FINAL Minutes of the
Mental Health and Substance Abuse Treatment Delivery Systems
Interim Committee

Monday, August 15th, 2006
State Hospital South, Blackfoot, Idaho

The meeting was called to order at 8:35 am by Chairman Skippen. Present were Senators Stegner, Compton, Coiner, Broadsword and Representatives Wood, Block, Garrett, and Henbest. Absent and excused was Senator Werk. Staff members present were Caralee Lambert, Amy Castro, Richard Burns, Cathy Holland-Smith and Lisa Kauffman, Legislative Services Office. Also present were Tracy Farnsworth, Tracy Goodin, and Duane Klomp, State Hospital South (SHS); Richard Armstrong, Leslie Clement, Bethany Gadzinski, Dick Shultz, Ed Axford, and Kathleen Allyn, Department of Health & Welfare; Patti Tobias, Judge Randy Smith, and Judge Bryan Murray, Judicial Branch; Mary Wells, State Department of Education; Gary Craw, and Robert Sidwell, Division of Vocational Rehabilitation; Dr. John Hanks, Pediatrician; Doug Call, National Alliance of the Mentally Ill; Lynn Whiting, Idaho Federation of Families; Dr. Linda Hatzenbuehler and Cynthia McCurdy, Idaho Council on Children's Mental Health; Crista Henderson, Mental Health Transformation Work Group; Sara Nye, Office of the Governor; Molly Steckel, Idaho Medical Association and Idaho Psychiatric Association; Stephen Weeks, Idaho Department of Health & Welfare Board Member; AJ Burns, Office of Performance Evaluations; Ed Marugg, Public Health District; and Sarah Woodley, Business Psychology Associates.

Tracy Farnsworth, Administrator, State Hospital South, welcomed the committee to the facility and presented a PowerPoint presentation on the history of the grounds. Located in Blackfoot, Idaho, SHS has operated continuously for the past 120 years serving the most acute mentally ill citizens of Idaho. Created and sustained over the years by the Idaho Legislature, the principle laws and procedures governing the Hospital's operation today are put forth in Idaho Code – Title 66. The Idaho Code also sets forth minimum standards and expectations for hospitals in Idaho, including the state hospitals.

Currently, SHS is licensed and funded to provide 90 adult psychiatric beds, 16 separate and distinct adolescent beds, and 29 skilled nursing home beds. It also maintains a statewide program to restore competency of criminal justice patients. Since 2001, SHS has been formally accredited by the Joint Commission on Accreditation for Healthcare Organizations. SHS also maintains certification from the Center for Medicare and Medicaid Services.

Services to adult and adolescent patients are provided with a modern Psychiatric Treatment Facility built in 1988. The 29 bed geriatric/psychiatric facility is housed in a renovated but dated 1930s era on-campus structure.

The majority of patients/consumers at SHS are between 25 and 45 years old. Since the mid-1990s, virtually all patients—60% of which are male—are court committed on the basis of presenting a danger to themselves or to others, or are gravely disabled. These

highly vulnerable patients/consumers almost always have one or more major mental illnesses that prevent them from living successfully and safely in a non-secure community setting.

The mission of SHS is to treat and stabilize these patients within 30-90 days and, where possible, return them to community living. Approximately 60% of the adult patients return to a community-based environment within 35-40 days. The remainders are transferred to longer term care units, usually at SHS, for approximately 90-180 days. Relatively few patients/consumers remain here for more extended periods of time. For most patients/clients, SHS functions as a 'safety net provider' or treatment facility of last resort.

Treatment is provided through an interdisciplinary team, including psychiatrists and other physicians, psychologists, nurses, therapeutic recreational specialists, and social workers. The team works with patients and their families to develop and implement individual treatment plans. Treatment includes evaluation, medications, individual and group therapy, education, recreation, and discharge counseling.

During the previous fiscal year 2006 SHS admitted 312 adult patients, 79 adolescent patients, and 14 geriatric patients. Most adult patients at SHS are diagnosed with schizophrenia, bipolar disorder, or depression; 55% were dually diagnosed and 75% with a documented history of substance abuse.

SHS also maintains a 16 bed adolescent unit that serves as a safety net provider for youth, ages 12-17, who have not responded favorably in less-restrictive community settings. The Adolescent Unit was established in 1984 largely in response to and as partial resolution of the high-profile "Jeff D." lawsuit. Many of today's adolescent patients are also dually diagnosed with either a substance abuse or developmental disability in addition to a severe mental and/or behavioral disorder.

Mr. Farnsworth broke the committee up into four small groups for a tour of four of the five units by staff members at SHS. Each group toured the Admissions Unit, Adolescent Unit, Syringa-Chalet Skilled Nursing Facility, and half the groups toured the 'C Unit', which deals with severe personality disordered patients and patients with severe affective disorders and the other half of the groups toured the 'D Unit', which serves the most cognitively impaired, persistently mentally ill patients. The groups returned to the main meeting room at the conclusion of their tour.

Representative Henbest inquired as to what kind of treatment is available in the Adolescent Unit for children who are dealing with substance abuse in addition to psychiatric disorders. Mr. Farnsworth replied that SHS does not provide treatment for substance abuse in the adolescents but for the adults they have a contract with The Road to Recovery who come in and provide assessment and educational services to the patient, but they don't provide actual treatment. Due to the overwhelming regulatory standards from the Joint Commission, SHS is unable to provide treatment for substance abuse in their facility. Mr. Farnsworth stated that there is a gap that needs to be filled in the lack

of resources available to treat the adolescents for substance abuse and getting treatment for the adults.

Senator Compton asked for clarification on the term ‘forensic’ which is used in this setting. Mr. Farnsworth stated that patients who have committed a crime but who have not been charged because there is some question as to their mental state are sent to SHS to be evaluated and treated so they can regain competency and then released so they can assist in their defense.

Chairman Skippen proceeded to ask for changes or approval of the minutes from the previous meeting. Chairman Skippen made two corrections to the minutes. Senator Broadsword made the motion to accept the minutes with corrections. Motion was seconded by Representative Block. The committee voted with unanimous consent to accept the minutes with corrections.

