AA or similar support groups. The CMHC has a support group for the dually diagnosed. This group meets once a week at KMC for one hour and averages about five people.

Three counties in the region have drug courts. The Court has contracted with Powder Basin Associates to provide assessments, treatment planning and treatment services. Referrals are made to the regional CMHC as needed.

REGION II- The Region II Mental Health Center has one clinician who is a certified substance abuse counselor assigned as a lead clinician for dual diagnosis-substance abuse issues. All mental health staff work conjointly with the Substance Abuse Contract agency in order to coordinate and optimize services for consumers who are receiving both mental health and substance abuse services.

Regional CMHC staff attend the monthly drug court coordinating team meetings. There is an identified liaison who consults with the court as needed. The CMHC also provided consultation services to the drug court counselors pertaining to mental health issues and provides screening services for any referrals received the from the court. There are currently four drug courts in the District.

REGION III- Region III Community Mental Health Center works closely with several entities to improve the accessibility of treatment for adults with severe, chronic mental illness. Bell Counseling, an established substance abuse treatment program in the region, provides a long-term residential treatment program for women. The Regional CMHC has also worked with the Port of Hope to assist clients in accessing detox, inpatient, and outpatient services for substance abuse issues. Region III Mental Health is an active participant in the Regional Substance Abuse Authority monthly meeting. This group is comprised of representatives from all of the local substance abuse treatment programs, school teachers, recovering community members, housing providers, school board members, police, and probation officers. They meet monthly to prioritize the use of substance abuse dollars for the entire region and complete Requests for

The regional CMHC has one staff person assigned to spend two hours weekly attending the Drug Court and conducting pre-screenings and consultations to the court on mental health issues. A complete screening is conducted to anyone referred to the CMHC from the drug court for assessing eligibility and developing individual treatment plans.

REGION VI- Region VI Mental Health Center sponsors a Dual Diagnosis group focusing on those with a severe and persistent mental illness and substance abuse. The group meets one time per week for an hour and a half. Regular attendance has been 5-7 consumers weekly. The group is conducted by licensed clinicians. Elements of the Bio-psycho-social recovery model with the 12-step model are the foundation for the group. They also incorporate motivational enhancements theory. The group is identified as having a good attendance rate. A weekly community dual diagnosis group is also offered in Blackfoot.

Regional CMHC staff is assigned to attend weekly staffing and to provide consultation, screening and referral services to the Drug Court committee. Consultation is also provided in determining if an individual would benefit from participation in the Drug Court. The program also continues to work with Road to Recovery staff to divert individuals before they come into contact with the legal system.

REGION VII - Region VII Mental Health Center offers two Dual Diagnosis groups each week for CMHC consumers. The groups are facilitated by the ACT team clinicians. The Regional Substance Abuse Authority has also contracted for services with a community provider for the provision of services for persons with a dual diagnosis. Additionally, three CMHC staff are assigned to attend five Drug Court weekly staffings. The CMHC staff provides screening and assessment services as referred by the court.

B. GOALS AND OBJECTIVES

GOAL 1: TO IMPROVE ACCESS, QUALITY AND APPROPRIATENESS OF SERVICES TO THE TARGET POPULATION, AND DEMONSTRATE IMPROVED QUALITY OF LIFE AND POSITIVE OUTCOMES FOR THE TARGET POPULATION.

Objective 1.1 Implement a new process for conducting MHSIP Satisfaction Surveys for consumers receiving DHW provided CMHC services by the end of FY04.

Population	Adults receiving ongoing DHW mental health services
Criterion	To improve access, quality and appropriateness of services
Brief Name	Consumer reported satisfaction with mental health services
Indicators	Percentage of consumers receiving DHW publicly provided services who rate positive satisfaction with services
Measure	
Numerator	Number of consumers who rate positive satisfaction with services
Denominator	Number of completed consumer satisfaction surveys
Sources of Information	IMHP, MHSIP Consumer Survey, CAMIS, Visual Basic

Special Issues	FACS is in the process of developing a new data tracking system to meet the MHSIP requirements. As a result of this transition, the previous data tacking systems will no longer be compatible with the new system and all previously collected data will no longer be comparable. New baseline measures for all performance indicators will need to be established during this FY.
Significance	Achieving competitive employment has been shown to be one of the key indicators of the recovery process for persons with SPMI. This objective supports the Planning Council's objective on continuum of care and community supports.

