MINUTES

(Approved by the Committee)

MENTAL HEALTH AND SUBSTANCE ABUSE INTERIM COMMITTEE

Tuesday, June 27, 2006
Idaho State School and Hospital, Nampa, Idaho

Members present were: Co-chair Senator Joe Stegner and Co-chair Representative Kathy Skippen, Senators Joyce Broadsword and Elliot Werk, and Representatives JoAn Wood, Sharon Block and Kathie Garrett. Senators Dick Compton and Chuck Coiner and Representative Margaret Henbest were absent and excused. Legislative Services Office staff present were Caralee Lambert, Cathy Holland-Smith, Amy Castro, Dick Burns and Charmi Arregui.

Others attendees included: Susan Broetje, W. Guy Tidwell and Michael Kennedy, ISSH; Richard Armstrong, Bill Walker, Ken Deibert, Kathleen Allyn, Bethany Gadzinski, Chuck Halligan, Anne Bloxham, Leslie Clement and Tracy Goodin, Idaho Department of Health and Welfare; Brent Reinke, Ryan Hulbert, Paul Carroll, Larry Callicutt and Sharon Harrigfeld, Department of Juvenile Corrections; Tom Beauclair and Gary Barrier, Department of Correction; Representative Nicole LeFavour; Representative Darrell Bolz; Justice Daniel T. Eismann, Patti Tobias and Norma Jaeger, Idaho Supreme Court; Hon. Brent J. Moss; Hon. John F. Varin; Tony Poinelli, Idaho Association of Counties; John Triplett, Nez Perce County; Rakesh Mohan and Ned Parrish, Office of Performance Evaluations; Sara Nye, Office of the Governor/Division of Financial Management; Molly Steckel, Idaho Medical Association/Idaho Psychological Association; Jacque Groff, St. Alphonsus; Sarah Woodley, Business Psychology Associates; and Captain Maxfield and Officer Booth from the Canyon County Sheriff's Office.

Following a legislative tour of the Idaho State School and Hospital (ISSH), the meeting was called to order at 10:40 a.m. by Co-chair **Senator Stegner**. He started a discussion of the committee's goals by reading the text of House Concurrent Resolution 63 (2006) and quoted from that Resolution operative language stating "the committee is to undertake and complete a study of the current mental health and substance abuse treatment delivery systems in Idaho." **Senator Stegner** said it was his hope that the tours of ISSH, State Hospital North and State Hospital South would assist the committee in understanding the network and delivery system of mental health and substance abuse in Idaho. He stressed the importance of coordination and good communication between the various ongoing efforts to learn how the state can be more efficient and responsive to the needs of its citizens.

Senator Stegner continued by stating that one of the dilemmas that he struggles with is a statistic that, in Idaho's state hospitals, there is a significant backlog and wait time for involuntary commitments by the court systems. Additionally, he has been told that as many as 50% of the people admitted to the two state hospitals in Orofino and Blackfoot come from Ada and Canyon Counties and asked for verification of these statistics. He noted that a solution to this dilemma may be increasing the capacity in the state or public system so that the largest populations of people needing services (such as those in Ada and Canyon Counties) can receive support in their regions.

Co-chair Representative Kathy Skippen referred to her personal experience and past jobs in dealing with juveniles in particular with mental health issues, as well as her service on the Joint Finance Appropriations Committee (JFAC). She expressed concern about the cost to the state in failing to look at mental health and substance abuse issues in a more comprehensive way, and wondered why the two areas have not been addressed since they drive state policy in terms of both budgets and human experience. She cited Idaho Department of Health and Welfare (IDHW) substance abuse treatment reports that point out that Idaho does not have an effective system of care. She said in looking at how these issues drive prison and correction populations, local governments are dramatically impacted.

Representative Wood stated that she would like to know what programs are available for mental health and substance abuse, and what part those programs play in keeping people out of juvenile corrections or prisons. What is the amount of money being spent, are the programs working, and what are the costs when compared to the cost of housing inmates in prison? **Representative Wood** also stated that she wanted to know about the possibility of putting treatment programs into one different agency. **Senator Stegner** added that Governor Risch moved the state in that direction already by creating a new behavioral health department in IDHW and stated such movement will be part of the committee's discussion.

Representative Wood asked whether a list of all of the treatment programs had been compiled along with the bottom line costs of such programs. **Ms. Cathy Holland-Smith**, Legislative Service Office, referred to a resource binder provided to committee members where some of this information is gathered.

Representative Block agreed that it was very important to address the treatment delivery system and hoped that the prevention issue would also be addressed. She pointed out the effects that a parent's drug use has on children.

Representative Wood noted that she had recently been in a meeting where testimony was given by successful graduates of the Drug Court and she was impressed by their drastic lifestyle changes and their gratitude for the program.

Ms. Holland-Smith briefly reviewed the contents of the committee members' resource binder. She noted that the Mental Health Transformation Work Group plans to have a draft of its strategic plan completed by July, 2006, and that will be provided to the committee. In

anticipation of future meetings, **Ms. Holland-Smith** said that community partners will be identified who can explain their role and participation in efforts to reform services around mental health and substance abuse.

Representative Garrett commented that information on the Medicaid budget was not included in the binder but was important since Medicaid pays for most of the mental health services available. **Ms. Holland-Smith** stated that the IDHW would be including information about Medicaid at a future presentation.

Ms. Sue Broetje from ISSH was the first presenter. She explained that ISSH is now a residential facility that serves people with developmental disabilities. ISSH is neither a school nor a hospital at this point; ISSH is not a mental health facility either. About 80% of ISSH residents have been dually-diagnosed, meaning they have a developmental disability and a mental health diagnosis. ISSH opened in 1918; at its peak the facility served about 1,000 people and it was sometimes referred to then as a "warehousing" operation. There has been a continuous decline in resident population; ISSH currently serves 95 residents. ISSH is licensed to serve 112 residents at capacity. In the last three years, the numbers of admissions and discharges have been about equal. Residents range in age from 12 to 80 years old; about 74% of the residents are male.

Ms. Broetje continued by stating that ISSH serves people with a broad range of disabilities. Since the mid-1990s, most residents are people with mild retardation who have significant maladaptive behaviors such as assaults on others, self-injuries, sexual offenses, people who attempt suicide, those in unsafe situations, and some who engage in property destruction. Admissions to ISSH are coordinated through regional staff, and **Ms. Broetje** said they are very aggressive in trying to find community placements. This year there were 74 cases for which ISSH helped find community placements. She emphasized that ISSH is a safety net for Idaho; when there is not a community agency or service provider that will be able to meet the needs of a person, ISSH serves as a residence of "last resort." **Ms. Broetje** continued by explaining the discharge coordination process as well as the wide range of services offered at ISSH, including nursing, occupational therapy, psychotherapy and dietary services. **Ms. Broetje** distributed an overview of ISSH information, a copy of which is available in the Legislative Services Office. She noted that there is a low 8% readmission rate at ISSH.

In response to a question from **Representative Skippen** regarding ISSH's budget, **Ms. Broetje** stated that because the resident population has declined over the years, there are often questions as to why the expenses do not decrease. She said there are a number of reasons for this. Personnel budgets reflect a shift in the type of client requiring high-level staff supervision. She noted that ISSH is not a secure facility due to regulations; no gates or doors are locked and there are no door alarms since that would be considered "restrictive." ISSH's protection for their clients and the community is totally through staff supervision, thus the reason for a high staff-resident ratio.

Senator Stegner asked if ISSH gets a significant number of requests for admission for people

who would require a secure facility that ISSH is not able to accept. **Ms. Broetje** answered that such a situation does occur. In response to **Senator Stegner's** question regarding where these people would then go, **Ms. Broetje** stated that they may end up in prison, although the prisons don't like to take people with developmental disabilities. There are few services for that type of person in the community. Private providers do not have the capacity either.

Senator Stegner asked **Ms. Broetje** if, in her opinion, there is a significant gap in service capability in Idaho and if so, how big this problem is. **Ms. Broetje** stated that there is a gap, but she would not define it as huge. She said a level of supervision in a more secure environment would be beneficial for the state. Nationwide, this seems to be a dilemma and there is a moderate gap where a person does not fit into the criminal justice system (where they would be at risk) and yet they do not fit into the developmental disability system either. **Senator Stegner** asked specifically about sexual offenders who are residents at ISSH, noting that obviously they have not been a security problem at ISSH. **Ms. Broetje** answered that ISSH developed a curriculum to treat sexual offenders with developmental disabilities, which was a big challenge. She added that ISSH had not gotten a lot of sexual offender referrals; they get many more referrals for people with other criminal behaviors, which are challenging because they are dangerous to each other and to staff. She said that there are many staff injuries as a result.

In response to a question from **Representative Skippen** regarding the connection between ISSH and the Department of Correction, **Ms. Broetje** said that while many of these people engage in criminal behaviors, they may not have been prosecuted because they are not legally competent.

Representative Wood asked if it would be possible to put a separate, secure facility at the ISSH site, allowing for more treatment capability. **Ms. Broetje** said that legally it could not be done under ISSH's funding source, but it could perhaps be done using another funding source. There would be nothing to prevent two different types of facilities on the same grounds, *i.e.* an additional secure facility with different funding. Such a change must be carefully planned since riskier individuals would be placed in closer proximity to a very vulnerable population.