Leslie Clement, Division Administrator for Medicaid, reviewed the coverage, service delivery, and utilization that Medicaid provides in regards to primarily mental health, but it also relates to substance abuse too. Ms. Clement stated that there has been a misconception that Medicaid does not cover mental health or substance abuse but there is a range of coverage available. However, it is difficult to separate the two out. There are in-patient substance abuse and mental health services available when it’s provided in a general acute hospital setting and they provide out-patient psychiatric and substance abuse care. Other services are location based such as federally qualified health centers or rural health clinics which can provide physician and clinic services. Medicaid does cover in-patient psychiatric services for participants under the age of 21 years and they also cover rehabilitative services, school-based services, and targeted service coordination which provides for the mentally ill.

Ms. Clement stated she was going to focus today on primarily community-based mental health services. There are three services: mental health clinic services, which are provided in a facility with physician oversight; psycho-social rehabilitative services, which are provided in the home and community; and targeted service coordination, which is also provided in the home and community and serves those with serious mental illnesses or who are severely emotionally disturbed (SED).

The Medicaid caseload is 12% of the Idaho total population, or approximately 170,585 clients, which is on the high side. In Idaho, there are 8,984 adults and 14,622 children accessing mental health services. It is difficult to get a handle on how much Medicaid pays for substance abuse and mental health programs. The national studies show that the Medicaid programs pay on the average 11.5% of their total Medicaid expenditures on mental health and substance abuse. Within that amount, 14% goes towards substance abuse related services and 86% goes towards mental health related services. Mental health spending has far outpaced the increase in Medicaid spending every year with a significant increase in 2003-2004.

The regional population vs. Medicaid enrollment is the highest in Region 3 at 16.77%, with Region 6 coming in with the second highest at 13.97%. Statewide the average is about 12%.

Ms. Clement compared the percentage of enrollment in Medicaid and compared it with the percentage of enrollees using mental health services by region. In Region 7, 22.9% of Medicaid enrollees are using mental health services and 12.9% of the region's population is on Medicaid. The rate is approximately $6,000 per user which correlates to the amount of services the individual is accessing.

When looking at emergency room use with diagnosis of mental illness, the trend is going up each year. Patients who had received community based mental health services 30 days or less before a visit to the emergency room were less likely to seek ER care than patients who had not received care 30 days prior.

Ms. Clement stated that some of the things that the Medicaid Division has tried to do are to address the quality and appropriate utilization. They spent a couple of years at the table with mental health work groups consisting of mental health providers, advocates, and other department staff to work through service definitions and expectations. Those rules have been presented in front of the legislative committees and they are making sure that when the services are discussed that it's clear on what is to be delivered and who should be delivering that service. They also decreased the amount of partial care that was available from 56 hours a week to 36 hours a week which was more reasonable.

They initiated a mental healthy pharmacy initiative which consisted of not doing prior authorization for mental health drugs but instead let prescribers know that if the patient they were prescribing for had multiple prescribers and they were falling outside of the normal amounts that issue needed to be reported and that has been very effective.

They received Legislative direction to initiate a credentialing system to insure that mental health providers had a certain level of accreditation. The follow up to this was a report detailing on-site clinic reviews which were disappointing and which showed that many providers did not have knowledge of or did not grasp the rules that had been put in place. They also instituted a new mental health agreement and enrollment process as a way of informing providers what the expectations were.

They also worked on Medicaid reform, HB 776, which made sure that they were defining benefits that addressed different population needs. HCR 48 helped to provide further Medicaid parameters for Medicaid participants who were of average health.

Based on the State direction that was received they obtained Federal authorization of three State plans- a basic benefit plan for patients of average health, enhanced benefits for those with disabilities and special needs, and a coordinated plan for those dually eligible for both Medicare and Medicaid.

The basic benefit plan is where they feel the individuals will receive appropriate coverage for the services they require. This plan provides a standard package of medical services available to all Medicaid enrollees including Prevention and Wellness Benefit. The mental health benefits provided under this basic plan are different than they have been in the past. They allow for only 26 mental health visits/services for each year with physicians and FQHCs exempted from this limit. It also eliminates coverage of partial care, psychosocial rehabilitation, and service coordination.

The enhanced benefits plan includes all coverage offered in the basic benefit plan plus long-term care coverage in an institution within the community. This is the plan where all the waivers are located. It includes developmental disability coverage plus the enhanced mental health coverage including partial care, psychosocial rehabilitation, service coordination, and expanded mental health clinic services. These services all require that individuals accessing these meet certain diagnostic criteria that indicate they have a SED or a serious mental illness.

Ms. Clement stated that a lot of work still needs to be done to improve the assessment process. Currently, individuals who have been receiving partial care are now encouraged to go in and get an updated assessment to see if they are eligible to access the enhanced benefits plan.

Senator Compton asked if the auditing of the psychosocial rehabilitation services had improved and Ms. Clement replied that in this new system the psychosocial services are being prior authorized in a consolidated unit through the Behavioral Health Division which enables them to authorize the appropriate services.

Representative Block asked how Idaho compares with other states in the nation in regards to spending on mental health. Ms. Clement replied that she has seen statistics that Idaho is on the bottom as far as spending but she does question how well the state reports on that issue so we may be higher in the ranking.

Representative Block asked if that ranking also included spending for substance abuse and Ms. Clement replied that it's harder for them to get their arms around the spending for substance abuse but no, the previous ranking does not include substance abuse.

Cathy Holland-Smith, Supervisor, Legislative Services Budget & Policy Analysis Office, gave the committee an overview in more detail of the budget and recent history of the budgeted programs within the Department of Health and Welfare, Department of Correction, Department of Juvenile Correction and Department of Education as they relate to mental health services and substance abuse. She reminded the committee that the 55 pages of budget information are located in their notebooks in Tab 6 if they would like to follow along. She wanted to reiterate that the budget does not include the $90M of Medicaid that Ms. Clement just discussed. This presentation represents all the state funds and Medicaid dollars that are spent by state agency programs which are separate from the outside provider payment that go through the Medicaid program, so you can add the $90M to the bottom line.

