

# Idaho

## UNIFORM APPLICATION FY 2010 - STATE PLAN

### COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

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Center for Mental Health Services  
Division of State and Community Systems Development

## **Introduction:**

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

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

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

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Idaho

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# Idaho

## Executive Summary

Please respond by writing an Executive Summary of your current year's application.

## EXECUTIVE SUMMARY

Idaho's public Community Mental Health Services are administered by the Department of Health and Welfare in the Division of Behavioral Health Services. Services are delivered through seven geographically defined regional programs. Regional community mental health centers provide adult and children's mental health service. State-level programs provide statewide coordination and technical assistance to regional service programs.

The Idaho Community Mental Health Block Grant Application is a one-year plan (FFY 2010) for both children's and adult mental health services. The statewide mental health system vision and program priorities which guide the Plan have been developed by the Mental Health Planning Council and the children's and adult mental health programs. The Planning Council's Annual Report to the Governor (July 2009) is also an important source of direction for the FFY 2010 Plan.

The children's program plan for FFY 2010 continues to focus on transformation to the development a comprehensive system of care among child-serving agencies. This focus is consistent with the Systems of Care approach to move the entire children's mental health service system toward family-centered, community-based, and interagency collaboration.

A major emphasis of the adult plan is system transformation in order to create a comprehensive, integrated, outcome driven, consumer and family guided system of care for persons with serious mental illness. Maintaining and integrating funding for community mental health services, and consumer and family empowerment are also priority areas of the adult plan, as well as an emphasis of the themes of (a) accountability, (b) better integration of treatment for substance abuse, and (c) the vision and hope of recovery.

Both plans address efforts to improve access to mental health services in a state with large rural/frontier areas and growing population centers, and the development of information systems and outcomes measures for improved accountability and continuous quality improvement. Additionally, the plan will address efforts toward general health and wellness of consumers and families that utilize the public mental health system.

## **Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS**

FISCAL YEAR 2010

I hereby certify that Idaho agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

### **Section 1911:**

Subject to Section 1916, the State<sup>1</sup> will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

### **Section 1912**

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

### **Section 1913:**

(a)(1)(C) In the case for a grant for fiscal year 2010, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

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<sup>21</sup>. The term State shall hereafter be understood to include Territories.

- (A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

**Section 1914:**

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

- (A) the principle State agencies with respect to:
  - (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
  - (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
- (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
- (C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
- (D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

- (A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

**Section 1915:**

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

**Section 1916:**

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

**Section 1941:**

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

**Section 1942:**

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

- (1) make copies of the reports and audits described in this section available for public inspection within the State; and
- (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

**Section 1943:**

- (a) The State will:
  - (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
  - (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
  - (2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
  - (3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section
  
- (b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

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Richard M. Armstrong, Director  
XXXXXXXX

Date

## CERTIFICATIONS

### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
  - (1) The dangers of drug abuse in the workplace;
  - (2) The grantee's policy of maintaining a drug-free workplace;
  - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
  - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management  
 Office of Grants Management  
 Office of the Assistant Secretary for Management and Budget  
 Department of Health and Human Services  
 200 Independence Avenue, S.W., Room 517-D  
 Washington, D.C. 20201

### 3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

### 4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

**5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director	
APPLICANT ORGANIZATION Idaho Department of Health and Welfare		DATE SUBMITTED

## DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB  
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352  
(See reverse for public burden disclosure.)

<b>1. Type of Federal Action:</b>  <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<b>2. Status of Federal Action</b>  <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	<b>3. Report Type:</b>  <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change  <b>For Material Change Only:</b> Year _____ Quarter _____  date of last report _____
<b>4. Name and Address of Reporting Entity:</b>  <div style="display: flex; justify-content: space-between;"> <span>Prime</span> <span>Subawardee</span> </div> <div style="margin-left: 150px;">Tier _____, if known:</div>  Congressional District, if known: _____		<b>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b>    Congressional District, if known: _____
<b>6. Federal Department/Agency:</b>    _____	<b>7. Federal Program Name/Description:</b>    _____  CFDA Number, if applicable: _____	
<b>8. Federal Action Number, if known:</b>   _____	<b>9. Award Amount, if known:</b>  \$ _____	
<b>10. a. Name and Address of Lobbying Entity</b> <i>(if individual, last name, first name, MI):</i>    _____	<b>b. Individuals Performing Services</b> <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i>    _____	
<b>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</b>	Signature: _____  Print Name: _____  Title: _____  Telephone No.: _____ Date: _____	
<b>Federal Use Only:</b>		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

## INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.  
  
(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

**ASSURANCES - NON-CONSTRUCTION PROGRAMS**

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.**

**Note:** Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age;
- (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director	
APPLICANT ORGANIZATION Idaho Department of Health and Welfare		DATE SUBMITTED

# Idaho

## Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

Public comment and input into the Community Mental Health Block Grant Plan is gathered in a number of ways. During plan development, Division of Behavioral Health program managers are asked to submit recommendation and goals to the Plan. This year the State Mental Health Planning Council spent considerable time developing the Report to the Governor. The Planning Council is also invited to submit goals to the Plan. The Council reviews and comments on the draft Plan during their August meeting. Planning Council members are also members of local Mental Health Boards and can take issues to the Boards for comment. A hard or electronic copy of the Plan is distributed to the Planning Council, to the Regional Mental Health Programs and to the Mental Health Board members and is available to any member of the public on request. The Community Mental Health Block Grant Plan on its internet site for public comment throughout the year.

Additionally, the Department utilizes the Web-BGAS to gather public comment. The website and login information is made available to the Planning Council members to make comment. It is also posted on the Department's website for the general public comment. This will allow any citizen in Idaho the opportunity to review and comment on the plan.

