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

Tuesday, September 19th, 2006
State Hospital North, Orofino, Idaho

The meeting was called to order at 8:35 a.m. Present were Co-Chair Senator Stegner, Co-Chair Representative Skippen, Senators Compton, Coiner, Broadsword, Werk and Representatives Wood, Block, and Garrett. Absent and excused was Representative Henbest. Staff members present were Caralee Lambert, Amy Castro, Richard Burns, and Lisa Kauffman, Legislative Services Office. Also present were Robert Bourassa and Debra Manfuu, State Hospital North; Judge John Bradbury, District Judge; Teresa Wolf, Nez Perce County Indigent Director; Carol Moehrle, Public Health District/North Central; Richard Armstrong, Kathleen Allyn Tracy Goodin, and Bill Walker, Department of Health and Welfare; Quane Kenyon and R. Roberge, Department of Health and Welfare Board; Molly Steckel, Idaho Medical Association; Lyn Darrington, Sarah Woodley and Amy Holly-Priest, Business Psychology Associates; Sue Summerton, Clearwater County District Courts; Zoe Cooley, Region 2 Mental Health Board; Bud Langerak, Bonneville County Sheriff's Office; Beverly Fowler, Change Point; A.J. Burns, Office of Performance Evaluations; Patti Tobias, Idaho Courts; Dean Ferguson, Lewiston Tribune; A. Jay Kessinger; and Sara Nye, Office of the Governor.

Following a committee tour of State Hospital North (SHN), Robert Bourassa, Administrative Director of SHN, gave a historical overview of the facility. SHN has 60 licensed beds and admits and treats individuals who are court-committed and who are considered dangerous to themselves or others and typically exhibit a significant thought disorder or severe mood disorder and have a co-occurring substance use. Fifty-five percent of SHN patients are discharged within 65 days and 42% are discharged within 101 days; the average stay is 82 days. The cost per day for treatment is $438. SHN currently operates with 89 FTPs (soon to be 109 FTPs in October 2006), which include 2 psychiatrists, 1 family practitioner, 1 advanced nurse practitioner, and a staff of nurses, Masters-prepared clinicians, therapeutic recreation specialists, pharmacists, lab techs and support personnel. The SHN expansion is expected to be completed by February 2007 and the hiring of the extra FTPs should be completed within the next few months.

Senator Compton asked how the staff decides when a patient is ready to go back into the community. Mr. Bourassa replied that a group of psychiatrists and those who work daily with the patient decide where the patient is in their treatment and if the level of care needed to support that patient can be provided outside of the facility.

Senator Compton asked if the extra money appropriated by the Legislature last session to bring salaries up to the market rate helped SHN recruit or keep qualified employees. Mr. Bourassa replied that the additional monies did help to bring current salaries up to market rate and it did help SHN to recruit another psychiatrist, but that in order to maintain these people, additional monies will be needed in order to stay competitive in a growing salary

market. Mr. Bourassa also noted that in order for SHN to obtain accreditation, it needs to have a full-time psychiatrist on staff.

Representative Garrett asked when a patient is ready to go back into the community but there are not sufficient resources to support that patient in recovery, e.g. housing and treatment programs, how much does that play into the readmission of that patient to SHN? Mr. Bourassa replied that this is a significant issue in readmission and without the community support to help them succeed the patients will return.

Representative Garrett asked if Mr. Bourassa could identify region by region where the needs of the patient being discharged are not being met by community support. Mr. Bourassa replied that it is a more significant issue in the rural areas of the state because the resources are not readily available.

Representative Block asked if there has been any research done on why patients have more violent behavior than they have in the past. Mr. Bourassa did not have an answer, but he stated that he suspects it is due to societal issues more than anything else.

Senator Werk asked how SHN compared to the national norms regarding facilities that are similar in readmission rates and length of stay and whether or not with the addition of the new staff and beds SHN would be close to the national norms. Mr. Bourassa replied that SHN participates in the Western Psychiatric State Hospital Association and that is who SHN benchmarks against. In comparing SHN's performance against the WPSHA benchmarks, SHN falls in the middle of the norms.

Judge John Bradbury, District Judge, Second Judicial District in Clearwater County, provided his perspective on the system that deals with those who have mental health or substance abuse problems. He noted that most offenders have a methamphetamine addiction as well as mental health or alcohol afflictions in the criminal proceedings over which he presides. Out of a prison population of 6,800 prisoners, about 1,350 of the inmates are on psychotropic medication. Of that number, about 60 inmates are acute care patients who need constant supervision. Another 190 need regular follow-up and monitoring to remain stable. The remaining inmates on medication are mainstreamed into the general prison population with regular but infrequent follow-ups. There are another 200 to 400 inmates that have been diagnosed with mental disorders that are not on medication.

According to Judge Bradbury, the question for the Legislature is whether it wants to send these people to prison or instead provide mental health care so that the mental health problems are dealt with and the subsequent addictions and criminal behavior are either avoided or controlled by early intervention and treatment.

Judge Bradbury continued by stating that up until the early to mid 1990's, Idahoans could voluntarily commit themselves for treatment at a state hospital. There was also a detox center at SHN where addicts could withdraw from their addictions and confront their mental health problems with medical supervision. Today, no voluntary commitments are

accepted (although the statute provides for them) and the detox center has been closed for several years.

In Idaho, to be eligible for an involuntary commitment to a state hospital, a person must be likely to injure himself or others or be gravely disabled due to mental illness. The available resources at state hospitals today are so limited that there is up to an eight week waiting list for those who have been voluntarily committed. The consequence is that gravely ill people who may be a danger to themselves or others are held untreated in jails or are treated in expensive private hospitals at state expense for extended periods of time.

People who are seriously ill but not ill enough to be involuntarily committed have two choices. If they live in or near Lewiston and are aware of their right to do so, they can voluntarily commit themselves to the psychiatric ward at St. Joseph's Regional Medical Center. The costs there range between $1,800 and $3,000 per day. SHN estimates its cost per patient at $438 per day.

Judge Bradbury stated that where a voluntary patient is indigent, the cost of private hospitalization is borne by either the county or the state. Neither plays a role in the admission process when an indigent self-commits at a private hospital. A long-term residential facility for mentally ill and addicted persons with a detox facility is needed. Such a facility could be a non-secure or low security facility like Cottonwood, depending on admission criteria. It should be available for voluntary commitments and referrals from the court system. Ideally, it would be located near a county jail or prison for those patients who need to be confined until given a medical release for a less secure facility or located near a community college to provide vocational training for the patient.

A long-term residential facility would treat the people who really suffer from mental disorders. It would relieve local law enforcement, the prison system, and the judiciary of having the sole responsibility for a public issue for which they are not specifically trained. Many of the current prisoners on psychotropic drugs may qualify for a non-secure or minimum security treatment facility. If just a third of them qualified, this would free up more than 400 prison beds. The rate at which the prison population is increasing could be reduced if the mental disorders and addictions could be treated before serious offenses occurred. Providing for treatment when the problem is illness and not criminality would allow the criminal justice system to deal with people who commit crimes because they really are criminals.