Richard Burns, Analyst, Legislative Services Budget & Policy Analyst, reviewed the methodology that was used in putting this document together. A comprehensive questionnaire was put together and sent out to the various agencies involved, asking them to respond to a number of questions, including identifying program or activity relating to the delivery of mental health or substance abuse services, providing a description of each program or activity, providing program and expenditure data for FY 2003-2007 by fund detail by grant for each program or activity, and to explain any differences between the appropriation and what they actually spent. They also asked for a description of each fund or grant describing such things as matching requirements, if the grant was capped, and when the grant was set to expire. In addition, they also asked for a general description and the types and number of positions that are assigned to a given program or activity, a brief history of each program or activity including when the program started and what problem was intended to be addressed by the establishment of the program, how it was created either by statue, executive order, by lawsuit, or by task force, and also what population the program was intended to serve by looking at eligibility requirements, program performance, and looking at caseload and workload indicators.

This questionnaire was sent out to the departments on July 25th, 2006 and they had one week to answer the questions and send it back, so the information presented today may not be as complete as hoped but it's a start and will give this committee a good indication of where everyone stands.

Mr. Burns reviewed the statewide report which is organized by functional area. The total spent for mental health was $73.5M, of which 97% was funded through the Department of Health & Welfare. The next category is substance abuse, and the total amount spent for the current year estimate is approximately $34.7M. A grand total of approximately $108.2M has been spent on both substance abuse and mental health programs, but add the additional $90M to that figure based on what Ms. Clement said was spent in the Medicaid area. State General Fund total expenditures on these programs for the current year are $61.4M that the state will spend out of tax dollars for the current fiscal year.

Ms. Holland-Smith reviewed the Health & Welfare portion of this budget review. She stated that DHW is presented a little bit differently than the other agencies primarily because they are shown as a budgeted program and there is actually an appropriation bill for each one of the programs within DHW. Their accounting system is very complex and they have a multitude of grants and other funding sources that are able to provide the level of spending in much greater detail than the other agencies are able to do at this time.

The first program Ms. Holland-Smith reviewed was a budgeted program called Community Hospitalizations. It was created in FY 2006 and prior to that had been part of the Adult Mental Health or Community Mental Health Services program. The legislature changed the requirements and the counties no longer had to pay for an individual who was committed to the state yet was in a private psychiatric facility. The counties felt like there was increasing pressure on their budgets because individuals were staying for a longer period of time than was funded by the counties so HB 579 was

passed to change this procedure, which made the state fiscally responsible for these individuals after a 24-hour period. It was difficult for DHW to absorb these costs so they asked for this item to be a separate budgeted item. The caseload has increased by over 70% during this past year and the expenses have nearly doubled. The average cost currently per individual is approximately $4,800. In FY 2006, JFAC did provide a $1.6M supplemental appropriation and DHW did transfer funds in from other programs so even though the appropriation was over $2.8M they ending up spending over $3M.

Ms. Holland-Smith stated that she believes that it is going to be very difficult to get through the FY 2007 with the estimate of $20M. There's nothing in the dynamics of who is being committed to the state and the activity that is going on that would suggest that figure would be less. She feels this is where the challenges will be.

There has been an effort on the part of legislative intent language in the appropriation bill asking DHW to be more aggressive on the contracts they have with the private providers. Currently they are using the Medicaid reimbursement rate, which is not necessarily a competitive rate, and so one of the challenges DHW has been given by the Legislature is to seek either regional or statewide contracts that make those rates more competitive.

Senator Stegner inquired if this was the result of the state hospitals being at capacity and the ongoing admission waiting list at these facilities. Ms. Holland-Smith replied that he was correct, this was a direct result of the increasing numbers of individuals being committed to the state for services, and, it's recognition that if services are needed within this state, the judges understand that is the only way you will get them since we don't take voluntary commitment anymore, we only take involuntary commitment, so the judicial process works more quickly when the individuals need care.

Ms. Holland-Smith reviewed the next program, which was State Hospital North (SHN). That has been a singly funded program for a long time. One of the major issues facing SHN was the lack of endowment income, which was eventually restored. Another issue was that in FY 2007 they received 20 new FTP. This was significant because of a lack of staff, they were not able to maximize the number of beds they had and they are in the process of renovating so they can increase their number of beds to handle more patients. At one time they did provide drug & alcohol treatment but that ended in early 2000. That money was shifted to substance abuse programs and SHN received the same amount in General Funds to cover that.

Representative Henbest inquired about the readmission rate of 39% at SHN in 2006, and wondered if the quality of the follow-up 30 days afterward was affected by the distance whether you lived locally or farther away. Ms. Holland-Smith said there is lack of information on tracking these individuals and their circumstances. There are support services provided to these individuals once they leave the state hospitals as well as medication assistance and some of these patients go directly under the care of ACT teams. Ms. Clement replied that DHW could run a report that would provide that information and Representative Henbest requested that one be sent to the committee.

Ms. Holland-Smith reviewed the next program, which was State Hospital South (SHS). This facility does receive Medicaid for both the elderly nursing home patients and the adolescent unit. The challenges SHS face are accessing the endowment funds, they had plenty but could not get an appropriation to access those funds, and that was taken care of. Another was Medicaid receipts; there was an accounting change on the Federal level that took some time to straighten out. Another was staffing challenges; cost per staff was going up substantially without relief. Their expenditures for 2006 were higher than their appropriation from the 2006 General Fund and that is because DHW transferred money from other programs into SHS to get equalization and to put the money where it was needed.

Ms. Holland-Smith reviewed the next program, which was Adult Mental Health, also referred to as Community Mental Health. There has been a substantial amount of growth in this program in the past few years. The Federal Government provided grants over an 8 year period to fund Adult Mental Health. It was understood that the states would pick up the funding once the Federal grants were exhausted, and that never happened. Under Adult Mental Health there is the Mental Health Authority and that is the staff that does the pre-authorization and the assessments for the Medicaid clients. There were substantial increases over the past few years with the addition of the ACT teams and the $2M one-time grant for infrastructure over the next two years. DHW is looking at whether or not they will be asking for a $1.4M supplemental because the Medicaid or Federal receipts have been going down.