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

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

### Data Reported by:

State FY   X  

Federal FY \_\_\_\_\_

### State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2008	Estimate/Actual FY 2009
<u>\$538,391</u>	<u>\$14,662,700</u>	<u>\$7,267,500</u>

### Waiver of Children's Mental Health Services

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

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

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

#### MOE Exclusion

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

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

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

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

#### MOE information reported by:

State FY   X  

Federal FY \_\_\_\_\_

#### State Expenditures for Mental Health Services

Actual FY 2007	Actual FY 2008	Actual/Estimate FY 2009
<u>\$29,859,900</u>	<u>\$30,935,028</u>	<u>\$23,293,500</u>

## **MOE Shortfalls**

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

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

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

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

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

**TABLE 1.****List of Planning Council Members**

<b>Name</b>	<b>Type of Membership</b>	<b>Agency or Organization Represented</b>	<b>Address, Phone and Fax</b>	<b>Email(If available)</b>
Block, Sharon	State Employees	Other	1093 Lakewood Dr Twin Falls, ID 83301 PH:208.734.6360 FAX:	sblock@house.idaho.gov
Calder, Stan	Consumers/Survivors/Ex-patients(C/S/X)	Region 1 Consumers	1785 Windsor Coeur D'Alene, ID 83815 PH:208.666.1638 FAX:	stanleysteamer51@yahoo.com
Clark, Shirley	Family Members of adults with SMI	Region V MH Board	Star Route Box 20 Albion, ID 83311 PH:208-673-5332 FAX:	
Ekhoff, Martha	Consumers/Survivors/Ex-patients(C/S/X)	Office of Consumer Affairs	1607 W. Jefferson St Boise, ID 83702 PH:208.336.5533.340 FAX:	mekhoff@mtnstatesgroup.org
Garrett, Kathie	Others(not state employees or providers)	Idaho Council on Suicide Prevention	2281 W Testle Dr Meridian, ID 83646 PH:208.344.5838 FAX:	kgarrettidaho@aol.com
Guidry, Patricia	State Employees	Medicaid	3232 Elder Street Boise, ID 83720 PH:208-364-1813 FAX:	guidryp@dhw.idaho.gov

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Hamilton, Gary	State Employees	Vocational Rehabilitation	1010 Ironwood Dr. Suite 101 Coeur d'Alene, ID 83814 PH:208.769.1441 FAX:	gary.hamilton@vr.idaho.gov
Harger, Bill	Family Members of adults with SMI	Region I NAMI	E-4741 Fernan Lake Rd Coeur D Alene, ID 83814 PH:208-664-8485 FAX:	bharger@imbris.com
Hatzenbuehler, Ph.D., Linda	State Employees	Education	College of Health Related Professions ISU, Box 8090 - CD 186 Pocatello, ID PH:208-282-2762 FAX:	hatzlind@isu.edu
Hinman, Michael	Others(not state employees or providers)	Region VII MH Advisory Board	482 Constitution Way #101 Idaho, ID 83402 PH:208-524-3660 FAX:	mikehinman@idaholegalaid.org
Hirsch, Pamala	Providers	Native American Community	Nez Perce Tribe - Nimiipuu Health PO Box 367 Lapwai, ID 83540 PH:208-843-2391 FAX:	pamh@nimiipuu.org
Huber, Rick	Consumers/Survivors/Ex-patients(C/S/X)	Region V Consumers	309 Pashermakay Court#7 Rupert, ID 83350 PH:208-436-1841 FAX:	rick2727272000@yahoo.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Johann, Linda	Family Members of Children with SED	Region I Parents	11655 W. Manitiba Court Post Falls,ID 83854 PH:208-769-1432 FAX:	ljohann@prodigy.net
Kauffman, Barbara	Consumers/Survivors/Ex-patients(C/S/X)	Region II Consumers	3336 16th Street Lewiston,ID 83501 PH:208-743-4708 FAX:	
Koltres, MD, Lisa	Providers	Family Physicians	3309 Hazelwood Circle Caldwell,ID 83605 PH:208.453.9470 FAX:	lkoltres@msn.com
Lymberopoulos, Christina	Family Members of Children with SED	Region II Parents	13630 Fremont Ave. Orofino,ID 83544 PH:208-476-9036 FAX:	chris@idahorealestaters.com
McCurdy, Cynthia	Family Members of Children with SED	Region VII	2546 W. 6300 Street Rexburg,ID 83440 PH:208-356-4204 FAX:	elitecyn@hotmail.com
Moss, Judge Brent	Others(not state employees or providers)	Madison County Court	PO Box 389 Rexburg,ID 83440 PH:208.356.6880 FAX:	bmoss@co.madison.id.us

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Perrien, Mary	State Employees	Criminal Justice	1299 N Orchard St Ste 110 Boise, ID 83706 PH:208.658.2144 FAX:	mperrien@idoc.idaho.gov
Santillan, Courtney	Others(not state employees or providers)	Advocate-Idaho Federation of Families for CMH	1509 S Robert St. Ste 101 Boise, ID 83705 PH:208-433-8845 FAX:208-443-8337	clester@idahofederation.org
Stayner, Micheal	Others(not state employees or providers)	Region VI MH Advisory Board	911 N. 7th Avenue Pocatello, ID 83206 PH:208-234-6141 FAX:	mstayner@pocatello.us
Tiffany, Rose Marie	Family Members of adults with SMI	Region 1 MH Advisory Board	13191 E Rosewood Dr St Maries, ID 83861 PH:208.689.3603 FAX:	tiffany83861@yahoo.com
Wherry-Toryanski, Kim	Others(not state employees or providers)	Aging	3380 Americana Terrace Ste. 120 Boise, ID 83706 PH:208-334-3833 FAX:	ktoryanski@aging.idaho.gov
Whiting, Lynne	Family Members of Children with SED	Region VII Parent	592 Tendoy Dr Idaho Falls, ID 83401 PH:208.403.9140 FAX:	llynniem57@hotmail.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Williams, Julie	State Employees	Housing	PO Box 7899 Boise, ID 83707 PH:208.331.4758 FAX:	juliew@ihfa.org
Wolf, Teresa	Others(not state employees or providers)	Region II MH Advisory Board	PO BOX 896 Lewiston, ID 83501 PH:208.799.3095 FAX:	teresawolf@co.nezperce.id.us
Wolfe-Stiles, Corinna	Providers	County Social Services	4477 Emerald Ste B100 Boise, ID 83706 PH:208-336-5353 X19 FAX:	cokinnaw@cableone.net

**TABLE 2. Planning Council Composition by Type of Member**

Type of Membership	Number	Percentage of Total Membership
<b>TOTAL MEMBERSHIP</b>	27	
Consumers/Survivors/Ex-patients(C/S/X)	4	
Family Members of Children with SED	4	
Family Members of adults with SMI	3	
Vacancies(C/S/X and Family Members)	4	
Others(not state employees or providers)	7	
<b>TOTAL C/S/X, Family Members and Others</b>	18	66.67%
State Employees	6	
Providers	3	
Vacancies	0	
<b>TOTAL State Employees and Providers</b>	9	33.33%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

# Idaho

## Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification  
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,  
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.

the role of the Planning Council in improving mental health services within the State.