Representative Garrett asked about ISSH's funding sources and whether residents are Medicaid-eligible. **Ms. Broetje** responded that ISSH has clients who have a mix of Medicare and Medicaid; ISSH is 70% federally-funded and 30% state-funded. All ISSH residents are Medicaid-eligible.

Representative Wood asked if parents of the residents are required to contribute to the cost of care. **Ms. Broetje** answered "no, not directly." Family members buy personal items but they do not contribute to daily operating costs. **Mr. Ken Deibert**, IDHW, added that there was an effort years ago to pass legislation to provide for parental support. He said the legislation was defeated rather soundly. ISSH is currently prohibited from pursuing parental support directly.

In response to a question from **Senator Broadsword** regarding why such supplemental funding was rejected, **Mr. Deibert** stated that he was not present during that legislative session, but parents who were say the Legislature chose not to make family contributions a requirement for

ISSH admission. He noted that the discussion was held prior to Medicaid becoming the primary funding source for ISSH.

Senator Stegner asked about the number of people that might normally be admitted to ISSH but are not because ISSH is not a secure facility. **Director Tom Beauclair**, Department of Correction (DOC), responded by saying that he could not give exact numbers, but the DOC sees about one referral per month that does not fit into the state mental health hospital continuum of care and who needs a secure facility. He pointed out another dilemma in that the DOC has the final approval when a judge makes a decision to send a person to prison, but if there is no place to put them other than lockdown in a secure environment 23 hours per day, that person has to be separated from the criminal offenders, which requires more staff. There is no Medicaid eligibility for inmates so he thinks this is a very large gap in the system.

Representative Garrett asked about the number of people with developmental disabilities who end up in prison in order to ensure security. **Mr. Beauclair** said that it was a fairly small number; nonetheless, he said that the dilemma is that there is no appropriate place to put them.

Ms. Broetje discussed staffing challenges at ISSH, particularly for entry level staff.

Senator Broadsword asked **Mr. Deibert** to give the committee the cost of community-based care versus the cost of care at ISSH. **Mr. Deibert** answered that the cost differential is significant; funding for the community-based Intermediate Care Facility for the Mentally Retarded (ICFMR) is capped at around $284 versus the cost of care at ISSH, which is much more expensive. In a personal care facility, the cost runs from $20,000 to $60,000 annually versus $100,000 annually at ISSH, but he noted that ISSH serves a very different population than those being cared for in the community. ISSH is the treatment resource of last resort; when people fail in community placements, they go to ISSH. ISSH has a full-time medical staff, pharmacy and psychiatric staff that provide the level of service that is necessary to provide this safety net.

Senator Broadsword inquired about the phrase "capped at $284" and asked if that meant that the cost could actually be more but they could not charge more than that. She said that she heard testimony last year that those costs were being exceeded on a regular basis and that they were not being compensated, so it was more difficult keeping these people in the community. If that continues, she asked whether there would be a greater demand on the state system. **Mr. Deibert** stated that there is a difference between the residential care providers and the ICFMR; he said these are two different kinds of facilities. There is a mechanism for adjusting rates at the level of ICFMR care; within the residential care arena, which was the discussion in the Legislature last year, there is not that same methodology that there is under the ICFMR system.

Ms. Kathleen Allyn was introduced as the new Administrator of the Division of Behavioral Health for the IDHW. She outlined three major areas for discussion regarding substance abuse, adult mental health and children's mental health, and introduced **Ms. Bethany Gadzinski**, Substance Abuse Program Manager for IDHW.

Ms. Gadzinski explained that the Alcoholism and Intoxication Treatment Act governs the provision of treatment services in Idaho. The Act designates the IDHW as the state substance abuse authority, establishes an advisory committee structure, and charges the IDHW with establishing a comprehensive program for treatment, including rules for approval of treatment programs. The Idaho Liquor Act establishes an amount of the liquor taxes to be dedicated to the alcoholism treatment account. The operations of the substance abuse services, funded by the Substance Abuse Prevention and Treatment Block Grant, state funds and Access to Recovery (ATRI) funds, is maintained in the Division of Behavioral Health. The IDHW contracts with two management services contractors to help manage the network of services from prevention through treatment. The ATRI Alliance is the oversight committee for the ATRI grant. The ATRI Alliance gave direction for spending that money in the regions. Eighty-five percent of the money must go into treatment and recovery support services in the community.

Ms. Gadzinski continued by stating that the priorities of the funding are: Native Americans, the Hispanic community, adolescents, and persons under court supervision. Each of the seven Idaho Regions has a Regional Advisory Council that meets at least quarterly. The councils provide for the coordination of, and exchange of information on, all programs relating to alcoholism and drug addiction, and act as liaisons among the departments engaged in activities affecting alcoholics and intoxicated persons.

Ms. Gadzinski distributed and discussed an organizational chart of the substance abuse program. A copy of these handouts are available in the Legislative Services Office. **Representative Skippen** stated that she had heard concern about the ATR grant and the definition of "treatment" versus "recovery" and asked for an explanation of the differences. **Ms. Gadzinski** answered that the ATR grant was a new way to look at treatment, recognizing that people recover in many different ways and it doesn't always require treatment. This allowed the IDHW to expand its treatment options, which are detoxification, outpatient treatment, intensive outpatient treatment, and residential treatment. The IDHW can also offer "wrap-around" services to help clients in their recovery; these services include case management, family, marital and life skills training, child care, transportation, and safe and sober communal housing. **Ms. Gadzinski** added that many meth addicts report that once they get sober, it is extremely hard to find jobs due to the condition of their teeth. This could send them into relapse, so dental care is also provided for some recovering addicts.

Representative Skippen asked if the percentages were dictated by the grant, and whether the bulk of the ATR grant could be used for treatment and some for recovery, or vice versa. **Ms. Gadzinski** responded that the current "soft" target is 51% for recovery and 49% for treatment. Many states argued that if there is a client who chooses treatment, that client should not be put on a waiting list because of dictated percentages. Now there is really no set percentage; the client calls and, if they are eligible for treatment and a slot is available, they will be given treatment. If the client requests recovery support services, they will be given those services. **Ms. Gadzinski** noted that some clients choose a combination of services.

Representative LeFavour asked if there was a lack of recovery support which could trigger stress, possibly sending someone back into treatment. **Ms. Gadzinski** said she did not have the relevant figures as to how many people come back into their system but agreed to get that information for the committee. She said that 40% of the clients complete treatment successfully.

Senator Werk asked for clarification about a person calling to ask for help and whether there was a "gatekeeper" who recommended what treatment was best for each client. **Ms. Gadzinski** answered that there is; a client calls a 1-800 number and it takes about two minutes to determine if he is financially eligible (at or below 175% poverty level) and whether the person fits into a priority population. The client is then referred to a qualified, professional care manager who conducts a 15-17 minute service assessment using a standard tool. The client is then given a recommended level of care based medically on how sick the client is. The client is also given his choice of recovery services.

Senator Werk asked if financial eligibility is set by someone other than the IDHW. **Ms. Gadzinski** responded that the IDHW can provide services to clients with incomes of up to 200% above poverty level based upon federal regulations. The IDHW, however, has chosen to use the standard of 175% and below because, even at that, not all clients can be served. The IDHW has looked into raising that percentage since as the population of Idaho grows, so does the addiction rate. There are about 36,000 people in Idaho who would qualify for services. Before the ATR grant, the IDHW served about 5,500 people; with ATR funding, it serves approximately 13,000.

Senator Werk asked if any studies had been done regarding what financial resources are required for private treatment. **Ms. Gadzinski** answered that there is a huge population, mainly the middle class, who could be deemed able to afford private treatment and who do not qualify for IDHW treatment services.

Senator Stegner asked if a big number of that population was choosing, at this point in their lives to not seek treatment unless court-ordered or through family intervention. **Ms. Gadzinski** responded that there has been no study done on that population; she said that the IDHW used to get 10,000 calls on the 1-800 phone number. With the advent of ATR, they now get 60,000. She noted that as more information is made available, hopefully more people are seeking treatment earlier but it usually takes some crisis to push an addict into treatment.

Representative Skippen asked if people are expected to make life-altering changes after spending 20 minutes on a phone assessment. **Ms. Gadzinski** stated that when a client decides he is ready to change his lifestyle, that is when he makes that phone call for help.

Representative Garrett said she was amazed how much money people are willing to spend on their addictive habit and how little they are willing to spend on their own treatment. She said an addict will spend $1,000 per month on his habit, but will not want to pay $6 of the $150 assessment fee. She asked about the ATR grant, which is set to expire August, 2007, and what it will take to replace those funds. **Ms. Gadzinski** answered that the IDHW is looking at several avenues to replace part, if not all, of the ATR funds. Additional funding will be put into the

block grant; she estimated that Idaho will get about $500,000 to $1 million in federal funding, and other grants are being applied for.