Ms. Holland-Smith reviewed the next program, which was Children's Mental Health. This program was created in 2006 and had previously been a part of Children's Services which was the Child Protection area. There are substantial amounts of money in this program that are going to support the child protective system. There are a high number of children in the protective system that need these services which include residential treatment, foster care administration, adoption assistance, or foster care benefits that are entitled to use some of this Federal money since a significant number of these children have been removed from their parent's or guardian's custody. There is still fine tuning that needs to be done within this program but as we go forward there will be better information available to serve this group.

The challenge in Children's Mental Health is how the system includes or excludes certain people and services. The individuals who don't fall into those categories of eligibility become frustrated and don't know where to go to access services. Legally, they must have a diagnosis of a SED, but, if the primary diagnosis is substance abuse they do not treat that child. By rule, certain developmental, conduct, or substance abuse disorders are excluded when they are the only diagnosed disorder. In both Adult Mental Health and Children's Mental Health there is a web that includes or excludes people based on their disease or based on whether or not they have a co-existing disorder, and that issue comes up over and over again.

The Jeff D. lawsuit, which has been going on since 1980, is still active and has cast a shadow on some of the discussion of how they are doing or not doing as it relates to the lawsuit.

Representative Henbest commented that the concept of substance abuse inducing a mental illness in children and mental illness in children inducing substance abuse disorder is getting much more intertwined and feels this committee may want to look at the policy of segregating and asyluming those diagnoses together.

Ms. Holland-Smith went over the last program within DHW which was Substance Abuse. There have been major budgetary changes within this program and there has been a lot of focus from the agency and the legislature as well. The DHW is primarily responsible for community-based treatment for Substance Abuse. The money from the Alcohol Intoxication Treatment Fund was taken away from SHN and put into Substance Abuse Treatment and then DHW took a like amount of dollars from the General Fund and shifted it to SHN. In 2007, we will be spending less General Fund dollars and more state dollars with the fund shift. The money from the Liquor Control Fund that was going into Medicaid was also shifted into the Substance Abuse Program. The Access to Recovery Grant (ATR Grant) is a 3–year $21M Federal grant that has greatly expanded the availability of services within the state. The money will be going away soon so discussions are underway for an alternative funding source.

Senator Stegner stated that the DHW told him they are putting in a $6.5M request for next year to cover the loss of the ATR Grant and that the Governor's Office is fully intending to support that request to replace those dollars so services can continue.

Richard Burns reviewed the procedures for the correctional facilities in how they deal with mental health and substance abuse. When an offender comes into the system they are sent to a diagnostic unit where they are assessed on their educational skills and mental health or substance abuse issues. The staff then tailors programs for these individuals that will hopefully help change some of the antisocial behavior patterns that the offender displays. The Department of Correction spends about $922,000 a year on mental health services, and employs 13 clinicians and 1 chief psychologist for this service. Regarding the Health Services Contract, they also paid for a psychiatrist technician, 1 psychiatrist and 1 psychologist.

Representative Henbest asked why there were only 7 budgeted FTPs when they showed 13 clinicians plus 1 chief of psychology and Mr. Burns replied that he would need to go back to the department for clarification on that issue since they had not had time to adequately review the data received.

Mr. Burns said approximately $600,000-$700,000 had been spent on the Breaking Barriers program to prevent future criminal behavior and risk factors. They also spent about $700,000 on the Cognitive Self-Change and Thinking for a Change programs. The Federal substance abuse grants have been used over the years to establish the smaller programs within the Department of Correction and the Department of Juvenile

Corrections but those grants have been dwindling the past few years. $1.5M was used to establish a 400-bed facility, 24/7, to work with offenders on their behaviors and attitudes beginning next February. The DOC will be requesting from the Legislature $8.1-8.3M in General Fund monies to annualize the cost of this facility.

Senator Stegner asked what the $1.5M was being used for this year. Mr. Burns replied that it recently went out for RFP, and they hope to begin phasing this program in by next February. The $1.5M is to get the program up and running. It will be a privately operated facility and would start by moving approximately 20 inmates into the system and establishing a culture there and then adding them in small increments until they reach the 400 threshold.

Senator Stegner asked if the facility had been identified yet and Mr. Burns replied that the previous DOC Director had identified a location out in Nampa but the RFP has gone out for bid so they are waiting to see what comes back.

Mr. Burns reviewed the DOJC and their three facilities in Nampa, Lewiston, and St. Anthony.

The Nampa facility has the longest history of specific focus on drug and alcohol treatment with the Choices Program. This program is in a locked, highly secure facility for up to 36 male residents who receive treatment for mainly criminal misconduct and drug and alcohol problems. The program operates as a therapeutic community in which the whole environment and all staff are part of therapeutic milieus designed to reduce the likelihood of relapsing into the abuse of substances. The total cost of the program could be viewed as drug and alcohol treatment, but the most specific budget items related to drug and alcohol treatment are the specialized treatment personnel and the curriculum materials used. Actual expenditures for this program were a little over $1.0M.

The Lewiston facility is similar in structure and program to the Choices Program in Nampa. The specific program there is the Milestone program and is a modified therapeutic community. The program originally opened with the capacity to serve 36 male residents, but in FY 2003 the facility was downsized to a capacity of 24 due to statewide budget reductions. In the last 2 months, the facility was reinstated to its former capacity of 36. Both the Milestone and Choices programs place strong emphasis on involving the youths' families in the counseling. Both programs also received funding from a Residential Substance Abuse Treatment (RSSAT) grant until FY 2004. Since that time the programs have been funded through state General Funds. Actual expenditures for this program were approximately $970,801.

The last facility is the one located in St. Anthony. There are about 140 male and female youth who reside in a staff secure unlocked setting. Until the beginning of FY 2007 there was no specific housing area for drug and alcohol treatment on this campus. Individual youth assessed as having substance abuse treatment needs as a high priority have been referred to treatment groups which meet for 2 hours per week. Two such groups per week have been facilitated by a clinician who is a certified Alcohol and Drug Counselor.

The same clinician provided about another two hours of individual counseling per week with a specific focus on substance abuse treatment. A specific housing unit for 10 male youth who have serious drug and alcohol problems began in June of 2006. Plans are being developed to provide those services while still attempting to continue the group and individual counseling previously provided. Actual expenditures for this program were $8,881.

