

**South Dakota**

**UNIFORM APPLICATION  
2011**

**STATE IMPLEMENTATION REPORT  
COMMUNITY MENTAL HEALTH SERVICES  
BLOCK GRANT**

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**Center for Mental Health Services**

**Division of State and Community Systems Development**

## **Introduction:**

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant ( 45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

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## II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

### Data Reported by:

State FY   X   Federal FY \_\_\_\_\_

### State Expenditures for Mental Health Services

Calculated FY	Actual FY	Estimate/Actual FY
1994	2010	2011
<u>\$689,452</u>	<u>\$721,815</u>	<u>\$721,815</u>

### Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

### III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

#### MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

#### MOE information reported by:

State FY   X   Federal FY \_\_\_\_\_

#### State Expenditures for Mental Health Services

Actual FY                  Actual FY                  Actual/Estimate FY

2009	2010	2011
<b>\$9,349,532</b>	<b>\$9,907,789</b>	<b>\$10,223,298</b>

## **MOE Shortfalls**

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall.

These conditions are described below.

### **(1). Waiver for Extraordinary Economic Conditions**

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

### **(2). Material Compliance**

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

Adult - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

## **Summary of Areas Previously Identified as Needing Attention-Adults**

The Division of Community Behavioral Health, formerly the Division of Mental Health and the Mental Health Planning Council have made major commitments to transformation of the deliver of mental health services to individuals and families in the public mental health system. Transformation activities for adults with severe and persistent mental illness have included development of recovery-oriented services that are strength-based, consumer driven, and integrated for individuals with co-occurring disorders. Infused throughout transformation activities is the provision of services that are culturally sensitive and competent.

As identified by the Advisory Council, the President's New Freedom Commission Goals and Recommendations that are integral to transformation activities in South Dakota are as follows:

- Goal 2: Mental Health Care is Consumer and Family Driven
  - 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
  - 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice
  - 4.4 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- Goal 5 Excellent Mental Health Care is Delivered and Research is Accelerated
  - 5.3 Improve and expand the workforce providing evidence based mental health services and supports

The Division of Community Behavioral Health, the Mental Health Advisory Council, and the community mental health centers have worked together to recognize unmet needs and service gaps across the community mental health system. Below are brief descriptions organized by area of need.

### **Training and Consumer Advocacy**

Lack of additional funding and continued decreases in Block Grant funding make it difficult to provide consumers and providers the necessary technical assistance and training opportunities on recovery-oriented, strength-based, consumer driven services. Important recovery components such as peer support specialists and consumer-based advocacy organizations need to be included in transformation activities.

Although community mental health centers have endorsed the implementation of the Comprehensive, Continuous, Integrated System of Care (CCISC) Model of integrated treatment for individuals with co-occurring disorders, there remains a need for additional training and technical assistance on implementation of integrated services for individuals. Trainings in the following areas need to be included in implementation of the CCISC model:

- Development of agency action plans for implementation
- Creation of screening and assessment tools to identify individuals with co-occurring mental health and substance use issues
- How to conduct integrated, strength-based assessments
- Development of policies and procedures on welcoming, integrated services for individuals with co-occurring disorders.

Additionally, there is a gap between higher education and the community mental health system. Professionals entering the community-based mental health system have not received training on recovery-oriented, strength-based, integrated, consumer/driven treatment for adults with severe and persistent mental illness. The Division of Community Behavioral Health needs to continue collaborative efforts with higher education institutions to include important activities in curriculums taught in colleges and universities.

#### Evidence-Based Practices, Data Collection, and Research

The majority of South Dakota is rural/frontier, with scarce resources, isolation, and transportation difficulties posing challenges with the implementation of evidence-based practices consistently across the state. Despite these barriers, the Division of Community Behavioral Health, the Advisory Council, and community mental health centers recognize the importance of further developing evidence-based practices, especially around illness management and recovery, and family psychoeducation. Furthermore, the Division of Community Behavioral Health and the community mental health system do not currently have data infrastructure in place to conduct point-in-time measurements for important performance indicators relative to recovery. These indicators include such measurements as change in living situation, criminal justice involvement, improved functioning, and social connectedness.

#### Access to Services and Workforce Development

Access to services throughout South Dakota remains an important issue, but especially in the very rural/frontier areas of the state. Many of the community mental health centers have large catchment areas that encompass great distances. Mental health providers in South Dakota have difficulty recruiting and retaining an adequate number of psychiatrists and mental health care professionals in rural/frontier areas. Complicating this issue is the lack of public transportation for individuals without reliable transportation to reach services. Additionally, the time and cost involved in providing services to geographically remote areas contributes to workforce issues. These barriers sometimes result in individuals being placed on waiting lists, and/or having to travel long distances to receive services.

Adult - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

## **Adult-Recent Significant Events**

### **Reorganization of the Division**

#### *Reorganization, Transition, and Integration*

Effective April 14, 2011, Governor Dennis Daugaard issued an Executive Order that called for the transition of behavioral health services from the Department of Human Services to the Department of Social Services. This transition included the Division of Mental Health, the Division of Alcohol and Drug Abuse, and the Human Services Center (the only state inpatient psychiatric hospital).

Effective May 16, 2011, the Divisions of Mental Health and Division of Alcohol and Drug Abuse have been dissolved, and two new divisions have been created: the Division of Community Behavioral Health and the Division of Correctional Behavioral Health. The Division of Community Behavioral Health includes both mental health and alcohol and drug services. The Division of Correctional Behavioral Health houses both mental health and substance abuse treatment services within the State's correctional system. In order to highlight the importance of prevention and early intervention, a separate Prevention Program has also been created and reports directly to the Secretariat. This is a critically important area and will lead to the development of a mental health and chemical dependency prevention framework in South Dakota. A Department of Social Services Deputy Secretary position was created that oversees day-to-day operations of the two Divisions noted above, the Prevention Program, and the Human Services Center.

The Department of Social Services includes the following divisions: Division of Adult Services and Aging, Division of Behavioral Health Services, Division of Child Care Services, Division of Child Protection Services, Division of Child Support, Division of Economic Assistance, Division of Finance and Management, Division of Legal Services, Division of Medical Services (State Medicaid Authority), and the Division of Operations and Technology, as well as the Human Service Center (the only state-operated, inpatient facility). The re-organization is resulting in an alignment of child serving agencies allowing for further integration which will aid in the development of fiscal, practice, and operational reform needed to implement systems of care statewide. While this is an exciting change to the system, as with any change, there are many details to work out.

#### *Behavioral Health Workgroup*

As part of the reorganization process, Governor Daugaard formed a workgroup to help guide the long term vision for a new behavioral health system. This group is headed by the Lieutenant Governor and a Senior Advisor from the Governor's Office. The workgroup also includes representatives from the Department of Social Services (including the Division of Community Behavioral Health), legislators, community mental health and substance use providers, inpatient behavioral health providers, advocacy groups, and county mental illness boards. The Behavioral Health Workgroup is developing recommendations for the Governor on key areas identified as necessary in the development of a behavioral health system. The group is utilizing the Governor's vision on creating efficiencies across the system and will also provide local level input into the

recommendations for the behavioral health system to serve those in need with the highest quality of service. An important piece to this is the identification of ways we can continue to help people with behavioral health needs achieve outcomes important to them and their families. Guiding principles of the Behavioral Health Workgroup include:

- “No wrong door approach” to service provision
- Services need to be focused on individualized recovery/resiliency driven outcomes
- Services are person-centered/family driven
- People are served in the least restrictive environment appropriate for their care and safety
- People are served with dignity and respect in a culturally responsive manner
- Services are available and accessible statewide
- Communities are involved and invested in service delivery

Workgroup members are currently focused on two major goal areas. These two goals and Workgroup discussion points are as follows:

- Define the role of the Human Services Center (state psychiatric inpatient facility)
  - Evaluate processes for accessing care on a voluntary basis
  - Explore opportunities to integrate and improve involuntary commitment processes
- Development of a statewide strategic behavioral prevention plan
  - Utilize evidence-based practices in all services
  - Identify prevention benchmarks across the state
  - Link to primary care, schools, daycares, etc
  - Work in collaboration with other state agencies
- Building Capacity of Local Communities
  - Integrating service delivery at the community level and ensuring care coordination among local providers is occurring creating a continuum of care
  - Exploring opportunities to include behavioral health in assisted living and long term care services
  - Identifying gaps and barriers for rural/frontier communities
- Access to Services
  - Assess current services and identify gaps, especially in rural/frontier areas
  - Availability of Crisis Care to divert individuals from inpatient psychiatric stays to community services
  - Partnering with Tribes across the state to increase the access to appropriate behavioral health services

### **Statewide Mental Health Planning and Coordination Advisory Council Activities**

The Division of Community Behavioral Health (DCBH), in partnership with the statewide Mental Health Planning and Coordination Advisory Council and Alcohol and Drug Abuse Advisory Council, has the responsibility to establish a system of public behavioral health services to meet individual and family needs relative to mental health and alcohol and drug services. The Mental Health Advisory Council has remained an

integral part of the Block Grant goals and activities. Over the last year, the Council has met twice and provided guidance to the Division of Mental Health on important topics such as:

- Coordination and planning of service delivery-including discussions on the creation of a Crisis Center in Rapid City and a mobile crisis response team in Sioux Falls.
- Feedback and recommendations to consider for technical assistance and support to continue to improve the availability of a strength-based, recovery/resiliency-oriented, client/family driven, and integrated system of care for individuals and families receiving services across the state.
- Improving advocacy efforts across the state for individuals, youth, families of youth, and families of adults.

During the past year, the Division of Community Behavioral Health has made concentrated efforts to keep the Mental Health Planning and Coordination Council informed of tasks and activities occurring as part of the reorganization and transition. Council members have had opportunity to make recommendations and provide feedback into the integration of behavioral health services, and how efficiencies and improvements may be created in the system. In light of the work South Dakota has done in the area of co-occurring services for individuals and families with mental health, Council members felt the prospect of integration of the Mental Health and Substance Abuse Block Grants created opportunities to further support the building of co-occurring capability across the state. In addition, they were excited to see the possibilities before our state with the integration of the mental health and substance use systems, specifically exploring creation of a Behavioral Health Council in South Dakota.

Unfortunately, during the last year, the individuals appointed as the Chair and Vice Chair both had terms expiring on the Council. Due to the transition to a new department and reorganization of behavioral health services, and seeking new appointments to the Council, there has not been opportunity to re-elect the Chair and Vice Chair positions on the Council. Additionally, the Council has not had the opportunity to meet as a full council prior to the submission of this Implementation Report. The Division of Community Behavioral Health is working diligently with the Council, and plan to meet December 8, 2011 to review the Implementation Report and provide a letter of support from the Statewide Mental Health Advisory Council.

### **Division of Community Behavioral Health Activities**

#### **Reorganization and Integration**

As discussed above, the last year's major focus has been the reorganization of behavioral health services into the Department of Social Services. Additionally, the former Division of Mental Health and the Division of Alcohol and Drug Abuse have been integrated into the Division of Community Behavioral Health. Transition processes have included:

- Partnering with local provider agencies to ensure seamless delivery of services
- Beginning work to refine accreditation practices to integrate the mental health and substance abuse accreditations into one process.

- In January 2011, revisions to the South Dakota Administrative Rules relative to community mental health services were promulgated. These new rules include an increased focus on recovery/resiliency, strength-based, client/family driven services that are provided in an integrated system of care, and requirements to develop continuous quality improvement processes for services provided across the state.
- Identify internal goals, roles and responsibilities of the Division.

*SOAR (SSI/SSDI Outreach, Access, and Recovery) Training*

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) are disability income benefits administered by the Social Security Administration (SSA) that also provide Medicaid and/or Medicare health insurance to individuals who are eligible. The application process for SSI/SSDI is complicated and difficult to navigate. The SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative in South Dakota is an approach that is supporting the Division of Behavioral Health to increase access to mainstream benefits for people who are homeless or at risk of homelessness through:

- ***Strategic Planning Meeting(s)*** to establish collaboration among key state and/or local stakeholders and to develop an action plan for implementing the SOAR approach
- ***Training*** of clinicians, case managers, and other community stakeholders in using SAMHSA's *Stepping Stones to Recovery* curriculum that includes a step-by-step explanation of an improved SSI/SSDI application process.

It is the hope that with the assistance of SOAR trained individuals, applicants for SSI/SSDI will see an increase in both time and approval rates. DCBH staff are beginning to meet with communities to plan the SOAR trainings across the state. Part of future plans that support expansion and sustainability include a “Train the Trainer” course for community members to have the ability to train other members in their own communities. The first of these community trainings was held August 30-31<sup>st</sup>, 2011, in Sioux Falls.

*Services to Veterans*

Due to the high incidence of mental disorders for veterans returning from Iraq, the Council of Mental Health Centers, the Council of Substance Abuse Directors, and the Division of Community Behavioral Health are continuing to collaborate with the South Dakota National Guard to provide mental health services to veterans returning from Iraq and their families. The Division of Community Behavioral health has participated in annual Mental Health Summits held by SD Department of Military and Veterans Affairs to help bridge military and community service systems for individuals and families, ensuring that civilian systems are supportive of pre- and post-development needs. Community mental health center staff also volunteers in Military Family Support Programs as rural area programs have a shortage of mental health professionals available.

The Suicide Prevention grant project partnered with state and federal agencies including the Department of Veterans Affairs to provide a free training that focused on post-traumatic stress disorder and suicide prevention in the military and veteran population on

May 10-11, 2011. Attendance was geared toward representatives of the military, government agencies and community partners, including health care providers, mental health counselors and social workers, first responders, support service providers, advocates and administrators. The focus was to train providers on the clinical practice guidelines for working with service members, veterans and family members coping with military related PTSD as well as training on suicide prevention with the military and veteran population using AMSR (Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals). Additionally, the training focused on increasing provider knowledge of military/veteran culture, including customs, systems of care and barriers to seeking treatment, as well as fostering cross-sector networking, relationships and contacts between the military, governmental agencies and community providers.

### Co-Occurring Capability Training

Through CO-SIG grant funds and activities, the DCBH continues to implement co-occurring capable services across the state for individuals and families with both mental health and substance use issues. The DCBH (which includes community-based mental health and alcohol/drug services) and the Human Services Center (HSC-state inpatient psychiatric facility) collaborate with providers, state stakeholders, individuals in recovery, and family members to develop a statewide quality improvement process for engaging every program in transformation efforts to become a welcoming, recovery-oriented, integrated system of care for all individuals, including those with co-occurring disorders. The goals include increasing the capacity and infrastructure of the behavioral health system to: 1) improve the recognition of co-occurring mental health and substance abuse issues, and 2) increase the provision of co-occurring treatment services across the state. South Dakota has adopted the Continuous, Comprehensive, Integrated System of Care (CCISC, Minkoff & Cline, 2004) framework to guide project activities. As part of implementation activities, provider staff across the state have participated in regional change agent trainings which are conducted in person and via teleconference. These trainings focused on providing additional resources in developing co-occurring capable services. Some of the trainings provided include:

- How to provide strength-based clinical supervision to staff across the agency
- Developing a integrated, strength-based needs assessment for clients and families
- Incorporating welcoming and respectful processes within agencies for individuals and families that come to the door for services
- Identifying and utilizing stages of change or readiness for change in treatment planning processes
- Crisis planning and risk management for individuals and families with co-occurring disorders

### Suicide Prevention

The Division of Community Behavioral Health was awarded a second Garrett Lee Smith Suicide Prevention and Early Intervention Grant in 2010. Currently, South Dakota funds 10 sub-grantees to perform suicide prevention activities tailored to their community's needs and resources. All project sites participate in an Advisory Group, discussing local community activities including development of loss teams, crisis beds in hospital

settings, and the use of Rural Primary Care tool kit. All project sites, including tribal partners and IHS (Indian Health Services) have re-formed the Statewide Suicide Prevention Task Force to provide feedback and guidance for long range strategic planning related to suicide prevention throughout South Dakota. Additionally, a Community Assessment Tool (CAT) is under development to meet the needs of the Suicide Prevention grantees that will allow teams to evaluate the effectiveness of current activities, as well as, the strengths of relationships and collaborations at multiple levels, both within and between agencies. The CAT will focus on aspects of prevention, intervention, and postvention, on three levels: universal (entire community), targeted (high risk populations), and indicated (those who are identified as high risk).