Ms. Gadzinski further discussed the IDHW's program, including client data from 2005 showing that 43% of the women in treatment are addicted to methamphetamine. She also discussed the outcomes of the substance abuse program from July 1, 2005 through March, 2006, from intake to discharge, stating that for adults there has been a 52% reduction in usage; for adolescents, 60%. With regard to criminal justice involvement, there has been an 87% reduction from intake to discharge and for adolescents an 80% reduction.

Mr. Chuck Halligan, Manager, Children's Mental Health Care Program, IDHW, gave an overview of the program. He stated that the legislative purposes of the Children's Mental Health Services Act, a voluntary services act, include: (1) emphasis on family support and involvement; (2) mental health services in which multiple agencies cooperate and collaborate; and (3) parents retain custody of their child.

Mr. Halligan stated that agencies collaborate and cooperate in planning and developing mental health services and treatment plans. He said there are 369,030 children in Idaho. The national projection for serious emotional disturbance is 5-9%, or 18,452 children in Idaho based upon the 5% estimate. Forty percent, or 7,448 children, need to access publicly-funded mental health services during the year.

Senator Broadsword asked if any research had been done on whether that percentage of children needing treatment follows through to adulthood. **Mr. Halligan** stated that he did not know what the prevalence estimate of that would be for adults.

Mr. Halligan continued by stating that publicly-funded mental health services include: family and community services, education, juvenile justice (both county and state), Medicaid (through psychosocial rehabilitation), clinic services, and inpatient hospitalization. Family and community services include 92 full-time employees, 62 clinicians serving children and families, 10 clinical supervisors, 1 psychiatrist, various support staff and administrative positions, contracted psychiatrists, therapists, residential care, and other providers. Family and Children's Services (FACS) include: assessment, case management, family support services, outpatient, respite care, day treatment, therapeutic foster care, residential treatment, inpatient, and crisis response.

Mr. Halligan discussed the number of clients served by the IDHW for fiscal years 2004 and 2005. **Senator Werk** inquired about the substantial jumps in outpatient and assessment services from fiscal year 2004 to fiscal year 2005 and whether there was a reason for those increases. **Mr. Halligan** said that there was a change in the IDHW's service delivery program in 2002-2003; the IDHW moved from a Children's Mental Health Service only to the private sector, paid for by Medicaid. Prior to 2002, a client would have to contact the local Children's Mental Health Program, get an assessment, a plan was done and then a referral was made in the private sector for outpatient services. The process was changed so that the private sector could do that assessment, formulate a plan and provide services. It opened up the number of providers who

could do assessments, which is the doorway to outpatient services.

Mr. Halligan continued by discussing system challenges which include: voluntary versus involuntary service, other system partner expectations, population growth, access to services, service availability, service quality, fragmented services, and the definition of "serious emotional disturbance." He mentioned four actions addressing these system challenges:

1. The Legislature passed a bill which amended Idaho Code 20-511A, allowing the court having jurisdiction of a child under child protection or the Juvenile Corrections Act to order the IDHW to provide an assessment of the child and the child's family and to develop a plan for that child's mental health needs. The court reviews the assessment and orders that those services be provided. The IDHW is then obligated to pay for the services, and this allows for a screening team and coordination.
2. The IDHW convened a Juvenile Justice/Children's Mental Health Work Group in 2005 to focus on the issues related to the two systems working together.
3. The Idaho Council on Children's Mental Health (ICCMH), which the Governor appointed, works on issues related to interagency collaboration and cooperation.
4. Service coordination using "wrap-around" services, which is an evidence-based approach to providing services to children and families who are involved in multiple systems and who are seriously, emotionally disturbed, has been implemented.

Mr. Halligan gave an update on the "Jeff D lawsuit." He said that the IDHW would soon have a motion for summary judgment into the federal court and the trial was to begin on September 5th and would last about 3 weeks. The trial is focused on the implementation of the court plan that was filed in 2001. He said that there are approximately 222 individual action items still in dispute which will be addressed at the trial. **Senator Stegner** stated that the committee would like to discuss the "Jeff D" situation in more detail at a later date and asked for a more in-depth history and status of the case as it progresses.

Representative Garrett said that as gaps were being identified, she wondered about the status for children's and adolescents' residential treatment, *i.e.* are those services available in adequate numbers to meet the need? **Mr. Halligan** answered that there is an abundance of residential care providers in Idaho licensed through the IDHW's central office, although he did not have the exact number. He said the IDHW does not contract with all of them; the Department of Juvenile Corrections also contracts with some. **Mr. Halligan** noted that there are enough beds, but whether the programs for the children are the right ones may be the question. The programs are targeted more toward adolescents. Family-like settings are used for the younger children. He said that it is hard to find placement for young sex offenders with developmental disabilities.

Ms. Anne Bloxham was introduced to speak about the IDHW's Adult Mental Health Program. In her overview of the program, **Ms. Bloxham** stated that, based on the 2004 U.S. Census, there are approximately 1 million adults in Idaho. At any given time, 20% of the adult population will have a mental illness; that means 204,170 Idahoans. Approximately 5.4% of the adult population is estimated to have a serious mental illness (meaning a diagnosable emotional, mental or

behavioral disorder that a person has or did have in the previous year) that impacts functioning in at least one major life area. Two percent of Idaho's population has severe, persistent mental illness that impacts functioning in at least two major life areas. In fiscal year 2005, the program served 19,573 persons, or approximately 2% of the adult population in Idaho.

Ms. Bloxham discussed the organization of Idaho's Adult Mental Health System, stating that there are seven regional mental health programs in Idaho and two state hospitals. State Hospital North can accommodate 55 beds and State Hospital South has 90 beds available. There are 22 field offices with approximately 249 full time staff. **Ms. Bloxham** continued by providing a brief overview of funding sources for Community Adult Mental Health for fiscal year 2007. She said that the target population in Idaho falls into three categories:

1. Adults with severe and persistent mental illness (SPMI)
2. Adults experiencing "psychiatric crisis" for up to 120 days
3. Adults with criminal charges

Those who receive services are primarily lower-income and indigent persons who do not have private insurance or Medicaid. Services are based on a sliding fee set in rule. The IDHW provides coordination for the involuntary treatment system, oversees the provision of designated examiner services, serves as a gatekeeper for the state hospital system, and provides pre-screening for Medicaid-eligible young adults (18-21) admitted to inpatient psychiatric services.

Ms. Bloxham stated that Mental Health Services also provides 24-hour crisis intervention, screening and assessment, service coordination, psychosocial rehabilitation (PSR), care management of PSR services, assertive community treatment/mental health court, medication follow-up, and short-term mental health intervention. **Ms. Bloxham** then discussed system outcomes in terms of hospital discharges and outcomes in the community.

Mr. Tom Beauclair, Director, DOC, was the next speaker. He stated that if he were asked to rank the two societal issues that impact DOC, they would be mental abuse and substance abuse. He emphasized that correction is a community issue which requires connectivity.

Mr. Beauclair explained that a criminal offender is different than a substance abuser; most substance abusers are offenders, but the severity of the criminality is a large part of what DOC focuses on. DOC assesses offenders and their need for treatment or control and management. Some need maximum control; others in the community may have committed a crime and are required to be under supervision and are assessed as low-risk. Then there is a mixture of those two populations in the total population of 20,000 offenders in Idaho. There are impact points that are very critical to understand in looking at the system. The criminal justice system is one of the most successful systems in terms of treating people because they hold a "hammer" over prisoners' heads and treatment is forced upon them. Experts indicate this works. **Mr. Beauclair** stressed that in this continuum of services, one of the biggest disconnects is the assessment piece. This should drive all of the work that they do not only in substance abuse, but also for mental health.

Mr. Beauclair continued by explaining that DOC uses what is called the TCU screening substance abuse assessment instrument; the IDHW uses a different system of criteria; and some parts of the Drug Court use what is referred to as the Gaines SS. **Mr. Beauclair** remarked that Patti Tobias and the Drug Court Committee have been instrumental in trying to develop a consensus so everyone will use the same assessment tool. He believes this is a big disconnect in the system and explained that when a person commits a crime, an assessment is done; if that person is sent to prison, another assessment is done; when treatment is given (sometimes in prison) yet another assessment is done; probation and parole will again refer the person for another assessment. According to **Mr. Beauclair**, this assessment strategy does not make sense from a policy point of view. He said that an assessment is necessary at every one of those impact points and subsets of impact points, but the same assessment tool should be consistently used.

Mr. Beauclair stated that in terms of what is the driving force behind criminal behavior, substance abuse is the number one risk factor. Eighty-three percent of offenders sentenced to a prison term have a documented substance abuse problem. Ninety-one percent of the inmates coming into the 120 day rider jurisdiction program have a documented substance abuse problem. These statistics closely mirror national statistics and reinforce the need to properly assess and have adequate resources to treat these individuals. There are currently 16,000 people under DOC's jurisdiction. The prison population has more than doubled in the last decade, and the biggest contributing factors are substance abuse and drug crimes. During this fiscal year, 461 inmates were added into the system; projections add about 30 inmates per month for the next four years. The Idaho prison population grew 3.4% last year, translating into much larger budget needs. **Mr. Beauclair** said that his budget grew from $129 million this year to $143.6 million in 2007. The community-supervised offender growth on probation and parole grew at 9.8% during the last fiscal year, and today DOC manages more than 11,800 people on probation and parole in Idaho. Forty-three percent of these persons are serving sentences for drug or alcohol crimes.