Mr. Burns reviewed the Judicial Branch, which houses the Drug Courts. Actual expenditures for this program were $1.5M. The Drug Courts operate under the statutory authority of the Idaho Drug Court Act, passed in 2001 by the Idaho Legislature, as part of a coordinated criminal justice strategy to address the drug/crime connection. This program has been extremely successful since its inception and most counties support the Drug Courts program.

Mr. Burns reviewed the Mental Health Courts within the Judicial Branch. Actual expenditures for this program were $693,100. Mentally ill offenders frequently experience an increase in the symptoms of their mental illness when incarcerated. Whether in jail or in prison, they represent a major liability and significantly greater management costs to counties or to the state. The Mental Health Courts operated in 6 of the 7 Judicial Districts at the end of 2005.

Senator Compton wanted to congratulate everyone who worked on this report since it was very comprehensive and clarified each program and the costs involved which painted a clear picture for the committee.

Patricia Tobias, Administrative Director of the Courts, introduced District Judges Randy Smith and Bryan Murray to give the committee a perspective from a felony sentencing judge on the mental health and substance abuse system.

Judge Smith, District 6 Judge, spoke about the felony perspective. The four functions that he is responsible for in sentencing are to protect society, deter the offender and others from committing crimes, rehabilitate the offender, and punish the offender. His options in sentencing are to send them to the penitentiary, put them on a Ryder for 180-days, or put the offenders on probation. The courts realized that they needed more options than the ones listed above because the offenders were not getting rehabilitated and were coming back year after year having committed new crimes. He stated that 80-90% of the felony cases that the District Judges see are related to either mental health issues or drugs and substance abuse. He said they need more alternatives for drug abuse and mental health treatment. He doesn't feel that those going through the drug and mental health courts are getting the actual treatment they need in order to break the cycle and get on the road to recovery. Sending them to the penitentiary doesn't do any good because they don't have access to the number of programs they need to succeed and they are intermingling with inmates who just get them in more trouble. Sending them on a Ryder for 180-days allows for some treatment but those programs are too short to allow for long-term success and they don't treat everyone who is sent on a Ryder based on test scores. Granting them probation really gives them no option at all, because the treatment programs are too short

to make long-term changes in behavioral patterns. Judge Smith stated that Idaho is sorely lacking in treatment programs. Bannock County has a 30-day program called the Share Program, which has been successful but there is not enough money to treat everyone that needs it.

The District Judges need a good assessment program which evaluates the offender so they know exactly what type of treatment needs to mandated. They also need more alternatives available, there are just not enough programs out there to serve the large number of people who need help. They need both long-term treatment programs and short programs, depending on the assessment of the individual, both inside and outside of the penitentiary system.

Judge Murray, Magistrate Judge in Bannock County, spoke about child protection which includes child abuse and neglect cases. He serves as chair of the Court's Child Protection Committee so his remarks are more statewide. With the increase in population there has also been an increase in drug or substance abuse addiction in adults, primarily the use of methamphetamine, and the children are the ones that suffer the most from this addiction. This has been devastating to the Juvenile Courts in the system. He sees the impact daily of the lack of services and opportunities to help these kids get out of the cycle of abuse. He developed the Child Protection Manual which he passed out to the committee. Child protection cases have doubled due to meth abuse and the lack of effective treatment available to the offenders is putting the children in foster home and alternative care situations. Their goal is to reunite the children with their family and to solve the problems that exist but they can't effectively do that when the parents are not getting the treatment they need. Meth users are so consumed by the drug and its effect on them that they end up choosing the drug over their families.

A better system of 'wrap around services' is needed, which include substance abuse treatment for the parents, availability of parenting and support classes to become better parents, employment opportunities and training, to help these parents overcome their addiction and to educate and help them become better, responsible parents and keep the families intact. This is a cheaper and more successful way to help these people than locking them up and separating them from their families. The 'wrap around' concept embraces whole community and family involvement in the treatment and support process, from physicians, school teachers, counselors, peers and family members.

In Idaho, 6.5% of kids are not accounted for in the school system, that's 1 out of every 15. What Judge Murray sees is the parents who are abusing drugs are taking their kids out of the school system because they don't want the schools to send DHW to the home for an evaluation, so you have a new generation of children who are not getting educated and will not be employable and who will have substance abuse problems just like their parents. Kids that don't have an education and have a substance abuse issue will end up in the state prison system, so it's a vicious cycle that needs to be broken with the availability of more treatment programs.

Senator Stegner asked if the judges felt that some of these new additions to the system should be state programs run by state employees or private provider programs. Judge Smith replied that there is more accountability in the drug courts with the liaison DHW has provided, but if you can get a private provider to do it more economically and quicker and provide the same level of care that would work, but he hasn't seen any evidence of anyone in the area wanting to step up to the plate privately and provide the level of care needed.

Representative Henbest told Judge Murray that she would be interested in partnering with him on tackling the educational neglect issue that the drug families face.

Representative Henbest asked about the mismatch of sentencing and the services that were available in DOC which came out in the Substance Abuse Report that the Office of Performance Evaluations published. She asked why criminal behavior that was identified was not matched to the correct substance abuse program to help that individual and asked that the committee consider making a recommendation to address this issue. Judge Murray replied that it's very frustrating for a judge to send an offender to a Ryder program or to probation and parole for treatment and then have a test say they are not ready for treatment so no treatment is given.

Senator Compton asked how successful the programs in UT and WA are and Judge Smith replied that from the statistics they have those programs are very successful for those kinds of treatment programs.

Chairman Skippen asked for figures on how much it costs to incarcerate a meth mom and put her children in foster care vs. the cost of treating that mom and keeping them with their families in a safe setting and providing treatment outside of prison. Ms. Tobias replied that she would work with Legislative Staff to provide a model to get the information requested.

Mary Beth Wells, Coordinator, Special Education, Department of Education, reviewed the Infant and Early Childhood Mental Health System of Care. It was created as a collaboration among the Governor's Early Care and Learning Cross System Task Force, Department of Health and Welfare, Department of Education, Idaho Association for the Education of Young Children, Idaho Head Start Collaboration Project, Boise State University and its partners at the local level which include: Health Districts, childcare providers, physicians, early learning programs, parents, faculty, and the community.