### **Community Crisis Response**

#### **Development of Community Crisis Services**

The Black Hills Mental Health and Substance Abuse Systems Change Collaborative was initiated by the John T. Vucurevich Foundation (JTVF) in response to a January 2007 Black Hills Community Needs Assessment. The report indicated serious gaps in access to mental health and substance abuse services for low and middle-income people. The major work of the Collaborative culminated in the establishment of a 24-hour Crisis Care Center in Rapid City designed to eliminate the “revolving door” of care for mental health and substance abuse patients and ensure a person can enter the system with the right service, at the right time, and at the right price. The Crisis Care Center opened on January 31, 2011. Since that opening day, the Center has steadily increased its hours of operation and the number of clients served, and is now open 24 hours per day, 7 days per week. The Crisis Center is staffed with one Qualified Mental Health Professional (QMHP) and two Emergency Medical Technicians (EMTs) at all times. In addition to those staff, there is one full time program coordinator and one part time medical director. The Crisis Center contracts with the county for on site and community case management. It also contracts with the Rapid City Regional Hospital’s Emergency Department for telephone back up. The Crisis Center is currently focused on receiving referrals from local law enforcement and the emergency department, although walk-ins still occur and are not turned away. The Center is designed to serve adults ages 18 and older. The target goal of the center is to divert 700 or more adults per year from being admitted into inpatient psychiatry, detox or jail.

### **Adult Client Advocacy Updates**

#### **South Dakota United for Hope and Recovery**

South Dakota United for Hope and Recovery (SD United) is the first and only consumer-run statewide mental health support and advocacy organization for adults with mental illness. The mission of SD United is “to come together as an amplified voice for the transformation of the mental health system to one of equality and full participation.” SD United collaborates with the National Empowerment Center to provide educational opportunities to individuals across the state. SD United members are very involved in transformation efforts across the state, with participation on local councils, the statewide Mental Health Advisory Council, and as one of the SD Partners in Transformation.

During the last year, SD United partnered with the National Empowerment Center to sponsor Dr. Dan Fisher on “Recovering Sanity: Together even the “Hopeless Can Heal” on the campus of Dakota Wesleyan University in Mitchell, SD. Dr. Fisher’s story of recovery serves as a model for others struggling to recover. His work in the mental health field has been recognized by his selection as a member of the White House Commission on Mental Health.

### NAMI

The National Alliance for the Mentally Ill-South Dakota (NAMI-South Dakota) has nine affiliates across the State and boasts an active statewide Consumer Council. NAMI-South Dakota also offered local and state support in the following areas:

- *Connection* is a recovery-focused support group led by trained mental health consumers for adults living with a mental illness.
- Recognized as an evidence based practice, *Family to Family* is NAMI’s psycho-education program led by trained family members for family members of adults with mental illness.
- *In Our Own Voice* is NAMI’s unique public education program in which two trained adult speakers share compelling personal stories about living with mental illness and achieving recovery. Additionally, an In Our Own Voice presentation was given during the quarterly trainings at the statewide Law Enforcement Training Center for new officers entering the field across the state.
- Customized trainings for corrections and court agencies statewide utilizing a core curriculum on Crisis Intervention Training.
- Annual educational conference in which NAMI partners with the Division of Community Behavioral Health (DCBH) to provide scholarships to individuals who have limited financial resources for attendance. DCBH also provides speakers to keep attendees updated on transformation activities at the state level. This past year, the DCBH gave presentations on Outcomes and Co-Occurring Services within the State of South Dakota.
- NAMI is also beginning to work with the newly formed Federation for Families chapter in Rapid City to offer the NAMI Basics education program for families of children and young adolescents.

Adult - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

## **FY2010 Block Grant Spending Report**

Through purchase of service agreements with eleven non-profit Community Mental Health Centers, the Division of Mental Health utilizes Block Grant funds to provide services to the following targeted populations.

### **Children Youth and Family Services (CYF)**

The Children's SED Program is an intensive and comprehensive, child-centered, family-focused, community-based, individualized system of care, which delivers mental health services to children with a serious emotional disturbance. The SED program provides access to a comprehensive array of services that address a child's physical, psychological, emotional, social, and educational needs. The SED program provides children with individualized services in accordance with the unique needs and potentials of each child. These services are provided to children within the least restrictive, most normative environment that is clinically appropriate and in a manner that is sensitive and responsive to children's cultural differences and special needs. The parents, families, and surrogate families of children with SED are full participants in all aspects of the evaluation, planning, and delivery of SED services, which are integrated with all involved child-serving agencies and programs. The goal of these services is to ensure that children with SED are able to live with their families and in their home community, whenever possible. The broad range of services that are provided through the children's SED program are as follows:

- 1) Individual Therapy
- 2) Family Education/Support/Therapy
- 3) Crisis Intervention
- 4) Collateral Contacts – treatment of an individual through necessary telephone or face-to-face contact with persons other than the identified child
- 5) Assessment and Evaluation
- 6) Psychological Evaluation
- 7) Group Therapy for Children with SED
- 8) Parent/Guardian Group Therapy
- 9) Intensive Family Services (IFS) – provided to families of youth under the jurisdiction of the Department of Corrections, which focus on resolving issues related to the child's successful return to the home
- 10) Liaison Services – consistent with treatment goals and intended to minimize the length of hospitalization

To be eligible for SED program services, the clinical record must contain documentation indicating that at least one child or adolescent in the family meets the criteria for being seriously emotionally disturbed. SED criteria are as follows:

- 1) The individual under 18 years of age; or is 18 through 21 years of age and needs a continuation of services that were started before the age of 18 in order to realize specific service goals or during transition to adult services; and
- 2) The individual exhibits behavior resulting in functional impairment which substantially interferes with, or limits the individual's role or functioning in the community, school, family or peer group; and
- 3) The individual has a mental disorder diagnosed under DSM-IV-TR (V Codes not included); and

- 4) The individual demonstrates a need for one or more special care services, in addition to mental health services; and
- 5) The individual has problems with a demonstrated or expected longevity of at least one (1) year or has an impairment of short duration and high severity.

Adult Comprehensive Assistance with Recovery and Empowerment (CARE) Services

The CARE Program is a comprehensive program for providing treatment, rehabilitation, and support services to identified consumers with SPMI, with the goal of helping individuals live successfully in the community. A CARE team is organized as a mobile group of mental health professionals who merge clinical, medical, and rehabilitation staff expertise within one service delivery team, which is supervised by a clinical supervisor. Services stress integration in normal community settings and are responsive to cultural differences and special needs. Outreach to consumers and the provision of services according to individual needs are the team’s highest priority, with the majority of clinical contacts occurring in settings outside of an office setting. The CARE team assumes responsibility for performing case management duties, which include:

- 1). maintaining current assessments and evaluations;
- 2). participating in the treatment planning process;
- 3). monitoring consumer progress;
- 4). assisting in locating, coordinating and monitoring medical, social, vocational, and psychiatric services as needed (including dental services);
- 5). developing a plan to manage consumer’s financial resources, including payee services as needed;
- 6). when appropriate, locating and maintaining suitable living environments, emergency services, and other activities necessary to maintaining psychiatric stability in a community-based setting; and
- 7). providing the following services:
  - a). crisis assessment and intervention;
  - b). liaison services
  - c). symptom assessment and management;
  - d). medication prescription administration, monitoring, and documentation;
  - e). direct assistance;
  - f). development of psychosocial skills;
  - g). encouragement for active participation of family and supportive social network; and
  - h). a system for communication and planning.

The following is the list of activities that the FFY 2010 CMHS Block Grant funds were expended for:

Administration	\$ 43,159.30
SPMI Adult MH Services	130,574.70
SED Children’s MH Services	<u>689,452.00</u>
Total	<u>\$ 863,186.00</u>

The following is the list of the Community Mental Health Centers that received FFY10 CMHS Block Grant funds.

<b>Community MH Center</b>	<b>Children SED Amount</b>	<b>Adult SPMI Amount</b>	<b>Total Amount</b>
Behavior Management Systems	\$68,037.64	\$35,379.00	\$103,416.64
Capital Area Counseling Services	\$57,144.38	\$0.00	\$57,144.38
Community Counseling Services	\$46,425.39	\$0.00	\$46,425.39
Dakota Counseling Institute	\$1,361.50	\$0.00	\$1,361.50
East Central Behavioral Health	\$4,341.09	\$0.00	\$4,341.09
Human Service Agency	\$165,048.46	\$24,389.70	\$189,438.16
Lewis and Clark Behavioral Health Services	\$153,238.76	\$70,806.00	\$224,044.76
Northeastern Mental Health Center	\$61,741.59	\$0.00	\$61,741.59
Southeastern Behavioral HealthCare	\$118,813.26	\$0.00	\$118,813.26
Southern Plains Behavioral Health Services	\$7,279.00	\$0.00	\$7,279.00
Three Rivers Mental Health Center	\$6020.93	\$0.00	\$6020.93
<b>Total</b>	<b>\$689,452.00</b>	<b>\$130,574.70</b>	<b>\$820,026.70</b>

Child - Report Summary of areas which the State identified in the prior FY's approved Plan as needing improvement

## **Summary of Areas Previously Identified as Needing Attention-Children**

The Division of Community Behavioral Health, formerly the Division of Mental Health, and the Mental Health Planning Council have made major commitments to transformation of the deliver of mental health services to individuals and families in the public mental health system. Transformation activities for adults with severe mental illness have included development of recovery-oriented services that are strength-based, consumer driven, and integrated for individuals with co-occurring disorders. Infused throughout transformation activities is the provision of services that are culturally sensitive and competent.

As identified by the Advisory Council, the President's New Freedom Commission Goals and Recommendations that are integral to transformation activities in South Dakota are as follows:

- Goal 2: Mental Health Care is Consumer and Family Driven
  - 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
  - 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice
  - 4.4 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- Goal 5 Excellent Mental Health Care is Delivered and Research is Accelerated
  - 5.3 Improve and expand the workforce providing evidence based mental health services and supports

The Division of Community Behavioral Health, the Mental Health Advisory Council, and the community mental health centers have worked together to recognize unmet needs and service gaps across the community mental health system. Below are brief descriptions organized by area of need.

### **Training and Consumer Advocacy**

Lack of additional funding and continued decreases in Block Grant funding make it difficult to provide children, families, and providers the necessary technical assistance and training opportunities on implementation of systems of care. Ensuring System of Care principles and values are shared across all stakeholder groups/disciplines is very important in transformation of the community mental health system. In addition, youth transitioning to the adult mental health system need supports that will assist them in a successful transition to independence in the community.

Although community mental health centers have endorsed the implementation of the Comprehensive, Continuous, Integrated System of Care (CCISC) Model of integrated treatment for individuals with co-occurring disorders, there remains a need for additional training and technical assistance on implementation of integrated services for individuals.

Trainings in the following areas need to be included in implementation of the CCISC model:

- Development of agency action plans for implementation
- Creation of screening and assessment tools to identify individuals with co-occurring mental health and substance use issues
- How to conduct integrated, strength-based assessments
- Development of policies and procedures on welcoming, integrated services for individuals with co-occurring disorders.

Additionally, there is a gap between higher education and the community mental health system. Professionals entering the community-based mental health system have not received training on strength-based, family driven, integrated systems of care for children with serious emotional disorders and their families. The Division of Community Behavioral Health needs to continue collaborative efforts with higher education institutions to include important activities in curriculums taught in colleges and universities.

South Dakota does not currently have funding to support ongoing consumer and family advocacy efforts that focus on issues related to mental health services provided to children with serious emotional disorders and their families. The Division is in support of families developing an advocacy organization so they might collaborate and assist in transforming the community mental health system into one that is responsive to and driven by children/youth and families receiving services.

#### Evidence-Based Practices, Data Collection, and Research

The majority of South Dakota is rural/frontier, with scarce resources, isolation, and transportation difficulties posing challenges with the implementation of evidence-based practices consistently across the state. Despite these barriers, the Division of Community Behavioral Health, the Advisory Council, and community mental health centers recognize the importance of further researching evidence-based practices that may fit with system of care development. Furthermore, the Division of Community Behavioral Health and the community mental health system do not currently have data infrastructure in place to conduct point-in-time measurements for important performance indicators relative systems of care. These indicators include such measurements as change in living situation, criminal justice involvement, out-of-home placements, improved functioning, and social connectedness. Continued focus needs to be on ensuring children and families are full participants in the development and implementation of performance indicators. In addition, focus must be placed on the development of continuous quality improvement processes that measure the quality of mental health services and whether they reflect services that are resiliency-based, family driven, and provided in an integrated system of care.

#### Access to Services and Workforce Development

Access to services throughout South Dakota remains an important issue, but especially in the very rural/frontier areas of the state. Many of the community mental health centers have large catchment areas that encompass great distances. Mental health providers in

South Dakota have difficulty recruiting and retaining an adequate number of psychiatrists and mental health care professionals in rural/frontier areas. Complicating this issue is the lack of public transportation for families without reliable transportation to reach services. Additionally, the time and cost involved in providing services to geographically remote areas contributes to workforce issues. These barriers sometimes result in children/youth and families being placed on waiting lists, and/or having to travel long distances to receive services.

Child - Report Summary of the most significant events that impacted the mental health system of the State in the previous FY

## **Child-Recent Significant Events**

### **Reorganization of the Division**

#### *Reorganization, Transition, and Integration*

Effective April 14, 2011, Governor Dennis Daugaard issued an Executive Order that called for the transition of behavioral health services from the Department of Human Services to the Department of Social Services. This transition included the Division of Mental Health, the Division of Alcohol and Drug Abuse, and the Human Services Center (the only state inpatient psychiatric hospital).

Effective May 16, 2011, the Divisions of Mental Health and Division of Alcohol and Drug Abuse have been dissolved, and two new divisions have been created: the Division of Community Behavioral Health and the Division of Correctional Behavioral Health. The Division of Community Behavioral Health includes both mental health and alcohol and drug services. The Division of Correctional Behavioral Health houses both mental health and substance abuse treatment services within the State's correctional system. In order to highlight the importance of prevention and early intervention, a separate Prevention Program has also been created and reports directly to the Secretariat. This is a critically important area and will lead to the development of a mental health and chemical dependency prevention framework in South Dakota. A Department of Social Services Deputy Secretary position was created that oversees day-to-day operations of the two Divisions noted above, the Prevention Program, and the Human Services Center.

The Department of Social Services includes the following divisions: Division of Adult Services and Aging, Division of Behavioral Health Services, Division of Child Care Services, Division of Child Protection Services, Division of Child Support, Division of Economic Assistance, Division of Finance and Management, Division of Legal Services, Division of Medical Services (State Medicaid Authority), and the Division of Operations and Technology, as well as the Human Service Center (the only state-operated, inpatient facility). The re-organization is resulting in an alignment of child serving agencies allowing for further integration which will aid in the development of fiscal, practice, and operational reform needed to implement systems of care statewide. While this is an exciting change to the system, as with any change, there are many details to work out.