Mr. Beauclair continued by stating that drug crimes impact population growth: ten years ago 37% of those committed to the DOC were committed or sentenced for a drug or alcohol crime; today that percentage is 47%. It is important to acknowledge the impact of meth use: in 2005, most inmates who acknowledged a drug problem specified meth as their drug of choice. In exit interviews of Idaho inmates, 52% said that the main reason they were in prison was meth.

Mr. Beauclair said that all the research shows that treatment works; combined with control and punishment, treatment is more effective. Punishment alone does not work, however, there are not enough treatment options in Idaho. Between 1996 and 2005, the incarcerated population in Idaho grew 78% and the probation and parole population grew 73%. Yet at the same time, treatment staff at DOC grew only 39%. During that same time, 11.5 drug and alcohol counselors were added when the offender population went up by 4,597 persons. Idaho has the capacity to serve only about 40% of the need.

According to **Mr. Beauclair**, the DOC capital budget will exceed $350 million this year just in the construction of basic needs to build more prisons in the state. In order to mitigate the growth in the prison population, **Mr. Beauclair** pointed out that the retained jurisdiction program has

been a good diversion program. Normally people are sentenced by a judge, sent to prison for 2.5 years and then leave on parole. The 120-day jurisdiction program allows the judge to retain jurisdiction: the offender goes to prison for 120-180 days, is evaluated and hopefully receives some intensive treatment, and the judge then has the ability to release the offender on probation back into the community rather than spending 2.5 years in prison. This year a record number of 1,950 offenders will go through the program. Ninety percent who went through the program in the past two years received probation; the rest went to prison. Of those receiving probation, 70% completed the program and were discharged. The program works and judges are doing a good job of evaluating which people are selected for the program. **Mr. Beauclair** said that every one of those successes saves the state $40,000.

Mr. Beauclair stated that last year, the Legislature funded the Correctional Alternative Placement Program (CAPP) and DOC is hoping to increase its treatment capacity. This program will be privately built and operated with 400 beds for specific treatment of substance abuse and will be located in the Treasure Valley. Two hundred beds will be for people in this program from 90-120 days or longer who are then released into the community. The other 200 beds will be a diversion for probation and parole violators, who are historically the largest group of people coming into prison. In Idaho, the recidivism rate over the last 3-4 years has been about 44%. He will be making a presentation to add an additional CAPP program this next year.

According to **Mr. Beauclair**, mental health courts and drug courts also play a major role in the diversion of inmates coming into or back to prison. Drug and alcohol crimes account for 42% of all females coming into prisons. He said that judges regularly tell him that if a person has committed a crime and is a meth user and pregnant, that person will go to prison. There is nowhere in the community system where the judge feels such women are safe. In calendar year 2005, 43 pregnant women were admitted to prison in Idaho.

Mr. Beauclair explained that mental health must also be considered with substance abusers. The DOC is currently the state's largest mental health facility. By statute, Idaho is required to offer a stand-alone, secure mental health facility. DOC addresses this requirement with lockdown prison cells. Nearly 30% of the Idaho prison population, or 2,100 inmates, are designated as having some type of mental illness; 251 inmates have mental health issues that are severe. With regard to mental health costs, **Mr. Beauclair** noted that treating mental health offenders costs about 1/10th of the DOC's health care contract costs, or about $1.5 million. During the current year, there were 19 planned use of force incidents in the prison system. These are highly trained, specialized individuals who respond at a very high cost; out of those 19 incidents, 14 involved mental health offenders. **Mr. Beauclair** said that 95% of the inmates will return to Idaho communities. We should want them to return much better than when they entered prison.

According to **Mr. Beauclair**, one of the consequences of not having adequate community mental health care is the criminalization of the mentally ill. Community health care is sometimes all that is needed to help people who might otherwise end up in the prison system. He gave an example of a woman in Pocatello who is in the prison system for stealing a coat out of a truck in cold weather. She had been identified as gravely disabled, having multiple state hospitalizations and

outpatient treatment, with poor medication compliance. She was found incompetent to proceed with trial initially, but was ultimately sent to prison despite her petty crimes. Mental health courts can deal with these types of people in the community with a number of volunteers.

Mr. Beauclair said that great improvements have been made in the system with mental health courts and drug courts. One of the problems is that inmates do not currently qualify for SSI, so they have to wait until they get out of prison to apply. They also do not currently qualify for HUD housing, and few homes are available for the mentally ill. It becomes much harder if they are a convicted felon and mentally ill, especially with any history of violence. Statewide, **Mr. Beauclair** said he believes there is a lack of expertise in the area of substance abuse and addiction and the interaction with mental health issues. There are not enough treatment providers, especially in rural areas, and the funding sources are not adequate or consistent. He said that national statistics show that the mentally ill are much more likely to recidivate than any other offender; they also tend to stay 12 months longer in prison.

Mr. Beauclair stated that the most urgent gap in the prisons is that they don't have a comprehensive treatment system. The prisons need a forensic unit. They will be asking for a behavioral unit inside the prison next year since they desperately need to do something with their mental health offenders. In terms of what is working, **Mr. Beauclair** cited mental health coordinators, reentry probation and parole officers, mental health courts, mental health coalitions, and finalizing a comprehensive mental health services manual. He noted that the top three priorities from a recent conference were listed as: (1) a cohesive system, a "one stop shopping" approach and continuity of care; (2) funding and more resources; and (3) more education and communication on mental health issues.

In summary, **Mr. Beauclair** stated that the state needs to do a comprehensive needs assessment. This has not been done in the last 15 years. DOC spent about 2 years just trying to understand what their capacity was in prison to provide treatment. In addition, he suggested the following:

1. Develop individualized, multi disciplinary treatment plans that address the full range of supervision, control and habilitation needs that are transferable across the state system.
2. Match offenders with supervision control and treatment programs appropriate to their assessed needs and perceived risks.
3. Provide a continuum of care for both the mentally ill and the drug abuser.

Senator Stegner asked about the need for a consistent, system-wide assessment at various levels of government ideally done at every impact point, and what the barriers were. **Mr. Beauclair** stated that there are funding issues and some problems with everyone serving different people. When the aspect of criminality is brought into this, there may need to be an additional assessment but he believes that they could all agree on an initial screening. The same assessment standards would go a long way in talking the same language and understanding the system better.

Senator Stegner asked if legislative help was needed for statewide motivation. **Mr. Beauclair** said he did not think so; he has seen tremendous progress in cooperation between agencies and

he thought the Drug Court coordinating committee was the best example of that.

Senator Stegner said that a behavioral unit was not funded for the prison during the last legislative session and asked how that differed from a forensic unit. **Mr. Beauclair** stated that the behavioral unit would be step-down unit where a person is noncompliant in taking their medication or is acting out and requiring some kind of intervention. Behavioral units stabilize them and then move them into the general population of the prison. The unit would be much higher staffed with mental health professionals rather than correctional officers.

Representative Garrett stated that on their facility development plan last year, the IDHW identified a need for a forensic unit. She asked who would be served by the forensic unit, how that would impact the community health care system, and what kind of people a forensic unit would serve. **Mr. Beauclair** answered that he could not speak for the IDHW, but he sees it as part of the correctional system. **Mr. Beauclair** said he thought the DOC was better equipped to handle those people although he didn't care who houses the forensic unit. The need is there. Potentially, a forensic unit could serve two roles, one for the criminally mentally ill who were very volatile and dangerous and one for the number of civil commitments who are currently being meshed in the prison population. He added that there was no reason that DOC and the IDHW could not jointly accomplish this; some people who would not come under the purview of DOC but are placed with the IDHW and need a secure facility. Contract employees or a mixture of the two agencies could manage that population. The benefit to that is with these extremely violent people, a highly trained security staff is critical for crisis situations.

Representative Skippen referred to the 16,000 persons under Idaho jurisdiction and the large number with substance abuse problems; she asked if there had been any kind of national study as to how many people could be diverted out of the correctional system if Idaho had a community-based mental health system where those people could be treated very early on. **Mr. Beauclair** replied that he did not have this information, but DOC could make some projections based on the numbers coming into the DOC system and what is lacking in the community that could potentially divert them. He mentioned that Washington has a research arm that has done significant research not just with mental health but with treatment for substance abuse. That research showed that for every $1 spent, a state saves $7 in return based on having the proper sequence of care in the community.

Representative LeFavour asked if there is an optimal amount of sentencing time that is the most productive. **Mr. Beauclair** said there is research that shows that a person who is coming into the system or back into the community who is low-risk should probably be supervised on probation and parole for one month and then cut loose. **Mr. Beauclair** stated that probation in Ada County is 48 months; probation in north Idaho is 24 months. Yet there is absolutely no difference in the recidivism rate. He said the same is true in prison, although he could not cite specific numbers. **Senator Broadsword** requested information regarding the amount of savings for the state based upon the shorter 24 months of probation time.