According to Judge Bradbury, rural ACT Teams currently work with the judicial branch to provide services through the Mental Health Courts. The legislative initiative for granting money for enhancement of Rural ACT Teams is to be used solely for the addition to existing ACT Teams. The only proposal that meets these criteria is to hire two more staff for the ACT Team to be based in Lewiston and to drive to Orofino and the outlining areas. It has been recommended that one staff full-time nurse and one staff full-time clinician would be the best arrangement moving the Region II ACT Team closer to fidelity with state and national standards for ACT staffing. The existing Lewiston ACT Team staff can act as a liaison with Social Security, the Idaho Housing Administration

and the CAP payee program or other Lewiston based agencies. ACT Teams doing outreach to Orofino and outlying areas would work closely with these communities to ensure wrap-around services (such as office location, medication monitoring services, support staff, referrals to private agencies, etc.), and would provide intensive case management, psychiatric and medication services, and psycho-social rehabilitation for clients in outlying areas.

Judge Bradbury noted the following problems with the above proposal:

- The primary function of two additional staff is to participate in Mental Health Court which requires the ACT Team to be located in the same county as the Court.
- Who would do the medication monitoring is an issue. This would be almost impossible for two new staffers to handle.
- Not being centrally located, new staff would have to travel 2 or more hours to get to outlying service areas.
- Two additional vehicles would be needed from an already depleted Lewiston motor pool.
- Daily ACT Team staff meetings would be difficult because outlying area staffers would need to leave the office early in the day.
- New hires would be on their own to service outlying areas and might not like unequal schedules, lack of rotation and unequal responsibilities.
- There would be the issue of DE's in the outlying areas, which would be an extra burden on existing ACT DE's because of travel and scheduling issues of Lewiston DE's having to go to outlying areas and Courts until new hires are qualified.
- Comp time accumulation for new staff would build up very fast if they are doing medication monitoring.
- Supervision issues would arise due to having two more staff with entirely different client case loads.
- Primary resources for clients (e.g. S.S., IHA) are located in Lewiston and would require shuffling paperwork back and forth.
- In short, to even try to implement this staff addition at the present time would stretch existing staff too thin.

Judge Bradbury continued by stating that an early child intervention program would help to identify children who may be at risk for mental health or substance abuse when they reach their teen or adult years. This program could be incorporated into the schools or be provided to children whose parents have a mental health or substance abuse history.

Representative Block asked if the early childhood intervention program could be incorporated into the school districts to identify at risk children at an early age. Judge Bradford replied that program would be better served by being in the Public Health Districts and administered as a community-based system that would be in conjunction with parenting classes.

Co-Chair Senator Stegner asked Judge Bradbury what he feels the greatest need is and what his priority would be. Judge Bradbury stated that the short term priority would be

to get treatment plans established in the rural areas that people could easily access. The long term priority would be to build residential treatment facilities.

Co-Chair Senator Stegner stated that he hoped with the renovation of SHN this coming year that the waiting list would decrease and he asked Judge Bradbury if he noticed any change in accessibility to SHN. Judge Bradbury stated that with the renovation. the average family in this area would be able to visit another member in SHN whereas if that person were housed at State Hospital South (SHS), the family could not afford to visit.

Senator Werk inquired about fragmentation of responsibility within the system -- people who don't communicate with each other (e.g. counties, DHW, courts, juvenile justice versus adult) and he asked for comments on how that fragmentation could be bridged. Judge Bradbury replied that the system needs an organizational structure that is focused on mental illness and addiction. A regional board is needed to take care of regional problems because not all regions cater to the same client or programs.

Teresa Wolf, Nez Perce County Indigent Director, explained the counties' responsibility for mental health and substance abuse treatment. The Transformation Work Group, of which she is a member, adopted The President's Freedom Commission on Mental Health Report which is guiding them in developing a new plan for Idaho. Their vision and goal is to reflect the needs and to understand good mental health which is essential to overall health. The problems identified by the Freedom Commission are the same as those in Idaho. The system is fragmented and the counties and the state have overlapping responsibilities for the same population. An increase in options needs to be explored.

Research has shown that individuals rotate back and forth between jails and homelessness and that jails are becoming the social service system of last resort. Studies indicate that 16% of state prisoners and 7% of federal prisoners suffer from mental illness. These individuals usually average longer lengths of incarceration than other inmates.

The cost of the mental health system impacts every town and county in the state. Indirect costs include loss of employment, inability to take care of one's family, lack of insurance coverage, the stigma of having a mental illness, and suicide. In 2003, Idaho ranked 7th in suicides per capita and has remained in the top 10 states for suicide for the last several years. Direct costs associated with suicide include treatment, rehabilitation, Medicaid, Medicare, SSI/SSD, jails and courts.

Ms. Wolf explained that the Department of Health and Welfare (DHW) is charged with providing services to individuals who are severely and persistently mentally ill as outlined by the Diagnostic and Statistical Manual. These diagnoses include schizophrenia, schizoaffective disorder, major affective disorder, delusional disorder and/or borderline personality disorder sufficiently severe to disturb at least two of the following: vocational/academic, financial, social/interpersonal, family, basic living skills, housing, community or health.

According to Ms. Wolf, DHW provides mental health services to too narrow of a group, and the services needed are not available in a timely manner. The state has not accepted voluntary admissions to either SHN or SHS since 1998. In some cases, a person must decompensate to a level where involuntary hospitalization is necessary before treatment begins. Services need to be available at the state level for individuals who are a danger to themselves or others including people seeking voluntary admission. The counties are not equipped with staff nor do they have the financial resources to provide care and treatment for these patients. Both private facilities and DHW encourage individuals to enter the system on a voluntary basis and the DHW acknowledges that even though this person is not committable by DHW standards, the person still needs hospitalization. The counties agree that patients should be allowed to enter the system voluntarily, however, they do not agree on who should be responsible for the payment of such care. The majority of counties are in agreement that voluntary admission is not a county services responsibility and they have been forced to resolve this issue in court.

Counties are responsible for the cost of commitment and treatment of indigents. If a person enters a private facility as an involuntary patient, the cost is distributed between both the county and state. Any person from that person's family can choose to admit the person voluntarily at a private facility. The length of stay is determined by the admitting facility that seeks county/state funds. The payment source is determined by whether the patient is an involuntary or voluntary patient. The county commitment costs are set forth in Idaho Code § 66-327 which states that responsibilities for the cost of commitment and care of adult patients shall be the responsibility of the person, their spouse, adult children or if indigent the county of that person's residence. If the court determines the individual is unable to pay for their commitment costs, the court puts that responsibility on the county under Chapter 35, Title 31, Idaho Code. DHW assumes custody after the person is determined committable by the court. Counties are responsible for the medical bills of the indigent under Chapter 35, Title 31, Idaho Code. The Boards of County Commissioners makes the determination of indigence under Chapter 35 and the courts make the determination of indigence under Chapter 3. Private providers seek payment for voluntary indigent mentally ill individuals under Chapter 3 as well. Individuals seeking treatment are encouraged to enter voluntarily if they are suicidal or a danger to self or to others.

