Minutes
Mental Health Subcommittee
Tuesday, December 11, 2007
9:00 a.m.
Room 204, Capitol Annex

The meeting was called to order at 9:05 a.m. by Cochairman Senator Joe Stegner. Other members present were Senator Tim Corder, Senator Patti Anne Lodge and Representative Margaret Henbest. Cochairman Representative Sharon Block and Representative Fred Wood were absent and excused.

Others present included Woody Richards, Intermountain Hospital; John and Martha Tanner, National Alliance on Mental Illness (NAMI); Corey Surber, St. Alphonsus; Kathie Garrett, Partners in Crisis; Jim Baugh, Co-Ad; Dick Schultz, George Thomas, Tracey Sessions and Kathleen Allyn, Department of Health and Welfare; Patti Tobias, Idaho Judiciary; Robert Luce, Deputy Attorney General; Molly Steckel, Idaho Medical Association and Idaho Psychological Association; Steve Millard and Toni Lawson, Idaho Hospital Association; Amy Holly-Priest, Business Psychology Associates; Tony Poinelli, Idaho Association of Counties; Bill Miller, M.D. and Claudia Miewald, Kootenai Medical Center; McKinsey Miller, Gallatin Group; Robert Banks, United Way of the Treasure Valley; Jack Cotton, RIMHBA; Colleen Allison, Kootenai County and Region I; Travis Chaney, Kootenai County Sheriff's Department; Representative Nicole LeFavour, District 19; Norma Jaeger, Supreme Court; Connie Cruser, Elmore County and Frank Eld, Valley County. Legislative Services Office staff members present were Eric Milstead, Amy Castro and Toni Hobbs.

After opening remarks from Cochairman Senator Stegner, Senator Lodge moved that minutes from the October meeting be approved, Senator Corder seconded. The minutes were approved unanimously by voice vote.

Mr. Eric Milstead, Legislative Services Office was introduced to review draft legislation relating to Idaho commitment laws. The drafts had been authorized by the subcommittee at the October 2007 meeting. **Mr. Milstead** explained that motions directed that draft legislation be developed for the following:

- A new standard or category for involuntary commitment;
- To provide for a single hearing and single standard that would apply for both inpatient and outpatient treatment; and
- To authorize the court's use of an abeyance of a petition for involuntary commitment.

It was determined that folding all three of these components into a single bill was the most practical approach. Draft legislation #EBM139 represents this effort. **Mr. Milstead** explained that this draft is largely the product of the Department of Health and Welfare's Kathleen Allyn and Rob Luce, Deputy Attorney General. Gary Payne of Idaho Psychological Association and

Jim Baugh of Co-Ad were also asked to review the draft and make comments.

Mr. Milstead explained that EBM139 adds a new subsection that broadens the definition of "likely to injure himself or others": Current subsections (a) and (b) define "likely to injure himself or others" as meaning that there exists a substantial risk that physical harm will be inflicted by the proposed patient (on himself or others)-as evidenced by threats or attempts to commit suicide or as evidenced by behavior which has caused such harm or places another in reasonable fear of sustaining such harm.

The new subsection (c) includes "where **there is a substantial risk that unless treated,** the proposed patient will continue to physically, emotionally, or mentally deteriorate to the point that the person will, in the reasonably near future, become a person describe under wither subsection (a) or (b).

Mr. Milstead went on to explain that the current definition of "mentally ill" (subsection (12)) is limited to a person who, among other descriptors, requires care and treatment at a facility. This subsection is broadened to include one who is described in the identical manner but who may require care and treatment through **outpatient treatment.**

The definition of "Gravely Disabled" (subsection 13) includes a broadened definition found in new subsection (13)(b) and provides that "one, who as the result of mental illness, **is so impaired that he is unable to understand his need for treatment, which if left untreated, will result in further deterioration to the extent that he will, in the reasonably near future, become a person described in subsection (a) of this section**." **Mr. Milstead** noted that subsection (a) defines one who is "gravely disabled" as one in danger of serious physical harm due to the person's inability to provide for his own basic personal needs.

A change in subsection (14) of this section modifies the definition of "outpatient treatment."

Subsection (16) provides for a definition of "Holding proceedings in abeyance." **Mr. Milstead** explained that this means an alternative to judicial commitment based upon an agreement entered into by all parties, including the proposed patient and agreed to by the court, providing for voluntary conditions of treatment, which holds in a state of suspension or inactivity the petition for involuntary commitment.

Senator Stegner commented that the subcommittee was at one point considering having a separate new category that encompassed definitions that stemmed from a history of mental illness. This definition in some states is defined as "Chronically mentally ill. " Both "chronically mentally ill" and using a history of mental illness have been avoided by incorporating this standard into existing statutes. He asked for comments as to why this is the preferred method over a new definition of "chronically mentally ill" or using a history of mental illness.

Mr. Rob Luce, Deputy Attorney General explained that his thought process came in part due

to discussion at the last meeting of the term "chronically mentally ill." The thinking is that this approach will be the least disruptive to existing statutes. He said the term "substantial risk" does not define what criteria is used to make the decision and so it can include history and chronic and so on.

Mr. Jim Baugh, Co-Ad, stated that his concerns had been largely addressed in the draft legislation and reiterated that he does not like the term "chronically mentally ill." He agrees that trying to address using previous history of mental illness and being dangerous is important.

Representative Henbest thinks this could also include newly diagnosed individuals that lack the insight to follow through with treatment. These people might not have a history of mental illness and they do not realize the danger of not getting treatment. It was explained that this concept is included in subsection (13).

Senator Stegner clarified that "history of mental illness" should be another point of consideration as well. **Mr. Baugh** said that people with a history of mental illness have reliable information on what will happen to them but those who are newly diagnosed have a more difficult time. He said that lack of insight and understanding of need for treatment needs to be included in both subsection (11) and (13). The revolving door population needs to be addressed as well. **Mr. Baugh** said he had no suggestion as to language at this time.

Representative Henbest said, in her opinion, it is possible upon first diagnosis to predict their behavior and predict whether or not they will comply with treatment or will injure themself or others. She said it is important not to let these people fall through the cracks and have to go in and out of the system before they get proper treatment.

Senator Stegner said there needs to be consideration given to whether or not there is a gap in the ability for the state to treat someone. He said there can be some adjustments made to the draft legislation but he would like something agreed upon by the end of the day.