Representative LeFavour said it would also be helpful to have information on Idaho's current

mandatory minimum sentences relating to substance abuse and other offenses. **Mr. Beauclair** responded that there are only ten statutes that impact DOC in terms of mandatory minimum sentencing. Most of these statutes involve meth delivery, at least with substance abuse, and politically that is going to be a difficult challenge. Those offenders are the majority of people coming into the DOC system who spend a significant amount of time in the system.

Justice Eismann stated that trafficking was often the typical drug offense which requires the mandatory minimum depending upon the quantity of drugs found. There would be a question as to whether there would actually be a lesser sentence without the mandatory minimum if the offender had large quantities of methamphetamine.

Mr. Brent Reinke, Director, Department of Juvenile Corrections (DJC) spoke next. **Mr. Reinke** referred to FedEx as an example of what needs to be done in Idaho in order to do a better job of tracking kids. **Mr. Reinke** said that there is a statewide effort between the 44 counties, the court system and DJC. A 1999 report prepared by Mr. Cliff Davis showed that in the 0-17 year-old age group, there were 15,940 youth considered seriously emotionally disturbed (SED) in Idaho; from ages 0-21 years, that number was 18,920. Mental health and substance abuse are now going to be meshed because it is very difficult in our population to separate them.

Mr. Reinke referred to research conducted by Dr. Ryan Hulbert which showed that 22% of Idaho's population are co-occurring, and that is a serious concern when looking at 430 youth that are within the state system. There are 6,200 kids in the juvenile justice system statewide. **Mr. Reinke** stated that it was recommended that out of that 15,900 youth considered SED, Idaho needs an overall child mental health system, not just the juvenile justice system, that is able to deal with the needs of 40% of that population on any given year. He said that 48% of the juveniles in DJC custody have been diagnosed with mental health issues. Thirty three percent of the juveniles in DJC custody have been diagnosed with SED. Twenty-seven percent of the juveniles on probation and 37% of the juveniles in detention have been diagnosed with mental health issues. Kids come from the counties and go back into the counties, and **Mr. Reinke** pointed out that the relationship between DJC and the counties is vitally important as one affects the other. Ninety-four percent of what is done with kids in the state happens within the 44 counties. Their goal is to get as many services for the kids as possible.

Mr. Reinke reviewed a handout entitled "Executive Summary" which, based upon the 10-year anniversary of the 1995 Juvenile Corrections Act, outlines what has and hasn't worked and the emerging trends and gaps. In regards to emerging trends in juvenile justice, **Mr. Reinke** referred to the felony arrest data for 10-17 year-olds. In 1994 there were 23,170 arrests and in 2004 there were 16,747, so there was a significant reduction. County detention beds in 1994 amounted to 9 facilities with 150 beds; in 2004 there were 12 facilities with 397 beds. **Mr. Reinke** pointed out that juvenile arrests for children aged 10 years and younger have increased 70% from 1999 to 2004. Sex offender statistics were up 26% in the last 5 years. Substance abuse figures show that 52.3% of DJC juveniles need substance abuse treatment and/or education. Mental health statistics show that 44% of juveniles in DJC have been diagnosed with mental health problems and 26% on probation and 33% in detention have been diagnosed with mental health problems.

The female offender population grew 10% between 1999 and 2004 and female commitments at DJC grew 15.2% between 1999 and 2004.

In regards to gaps and areas of concern, **Mr. Reinke** stated that everyone wanted mental health and substance abuse combined. Transition and reintegration services were also listed as a gap, as were female offender services. A goal and objectives for each concern are listed on the "Executive Summary."

Mr. Reinke continued by stating that according to the Idaho Department of Education, 37.2% of high school seniors are illegal substance users. This figure does not include alcohol or tobacco use. Probation departments state that one-third of the 6,200 juveniles under supervision report substance abuse and are in need of services. Fifty-four percent of DJC juveniles have exhibited the need for substance abuse treatment and/or education. **Mr. Reinke** noted that this data reflects use/abuse of marijuana, methamphetamines, cocaine, and other illegal substances.

Mr. Reinke emphasized that state/county/court partnerships are critical. **Representative Wood** referred to the 48% of juveniles in DJC custody who have been diagnosed with mental health issues and asked what the mental health problems of these kids were. **Dr. Ryan Hulbert**, the Clinical Services Administrator, responded by stating that these issues could be post-traumatic stress disorder, depression, bipolar disorder and ADHD, most of which are the results of a harsh upbringing as children. He said a needs assessment was done by DJC seven or eight years ago with regard to capacity for 2007-2008, and he projected they should have 670- 690 juveniles in custody; today they have 430. **Mr. Reinke** said that county juvenile probation departments and the courts agree that if there were more services available locally, including residential care, DJC would see fewer commitments per year.

Mr. John Triplett was introduced as the Director of the Region 2 Juvenile Detention Center, Nez Perce County. **Mr. Triplett** said that his office deals daily with children between the ages of 5-21 years and adults up to age 90. He said they are beginning to see the correlation of these 5 year-olds who could eventually end up in DOC's custody. They do a survey twice a year to see how many kids are in the system with mental health issues, probation and detention. There were two findings: there are higher numbers of restraints on the detention side with juveniles who are mentally ill and there is lack of training for the detention staff and probation officers. POST Academy training is mandatory, but they are not equipped to deal with very aggressive behaviors that mentally ill people can demonstrate. **Mr. Triplett** said they have a juvenile now in custody at DJC who has acute problems and the only appropriate place for him is in Intermountain Hospital at a daily cost of $1,800.

Senator Werk asked if POST Academy adequately trained attendees in the area of mental illness. **Mr. Triplett** clarified that people do not receive enough training in the specific area of how to handle a mentally ill juvenile who is out of control. They are given a correctional focus but not necessarily a mental health focus. Detention centers have become de facto mental health institutions. **Senator Werk** asked if the two could be separated at this point. **Mr. Triplett** answered "no." **Senator Werk** said that perhaps a different level of training needs to be added to

the POST curriculum in the area of mental health issues. **Mr. Triplett** said he does not think that these juveniles should ever be in a detention center; he thinks that they should be in a state institution and not in a county-operated facility.

Senator Stegner stated that the counties have economic disincentives to deal with mentally ill juveniles. From a matter of efficiency, he said it is better to have several state centers to deal with these juveniles on a professional basis rather than the 44 counties with perhaps less than qualified personnel trying to deal with mentally ill juveniles. He asked if, other than the financial incentive, **Mr. Triplett** was suggesting there was an efficiency benefit also? **Mr. Triplett** stated that there were only 12 detention centers; juveniles do commit crimes and they also have mental health problems, and the two go hand in hand. He suggested that there are not enough people working at the community level to solve the problem. There had been a displacement onto the counties and it is left to DJC to try to fix the problem, thereby producing inefficiency when dealing with a mentally ill juvenile. **Mr. Triplett** said that 27% of the juveniles on probation are under at least one mental health diagnosis; 37% of the juveniles in detention are under at least one mental health diagnosis. An estimated 23% of juveniles on probation and in detention are dual-diagnosis (mental health and drug/alcohol issues present) or about 1,431 youth. A Congressional report showed that 349 of the 524 juvenile detention centers in the U.S. reported holding youth who are waiting for community mental health treatment; this sample included over 15,000 youth at a cost of over $100 million per year in housing costs. In 2004, county-operated detention centers spent an estimated $323,846 per year housing mentally ill juveniles.

Representative Wood said that in her experience she has found that not all kids react to medications the same. She does not view a program in which juveniles are given 3-4 drugs as totally workable. She asked if there could be a problem from allergy or drug interaction and whether that had been examined carefully. **Mr. Triplett** said he personally thinks that kids are overmedicated most of the time; he said other professionals could better speak to that issue. He noted that IDHW estimates there are over 17,000 youth in Idaho with SED. As part of the Jeff D. lawsuit, counties became involved in not only the creation of the regional council, but also subsequent local councils to try to fill gaps in services for kids who are mentally ill and to identify more problem kids in the community. That model quickly changed to a wrap-around service model. Instead of identifying juveniles to bring into the system, they have now decided against more identification or referrals, but there will be a caseload of 8-10 per wrap-around specialist. He said that right now there are about 71 juveniles who are receiving services under the local council, eight from District 2. This was done to better meet the needs of the juveniles.

Mr. Triplett continued by pointing out that in the District 2 budget for July 1, 2005 to June 30, 2006, "regional expenses" of $12,768 included parent support, supplies, hotel expenses, a traveling art display and a conference in Boise. This money had been earmarked for children with SED. **Mr. Triplett** said he thinks there is a problem in Nez Perce County with their local council when you have four members of IDHW sitting on it with 4 votes and county probation has 1 vote; IDHW outvotes DJC on the types of services that DJC thinks are needed. He pointed out that in Nez Perce County, the expenses included day camps in the amount of $4,400 in one month, swimming passes for $866, and self-esteem enhancements (deemed necessary by IDHW)

in the amount of $1,834 for tennis shoes and ice cream. **Mr. Triplett** said he was frustrated with the $5,171 tab for a trip to Orlando for two parents and a staff member from IDHW.