A system of care is a comprehensive range of mental health services and supports that are coordinated to meet the changing needs of children and their families within a community. The values of the system of care include: family voice, child and family-oriented care, relationship based, cultural competence, natural environments, and evidence-based practices. A true system of care is about partnership—a partnership made up of service providers, families, teachers, and others who care for a child. The team develops an individualized service plan that builds on the unique strengths of each

child and each family. This customized plan is implemented in a way that is consistent with the family's culture and language.

This system of care focuses on the following:

- Prevention, which is the implementation of public information and care that foster the development of healthy relationships between infants and young children and their families. The priority population is expectant families and families of children ages birth through 5 years who are at risk because of biological or environmental factors;
- Early intervention, which is achieved through the enrollment of children of families eligible for early intervention services that support infants and young children who experience social and emotional concerns. The priority population is families of children with developmental delays, disabilities, health related problems, or multiple risk factors;
- Treatment, which is provided by incorporating evidence based mental health services for families with infants and young children or parents who have been identified with disorders that indicate significant mental health impairment. The priority population is families of children diagnosed with emotional disorders, serious emotional disturbances, or who have experienced foster care services, abuse, neglect, or trauma;
- Professional development, which is the key to strengthening and expanding the delivery systems that enable the optimum accessibility to early childhood professional who can meet the needs to infants and young children and their families.

The Department of Education mandates schools to search for, evaluate, identify and serve students whose emotional and/or mental health disabilities have an impact on their education. This decision to serve is not automatic. A complex set of procedures must be followed to protect the student's individual rights, the rights of the family and the rights of the school district.

DHW services are voluntary and require the informed consent of the child/adolescent's parent or guardian to provide mental health services to their children. There is no mandate for the DHW to seek out and then serve children with serious emotional disturbances. It is the responsibility of the parents of children needing services to apply for CMH services, therefore demonstrating a desire to receive mental health services for the child.

Gary Craw, Treasure Valley Corrections Program Regional Manager, Division of Vocational Rehabilitation, and his partner, Robert Sidwell, a Rehabilitation Counselor, gave an overview of the program that Voc Rehab offers.

Vocational Rehabilitation is a program funded by 78.7% Federal government funds and 21.3% non-federal source funds provided by State General Funds enhanced by dedicated funds collected by the agency. Clients must meet eligibility criteria including the presence of a physical or mental impairment, which constitutes a substantial impediment

to employment, and there is the expectation that the individual can benefit in terms of an employment outcome from Vocational Rehabilitation services.

There are 40 field offices statewide and in FY 2005 they rehabilitated 1,907 people back to employment. Out of those, 624 individuals were determined to have psychological diagnoses or impairments which include substance abuse and mental health or emotional behavior disabilities, 170 of those individuals had specific mental health diagnoses, 301 had substance abuse problems, and 51 were in the juvenile category.
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41.5% of all clients served in FY 2006 were determined to have a mental health or substance abuse condition as one of their disabilities. Of these clients, 62.8% have mental health or substance abuse as their primary disability. $3,694,047 of a total of $9,752,647 was spent on these clients for direct services. A total $517,884 was spent by the agency in FY 2006 on mental health and substance abuse treatment for all VR clients. Of that amount, $394,437 was spent for mental health and substance abuse treatment on those clients with mental health and substance abuse as one of their disabilities.

Dr. John Hanks, D.O., Pediatrician, with special qualifications in Adolescent Medicine, updated the committee on two programs, the MATCH program, which is Mental Health Access to Children, and SPAN IDAHO, which is Suicide Prevention Action Network of Idaho. Dr. Hanks stated that the quality of physicians interacting with children is very high and that generally overall children are healthier than they have ever been due to better health care. But, even though the access to programs for mentally ill children is high quality the programs are limited. The statistics show that 1 in 5 children have a mental health disorder. Such chemical imbalances can cause a child to suffer from depression or bipolar causing the world to look bleaker and more overwhelming than it is which is the leading cause of suicide in teenagers.

The MATCH program is designed to provide immediate access to children in need of psychiatric care. The program increases primary care physicians' knowledge about the latest mental health disorders and treatments. It is also designed to support primary care physicians with consultation and guidance as they provide a medical home for their pediatric patients. A child identified by their doctor as having potential mental health problems is eligible for MATCH, regardless if the patient has private insurance, state insurance or no insurance. Once referred, MATCH will contact the parents to set up an appointment to meet with the Family Coordinator. Each Family Coordinator has a Doctorate in Psychology and can assess if pre-testing is needed. Prior tests, information from the school, and the doctor's assessment are collected. The child and his or her parents will meet with the psychiatrist. A treatment plan is created outlining additional steps the physician and the family can take to ensure the best help is provided for their son or daughter. The child returns to their doctor for any medication and follow up treatment. The whole process takes approximately two weeks.

The SPAN IDAHO works to prevent mental illness in Idaho teenagers and young adults which can lead to suicide. It is the 2nd leading cause of death in the 15-24 and 25-34 year age groups. Idaho is consistent with other states with the highest suicide rates, and in

2004, there were 239 people who completed suicide in Idaho between the ages of 15-54. Most suicides are by men, and most involve firearms. Among High School teens, 17.8% attending traditional schools reported seriously considering suicide in 2003. SPAN IDAHO works closely with DHW but suicide prevention is not funded by the State of Idaho which is something he would like to see changed.

Representative Henbest asked Dr. Hanks that if the State were to fund suicide prevention, what would he envision that program to look like. Dr. Hanks replied that he would like to see an initial investment in the $250,000 to $500,000 range with an ongoing investment of $1M a year to fund a comprehensive program that would have an impact on the suicide rate in Idaho.