Senator Corder said he is hearing **Mr. Baugh** say he is ok with the language in subsection (11) dealing with the insight into the need for care. **Mr. Baugh** said that would be helpful. He suggested that language as follows:

- "or the proposed patient has demonstrated that he so impaired that he is unable to understand his need for treatment and is unlikely to comply with that treatment and if left untreated his condition will continue to deteriorate.....

This does not require a person to have failed in treatment before but it does say some evidence needs to exist that the person is unlikely to comply with treatment. This would require evidence to both the lack of insight and the probability of noncompliance with treatment.
This language would be at the beginning subsection (c).

Mr. Milstead continued with an explanation of the changes made to Section 66-329, Idaho Code. Amendments here add provisions relating to proceedings for the involuntary care and

treatment of mentally ill persons by the Department of Health and Welfare. Under these amendments a court will hold a single hearing with a single standard to determine judicial commitment to the Department. The Department then, within 24 hours, will determine either the least restrictive available facility or "**outpatient treatment."**

Subsection (11) provides: If upon completion of the hearing and consideration of the record, and after consideration of reasonable alternatives, including, but not limited to holding the proceedings in abeyance for up to thirty days, the court finds by clear and convincing evidence that the proposed patient is mentally ill and is, because of this, likely to injure himself/others or is gravely disabled due to mental illness.

The court shall order the proposed patient committed to the custody of the department director for observation, care and treatment for an indeterminate period not to exceed one year.

Then, within 24 hours of that order, the department director, through his dispositioner, shall determine, the least restrictive available facility or outpatient treatment consistent with the needs of each patient committed under this section for observation, care, and treatment.

New subsection (12) provides a mechanism, with safeguards, that will allow for patients to be moved from outpatient treatment to inpatient treatment depending upon findings by the department director. The new subsection includes the following provisions:

- If any authorized personnel determine that the patient is either failing to adhere to the terms of outpatient treatment or the patient refuses outpatient treatment or such treatment is not effective, the department director shall cause the patient to be transported by law enforcement to the least restrictive available facility for observation, care and treatment on an inpatient basis.

- Within 48 hours of such transfer, the department director through his dispositioner, shall notify the court, the patient's attorney, and either the patient's spouse, guardian, adult next of kin, or friend of the change in disposition and provide a detailed affidavit reciting the facts and circumstances supporting the transfer.

- The court shall conduct an ex parte review of the notice and affidavit within 24 hours, and determine whether the change is supported by probable cause. If the court determines that the transfer was not supported by probable cause, the department will continue with outpatient treatment on the same or modified terms and conditions.

Mr. Baugh commented that the procedure up to the point of placing someone in inpatient treatment seems to be in compliance with due process. He stated that, under Idaho constitutional law, after being placed in an inpatient facility, a person needs to have the opportunity for a hearing, not ex parte review of affidavits. He thinks there has to be an opportunity for a hearing after being placed in a hospital. **Mr. Luce** did not agree and said he was not sure that the

Supreme Court case cited by Mr. Baugh is still good law for Idaho. He said the case in question dealt with a different statute. In his opinion the court can say the Department can do this for safety reasons without a pre-hearing. Currently the court says that some type of notice and hearing is required but it is not specific. **Mr. Luce** said the task is to come up with a procedure that balances the process and protects civil liberties without the burden of another hearing.

Senator Stegner recognized the difference in viewpoints and said he would try to allow discussion to resolve them.

Senator Corder asked what the difference was timewise between an ex parte review as opposed to an actual hearing. **Mr. Luce** said the ex parte review is to determine whether the action was appropriate by reviewing affidavits and so on. In response to another question from **Senator Corder, Mr. Baugh** answered that in his opinion, moving a person from outpatient to inpatient treatment is a deprivation of liberties. The question is what process is required and whether ex parte review is enough. **Mr. Baugh** added that ex parte review can take place in a matter of minutes; the judge gets the affidavit, reads it and makes the decision. He said there is no opportunity for the patient to participate at all.

Ms. Kathleen Allyn, Department of Health and Welfare cautioned not to lose sight of the fact that the standard for inpatient and outpatient commitment is the same in this legislation. It is a clinical decision where the person would best be treated. This is just an effort to expedite a move back to inpatient treatment because the person was eligible for that when the initial hearing was held. It is an attempt to balance liberty interests with the fact that no one uses outpatient commitment because it is too cumbersome and clogs the courts with additional proceedings.

Mr. John Tanner, NAMI agreed with Ms. Allyn. He said it is important not to make transferring a patient to inpatient care too difficult if they are not complying with treatment.

Senator Stegner explained that the reason the subcommittee was reviewing outpatient commitment was due to the fact that many experts testified that it is a very cumbersome process that is almost never used. The goal is to create an opportunity to make this more effective and to make it an option for treatment that will actually be used. He said he would be inclined to allow this language to be drafted as legislation to see that if it does make a difference in bringing outpatient treatment to Idaho as an option and to let the legal issues play out. He would like to see something that can be evaluated by the state of Idaho over time to see if it does what it was intended to do. **Senator Corder** agreed with **Senator Stegner**. A decision on adoption of the draft was deferred until later today.

Mr. Milstead moved on to draft legislation #EBM134 that revises jurisdiction and venue as these relate to counties. **Senator Stegner** said this jurisdiction issue has actually caused people to be released without receiving any treatment only because of where they resided.

Mr. Milstead explained that section 66-328 of this draft eliminates language that includes

conditions required for a mentally ill person to receive treatment in a county in which they are found, not only in which they reside.

Senator Stegner said this consideration was brought forward due to the fact that in many parts of the state treatment is limited to larger communities with no treatment available in smaller communities. This is to allow the county where someone is physically found to have jurisdiction. Currently the language requires that the county of residency is required to pay for the person's treatment if they are indigent.

Mr. Poinelli said that this was requested language from Nez Perce County and that he agrees with some of it. He noted that there was another suggestion that dealt with nonresidents and he thinks another subsection needs to be added

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Mr. Milstead went on to page 3 of the draft in subsection (h) dealing with involuntary detention. This language does basically the same thing. It allows the county where the proposed patient is found to commence involuntary commitment proceedings.

Representative Henbest asked whether this creates a situation where counties fight over who is responsible for payment. **Mr. Poinelli** said the intent of this draft was to eliminate that fighting. **Representative Henbest** asked whether the word "or" actually fixes it. **Mr. Poinelli** said he thinks it does. He said he would still run the language past the prosecutors office for their comments.