Representative Garrett asked about wrap-around services, stating that nationally they are considered as best practices. She asked if there is something wrong with the way Idaho does wrap-around services since we should be receiving results. **Mr. Triplett** answered that wrap-around services are a good model, but there needs to be a more dynamic model that goes above and beyond the means of what is currently being provided through better allocation of the resources. He said he does not believe that buying tennis shoes and ice cream for juveniles is the best use of that resource; he would prefer to wrap those dollars around the specific needs of that juvenile, *i.e.* his or her mental health issue.

Mr. Triplett listed obstacles to adequate treatment as the following:

1. Nez Perce County has an average wait on the telephone for an assessment of 5 hours.
2. There is an approximately six month waiting list for inpatient treatment — 28 day average for Nez Perce County but as long as nine months this past fiscal year.
3. The daily rate in detention is $170/day for Nez Perce County. The county spent over $10,000 per youth who are preparing to go to inpatient treatment, *i.e.* drying them out for treatment.

Representative Skippen asked how many inpatient adolescent treatment beds there are in Idaho. **Mr. Triplett** said there are two or three facilities that work with substance abuse. In north Idaho, they send the juveniles to Spokane, Washington. **Representative Skippen** said she thought there were 16 beds recently closed for lack of use. **Mr. Triplett** said he could only speak to funding, pointing out the 6-9 month wait in DJC for a juvenile to get treatment.

Representative Garrett asked if **Mr. Triplett** had seen an impact with ATR grant money. **Mr. Triplett** answered that when a juvenile calls in, they are given a service rating and a choice of services offered. When given a choice, he has found that juveniles choose the lesser service. **Mr. Triplett** said that, according to recent studies, he thinks that 18-24 months is an average inpatient stay required to adequately deal with the degenerative brain function but also to rebuild the juvenile due to the severe addiction. When the 28-day option is offered, it really just creates a bigger craving when the juvenile comes back into the county.

Mr. Triplett said the county hired a clinical supervisor to work with both adults and juveniles. He hopes that in October the county commissioners will fund an employee to work on adolescent substance abuse. He added that the county can no longer rely on the treatment services being offered by the state, so it is taking money from programming that could be used elsewhere to put into something that is critical to costs as well as to the livelihood of kids. **Mr. Triplett** said the counties are fortunate to have a partnership with DJC; they buy open beds using DJC's money in order to prevent kids from being committed to DJC custody. He said that statewide, if left unattended, there will be higher commitment rates at DJC, and higher costs to the counties for detaining kids. In his opinion, there is little to no treatment available right now for the real acute needs of juveniles in the system for substance abuse and mental health. **Mr. Triplett** concluded

by saying that there is a real frustration on the part of county commissioners and courts regarding the "displacement" of responsibility for these juveniles.

Mr. Reinke discussed an overview of DJC treatment services for juvenile offenders with diagnosed mental illness in 2005. In 1999, there were 20 employees working in the area; in January 2006 there were 33 employees due to the support of the Legislature and the Governor and also due to a reallocation of resources. He noted that there is a constitutional mandate to provide services to juveniles in the custody of DJC.

Mr. Reinke then shifted the discussion from mental illness to substance abuse. He referred to a 2005 report by the Office of Performance Evaluations regarding substance abuse services in the state. DJC responded to that report by reutilizing their continuous improvement programs to reevaluate existing substance abuse services in order to ensure that everything DJC does is evidence-based and moving toward best practices. DJC is working with relevant stakeholders to trace outcomes of substance abuse of juveniles in its custody and is looking forward to the implementation of House Bill 833 and the establishment of the interagency substance abuse commission.

Mr. Reinke said that there were two decision points during the 2006 legislative session. One was the $700,000 appropriation that DJC has been working on with IDHW and JFAC. He showed a slide with five areas of legislative intent.

1. Funding is to be used for juvenile mental health services.
2. DJC will work collaboratively with IDHW and Idaho communities to meet the needs of juvenile offenders who have been diagnosed with a mental illness.
3. Dispense funds on an as-needed basis to counties for individual juvenile offenders for programs that are research-based and considered best practices.
4. Administration of screening tools that determine functioning level and risk level of criminal behavior determined by using the Child and Adolescent Functional Scale (CAFAS) and the Youth Level of Service Case Management Inventory (YLS/CMI).
5. Progress will be reported to the Legislature (JFAC) at the beginning of the session.

Mr. Reinke said that DJC's target population is juvenile offenders diagnosed with a mental illness who cannot access services with existing programs through Medicaid, Social Security or IDHW. Juvenile offenders are defined as juveniles who have been arrested for an offense. He said that the 2006 Legislature approved $4.4 million to construct a mental health unit at JCC Nampa. This 24-bed unit will not serve as a long-term residential treatment setting for those juveniles in state custody with chronic special need conditions, such as mental retardation and/or organic brain damage. Instead, the purpose is to provide assessments, stabilization and short-term treatment in a self-contained unit designed to safely manage 24 juveniles in DJC's custody, including juveniles with SED as defined by IDHW who may also show a high level of physical aggression. The length of stay would be 30-90 days in that facility. The projected cost in today's dollars, funded by the general fund, would be about $375-$400 daily at an 85% occupancy rate; right now DJC is paying anywhere from $350 $1,500 per day for such treatment. While juveniles are in this setting, the family unit will be evaluated to determine the best long-term placement

resources for that juvenile. The target population would include juveniles in DJC custody who have been previously placed in a subacute private hospital. These 24 beds will provide a very important component in the continuum of mental health services in the juvenile justice system in Idaho. They will operate with a steady number of open beds to provide a 24/7 safety net for juveniles requiring mental health stabilization.

Mr. Reinke said that DJC would also like to investigate and possibly implement pre-assessment services for juveniles with mental health issues for juvenile justice judges so these juveniles may not have to be committed to DJC custody in order to receive mental health treatment. **Mr. Reinke** said there is a need for this in the state. He concluded by reiterating the need to do a better job of tracking and providing services to kids across the state.

Representative Block asked at what early age children show signs that they may later be an offender. Is something going to address the need to intervene very early in life to avoid at risk behaviors? At school age, she asked, is there any program that would be below the level of the offender program that could address children who are at the early stage of at risk behavior? **Mr. Reinke** answered that the "Executive Summary" handout showing the 70% increase in the ten-year-old arrest rate from 1999 to 2004 speaks volumes. He said DJC is very concerned about young children who are being expelled from school and spending time in detention. He said he hoped the Department of Education would have an opportunity to address **Representative Block's** questions more comprehensively.

Patti Tobias, Administrative Director for the Idaho Supreme Court, was welcomed. She said that in the late 1990's and early 2000's, the judges identified substance abuse as one of the most critical problems facing the judiciary. Since then, judges have been very innovative in trying to deal with the increasing impact of substance abuse and, in more recent years, mental illness. The judges were asked to talk about their perspectives on what Idaho needs from a mental health and substance abuse system. She introduced the three-judge panel:

1. **Justice Daniel T. Eismann**, Justice of the Idaho Supreme Court, Chair of the Statewide Coordinating Committee for Drug Courts and Mental Health Courts. **Justice Eismann** started the first Drug Court in Ada County and has been a leader in this area.
2. **District Judge Brent J. Moss** from Rexburg is the President of the District Judges Association and the recognized leader of Mental Health Courts. **Ms. Tobias** noted that the Bonneville Mental Health Court was recently recognized as one of five national learning sites.
3. **Judge John F. Varin** is a Magistrate Judge in Camas County and a leader in juvenile justice matters and dealing with substance abuse and mental illness.

Justice Eismann began the panel discussion by addressing methamphetamine use in the state. He said he was appointed a district judge in Ada County in 1995 and two years later he realized that Idaho needed a better way of dealing with drug addicts, particularly methamphetamine addicts. He had heard about a Drug Court in California so he researched drug courts and set up and presided over one in Ada County for two years. He noted that 75% of the people who come into the Ada County Drug Court are there for possession of methamphetamine, the most significant drug being dealt with in the criminal justice system.

Justice Eismann continued by explaining that addiction is a brain disease; people choose to take drugs, but once they become addicted there is a significant change in their brain chemistry. The disease process is long-lasting and permanent in some areas. Methamphetamine increases the level of dopamine in the brain. He described the physical sensations that addicts feel and the reasons for their often violent behaviors and intense cravings. He noted that eating a favorite food can raise a person's dopamine level to about 150% of normal; sex raises it to 200%; nicotine to 225%; crack cocaine to about 350% of normal; and smoked methamphetamine to about 1,000% to 1,500% of normal. The high from meth will last 8-24 hours compared to crack cocaine, which lasts 10-30 minutes. Four hours after smoking meth, the levels of dopamine in an addict's brain will be down to the highest level they reach smoking crack cocaine. **Justice Eismann** said that meth is neuro-toxic, in that the levels of dopamine in the brain are toxic to brain cells. He referred to one study that showed that for 22 addicts who used meth for ten years they lost, on average, 11% of their brain tissue. In the brain center for making new memories, they lost 8% of their brain tissue, which would be comparable to having early Alzheimer's disease. There is very short-term memory loss and difficulty with abstractions and impulse control. Brain scans done on meth addicts show that it takes 1-2 years of sobriety before even just the metabolism rate in the brain returns somewhat to normal. It takes 2-4 months of sobriety before the brain is clear enough to even be able to work with the addict.