The daily bed rate charge for private facilities for psychiatric admissions varies from county to county, ranging from $559.20 up to $985.15 per day, and $1,863.00 per day in an ICU facility. The daily rate at SHN is $438.00. Ms. Wolf handed out a Daily Hospital Bed Rate Schedule that compares the costs of different facilities, private and state, and involuntary and voluntary commitment, for a 27-day stay. The Catastrophic Health Care Cost Program (CAT) Annual Report of Counties shows that the cost for mental health care over the last 4 years is approximately $2.6 million per year. In 2004/2005, CAT reported that $2.9 million was spent for mental health care alone.

Ms. Wolf stated that the counties are working under antiquated laws that hinder helping those in need. The state no longer accepts voluntary patients at state facilities due to long waiting lists for involuntary patients needing treatment. More funding is needed as well

as a clarification of the law outlining responsibility. Regarding children's mental health, the counties assume the same costs for involuntary admission for children as they do for adults. However, counties have no responsibility for costs of voluntary treatment for children under Idaho Code § 16-2431. The law needs to be consistent for both children and adults.

In response to a question from Senator Werk, Ms. Wolf replied that Idaho is 49th in the nation in spending for mental health care per capita.

Representative Garrett asked if Ms. Wolf would recommend removing all health care off of the county indigency requirements or just the mental health portion. Ms. Wolf replied that she does not see the need to remove either all health care or the mental health portion off of the county indigency requirements.

Representative Wood updated the committee on a Region VII Pilot Project Proposal. She said she enlisted the help of the Director of Department of Correction, as well as key elected officials, judges, state and county correction personnel, law enforcement and treatment specialists in Region VII. Their partnership is interested in designing a cost-efficient and reproducible model that includes a balanced approach of substance abuse and mental health treatment for community members who enter the criminal justice system based on a felony. They want to offer the best opportunity for a life-changing transition to a non-criminal, alcohol and drug-free life. The desire is to build a community system of care that has accountability, addresses community protections needs and fosters competency development for the treatment providers.

According to Representative Wood, a major component of the pilot project would be to demonstrate that by utilizing a variety of levels of incarceration in a multi-county jail facility, near a supportive family, and a continuum of appropriate treatment and supervision, it will create new life opportunities for community members, create a safer place to live in, and ultimately reduce the overall cost of incarceration and treatment for the Idaho Department of Correction.

The project model will focus on assisting communities within Region VII to build a continuum of care including, but not limited to, prevention and education, early intervention and diversion, assessment and case management, treatment, recovery and maintenance, and crisis intervention. The proposed project model focus areas include:

- Reduce referrals to the state prison system from Region VII;
- Develop and implement more effective ways to reduce recidivism;
- Implement a more effective state and county partnership with a focus on state corrections and county probation (private partnerships will be sought and encouraged including doctors and businesses in the multi-county area);
- Integrate a treatment philosophy for both substance abuse and mental health disorder treatment; and
- Include the offender's family in treatment, as appropriate, to ensure successful transition.

Key components of the project model would include judges receiving increased local sanction options with treatment and accountability attached, as well as:

- For offenders on state probation, a continuum of retained jurisdiction options with state funding will be proposed that allows a District Judge to incrementally step up or step down a chemically dependent or mentally ill offender for different lengths of incarceration and/or supervision, through varying levels of regional housing including secure jail facilities with treatment, staff secure facilities, group housing and intensive outpatient;
- A proposal to increase all existing housing programs. Unmet housing needs are a critical component to current system failure. People leaving prison or county jails need adequate housing in the community if they expect successful transition. Probation officers and treatment providers need housing available to provide immediate diversion from jail or hospitalization. This project would focus on increasing the community's capacity to provide crisis housing beds with immediate access available 24 hours a day, seven days a week;
- Enhanced community supervision with additional probation staff (i.e. state and county probation officers/housing staff/paraprofessionals). This will accomplish the much needed increase in necessary monitoring and accountability. While supervision is necessary to assure compliance, they also seek to catch those under supervision doing things right and to provide appropriate recognition for success;
- Expand the Drug Court capacity to include pre-sentence diversion and pre-adjudication. This provides the judges with additional tools to address recidivism;
- Design sanction options to support the maintenance of those who have or could have local jobs. Bonneville County is currently in the active design phase of a new and expanded work release facility and limited expansion of their hard-wall secure jail. As part of a model project, a cooperative state-county agreement to include some level of expanded jail capacity and incorporate treatment facilities within the secure jail and the work release center would ensure a substantial increase in access to mental health and substance abuse treatment. Timely approval of a pilot project will ensure that an increased number of offenders will be enrolled in the work release program with treatment available at night. The work release center beds cost half that of a hard-wall jail bed rental, $40 vs. $20 per day;
- Increased access to vocational rehabilitation, Eastern Idaho Technical College, University Place and continuing education opportunities will be vital to the success of the pilot project. Probationers need the opportunity to become productive, successful and self-sufficient community members.

Additionally, the proposal includes the development of an Integrated Treatment Philosophy Model for those with mental health and substance abuse problems:

- Appropriate, integrated services for those in need that will support recovery and improve overall health, and can ameliorate the effects their disorders have on their family, friends, and society. Helping offenders stay in treatment, find housing and jobs, and develop better social skills and judgment will begin to substantially diminish some of the most costly societal problems including crime, HIV/AIDS, and domestic violence.

- Access to needed medications to address both medical issues and psychiatric illness will be a component of the project model. Grants from pharmaceuticals under a doctor's supervision will be sought.
- All agencies working with offenders must use a standardized assessment and evaluation process. They will support implementing the Minkoff Model which is a comprehensive, continuous, integrated system of care model. It is based on implementing principles of successful treatment intervention that are derived from available research and incorporated into an integrated treatment philosophy that utilizes a common language that makes sense from the perspective of both mental health and substance disorder treatment specialists.

Representative Wood continued by stating that families must have the opportunity to be involved in treatment:

- The project would identify the underlying family issues of those receiving treatment and would address those issues with evidence-based treatment and programs that have proven to be effective. Implanting family treatment into the project model will yield significant positive results for the offender and potentially curtail current and future criminal activity of family members.

The project model would also tentatively include a local oversight group to assist in designing the proposed outcomes and reporting schedule for the project. In collaboration with the oversight group, the project would need authority to make needed adjustments throughout the project's development and implementation to ensure success. In the process of designing a successful, reproducible model, the project will seek to remove some of the current barriers that make working with state, county and private partners a challenge.

Representative Wood explained that the proposal will include a statement on financial management and reporting. The initial proposal may include a request to make Bonneville County the agency of record for financial reporting and administration. Bonneville County has the ability to create a separate and auditable budget within its regular budget system that will successfully track and report expenses and revenue. They will ask for statistics from one or more state agencies to develop an appropriate success measurement system. They will also include a statement on an anticipated reporting system on outcomes and successes in treatment. As in the financial model, they will ask for statistics from one or more state agencies to develop a success measurement tool.