<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

### **State Planning Council Charge, Role and Activities**

The Idaho State Planning Council on Mental Health oversees the development of both P.L. 102-321 Adult and Children's Plans. The Council has the required membership with less than 50% of the members being state employees and/or service providers. Council members include representatives from the areas of housing, law enforcement, education, juvenile justice, vocational rehabilitation, social services, mental health, Medicaid, consumers, and families of both adult and child consumers. The Hispanic and Native American communities are also represented on the Council.

From a children's mental health perspective, the Council strives for participation from families and to identify family members, normally parents, from each region of the state. These are families of children with an SED who have received or are currently receiving services. The services do not necessarily need to be received from the Department of Health and Welfare. Additionally, the Council includes youth consumer representation.

The State Planning Council on Mental Health is established by Governor's Executive Order 98-06. It prides itself on being very active and participatory. Consumers, family members, and advocates far outnumber state employees and providers in attendance at meetings. Council members are well informed on the issues facing the public mental health system. Council members and the mental health program have a long history of fostering a good working relationship characterized by mutual respect. Both adult and children's mental health planning issues are addressed by the Council.

In the 2006 Legislative Session, the Legislature codified the Idaho State Planning Council on Mental Health by approving SB1389. They amended the Regional Mental Health Services Act bill language is identified below:

39-3125. STATE PLANNING COUNCIL ON MENTAL HEALTH. (1) A state planning council shall be established to serve as an advocate for adults with a severe mental illness and for seriously emotionally disturbed children and youth; to advise the state mental health authority on issues of concern, policies and programs and provide guidance to the mental health authority in the development and implementation of the state mental health systems plan; to monitor and evaluate the allocation and adequacy of mental health services within the state on an ongoing basis; to ensure that individuals with severe mental illness and serious emotional disturbances have access to treatment, prevention and rehabilitation services including those services that go beyond the traditional mental health system; to serve as a vehicle for intra-agency and interagency policy and program development; and to present to the governor and the legislature by June 30 of each year a report on the council's achievements and the impact on the quality of life that mental health services has on citizens of the state.

(2) The planning council shall be appointed by the governor and be comprised of no less than fifty percent (50%) family members and consumers with mental illness. Membership shall also reflect to the extent possible the collective demographic characteristics of Idaho's citizens. The planning council membership shall strive to include representation from consumers, families of adult individuals with severe mental illness; families of children or youth with serious emotional disturbance; principal state agencies including the judicial

branch with respect to mental health, education, vocational rehabilitation, criminal justice, title XIX of the social security act and other entitlement programs; public and private entities concerned with the need, planning, operation, funding and use of mental health services, and related support services; and the regional mental health board in each department of health and welfare region as provided for in section 39-3130, Idaho Code. The planning council may include members of the legislature and the state judiciary.

(3) The planning council members will serve a term of two (2) years or at the pleasure of the governor, provided however, that of the members first appointed, one-half (1/2) of the appointments shall be for a term of one (1) year and one-half (1/2) of the appointments shall be for a term of two (2) years. The governor will appoint a chair and a vice-chair whose terms will be two (2) years.

(4) The council may establish subcommittees at its discretion.

The State Planning Council on Mental Health meets at least twice a year for two days each session. The Council's Executive Committee meets more frequently (if necessary) by conference call to address emergent business and to plan upcoming meetings.

The Planning Council participates in setting Mental Health Block Grant Plan goals, reviews and comments on the draft Plan and Implementation Report, and reports to the Governor on the adequacy of mental health services in the state. The Council participates in determination of Mental Health service system strengths, needs and priorities. During the legislative session, the Council sponsors a legislative breakfast which provides an opportunity to spotlight state mental health services system progress, needs and initiatives.

The Council maintains four standing subcommittees. The Legislative/Advocacy & Education subcommittee, the Data/Performance Indicators & Outcomes subcommittee, the Transformation subcommittee and the Children's Mental Health subcommittee, which assures more in-depth review of children's issues including monitoring of the children's mental health system.

# Idaho

## Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

## **Overview of State System**

The Idaho Department of Health and Welfare is an umbrella human services agency reporting directly to the Governor, and includes the Divisions of Health, Information and Technology Services, Enterprise Information Systems, Human Resources, Family and Community Services, Medicaid, Welfare, Management Services, and the Division of Behavioral Health. Departmental services are delivered statewide through seven Health and Welfare service regions. All Community Mental Health Centers in Idaho are state-operated programs and facilities. All such services are provided through this regional system with each region comprising a specific geographic area.

The Division of Behavioral Health is one of several Divisions in the Department of Health and Welfare. The Division of Behavioral Health includes the Adult and Children's Mental Health programs, the Substance Use Disorders program, and the two state operated psychiatric hospitals. In January 2009, the Data Unit was established to provide data expertise and support to the Division. In June 2009, a Program Manager for a new Quality Assurance/Utilization Management Unit was hired.

The Department operates two Idaho State psychiatric hospitals, State Hospital North (SHN) in Orofino and State Hospital South (SHS) in Blackfoot. The Idaho State School and Hospital (ISSH, located in Nampa) serves persons with developmental disabilities.

In Idaho, individuals who have committed a crime may receive alternatives to regular prison sentences. Those who have not committed serious crimes and who are otherwise eligible by diagnosis may be treated through regional Mental Health Court programs. Those who are deemed not competent may be hospitalized at SHS or SHN until symptoms stabilize. In SFY 2009, there were 62 forensic patients served at SHS. Those who have committed more serious crimes and who are determined to be a continued risk of danger to self or others have historically been put in a separate portion of the prison.

In SFY 2009, efforts were directed to establish a temporary 16 bed forensics unit at Idaho State School and Hospital (ISSH). Because of the economy, these plans are on hold. Plans to build a more permanent 24 bed forensics facility continue to be developed.

Adult and children's mental health services are provided through seven regional, state owned and operated community mental health centers (CMHC's). A close working relationship exists between the regional CMHC's and the two state psychiatric hospitals. The Behavioral Health central office program provides system coordination and leadership, policy and standards development, rule promulgation and interpretation, technical assistance, training and consultation to support and expand an organized statewide system of care that is consumer and family driven and community-based. Each regional Adult Mental Health program collaborates with Mental Health Courts. Eligible Mental Health Court clients are served by regional Assertive Community Treatment (ACT) teams.