Mr. Milstead said that draft #EBM139 amended 66-329 and EBM134 also amends 66-329 and asked if these should be combined into one draft. **Senator Stegner** said in his opinion the two should be separate.

It was decided that interested parties would meet during the break to draft possible language changes for discussion later in the day by the subcommittee.

Ms. Amy Castro, Legislative Services Office Budget and Policy was introduced to review SCR108 from the 2007 session. This resolution requested that an independent contractor review Idaho's current mental health and substance abuse treatment delivery system.

Ms. Castro distributed a copy of the contract that was entered into on December 1, 2007 between Legislative Services Office and the Western Interstate Commission for Higher Education (WICHE). She commented that the time frame for completion of the study has been extended to June 30, 2008 because it took so long to get the contract signed.

She explained that SCR108 outlined all of the categories that the Mental Health and Substance Abuse Interim Committee wanted covered. She said the report is to result in an implementation plan on how to change the system. The resolution did not limit the review to specific categories, but it did specify that certain categories be looked at. In response to a suggestion from **Senator**

Stegner, Ms. Castro read sections "a." through "g." from SCR108 covering the scope of recommendations.

Ms. Castro added that this subcommittee also outlined some specific items as follows:

- To have background research analysis done on what other state systems look like
- Review of the entire management structure; not individual managers but management of the mental health and substance abuse system
- System integration and transformation (look at transformation grants and federal funding opportunities)
- Creation of improved system access for behavioral health for adults
- Look at data systems and infrastructure
- Do a fiscal analysis, timeline, capacity building recommendation and statutory change recommendations

Senator Stegner commented that there are a number of things that were recommended for this implementation plan that are moving forward.

Senator Stegner said he is not sure where to address payments for indigent mental health. He noted that Nez Perce County had made recommendations that the state change the procedure for indigent mental health payments and remove costs from counties and have it assumed by the state. This would be an attempt to remove barriers for mental health treatment in many counties. He said he has been trying to decide if this committee should make a recommendation in this area. He recommended that the subcommittee wait for the report from WICHE on the implementation plan and take the issue up again next year. He said, in his opinion, this is one of the most serious problems that the state faces in the realm of mental health services. He plans to continue to push this issue in an attempt to have the state take over the responsibility of payment for indigent mental health treatment. He noted that funding is a significant barrier for access to mental health treatment and that there are ten counties in Idaho that refuse to pay for indigent mental health treatment.

Representative Henbest agreed that the financing system is dysfunctional. She noted that when someone enters systems through an emergency room and is indigent a lien is placed on their home or property. In her opinion this adds to their stress in a time that is already very stressful and upsetting. She agreed with **Senator Stegner** that the state should be responsible for indigent mental health payments. She also realizes that there are significant costs involved in doing this. **Representative Henbest** added that another important issue that was brought up by the counties was how to deal with bills for people with multi-diagnosis. In her opinion this also warrants further study.

Director Debbie Field, Office of Drug Policy, was introduced by **Senator Stegner.** She briefly spoke to the Task Force regarding the Interagency Committee on Substance Abuse, Prevention and Treatment (ICSA) that is studying the delivery of Idaho's substance abuse services. She said this has been a very collaborative effort between many agencies that have been meeting once a

week since February. She said she is really proud of the work that has been done by this group and is looking forward to receiving their report. **Senator Stager** thanked **Director Field** and said he recognized the improvements and collaboration of this group. He said he is very proud of the efforts that the state is engaged in at the moment in this area.

Michelle Britton, Health and Welfare Administrator, Family and Community Services was introduced to discuss proposed uses for the Idaho State School and Hospital (ISSH).

Ms. Britton explained that ISSH is licensed as an intermediate care facility for the mentally retarded (ICFMR). This means that there are very strict rules and regulations regarding operation of the facility. She said the reality is that the client population at the facility is one of the most challenging to deal with. Virtually all of the new admissions to ISSH are people with developmental disabilities and mental health disorders. This means by and large these clients are assaultive, aggressive, dangerous, self injurious and some are even sexual predators.

She said, as a result of this, it is very difficult to meet all of the regulations as an ICFMR. In looking at the configuration of the space, they have larger buildings congregating 20 people who are already challenging people to be with. In her opinion, this does not help in managing the client population.

Ms. Britton said the sense is that ISSH is declining as an effective facility. They have 188 acres and in her opinion, those acres could be put to better use. In the early years of ISSH there were about 1,000 clients and it was a self sustaining operation that actually had cattle and grew food. This was a 600 acre campus. Today only 188 acres are used with about 95 residents. Other uses on the campus include a secure facility for the Department of Juvenile Corrections, the Department of Correction has a work center, JobCorp has a large operation that is basically their statewide operation center and there are two golf courses, Ridgecrest and Centennial, on the perimeter of the campus.

Senator Stegner clarified that the 95 clients at ISSH are strictly Department of Health and Welfare clients. **Ms. Britton** said that was correct.

Ms. Britton went on to say that in 1997 there were 112 clients at ISSH and 144 over the course of the year with admissions and discharges. In 2001, 110 clients were served and in 2004, there were only 94. She said the reason for this decline in population is that state of the art services for people with developmental disabilities is often found in their communities. These individuals can work in their community, go to school there and have treatment services delivered where they live. Over the years, treatment has moved away from the idea of putting these individuals in one large institution. She said that Medicaid has been a gateway for providing more community services and by and large the vast majority of clients are well served in the private sector in their communities.

Ms. Britton said that as they see the referrals diminish, ISSH is relicensed at the lower level.

The facility is now licensed to take 95 clients. Due to this decrease in occupancy, the department is proposing to:

- Convert 20 beds to serve the mentally ill for fiscal year 2009 using the Birch building;
- Convert 20 more beds to serve the mentally ill using the Aspen building in 2010; and
- Have 40 beds available for the mentally ill in fiscal year 2011.

Ms. Britton explained that the reason for the changing the campus include:

- The state needs beds for the mentally ill;
- New admissions at ISSH have both a disability and mental illness;
- New construction is more costly than a remodel of existing space;
    - $44/sq ft remodel vs. $404/sq ft construction of secure facility vs. $161/sq ft for quadplex;
- ISSH has adequate acreage;
- There is a high rate of injury for staff;
- Licensure as an ICFMR is challenging;
- ISSH census will and should continue to decline;
- Service costs at ISSH today are expensive:
    - $780/day vs. $235/day vs. $140/day.