A critical component to the success of the pilot project will be an immediate priority to hiring and retaining mental health counselors and strengthening the skills they will need to address substance abuse and criminology. They want to enter into treatment contracts on a local level that provide financial incentives to hire and retain highly skilled counselors and clinical supervision/program administrators. Representative Wood stated that the group recognized that the ultimate goal of a model project would be to create an alternative to building more prisons.

Bud Langerak, Bonneville County Sheriff's Office, spoke about the new work release center that is currently in the design phase which will increase jail space. The goal is to take the existing 64-bed work release center and turn it into a more secure jail facility to help with the expansion by increasing bed space to 150-200 beds. He said the Bonneville County Sheriff's Office felt this would be a good way to incorporate the pilot project into their expansion. He said that if the committee was interested, he could provide a formal proposal including a budget and a 5-year pilot plan to give everyone a good idea on the rate of recidivism and what treatment programs work. The Bonneville County Sheriff's Office would need to expand its current remodeling plans to include classrooms and possibly more treatment space, which will increase construction costs. The proposed new work release center would be a separate facility from the secure facility.

Representative Garrett commented that if she were mentally ill, she would commit a crime so that she could get the services that would be offered by the pilot project. She said the committee needs to look also at how to provide transitional housing and job help and core services to people without them having to commit a crime to get those services.

Senator Compton asked if there was a component to the proposed project that would deal with juveniles. Mr. Langerak replied that they targeted adults in the project but he would like the committee to consider adding juveniles so they can dually treat adults and juveniles.

Representative Wood stated that the juvenile component was discussed. They had planned to meet with the director at St. Anthony and with the Department of Juvenile Corrections but they wanted to get feedback and direction from this committee if there was interest in supporting this project.

Kathleen Allyn, Administrator, Division of Behavioral Health, DHW, presented DHW's plan for the state's behavioral health services. She said there is no dispute that Idaho's behavioral health services are inadequate to meet present needs. Numerous groups have identified problems with the mental health and substance abuse delivery structure. What is lacking is a clear and organized strategy that prioritizes needs, includes cost estimates for proposed program changes, and identifies the steps need to develop a public behavioral health system.

Ms. Allyn addressed three areas:

1. Immediate actions that have been initiated to improve current services, primarily community-based services;
2. Legislative proposals to further the process of building a behavioral health system during FY 2008; and
3. Longer-term proposals to implement a behavioral health system.

To put these proposals in context, Ms. Allyn spoke about the elements of a 'good' public behavioral health system. She drew from the literature in the field, the collective wisdom

of the Behavioral Health staff and their years of professional practice, and the ongoing work of the numerous state councils and committees.

I. System Characteristics
According to various authorities, including the President's Freedom Commission on Mental Health, the characteristics of a good public behavioral health care system include:

1. Client focus and engagement;
2. Commitment to recovery and resiliency;
3. Clarity of system design;
4. Clinical and service excellence;
5. Sufficiency of resources;
6. Attention to human resources;
7. Equity of access;
8. Integration of care;
9. Community-based solutions;
10. Accountability for public funds.

Idaho should work to assure these 10 characteristics of a 'good' system are present throughout the behavioral health system. These characteristics should be used to judge what changes are needed to make a more effective system of services. They are the basis for the recommendations for priorities and system changes presented by DHW.

II. Service Array
Ms. Allyn discussed the following services that a good behavioral health system needs:

- Prevention in education services aimed at educating the community and selected populations, such as pregnant women, parents and primary care physicians, about risk and protective factors related to mental health and substance abuse.
- Early intervention and diversion services to identify at-risk individuals and their families and reduce risk factors, increase resiliency or recovery factors and divert individuals from inappropriate settings such as jails or hospitals.
- Comprehensive assessment and case management—a comprehensive evaluation of all presenting disorders, development of a single plan of care implemented across systems and funding sources, and coordination of services.
- Intensive community-based treatment services such as outpatient and residential services, and specialized therapies such as functional family therapy designed to address the short-term but intense needs of high risk individuals.
- Broad-based community recovery and maintenance supports such as client and family support services, supportive housing/living arrangements, and a range of psychosocial rehabilitation, supported employment, and family-based wrap-around services.
- Crisis intervention services that include mobile crisis, ACT teams, and respite services.

Not all potential services under each category can or should be made available in every community. Some services may not be economically feasible. An inpatient psychiatric

hospital, for example, requires a large capital investment, ongoing financial support and professional resources that may not be available in every region. However, in order to have a 'good' behavioral health system, each region should work to develop services in each of the categories.

Finally, a good behavioral health system must include specific services and system designs for different age groups and cultures. There is a need for the system to be able to treat dually-diagnosed individuals. The system must also be able to deal with the special challenges presented by the juvenile justice and adult correction populations.

3. Department Actions Already Underway

Ms. Allyn stated that most of the recommendations discussed add to or strengthen community-based services in each of the categories mentioned. A few are directed at strengthening the underlying infrastructure of the system. The proposals also move toward greater integration of substance abuse and mental health services.

DHW has already initiated (or soon will initiate) the following actions:

1. Partner with District Health Departments in mental illness and substance abuse primary prevention. DHW has contacted the directors of the District Health Departments about implementing prevention and education programs on mental health and substance abuse issues in partnership with DHW. The District directors have expressed an interest in becoming involved in mental health and substance abuse primary prevention and education. This partnership will strengthen prevention efforts around the state.
2. Partner with the courts in co-occurring disorder training. DHW is working with the courts to develop co-occurring mental health and substance abuse training for DHW staff and others working with drug and mental health courts. This is a first step in developing an integrated evidence-based model for dealing with co-occurring mental health and substance abuse disorders.
3. Increase the number of children/adolescents receiving wrap-around services. DHW has developed a plan being presented for approval next week to the Idaho Children's Mental Health Council (ICCMH). This plan will significantly increase the number of children and adolescents with serious emotional disturbances (SED) served by wrap-around services. This will be accomplished by contracting to have parents with children who are SED and others trained to facilitate the wrap-around process. The current wrap-around specialists, who are masters level clinicians, will continue to work in the children's mental health program. They will provide supervision of the paraprofessional wrap-around facilitators, clinical assessments, and case management of the treatment plans developed through the wrap-around process. Ms. Allyn stated that this change is initially expected to increase the capacity of the program to serve 210 additional children by August 2007. However, the ability to sustain this effort is dependent on the approval of a Decision Unit to maintain the current level of funding in fiscal year 2008.
4. Improve the mental health data system. Ms. Allyn noted that part of the infrastructure needed to support these improvements is better access to data. At present, for the adult mental health program to run reports, 14 different databases

must be accessed. This is not an efficient process. The Division was awarded a federal Data Infrastructure Grant that can be used to analyze data needs and develop a plan for meeting those needs. The plan will include recommendations on the best way to integrate the adult data with the children's and substance abuse data. The Division began that study September 1st and hope to have it completed before the end of the year.

IV. DHW Actions For Next Year Requiring A Decision Unit

Ms. Allyn turned next to initiatives that DHW is proposing as Decision Units (DUs) to be brought before the Legislature in 2007. While DHW has proposed these DUs, it does not know at this time if they will be included in the new Governor's budget.