#### *Behavioral Health Workgroup*

As part of the reorganization process, Governor Daugaard formed a workgroup to help guide the long term vision for a new behavioral health system. This group is headed by the Lieutenant Governor and a Senior Advisor from the Governor's Office. The workgroup also includes representatives from the Department of Social Services (including the Division of Community Behavioral Health), legislators, community mental health and substance use providers, inpatient behavioral health providers, advocacy groups, and county mental illness boards. The Behavioral Health Workgroup is developing recommendations for the Governor on key areas identified as necessary in the development of a behavioral health system. The group is utilizing the Governor's vision on creating efficiencies across the system and will also provide local level input into the

recommendations for the behavioral health system to serve those in need with the highest quality of service. An important piece to this is the identification of ways we can continue to help people with behavioral health needs achieve outcomes important to them and their families. Guiding principles of the Behavioral Health Workgroup include:

- “No wrong door approach” to service provision
- Services need to be focused on individualized recovery/resiliency driven outcomes
- Services are person-centered/family driven
- People are served in the least restrictive environment appropriate for their care and safety
- People are served with dignity and respect in a culturally responsive manner
- Services are available and accessible statewide
- Communities are involved and invested in service delivery

Workgroup members are currently focused on two major goal areas. These two goals and Workgroup discussion points are as follows:

- Define the role of the Human Services Center (state psychiatric inpatient facility)
  - Evaluate processes for accessing care on a voluntary basis
  - Explore opportunities to integrate and improve involuntary commitment processes
- Development of a statewide strategic behavioral prevention plan
  - Utilize evidence-based practices in all services
  - Identify prevention benchmarks across the state
  - Link to primary care, schools, daycares, etc
  - Work in collaboration with other state agencies
- Building Capacity of Local Communities
  - Integrating service delivery at the community level and ensuring care coordination among local providers is occurring creating a continuum of care
  - Exploring opportunities to include behavioral health in assisted living and long term care services
  - Identifying gaps and barriers for rural/frontier communities
- Access to Services
  - Assess current services and identify gaps, especially in rural/frontier areas
  - Availability of Crisis Care to divert individuals from inpatient psychiatric stays to community services
  - Partnering with Tribes across the state to increase the access to appropriate behavioral health services

### **Statewide Mental Health Planning and Coordination Advisory Council Activities**

The Division of Community Behavioral Health (DCBH), in partnership with the statewide Mental Health Planning and Coordination Advisory Council and Alcohol and Drug Abuse Advisory Council, has the responsibility to establish a system of public behavioral health services to meet individual and family needs relative to mental health and alcohol and drug services. The Mental Health Advisory Council has remained an

integral part of the Block Grant goals and activities. Over the last year, the Council has met twice and provided guidance to the Division of Mental Health on important topics such as:

- Coordination and planning of service delivery-including discussions on the creation of a Crisis Center in Rapid City and a mobile crisis response team in Sioux Falls.
- Feedback and recommendations to consider for technical assistance and support to continue to improve the availability of a strength-based, recovery/resiliency-oriented, client/family driven, and integrated system of care for individuals and families receiving services across the state.
- Improving advocacy efforts across the state for individuals, youth, families of youth, and families of adults.

During the past year, the Division of Community Behavioral Health has made concentrated efforts to keep the Mental Health Planning and Coordination Council informed of tasks and activities occurring as part of the reorganization and transition. Council members have had opportunity to make recommendations and provide feedback into the integration of behavioral health services, and how efficiencies and improvements may be created in the system. In light of the work South Dakota has done in the area of co-occurring services for individuals and families with mental health, Council members felt the prospect of integration of the Mental Health and Substance Abuse Block Grants created opportunities to further support the building of co-occurring capability across the state. In addition, they were excited to see the possibilities before our state with the integration of the mental health and substance use systems, specifically exploring creation of a Behavioral Health Council in South Dakota.

Unfortunately, during the last year, the individuals appointed as the Chair and Vice Chair both had terms expiring on the Council. Due to the transition to a new department and reorganization of behavioral health services, and seeking new appointments to the Council, there has not been opportunity to re-elect the Chair and Vice Chair positions on the Council. Additionally, the Council has not had the opportunity to meet as a full council prior to the submission of this Implementation Report. The Division of Community Behavioral Health is working diligently with the Council, and plan to meet December 8, 2011 to review the Implementation Report and provide a letter of support from the Statewide Mental Health Advisory Council.

### **Division of Community Behavioral Health Activities**

#### **Reorganization and Integration**

As discussed above, the last year's major focus has been the reorganization of behavioral health services into the Department of Social Services. Additionally, the former Division of Mental Health and the Division of Alcohol and Drug Abuse have been integrated into the Division of Community Behavioral Health. Transition processes have included:

- Partnering with local provider agencies to ensure seamless delivery of services
- Beginning work to refine accreditation practices to integrate the mental health and substance abuse accreditations into one process.

- In January 2011, revisions to the South Dakota Administrative Rules relative to community mental health services were promulgated. These new rules include an increased focus on recovery/resiliency, strength-based, client/family driven services that are provided in an integrated system of care, and requirements to develop continuous quality improvement processes for services provided across the state.
- Identify internal goals, roles and responsibilities of the Division.

*SOAR (SSI/SSDI Outreach, Access, and Recovery) Training*

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) are disability income benefits administered by the Social Security Administration (SSA) that also provide Medicaid and/or Medicare health insurance to individuals who are eligible. The application process for SSI/SSDI is complicated and difficult to navigate. The SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative in South Dakota is an approach that is supporting the Division of Behavioral Health to increase access to mainstream benefits for individuals and families who are homeless or at risk of homelessness through:

- ***Strategic Planning Meeting(s)*** to establish collaboration among key state and/or local stakeholders and to develop an action plan for implementing the SOAR approach
- ***Training*** of clinicians, case managers, and other community stakeholders in using SAMHSA's *Stepping Stones to Recovery* curriculum that includes a step-by-step explanation of an improved SSI/SSDI application process.

It is the hope that with the assistance of SOAR trained individuals, applicants for SSI/SSDI will see an increase in both time and approval rates. DCBH staff are beginning to meet with communities to plan the SOAR trainings across the state. Part of future plans that support expansion and sustainability include a “Train the Trainer” course for community members to have the ability to train other members in their own communities. The first of these community trainings was held August 30-31<sup>st</sup>, 2011, in Sioux Falls.

*Services to Veterans and their families*

Due to the high incidence of mental disorders for veterans returning from Iraq, the Council of Mental Health Centers, the Council of Substance Abuse Directors, and the Division of Community Behavioral Health are continuing to collaborate with the South Dakota National Guard to provide mental health services to veterans returning from Iraq and their families. The Division of Community Behavioral health has participated in annual Mental Health Summits held by SD Department of Military and Veterans Affairs to help bridge military and community service systems for individuals and families, ensuring that civilian systems are supportive of pre- and post-development needs. Community mental health center staff also volunteers in Military Family Support Programs as rural area programs have a shortage of mental health professionals available.

The Suicide Prevention grant project partnered with state and federal agencies including the Department of Veterans Affairs to provide a free training that focused on post-

traumatic stress disorder and suicide prevention in the military and veteran population on May 10-11, 2011. Attendance was geared toward representatives of the military, government agencies and community partners, including health care providers, mental health counselors and social workers, first responders, support service providers, advocates and administrators. The focus was to train providers on the clinical practice guidelines for working with service members, veterans and family members coping with military related PTSD as well as training on suicide prevention with the military and veteran population using AMSR (Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals). Additionally, the training focused on increasing provider knowledge of military/veteran culture, including customs, systems of care and barriers to seeking treatment, as well as fostering cross-sector networking, relationships and contacts between the military, governmental agencies and community providers.

### *Co-Occurring Capability Training*

Through CO-SIG grant funds and activities, the DCBH continues to implement co-occurring capable services across the state for individuals and families with both mental health and substance use issues. The DCBH (which includes community-based mental health and alcohol/drug services) and the Human Services Center (HSC-state inpatient psychiatric facility) collaborate with providers, state stakeholders, individuals in recovery, and family members to develop a statewide quality improvement process for engaging every program in transformation efforts to become a welcoming, recovery-oriented, integrated system of care for all individuals, including those with co-occurring disorders. The goals include increasing the capacity and infrastructure of the behavioral health system to: 1) improve the recognition of co-occurring mental health and substance abuse issues, and 2) increase the provision of co-occurring treatment services across the state. South Dakota has adopted the Continuous, Comprehensive, Integrated System of Care (CCISC, Minkoff & Cline, 2004) framework to guide project activities. As part of implementation activities, provider staff across the state have participated in regional change agent trainings which are conducted in person and via teleconference. These trainings focused on providing additional resources in developing co-occurring capable services. Some of the trainings provided include:

- How to provide strength-based clinical supervision to staff across the agency
- Developing a integrated, strength-based needs assessment for clients and families
- Incorporating welcoming and respectful processes within agencies for individuals and families that come to the door for services
- Identifying and utilizing stages of change or readiness for change in treatment planning processes
- Crisis planning and risk management for individuals and families with co-occurring disorders

### *Systems of Care Development and Training*

The Division of Community Behavioral Health continued to support community mental health centers offer college students internships in the community-based mental health system. This affords them the opportunity to learn first hand about providing strength-based and consumer driven services in an integrated system of care.

During this past year, the Division of Community Behavioral Health continued to participate in community level SOC Steering Committees in the Sioux Falls, Rapid City, and Pierre communities. These local SOC Steering Committees are comprised of family members; mental health, chemical dependency, child welfare, corrections, education and judiciary professionals; spiritual leaders/ministerial leaders; as well as other civic and child-serving community partners. Through membership, they've adopted the SOC values and principles and are working to conduct self-assessments and complete strategic planning around SOC development at the local level. Each partner organization in the local SOC Steering Committees contributes in two ways: (1) by participating at the community table and (2) by focusing on itself and on improving its internal application of the core SD-SoC values and guiding principles.

Since 2008, Jessica Tomasko, consultant with Western Interstate Commission for Higher Education, has been working with the three SOC Sites in South Dakota on identifying barriers and opportunities for systems of care development in their communities. Current activities include working with local SoC Steering Committees to implement the use of the Systems of Care Assessment Tool (SOCAT). The SOCAT is a tool meant to help organizations self-assess the need to further incorporate systems of care values and principles into their respective systems, and help find meaningful next steps in SOC implementation. In the last few months, Jessica has met with Sioux Falls staff within Child Protection Services, Court Services, and Corrections to assist them in utilizing the SOCAT and developing goals around issues identified as the tool is completed. Additionally, Ms. Tomasko is providing technical assistance to each of the sites in preparing action plans and providing guidance in facilitating local SOC meetings.

Students from the University of South Dakota's social work classes attended a workshop on Systems of Care 101 as an initial commitment to moving the components of current transformation into the higher education learning system. The university has received a grant to assist them in bridging the gap between workforce and education so that students are better prepared for child welfare, mental health and other related jobs upon graduation. Participants are developing a beginning understanding of the basic purpose, components, and process of Systems of Care and strengths-based approach, including critical aspects of Youth & Family Teams, strengths-based and family engagement processes, and related competencies. Facilitators reviewed system transformational efforts across South Dakota (including core values), what it means to be a "Change Agent", family-centered practices, paperwork requirements, and critical next steps. Aside from USD educators and students, participants included staff from Department of Corrections, Department of Social Services, Unified Judicial System and the Center for Disabilities.

### *Suicide Prevention*

The Division of Community Behavioral Health was awarded a second Garrett Lee Smith Suicide Prevention and Early Intervention Grant in 2010. Currently, South Dakota funds 10 sub-grantees to perform suicide prevention activities tailored to their community's needs and resources. All project sites participate in an Advisory Group, discussing local

community activities including development of loss teams, crisis beds in hospital settings, and the use of Rural Primary Care tool kit. All project sites, including tribal partners and IHS (Indian Health Services) have re-formed the Statewide Suicide Prevention Task Force to provide feedback and guidance for long range strategic planning related to suicide prevention throughout South Dakota. Additionally, a Community Assessment Tool (CAT) is under development to meet the needs of the Suicide Prevention grantees that will allow teams to evaluate the effectiveness of current activities, as well as, the strengths of relationships and collaborations at multiple levels, both within and between agencies. The CAT will focus on aspects of prevention, intervention, and postvention, on three levels: universal (entire community), targeted (high risk populations), and indicated (those who are identified as high risk).

### **Family Advocacy Updates**

#### *Federation for Families*

In March 2011, local family advocates in Rapid City, South Dakota organized to become the first state chapter organization of the Federation of Families, a national family support and advocacy organization. The Parents 4 Parents Organization have identified five goals as they move forward with improving family advocacy within the Rapid City community and across the state. The five goals are:

- 1) Be a resource for individuals and families looking for education, information, services and supports. This includes identifying and promoting trainings and materials that educate/support families.
- 2) Increase public awareness of the Parent Support Group and resources available, which includes increasing the knowledge of community members who have consistent contact with individuals/families in need, and educate them to make appropriate referrals.
- 3) Identify and train advocates in specialty areas to assist in a peer support system
- 4) Help families to be part of decision making at all levels by being the point of contact for a collective voice and a feedback loop to providers
- 5) Advocate for systemic, legislative, and/or funding changes to benefit families.

Parents 4 Parents have developed a website: <http://parents4parentsbh.org> featuring local resources for parents and families. They have contracted with a statewide resource (211) to research and print a Mental Health Resource Guide for the Black Hills. 211 is the three-digit telephone number assigned by the Federal Communications Commission for the purpose of providing quick and easy access to health and human services for individuals across the state. Furthermore, Parents 4 Parents are planning quarterly conferences for parents on various topics. The first conference occurred in October 2011 focused on providing education to families on Individual Education Plans (IEPs) and services offered as part of the education system for families of children with behavioral health needs. The Division of Community Behavioral Health is looking forward to partnering with Parents 4 Parents to further implement statewide family networking and advocacy efforts.

Child - A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

## **FY2010 Block Grant Spending Report**

Through purchase of service agreements with eleven non-profit Community Mental Health Centers, the Division of Mental Health utilizes Block Grant funds to provide services to the following targeted populations.