The goals for the department's proposal are to:

- Improve safety for staff and clients;
- Create psychiatric beds for the mentally ill;
- Reduce cost per ISSH client;
- Reduce overall costs of care to the State for MI and DD populations.

Costs for the fiscal year 2009 regarding ISSH request are:

• Demolish old buildings	$268,000
• Construct 2 quadplexes (DD)	$2,200,000
• Remodel Birch Bldg. (MI)	$784,000
• Total	$3,252,000

Fiscal Year 2010 requests include:

• Construct 1 quadplex	$1,100,000
• Remodel Aspen Bldg.	$784,000
• Staff costs for Birch Bldg.	$1,300,000
• Operating costs for Birch Bldg.	$90,000
• Total	$3,274,000

Ms. Britton went on to discuss the timeline for these proposals.

July 2007 95 DD residents Work discharge plan (this is a plan to actually discharge patients to other treatment options)	**January 2008 Request** Birch remodel 2 Quadraplexes
July 2008 82 DD residents 10 vacant beds at Birch Remodel Birch Construct 2 quadplexes	**January 2009 request** Birch operating Aspen remodel 1 quadplex
July 2009 69 DD residents 20 MI patients (Birch) Remodel Aspen Construct 1 quadplex	**July 2010** +80 DD residents 20 MI patients (Birch) 20 MI patients (Aspen)
January 2010 request Aspen operating	

Ms. Britton explained that there are some challenges to the plan. Those include:

- Guardian preferences;
- Low reimbursement in private system;
- Restricted admission for DD clients for two years;
- Facility standards;
- Advocates;
- Criminal justice system.

Ms. Britton said that although many people do not think there should be facilities such as ISSH for those with developmental disabilities, she does not agree with that.

Representative Henbest asked for clarification of the role of guardians when the state is who is paying the bill and who actually makes decisions for care. **Mr. Luce** said that the Olmstead decision does not address this issue. He noted that there were two very low court decisions from Pennsylvania that dealt with this issue of whether the guardian has the ultimate say in treatment. He said his reading of those cases and the Idaho statutes seem to say that the guardian has the ability to say where their ward will be. **Mr. Baugh** said that in his opinion the Olmstead decision does not require a state to move someone whose guardian wants them in a particular facility. However he said that he does not think there is any body of law that says that a guardian can demand that their ward be housed in a state institution.

Representative Henbest asked whether their idea of dropping enrollment in ISSH by ten was realistic. **Ms. Britton** said she believed so but that they really need to focus on it. She added that the staff there is very committed to this idea that people need to live closer to their own homes and families. She said they have looked at restructuring their admission and discharge processes to make sure Medicaid is with them every step of the way so they know the clients and the resources that are available. **Ms. Britton** said ISSH will take these people back if necessary but the experience is that if someone receives treatment with medication and discharges from ISSH, with help from a crisis prevention team, they rarely return to ISSH.

Representative Henbest commented that heating and cooling costs for these older buildings are very expensive and said she would like to see the amount of money that would be saved if buildings are demolished and remodeled.

Senator Corder asked what the cost per day will be if this transition happens. **Ms. Britton** said they have not calculated that at this time. She said they need to consider funding because 75% will be federal Medicaid funding and there will be shared costs with the Division of Behavioral Health. **Ms. Britton** said the department is starting to leave positions vacant in anticipation of the change and that she sees significant reduction in costs for several years that could stop costs per day from going up to $1,000. **Senator Corder** said he struggles with the idea that this committee could make a decision on the facility without knowing what the cost will be when it is completed. In his opinion costs need to be lower if this is to be done. **Ms. Britton** said that if costs get to $1,000 per day, the population will be lower and that ISSH will not have a higher budget than today. She said they have to get to the threshold of discharges before worrying about this. She added that they will be sharing costs with other agencies for laundry, pharmacy and so on. **Ms. Castro** commented that this topic is scheduled for a ½ hour time slot on the JFAC budget hearing and that might explain more.

Senator Stegner voiced concern about the objective in terms of total beds for mental health in the long term. He said having 40 new beds available is helpful but his objective is to attempt to have an actual state mental health hospital in the Treasure Valley so that these patients are not required to be transferred to state hospital north or south. He thinks there needs to be 80 to 100 beds and asked whether this is being considered. He said the Treasure Valley needs to have access to state hospital beds and this could also allow the possibility of voluntary commitments to those facilities. **Ms. Kathleen Allen, Division of Behavioral Health** said they intentionally kept the initial proposal short on specifics due to the fact that they need to get a concept and then start to figure costs. She said it is difficult beyond two years to be very specific. She has looked at alternatives that would include existing buildings and some that would build new buildings. **Ms. Allyn** said there is thinking and planning beyond the three year time frame being discussed.

Ms. Allyn went on to discuss another proposal for a 300 bed Department of Correction (DOC) facility at the ISSH campus of which Health and Welfare will have 40 beds. She said that the people from WICHE toured the ISSH buildings and thought many of the buildings would be excellent as psychiatric treatment facilities. Concern was voiced about putting up perimeter

fencing.

Ms. Allyn explained that in calendar year 2007, involuntary commitments to the Department averaged about 73 per month through October. A few of these are considered extremely dangerous to others; about 25 clients fall into the "extremely dangerous to others" category.

If someone is found by a court to be extremely dangerous, Idaho law permits them to be housed in the mental health unit at the DOC maximum secure facility. That unit only has 12 beds and is almost always full. Apart from these 12 beds, there is no secure psychiatric facility in Idaho. There is also no out-of-state secure placement. Most of these people are currently housed at one of three state hospitals and a few are being treated in jail while others are being treated on an outpatient basis in the community.

Ms. Allyn said that once the DOC facility is constructed in about 4 to 6 years, there will be a secure facility to house these dangerous individuals and the use of the psychiatric treatment facilities on the ISSH campus can be broadened to include more typical psychiatric hospital clients.

Ms. Allyn addressed concerns about the use of state resources to develop another psychiatric hospital by saying that the state already provides significant resources for psychiatric hospitalization through community hospitalization programs. She noted that rates being paid to private community hospitals are sometimes double what would be paid at state hospitals.

She pointed out that most of the clients in community hospitals are from Regions 3 and 4 and said that creating additional hospital capacity in southwest Idaho would create less expensive state hospitalization in the communities. This additional capacity may also allow for some voluntary admissions which are currently not possible.