1. Transition from Access to Recovery (ATR) to State Priorities. The ATR Grant is scheduled to end in August 2007 and has funded a significant portion of the substance abuse services in the state over the last two years. While there may be a potential to carry some federal funds beyond the end of the grant, that is very uncertain. Rather than risk severe service reductions, DHW is asking for an additional $6.5 million in general funds, additional receipts spending authority of $1.5 million, and anticipating a $460,000 increase in federal Block Grant funds. This will make the total proposed budget for state substance abuse services in FY 2008 come to about $20.4 million, of which $6.5 million are new state general fund dollars.

   This money will provide critical substance abuse services previously funded by the approximately $7.6 million per year in federal funds received through the ATR Grant. DHW proposes to refocus the priorities - mixing new general funds with existing general funds, an increased Block Grant and additional receipts authority- to address the state needs:

   a. Fund Prevention/Education at Current Level. In the area of substance abuse prevention and education, the funding effort from FY 2007 to FY 2008 will remain essentially the same at approximately $2.9 million. DHW will continue to move community-based prevention service providers to evidence-based and emerging best practices and also involve the District Health Departments in the prevention and education effort.
   b. Establish a New Adolescent Early Intervention Service. DHW proposes to use part of the additional general fund monies to initiate two new community-based early intervention services for FY 2008. One new service will be directed at adolescents who have completed school substance abuse programs but are still at substantial risk of abusing substances. The program will cost just over $650,000 and serve about 1,000 youth.
   c. Establish a New Early Intervention Program for Children of Addicts. The other new community-based early intervention program is directed at children of addicts. This program will work with children whose parents are in treatment for drug addiction to prevent the children from becoming addicts. This program will cost about $900,000 and serve about 2,500 youth. The total cost of the two new programs is $1.67 million.

d. Localize Substance Abuse Services. In the category of assessment and case management, the DHW proposes to replace the current 1-800 number with 30 staff to be located in the Regions. The program will cost about $1.94 million – about $160,000 more than was spent last year on the 1-800 number, assessment and case management. The staff will provide local, community-based assessments for services and act as case managers for complex cases. The staff will be supervised by the current Regional Mental Health Program Manager. In addition to working with the general public, the staff will work with local probation and parole to access treatment for clients being released from jail or prison and will work with local mental health clinicians to access treatment for clients with co-occurring disorders and with physicians to access care for pregnant and parenting women. In adding these employees, the substance abuse system will be more community-based and accessible to clients.
e. Increase Funding for Direct Treatment Services. The funding for direct treatment services is increased by about $461,000 to $9.2 million, of which $800,000 are new general fund dollars. Treatment administrative costs, including personnel, operating and management costs, are reduced by about $1 million to just under $2.5 million, of which about $593,000 are new state general funds.
f. Contract for Quality Improvement. To strengthen the underlying infrastructure, DHW proposes to contract for program accreditation and continuous quality improvement. The cost of the contract is $135,000 in new general fund dollars.
g. Maintain Recovery Support Services. Recovery support services in FY 2008 will be funded at about the same level as FY 2007, at $2 million, of which about $1.4 million are new general fund dollars.

2. Co-locate Clinicians with County Juvenile Justice Programs. DHW is proposing a Decision Unit to add two clinicians to each region to work with the county juvenile justice system. Although based in the Department Region, these clinicians will be available to travel to each county to work directly with county staff. They will assess county juveniles for mental health disorders and either place them in DHW treatment services if they have a serious emotional disturbance or try to place them in community services. The clinicians will also be trained to do a substance abuse screen. If the screen is positive, they will refer clients to the community-based substance abuse program staff for further assessment. The addition of these clinicians is expected to decrease the amount of time it takes for juvenile justice clients to access services. It will increase the capacity of the program to serve clients. The clinicians will be able to provide assessment to an additional 525 youths per year, which is a 29% increase over the current capacity of 1,803 per year. It will also increase the capacity of the Children's Mental Health (CMH) program to provide case management to an additional 338 youth, which is a 23% increase over the current capacity of 1,475. The DU cost is $1.3 million, of which $1.16 million are general fund dollars.

3. Expand Wrap Around Services for Children's Mental Health at Current Funding Levels. DHW is proposing a DU to maintain funding of the Cooperative Agreement, which is the federal grant that currently funds wrap-around services for children and adolescents with SED. The grant is beginning its 5th year and the federal match drops from a one-for-one match to one federal dollar for every two state dollars. The DU is for $130,000 in general funds to maintain the current funding for CMH. As previously mentioned, subject to approval of the ICCMH, DHW will immediately begin implementing a plan to triple the number of children and adolescents served by wrap-around services using current funding. The proposed DU will allow DHW to continue that effort in fiscal year 2008.
4. Increase the Capacity of the Community Mental Health Centers. DHW is seeking a DU to increase by two per Region the number of state staff providing core adult mental health services. Since DHW refers most insured and Medicaid clients to private providers for treatment, these state clinicians will serve primarily the uninsured population. The addition of these clinicians is expected to increase the capacity of the adult mental health program to provide over 250 additional crisis screenings, court-ordered assessments or telephone screenings and to provide on-going treatment services to over 360 new clients. There will also be a small reduction in caseloads for all staff. The DU also adds an FTE to analyze performance and outcomes data. The cost of this DU is $1.24 million, of which $1.08 million are general fund dollars.
5. Provide Integrated Mental Health and Substance Abuse Training. DHW is requesting funds to develop a training program that integrates mental health and substance abuse services and provide the training at the local level. With the creation of the Division of Behavioral Health, the opportunity and need to exist to keep all behavioral health clinical staff and community partners informed about evidence-based and best practices in mental health, substance abuse and co-occurring disorders. The DU also expands training in the CMH program in connection with the federally-approved Program Improvement Plan (PIP) for child welfare services. The DU adds one clinician trainer in each of the seven regions at a cost of $561,000 of which $533,000 are general funds.
6. Determine the Resources Necessary for JCAHO Accreditation of SHN. DHW is submitting a DU for funding to assess what it will take in staffing, physical plant changes and, ultimately, the cost for SHN to be JCAHO-accredited. The estimated cost of the study is $40,000 in general funds.
7. Conduct Quality Assurance of Medicaid Mental Health Clinic Services. DHW is proposing a DU to initiate quality assurance reviews of mental health clinics that provide services to Medicaid clients, including partial care services. Specifically, DHW is asking for 15 state staff -- 13 will be in Regional offices conducting on-site mental health clinic quality assurance audits, initial complaint investigations, and technical assistance and training on mental health clinic rules; 1 FTE will supervise both the existing psycho-social rehab prior authorization and quality assurance unit and the mental health clinic quality assurance unit; and 1 FTE will provide administrative support to both units. The cost of this DU is $1.1 million, of which $558,000 are general fund dollars.

V. Longer-Term Department Actions

Ms. Allyn next spoke about actions that will be started in the next 12 months but will take more time to complete.