Justice Eismann stated that graduates of Drug Court tell him that they typically do not even remember the first 2-4 months of treatment. It usually takes about six months of sobriety before there has been enough change in the addict's life for him to actually see something positive in treatment. **Justice Eismann** has been told that it takes 2-7 years for a meth addict's pleasure and reward center in the brain to return to normal. Because of that, meth addicts need long-term treatment — a 90-day program is a waste of money. They need 12-18 months of outpatient treatment to have a good chance of successful treatment. He noted that addiction is a relapsing disease, so there will never be 100% success. Addicts' brains remember the euphoria of being high — even addicts who have been clean for years can look at a picture of something associated with their drug and their whole brain lights up and they report that the craving comes back more intensely than when they were using drugs. This is one of the challenges of dealing with methamphetamine addicts; their brains have been significantly altered.

The good news, **Justice Eismann** said, is that they are having success in Drug Court. When he started the Drug Court in Ada County, they kept detailed records so statistics could be verified. A study tracked graduates of Drug Court for 851 days on average and the comparison group only 660 days. Recidivism was considered any reoffense during the period when they were being followed. The study found that the comparison group had a 63% recidivism rate compared to 38% for the Drug Court group. Those rearrested for trafficking or drug-related offenses was 42% in the comparison group and 17% for the Drug Court group. Rearrests for Drug Court graduates stood at 19%, with 0% for trafficking offenses and 9% for a drug-related offense; only 8% were rearrested more than once. Rearrests for graduates of Drug Court were 2% compared to 51% for the comparison group. Another important point is that over 30 women in the Ada County Drug Courts gave birth to babies who were born drug-free. According to information from St. Al's, the

initial medical cost for a drug affected baby is about $250,000.

Justice Eismann listed a number of reasons why Drug Courts work, noting that nationally the studies show that they are the most effective tool available to deal with people in the criminal justice system who are drug addicts:

1. Frequent, random, observed drug testing.
2. People who enter Drug Court enter treatment sooner and stay longer.
3. Drug addicts rarely voluntarily go into treatment, so they enter Drug Court after being arrested. It takes 16 months to graduate from Drug Court in Ada County.
4. Frequent court sessions, particularly with high-risk offenders; having to come back to court every other week has an impact on recidivism. Knowing that a judge has not forgotten about the addict has a positive impact on that addict.
5. Drug Court now includes cognitive restructuring (criminal thinking patterns) to treat an addict who might be sober but still has criminal thinking errors.
6. Seventy-five percent of the women and 25% of the men who come into Drug Court report they have been the victims of sexual or physical abuse, so that must also be addressed.
7. Drug Court is not adversarial. A team is made up of the Drug Court judge, prosecuting attorney, defense attorney, drug coordinator, counselor, and probation officer, all working together to get the person off drugs.
8. Sanctions and rewards help Drug Court addicts. According to **Justice Eismann**, rewards work much better than sanctions because addicts cannot see the connection between actions and consequences. Meth has often affected the cognitive ability of the brain so much they truly cannot connect correctly, so Drug Court works to help them recognize that consequences follow their actions. Addicts are rewarded when they do well and receive other consequences when they do poorly. Simple rewards work, and addicts remember when judges say and do kind things to and for addicts.
9. Drug Courts work because they deal with addicts in their own communities. Recovering addicts in Drug Court have to get jobs, deal with family and friends, and must learn how to be successful in their community without drugs.
10. One of the biggest relapse factors is simply stress, so through Drug Court addicts learn how to deal with stress without relying on drugs.

Justice Eismann stated there are currently 37 Drug Courts in Idaho, 28 adult Drug Courts, 18 felony, 9 DUI, 1 family Drug Court, and 9 juvenile Drug Courts. Idaho needs access to continuum care. Addicts cannot begin the long process when they are high. It takes about 2 weeks to detox and get an addict clean to begin their work. Some people get detoxed in jail since there are often waiting lists to get in. **Justice Eismann** said that a residential facility is needed with beds available for the two week detox period and for women who are pregnant and won't stop using drugs. They need to be in a drug-free environment for the safety of their babies. Drug Courts have been able to work with IDHW and DOC to get assessments for everyone coming into Drug Court, which is essential for evaluation and the addict's success. The addition of probation officers to work with the Drug Court has been a valuable resource and the ability to make home visits helps get information to help keep the addict clean.

Justice Eismann said that in the Ada County Drug Court, the average age of a graduate is 31 years; the average length of time for their drug use is 17 years. By their own report, the average value of the drugs taken prior to arrest was about $125 per day. Forty-five percent of graduates are male and 55% female. At the time of their arrest, 33% were unemployed; at graduation 94% are employed full-time and those who are not employed are attending school full-time or, in the case of graduates who may be mentally ill, are doing positive community service. Graduate incomes increased on average over $12,000 yearly in Ada County compared to the time previous to entering Drug Court. **Justice Eismann** said that seeing families come back together and having relationships restored is an invaluable result of the Drug Court process.

Honorable Brent J. Moss talked next about Mental Health Court. Mental Health Court was started two years after Drug Court because there were people who were falling through the cracks. Addicts were getting clean and sober but were unable to stay that way. IDHW provided assistance in their Drug Court and the social worker was an administrator for the ACT team, so they followed **Justice Eismann**'s lead and went to California to see how their mental health court system worked. They came back to Idaho to bring DOC, IDHW and private providers together to discuss patterning Mental Health Court after the Drug Court. They focused on people with Access I diagnosis. **Judge Moss** indicated that 85% of those in Mental Health Court are also dually-diagnosed, which is critical, and they are all being treated for one or the other issue.

Judge Moss explained that some inmates have spent years in prison in maximum security without receiving mental health treatment; they are then rearrested and sent to Mental Health Court and have been successfully integrated into the community. Every person in Mental Health Court would be headed to prison or long-term jail sentences if not for this option for treatment. Eighty-five percent of the cases deal with substance abuse, so proper assessments are critical as well as the person being clean and sober before starting treatment. Mental Health Court lasts 18-24 months; at graduation, the offender will be able to identify his mental illness, identify his medications and why he takes them and how they affect his illness. Family members get involved in Mental Health Court because it is a family disease. Mental Health Court has graduated fifteen people so far, there have been no rearrests, jail time is down 85%, and hospitalization days are down 97%. This creates significant savings.

Judge Moss commended the DOC, which has a full-time probation officer working strictly with mental health people going from county to county. He also commended IDHW for providing an office for that probation officer; the collaboration works. He would like to see crisis intervention training for officers who he believes need to be trained statewide so that when a person with a mental illness surfaces, that crisis team can show up and make a difference in diffusing the crisis situation. In each community there are probably officers interested in doing just that, he said.

Judge Moss said that interim housing needs to be made available where mentally ill persons can be taken with treatment available to stabilize them. County jails exacerbate their problems. Because Idaho is a rural state, transportation is also a need since many people are unable to get to and from meetings and treatment. This transportation component is especially important because Mental Health Court is intense for the first 3-6 months.

Judge Moss continued by stating that all of the graduates thus far have jobs, even though many are disabled; they work to the extent of their ability to work. Two graduates attend college and are working toward their B.S. degree; both of these graduates have been dually-diagnosed. **Judge Moss** said that collaboration is important but pointed out that whenever the Legislature does something to one area, it affects another area and can often cause a ripple effect. **Judge Moss** said that he has probation officers with 95 people on their caseload. Because of that caseload, when the probation violations come in, the officers do everything they can but supervision cannot be done well. By the time the judge sees them, he must turn them back to probation, where they cannot possibly get the services they need due to high caseloads, or send them to prison. **Judge Moss** said he has sent more people to prison in the past 2 years than in the previous ten years. He concluded by reiterating the successes of the Mental Health Courts.

Honorable John F. Varin addressed the issues of juvenile offenders both inside and outside of Drug Court. He shared examples of juveniles he deals with in his courtroom, including those who have suffered serious abuse and were acting out as a result. He cited one particular juvenile whose mother was a meth addict; the juvenile was on medication for ADHD and is bipolar. **Judge Varin** cited as another example a 16-year-old girl who was a meth addict and the mother of a two-year-old daughter. The girl successfully completed an inpatient program, is on several psychotropic drugs for various diagnoses, is living with her mother and her mother's new husband in a community 25 miles from the nearest outpatient treatment, and is on probation. She is Medicaid-eligible but not getting many services.

Judge Varin said that what would help him with the cases he deals with are quick evaluations and screenings of the families and any mental health and substance abuse issues. Judges need to know what surrounds trauma issues in order to make correct decisions that affect everyone. The juvenile needs to be given treatment very quickly with competent evaluation so that judges can structure orders for the juvenile and his or her family. The community and the family need to be engaged in this process. Everyone working with juveniles needs to understand techniques to prevent relapse, and a high level of structure is needed. Such a structure would provide that the juvenile is being contacted on a daily basis if necessary. **Judge Varin** mentioned that contact with meth addicts occurred at a rate of 100 times per week in the early stages of Meth Court including phone calls to help addicts remember that they are involved in a court process. Frequent, random, supervised drug testing needs to occur; this is the best accountability factor they have.