In response to a question from **Senator Lodge, Ms. Allyn** said there are 55 beds at State Hospital North and 130 beds at State Hospital South. These are divided between skilled nursing and an adolescent unit.. She noted that 41% of those committed to these facilities come from Regions 3 and 4 in the Treasure Valley.

Ms. Tanner spoke in support of the state hospital system. She said it is a place for people to go to when other treatment has failed and because costs are lower people can actually receive care and treatment longer.

The next agenda item were grant proposals for the regional community grant program from:

- Kootenai County, Regional Mental Health Board, Region 1;
- Family Health Services, Regional Mental Health Board, Region 5
- United Way of Treasure Valley/Ada County, Regional Mental Health Board, Region 4

Presenters from Kootenai County included Ms. Colleen Allison, Grant Administrator; Jack

Cotton, Region 1; Judge John Mitchell, Mental Health and Drug Abuse Court; Dr. Bill Miller and Ms. Claudia Miewald, Kootenai Medical Center; Captain Travis Chaney, Kootenai County Sheriff's Department and Kootenai County Commissioner Todd Tondee.

The request includes a one time development grant (to build a mental health building (split wing) for juveniles and adults) and a multi-year development grant for a program to assess services currently available and/or needed, and to devise a plan to funnel moneys for treatment and other determined needs for the mentally ill.

According to the presenters the most effective plan is one that could be a pilot program for the state of Idaho that would combine the two grant dollars into a single project and have both a building and a program to disburse dollars into assessed areas of need.

Being given the opportunity to do "the plan" in its entirety would address the problem of sustainability. These two proposals, according to Kootenai County, would give facts and financial information that all areas in government need in order to address the problem.

Senator Stegner commented that there could be a perception that such a facility would be a threat to the hospital because they currently provide services for psychiatric care in the area. He noted that Kootenai Medical Center is saying that is not the case and this is a partnership and a broadening of services for the area and for patients. **Ms. Miewald** agreed and said this program would allow them to support more people with appropriate levels of care. Many psychiatric holds do not need such intense levels of psychiatric care. Many times patients are refused treatment because the hospital facility is full.

Representative Henbest clarified that the request is for funding to build a facility on Kootenai Medical Center (KMC) campus and that the building be given to the KMC. She asked who would pay once someone was put in the facility. **Ms. Miewald** said that currently the county pays the hospital for care provided. It is their opinion that the new facility would cost about ½ as much so that could save the county a lot of money. **Ms. Allison** added that a final decision needs to be made regarding owning the building outright or leasing it for 99 years.

In response to a question from **Representative Henbest**, it was stated that costs per day for this type of a facility would be about $300 to $400. **Ms. Allison** said that early in the discussions the hospital agreed that a clinic in the area could run such a facility at lesser cost than the hospital. She said she would get firmer figures to prove this. **Commissioner Tondee** said that this facility will not require the same amount of care, detail or expertise in taking care of patients until they are stabilized. Hospital care is more expensive because of the type of care provided.

Senator Stegner said this proposal is exactly what he envisioned when this grant program was implemented. The legislature wanted to establish regional priorities for counties through collaborative efforts. In his opinion this is direction the state should be going.

Senator Stegner commented that their request for $2 million is the total amount that has been appropriated so far for all grants. He asked what the region's response would be if they were awarded a partial grant. He asked whether they could come up with part of the money themselves. **Ms. Allison** said the region is working together and it would be up to county commissioners, hospital administrators and the counties themselves to consider this in their budgets. She did say they have recognized the need and usually once that is recognized, solutions can be found.

Senator Stegner said that Region 2 has almost the exact same concept as this for the same exact purpose. He thinks it is great to see this regional cooperation in several areas. Region 2 has taken a different approach and has designated a portion of the new jail facility as a mental holding facility for this purpose.

Senator Stegner said it is his vision for each region in the state to have this capability and that asking each region to identify priorities and solutions will be the most successful route to take.

A complete copy of the Region 1 plan is available at the Legislative Services Office.

James Schroeder, Family Health Services in Twin Falls, Idaho presented a multi-year grant program proposal for Region V. He explained the current situation in the Magic Valley as follows:

- Limited access to mental health and substance abuse treatment
- Available services are fragmented among multiple agencies
- At risk children are being left behind and often end up in juvenile court and later transition to the adult justice system
- Money is being spent with limited results
- Overmedication occurs, especially in children
- Juvenile justice
    - Many with MH diagnoses and meds
    - Little continuity
    - High recurrence of repeat detentions

The goal of the project:

- Create Network
- Link agencies currently providing services
- Focus on children and their families
- Combine Services
- One delivery site for mental health outpatient services (psych, education)
- Connection between inpatient and outpatient
- "Medical Home" concept for these very at risk residents (linkage of substance abuse, mental health, medical, etc.)
- Connection between justice system and providers

Partners include:

- Family Health Services
- St. Luke's Magic Valley
- Southern Idaho Learning Center
- Region V
- Departments of Adult and Juvenile Corrections
- Fifth Judicial District Judges
    - Judge Barry Wood
    - Judge Richard Bevan
- Twin Falls County
- College of Southern Idaho

The project:

- Establish an outpatient facility with the following components:
    - Mental Health (individual, group, family)
    - Psychiatrists
    - Psychologists
    - Social Workers
    - Counselors
    - Substance Abuse
    - Counselors
    - Intensive Outpatient Program
    - Medical: pediatrician/family practice
    - Well child care
    - Acute needs
    - Education
    - Parenting
    - Coping skills
    - Other Social Services
    - PSR
    - Case Management
- Children and families are the focus
- Bilingual services
- Uninsured/Underinsured a major component, especially in adults
- Quality indicators
    - Evidence Based Medicine
    - Incarceration rates
    - Inpatient hospital stays
    - Unemployment
- Community Navigator Concept
    - Regular meetings with partners
    - Continue to expand group to other community providers
    - Patient-focused staffing meetings held regularly

- Community Network Meetings
  - Continually adjusting to community needs

Mr. Schroeder explained that funding and budget will be included in their grant application. He said they are continuing to look for federal assistance as well as state assistance.
The actual request is as follows:

- Year 1: $1,545,000
  Network income: $1,000,000
  Grant contribution: $ 545,000

- Year 2: $1,775,000
  Network income: $1,375,135
  Grant contribution: $ 400,000

- Year 3: $1,818,000
  Network income: $1,628,742
  Grant contribution: $ 190,000

Mr. Schroeder said that grant funds would provide Electronic Medical Records (EMR) start-up, licences, software, hardware and network costs. These funds would also help offset the cost of case managers and navigators and they would help with indigent costs.