1. Develop a Behavioral Health System Implementation Plan

a. Better Coordinate and Integrate Department Behavioral Health Services. DHW needs to get its own house in order and will develop a behavioral health system implementation plan to coordinate and integrate DHW behavioral health services, including Medicaid-purchased services. The plan will be based on priorities identified by key statewide committees and regional advisory groups, and will include cost estimates for proposed program changes. It will incorporate evidence-based or emerging best practices and include expected outcomes from services as well as a management and improvement process. It will also identify the steps needed to implement the plan.

b. Integrate Mental Health and Substance Abuse Advisory Groups. As part of that plan, DHW will work with public advisory groups to identify gaps in community-based services and the regional priorities to fill those gaps. Advisory groups are a potentially valuable resource but to date DHW has not used them effectively. At the same time, there are at least 12 groups that have been created by statute or actions of prior Governors and there may need to be a consolidation of some of these groups. DHW will work with these groups to determine with them how best to fulfill the statutory or executive mandates and make what changes they can right away.

c. Address the Recommendations of the Estime Report. The recommendations of the Mental Health Facilities Plan, dated September 29, 2005, will also be addressed. Known as the Estime Report, this document made the following recommendations:

i. Improve Recruitment and Retention of Mental Health Professional Staff. DHW has made some progress in the area of recruitment and retention of mental health professionals -- base salaries for physicians, particularly psychiatrists, have increased by 6.7%. There is now a second psychiatrist at SHN (Dr. Karla Eisele). DHW has also raised the base salaries of nurses by 10.5% and social workers by 9.3%. In addition to these base pay increases, DHW also provided some bonuses and short-term salary increases to these professional staff during last fiscal year. Ms. Allyn noted that DHW is grateful to the Legislature for supporting all of these increases, but noted that while this seems to be helping with retention, it is too soon to know for certain how effective these measures have been. Even so, Idaho remains a mental health professional shortage area and a plan to attract/retain more professionals is being developed.

ii. Develop Community-Based Crisis Respite Facilities. Another recommendation of the Estime Report is to develop 8-bed, 72-hour crisis respite facilities. The estimated cost of

one of these facilities in 2005 was $1.2 million for construction costs and an additional $1.46 million in operating costs. These community-based facilities can provide psychiatric evaluation, crisis stabilization and intervention, medication management and monitoring, and substance abuse detoxification. They can avoid the need for more expensive inpatient hospitalization. During the last session, the Legislature appropriated $2 million to be awarded as grants to regions to start up mental health or substance abuse services. The deadline for the first round of grant applications is October 1, so there may be proposals for such facilities. If not, DHW will proceed with a proposal to develop them.

iii. Resolve How to Care for People with Mental Illness that Makes Them Dangerous to Themselves or Others. Idaho needs a way to care for people who, due to mental illness, pose a significant danger to themselves or others. Over the past 12 months there were about 40 adults who needed to be kept in a secure environment to prevent harm to themselves or others. About 30 of them have committed violent acts but cannot stand trial because they cannot assist in their defense. About 10 of them have not engaged in criminal behavior but need to be kept in a secure facility to prevent them from harming themselves or others. Idaho desperately needs a secure psychiatric facility or facilities for these people. The state hospitals do not have the secure environment to care for them. The Department of Correction secure facility of 12 beds is nearly always full. The question is easy to state: Do we build one secure facility to house both convicted and non-convicted people or do we build more than one facility to separate those adjudged guilty from those who have not been convicted of a crime? The answer is more difficult -- one facility appears to be more cost effective, but two or three facilities seem more appropriate from a philosophical point of view as well as for purposes of access.

At the same time, for the safety of staff, clients and the public, we must take some action during the interval before additional secure space can be constructed. State staff are currently being asked to take care of dangerous people in facilities that were not designed for that purpose. Not only does this put staff in jeopardy, it also poses a risk of injury to the client and other clients and the public in the event of an escape from a non-secure building. This risk to staff, clients and the public is not acceptable and must be addressed as

soon as possible. DHW is examining this issue and plans to bring a proposal to the next legislative session.

iv. Develop Public-Private Partnerships to Develop and Operate New Facilities. The Estime Report recommends the development of new facilities for detoxification and transitional housing. Both of these are important services in a behavioral health continuum of care. Once DHW knows the results of the grant program, the status of these services will be assessed.

DHW expects the Behavioral Health System Implementation plan to be completed in time to submit budget and legislation proposals to the 2008 Legislature. Implementation of the plan will begin as soon as the plan is complete.

2. Implement an Integrated System of Care Model for Co-occurring Disorders. Ms. Allyn noted that it was mentioned earlier that DHW is starting a program to train field staff about co-occurring disorders as an initial step in implementing an integrated model for co-occurring psychiatric and substance abuse disorders. An estimated 50% of individuals with severe mental illness also will develop a substance abuse disorder during their lives. Co-occurring diagnoses are the expectation, not the exception to the rule. Further, when mental illness and substance abuse diagnoses co-occur, they both must be treated as the primary diagnosis.

3. Review Medicaid Funding of Mental Health and Substance Abuse Services. According to the report developed by the Legislative Services Office, Idaho currently spends about $61 million in state general fund monies (not including Medicaid state match) on mental health and substance abuse services. Although some of that money may be serving as a match for other federal programs, a portion of that general fund money potentially could be used to leverage additional federal money through Medicaid. Idaho's Medicaid coverage of substance abuse services is indirect and limited only to acute care hospitalization and to counseling where there is a primary mental illness diagnosis. Community-based mental health services funded by Medicaid are limited in scope rather than comprehensive. As the Department rolls out Medicaid reform, there is an opportunity to review Medicaid coverage of mental health and substance abuse treatment. However, any proposed expansion of Medicaid coverage needs to demonstrate that the expenditure is replacing services currently covered by general funds or that no additional general funds are being spent to fund an expansion of services. The services proposed to be covered must meet efficacy (i.e. evidence-based and emerging best practices) as well as quality criteria.

4. Adopt Uniform Assessment Tools. DHW will work with other public agencies to adopt uniform assessment tools for mental health and substance abuse assessments. For substance abuse assessments, DHW will be contracting to identify the best substance abuse assessment tool to assist in the effort of adopting standard assessments.

5. Broaden the Definition of Serious Emotional Disturbance Used for Children and Adolescents. Related to the DUs discussed earlier, a recurring concern raised by DHW's partners and families is the definition of serious emotional disturbance (SED) used by DHW. The exclusion of conduct disorders as a serious emotional disturbance is a particular point of contention. The Division is currently reviewing its definition of SED to determine the impact of broadening the definition to include conduct disorders within defined parameters. An initial review indicates that the definition could be broadened to include the majority of juvenile justice clients who were denied eligibility for DHW services. It would require that the CMH DUs be approved. Division staff will be working on this proposal with the CMH/Juvenile Justice workgroup to gain consensus on the definition of SED.

6. Negotiate Reduced Rates for Community Hospitalization. In the area of mental health treatment, DHW currently contracts with community hospitals for inpatient care until the patient is able to get into one of the state hospitals. The rates being paid for community hospitalization vary from $550 to $1,000 per day. In some regions, they may be paying the best price they can get but in other areas, there may be an opportunity to contract with a single provider for this service. Over the next year DHW will be negotiating contracts for community hospitalization where a better rate may be possible.