# Idaho

## Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

## NEW DEVELOPMENTS AND ISSUES

### 1. Economic Downturn

Idaho's economy was seriously impacted in a negative direction in SFY 2009. One of Idaho's largest employers, Micron, laid off approximately 1,500 employees in October 2008 and announced plans to lay off another 2,000 in February 2009. Idaho Department of Labor statistics indicate that June's unemployment rate of 8.3 percent was a 25-year high compared to last year's rate of 4.7 percent. This percentage reflects a June 2009 figure of over 62,000 unemployed compared to a June 2008 number of less than 36,000. Unemployment rates in rural counties were higher, with an average 10 to 12 percent in June 2009. According to the Department of Health and Welfare, more than 151,000 people qualified for food assistance in May 2009 compared to 100,000 in May 2008. It is anticipated that these numbers will increase because the eligibility rules that prevented those with assets over \$2,000 from qualifying for food assistance were temporarily suspended on June 1, 2009.

Regarding Medicaid, the legislature passed House Bill 123, which amended "...existing law relating to public assistance and welfare to provide for Medicaid reduction." This bill states that "With the exception of the nursing facilities at Idaho state veterans homes, each skilled care facility's quarterly rate will be decreased two and seven-tenths percent (2.7%) from July 1, 2009 through June 30, 2010. Legislators approved \$20.1 million for completion of the Medicaid Management Information System (MMIS) which is targeted to start in 2010. This system will include claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals.

Although there were Federal Center for Medicare and Medicaid (CMS) funding opportunities, Idaho did not receive any of these dollars. Idaho was not aware that the Cash and Counseling funding option applied to mental health services. Idaho did not apply for the Home and Community-Based Waiver (HCBS) or Home and Community Based Services Option because the State budget did not have the required State match funds. There were increased federal funds allocated through January 1, 2011, which decreased the State's Medicaid contributions by \$52 million for SFY 2009 and by \$73 million for SFY 2010.

The Department of Health and Welfare, with approval for approximately 3,136 employees, was affected by the economic downturn. An initial six percent across the board budget cut was addressed by layoffs, vacancy savings (20 positions) and having all state employees take a mandatory, unpaid three days of furlough as well as cuts in operating, capital, and trustee and benefits from January to April 2009. The plan to address the additional mandated five percent personnel cut of \$9.5 million for SFY 2010 included restructuring the Regional Directors such that three positions serve all seven regions instead of one per region. Cutting positions of four Regional Director and their assistants resulted in an estimated \$500,000 cost savings. Additional activities include layoffs (23 people); an additional required four days of furlough for all state employees; vacancy savings (an additional 27 positions); and a transfer of budget funds from

operations to personnel. Estimates indicate that the four furlough days alone will save 37 full time jobs.

With respect to cost cuts, increased efficiencies and best practice service delivery for the Adult Mental Health (AMH) system, several factors have been considered. Every effort has been made to save jobs of front line staff. Several community hospitalization contracts have been re-negotiated, many at reduced rates. Policy and procedure development and implementation efforts are ongoing in order to ensure core business practice consistencies across regions. An Adult Mental Health Appeal Process has been established. A client-perspective outcome measure, the Outcome Questionnaire (OQ) and the youth version of this instrument, the Youth Outcome Questionnaire (YOQ) continues to be piloted in Region 6 in an effort to inform interventions based on client outcome perceptions. Region 3 developed an incentive program to decrease no-shows for psychiatric appointments.

## **2. Idaho Mental Health Transformation**

Mental Health Transformation is an ongoing focus for the State of Idaho. Efforts to address transformation have included initial developmental efforts of a transformation workgroup, a review of the mental health and substance use service delivery system by the Western Interstate Commission for Higher Education (WICHE) Mental Health Program, and the establishment of a new transformation workgroup.

Under the direction of Governor Dirk Kempthorne, Idaho initiated the Idaho Mental Health Transformation Work Group (TWG) in early 2006 in response to the recommendations of the President's New Freedom Commission report (2003). Guided by a steering committee composed of local and state government leadership, professional associations, consumer groups and other stakeholders, the TWG met from 2006 until 2007 and delivered a *Comprehensive Statewide Mental Health Transformation Action Plan 2007: The First Steps* (December 2006). According to this plan, the goals of a transformed system in Idaho were to 1) "Effect a paradigm shift by transforming the way we as a community think about and embrace mental health, understanding that mental health is essential to overall health...[2] Achieve a consumer-driven system of care by transforming the mental health delivery system to one that is based on individual strengths and needs, emphasizes resiliency and recovery, and features accessibility...[3] Organize the structure to sustain the vision by transforming the manner in which resources are provided, coordinated and delivered." (p. 3).

According to Senate CR Number 108 (2007) and through the Legislative Health Care Task Force, the Idaho State Legislature directed implementation of a study to review Idaho's mental health and substance abuse treatment delivery system and to recommend system improvements. The Legislature contracted with the Western Interstate Commission for Higher Education (WICHE) Mental Health Program to conduct this study. Areas assessed included treatment capacity, cost, eligibility standards and areas of responsibility. The study process included five site visits, 150 stakeholder interviews and use of a web-based survey with responses from 550 Idaho stakeholders. The final written report with recommendations, *2008 Idaho Behavioral Health System Redesign*, was submitted in August 2008.

The Governor convened the Behavioral Health Transformation Workgroup in April 2009 to promote the legislature's interest in advancing the provision of core services from the regions to private provider community settings as outlined in the WICHE *2008 Idaho Behavioral Health System Redesign* report. This group includes representation from DHW, the courts, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County Sheriff's Office, the Department of Education, a private provider, business, the Association of Counties, and the Department of Correction. Recommended WICHE goals that are being considered include 1) Establish a coordinated, efficient state infrastructure with clear responsibilities and leadership authority and action, 2) Create a comprehensive, viable regional or local community delivery system, 3) Make efficient use of existing and future resources, 4) Increase accountability for services and funding, 5) Provide authentic stakeholder participation in the development, implementation and evaluation of the system, and 6) Increase the availability of, and access to, quality services.

### **3. Adult Mental Health Data System Activities**

The Behavioral Health (BH) Monthly Data Report was piloted in December 2006, using regional hand counts of each element that were submitted to Central Office, where they were manually tallied into a statewide monthly report. This report has continued to evolve since that time, as the Leadership Team refines data definitions and identifies either more effective means of data capture or additional elements that need to be tracked.

During SFY 2009, the two State Hospitals (North and South) completed Vista installation and implementation. The AMH program pursued the joint purchase and use of the WITS system by both the AMH and the Substance Use Disorders (SUD) programs. On the AMH side, the WITS system was programmed with the Client Level Reporting Project (CLRP; see paragraph below) data definitions of the NOMS. Development of WITS was completed by June 2009, and implementation and training activities are scheduled through SFY 2010 with the expectation of system use by October 2009.