The payor mix would be:

- Pediatric Program (estimates):
  - 70% covered by Medicaid or other insurance
  - 30% not covered
- Adult Program (actual):
  - 22% covered by private insurance
  - 15% covered by Medicaid/Medicare
  - 63% uninsured

Going forward, **Mr. Schroeder** explained that the network plans include combining the current provider services into one location and to move all psychiatrists between St. Luke's and FHS to an outpatient/inpatient model versus the current outpatient or inpatient. Applications have been sent to the state for intensive outpatient and PSR services.

He noted that they are currently converting their administrative offices in a mental health treatment facility and will expand that as they can. The hope is that people will be able to move into this facility by late spring 2008. Without the grant or federal assistance that is being proposed, they will have to scale back case managers and the like and implement them as funds become available. **Mr. Schroeder** said this is a very unique opportunity for communities and providers to come together to solve a serious problem.

Senator Stegner clarified that this original concept focused on a single point of access but this proposal initially focused on a new facility as part of another grant in Twin Falls. He asked how much money was requested for this initial grant. **Mr. Schroeder** said he was not sure of the exact amount they applied for. Estimated building costs were around $900,000 and they asked for a significant portion of that. **Senator Stegner** asked whether that was envisioned to be a regional facility. **Mr. Schroeder** said the proposal was to start the main facility concept for the region in Twin Falls with acknowledgment that branches would be necessary in other communities to make this work.

In response to more comments from **Senator Stegner, Mr. Schroeder** agreed that they do have a strong commitment for this from the community and they are moving forward with federal grants that will allow them to get started. He said they are relocating services currently being provided into one location. Expansion of the services provided and to broaden the concept of the clinic is where they will need additional funding.

Mr. Schroeder said the court system has specifically approached them to provide this service because the courts are not overly satisfied with the current system. He added that the overall patient population in mental health programs in Twin Falls is about 1,200. Ninety percent of those have a dual diagnosis with substance abuse. This shows that there is a huge need just among current patients for more treatment facilities. Adding single diagnosis and the medical side of substance abuse, the need is significant and will be a serious funding need.

Representative Henbest asked for clarification of their vision of this project. **Mr. Schroeder** reiterated that the plan was to establish a centralized facility for treatment and that it would provide more comprehensive service. He said even it they receive no funding, they will continue to try this approach.

Representative Henbest asked whether any of the community partners are in a position to help with funding. **Mr. Schroeder** said that St. Lukes and Family Health Services are the only two partners in a position to do this currently.

Senator Lodge asked how far along they are in terms of start-up for sharing information to develop an EMR system. In her opinion this would allow for great cost savings in the long run. **Mr. Schroeder** said the health center has not been able to implement an EMR in their facilities. He said St. Lukes is the lead agency in that regard and they have the infrastructure and IT support built in. He said research has been done on how to share that information.

Mr. John Key, St. Lukes commented that there is a definite need in this arena. In his opinion this Magic Valley partnership is one of the most unique he has ever seen. He said financial arrangements already exist to work with valley health services and these services will continue to grow.

Mr. Key said, regarding EMR, that they have around 50 physicians who share information for a

community health record in Twin Falls and there is a roll out plan that will increase that number to 80 over the next twelve months. This has been recognized nationally.

He went on to note the fact that their relationship with the Department of Health and Welfare will allow them to bring more efficiency and effectiveness to the program.

Ada County Commissioner Paul Woods representing the Board of Ada County Commissioners introduced the Region IV Substance Abuse and Mental Health Crisis Center proposal for $900,000. He explained that a public-private partnership has now raised the capital dollars necessary to build a regional substance abuse and mental health center located in Ada County to provide services citizens of Ada, Boise, Elmore and Valley counties. The only remaining task is the operational parameters and financial structure of the center.

Ada County is offering to serve as the administrator of the regional substance abuse and mental health crisis center contingent upon ongoing financial support of all the partners.

He went on to say that for the past decade, the region has recognized that there is no current medical facility to treat non-incarcerated low-income individuals who suffer from either drug or alcohol withdrawal syndrome or voluntary mental health service needs. He said the costs to the community for not intervening are expensive hospital charges or even incarceration. Medical stabilization is a necessary first step before effective treatment can occur and abstinence can be attained.

Commissioner Woods said that according to the BSU Center for Health Policy, 17,400 people in the Treasure Valley struggle with at least one chemical addiction. Private medical centers turn away 335 people monthly who are voluntarily seeking treatment due to lack of resources.

The project will be located on a 1.4 acre site in Boise with an 8,500 square foot facility owned by Boise City/Ada County Housing Authority. Ada County is proposing to administer the operations of that facility under a contract with a private provider.

The anticipated scope of the project will include:

- a sobering station that will act as a safe environment for people whose impairment due to alcohol intoxication is judged to put them and the greater community at risk;
- a 12 bed detoxification facility whose average length of stay will be 3 to 5 days to stabilize chronic addict's/alcoholic's physical condition and to afford medically monitored care during the process; and
- an 8 bed, sub-acute psychiatric crisis stabilization unit of similar duration designed to address psychiatric instability and divert expensive, acute psychiatric hospitalization.

The center will unify the three above services into an integrative healing facility that will be a single point of access for persons in psychiatrically or medically compromised conditions due to mental health or substance abuse crises. The facility will operate 24 hours a day, 7 days per week

and will be fully staffed.

Anticipated Impact

- The center will service an estimated 1,000 patients annually, not counting sobering;
- Indirect savings include enhancing the qualify of life of impacted patients, the families and their neighbors in the Treasure Valley;
- Associated reduction in crime rates and an improvement in public safety;
- Reduction in the incidence of incarceration and use of the penal system; and
- The center will serve as the statewide model for public/private partnership to enhance the continuum of care and the delivery of critical care services to the community.

Senator Stegner asked whether this proposal was identical to a grant proposal made earlier this year that had been denied. He said he thought that proposal was also interested in one time construction money. **Commissioner Woods** said this proposal is in many ways identical to that prior proposal but there will not be an additional request for capital funding at this time. It is their feeling that if they can secure operating dollars, it will be easier to secure capital campaign.