### **Children Youth and Family Services (CYF)**

The Children's SED Program is an intensive and comprehensive, child-centered, family-focused, community-based, individualized system of care, which delivers mental health services to children with a serious emotional disturbance. The SED program provides access to a comprehensive array of services that address a child's physical, psychological, emotional, social, and educational needs. The SED program provides children with individualized services in accordance with the unique needs and potentials of each child. These services are provided to children within the least restrictive, most normative environment that is clinically appropriate and in a manner that is sensitive and responsive to children's cultural differences and special needs. The parents, families, and surrogate families of children with SED are full participants in all aspects of the evaluation, planning, and delivery of SED services, which are integrated with all involved child-serving agencies and programs. The goal of these services is to ensure that children with SED are able to live with their families and in their home community, whenever possible. The broad range of services that are provided through the children's SED program are as follows:

- 1) Individual Therapy
- 2) Family Education/Support/Therapy
- 3) Crisis Intervention
- 4) Collateral Contacts – treatment of an individual through necessary telephone or face-to-face contact with persons other than the identified child
- 5) Assessment and Evaluation
- 6) Psychological Evaluation
- 7) Group Therapy for Children with SED
- 8) Parent/Guardian Group Therapy
- 9) Intensive Family Services (IFS) – provided to families of youth under the jurisdiction of the Department of Corrections, which focus on resolving issues related to the child's successful return to the home
- 10) Liaison Services – consistent with treatment goals and intended to minimize the length of hospitalization

To be eligible for SED program services, the clinical record must contain documentation indicating that at least one child or adolescent in the family meets the criteria for being seriously emotionally disturbed. SED criteria are as follows:

- 1) The individual under 18 years of age; or is 18 through 21 years of age and needs a continuation of services that were started before the age of 18 in order to realize specific service goals or during transition to adult services; and
- 2) The individual exhibits behavior resulting in functional impairment which substantially interferes with, or limits the individual's role or functioning in the community, school, family or peer group; and
- 3) The individual has a mental disorder diagnosed under DSM-IV-TR (V Codes not included); and

- 4) The individual demonstrates a need for one or more special care services, in addition to mental health services; and
- 5) The individual has problems with a demonstrated or expected longevity of at least one (1) year or has an impairment of short duration and high severity.

Adult Comprehensive Assistance with Recovery and Empowerment (CARE) Services

The CARE Program is a comprehensive program for providing treatment, rehabilitation, and support services to identified consumers with SPMI, with the goal of helping individuals live successfully in the community. A CARE team is organized as a mobile group of mental health professionals who merge clinical, medical, and rehabilitation staff expertise within one service delivery team, which is supervised by a clinical supervisor. Services stress integration in normal community settings and are responsive to cultural differences and special needs. Outreach to consumers and the provision of services according to individual needs are the team’s highest priority, with the majority of clinical contacts occurring in settings outside of an office setting. The CARE team assumes responsibility for performing case management duties, which include:

- 1). maintaining current assessments and evaluations;
- 2). participating in the treatment planning process;
- 3). monitoring consumer progress;
- 4). assisting in locating, coordinating and monitoring medical, social, vocational, and psychiatric services as needed (including dental services);
- 5). developing a plan to manage consumer’s financial resources, including payee services as needed;
- 6). when appropriate, locating and maintaining suitable living environments, emergency services, and other activities necessary to maintaining psychiatric stability in a community-based setting; and
- 7). providing the following services:
  - a). crisis assessment and intervention;
  - b). liaison services
  - c). symptom assessment and management;
  - d). medication prescription administration, monitoring, and documentation;
  - e). direct assistance;
  - f). development of psychosocial skills;
  - g). encouragement for active participation of family and supportive social network; and
  - h). a system for communication and planning.

The following is the list of activities that the FFY 2010 CMHS Block Grant funds were expended for:

Administration	\$ 43,159.30
SPMI Adult MH Services	130,574.70
SED Children’s MH Services	<u>689,452.00</u>
Total	<u>\$ 863,186.00</u>

The following is the list of the Community Mental Health Centers that received FFY10 CMHS Block Grant funds.

<b>Community MH Center</b>	<b>Children SED Amount</b>	<b>Adult SPMI Amount</b>	<b>Total Amount</b>
Behavior Management Systems	\$68,037.64	\$35,379.00	\$103,416.64
Capital Area Counseling Services	\$57,144.38	\$0.00	\$57,144.38
Community Counseling Services	\$46,425.39	\$0.00	\$46,425.39
Dakota Counseling Institute	\$1,361.50	\$0.00	\$1,361.50
East Central Behavioral Health	\$4,341.09	\$0.00	\$4,341.09
Human Service Agency	\$165,048.46	\$24,389.70	\$189,438.16
Lewis and Clark Behavioral Health Services	\$153,238.76	\$70,806.00	\$224,044.76
Northeastern Mental Health Center	\$61,741.59	\$0.00	\$61,741.59
Southeastern Behavioral HealthCare	\$118,813.26	\$0.00	\$118,813.26
Southern Plains Behavioral Health Services	\$7,279.00	\$0.00	\$7,279.00
Three Rivers Mental Health Center	\$6020.93	\$0.00	\$6020.93
<b>Total</b>	<b>\$689,452.00</b>	<b>\$130,574.70</b>	<b>\$820,026.70</b>

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	31	32	33	33	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** Ensure all individuals statewide have access to recovery-oriented, integrated mental health services.

**Target:** Increase number of adults with severe mental illness served in the community mental health system by 1% each year.

**Population:** Adults with severe mental illness.

**Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services

**Indicator:** Percentage of adults with severe mental illness served.

**Measure:** Numerator: Number of adults with severe mental illness served during FY with state funding.  
Denominator: Estimated number of adults with severe mental illness across the state (prevalence)

**Sources of Information:** DCBH Information System, WICHE Estimation of MH Need, WICHE Mental Health Program <http://psy.utmb.edu>

**Special Issues:** The FY11 total includes additional adults who were served through an expansion of funding received to alleviate waiting lists.

The DCBH relies on a data collection system (STARS) to track client information and process billing. State totals provide unduplicated counts of individuals served statewide. STARS is interfaced with the Department of Social Services Medicaid Management Information System (MMIS) which captures data specific to Medicaid eligible consumers. The DCBH and the Department of Social Services work closely to ensure the two systems are compatible and HIPAA compliant. Due to this collaboration, the total number served includes both Medicaid and state funded individuals.

Prevalence data from WICHE was used rather than the information provided in the Federal Register. WICHE's data provided prevalence estimates broken out by severe and persistent mental illness, rather than only severe mental illness. Breakouts were also by county, based on the demographics of each county. The WICHE data was computed based on census information from 2000. This data assumes the growth in the number of adults with severe and persistent mental illness is at the same rate as the total population.

**Significance:** Assuring access to mental health services for individuals with severe and persistent mental illness is a priority of the Division of Community Behavioral Health and the Mental Health Block Grant Legislation.

**Activities and strategies/ changes/ innovative or exemplary model:**

The FY10 number of adults with severe mental illness includes individuals who were served through an expansion in funding used to alleviate waiting lists. The Division of Community Behavioral Health continues to explore opportunities to increase funding for services to adults with severe and persistent mental illness.

The Division of Community Behavioral Health works with the Department of Social Services, Office of Medical Services to provide reimbursement for telepsychiatry services to individuals and families receiving services through the community mental health system. This has helped to ensure individuals in the most remote/frontier portions of the state have access to mental health services. In addition, the Division allows community mental health centers to bill a rural rate for mental health services provided to adults with severe mental illness. This rural rate is 20% higher than the regular rate for services and can be used for any services provided 20 miles or more from a main or satellite office.

**Target Achieved or Not Achieved/If Not, Explain Why:**

Target achieved. 5,635 individuals were served during FY11.

## ADULT - IMPLEMENTATION REPORT

Transformation Activities:

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	11.16	9.90	9.90	10.72	92.35
Numerator	181	152	--	182	--
Denominator	1,622	1,536	--	1,698	--

### Table Descriptors:

<b>Goal:</b>	Decrease re-admissions to the state psychiatric inpatient facility through the provision of a comprehensive, organized, community-based system of mental health care for adults with severe mental illness.
<b>Target:</b>	Reduction in percentage of admission rates to the State Psychiatric Hospital within 30 days.
<b>Population:</b>	Adults with severe mental illness
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Decreased rate of 30 day re-admissions to the state psychiatric hospital (HSC)
<b>Measure:</b>	Numerator: Number of persons, aged 18+, who are readmitted to HSC within 30 days Denominator: Number of persons, aged 18+, who are discharged from HSC during the last year
<b>Sources of Information:</b>	HSC Information Systems
<b>Special Issues:</b>	The number of re-admissions is comprised of a duplicate count (i.e., an adult re-admitted repeatedly would be counted at each re-admission).
<b>Significance:</b>	Reducing the utilization of state psychiatric inpatient beds will be a reflection on implementation of recovery-oriented, consumer driven, integrated services being provided within the community mental health system.
<b>Activities and strategies/ changes/ innovative or exemplary model:</b>	<p>The Division Community Behavioral Health, the Human Services Center, and community mental health centers continue to collaborate to improve discharge planning ensuring all individuals, once discharged from the hospital, are aware of and have immediate access to mental health services in the community.</p> <p>The Division of Community Behavioral Health continues to offer the Indigent Medication Program to individuals discharging from the Human Services Center, in order to assist these individuals with obtaining psychotropic medications while other longer term funding options are pursued.</p> <p>The Division of Community Behavioral Health meets with the Clinical Management Team on a regular basis to explore opportunities for further workforce development to assist in reducing the number of hospitalizations/re-</p>

admissions for adults with severe and persistent mental illness. Workforce development includes trainings on recovery and integrated treatment for individuals with co-occurring mental health and substance use issues.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. The 30 day re-admission rate raised .8% over last year's totals. The Human Services Center had 1698 total discharges in FY2011 . This was an increase of 162 over FY10 numbers. With the additional admissions, the re-admission rate rose from 152 to 191. The Division of Community Behavioral Health is unsure why the increase, but feels that some of the raise in numbers may be attributed to the increased screening for co-occurring issues and treating both mental health and substance use issues concurrently. Over the next year, the Division of Community Behavioral Health will work closely with the Human Services Center and community providers to identify areas of improvement needed for discharge planning and availability of community-based services.

## ADULT - IMPLEMENTATION REPORT

**Transformation Activities:**

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	25.28	20.18	20.18	22.32	90.41
Numerator	410	310	--	379	--
Denominator	1,622	1,536	--	1,698	--

Table Descriptors:

**Goal:** Decrease re-admissions to the state psychiatric inpatient facility through the provision of a comprehensive, organized, community-based system of mental health care for adults with severe mental illness.

**Target:** Reduction in percentage of re-admission rates to the State Psychiatric Hospital within 180 days

**Population:** Adults with severe mental illness

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Decreased rate of re-admissions to State Psychiatric Hospitals within 180 days

**Measure:** Numerator: Number of persons, age 18+, who are readmitted to HSC within 180 days  
Denominator: Number of persons, aged 18+, discharged from HSC during the past year

**Sources of Information:** HSC Information System

**Special Issues:** The number of re-admissions is comprised of a duplicate count (i.e., an adult readmitted repeatedly would be counted at each re-admission).

**Significance:** Reducing the utilization of state psychiatric inpatient beds will be a reflection on implemetation of recovery-oriented, consumer-driven, integrated services within the community based mental health system.

**Activities and strategies/ changes/ innovative or exemplary model:** The Division of Community Behavioral Health, the Human Services Center, and community mental health centers continue to collaborate to improve discharge planning ensuring all individuals, once discharged from the hospital, are aware of and have immediate access to mental health services in the community.

The Division of Community Behavioral Health continues to offer the Indigent Medication Program to individuals discharging from the Human Services Center in order to assist these individuals with obtaining psychotropic medications while other long term funding options are pursued.

The Division of Community Behavioral Health meets with the Clinical Management Team on a regular basis to explore opportunities for further workforce development to assist in reducing the number of hospitalizations/re-

admissions for adults with severe and persistent mental illness. Workforce development includes trainings on recovery and integrated treatment for individuals with co-occurring mental health and substance use issues.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. The 180 day re-admission rate raised 2% over last year's totals. The Human Services Center had 1698 total discharges in FY2011 . This was an increase of 162 over FY10 numbers. With the additional admissions, the re-admission rate rose from 310 to 379. The Division of Community Behavioral Health is unsure why the increase, but feels that some of the raise in numbers may be attributed to the increased screening for co-occurring issues and treating both mental health and substance use issues concurrently. Over the next year, the Division of Community Behavioral Health will work closely with the Human Services Center and community providers to identify areas of improvement needed for discharge planning and availability of community-based services.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	2	1	1	1	100
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** Provide a comprehensive, organized, community-based system of mental health care for adults with severe mental illness to include access to evidence-base practices.

**Target:** Maintain the number of evidence based practices available across the state.

**Population:** Adults with severe mental illness.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Number of evidence based practices across the state for adults with severe mental illness.

**Measure:** Total number of evidence based practices across the state for adults with severe mental illness.

**Sources of Information:** DCBH Information System (STARS)

**Special Issues:** The Division of Community Behavioral Health currently offers only ACT as a statewide evidence based practice for adults with severe mental illness.

**Significance:** There are four ACT programs across the state. Each of the ACT programs is housed within a community mental health center that also offers less intense mental health services for adults with severe mental illness.

**Activities and strategies/ changes/ innovative or exemplary model:** Due to existing budget constraints and lack of additional funding to add evidence-based practices, the Division of Community Behavioral Health will be setting a goal of maintaining those evidence-based programs South Dakota currently offers. The Division and the community mental health system will, however continue to explore options of implementing additional evidence-based practices.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target achieved.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**  **Indicator Data Not Applicable:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved or Not Achieved/If Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**  **Indicator Data Not Applicable:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved or Not Achieved/If Not, Explain Why:**

## ADULT - IMPLEMENTATION REPORT

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	4.45	4.08	4.08	4.01	98.28
Numerator	228	222	--	226	--
Denominator	5,118	5,443	--	5,635	--

Table Descriptors:

**Goal:** Provide a comprehensive, organized, community-based system of care for adults with severe mental illness to include access to an array of appropriate services and resources.

**Target:** Increase the number of individuals receiving ACT by .1% over the current level.

**Population:** Adults with severe mental illness

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of individuals receiving ACT services.

**Measure:** Numerator: Statewide total of individuals receiving ACT services  
Denominator: Total number of adults with severe mental illness receiving community mental health services.

**Sources of Information:** DCBH Information System (STARS)

**Special Issues:** The Division of Community Behavioral Health, along with IMPACT Programs work together to identify individuals who require the intense services that IMPACT provides. These individuals have been unsuccessful in other community placements and have had frequent hospitalizations.

**Significance:** The Division of Community Behavioral Health believes that IMPACT is an important service to offer to adult clients who have been unsuccessful in less intense services. Providing quality, recovery-oriented mental health services to individuals with severe mental illness is a priority of the Division of Community Behavioral Health and the Mental Health Block Grant Legislation.

**Activities and strategies/ changes/ innovative or exemplary model:** The Division of Community Behavioral Health and the IMPACT Programs are working closely together to assure fidelity to the evidence-based ACT model through the use of the SAMHSA ACT toolkit. In addition, the IMPACT Programs and the Division of Community Behavioral Health collaborated to develop performance indicators that are outcome driven, individualized, and recovery based. These outcome measures are collected quarterly from clinicians and semi-annually from consumers. The Division and IMPACT Programs are now beginning to analyze the data collected and further refine performance indicators to ensure they continue to meet the needs of consumers and the system as a whole.

**Target Achieved** Target Not achieved. However, we were only .07% from achieving this target.

**or** Additionally, the number served in ACT did increase by 4 individuals over FY10  
**Not Achieved/If** numbers. Budget cuts and constraints during the last FY may have contributed to  
**Not, Explain Why:** not achieving this target. The Division of Community Behavioral Health will  
continue to partner with local providers to support increased access to  
appropriate levels of care, including IMPACT services.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**  **Indicator Data Not Applicable:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved or Not Achieved/If Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	.76	.51	0	N/A	N/A
Numerator	39	28	--	0	--
Denominator	5,118	5,443	--	N/A	--

Table Descriptors:

**Goal:** Provide a comprehensive, organized, community-based system of mental health care for adults with severe mental illness to include access to integrated treatment for individuals with co-occurring disorders.

**Target:** Increase the number of individuals receiving integrated treatment through Serenity Hills by .1% per year.

**Population:** Adults with severe mental illness with co-occurring mental health and substance use issues.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Number of persons with severe mental illness receiving Serenity Hills Services.