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 2. Competitive employment				
Value			5%	
If rate: **Numerator:** Number of consumers receiving DHW MH services who report competitive employment **Denominator:** Number of consumers receiving DHW MH services in Idaho	**No comparison data available**			

Objective 1.3 Establish a baseline rate for consumers receiving DHW provided mental health services who report independent housing during FY04.

Population	Consumers receiving DHW provided mental health services
Criterion	To improve access, quality and appropriateness of services
Brief Name	Assisted/supportive housing
Indicators	Percentage of consumers receiving DHW MH services who report independent living during FY04
Measure	
Numerator	Number of consumers receiving DHW mental health services who report an independent living arrangement during FY04
Denominator	Number of consumers receiving DHW mental health services in Idaho
Sources of Information	IMHP, CAMIS, VBROD
Special Issues	FACS is in the process of developing a new data tracking system to meet the MHSIP requirements. As a result of this transition, the previous data tracking systems will no longer be compatible with the new system and all previously collected data will no longer be comparable. New baseline measures for all performance indicators will need to be established during this FY.
Significance	Achieving and maintaining independent housing is an important

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 4. Supportive housing				
Value				
If rate: **Numerator:** Number of consumers receiving DHW mental health services who report supportive residential services during FY04 **Denominator:** Number of consumers receiving DHW MH services in Idaho	**No comparison data available**			

Objective 1.5 **Maintain the previous fiscal years level the % of persons seen for a first face to face appointment at their community mental health provider within 7 days of discharge from a state hospital in Idaho.**

Population	Persons discharged from state hospitals
Criterion	To improve access, quality and appropriateness of services
Brief Name	Community follow-up after state hospital discharge
Indicators	Percentage of persons seen at their community mental health provider within seven days of discharge from a state hospital in Idaho
Measure	
Numerator	Number of persons in FY04 seen by community provider within seven days of discharge from state hospital
Denominator	Number of persons discharge from state hospital
Sources of Information	State hospital database
Special Issues	This objective supports the Planning Council's objective on, quality, continuum of care and community supports.
Significance	Timely follow-up in the community is a significant indicator for successful community integration and for reducing the rate of re-hospitalization.

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 5. Community follow-up after state hospital discharge				

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 6. Readmission rates following state hospital discharge				
Value	5.6.%	5.6.%	5.6.%	
If rate: **Numerator:** Number of persons readmitted within thirty days of state hospital discharge in FY04 **Denominator:** Number of persons discharged from a state hospital				

Objective 1.7 **Maintain at the previous fiscal year's level the % of persons discharged from a state hospital in Idaho who keep their first medication follow-up appointment with a physician or physician extender at their community mental health provider.**

Population	Adults discharged from a state hospital in Idaho
Criterion	To improve access, quality and appropriateness of services
Brief Name	Community follow-up with physician
Indicators	Percentage of persons discharged from a state hospital who keep their first medication follow-up appointment with a physician or physician extender at their community mental health provider
Measure	
Numerator	Number of persons in FY04 who keep their first medication follow-up appointment with a physician
Denominator	Number of persons discharged from a state hospital
Sources of Information	State hospital databases
Special Issues	This objective supports the Planning Council's objective on quality, continuum of care and community supports.
Significance	Keeping their first medication follow-up appointment in the community is a key indicator of successful community reintegration and treatment compliance.

Indicators	Finalize and adopt a statewide plan and policies for CMHC's and drug courts
Measure	
Numerator	
Denominator	
Sources of Information	
Special Issues	The mental health system has been impacted with the implementation of Drug Courts resulting in an increased demand for coordination, consultation, assessment and treatment services. A formalized agreement between the Courts and the Adult Mental Health program will facilitate continuity of care and maximize opportunities for diversion to treatment.
Significance	This objective corresponds to the State Planning Council's Adult Mental Health priorities to develop professional competencies and standards, equitable access to care and to define and further develop an array of mental health services.

Objective 1.10 Identify and adopt outcome measures and performance standards for Community Supported Employment providers during FY2004.

Population	CSE providers, consumers and providers of public mental health services,
Criterion	To improve access, quality and appropriateness of services
Brief Name	Community supported employment standards
Indicators	Identify and adopt CSE outcome measures and performance standards
Measure	
Numerator	
Denominator	
Sources of Information	
Special Issues	To improve the quality and accountability for employment services received by Idaho consumers.
Significance	This objective corresponds to the State Planning Council's priorities of recognizing outcome measures as persuasive data and to develop professional competencies and standards.