The Division of Behavioral Health continues to pursue strategies to allow improved data infrastructure development for both the long and short-term data needs in the AMH program. The AMH program is currently working with data entry specialists from each region to identify data needs and training opportunities. The Data Infrastructure Grant (DIG) helps to support these efforts.

The Division of Behavioral Health was awarded a Client Level Reporting Project (CLRP) grant in the winter/spring of 2008. This award allows three regions (i.e., Regions 1, 5 and 6) to pilot the Data Dictionary and Protocol that were developed by the nine participating states in an effort to create increased consistency and standardization in data capture and reporting of the National Outcome Measures (NOMS). This project has completed a test case deliverable and a deliverable of FY 2008 service data with CLRP data definitions. It will complete the final deliverable of SFY 2009 NOMS data by the project end date in September of 2009.

#### **4. Patient Assistance Program (PAP)**

A Patient Assistance Program (PAP) software package was purchased for approximately \$50,000. This software automates the application process for the indigent benefits offered by many pharmaceutical companies, allowing clients to receive needed medications at no cost. The automation frees up staff time and essentially offers these benefits to more clients. If the costs of the medications received for free are calculated at average wholesale price (AWP), the benefit received by clients for February 2009 alone exceeds \$800,000.

#### **5. Telehealth Service Implementation (TSI) Project**

The Department of Health and Welfare established a Telehealth System Implementation (TSI) videoconferencing work group that produced a Strategy for Video Conferencing Plan in April 2008. The purpose of the TSI project was to use information technology to assist government efforts to increase efficiency, reduce costs, and improve health and behavioral health access, services and education to Idaho citizens. Videoconferencing equipment priority use is the need for telemedicine to expand psychiatric service access to prevent crises and maintain client stabilization, especially in rural and frontier areas.

During SFY 2009, equipment (i.e., the Polycom HDX 7000 Series with high definition video, voice and content sharing capabilities, Sony Bravia HDTVs and flat panel audiovisual carts with locking cabinets) was installed and tested at Central Office, State Hospital South, State Hospital North and each of seven regions. As of September 2008, eleven high definition videoconferencing sites were available for site to site use. Sites included regional main offices, central office and three state hospitals (State Hospital South, State Hospital North and Idaho State School and Hospital). Since that time, the system was expanded to allow multi-site videoconferencing. As of May 2009, up to eight sites could participate simultaneously. Alternatively, four sites could simultaneously videoconference in high definition.

Although installed for less than a year, the videoconferencing equipment has been used for a multitude of purposes by a variety of agencies. Purposes include availability to coordinate statewide communications in the event of a disaster, provision and enhancement of psychiatric services, site reviews, hospital discharge planning, statewide meetings, supervision, training and education. The Behavioral Health program has expanded access to psychiatric care and services to adults with a serious mental illness in rural and frontier areas through high definition videoconferencing. The Self Reliance program used this system to facilitate implementation of the Idaho Benefits Information System. Medicaid found it useful for provider trainings on new mental health rules. Idaho State School and Hospital used the system to evaluate drug wholesalers. The State Planning Council on Mental Health has found videoconferencing to be an effective way to extend their budget while continuing to have meetings to address mental health issues. The Second District Drug Court has used it for training and education. The Idaho Supreme Court has offered team training sessions on topics such as child protection and drug court.

The federal government recently indicated interest in piloting the use of videoconferencing to conduct mental health block grant review meetings with up to five states. Idaho expressed interest in participating in such a pilot project. If successful, this process would save state employee time and federal money that has historically been directed to allow staff to travel to another state for block grant defense.

As of May 2009, three contracted psychiatrists were providing telemedicine from the Boise Central Office. From September 2008 through May 2009, Region 2 estimated that 360 clients received psychiatric services through this system. Region 7 began using these services in February 2009, with an estimated 180 clients benefitting through May 2009.

Idaho is primarily a rural and frontier state with all Idaho counties designated as mental health professional shortage areas. Psychiatric coverage is difficult to ensure across the State. Travel costs can be expensive. In a lean economic climate, all methods of cost reduction without compromising services are critical. Use of videoconferencing technology reduces costs with a high return on investment. High definition equipment allows for the provision of telemedicine, education, site reviews and meetings without the requirement of travelling to a central location for a face to face meeting.

Use of the videoconferencing equipment began slowly from September through December 2008, but increased rapidly from January 2009. From September through December 2008, the recognized cost savings was \$15,485. From January through May 2009, the cost savings for all users totaled \$182,388. The cost savings related to the TSI project as measured by reduction in travel costs (i.e., mileage, airfare, staff time to travel, per diem, hotel and other miscellaneous costs accrued in the course of travel to attend face to face meetings) has exceeded installation costs in less than a year. The total equipment costs of \$189,000 included cameras, monitors, carts, routers and a Multi-Channel Unit (MCU) device that enables simultaneous linkages to more than two connections. From September 2008 through May 2009, the total savings across all users was \$197,873.

## **6.Forensics**

Regional AMH Program Managers continue collaboration efforts in response to increased requests for best practice services to mental health court referrals. During SFY 2009, Mental Health Court Utilization increased to approximately 90% of capacity. A Forensic Psychiatrist was hired in Region 4 to provide services to increased numbers of clients referred from the criminal justice system.

The model used to support mental health referrals as an alternative to jail is a provision of intensive ACT services and collaboration with court representatives to develop an individualized treatment plan that allows participants to stabilize and learn additional life management skills such as taking necessary medications, avoiding drug and alcohol use and avoiding criminal activities that brought them into the legal system.

In addition to collaborating with the courts and corrections to establish referral, assessment, monitoring and treatment procedures, regional AMH programs also review and revise treatment services as needed in an effort to provide best practice, efficient and effective services. Besides use of the CCISC model of treatment for co-occurring disorders, all regional programs also have access to the Eli-Lilly Wellness curriculum and the Eli-Lilly Differential Diagnosis materials.

### **7. Crisis Services; Crisis Intervention Teams and Home Recovery Teams**

The 2006 Legislature allocated two million dollars in State Fiscal Year 2007 to fund collaborative regional projects designed to meet unmet service needs for adults and/or children diagnosed with a serious mental illness and/or substance abuse. Eight projects were offered grant awards. One of these Service Plan Component projects provided for joint crisis training for law enforcement and mental health staff. In State Fiscal Year 2008, additional funds were allocated to support similar One-Time Development (i.e., \$2,000,000) projects. One award funded early intervention and crisis treatment (mental health, substance use, criminal involvement), including a transitional housing component. These training opportunities have allowed the development of Crisis Intervention Teams (CIT) in Regions 4 and 6.