**Measure:** Numerator: Number of adults with severe mental illness receiving services through Serenity Hills for current FY.  
Denominator: Total number of adults with severe mental illness receiving community mental health services during the current FY.

**Sources of Information:** DCBH Information System (STARS)

**Special Issues:** For the past several years, the Division of Mental Health reported the Serenity Hills program as an evidence based practice. Serenity Hills was the only residential facility of its kind, providing integrated mental health and substance abuse services. As South Dakota has moved towards integrated, recovery-oriented services across both mental health and substance abuse systems, Serenity Hills has become a halfway house focused on alcohol and drug needs with the ability to also meet mental health needs.

The Division of Mental Health plays an important role in the development of co-occurring disorder services within the state. The Department of Human Services, which houses both the Division of Alcohol and Drug Abuse and the Division of Mental Health supports integrated treatment for individuals with co-occurring disorders.

**Significance:** Assuring access to mental health and chemical dependency services is of primary importance due to the increasing numbers of individuals diagnosed with co-occurring disorders.

**Activities and** Integration of mental health and substance abuse services for individuals with co-

**strategies/  
changes/  
innovative or  
exemplary model:** occurring disorders has been identified as a priority area by the Mental Health Planning and Coordination Advisory Council and the Division of Mental Health. The Division of Mental Health, the Division of Alcohol and Drug Abuse, the Human Services Center, and community mental health and alcohol/drug providers have adopted integration of the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing statewide systems change to improve access and outcomes for individuals and families with co-occurring disorders.

Serenity Hills is in the process of identifying a Change Agent within their program that will attend regional/statewide change agent meetings and share information gathered with other staff to improve the development of welcoming attitudes/policies, strength-based treatment including integrated assessments, screening, use of stage matched interventions, and building of core competencies in implementation of integrated treatment and improvement of co-occurring capable programming.

**Target Achieved  
or  
Not Achieved/If  
Not, Explain Why:** This goal was removed during the last FY update to South Dakota's Block Grant activities and goals. As community mental health centers are improving the delivery of integrated treatment, individuals with co-occurring issues are indicating they would like to receive services within their own community, rather than having to move to an unfamiliar service provider to receive the services they need/want. This change in philosophy and service delivery may have contributed to the decrease in the number of individuals being served through Serenity Hills. Serenity Hills is no longer viewed as the only co-occurring program in the state. It has been re-classified as a halfway house with the capacity to also provide mental health services, similar to other halfway houses. Therefore, there are no numbers to report for this goal.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**  **Indicator Data Not Applicable:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved or Not Achieved/If Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**  **Indicator Data Not Applicable:**

**Name of Implementation Report Indicator:** Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved or Not Achieved/If Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	55.87	61.45	63	62.23	98.78
Numerator	138	153	--	145	--
Denominator	247	249	--	233	--

Table Descriptors:

**Goal:** Improve client perception of care through the provision of a comprehensive, organized, community-based system of care for adults with severe mental illness that includes access to an array of appropriate services and resources.

**Target:** Increase the number of people reporting positively about outcomes by 2% each year.

**Population:** Adults with severe mental illness.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Number of consumers reporting positively regarding outcomes.

**Measure:** Numerator: Number of positive responses reported in the outcome domain on the adult consumer survey.  
Denominator: Total responses reported in the outcome domain on the adult consumer survey.

**Sources of Information:** MHSIP Adult Consumer Surveys

**Special Issues:** This indicator demonstrates positive responses on outcomes for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. Eight questions are analyzed in determining positive reporting of outcomes by consumers. Individuals completing the survey must check "strongly agree" or "agree" that direct services have resulted in:

- \* I deal more effectively with daily problems
- \* I am better able to control my life
- \* I am better able to deal with crisis
- \* I am getting along better with my family
- \* I do better in social situations
- \* I do better in school and/or work
- \* My symptoms are not bothering me as much
- \* My housing situation has improved

**Significance:** The Division of Community Behavioral Health recognizes the importance of positive outcomes for individuals receiving mental health services within the community mental health system. As the system transforms to a more client driven, strength-based system, positive outcomes will become a very important indicator towards the quality of services.

**Activities and strategies/ changes/ innovative or exemplary model:**

Utilizing the MHSIP Survey, the Division continues to survey a sample of adults from across the state. WICHE collaborates with the Division of Community Behavioral Health to provide data analysis and reports on the survey responses. This information is then shared with the Advisory Council, Clinical Management Team, consumers, and family members. Information presented includes data analysis, data trends, and exploration of possible explanations for data. The overall goal is for community mental health centers to begin to include outcome measurement within their continuous quality improvement plan.

The Division of Community Behavioral Health meets with the Clinical Management Team on a regular basis to further develop and refine client level reporting capabilities for indicators related to participation in treatment planning. This process includes implementation of semi-annual data collection on quality of life indicators for individuals receiving community mental health services. Included in the quality of life indicators are questions related to participation in treatment planning. This information will be provided in STARS, the DMH's management information system.

**Target Achieved or Not Achieved/If Not, Explain Why:**

Target not achieved. However, the percentage reporting positively regarding outcomes did increase .8% over FY10 percentages. The Division of Community Behavioral Health considers perception of care as an indicator in the development of recovery-oriented services. The small increase in those indicating improved outcomes could be a reflection of the transformation of the mental health system to a more recovery-oriented, consumer-driven system, and individuals becoming more knowledgeable about service options that should be available to them. Over the next year, the Division of Community Behavioral Health will be working closely with providers to discuss data from the MHSIP surveys and explore opportunities to further improve outcomes for individuals receiving mental health services.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	25.33	24.89	26	26.61	102.35
Numerator	1,942	2,118	--	2,328	--
Denominator	7,668	8,508	--	8,748	--

Table Descriptors:

**Goal:** Improve employment options for adults with severe mental illness through community mental health provider collaboration with the Division of Rehabilitation Services and other employment providers within the community.

**Target:** Increase in the number of consumers who report they are working by 2% each year.

**Population:** Adults with severe mental illness

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems

**Indicator:** Percentage of adults receiving community mental health services that report they are working.

**Measure:** Numerator: Number of Persons Employed Competitively Full or Part Time  
Denominator: Employed: Competitively Employed Full or Part time + Unemployed + Not in Labor Force:Retired, Sheltered Employment/Workshops, Other (homemaker, student, volunteer, disabled, etc.)

**Sources of Information:** DCBH Information System (STARS)

**Special Issues:** This performance indicator is collected only at admission and discharge. In addition, this data excludes persons whose employment status was "Not Available".

**Significance:** As the system moves towards recovery, the Division recognizes employment as being a very important positive outcome for adults receiving community mental health services.

**Activities and strategies/ changes/ innovative or exemplary model:** The Division of Community Behavioral Health works closely with the Division of Rehabilitation Services (DRS) to increase the employment opportunities for individuals with severe mental illness. This collaboration includes examinations of current employment programs offered through community mental health centers, and how to expand these programs across the state. Furthermore, DRS is updated a Memorandum of Understanding with the community mental health centers to reflect increased collaboration between these agencies.

In addition, the Division Community Behavioral Health, as part of the Data Infrastructure Grant is working with providers to develop client level reporting capabilities for employment outcomes. This will give the Division a clearer picture of employment and positive outcomes for individuals receiving community mental health services.

**Target Achieved** Target achieved.  
**or**  
**Not Achieved/If**  
**Not, Explain Why:**

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Adult - Decreased Criminal Justice Involvement  
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	76.92	81.25	82	60	73.17
Numerator	10	13	--	6	--
Denominator	13	16	--	10	--

Table Descriptors:

**Goal:** Decrease criminal justice involvement through the provision of a comprehensive, organized, community-based system of care for adults with severe mental illness that includes access to an array of appropriate services and resources.

**Target:** Increase by 1% each year the number of consumers who report no re-arrests in Year 2 after arrest in Year 1.

**Population:** Adults with severe mental illness.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percent of consumers arrested in Year 1 who were re-arrested in Year 2.

**Measure:** Numerator: Number of adult consumers reporting arrests in T1 who were not re-arrested in T2 (new and continuing clients combined)  
Denominator: Number of adult consumers reporting arrests in T1 (new and continuing clients combined)

**Sources of Information:** MHSIP Adult Consumer Survey

**Special Issues:** MHSIP Surveys are conducted on an annual basis. A random sample of individuals that have received services during 3 months prior to dissemination of the surveys are chosen. WICHE conducts the data analysis and completes the data reports for the Division of Mental Health.

**Significance:** The Division of Community Behavioral Health recognizes that individuals receiving community mental health services may also be involved with the criminal justice system. It is a priority of the Division, community mental health centers, and the Advisory Council to assist individuals involved with the criminal justice system in an effort to decrease criminal justice involvement through the provision of a comprehensive, organized, community-based system of care.

**Activities and strategies/ changes/ innovative or exemplary model:** The Division of Community Behavioral Health, the Advisory Council, and the community mental health centers are working to develop performance indicators relative to criminal justice involvement.

**Target Achieved or Not Achieved/If** Target not achieved. Only 60% of individuals reporting arrests during Year 1 also reported no re-arrests during Year 2. As this indicator is important in the transformation to recovery-oriented, consumer-driven services, the Division of

**Not, Explain Why:** Community Behavioral Health will continue to monitor criminal justice involvement for individuals receiving mental health services. The Division has partnered with community mental health centers to develop an outcome tool that looks at arrests during previous 90 days. This outcome tool is being implemented statewide in December 2011. The Division is hopeful that this tool will provide more accurate information on criminal justice involvement than random sampling through the MHSIP Survey.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	1.50	1.60	N/A	N/A	N/A
Numerator	115	136	--	153	--
Denominator	7,667	8,508	--	N/A	--

Table Descriptors:

**Goal:** Improve stability in housing through the provision of a comprehensive, organized, community-based system of care for adults with severe and persistent mental illness that includes access to an array of appropriate services and resources.

**Target:** Decrease the percentage of consumers reporting homeless or living in shelter.

**Population:** Adults with severe and persistent mental illness

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of adults receiving mental health services that indicate they are homeless or in shelters at the time of admission to services.

**Measure:** Numerator: Number of Persons Homeless at admission, age 18+  
Denominator: From URS Tables, all persons with living situation excluding (-) persons with living situation not available.

**Sources of Information:** DMH Information System (STARS)

**Special Issues:** This performance indicator is only collected at admission and discharge.

**Significance:** Stability in housing is an important performance indicator to assist the Division of Mental Health in the transformation of community mental health to a more recovery-oriented system.

**Activities and strategies/ changes/ innovative or exemplary model:** Over the next two years, the Division of Mental Health and the community mental health centers, with assistance through the DIG Grant, will be developing client level performance indicators around living arrangements and stability in housing. This client level data will be reported at various points in time during service delivery.

In addition, the Division of Mental Health participates in the Statewide Interagency Council on Homelessness. This Council meets on a quarterly basis and has focused on the following goals for reducing homelessness across South Dakota.

- 1)Work with the South Dakota Homeless Consortium to achieve the data necessary to understand the scope of homelessness and the factors contributing to it.
- 2)Educate and work with local entities to understand each other's programs.
- 3)Evaluate outreach with state programs, including getting out into the facilities and one-stop shops, and making improvements as needed.
- 4) Development of toolkits containing best practices for reducing homeless

numbers.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. Possible explanations could be the economic downturn over the last year, which may be attributable to the increased number of individuals reporting homelessness at admission. Although the count of individuals is higher than in previous years, the Division of Mental Health and the community mental health centers will continue to utilize the PATH program and additional mental health services to ensure individuals who are homeless obtain housing as quickly as possible.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:** ]

**Name of Implementation Report Indicator:** Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	59.20	63.67	65	67.52	103.88
Numerator	148	163	--	158	--
Denominator	250	256	--	234	--

Table Descriptors:

- Goal:** To assist in increasing social supports through the provision of a comprehensive, organized, community-based system of care for adults with severe mental illness that includes access to an array of services and supports.
- Target:** Increase the number of adults in the community mental health system reporting increases in social supports and/or social connectedness by 2% each year.
- Population:** Adults with severe mental illness.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of individuals reporting increased social connectedness/social supports
- Measure:** Numerator: Number of individuals responding positively to questions related to social connectedness/social supports.  
Denominator: Total number of individuals responding to social connectedness/social support questions.
- Sources of Information:** MHSIP Adult Consumer Survey
- Special Issues:** This indicator demonstrates positive responses on outcomes for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. Four questions are analyzed in determining positive reporting of social supports/social connectedness by consumers. Individuals completing the survey must check "strongly agree" or "agree" to the following statements:  
\* I am happy with the friendships I have  
\* I have people with whom I can do enjoyable things  
\* I feel I belong in my community  
\* In a crisis, I would have the support I need from my family and friends.
- Significance:** The Division of Community Behavioral Health recognizes the importance of social supports/social connectedness for individuals receiving mental health services within the community mental health system. As the system transforms to a more recovery-oriented, individualized, strength-based system of care, social connectedness will be an important indicator towards the quality of services.
- Activities and strategies/** The Division of Community Behavioral Health is working with WICHE to present MHSIP survey results to the Clinical Management Team and the Council of

**changes/  
innovative or  
exemplary model:** Mental Health Centers. This information includes data analysis, data trends, and exploration of possible explanations for data. The overall goal is for community mental health centers to begin to include outcome measurement as part of their quality improvement process and plans.

The Division works closely with the Clinical Management Team to build a system that is responsive to consumer needs and wants. In the process of transforming the mental health system, social supports/social connectedness is a crucial piece in treatment planning and service delivery.

**Target Achieved** Target achieved.  
**or**  
**Not Achieved/If**  
**Not, Explain Why:**

## ADULT - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	60.73	63.24	65	64.66	99.48
Numerator	150	160	--	150	--
Denominator	247	253	--	232	--

### Table Descriptors:

<b>Goal:</b>	To improve levels of functioning through the provision of a comprehensive, organized, community-based system of care for adults with severe mental illness that includes access to an array of appropriate services and resources.
<b>Target:</b>	Increase in the number of individuals reporting increased levels of functioning by 2%.
<b>Population:</b>	Adults with severe mental illness.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services 4:Targeted Services to Rural and Homeless Populations
<b>Indicator:</b>	Percentage of consumers receiving community mental health services who report increased levels of functioning.
<b>Measure:</b>	Numerator: Number of individuals responding positively to MHSIP survey questions related to level of functioning. Denominator: Total number of individuals responding to level of functioning MHSIP questions.
<b>Sources of Information:</b>	MHSIP Adult Consumer Surveys
<b>Special Issues:</b>	This indicator demonstrates positive responses on outcomes related to level of functioning for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. Five questions are analyzed in determining positive reporting of improved level of functioning by consumers. Individuals completing the survey must check "strongly agree" or "agree" to the following statements: * I do things that are more meaningful to me. * I am better able to take care of my needs. * I am better able to handle things when they go wrong. * I am better able to do things that I want to do. * My symptoms are not bothering me as much.
<b>Significance:</b>	The Division recognizes the importance of increased level of functioning for individuals receiving mental health services within the community mental health system. As the system transforms to a more recovery-oriented, individualized, strength-based system of care, level of functioning will an important indicator towards the quality of services.

**Activities and strategies/ changes/ innovative or exemplary model:** The Division of Community Behavioral Health and WICHE are presenting information on the MHSIP surveys to community mental health providers. Discussions will include interpretation of data and results, and opportunities for collaboration with other agencies to assist in increasing level of functioning for individuals receiving services through the community mental health system.