Senator Stegner asked how they plan to develop further relationships with the other partners and where they fit in. **Mr. Frank Eld, Valley County Commissioner and Mental Health Board member** spoke in support of the idea and said that rural counties could not come up with this type of facility. He said his county has not been involved in day to day work being done on this but that they want to be involved in the development of protocols. Valley County is two hours away from the facility and they just want to develop a better place to put these people rather than rural jails or transporting them to Ada County to be placed directly in a mental health type facility as a mental hold. They view this proposal as a viable option to what is done today. He said they do not know all the details but will be at the table as it is developed. **Senator Stegner** asked what the participation level of Valley County will be cost wise. **Mr. Eld** said it would be on a fee basis. And that they are already paying considerable money for mental holds through indigent funds.

Ms. Connie Cruser, Elmore County Commissioner and Mental Health Board member said that Elmore County is very excited to have access to a program like this. Elmore County has the same problem with transporting as Valley County. She added that this would also be paid on a fee basis.

Representative Henbest commented that in listening to the last two presentations the idea of hubs and satellites in regions is something that is wanted and needed.

Mr. Matt Beebe, Canyon County Commissioner said that Canyon County is conceptually on board with this idea. Canyon County is highly impacted by this issue. **Senator Stegner** noted that Canyon county is part of Region III but that he does not see the state objecting to a multi-regional effort. **Senator Stegner** asked whether Canyon County would have an issue with the facility being located in Ada County. **Mr. Beebe** said not really because many facilities they send

patients to, including Intermountain Hospital, are located in Ada County. He said the Treasure Valley really needs such facilities to provide these services regardless of where they are located.

Mr. Bob Banks, United Way of the Treasure Valley commented that this has been a tremendous community effort. He said this is a great opportunity and encouraged everyone to stay with it and work out the final details. He said he has made a personal commitment to make sure that other counties interests are heard and represented and that this responds to their needs.

Senator Stegner asked whether there is a fear that this would jeopardize Franklin House. **Mr. Ted Burgess, St. Alphonsus Regional Medical Center** said that they currently operate Franklin House under the jurisdiction of the Department of Health and Welfare. He said this project actually proposes to save Franklin House which is slated for closure as early as June 30, 2008. The budget appropriation this project is requesting will secure the ongoing relocation of Franklin House services.

Mr. Burgess explained that most of the population at Franklin House have a cooccurring issue; either a psychiatric crisis compelled by recent substance use or substance use that has been engaged as a maladaptive coping strategy to try to manage their mental illness.

He said not only will this save Franklin House but it will more comprehensively treat this very complicated population and help stop the revolving door process.

Ms. Kathleen Allyn was introduced to give an update on the Assertive Community Treatment (ACT) teams and Mental Health Courts. This complete presentation is available at the Legislative Services Office.

Ms. Allyn explained that ACT teams were developed in the early 1970's to prevent repeated hospitalizations for people with severe mental illness. In the 1990s NAMI endorsed ACT and made it a national priority. ACT also has become part of best practice standards and is one of six toolkits implemented as part of the National Evidence-Based Practices Project. Now, more than 35 states have implemented ACT to various degrees.

Among the characteristics of ACT Teams -- services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services clients need to achieve their goals. The team is directed by a team leader and a psychiatrist and includes a sufficient number of staff from the core mental health disciplines, at least one peer specialist, and a program/administrative support staff who work in shifts to cover 24 hours per day, seven days a week to provide intensive services. The ACT Team is mobile and delivers services in community locations to enable each client to live in their own residence and work in community jobs rather than expecting the client to come to the program. The model also provides that each ACT team has the capacity to provide a minimum staff-to-client ratio of at least one full-time equivalent staff person for every 10 clients not including the psychiatrist and program assistant. This is the model for urban areas.

For rural areas like most of Idaho, the standards are less well defined with models suggesting staffing ratios of 7 to 10 clients per staff. A position added to the original ACT team model in the late 80s is that of substance abuse specialist. This was done in recognition of the fact that many people with serious mental illness also have substance use disorders.

Ms. Allyn continued that currently, the Department of Health and Welfare has ACT Teams in each of the 7 Health and Welfare Regions. **Ms. Allyn** provided a chart showing the composition of the Department's ACT teams. The description of staff composition is based on a fidelity model proposed by the NAMI ACT Technical Assistance Center so you can see how the teams around the state compare. This chart is available from the Legislative Services Office.

Ms. Allyn said that we need to continue to build these teams. Two positions in particular that are under-represented are the substance abuse specialist and the peer specialist. The substance abuse specialist is just that – it is someone who is able to provide basic substance abuse treatment. She has asked the Regions to get this position staffed as soon as reasonably possible. A peer specialist is a person who is or has been a recipient of mental health services for severe and persistent mental illness. Because of life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Idaho currently does not have many people who have been trained as peer specialists. The Department has obtained technical assistance from the federal government and is working with state Office of Consumer Affairs to sponsor the training needed to develop this resource.

Ms. Allyn went on to say that few states have the number of mental health courts per capita that Idaho has. Few states staff mental health courts exclusively with ACT Teams. Based on national statistics, nearly 8 percent or one million -- of nearly 13 million detentions each year in U.S. jails are people with mental illness. In a comparable year, there were about 650,000 adult admissions with severe mental illness to any type of psychiatric hospital. Put another way, as a group, people with severe mental illness are one-and-a-half times more likely to be jailed than hospitalized.

By partnering with the mental health courts, we can work to reduce the number of people caught up in the criminal justice system because they are mentally ill. We can close the revolving door that some of the chronically mentally ill are caught in.

Her presentation includes a graph showing the mental health court capacity and the actual number of court clients being seen by the court based on judicial districts. In most cases these courts are not up to capacity. **Senator Stegner** said this information will be disturbing to the legislature. He asked for some of the reasons for this. **Ms. Tracy Sessions** who has been an ACT team coordinator said there are not really any good reasons. She said some areas say judges have asked them to go slowly but that is not an acceptable answer. In a meeting that was held last week, **Ms. Allyn** told staff to focus on the mental health court capacity. She said they were given clear direction and expectations. She said the plan is to work with the regions to bring the mental health courts up to 85% capacity within 90 days and up to 95% within 120 days. **Ms. Allyn** said

there is too much resource and this is too important of an effort to not utilize this to its fullest.