During SFY 2009, an innovative public-private partnership was formed in Region 4. The Home Recovery Team (HRT) provides in home support, treatment and resource development for individuals who are at risk of out of home placement in more restrictive levels of care. Although this program is new, results have been promising.

### **8. Peer Specialist Certification and Placement with ACT Teams**

Through a contract with the Division of Behavioral Health, the Office of Consumer Affairs took responsibility to develop and implement a Peer Specialist Certification program in Idaho. Fifteen consumers were trained in February 2009, with twelve passing the certification exam. Seven certified Peer Specialists have been placed; one in each of seven regional Assertive Community Treatment (ACT) teams. Certified Peer Specialists are expected to complete their own Wellness Recovery Action Plans (WRAP) in addition to completing the Peer Specialist Certification training.

### **9. Housing and Homelessness**

During SFY 2009, there were several activities directed to housing and homelessness. A federal audit of the Pathways in Transition from Homelessness (PATH) grant provided an opportunity for each region to use feedback to develop an action plan to reflect opportunities for improvement in efforts to provide outreach and prevent homelessness among adults diagnosed with a serious mental illness. The Charitable Assistance to Community's Homeless (CATCH) program that mobilizes community resources to help address homelessness was expanded to include Region 3 in addition to Region 4. The process for accessing Shelter Plus Care beds has been standardized, leading to an increased level of regional involvement with these housing vouchers.

# Idaho

## Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

## 2009 Idaho Legislative Changes

Regarding Medicaid, the legislature passed **HB 123**, which amended "...existing law relating to public assistance and welfare to provide for Medicaid reduction." This bill directs that the quarterly rate at skilled care facilities will be decreased two and seven-tenths percent (2.7%) from July 1, 2009 through June 30, 2010, with the exception of nursing facilities at Idaho State veteran's homes. Legislators approved \$20.1 million for completion of the Medicaid Management Information System (MMIS) which is targeted to start in 2010. This system will include claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals.

**HB 321** authorized \$846,600 "...of ongoing funding within the Mental Health Grants Program for the Region 4 Dual Diagnosis Crisis Intervention beds...[and]... \$1,165,000 base ongoing funding to be continued in fiscal year 2010 for the Region 7 grant project that was selected in fiscal year 2008." The Region 7 project referred to provides mental health and substance use treatment at the jail in Bonneville County. While the 2009 economic downturn has not allowed for funding for a new round of mental health community development grant projects, the opportunity to develop such projects in previous years (see descriptions of HB 651 and SB 1143 below) continues to positively impact the mental health service delivery system through other previously developed programs as well (e.g., transitional housing, CIT training).

**SB 1065** addresses Regional Mental Health Boards. It revises the board to reflect 17 members instead of 14. Membership representation is to include "...three (3) county commissioners; two (2) department of health and welfare employees who represent the mental health system within the region; two (2) parents of children with a serious emotional disturbance, as defined in section 16-2403, Idaho Code, provided each parent's respective child is no older than twenty-one (21) years of age at the time of appointment; a law enforcement officer; three (3) adult mental health services consumer representatives, advocates or family members; a provider of mental health services within the region; a representative of the elementary or secondary public education system within the region; a representative of the juvenile justice system within the region; a physician or other licensed health practitioner from within the region; a representative of a hospital within the region; and a member of the regional advisory substance abuse authority." Select regional mental health board members provide regional representation on the State Planning Council for Mental Health.

**SB 1158** states that it "Amends and adds to existing law relating to the medically indigent to provide certain Department of Health and Welfare responsibilities for the Medically Indigent Program; to revise county and administrator responsibilities for the program; and to provide legislative intent." This legislation directs counties to pay costs of confinement, plus medical care and expenses while confined. This legislation defines medically indigent as "...any person who is in need of necessary medical services and who...does not have income and other resources available...to pay for necessary medical services." Additionally, the "Powers and Duties of the Department" are also outlined in SB 1158. Among other things, the Department is responsible to "(1) Design and manage a utilization management program and third party recovery system for the medically

indigent program... (3) Implement a Medicaid eligibility determination process for all potential applicants. (4) Develop and implement by July 1, 2010, in cooperation with the Idaho association of counties and the Idaho hospital association, a uniform form to be used for both the initial review, pursuant to section 31-3503E, Idaho Code, and the application for financial assistance pursuant to section 31-3504, Idaho Code.”

**HB 106** amends law related to mental health examinations of defendants. According to HB 106, “If there is reason to believe the mental condition of the defendant will be a significant factor at sentencing ... the court shall appoint at least one (1) psychiatrist, licensed psychologist or other professional determined by the court to be qualified to examine the defendant’s mental condition to examine and report upon the mental condition of the defendant.”

Three IDAPA rules focused on Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD). **IDAPA 16.04.03.08.01** adopts rules governing fees for Community Mental Health Services. **IDAPA 16.03.05.08.01** adopts pending rules that align AABD eligibility with “... federal regulations allowing special immigrants eligibility for benefits under this program.” Specifically, this adds coverage for Afghan and Iraqi Special Immigrants. **IDAPA 16.03.05.08.02** amends pending rule “... so that the census income is excluded from Medicaid only.” This allows temporary income exemption for short-term employees hired to assist with Census 2010 efforts, which “... will allow low income individuals who are eligible for assistance through AABD to earn additional income and gain job experience on a temporary basis without jeopardizing their Medicaid benefits.”

Several pieces of legislation related to the economy. **HB 321, HB 268, HB 314, HB 316** and **HB320** stated that, “An emergency existing therefore, which emergency is hereby declared to exist...” These bills directed state salary reductions of 5% such that “... agencies and institutions shall reduce all salaries of classified and nonclassified employees, regardless of fund source, by three percent (3%) for fiscal year 2010... Agencies shall use personnel cost savings, furloughs, and a reduction in force to manage the remaining two percent (2%) in funding reductions.” **SB 1227 Section 15** later directed that “It is the intent of the Legislature that the provision of any act appropriating moneys which contains a three percent (3%) reduction in salaries of classified and nonclassified employees regardless of fund source is null, void and of no force and effect.” As a result of this later legislation, the Division of Behavioral Health did not cut salaries to meet the 5% budget cut. Instead this cut was managed by vacancy savings, layoffs and a mandatory four days of furlough for each full time state employee.