Doug Call, National Alliance of Mental Illness (NAMI), stated that he was a volunteer with NAMI and that he has a son with schizophrenia who has been ill for many years. NAMI believes there is a problem in Idaho with the current mental health system because it is difficult to get access or help. Mr. Call designed the course that the POST Academy used to educate their officers in how to deal with people who exhibit mental illness symptoms. His son had some run ins with law enforcement which prompted Mr. Call to design the course. He states that help for the mentally ill in Idaho is calling 911, but a lot of officers do not have the training or experience to humanely and adequately handle the mentally ill and when they do take them into custody they handcuff them and then take them to a facility where it will be another day or so before they are evaluated. Officers in smaller counties may not have the training necessary to deal with the mentally ill and NAMI feels that is an area that needs to be improved. Mental illness is a lifelong disease and the patients don't belong in a medical hospital or even a prison, they need to be treated in a facility that specializes in their particular affliction so they can get the correct services and medication so they can lead productive lives outside of a facility setting.

Lynne Whiting, Idaho Federation of Families for Children's Mental Health, stated that this organization is a family-run organization that focuses on the issues of children and youth with emotional, behavioral, or mental health needs and their families. The Federation provides local education opportunities for families and other community members. Advocacy through Family support specialists is available to families, along with support groups, and opportunities for families to help other families through parent-to-parent support. Assistance for parents and families is available as they navigate Idaho's children's mental health system. Families are encouraged to share their strengths and knowledge with other families through committees, community boards, and opportunities on the Federation Board of Directors. A variety of programs are available to youth in Idaho, including Sib Shops, youth councils, and youth support groups. Too often, families have exhausted their own financial resources, including health insurance benefits, and are not eligible for Medicaid. And, a lot of families have to place their child in residential treatment programs through the child welfare system or through the juvenile justice programs in order to address their youths' mental health problems.

Incentives are needed to develop effective community-based systems of care to help families keep their children with emotional, behavioral, or mental disorder at home, in

school, and out of trouble, particularly in rural areas of the state. Without community-based treatments and services, parents have to make an otherwise unthinkable choice between retaining responsibility for a relationship with their child or giving over decision making authority or control to a state agency in order to obtain the help their child desperately needs. This can lead children to believe that their family have abandoned them, thus irreparably harming the bond between the child and family. Children who need intensive mental health services must not deprived of their right to be fully connected to their family. Their parents, siblings, and extended family are the only consistent and unconditional, lifelong source of emotional support for children with significant mental health problems.

Representative Wood asked how many families in Idaho participate in this program, and Mrs. Whiting stated that she did not have those numbers available with her today but that she would get them to the committee.

Cynthia McCurdy, Idaho Council for Children's Mental Health (ICCMH), stated the fact that it needs to be recognized that there are three different definitions for people with SED (Severely Emotionally Disturbed). One, from an educational standpoint; two, from the Idaho Council for Children's Mental Health; and the third from DHW. She does not believe that the current system is functioning well. She believes there is a lack of faith and integrity within State agencies to make it better. She would like to see a mindset change within the agencies and the legislature and for them to take a hard look at the programs out there for SED children and to expand those programs and make them more accessible. The bottom line is that there are a large number of children in our state that are not getting the services that they need and they cannot access the services that are available. There is a huge concern in the State of Idaho in the system of care that there is no single point of authority and that is an issue that comes up over and over again at all levels of the system. She is an advocate of the 'wrap around' concept that was discussed in an earlier presentation. That system is a family focused system where the community comes together to help this child succeed. She feels that every region should have this system in place, but the funds are not there to support that. Funding needs to be increased so more specialists can be put into the regions to help these children and their families get the help they need to succeed. There is currently a waiting list for 'wrap around' services and those children who are SED cannot wait for resources, they need them now in order to succeed and be successful. It is her hope that we may all have the same vision as to where we are going with Children's Mental Health in our state the future so all the children receive the level of care that they need. We have a responsibility to make certain that these children are successful and can and will live productive lives.

Dr. Linda Hatzenbuehler, Idaho State Planning Council on Mental Health & Idaho Council on Children's Mental Health (ICCMH) is here representing both organizations. The purpose of the Idaho State Planning Council on Mental Health was dictated by the Federal government when Federal block grant funding for State mental health services were established. The Federal law requires states and territories to engage in mental health planning in order to receive Federal mental health funds, which is approximately

$1.3M for Idaho at this time. They are also required to service advocates for the public mental health system and to monitor the entire public health system, not just the programs funded by the block grant dollars. The legislation further mandates that mental health consumers and family members be involved in the planning efforts through membership on the Idaho State Planning Council on Mental Health, and that state agency representatives also serve on the Council.

The second group that she is representing is the ICCMH which has been referred to by Ms. McCurdy, the previous presenter. The purpose of ICCMH was established to develop state level leadership in the development of an integrated system of care for children with mental health needs. The primary purpose was to bring together the heads of the various departments in the state who were involved in the care of children with SED, which included DHW, DOJC, and the State Department of Education, and the Council is chaired by the Lt. Governor of the State.

These councils are in line with the President's New Freedom Commission on Mental Health. They are trying to transform the mental health system so that it becomes consumer and family driven. Dr. Hatzenbuehler attended the last Idaho State Planning Council on Mental Health meeting and she reviewed the recommendations with this committee that they had made. They did not recommend reorganizing the state agencies in regards to mental health programs. But, they did recommend the following: supportive housing for all people in the institutions and accreditation of State Hospital North. The first step towards transformation of the system is to embrace and accept the concept that consumers and their families do know what the patient needs.

Dr. Hatzenbuehler attended meetings at both DOC and DHW and both agencies are unhappy with the options available in the current system. SHS doesn't feel that it can manage the growing forensic population which is increasing. DOC feels that it lacks the resources to provide the necessary treatment to persons with mental illness who are currently in their custody. Both agencies will be recommending the development of a new facility in Idaho to serve clients with mental illness. However, two issues regarding this facility will need to be addressed: one, where do you put it; and two, under whose jurisdiction would it be placed? Would it be a correctional institution and placed on the campus at one of the prisons or would it be a hospital? And, who would be admitted and housed and what kind of facility would it be? Depending on where it's placed and whose jurisdiction it falls under would decide who is admitted and who it treated.

Last week the Idaho State Planning Council on Mental Health took the initiative to establish a subcommittee to study this issue, and they will be developing a policy statement in regards to this new facility. This will be one of many initiatives the Council is developing and planning on presenting to the Legislature very soon.