Ms. Allyn went on to discuss the situation. She said that ACT has been found to be effective in reducing the use and number of days in the hospital and moderately effective in improving symptoms. However, ACT has not been consistently effective in reducing arrests/jail time or improving social adjustment, substance abuse, and quality of life. Based on the research to date, ACT alone is not enough to keep people with severe mental illness out of jail. Extra interventions that specifically target reduction of criminal behavior need to be added to the existing mix of ACT services. This recognition of the limitations of ACT with the criminal justice population has led to specialized ACT teams that shift the focus from just preventing hospitalizations to preventing jail detention and recidivism for people with severe mental illness who are involved in the justice system. The name "forensic" ACT or FACT is the emerging name for these hybrid teams. She said this is what Idaho has been doing; making changes to the standard ACT model in an attempt to better serve the mental health court clients or stretch resources.

The problem with the FACT concept is that there is little standardization of program practices and staffing and no clearly specified clinical model for FACT, especially with respect to criminal behavior. As a result, the evidence about the effectiveness of FACT in reducing arrests and keeping people out of jail is inconsistent because not much data has been collected.

Ms. Allyn added that there are also inherent philosophical conflicts in the pairing of mental health clinicians with the courts and law enforcement. A clinician on an ACT or FACT Team must successfully interface with the criminal justice system which has the expectation that the FACT team serves as an extension of law enforcement. This means the clinician must reconcile the sometimes conflicting role of law enforcement as protector of the public safety with the role of mental health professional as a promoter of consumer recovery.

Getting back to mental health court capacity, one of the conflicts we see is a difference of opinion on who should be admitted to the mental health court program. Clinicians see the decision as solely a clinical one; court personnel believe other factors, in addition to clinical factors, should be considered.

Ms. Allyn stated that one of the problems is that there is insufficient data to support either position. In her opinion, Idaho is in a unique position to resolve some of the current issues relating to ACT and FACT teams. Working with the courts, she said there is a need to proceed cautiously in diverting from the ACT model and to do it in a measured and evaluated way. This is going to require a more consistent approach than the Department is currently taking and require proposing changes to the ACT model that test identified specific interventions focused on reductions in criminal behavior. We have the additional challenge of operating in rural and frontier areas that require modifications to the ACT model to meet the needs of areas that can't support current ACT models. We are also working on developing the data gathering processes to be able to evaluate the efficacy of our efforts.

Even in the absence of hard data, there are approaches which have shown promise in reducing recidivism rates. These include peer support and specialized cognitive behavioral therapies. Dual diagnosis capability is another element that seems to be needed for clients in the criminal justice system. There also needs to be the capability to assess for and work with developmental disabilities in clients.

Ms. Allyn stated that there are more trauma issues with the criminal justice population and that this population has more difficulty finding housing once they are out. She added that more effective ways to deal with clients who have Axis II or personality disorder diagnoses need to be found.

She said the challenge is to determine which approaches will contribute to the development of an effective model for FACT that incorporates specific interventions that focus on the reduction of criminal behavior and recidivism.

Ms. Allyn thanked the Legislature for the support provided to this effort. She said the Department is committed to continue this work with the courts and law enforcement toward the recovery of people with severe mental illness who now revolve in and out of the criminal justice system.

Senator Stegner asked whether the 85% for the mental health court is a recognized target. **Ms. Session** said that was just **Ms. Allyn's** target number chosen to get them closer to 100%. **Senator Stegner** asked how the courts feel about this. **Ms. Norma Jaeger, Idaho Supreme Court,** said judges are eager to see these capacities reached. Once reached there will actually be additional clients that judges want to see in these courts. She commended the Department for all the efforts being made to move the system along. Identifying challenges to be overcome is helping the system come to grips with cooccurring mental and substance abuse disorders. It is important to overcome the perception that if substance abuse is resolved mental illness will go away. The proper issue is how to deal with the mental health symptomology and reduce it to see whether it is caused by substance abuse or if it is preexisting.

Representative Henbest suggested looking at region 7 and why that is working and sharing that with those that are not using the courts to capacity. She said another question is who gets access.

Ms. Tanner said she has been involved in mental health courts in Region 7 and does not want them to take Access 2 patients because there are already many others that are not getting treatment. She said we need to treat those that we know how to treat.

Mr. Baugh commented that some of this information represents a decreased focus on the mentally ill that have not committed crimes and cautioned taking resources away from that group to serve the other part of the mentally ill population that has committed crimes.

Ms. Castro said that there is a minimum of 10 people for every act team that would be

interacting with the mental health court clients. These teams are not funded or budgeted together with the mental health courts. This means the mental health court capacity has been increased but there has not necessarily been an increase in ACT teams capacity. This puts them in a difficult position of trying to manage the noncriminal justice population that need service by ACT teams. **Senator Stegner** said it was exactly that point that he was hoping to address by the review of ACT teams for this committee. In his opinion there will be a political challenge in terms of convincing JFAC to increase the appropriation for ACT teams if the courts are not at capacity. **Ms. Castro** commented that there should be a differentiation between mental health court capacity and ACT team mental health court capacity so that JFAC can see the difference.

Ms. Sessions commented that as the state moves forward with the new commitment law, ACT teams will become even more important and valuable. She said she would hate to see anything that would diminish that capacity for noncriminal clients that need mental health treatment.

The committee moved on to discuss draft legislation #EBM139 from earlier in the day. The subcommittee had directed staff to work during the day with Co-Ad and the Department of Health and Welfare to address concerns that had been raised. After discussion of the agreed upon revisions, **Representative Henbest** moved that the subcommittee submit EBM139 with the revised language to the Health Care Task Force to be part of their recommendations to the Legislature. **Senator Lodge** and the motion carried on voice vote.

Senator Corder moved that draft legislation #EBM134 be forwarded to the Health Care Task Force as well. **Senator Lodge** seconded and that motion carried by voice vote.

Representative Henbest asked whether it would be appropriate to make recommendations for the building adaptations for ISSH to the Health Care Task Force. **Ms. Allyn** said the decision unit for that is with the Governor and there is indication that it is being received favorably. **Mr. Woody Richards representing Intermountain Hospital** spoke that he would like to discuss other options for this before a final decision is made.

Senator Stegner said he would be in favor of this subcommittee deferring until the WICHE report is complete before making any recommendations. If the governor gives approval, the legislature could move forward. **Representative Henbest** added that germane committees will make recommendations to legislature on this matter as well.

The meeting was adjourned at 5:30 p.m.