### **Relevant 2008 Idaho Legislative Changes**

Several articles of 2008 legislation affected the AMH system in Idaho. **Senate Bill 1426** addresses the care and commitment of those diagnosed with a mental illness. This bill amends and repeals existing law relating to the hospitalization of the mentally ill. Senate Bill 1426 revises definitions and ensures “... the care of mentally ill persons shall be had in the county where such person resides or in the county where such person is found.” It also addresses consideration of reasonable alternatives to commitment and “... transport

of a committed patient from outpatient treatment to the least restrictive available facility on an inpatient basis...notice of such transfer...judicial review ... [and]...show cause order and determination.”

Two House Bills were particularly relevant for the AMH system. **House Bill 626** provides for an additional Department of Health and Welfare state fiscal year 2009 appropriation to support Community Hospitalization, state Hospital North and State Hospital South. This bill also “...directs the Department of Health and welfare to pursue contracts for mental health hospitalization services.” **House Bill 651** allows for appropriation of funds to the Department of Health and Welfare for state fiscal year 2009 for Community Mental Health Service provision. It also appropriates \$1,240,000 to continue the Region VII Multi-Year Development grant correctional alternative pilot project and \$900,000 to “...establish dual diagnosis crisis intervention beds in Region 4 that will be contractually operated by Ada County.” Additionally, this bill directs that \$1,000,000 be available “...for mental health grants in the Community Health Grant Program.”

Rules changes affecting AMH services were also approved in 2008. The **IDAPA 16.07.01** Chapter outlines rules governing Behavioral Health fee schedules, including charges for Adult Mental Health Services and Charges for Children’s Mental Health Services. The **IDAPA 16.07.10** chapter outlines rules related to Behavioral Health Development grants. The **IDAPA 16.07.33** chapter provides further definition to Adult Mental Health Services rules. This chapter includes, but is not limited to, descriptions of Administrative Appeals, Confidentiality, Eligibility Determination, Charges for Mental Health Services and Waivers.

Legislation from **2007** significantly affected the provision of AMH system services in 2008. Specific bills influencing service provision were Senate Bills 1143 and 1149 and Idaho Code 19-2524. Senate Bill 1143 authorized funding of development grants for mental health and substance abuse treatment services “...through the state mental health authority, working in coordination as a development grant advisory group with the department of correction, the department of juvenile corrections, the courts and the regional mental health board.” This bill further stated that development projects “...shall include, but not be limited to: twenty-four (24) hour emergency psychiatric services, short-term psychiatric beds, crisis intervention teams, transitional housing and detoxification facilities.”

Senate Bill 1149 authorized the courts to “...order defendants to undergo substance abuse assessments and mental health examinations; to provide for plans of treatment for substance abuse; to set plans of treatment for mental health; to require criminogenic assessments and the delivery of such assessments to specified persons; to require that certain assessments, reports and plans of treatment be sent to the Department of Correction in certain circumstances; and to provide for payment of assessment and treatment expenses.” Regional Behavioral Health Program Managers explored options for a common assessment instrument and procedure to respond to this legislation, and chose to use a revised version of the existing BCSR. The Common Assessment

instrument was developed in an effort to provide a more thorough, clinical guideline for assessing mental health symptoms. The GAIN was considered, but rejected because the full GAIN took too long to administer and the quick version did not fully capture the mental health assessment needs. The Substance Use Disorders (SUD) program found that the GAIN instrument did meet their needs for substance use disorder assessments.

Idaho Code 19-2524 supports SB 1149. Idaho Code 19-2524 created a new section to the Judgment Chapter of the Criminal Procedure Title of the Idaho Code that dealt with substance use and mental health treatment and allowed judges some broadened sentencing options. The legislation allowed a judge to order a substance abuse assessment and/or a mental health examination for certain convicted felons and felony parole violators that appeared before the court. Based on the results of an assessment or examination, and if the court placed the defendant on probation, a judge could order, as a condition of probation, that the defendant undergo treatment consistent with a treatment plan contained in the assessment or examination report. A treatment plan would be subject to modification by the court.

### **Relevant 2007 Idaho Legislative Changes**

During the 2007 Legislative session, there were two senate bills that were particularly relevant for adult mental health, **SB 1143 and SB 1149**. SB 1143 authorized funding of development grants for mental health and substance abuse treatment services "...through the state mental health authority, working in coordination as a development grant advisory group with the department of correction, the department of juvenile corrections, the courts and the regional mental health board." This bill further states that development projects "...shall include, but not be limited to: twenty-four (24) hour emergency psychiatric services, short-term psychiatric beds, crisis intervention teams, transitional housing and detoxification facilities."

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Two additional changes, described in **Idaho Code 19-2524 and IDAPA 16.03.10**, were especially pertinent to the Adult Mental Health system. **Idaho Code 19-2524** is in support of SB 1149. Idaho Code 19-2524 created a new section to the Judgment Chapter of the Criminal Procedure Title of the Idaho Code that deals with substance abuse and mental health treatment and allows judges some broadened sentencing options. The legislation allows a judge to order a substance abuse assessment and/or a mental health examination for certain convicted felons and felony parole violators that appear before the court. Based on the results of an assessment or examination, and if the court places

the defendant on probation, a judge may order, as a condition of probation, that the defendant undergo treatment consistent with a treatment plan contained in the assessment or examination report. A treatment plan would be subject to modification by the court.

**IDAPA 16.03.10** refers to Medicaid enhanced plan benefits. Rule changes include: “1) To be eligible to receive Enhanced Plan mental health services for psychotherapy, adults must meet the eligibility criteria of ‘serious mental illness,’ as defined in federal regulations. 2) Children must meet the eligibility criteria of ‘serious emotional disturbance,’ as defined in Section 16-2403, Idaho Code. 3) When determining whether an individual meets the diagnostic and functional eligibility criteria for Enhanced Plan mental health services for psychotherapy, the Diagnostic and Statistical Manual of Mental Disorder, 4<sup>th</sup> Edition, Text Revision (DSM-IV-R) will be used for both children and adults along with a comprehensive assessment.

# Idaho

## Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

### **State Agency Leadership**

The Division of Behavioral Health provides system leadership, consultation, technical assistance, rule promulgation and training. The Adult Mental Health and Children's Mental Health programs within the Division provide support and coordination of system improvement (including the areas of consumer and family member empowerment), the development and establishment of policies, standards and best practice procedures, rule promulgation and interpretation, overseeing federal grant applications and contract development and monitoring.