Crista Henderson, member of the Mental Health Transformation Group, briefed the committee on the progress they have made. They are a group of 45+ people representing different agencies and programs within the state. They have adopted the President's New Freedom Commission on Mental Health which outlines the national goals and objective

for transformation that are based on the best science and practice available. They are preparing a Comprehensive Mental Health Action Plan in response to this Commission. They have developed workshops to develop draft materials and have outreach programs for their stakeholder groups, soliciting feedback and sharing information between all groups at every point of the process. They share a Draft Vision and Goals and discuss with the stakeholders the meaning of their vision and their sense of viability. There are many challenges to overcome but they are working on addressing each and every one of them. The Draft Vision and Goals plan is intended to address all statewide issues of concern so fundamental changes can be made in how the state addresses mental health issues.

Rick Huber, Transformation Work Group Subcommittee member, spoke about the challenges those with mental illness deal with. He was diagnosed with schizophrenia in college in the early 1980's and had a few bad experiences with law enforcement but once they found out that he had insurance, then their attitude changed and he was taken to the hospital where he finally received treatment and the proper medication for his illness.

Ms. Henderson stated that Idaho's mental health system of care can be transformed to assist people of all ages with mental illnesses and have their families direct their care, that public and private agencies and the government can work together to help these people get the treatment they need in a timely manner, and that services for these families will be readily available for the ones who need them most. Education on the diagnosis is also important for both the family and the patient to succeed in treatment. The three goals of this Transformation Work Group are: 1) transform the way we as a community think about and embrace mental health, understanding that mental health is essential to overall health; 2) transform the mental health delivery system to one that is based on individual needs, emphasizes recovery, and features accessibility; and 3) transform the manner in which resources are provided, coordinated, and delivered to ensure a sustainable system.

Chairman Skippen opened up the meeting for questions from the committee to any of the presenters. First however, the next meeting was set for Tuesday, September 19th, at State Hospital North. Representative Henbest stated that she had prior commitments and could not attend the next meeting. The floor was then opened up for questions by the committee.

Senator Compton said his advice to Ms. Henderson is that he thinks her group has done a lot to increase awareness of mental health issues but that her group needs to prioritize their goals and then to take them one by one to achieve those transformation goals because transformation of any kind takes time.

Senator Stegner commented that he was intrigued to hear that there was positive support for a treatment facility within the state and Dr. Hatzenbuehler replied their goal is to get to the deinstitutionalization of patients and have more treatment facilities and programs available to help these people lead productive lives. Senator Stegner stated that one of the objectives of this subcommittee was to establish priorities and this concept deserves consideration. He stated that would like Dr. Hatzenbuehler to also consider a combined

facility which would be comprised of a corrections portion which would be under the direction of DOC personnel and a portion that would be a secured hospital setting that would qualify as a secure hold that is not correction related. A possible sharing of staff and services should be considered also. He would like her to get back to this committee on the feasibility of this scenario.

Representative Wood asked Rick Huber about his recommendation on police officers getting more training in dealing with mentally ill patients and EMP personnel handling the calls that deal with the mentally ill. She wanted to know if legally there were problems with liability if the patient were injured. Mr. Huber replied that there is a law in effect that exempts officers or people from liability if the patient is injured during the commitment proceeding. Representative Wood asked if there was liability release also for the EMP personnel and Mr. Huber replied that was understood that it was part of the job but that they have specialized training to deal with patients in that situation.

Representative Henbest asked Dr. Hatzenbuehler why they are not considering a regional in-patient service that serves the whole array of conditions--such as forensic, mental illness, substance abuse, psychiatric illness--instead of having individual facilities or programs that treat singular diseases when many of these patients suffer from several diseases. She likened it to a person being admitted to the hospital with one diagnosis but then needing care for another condition, it's all treated within that one facility and the patient receives medical care for all their co-existing conditions at one time. Dr. Hatzenbuehler replied that the concept is very close to what the council is talking about and if the goal is to treat mental health like physical health then that is where they need to put their focus.

Representative Garrett stated that she feels that if you do co-house patients with a variety of conditions as stated above that those patients will be labeled as having criminal justice problems if you include the forensic patients in that facility because there would be no way people on the outside would know who was in there for forensics, who was being treated for substance abuse or who was being treated for a mental illness. These are all perceived very differently by the public who overall is uneducated in these matters unless they have a family member themselves who is dealing with one of these conditions. She feels that the forensic hospital should be considered as a separate facility to avoid this.

Senator Broadsword wanted to thank everyone who had presented today and said that it had been very informative for her since this was not her area of expertise. She felt she was walking away today much more informed and with a better understanding of what the mentally ill and substance abusers face when they are trying to get treatment and become productive members of society, and most importantly, what the families face in terms of trying to get their loved ones help.

Representative Wood wondered about the young patients that are misdiagnosed such as those with ADD, ADHD, and autism and wondered if these type of things are considered mental health illnesses or not. Ms. McCurdy replied that those are considered developmental issues, as are eating disorders, and that DHW has a program to deal with

younger children in identifying those problems at an early age so they can get the support and treatment they need to overcome or at least deal with them.

Representative Garrett said that the reason they refer to children with developmental issues as SED is because they don't want to give them a mental health diagnosis and label them in that respect. Some parents want a diagnosis to solidify for them what the problem is but Representative Garrett said DHW uses a scoring system which if it raises to a level where it interferes with their daily living activities that is when they begin assessing the child for their needs. She stated that many kids who exhibit developmental disorders never actually develop mental illnesses when they become adults.

Ms. McCurdy asked who the presenters would submit their questions to from today and Chairman Skippen told her to submit them to Caralee Lambert who is the Legislative Services lead staff person.

Ms. Lambert stated that the next meeting which will be held September 19th at SHN may be the last meeting before the committee will sit down and make their final recommendations, and that they will be hearing from the counties, public prosecutors, and DHW. If there are any other agencies or groups the committee would like information from, let Ms. Lambert know as soon as possible so that she can invite them to speak at the next meeting.

Senator Broadsword made a motion to adjourn; motion was seconded by Senator Compton. The committee voted with unanimous consent to adjourn until the next meeting on September 19th, 2006, at SHN.

Meeting was adjourned at 5:23 pm