PROJECTED TO BE SERVED FY2004

SERVICE TYPE	PUBLIC
ACT Teams	392
Psychiatric Rehabilitation	2,934
Targeted Case Management	595
Outpatient Clinic Services	100
Other MH Services (Medication Only, Crisis Response, etc.)	7,961
Total Persons Served To Be Served	11,982

PROJECTED ADULT/SPMI POPULATIONS, BY REGION

	Regions							
	I	II	III	IV	V	VI	VII	TOTAL
2000 Adult Population	130,928	77,680	133,101	250,556	114,778	105,645	112,235	924,923
Estimated Adult SMI Population (5.4%)	7,070	4,195	7,187	13,530	6,198	5,705	6,061	49,946
Estimated Adult SPMI Population (2.6%)	3,404	2,020	3,461	6,514	2,984	2,747	2,918	24,048

	is likely that at best we will only maintain at the same level of the previous year the number of persons we serve in FY04. This objective supports the Planning Council's priorities related to equitable access to care.

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 1. DHW service penetration				
Value	9,898	11,982	11,982	
If rate: **Numerator:** **Denominator:**				

Objective 2.2 Establish a baseline count for the numbers of Hispanic/Latino and American Indian consumers accessing Adult CMHC services in the state during FY04.

Population	Adults of Latino/Hispanic heritage and American Indians with receiving DHW Mental Health services
Criterion	To improve access, quality & appropriateness of services
Brief Name	Hispanic/Latino and American Indian access to services
Indicators	The number of Latino/Hispanic and American Indian consumers receiving services
Measure	Number of Latino/Hispanic and American Indian consumers receiving services in FY04
Numerator	
Denominator	
Sources of Information	DHW databases (DAR, IMHP, CMIS)
Special Issues	This is a variable the state has not previously had the capacity to track. A baseline will be established during this FY for use in future year's planning and system evaluation to evaluate and ensure equal access to services for minority populations.
Significance	Outreach to minority populations and equitable access to minority populations remains an important issue, both nationally and as a way of demonstrating Idaho's commitment to serve minority populations. This objective supports the Planning Council's priorities on equitable access to care.

CRITERION 4

TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS: The plan provides for the establishment and implementation of a program of outreach to and services for individuals with SMI or SED who are homeless; and additionally describes the manner in which mental health services will be provided to individuals residing in rural areas.

A. NARRATIVE

1. ESTABLISHMENT AND IMPLEMENTATION OF OUTREACH TO, AND SERVICES FOR, SUCH INDIVIDUALS WHO ARE HOMELESS.

Outreach to, and services for, homeless individuals with serious mental illness are provided in Idaho under the auspices of the Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program of the Center for Mental Health Services. Idaho has participated in this federal grant program for the past eight years and anticipates Project funding for FY 2004.

The homeless population comprises those individuals who have a serious mental disorder diagnosable under DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 1994), which includes: schizophrenia, schizoaffective disorder, major affective disorder, delusional disorder, or borderline personality disorder.

PATH funding is distributed to each of our seven regional mental health centers, which are responsible for delivering the needed and appropriate services. State general funds are used by each DHW Region to supplement PATH Grant allocations; however, PATH grant monies are the primary source of funding for services to persons that with serious mental illness who are homeless.

PATH funds are used to provide services, basic housing essentials and emergency housing for adults with a serious mental illness and are homeless or at risk of becoming homeless. The availability of these funds prevents the vulnerable population of severely mentally ill adults from becoming homeless by enabling them to receive services to stabilize their lives, find and maintain housing, and access basic services in the community.

Due to annual variations in the grant award, services will be provided on an as needed basis with the exception of contracted funds within each region and those funds targeted for specific projects. This option will allow the regions flexibility in providing services to the homeless population.

The following services are available through the PATH program to be included within the scope of the regional plans: outreach; screening and diagnostic treatment; habilitation and rehabilitation; vocational rehabilitation; community mental health; alcohol or drug treatment;

a range of social, psychological and economic factors that must be considered in delivering services in rural areas. Among these factors are:

(1) Low population densities make it difficult to provide some services (for example, inpatient treatment) which require a "critical mass" of consumers to be economically and programmatically viable.

(2) There can be difficulties associated with the availability of professionally trained staff in rural areas. In addition, it is often difficult to attract and retain qualified staff to move to rural areas to work.

(3) The incidence of poverty is likely to be higher in rural areas.

(4) In rural areas, long distances and lack of transportation options can be barriers to service access.