**Target Achieved or Not Achieved/If Not, Explain Why:** If rounding up to the next highest percentage, target is achieved.

## ADULT - IMPLEMENTATION REPORT

**Transformation Activities:** ]

**Name of Implementation Report Indicator:** Adults receiving services in predominately frontier/rural areas

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	40	42	43	42.70	N/A
Numerator	316	331	--	334	--
Denominator	783	783	--	783	--

Table Descriptors:

**Goal:** Provide comprehensive mental health services to homeless and rural populations of adults with severe mental illness.

**Target:** Increase access to services in rural community mental health catchment areas by 1% each year.

**Population:** Adults with severe mental illness.

**Criterion:** 4: Targeted Services to Rural and Homeless Populations

**Indicator:** Number of adults receiving services in catchment areas that are predominately frontier.

**Measure:** Numerator: Numbers of adults with severe mental illness who receive services in the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Services.  
Denominator: Estimated prevalence of adults with severe mental illness in the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Services.

**Sources of Information:** Numerator: DCBH Information System (STARS)  
Denominator: Western States Resource Book: State Mental Health Authority Survey and Needs Assessment-WICHE Estimation Project (<http://psy.utmb.edu/estimation/index.htm/south%20Dakota.htm>)

**Special Issues:** Prevalence data estimates that the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Services have the lowest rate of CARE services provided. When considering causal factors, the demographics of each county within these catchment areas provides insight into the combination of barriers to be overcome. Consider (1) population per square mile (2) percentage of Native Americans and Native American Reservations (average between the three catchment areas of over 50% Native American individuals and 3 Native American Reservations) and (3) percentage living under 100% of the federal poverty level (average about 40% of the population is under 100% of the federal poverty level).

**Significance:** Three Rivers Mental Health Center and Southern Plains Behavioral Health Services provide services in the most rural areas of South Dakota. These agencies also serve two of the State's largest Indian Reservations.

**Activities and strategies/ changes/** The Division of Community Behavioral Health continues to collaborate with the Department of Social Services, Office of Medical Services, to provide telepsychiatry reimbursement for individuals living in rural/frontier areas. In

**innovative or exemplary model:** addition, the Division allows community mental health centers to bill a rural rate for mental health services provided to individuals residing 20 miles or more from a main or satellite office. This rural rate is 20% higher than the regular CARE rate.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved, however fell only .3% short of meeting the target. Positively, even with budget cuts, Southern Plains Behavioral Health Services and Three Rivers Mental Health/CD Center were able to serve an additional 3 individuals over last year's totals. The Division of Community Behavioral Health will continue to work with providers to identify gaps in services and improve access and availability of behavioral health services in the most rural/frontier areas of the state.

## ADULT - IMPLEMENTATION REPORT

Transformation Activities:

**Name of Implementation Report Indicator:** Average amount of public funds expended on mental health services for adults with SPMI

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	2,630	2,522	2,670	2,383	N/A
Numerator	13,459,306	13,729,937	--	13,428,972	--
Denominator	5,118	5,443	--	5,635	--

Table Descriptors:

**Goal:** Ensure resources for services to adults with severe mental illness are allocated based on consumer need.

**Target:** Increase the amount of public funds expended per adult with severe mental illness in relation to inflationary increases.

**Population:** Adults with severe mental illness.

**Criterion:** 5:Management Systems

**Indicator:** Average amount of public funds expended on mental health services for adults with severe mental illness.

**Measure:** Numerator: Total amount of direct service expenditures for adults with severe mental illness in state fiscal year.  
Denominator: Total number of adults with severe mental illness receiving services in state fiscal year.

**Sources of Information:** DCBH Information system (STARS)

**Special Issues:** None

**Significance:** Ensuring resources are allocated appropriately across the community mental health system is a priority of the Division of Community Behavioral Health.

**Activities and strategies/ changes/ innovative or exemplary model:** The Division of Community Behavioral Health continues to work with the Mental Health Advisory Council and community mental health centers to make certain public funds are continuing to be allocated according to consumer needs.  
The Division of Community Behavioral Health meets with a Financial Workgroup, consisting of representation from the Division of Mental Health, the Division of Budget and Finance (also within the Department of Human Services), and community mental health centers. This Workgroup focuses on cost allocation and rate setting for services provided to individuals across the community mental health system.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. FY11 funds did not have an inflationary increase in FY11 due to the current economic situation. However, the community mental health centers were able to serve additional consumers through waiting list expansion. The number of individuals served increased more than the target, thereby causing a decrease in the average expenditures per person. The Division of Mental Health will continue to monitor the public expenditures and the average

funding/person to ensure individuals are receiving high quality mental health services.

## ADULT - IMPLEMENTATION REPORT

**Transformation Activities:**

**Name of Implementation Report Indicator:** Number of individuals who are homeless, or at risk of homelessness, receiving PATH housing funds

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	19.50	19.50	19.50	0	0
Numerator	471	471	--	0	--
Denominator	2,413	2,413	--	0	--

Table Descriptors:

- Goal:** Provide comprehensive mental health services to homeless and rural populations of adults with severe mental illness.
- Target:** Maintain number of homeless individuals served through PATH.
- Population:** Adults with severe mental illness and children with SED and their families that are homeless or at imminent risk of homelessness.
- Criterion:** 4:Targeted Services to Rural and Homeless Populations
- Indicator:** Number of adults and children/families who are homeless, or at risk of homelessness, receiving PATH services.
- Measure:** Numerator: Numbers of adults with severe mental illness and children with serious emotional disorders and their families, who are homeless, or at risk of homelessness, and who receive PATH services.  
Denominator: Estimated number of homeless individuals statewide.
- Sources of Information:** PATH annual reports from PATH providers, the 1999 Quantitative Assessment of Estimated Number of Homeless Adults, Children and Youth in South Dakota, and updated numbers using 2008 population estimates from the US Census Bureau.
- Special Issues:** PATH final numbers are not due until December of each year. Therefore, FY11 final numbers are not yet available. Our projections and targets are based on change between FY09 and FY10 numbers served.

The Division of Community Behavioral Health does not foresee additional funding through PATH. Therefore, target percentages will remain the same through all three years of the grant.

The 1999 Quantitative Assessment of Estimated Number of Homeless Adults, Children and Youth in South Dakota and the use of the Annual Estimates of the Population for Counties of South Dakota: April 1, 2000 to July 1, 2005 (completed by the U.S. Census Bureau) identified 8,676 individuals as homeless. Based on the July 1, 2005 population estimates, this was 1.11% of the State's total population. Utilizing the national estimate that 30% of homeless individuals meet the criteria for severe mental illness or serious emotional disorders, the number of individuals who were homeless and have a mental illness in South Dakota was projected to be 2,603. This figure was 30% of the 8,676 estimated homeless individuals in the State in 2005. The Division of Mental Health updated this number by applying this same estimate to the US Census Bureau's estimated population of South Dakota as of July 1, 2008. The projected number of

homeless individuals is estimated to be 8,042. Using previous calculations, the number of individuals who are homeless and have a mental illness in South Dakota was projected to be 2,413. This figure is 30% of the 8,042 estimated homeless individuals in the State as of July 1, 2008.

- Significance:** Assuring that PATH resources are being provided appropriately and according to the needs of individuals in the target population is a primary goal of the Mental Health Block Grant law and a contingency of PATH funding.
- Activities and strategies/ changes/ innovative or exemplary model:** The Division of Community Behavioral Health works closely with PATH providers to ensure individuals are receiving services that are individualized, strength-based, and recovery focused. The Division is also working with PATH providers to identify performance indicators and outcome measures that will assist PATH programs in providing the highest quality of services possible.
- Target Achieved or Not Achieved/If Not, Explain Why:** Target N/A at this time. The final reports for FY11 PATH numbers are not due until the end of December 2011. Therefore, actual PATH numbers for FY11 cannot be reported at this time.

**ADULT - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Participation in Treatment Planning

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	65	69.50	71	67	N/A
Numerator	163	166	--	144	--
Denominator	249	239	--	215	--

Table Descriptors:

**Goal:** Improve participation in treatment planning through the provision of a comprehensive, organized, community-based system of care for adults with severe mental illness that includes access to an array of appropriate services and resources.

**Target:** Increase in the number of consumers who report they are participating in treatment planning by 2% each year.

**Population:** Adults with severe mental illness.

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of adults receiving community mental health center services who report participation in treatment planning.

**Measure:** Numerator: Number of consumers surveyed reporting positively regarding participation in treatment planning.  
Denominator: Total number of consumers surveyed that answered participation in treatment planning question(s).

**Sources of Information:** MHSIP Adult Consumer Survey

**Special Issues:** This indicator demonstrates positive responses on outcomes related to participation in treatment planning for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis. Consumers must have answered "agree" or "strongly agree" to the question, "I, not staff, have decided my treatment goals."

**Significance:** Evidence of participation in treatment planning for individuals receiving mental health services within the community mental health system as a high priority for the Division of Community Behavioral Health. As the system continues transformation efforts towards a recovery-oriented system, consumer/family driven treatment will continue to be an important indicator regarding the quality of services.

**Activities and strategies/ changes/ innovative or exemplary model:** The Division of Community Behavioral Health works with SDUnited, a consumer advocacy organization, and South Dakota NAMI to support continued collaboration and training to improve recovery-oriented, consumer driven services. This collaboration provides stipends to consumers to attend important trainings/workshops. Together, we continue to explore opportunities to bring technical assistance to our state to further efforts on the development of an

integrated, recovery-oriented system.

In addition, the Division of Community Behavioral Health continues to refine the Accreditation process with community mental health centers. This process includes interviews with adult consumers, asking questions related to quality of care, treatment planning, and satisfaction with services provided. This increased focus on consumer-driven, recovery-oriented, strength-based treatment will assist in driving the system towards improvements in participation in treatment planning for adults receiving community mental health services.

The Division of Community Behavioral Health meets with the Clinical Management Team on a regular basis to further develop and refine client level reporting capabilities for indicators related to participation in treatment planning. This process includes implementation of semi-annual data collection on quality of life indicators for individuals receiving community mental health services. Included in the quality of life indicators are questions related to participation in treatment planning. This information will be provided in STARS, the DCBH management information system.

**Target Achieved  
or  
Not Achieved/If  
Not, Explain Why:**

Target not Achieved. The number of total responses and positive responses dropped from last FY totals. This caused a decrease in the percentage. The Division of Community Behavioral Health has partnered with providers to implement the use of an Outcome tool that asks questions related to participation in treatment planning. This will be completed with all individuals with a severe mental illness that are receiving community-based mental services. Implementation date statewide is tentatively set for December 2011. The Division is hopeful that asking participation questions of all individuals receiving services, rather than just a sample, will help to improve the number reporting participation in treatment planning.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	33	34	35	36	102.86
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:** Ensure all children with serious emotional disorders (SED) and their families have access to appropriate mental health services across the state.

**Target:** Increase the number of children with SED served through the community mental health system in proportion to prevalence estimates of statewide totals of children with SED.

**Population:** Children with SED

**Criterion:** 2: Mental Health System Data Epidemiology  
3: Children's Services

**Indicator:** Number of Children with SED served.

**Measure:** Numerator: Numbers of children with SED served through state funding  
Denominator: Estimated number of children with SED.

**Sources of Information:** DCBH Information System (STARS), WICHE Estimation of Mental Health Need, WICHE Mental Health Program <http://psy.utmb.edu>

**Special Issues:** The FY11 total for the number of children with SED included additional children served through an expansion of funding received to alleviate waiting lists.

The DCBH relies on a data collection system (STARS) to track client information and process billing. State totals provide unduplicated counts of individuals served statewide. STARS is interfaced with the Department of Social Services' Medicaid Management Information System (MMIS) which captures data specific to Medicaid eligible children/families. Therefore, the number of children served through the Division includes those that are funded through Medicaid.

Prevalence data from WICHE was used to determine the estimated number of children with SED. The WICHE data was computed based on census information from 2000. This data assumes the growth in the number of children with SED is at the same rate as the total population.

**Significance:** Assuring access to mental health services for children with SED is a priority of the Division of Community Behavioral Health and the Mental Health Block Grant legislation.

**Activities and strategies/ changes/ innovative or exemplary model:** The Division of Community Behavioral Health works with the Department of Social Services, Office of Medical Services to provide reimbursement for telepsychiatry services to individuals and families receiving services through the community mental health system. This has helped to ensure children and families in the most remote/frontier portions of the state have access to mental health

services. In addition, the Division of Community Behavioral Health allows community mental health centers to bill a rural rate for mental health services provided to children with SED and their families. This rural rate is 20% higher than the regular rate for services and can be used for any services provided 20 miles or more from a main or satellite office.

**Target Achieved** Target Achieved. 5,578 children with serious emotional disorders and their  
**or** families were served during FY11.  
**Not Achieved/If**  
**Not, Explain Why:**

## CHILD - IMPLEMENTATION REPORT

**Transformation Activities:**

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	2.64	1.68	1.68	2.94	57.14
Numerator	8	5	--	9	--
Denominator	303	298	--	306	--

### Table Descriptors:

<b>Goal:</b>	Decrease re-admissions within 30 days through the provision of a comprehensive, organized, community-based system of care for children with SED and their families, including access to an array of appropriate services and resources.
<b>Target:</b>	Maintain low 30 day inpatient readmission rate.
<b>Population:</b>	Children with serious emotional disorders
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Rate of re-admissions to State Psychiatric Hospital within 30 days.
<b>Measure:</b>	Numerator: Number of persons, under age 18, who are readmitted to HSC within 30 days. Denominator: Number of persons, under age 18, discharged from HSC during the past year.
<b>Sources of Information:</b>	HSC information system
<b>Special Issues:</b>	The number of re-admissions is comprised of a duplicate count (e.e., a child readmitted repeatedly would be counted at each re-admission.)
<b>Significance:</b>	Reducing the utilization of state psychiatric inpatient beds will be a reflection on implementation of Systems of Care within the community based mental health system.
<b>Activities and strategies/ changes/ innovative or exemplary model:</b>	<p>The Division of Community Behavioral Health offers the Indigent Medication Program assistance for children discharging from the Human Services Center and their families, in order to assist these individuals with obtaining psychotropic medications while other longer term funding options are pursued.</p> <p>The Division of Community Behavioral Health and the Clinical Management Team explore opportunities for further workforce development to assist in reducing the number of hospitalizations for children with SED. Workforce development includes trainings on systems of care philosophy, wrap around services, and parent partnerships.</p> <p>The Division of Community Behavioral Health participates in the State Placement and Review Committee on a weekly basis. This group approves all in-state and out-of state placements for children that may be in need of specialized services.</p>

Discussions on referrals include education for other state agencies on the systems of care philosophy, and exploring opportunities for services within the communities rather than placements such as inpatient psychiatric facilities.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. The number of children being readmitted within 30 days increased by 4 individuals, and the total number of discharges also increased. The Division of Community Behavioral Health is unsure why the increase, but feels that some of the raise in numbers may be attributed to the increased screening for co-occurring issues and treating both mental health and substance use issues concurrently. Additionally, the increase in numbers could be related to South Dakota keeping youth in-state for treatment rather than in out-of state facilities. Over the next year, the Division of Community Behavioral Health will work closely with the Human Services Center and community providers to identify areas of improvement needed for discharge planning and availability of community-based services.