Judge Varin continued by stating that putting a juvenile in detention is not an appropriate response. We need to find out what caused that juvenile to relapse and to have that screening capability and relapse prevention analysis. Specialized professionals need to be involved in order to give the court direction for that juvenile's success. Transitional housing is also needed, he said. He noted that adolescent substance abuse is the best predictor of adult substance abuse. He said it is critical for the judge to know what services are being provided to a juvenile so that counter efforts are not the cause of that juvenile's lack of success. Consistency is critical. Communication needs to be effective; if a juvenile fails a drug test, the court needs to know promptly because it becomes a community safety issue.

Judge Varin said they definitely need effective diversion programs for juveniles. The issue of trauma, he said, is a massive problem that is not being addressed effectively in either the private sector or within state agencies. He commented that two ISU professors have a national grant to work with these types of trauma issues and there are amazing statistics in terms of the implications of trauma and how that causes later involvement in crime and unacceptable behaviors. The professors have been primarily working with health professionals but they are anxious to work with DJC and judicial officials to create a better understanding of these critical points. **Judge Varin** concluded by citing a Robert Wood Johnson Foundation study that showed that only 10% of adolescents who need substance abuse treatment get treatment and emphasizing the importance of community engagement.

Representative Wood said that if she had her way, there would be a mini-prison for drug and alcohol treatment and mental health attached to each Drug Court district rather than having a big prison. She asked what the judges meant about transitional housing and how that would be done, *i.e.* would it be a foster home type setting? **Judge Moss** answered that for his Mental Health Court, he needs a safe place for 1-3 months for people coming out of jail; nobody wants them back. The transitional housing needs to be a place where an ACT team can actually supervise the juveniles. In Florida, the state purchased a number of cottages and their state mental health people were on site 24 hours a day. People coming out of the judicial system need that type of temporary housing, with the objective being treatment for mental health and substance issues. Then they can then be transitioned out as quickly as possible into the community.

Representative Wood referred to private providers and consistency. She asked if there was a weakness in utilizing family members who could be educated in order to be better equipped to deal with problems. **Judge Varin** answered that he does not have jurisdiction over private providers; Medicaid stops for juveniles who are in detention. He said that some private providers do show up in court, but the problem is consistency. Private providers need to be properly trained in terms of court processes, and they need to understand the necessity for good communication.

Representative Skippen asked **Judge Varin** about his references to "engaging the community" and asked what that looked like to him. **Judge Varin** responded that this is a huge area and said that the judges are involved in an ATR Committee statewide which is focusing on that. They agree that Idaho state government cannot do much with the methamphetamine epidemic. It must be addressed at the local level. One of the ways to approach this is through the dissemination of information that will educate everyone about the shocking facts and statistics surrounding methamphetamine use. Using diversion boards and youth accountability boards across the state was mentioned as being a helpful component in working very early with juveniles on substance abuse issues. Community volunteers could be engaged in many ways for prevention up-front. Commercials need to be used for education and prevention. **Judge Varin** added that a team needs to be formed around a meth addict to provide a support network.

Senator Stegner asked about the procedure for the situation when there is a dual diagnosis; to get that person clean and sober first, does that person go to the Drug Court or the Mental Health

Court? **Justice Eismann** said it depended upon how things manifest themselves. Usually, by the time an individual enters the court system, there is enough of an indication if the individual has a major mental health issue. However, if they find out that because of substance abuse the mental health issue has emerged, once they are clean and sober, that mental health issue diminishes and they are diverted over to the Drug Court. It can also work in the opposite way.

Representative Wood said she hears frequently about discouragement with probation and parole officers and their huge caseloads. She suggested that the committee make that a priority as to how the counties could be helped. **Judge Varin** recommended a documentary entitled "New Asylums." It focuses on an Ohio prison system and documents what transpired over the years, pointing out how mental illness is dealt with within prisons. He said that if communities could view this, it would be a real wake-up call regarding mental illness and criminal justice.

The next presenter was **Mr. Tony Poinelli**, Idaho Association of Counties. He introduced **Captain Maxfield** and **Officer Booth** from the Canyon County Sheriff's Office. **Captain Maxfield** said that he has been with the Canyon County Sheriff's Office for over 20 years and has been involved with the community mental health coalition of West Valley Medical Center for several years. He addressed specifically the use of involuntary mental holds by law enforcement, since they are a very serious issue especially in his area. In an involuntary mental hold, officers detain the person and take them to West Valley Medical Center, which is the contract provider for Canyon County. An evaluation is done in the emergency room by a state designated examiner with the law enforcement officer present. Several hours elapse with that officer out of service while he is watching this mental health patient until either the patient is placed in the hospital or transported elsewhere. Law enforcement often has to make transports to Twin Falls since that may be the location of the only available bed for mental health care. The person is placed in a police vehicle for 6 hours when they should be receiving emergency medical treatment for their condition. This takes one or more officers out of service and off the streets for that time period.

Captain Maxfield stated that there is a severe scarcity of available beds that the law enforcement community can access for detainees with mental health problems of an emergency nature. If beds are not available anywhere, they have to wait. Recently a police officer spent 9.5 hours watching a patient in a city police station waiting for a bed to open up. It is a very serious issue, not only logistically for the sheriff's office, but also for the mental health community itself.

Senator Stegner said that he has heard this story repeatedly, and he has also heard of patients being driven to a county line and being released or patients being held in the back seats of patrol cars for hours. **Captain Maxfield** said that had been an option in the past; to the sheriff's office, it would make more fiscal sense to put that person in a patrol car and drive them around for 3 4 hours until a bed opened up rather than to make a round trip to Twin Falls and on the way back have another officer going to pick the person up to bring them back to court.

Officer Booth said that in his county there has been a cooperative effort between hospitals, local

law enforcement agencies and IDHW. But even with regular meetings, they still run into problems. He mentioned several involuntary committals which were emergency situations; people are taken into custody who may be gravely disabled or in imminent danger to themselves or others. When there are no available beds in the Treasure Valley, Twin Falls becomes the nearest place with a bed. He said that on two recent occasions officers transported a patient to Twin Falls and were en route back when a bed opened up in Treasure Valley. Then a second patrol car and officers were dispatched to go get that patient. Transport time without services is a huge issue; the officers are off the street and can do very little to help that patient.

Representative Wood asked if these people needed mental health care in an immediate crisis situation. **Officer Booth** answered that they are specifically people who are committed involuntarily to the system. A law enforcement officer has taken that person into protective custody. The person was then evaluated by a physician and it was determined that the person needs to be brought into protective custody, *i.e.* committed to the state. In response to a question from **Representative Wood**, **Officer Booth** stated that the term "looking for a bed" meant that the patient needs treatment, but added that these people do not necessarily have criminal issues.

Mr. Poinelli said that a person should not have to commit a crime or be accused of committing a crime to get treatment. He added that there is shared responsibility between counties, courts, prosecutors, local law enforcement, and state agencies who are all actively involved in that involuntary commitment process. Most counties (probably half) have protocols established with IDHW and local hospitals and others; other counties have had a difficult time getting such protocols established.

Mr. Poinelli illustrated the situation in Cassia County, where a medical doctor who came from out-of-state with significant mental health training approached the Cassia County Commissioners several years ago and they set up a costly initial contract for services. Over a period of time, it seems to be working. **Mr. Poinelli** gave a scenario of how that works in Cassia County: When a person is picked up by local law enforcement, he is brought into a hospital facility. At that point, the protocol is that the contract doctor is called either by the officer or by the facility. The doctor is on call 24/7 as well as during his vacation time. He then makes an evaluation, in person or by phone until he can see the patient, which helps the county avoid sending these individuals to a facility for a long period of time. The evaluation takes at least two hours and the person can receive discussion and/or treatment with that doctor. **Mr. Poinelli** said this has helped Cassia County considerably.

Mr. Poinelli said that some sheriffs' offices face difficulties with regard to costs. Costs range anywhere from $850-$1,500 daily for a bed for mental health or substance abuse treatment. It is also very difficult for the counties around the state to get a designated examiner on weekends or evenings. Sheriffs need additional designated examiners. He also stated that prosecuting attorneys need additional training. The 44 counties have many different ways of doing things; some consistency is needed, and he said that changes in statutes may be needed to clarify procedures for prosecutors. He mentioned that additional training for local law enforcement at

POST may also be necessary. Transitional housing is also very important. Because substance abuse is such a significant factor, there is a need for detox beds. **Mr. Poinelli** concluded by reiterating that treatment needs to be community-based.

Representative Wood said that the juvenile center in her area could be fashioned into transitional housing in some way, and she invited input as to how that could be done. She suggested a possible pilot project.

Senator Stegner announced that the committee would meet again on August 14th at State Hospital South in Blackfoot. On September 19th, the committee would meet at State Hospital North in Orofino.

The meeting was adjourned at 5:20 p.m.