(5) Social and geographical isolation can produce significant psychological difficulties for the individual and the family.

d. How are Services Delivered in Rural Areas of Idaho?

It is clear from the statistics stated above that Idaho is predominantly a rural state. Staff in our state-provided community mental health system have developed extensive skills and knowledge about how to effectively and efficiently deliver services to isolated rural communities and individuals.

Below are listed some of the ways in which the public adult mental health system in Idaho has attempted to address and reduce some of the inherent problems of rural service delivery.

(1) The state has made and continues to make significant investments in technology, including personal computers and computer networks, laptop computers, cellular phones, electronic mail and fax machines. Telephone conference calls, with the ability to bring together 10 or 12 individuals from all over the state, are used extensively. In the area of electronic mail, we have a daily system of notification regarding admissions, discharges and problem cases at the state hospitals. During FY 2004, the innovation of tele-mental health will continue to be explored and evaluated as a resource for delivery of services to rural areas.

(2) Significant resources are committed to transportation costs (especially the purchase and lease of vehicles) to enable workers in the field to staff satellite offices, make home visits and respond to community crises.

(3) Evolving methods of treatment (e.g., Assertive Community Treatment, psychiatric rehabilitation, and mobile crisis teams) in the state represent a movement away from office or clinic-based service to services delivered in the client's community setting. This is an approach that is much more responsive to the needs of persons residing in rural areas.

Measure:	Number of homeless mentally ill served in FY04
Numerator	
Denominator	
Sources of Information:	DHW databases (DAR, IMHP, CAMIS, VBROD and ABCD)
Special Issues:	It is anticipated the number served will decrease during FY 04 as there will be no new funds available to meet the demands of inflation and increasing expenditures.
Significance:	It is important to demonstrate continued outreach to this vulnerable population, and to account for the expenditure of Federal PATH grant funds. This objective supports the State Planning Council's priorities to develop community supports and resources for housing and to provide equitable access to care and an array of services.

	FY 2002 Actual	**FY 2003 Projection**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: 1. Number of homeless mentally ill receiving services				
Value	1,188	1,252	1,153	
If rate: Numerator: Denominator:				

Objective 4.2 Each regional CMHC will conduct at least one mental illness awareness training with local providers of homeless services by the end of FY2004.

Population:	Providers of services to adults in Idaho who are mentally ill and homeless (or at risk of becoming homeless)
Criterion:	Targeted services to rural and homeless populations
Brief Name:	Regional training for providers of homeless mentally ill providers
Indicators:	Number of regional trainings for providers completed
Measure:	Number of regional trainings of providers completed by the end of FY04
Numerator	
Denominator	
Sources of Information:	Self report
Special Issues:	This objective supports the Planning Council's objective on continuum of care and community supports.
Significance:	Training providers will improve the quality and appropriateness of the services being provided to the homeless mentally ill population in Idaho.

Sources of Information:	Self report
Special Issues:	The Shelter Plus Care program presents significant opportunities to provide permanent housing for homeless mentally ill persons who would otherwise not have access to housing.
Significance:	This objective supports the Planning Council's priorities to develop community supports and resources for housing.

CRITERION 5

MANAGEMENT SYSTEMS: The plan contains a description of the financial resources, staffing and training necessary to implement the plan, including programs to train individuals as providers of mental health services, with emphasis on training of providers of emergency health services regarding mental health. Also, the plan describes the manner in which the state intends to expend the grant for the fiscal year involved to carry out the provisions of the plan.

A. NARRATIVE

1. DESCRIPTION OF THE FINANCIAL RESOURCES AND STAFFING NECESSARY TO IMPLEMENT THE REQUIREMENTS OF THE PLAN

a. Financial Resources

Please refer to the Maintenance of Effort Report on page 16 of this plan, which describes the total financial resources projected to be available for Idaho's community mental health services in FY04. The major categories of revenue are: State General Funds, Federal Funds, Mental Health Receipts and Other Sources.

b. Staff Resources

Due to a 3.5% budgetary holdback during FY03, 11 full time positions were eliminated in the DHW Adult Mental Health program. Management Services reports the following distribution of full time equivalent (FTE) staff as of 7/1/2003. In addition, the following chart identifies the regional distribution of clinical professional staff and physicians.