## CHILD - IMPLEMENTATION REPORT

**Transformation Activities:**

**Name of Implementation Report Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	11.55	8.05	8.05	11.44	70.37
Numerator	35	24	--	35	--
Denominator	303	298	--	306	--

Table Descriptors:

**Goal:** To decrease re-admissions to a state psychiatric facility through the provision of a comprehensive, organized community-based system of care for children with SED and their families, including access to an array of appropriate services and resources.

**Target:** Maintain low 180 day inpatient readmission rate.

**Population:** Children with SED

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Rate of re-admissions to the state psychiatric hospital within 180 days.

**Measure:** Numerator: Number of persons, under age 18, who are re-admitted to HSC within 180 days.  
Denominator: Number of persons, under age 18, discharged from HSC during the past year.

**Sources of Information:** HSC information system

**Special Issues:** The number of re-admissions is comprised of a duplicate count (i.e., a child readmitted repeatedly would be counted at each re-admission.)

**Significance:** Reducing the utilization of state psychiatric inpatient beds will be a reflection on implementation of Systems of Care within the community based mental health system.

**Activities and strategies/ changes/ innovative or exemplary model:** The Division of Community Behavioral Health offers the Indigent Medication Program assistance for children discharging from the Human Services Center and their families, in order to assist these individuals with obtaining psychotropic medications while other longer term funding options are pursued.

The Division of Community Behavioral Health and the Clinical Management Team are exploring opportunities for further workforce development to assist in reducing the number of hospitalizations for children with SED. Workforce development includes trainings on systems of care philosophy, wrap around services, and parent partnerships.

The Division of Community Behavioral Health participates in the State Placement and Review Committee on a weekly basis. This group approves all in-state and out-of state placements for children that may be in need of specialized services.

Discussions on referrals include education for other state agencies on the systems of care philosophy, and exploring opportunities for services within the communities rather than placements such as inpatient psychiatric facilities.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. The number of children being readmitted within 180 days increased by 11 individuals, and the total number of discharges also increased. The Division of Community Behavioral Health is unsure why the increase, but feels that some of the raise in numbers may be attributed to the increased screening for co-occurring issues and treating both mental health and substance use issues concurrently. Additionally, the increase in numbers could be related to South Dakota keeping youth in-state for treatment rather than in out-of state facilities. Over the next year, the Division of Community Behavioral Health will work closely with the Human Services Center and community providers to identify areas of improvement needed for discharge planning and availability of community-based services.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	0	0	1	0	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

- Goal:** Increase the availability of evidence based practices for children with SED and their families through the provision of a comprehensive, organized, community-based system of care, including access to an array of appropriate services and resources.
- Target:** Increase by one the number of evidence based practices available in the state. (Starting in FY10). This performance indicator was omitted in the FY09 Block Grant Application, therefore South Dakota did not set an FY09 target in this area.
- Population:** Children with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of evidence based practices across the state for children with SED and their families.
- Measure:** Total number of evidence based practices across the state for children with SED and their families.
- Sources of Information:** DMH Information System
- Special Issues:** This performance indicator was omitted in the FY09 Block Grant Application, therefore South Dakota did not set an FY09 target in this area.
- The Division of Community Behavioral Health has not implemented statewide evidence-based practices for children with SED and their families. However, the Division is developing and implementing a Systems of Care Model across the state, including integrated treatment for children and families with co-occurring disorders. The Division of Community Behavioral Health, the Mental Health Advisory Council, and the Clinical Management Team will continue to explore opportunities for implementation of evidence-based practices for children and families that would fit into the Systems of Care Model.
- Significance:** The Division of Community Behavioral Health believes that evidence-based practices are very important services to offer children with SED and their families. Providing a system of care that includes recovery-oriented, strength-based, integrated treatment is a priority of the Division and Mental Health Block Grant legislation.
- Activities and strategies/ changes/** South Dakota currently has three pilot sites implementing systems of care, Behavior Management Systems, Southeastern Behavioral HealthCare, and Capital Area Counseling Services. Wrap-Around Services, an evidence-based

**innovative or exemplary model:** practice, will be offered as part of the array of services available at these three community mental health centers. Although not fully implemented, all pilot sites are currently receiving training and technical assistance to begin providing wrap-around services.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. All of the pilot sites are working on implementation of systems of care, including the evidence-based practice of Wrap Around Services. Although working to implement, the pilot sites are not at a capacity to allow reporting a solid evidence based practice. The Division and the pilot sites will work together to improve partnerships and coordination necessary to increase the availability of Wrap-Around Services to children and families receiving services in the public mental health system.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**  **Indicator Data Not Applicable:**

**Name of Implementation Report Indicator:** Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved or Not Achieved/If Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**  **Indicator Data Not Applicable:**

**Name of Implementation Report Indicator:** Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved or Not Achieved/If Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**  **Indicator Data Not Applicable:**

**Name of Implementation Report Indicator:** Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	N/A	--
Denominator	N/A	N/A	--	N/A	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Activities and strategies/ changes/ innovative or exemplary model:**

**Target Achieved or Not Achieved/If Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	56.76	63.69	65	60.49	93.06
Numerator	84	100	--	98	--
Denominator	148	157	--	162	--

Table Descriptors:

**Goal:** To improve client perception of care through the provision of a comprehensive, organized, community-based system of care for children with SED and their families that includes access to an array of appropriate services and resources.

**Target:** Increase by 2% the number of families of children with SED reporting positively about outcomes.

**Population:** Families of children with SED receiving community mental health services

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Number of families of children with SED reporting positively about outcomes

**Measure:** Numerator: Number of positive responses reported in the outcome domain on the YSS-F.  
Denominator: Total responses reported in the outcome domain on the YSS-F.

**Sources of Information:** MHSIP YSS-F Survey

**Special Issues:** This indicator demonstrates positive responses on outcomes for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. Eight questions are analyzed in determining positive reporting of outcomes by families. Individuals filling out the survey must check "strongly agree" or "agree" to the following statements:

- \* My child is better at handling daily life
- \* My child gets along better with family members
- \* My child gets along better with friends and other people
- \* My child is doing better in school and/or work
- \* My child is better able to cope when things go wrong
- \* I am satisfied with our family life right now
- \* My child is better able to do the things he or she wants to do

**Significance:** Indication of positive outcomes plays an important role in the development of systems of care and recovery-oriented services for children with SED and their families.

**Activities and strategies/ changes/ innovative or exemplary model:** Utilizing the MHSIP Survey, the Division continues to survey a sample of families from across the state. WICHE collaborates with the Division of Mental Health to provide data analysis and reports on the survey responses. This information is then shared with the Advisory Council, Clinical Management Team, consumers, and family members. Information presented includes data analysis, data trends, and exploration of possible explanations for data. The overall goal is for

community mental health centers to include outcome measurement as part of their continuous quality improvement plans.

The Division of Community Behavioral Health and the Systems of Care pilot sites are working together to further the development of a competent workforce through the provision of training on essential components within the system of care framework. The goal is to improve competencies in the workforce, which should then lend itself to improved outcomes and client perception of care.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. The number of families reporting positively regarding outcomes decreased by approximately 4% over FY10 totals. The Division of Community Behavioral Health feels this may be attributed to the increased implementation of family driven services in an integrated system of care, and parents/guardians feeling like they have more control over treatment and what should be provided. The Division of Community Behavioral health, community mental health providers, and children/family stakeholders will continue to monitor perception of care as an important indicator in the development of systems of care for children and families receiving mental health services in the public mental health system.

## CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	14.86	15.57	17	10.40	61.18
Numerator	22	26	--	18	--
Denominator	148	167	--	173	--

### Table Descriptors:

<b>Goal:</b>	To increase the number of children with SED that report an improvement in number of days in school as a result of receiving mental health services.
<b>Target:</b>	Increase the number of children with SED reporting positively about school attendance by 2% each year.
<b>Population:</b>	Children with SED
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Percentage of children and families who report an improvement in school attendance since beginning to receive mental health services.
<b>Measure:</b>	Numerator: The number of children/families surveyed reporting improvement in school attendance/participation (both new and continuing clients) Denominator: The total responses to school participation/attendance questions (both new and continuing clients)
<b>Sources of Information:</b>	MHSIP YSS-F Survey
<b>Special Issues:</b>	The YSS-F Surveys are conducted on an annual basis. A random sample of children/families that have received services during the 3 months prior to dissemination of surveys are chosen. WICHE conducts the data analysis and completes the reports for the Division of Mental Health.
<b>Significance:</b>	Increased school attendance is an important performance indicator in the development of systems of care for children with SED and their families.
<b>Activities and strategies/ changes/ innovative or exemplary model:</b>	Utilizing the MHSIP Survey, the Division continues to survey a sample of families from across the state. WICHE collaborates with the Division of Mental Health to provide data analysis and reports on the survey responses. This information is then shared with the Advisory Council, Clinical Management Team, consumers, and family members. Information presented includes data analysis, data trends, and exploration of possible explanations for data. The overall goal is for community mental health centers to include outcome measurement as part of their continuous quality improvement plan.

The Division of Community Behavioral Health and the Systems of Care pilot sites are working together to further the development of a competent workforce through the provision of training on essential components within the system of care framework. The goal is to improve competencies in the workforce, which should then lend itself to improved outcomes including school participation and

attendance.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. Encouragingly, an additional 6 families over FY10 numbers responded to the FY11 survey. The Division of Community Behavioral Health is unsure why the decrease in overall improvement. The Division of Community Behavioral Health has noticed that over 20 additional families indicated that the question regarding school improvement was not applicable. On a positive note, this could be attributed to not having issues prior to receiving services. The Division of Community Behavioral health, community mental health providers, and children/family stakeholders will continue to monitor perception of care as an important indicator in the development of systems of care for children and families receiving mental health services in the public mental health system.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	42.86	100	100	33.33	33.33
Numerator	3	3	--	1	--
Denominator	7	3	--	3	--

Table Descriptors:

**Goal:** To increase the number of children with SED reporting no re-arrests between year one and year two.

**Target:** Increase by 1% the number of youth who report no re-arrests in Year 2.

**Population:** Children with SED

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percentage of youth arrested in year one who were re-arrested in yr 2

**Measure:** Numerator: Number of youth reporting no re-arrests in year two (both new and continuing clients)  
Denominator: Number of youth reporting arrests in year one (both new and continuing clients)

**Sources of Information:** YSS-F MHSIP Survey

**Special Issues:** YSS-F Surveys are conducted on an annual basis with families of children with serious emotional disorders. A random sample of families that have received services during 3 months prior to dissemination of surveys are chosen. WICHE conducts the data analysis and completes the reports for the Division of Mental Health.

**Significance:** The Division of Mental Health recognizes that many children receiving community mental health services may also be involved with the criminal justice system. It is a priority of the Division of Mental Health, community mental health centers, and the Advisory Council to assist individuals involved with the criminal justice system to address mental health and/or other complex need issues in an effort to increase the number of children with SED reporting no re-arrests.

**Activities and strategies/ changes/ innovative or exemplary model:** Utilizing the MHSIP Survey, the Division continues to survey a sample of families from across the state. WICHE collaborates with the Division of Mental Health to provide data analysis and reports on the survey responses. This information is then shared with the Advisory Council, Clinical Management Team, consumers, and family members. Information presented includes data analysis, data trends, and exploration of possible explanations for data. The overall goal is for community mental health centers to include outcome measurement as part of their continuous quality improvement plan.

The Division of Mental Health meets with the Clinical Management Team on a

quarterly basis to further develop and refine client level reporting capabilities for criminal justice involvement. This process includes implementation of data collection on a quarterly basis through STARS, the Division's management information system. Additionally, training is available for providers on data collection, piloting of data collection, and data analysis to determine baselines. Lastly, discussions occur on how to interpret the results and opportunities for collaboration with other state agencies to decrease the level of criminal justice involvement for youth receiving services through the community mental health system.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. The Division of Community Behavioral Health feels that as this is a sample of individuals receiving services across the state, it is not a very accurate telling of youth/adolescents having involvement in the criminal justice system. The numbers reported are so small, that they cannot be significantly valid as a measure for criminal justice involvement. As a decrease in criminal justice involvement is a very important indicator in the development of systems of care for children and families, the Division of Community Behavioral Health, the community mental health providers, and children/family stakeholders will continue to monitor this performance indicator.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	0	0	N/A	N/A	N/A
Numerator	0	0	--	N/A	--
Denominator	4,926	4,968	--	N/A	--

Table Descriptors:

**Goal:** To improve stability in housing through the provision of a comprehensive, organized, community-based system of care for children with SED and their families, including access to an array of appropriate services and resources.

**Target:** Decrease the percentage of youth reporting homelessness or living in shelters.

**Population:** Children with SED

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percent of youth homeless or residing in shelters.

**Measure:** Numerator: Number of Youth reported Homeless at admission  
Denominator: From URS Table, all youth with living situations, excluding persons with living situations unavailable.

**Sources of Information:** DMH management information system.

**Special Issues:** Information on housing situations is only collected at admission and discharge.

**Significance:** Stability in housing is an important performance indicator to assist the Division of Mental Health in the transformation of community mental health to an integrated system of care for children with SED and their families.

**Activities and strategies/ changes/ innovative or exemplary model:** The Division of Mental Health participates in the Interagency Council on Homelessness meetings on a quarterly basis. Goals included in activities of the Council are: 1) Work with the South Dakota Homeless Consortium to achieve the data necessary to understand the scope of the homelessness and the factors contributing to homelessness; 2) Educate and work with local entities to understand each other's programs; 3) Evaluate outreach with state programs, including getting out into the facilities and one-stop shops, and making improvements if needed; and 4) Development of toolkits containing best practices for reducing homeless numbers.

The Division is also represented on the Housing for the Homeless Consortium, which meets quarterly, to provide opportunities for networking with other providers across the state, problem solving difficult situations, sharing resources, and gaining knowledge of new funding opportunities for housing. Additionally, the Consortium is the mechanism used to apply for the federal homeless assistance funds, such as the Continuum of Care Grant. Also, the Consortium sponsors an annual Homeless Summit that includes workshops on such issues as trauma informed care and motivational interviewing.

The Division works with the Clinical Management Team to further develop and refine client level reporting capabilities for changes in living situation. This process includes implementation of data collection on a quarterly basis through STARS, the Division's management information system. Additionally, training is available for providers on data collection, piloting of data collection, and data analysis to determine baselines. Lastly, discussions occur on how to interpret the results and opportunities for collaboration with other state agencies to increase the stability in housing situations for youth and families.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target achieved. No children were reported as homeless at admission during the last fiscal year. The Division of Mental Health will continue to monitor this performance indicator to ensure children and families have access to housing and appropriate supports and services.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	84.97	86.50	87	85.63	98.43
Numerator	130	141	--	143	--
Denominator	153	163	--	167	--

Table Descriptors:

- Goal:** To assist in increasing social supports through the provision of a comprehensive, organized, community-based system of care for children with SED and their families, including access to an array of appropriate services and supports.
- Target:** Increase the number of children/families reporting improvement in social connectedness by 1% each year
- Population:** Families of children with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of families of children with SED responding with improvements in social supports/social connectedness.
- Measure:** Numerator: Number of families of children with SED responding positively to questions related to social connectedness/social supports.  
  