7. Conduct a Community and Family Psychoeducation Pilot. A recently developed program designed to prevent the onset of psychosis early in life is being conducted by researchers at the Maine Medical Center. Known as the Portland Identification and Early Referral Project (PIER), the program is based on the knowledge that psychotic episodes physically damage the brain and preventing the onset of the psychotic phase of the disease is critical for preventing life-long problems. The treatments used in the program are all standard, empirically-validated approaches. The critical feature of this effort is the clinical outreach by a team to general practitioners, school guidance counselors, and the population at large to educate and inform them about the early signs of psychosis. At-risk youth are identified and provided family intervention and education along with medication therapy. They are being tracked over time to determine whether this prevention/early intervention strategy will result in less dysfunction later. Early experience is showing that this approach clearly and dramatically reduces later problems. The Division has been in touch with Dr. William McFarlane, one of the project managers, about the possibility of piloting this program in Idaho and is in the early stages of assessing what will be required to conduct a limited pilot.

8. Work With Other Agencies to Clearly Establish Agency Responsibilities. Ms. Allyn noted that numerous comments have been made to the committee about what agency has the responsibility for providing mental health and substance abuse services. Based upon a review of interactions between the Division and the counties, Juvenile Corrections, Adult Correction, the schools and the courts, it is not always clear either in law or policy where responsibility for providing or paying for services lies. The Division will begin discussions with each of these entities to identify and resolve disputed areas of responsibility. In some cases, this may be an easy task; in other cases, it will take some time to work through.

The plan is to jointly develop a flow chart showing an individual's process through a given system and identify each point at which a mental health or substance abuse assessment or service may be needed. The next step will be to identify areas of disagreement about whose responsibility it is to provide the service and whose responsibility it is to pay for it and reach consensus on what make sense from a system standpoint. To the extent that additional resources are needed to carry out the responsibilities identified, a plan will be developed to seek additional resources. Ultimately, the agencies will develop and enter into memoranda of understanding or joint protocols setting forth each agencies role and responsibilities.

Following is a summary of the proposals for a behavioral health continuum of care:

DHW will be increasing prevention and education programs through:

- Partnering with District Health Departments in mental illness and substance abuse primary prevention;
- Cross-training Division staff and others in mental health and substance abuse; and
- Conducting a community and family psychoeducation pilot to recognize the early signs of psychosis.

DHW will be increasing early intervention and diversion services by:

- Providing a new service for adolescents who are identified as not being 'reached' by standard programs; and
- Providing another new service directed at children whose parents are drug addicts.

In the areas of assessment and case management, DHW will be:

- Working with other state agencies to standardize assessments for both mental health and substance abuse issues;
- Partnering with the courts to train staff about assessing and treating co-occurring disorders of substance abuse and mental health;
- Co-locating additional state clinicians with county juvenile justice staff to provide assessments and referrals to mental health and substance abuse services; and
- Adding state staff in the regions to localize assessment and case management for substance abuse treatment and recovery.

In the area of treatment, DHW will be:

- Negotiating more favorable contracts for community hospitalization; and
- Looking at the resources necessary to achieve accreditation of SHN.

Across the categories of assessment, case management, treatment, recovery maintenance, and crisis intervention, DHW proposes to:

- Increase the capacity of the community mental health clinics by adding two clinicians per Region; and
- Restructure the current wrap around process to more than triple the number of children served.

To strengthen the continuum from early intervention and diversion to crisis intervention, DHW proposes to:

- Broaden the definition of 'serious emotional disturbance' used for children and adolescents;
- Implement an integrated system of care model for co-occurring disorders; and
- Review Medicaid funding of mental health and substance abuse services.

To strengthen the entire continuum, DHW will develop a Behavioral Health System Implementation Plan.

To strengthen the infrastructure of the Behavioral Health system, DHW proposes to:

- Improve the mental health data system;
- Contract for quality improvement of substance abuse services;
- Provide quality assurance of mental health clinic services, including partial care, provided to Medicaid clients; and
- Work with other agencies to clearly establish agency responsibilities.

In conclusion, Ms. Allyn stated that in order for a behavioral health system to be effective, there must be a system of care and not just a collection of services. Building that system will require strong and consistent leadership, a single, clear vision, and consensus and momentum for implementing that vision. It will require an informed and supportive public and active engagement in the system by clients, families and advocates. It will require a system-wide culture that fosters and supports constant learning, change, challenging of sacred principles, and trying out new ideas throughout the system.

Senator Werk inquired about the $2 million that was set aside, and asked whether, if grants are not received and if nobody meets the qualifications or if money is left over, will DHW then use the money itself to build detox centers? Ms. Allyn replied no, that instead what she was suggesting is that there may be an application for a crisis facility that, if awarded, would do away with the need for a crisis facility in that region. The $2 million is a grant program that goes to proposals that are coming from the regions from local partnerships and will be expended only for those grants.

Representative Garrett asked that the DHW do some research on what is happening nationwide on co-locating adjudicated and non-adjudicated persons, including the court cases and how those cases have been decided, who runs the facility, and whether that is appropriate. She stated that if the committee could review research on what is working well, what is not working, and what is legally appropriate nationwide, then members of the committee would have some level of comfort as to how to proceed. Ms. Allyn stated it is a difficult issue and DHW is gathering information to address that.

Senator Werk asked about longer-term actions in relation to the assessment tools that have been mentioned. He inquired as to how long the DHW is talking about, e.g., can DHW implement these actions in 6 months to a year or are they looking at a longer time? Ms. Allyn replied that it can be done in less than 5 years, but it will depend upon reaching agreement. She feels that if they have good, solid, evidence-based data and research in

the substance abuse area, that is going to help quite a bit. The mental health assessment tools are less problematic because they are more established.

Senator Werk asked if Ms. Allyn anticipated that the Legislature would need to step in for the short-term and determine which assessment tools to use. Ms. Allyn replied that she would never anticipate the Legislature doing so; she feels that DHW should be doing that as the providing agency. This should not require legislative action.

Representative Garrett asked what the catalyst would be to bring all of the agencies together to agree on assessment tools since all the agencies seem to want to use their own programs. Ms. Allyn replied that this is the stumbling block and DHW has been talking with the courts, Department of Juvenile Corrections, and Department of Correction and at this time have not reached a consensus yet. If it is not possible for everyone to agree on a plan, DHW would then appreciate the help of the Governor's Office or the Legislature to come to the table and try to come to a conclusion.

Senator Compton commented that other states face these issues as well as Idaho and asked if DHW had looked at models that are currently in place. Ms. Allyn replied DHW has looked at other states and there is a lot of literature out there, but the problem is that each state faces its own problems and so Idaho cannot model another state's program in its entirety. Adjustments need to be made to that model, so DHW is looking at that now to see what might work in Idaho.

Representative Skippen commented that she was troubled by an earlier comment that was made that the Legislature should not have to step in and take a leadership role in some of these things. She said that when she looks back at the progress that has been made, it has been made because the Legislature stepped in and made decisions that DHW did not make. She wanted to know if the mindset in DHW with a new director and new staff is going to change so that they will take the lead and the initiative to get these things done instead of the Legislature having to step in and do it for them. Ms. Allyn replied that as far as she was concerned, the mindset is there and that will change. However, DHW cannot do it alone, and neither can the Legislature. The executive and judicial branches need to be involved as well.