STATEWIDE DISTRIBUTION OF STAFF as of 7/01/2003

Region	Statewide Distribution of Clinical Professional Staff**	Statewide Distribution of MD's/Psychiatrists^	Total # of Established FTE's
I	23.8	2	**29.58**
II	19.4	1 Region 3 SHN	**22.10**
III	25	.7	**28.50**
IV	29	6	**37.00**

CHILDREN	
Children's Services/Jeff D	$ 111,667
Respite Care	$ 55,000
Family Support/Advocacy Contract	$ 155,000
Total Children Services	$ **321,667**
Administration	**$90,079**
TOTALS	**$ 1,801,576**

Under the State Planning Council on Mental Health's leadership we are attempting to improve the tracking of expenditures related to the Federal Community Mental Health Block Grant. Since FY 2000 we have directly assigned increases in the Block Grant allocation to specific activities.

The following innovative projects will be specifically funded with Federal Community Mental Health Block Grant (CMHBG) funds in FY2004:

- Consumer and family member empowerment initiatives, including funding for the Office of Consumer Affairs and Technical Assistance, the Idaho Chapter of the National Alliance for the Mentally Ill (NAMI-Idaho), and a statewide consumer conference **(Total $142,000)**

- **$291,315** will be distributed to the seven regional CMHC programs to support their personnel budgets for clinical (direct service) positions.

- **$20,000** will be used to support the meetings and activities of the Idaho State Planning Council on Mental Health and the Regional Mental Health Advisory Boards.

- **$12,568** will be used to support training to enhance best practice standards and competencies in the Adult Mental Health Program.

The remaining Federal CMHBG funds are placed in DHW's Mental Health Cost Pool and allocated to various community mental health program categories by the use of a Random Moment Time Study. It is expressly understood, as required by Public Law 102-321, that no Federal CMHBG funds are to be used for inpatient services.

3. DESCRIPTION OF STAFFING AND TRAINING FOR MENTAL HEALTH PROVIDERS NECESSARY TO IMPLEMENT THE PLAN INCLUDING TRAINING OF PROVIDERS OF EMERGENCY HEALTH SERVICES REGARDING MENTAL HEALTH

The FACS Adult Mental Health Program will continue in FY2004 to assume primary responsibility for identifying the statewide training needs of the public mental health service system. As the Department of Health and Welfare continues its efforts with consolidation and

Objective 5.1 **A statewide consumer conference will by held by the end of FY04.**

Population:	Consumers of mental health services
Criterion:	Management systems
Brief Name:	Consumer conference
Indicators:	Consumer conference conducted
Measure:	
Numerator	
Denominator	
Sources of Information:	Self report
Special Issues:	This supports the Planning Council's priority to support consumer involvement.
Significance:	Idaho remains committed to consumer empowerment and recovery and will commit funding to support a statewide consumer conference.

	FY 2002 Actual	**FY 2003 Projection**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: 1. Consumer Conference				
Value	N/A	N/A	1 statewide	

Objective 5.2 **The FACS Division will provide statewide training on Assertive Community Treatment by the end of FY04.**

Population:	Providers of public mental health services and emergency medical service providers in Idaho
Criterion:	Management systems
Brief Name:	Training for mental health service providers
Indicators:	Training provided
Measure:	Number of training opportunities completed
Numerator	
Denominator	
Sources of Information:	Self report
Special Issues:	Continued opportunities for training related to ACT and crisis response have been identified as training priorities by the CMHC programs.
Significance:	This objective supports the Planning Council's priorities on quality and continuum of care.

Value: Number of training opportunities completed	1	1	1	
If rate: **Numerator:** **Denominator:**				

Objective5.5 The Adult Mental Health Program will develop and adopt a standardized Designated Examiner training program during FY04.

Population:	Providers of public mental health services in Idaho
Criterion:	Management systems
Brief Name:	Designated Examiner training
Indicators:	Training program developed
Measure:	Training program developed
Numerator	
Denominator	
Sources of Information:	Self report, Management Services
Special Issues:	A primary goal of the FACS Division is to achieve greater statewide consistency and improve clinical competencies.
Significance:	This objective supports the Planning Council's priorities on quality.

Objective 5.6 The Adult and Children's Mental Health Programs will develop and provide joint training on the provision of mental health services to children with SED and adults with SPMI for Healthy Connections primary care physicians during FY 04.

Population:	Providers of public mental health services and Healthy Connects primary Care Physicians in Idaho
Criterion:	Management systems
Brief Name:	Training for primary care physicians
Indicators:	Training developed and provided
Measure:	Number of training opportunities completed
Numerator	
Denominator	
Sources of Information:	Self report
Special Issues:	
Significance:	This objective corresponds with the New Freedom Commission Recommendation 1.2 which recommends addressing mental health with the same urgency as physical health as well as the State Planning Council's Adult Mental Health priorities related to continuum of care.