Denominator: Total number of families responding to social connectedness/social support questions.
- Sources of Information:** YSS-F MHSIP Survey
- Special Issues:** This indicator demonstrates positive responses on outcomes for children and families receiving services within the public mental health system. The survey tool used was the 28-item YSS-F MHSIP Survey. The survey is completed on an annual basis with children and families receiving services from the eleven community mental health centers. Four questions are analyzed in determining positive reporting of social supports/social connectedness by families. Family members of children with SED completing the survey must check "strongly agree" or "agree" to the following statements:  
 \* I know people who will listen and understand me when I need to talk  
 \* I have people that I am comfortable talking with about my child's problem  
 \* In a crisis I would have the support I need from family or friends  
 \* I have people with whom I can do enjoyable things
- Significance:** The Division of Community Behavioral Health recognizes the importance of social supports/social connectedness for children and families receiving services within the community mental health system. As the system transforms to a recovery-oriented, integrated system of care, improved social supports/social connectedness will be an important indicator towards the quality of services.

**Activities and strategies/ changes/ innovative or exemplary model:** Utilizing the MHSIP Survey, the Division continues to survey a sample of families from across the state. WICHE collaborates with the Division of Mental Health to provide data analysis and reports on the survey responses. This information is then shared with the Advisory Council, Clinical Management Team, consumers, and family members. Information presented includes data analysis, data trends, and exploration of possible explanations for data. The overall goal is for community mental health centers to include outcome measurements as part of their continuous quality improvement plan.

The Division of Community Behavioral Health works closely with the three System of Care pilot sites to build a system that is responsive to child/family needs and wants, and allows the building of natural supports and social connectedness for children and families. The Division will continue to measure social supports/social connectedness as one criteria for determining the effectiveness of system of care development.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. However, on a positive note, the number reporting improved social connectedness did not decrease from last year numbers. In fact, the number of families reporting positively increased by 2. Building of natural support systems and social connectedness is an important indicator in the development of systems of care for children and families. The Division of Community Behavioral Health, community mental health providers, and child/family stakeholders will continue to monitor this performance indicator to ensure higher quality of life through improvement in the delivery of mental health services.

## CHILD - IMPLEMENTATION REPORT

Transformation Activities:

Name of Implementation Report Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	56.08	66.46	68	63.58	93.50
Numerator	83	105	--	103	--
Denominator	148	158	--	162	--

### Table Descriptors:

<b>Goal:</b>	To improve levels of functioning through the provision of a comprehensive, organized, community-based system of care for children with SED and their families, including access to an array of appropriate services and resources.
<b>Target:</b>	Increase in the number of children/families reporting improved levels of functioning by 2% each year.
<b>Population:</b>	Children with SED and their families.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services 4:Targeted Services to Rural and Homeless Populations
<b>Indicator:</b>	Percentage of families receiving CMHC services who report improved levels of functioning.
<b>Measure:</b>	Numerator: Number of families of children with SED surveyed who report improved levels of functioning Denominator: Total number of responses to questions in improved levels of functioning.
<b>Sources of Information:</b>	YSS-F MHSIP Survey
<b>Special Issues:</b>	This indicator demonstrates positive responses on increased levels of functioning for children and families receiving services within the public mental health system. The survey tool used was the 28-item YSS-F Survey. The survey is completed on an annual basis with children/families receiving services from the eleven community mental health centers. Five questions are analyzed in determining positive reporting of improved levels of functioning by families. Family members filling out the survey must check "strongly agree" or "agree" to the following statements: <ul style="list-style-type: none"> <li>* My child is better able to do things he or she wants to do</li> <li>* My child is better at handling daily life</li> <li>* My child gets along better with family members</li> <li>* My child gets along better with friends and other people</li> <li>* My child is better able to cope when things go wrong</li> </ul>
<b>Significance:</b>	The Division of Community Behavioral Health recognizes the importance of improved functioning for children and families receiving services within the community mental health system. As the system transforms to a recovery-oriented, integrated system of care, improved functioning will be an important indicator towards the quality of services.

**Activities and strategies/ changes/ innovative or exemplary model:** Utilizing the MHSIP Survey, the Division continues to survey a sample of families from across the state. WICHE collaborates with the Division of Mental Health to provide data analysis and reports on the survey responses. This information is then shared with the Advisory Council, Clinical Management Team, consumers, and family members. Information presented includes data analysis, data trends, and exploration of possible explanations for data. The overall goal is for community mental health centers to include outcome measurement as part of their continuous quality improvement plans.

The Division of Community Behavioral Health works closely with the three System of Care pilot sites to build a system that is responsive to child/family needs and wants, and allows the building of natural supports and social connectedness for children and families. The Division will continue to measure improved levels of functioning as one criteria for determining the effectiveness of system of care development.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. The number of families indicating improvements in level of functioning dropped by 2 from last year. The Division feels this may be attributable to further development of family driven services, and families being more aware of what outcomes should be occurring as a result of community mental health services. Improved functioning for children and families is important in the development of systems of care for children and families. The Division of Mental Health, community mental health providers, and child/family stakeholders will continue to monitor this performance indicator to ensure children/families are continuing to experience higher quality of life through improved service delivery.

## CHILD - IMPLEMENTATION REPORT

Transformation Activities:

**Name of Implementation Report Indicator:** Children receiving services in predominately frontier/rural areas

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	42	37	38	38	100
Numerator	470	417	--	424	--
Denominator	1,129	1,129	--	1,129	--

### Table Descriptors:

<b>Goal:</b>	Provide comprehensive mental health services to frontier/rural populations of children with SED and their families.
<b>Target:</b>	Increase access to services for children with SED and their families by 1% each year
<b>Population:</b>	Children with SED and their families
<b>Criterion:</b>	4: Targeted Services to Rural and Homeless Populations
<b>Indicator:</b>	Number of children receiving services in catchment areas that are predominately frontier
<b>Measure:</b>	Numerator: Number of children with SED who receive services in the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Services Denominator: Estimated prevalence of children with SED in the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Services
<b>Sources of Information:</b>	DCBH information system (STARS), Western State Resource Book: State Mental Health Authority Survey and Needs Assessment-WICHE Estimation Project <a href="http://psy.utmb.edu/estimation/index_htm/South%20Dakota.htm">http://psy.utmb.edu/estimation/index_htm/South%20Dakota.htm</a>
<b>Special Issues:</b>	Prevalence data estimates that the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Services have the lowest rate of SED services provided. When considering causal factors, the demographics of each county within these catchment areas provide insight into the combination of barriers to be overcome. Consider (1) population per square mile (2) percentage of Native Americans and Native American Reservations (average between the two catchment areas of over 50% Native American individuals and 2 Native American Reservations) and (3) percentage living under 100% of the federal poverty level (average about 40% of the population is under 100% of the federal poverty level).
<b>Significance:</b>	Three Rivers Mental Health Center and Southern Plains Behavioral Health Services provide services in the most rural areas of South Dakota. These agencies also serve two of the State's largest Indian Reservations.
<b>Activities and strategies/ changes/ innovative or</b>	The Division of Community Behavioral Health continues to collaborate with the Department of Social Services, Office of Medical Services, to provide telepsychiatry reimbursement for individuals living in rural/frontier areas. In addition, the Division allows community mental health centers to bill a rural rate

**exemplary model:** for mental health services provided to individuals residing twenty miles or more from a main or satellite office. This rural rate is 20% higher than the regular CARE rate.

**Target Achieved** Target achieved.

**or**

**Not Achieved/If**

**Not, Explain Why:**

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Individuals who are homeless, or at risk of homelessness, receiving PATH funds

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	20	20	0	N/A	N/A
Numerator	471	471	--	N/A	--
Denominator	2,413	2,413	--	N/A	--

Table Descriptors:

**Goal:** Provide comprehensive mental health services to homeless and rural populations of children with SED and their families.

**Target:** Maintain the number of homeless individuals and children/families served through PATH

**Population:** Adults with SMI and children with SED and their families

**Criterion:** 4:Targeted Services to Rural and Homeless Populations

**Indicator:** Number of adults and children/families who are homeless, or at risk of homelessness, receiving PATH funds and services.

**Measure:** Numerator: Number of adults with SMI and children with SED and their families who are homeless or at risk for homelessness, and who receive PATH housing funds.  
Denominator: Estimated number of homeless individuals statewide.

**Sources of Information:** PATH annual reports from PATH Providers, the 1999 Quantitative Assessment of Estimated numbers of Homeless Adults, Children, and Youth in South Dakota, and updated numbers using 2008 population estimates from the US Census Bureau.

**Special Issues:** PATH final numbers are not due until December of each year. Therefore, FY11 final numbers are not yet available.

As the Division of Community Behavioral Health does not foresee additional funding through PATH, the target percentages will remain the same through all three years of the grant.

**Significance:** The 1999 Quantitative Assessment of Estimated Number of Homeless Adults, Children, and Youth in South Dakota and the use of the Annual Estimates of the population for Counties in South Dakota: April 1, 2000 to July 1, 2005 (U.S. Census Bureau) identified 8,676 individuals as homeless. Based on the July 1, 2005 population estimates, this was 1.11% of the State's total population. Utilizing the national estimate that 30% of homeless individuals meet the criteria for severe mental illness or serious emotional disorders, the number of individuals who were homeless and have a mental illness in South Dakota was projected to be 2,603 in 2005.

The Division of Community Behavioral Health updated this number by applying this same estimate to the US Census Bureau's estimated population of South Dakota as of July 1, 2008. The projected number of homeless individuals is

estimated to be 8,042. Using previous calculations, the number of individuals who are homeless and have a mental illness in South Dakota was projected to be 2,413. This figure is 30% of the 8,042 estimated homeless individuals in the State as of July 1, 2008.

Assuring resources are being provided appropriately and according to the needs of individuals in the target population is a primary goal of the Mental Health Block Grant law and a contingency of PATH funding.

**Activities and strategies/ changes/ innovative or exemplary model:** The Division of Community Behavioral Health works closely with PATH providers to ensure individuals are receiving services that are individualized, strength-based, and provided with a recovery focus. The Division is also working with PATH providers to identify performance indicators and outcome measures that will assist PATH programs in providing the highest quality of services possible.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target N/A at this time. The final reports for FY11 PATH numbers are not due until the end of December 2011. Therefore, actual PATH numbers for FY11 cannot be reported at this time.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Participation in Treatment Planning

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	78	88	90	88	N/A
Numerator	116	144	--	146	--
Denominator	148	164	--	166	--

Table Descriptors:

**Goal:** Improve participation in treatment planning through the provision of a comprehensive, organized, community-based system of care for children with SED and their families, including access to an array of appropriate services and resources.

**Target:** Increase in the number of children/families reporting positively about participation in treatment planning by 2% each year.

**Population:** Children with SED and their families.

**Criterion:** 3:Children's Services

**Indicator:** Families of children/youth with SED reporting participation in treatment planning

**Measure:** Numerator: Number of families of children/youth with SED receiving community mental health services who report positively regarding participation in treatment planning.  
Denominator: Total number of families responding to participation in treatment planning questions.

**Sources of Information:** YSS-F MHSIP Survey

**Special Issues:** This indicator demonstrates positive responses on outcomes related to participation in treatment planning for children and families receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis with families receiving services from the eleven community mental health centers. The families must respond "strongly agree" or "agree" to two of four survey statements:  
\* I helped to choose my services  
\* I helped to choose my treatment plan goals  
\* I was actively involved in my own treatment  
\* I, not staff, decided my treatment goals

**Significance:** Evidence of participation in treatment planning for families of children/youth with SED is a high priority for the Division of Community Behavioral Health. As the system transforms to a recovery-oriented system of care, consumer/family driven treatment will continue to be an important indicator regarding the quality of services.

**Activities and strategies/ changes/ innovative or** Utilizing the MHSIP Survey, the Division continues to survey a sample of families from across the state. WICHE collaborates with the Division of Mental Health to provide data analysis and reports on the survey responses. This information is then shared with the Advisory Council, Clinical Management Team, consumers,

**exemplary model:** and family members. Information presented includes data analysis, data trends, and exploration of possible explanations for data. The overall goal is for community mental health centers to include outcome measurement as part of their continuous quality improvement plan.

The Division of Community Behavioral Health works closely with the three System of Care pilot sites to build a system that is responsive to child/family needs and wants, and allows the families/children to participate in treatment as much as possible. The Division will continue to measure participation in treatment as one criteria for determining the effectiveness of system of care development.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. Although we did not increase to 90%, the number of families reporting positively did not decrease from last year's totals. The Division of Community Behavioral health, community mental health providers, and children/family stakeholders will continue to monitor perception of care as an important indicator in the development of systems of care for children and families receiving mental health services in the public mental health system.

**CHILD - IMPLEMENTATION REPORT**

**Transformation Activities:**

**Name of Implementation Report Indicator:** Public Funds expended on mental health services for children with SED

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2009 Actual	FY 2010 Actual	FY 2011 Target	FY 2011 Actual	FY 2011 Percentage Attained
Performance Indicator	1,537	1,797	N/A	1,520	N/A
Numerator	7,794,713	9,367,977	--	8,479,881	--
Denominator	5,072	5,214	--	5,578	--

Table Descriptors:

**Goal:** Ensure resources for services to children with SED and their families are allocated based on consumer need.

**Target:** Increase the amount of public funds expended on mental health services for children with serious emotional disorders.

**Population:** Children with SED

**Criterion:** 5:Management Systems

**Indicator:** Average amount of public funds expended on mental health services for children with SED

**Measure:** Numerator: Total amount of state funded direct service expenditures for children with SED in state fiscal year.  
Denominator: Total number of children with SED receiving services in state fiscal year.

**Sources of Information:** DCBH Information System

**Special Issues:** None

**Significance:** Ensuring resources are allocated appropriately is a priority of the Division of Community Behavioral Health.

**Activities and strategies/ changes/ innovative or exemplary model:** The Division of Community Behavioral Health continues to work with the Mental Health Advisory Council and community mental health centers to make certain public funds are continuing to be allocated according to consumer needs.

The Division of Community Behavioral Health meets with a Financial Workgroup, consisting of representation from the Division of Mental Health, the Division of Budget and Finance Division (also within the Department of Human Services), and community mental health centers. This Workgroup focuses on cost allocation and rate setting for services provided to individuals across the community mental health system.

**Target Achieved or Not Achieved/If Not, Explain Why:** Target not achieved. FY11 funds did not have an inflationary increase in FY11 due to the current economic situation. However, the community mental health centers were able to serve additional children/families through waiting list expansion. The number of individuals served increased more than the target, thereby causing a decrease in the average expenditures per person. The Division of Mental Health will continue to monitor the public expenditures and the average

funding/person to ensure individuals are receiving high quality mental health services.

Upload Planning Council Letter for the Implementation Report

During the past year, the Division of Community Behavioral Health has made concentrated efforts to keep the Mental Health Planning and Coordination Council informed of tasks and activities occurring as part of the reorganization and transition. Council members have had opportunity to make recommendations and provide feedback into the integration of behavioral health services, and how efficiencies and improvements may be created in the system. In light of the work South Dakota has done in the area of co-occurring services for individuals and families with mental health, Council members felt the prospect of integration of the Mental Health and Substance Abuse Block Grants created opportunities to further support the building of co-occurring capability across the state. In addition, they were excited to see the possibilities before our state with the integration of the mental health and substance use systems, specifically exploring creation of a Behavioral Health Council in South Dakota.

Unfortunately, during the last year, the individuals appointed as the Chair and Vice Chair both had terms expiring on the Council. Due to the transition to a new department and reorganization of behavioral health services, and seeking new appointments to the Council, there has not been opportunity to re-elect the Chair and Vice Chair positions on the Council. Additionally, the Council has not had the opportunity to meet as a full council prior to the submission of this Implementation Report. The Division of Community Behavioral Health is working diligently with the Council, and plan to meet December 8, 2011 to review the Implementation Report and provide a letter of support from the Statewide Mental Health Advisory Council.

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.