Senator Werk stated that the committee heard a lot about the need for early intervention and asked what Ms. Allyn thought about reviving the Community Resource Officer Program that was cancelled in the schools. Ms. Allyn replied that the program was very successful and she would like to see it reinstated within the schools to identify issues early. Senator Werk asked if she felt that was the Department of Education's responsibility to reinstate the program within the schools rather than DHW. Ms. Allyn replied she did not care who was responsible for the program, but if DHW took it over it would need to sit down with the schools to see exactly how the program could be best set up to be successful.

Senator Werk said he felt that everything discussed at the meeting was basically bogged down in the system and wondered if it would be better off as a separate department. Ms.

Allyn replied that to her, what is important is to fund mental health and substance abuse services and if the Legislature finds the DHW not trustworthy enough to fund it, and it needs a separate department, then so be it. The disadvantages to that it the question of what do you carve out of DHW, e.g. all of the Medicaid mental health and substance abuse, and what do you leave in. Medicaid spends approximately $90 million on mental health and substance abuse and that is a coordinated effort. Child protection is closely tied to Children's Mental Health and Adult Mental Health and Substance Abuse as well, so that would need to be carved out of DHW and included in the new department. There are too many things that are related and so that concept would need to be looked at very closely before action was taken.

Carol Moehrle, Public Health Director for the North Central District Health Department, was the final presenter and discussed the regional structure and why that works so well. She explained that the seven Public Health Districts were established by the Legislature in 1970 to ensure that preventative public health services were available to Idaho citizens in all 44 counties. The purpose of the Public Health Districts is to prevent disease, disability and premature death. They promote healthy lifestyles by offering programs available to children and adults. They also protect and promote the health and quality of the environment.

Ms. Moehrle stated that the Public Health Districts work so well because of local control and oversight. They can look at issues in a timely fashion and deal with them at a Board of Health meeting, or sooner if needed. The local Board also oversees all of the policies and the delivery of services.

The Public Health Districts offer many services, including immunizations, children's services, women's health screenings, WIC, Family Planning Clinics, adolescent outreach, STD clinic, and pregnancy risk reduction. Their environmental health section deal with issues involving food protection, public drinking water safety, septic permitting, and solid waste issues. Their epidemiology and surveillance programs deal with communicable disease prevention and control, disease investigation, disease surveillance, disease education, and food-borne outbreaks. Their health education programs include diabetes prevention, injury prevention, smoking cessation/tobacco prevention, car seat/safety belt promotion, and breast and cervical cancer screening. Other services include emergency planning, health care liaisons, strategic national stockpile, and risk communication.

Ms. Moehrle emphasized that the Public Health Districts are not part of DHW. The relationship between the two departments is two-fold:

- Delegated: Responsibility for delivery of programs was delegated by the Board of Health and Welfare to the Public Health Districts in 1971.
- Contractual: Public Health is the local delivery arm for carrying out many federal contract requirements for the state.

The Public Health Districts work well because of the following:

- Local control and local oversight;
- Accountability to local policy making boards;

- Commissioners are accountable to the people; and
- Local policymaking boards address needs identified as well as assure a coordinated delivery for services that impact all citizens of Idaho

Ms. Moehrle noted that the one thing currently missing in their system is prevention programs. They would like to integrate mental health into the primary health care that people receive. There is a role that medical providers can play in the prevention and early detection of mental health. They would also like to see substance abuse prevention programs initiated during pregnancy. In order to get the maximum return on an investment such as this, they would like to implement evidence-based programs that have proven outcomes and that have the ability to prevent the cycle from occurring.

Senator Broadsword asked if there was a way that Public Health Districts could use their immunization clinics and nurses to distribute some of DHW's educational material. Ms. Moehrle said they are currently looking at incorporating that material into their program.

In response to a question from Senator Compton, Ms. Moehrle replied that the hospitals provide beginning parenting classes for expectant parents.

Co-Chair Representative Skippen commented that when a department tries to restructure, it always gets down to a centralized structure rather than a regionalized structure. She stated that a regionalized structure looks different and wondered if the Public Health Districts operate on a centralized structure or is it all regionalized. Ms. Moehrle replied that there is no centralized structure except that they purposely choose to meet and be that structure.

Co-Chair Representative Skippen asked how the structure with County Commissioners works for those who are in an elected position but who have no expertise in the health care area, i.e. how does that benefit or hinder what the Public Health Districts do? Ms. Moehrle replied that it both helps and hinders but it balances out. The biggest challenge is keeping everyone educated and updated on the issues so they can make informed decisions.

Co-Chair Senator Stegner stated that one of the considerations that some in the Legislature want to review is the possibility of trying to obtain the efficiencies of the public health boards in the delivery of mental health and substance abuse services. Having local commitments and buy-ins from citizens and developing local leadership and setting local priorities and utilizing local assets would be a plus in an enhanced delivery system for mental health and substance abuse treatment. When exploring that option, one of two considerations is to just give the Public Health Districts that responsibility. The other option is to create a separate parallel organization that would do the same thing. He asked Ms. Moehrle which method she would prefer. Ms. Moehrle replied that it would probably make more sense to create a separate parallel organization because if public health expanded their organization, other programs would probably get lost in the expansion.

Co-Chair Senator Stegner began committee discussion and asked if there was any additional information or interest in hearing from other programs. Representative Wood said she would be interested in hearing from actual providers who provide treatment in both mental health and substance abuse. She would like to know what the programs look like and what has been successful. Senator Broadsword stated she would be interested in hearing from providers also but wondered if that would have any impact on the committee as a whole in determining the future of mental health and substance abuse.

Senator Werk replied that one of the presenters spoke of a service provider that went out of business due to lack of reimbursement and he stated that if there were problems with the reimbursement system, this is something the committee should review.

Co-Chair Representative Skippen asked about models that are being used in other states, showing how they reimburse providers or, if the state is providing the services, how that is implemented. Representative Wood said she would like to see other states' models as well, and she would like to compare their provider requirements with Idaho's.

Co-Chair Representative Skippen stated that the proposed pilot program was intriguing and asked if something similar is being done other states, if there is data on any successes or failures.

Representative Garrett stated she would like a flow chart similar to the one Ms. Allyn alluded to that would establish which agencies were responsible for which treatments so the families involved could have some sense of who was in charge of what program and what treatment. She also would like to explore the county versus the state role in the indigency fee issue. She said she would like to see both those issues resolved before the committee goes forward with a new plan. She would also like to emphasize that the Board of Health and Welfare needs to take a stronger stand on how to adequately address mental health and substance abuse in Idaho.

Co-Chair Representative Skippen addressed the audience and requested that if there were any questions that they didn't get an answer to today to please submit those to a staff member so it can be addressed. Or, if anyone has comments or information on something the committee should be considering, please forward that to the staff as well.

Co-Chair Senator Stegner stated that a future meeting would be scheduled soon. The meeting was adjourned at 4:10 pm.