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Idaho Bureau of Disaster Services **Idaho Emergency Operation Plan** (Revised February 2003)

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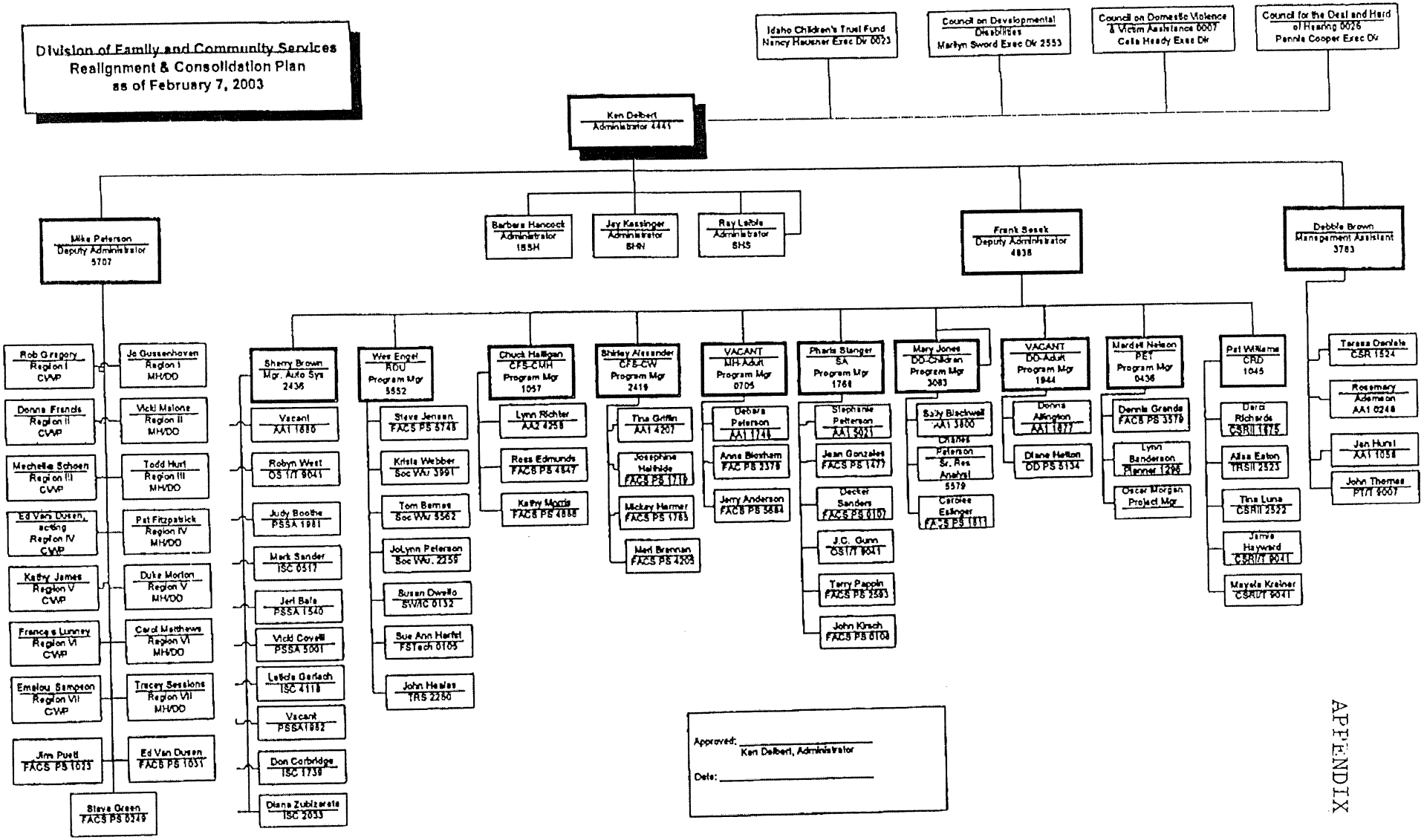
Idaho Supreme Court **Evaluating the Effectiveness of Drug Courts in Idaho: Report to Governor Dirk Kempthorne and the First Regular Session of the 57th Idaho Legislature**, (January 6, 2003)

Division of Family and Community Services
Realignment & Consolidation Plan
as of February 7, 2003



APPENDIX