The Division of Behavioral Health management team was put in place in SFY 2007 as part of the overall realignment and consolidation of the Department of Health and Welfare to improve accountability, consistency and efficiency in lines of authority and responsibility Mental Health and Substance Abuse. This resulted in direct lines of authority between the regional programs and the Division of Behavioral Health Administration. Responsibility for program budgets, policy development and implementation and quality assurance were shifted to the Division Administration. The seven Program Managers report to the Mental Health Bureau Chief, Scott Tiffany, who oversees the Adult and Children's Mental Health programs. The Mental Health Bureau Chief reports to the Division Administrator, Kathleen Allyn.

Under the leadership of the Central Office Mental Health Bureau Chief, the Behavioral Health (BH) Management Team met on a bi-monthly basis in SFY 2009 and was a primary vehicle for policy development, system coordination and system improvement. This leadership team is composed of seven regional BH program managers, the administrative directors of the two state hospitals, the Mental Health Bureau Chief, the Substance Use Disorders Program Manager, and the Children's Mental Health Program Manager.

In May 2009, the Regional Directors were re-organized. Instead of one Regional Director (RD) in each of seven regions, there is now one RD responsible for Regions 1 and 2; one for Regions 3 and 4 and one for Regions 5, 6 and 7. Regional Directors continue to be responsible to facilitate regional efforts designed to promote effective and efficient mental health and substance use service provision.

# Idaho

## Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

The Children's Mental Health Program and the Adult Mental Health Program have been integrated to create the Division of Behavioral Health. This is a combined response between Adult and Children's Mental Health programs. Please see the Adult section for Idaho's response.

# Idaho

## Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

## NEW DEVELOPMENTS AND ISSUES

### 1. Economic Downturn

Idaho's economy was seriously impacted in a negative direction in SFY 2009. One of Idaho's largest employers, Micron, laid off approximately 1,500 employees in October 2008 and announced plans to lay off another 2,000 in February 2009. Idaho Department of Labor statistics indicate that June's unemployment rate of 8.3 percent was a 25-year high compared to last year's rate of 4.7 percent. This percentage reflects a June 2009 figure of over 62,000 unemployed compared to a June 2008 number of less than 36,000. Unemployment rates in rural counties were higher, with an average 10 to 12 percent in June 2009. According to the Department of Health and Welfare, more than 151,000 people qualified for food assistance in May 2009 compared to 100,000 in May 2008. It is anticipated that these numbers will increase because the eligibility rules that prevented those with assets over \$2,000 from qualifying for food assistance were temporarily suspended on June 1, 2009.

Regarding Medicaid, the legislature passed House Bill 123, which amended "...existing law relating to public assistance and welfare to provide for Medicaid reduction." This bill states that "With the exception of the nursing facilities at Idaho state veterans homes, each skilled care facility's quarterly rate will be decreased two and seven-tenths percent (2.7%) from July 1, 2009 through June 30, 2010. Legislators approved \$20.1 million for completion of the Medicaid Management Information System (MMIS) which is targeted to start in 2010. This system will include claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals.

Although there were Federal Center for Medicare and Medicaid (CMS) funding opportunities, Idaho did not receive any of these dollars. Idaho was not aware that the Cash and Counseling funding option applied to mental health services. Idaho did not apply for the Home and Community-Based Waiver (HCBS) or Home and Community Based Services Option because the State budget did not have the required State match funds. There were increased federal funds allocated through January 1, 2011, which decreased the State's Medicaid contributions by \$52 million for SFY 2009 and by \$73 million for SFY 2010.

The Department of Health and Welfare, with approval for approximately 3,136 employees, was affected by the economic downturn. An initial six percent across the board budget cut was addressed by layoffs, vacancy savings (20 positions) and having all state employees take a mandatory, unpaid three days of furlough as well as cuts in operating, capital, and trustee and benefits from January to April 2009. The plan to address the additional mandated five percent cut of \$9.5 million for SFY 2010 included restructuring the Regional Directors such that three positions serve all seven regions instead of one per region. Cutting positions of four Regional Director and their assistants resulted in an estimated \$500,000 cost savings. Additional activities include layoffs (23 people); an additional required four days of furlough for all state employees; vacancy savings (an additional 27 positions); and a transfer of budget funds from operations to

personnel. Estimates indicate that the four furlough days alone will save 37 full time jobs.

With respect to cost cuts, increased efficiencies and best practice service delivery for the Adult Mental Health (AMH) system, several factors have been considered. Every effort has been made to save jobs of front line staff. Several community hospitalization contracts have been re-negotiated, many at reduced rates. Policy and procedure development and implementation efforts are ongoing in order to ensure core business practice consistencies across regions. An Adult Mental Health Appeal Process has been established. A client-perspective outcome measure, the Outcome Questionnaire (OQ) and the youth version of this instrument, the Youth Outcome Questionnaire (YOQ) continues to be piloted in Region 6 in an effort to inform interventions based on client outcome perceptions. Region 3 developed an incentive program to decrease no-shows for psychiatric appointments.

## **2. Idaho Mental Health Transformation**

Mental Health Transformation is an ongoing focus for the State of Idaho. Efforts to address transformation have included initial developmental efforts of a transformation workgroup, a review of the mental health and substance use service delivery system by the Western Interstate Commission for Higher Education (WICHE) Mental Health Program, and the establishment of a new transformation workgroup.

Under the direction of Governor Dirk Kempthorne, Idaho initiated the Idaho Mental Health Transformation Work Group (TWG) in early 2006 in response to the recommendations of the President's New Freedom Commission report (2003). Guided by a steering committee composed of local and state government leadership, professional associations, consumer groups and other stakeholders, the TWG met from 2006 until 2007 and delivered a *Comprehensive Statewide Mental Health Transformation Action Plan 2007: The First Steps* (December 2006). According to this plan, the goals of a transformed system in Idaho were to 1) "Effect a paradigm shift by transforming the way we as a community think about and embrace mental health, understanding that mental health is essential to overall health...[2] Achieve a consumer-driven system of care by transforming the mental health delivery system to one that is based on individual strengths and needs, emphasizes resiliency and recovery, and features accessibility...[3] Organize the structure to sustain the vision by transforming the manner in which resources are provided, coordinated and delivered." (p. 3).

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The Department of Health and Welfare established a Telehealth System Implementation (TSI) videoconferencing work group that produced a Strategy for Video Conferencing Plan in April 2008. The purpose of the TSI project was to use information technology to assist government efforts to increase efficiency, reduce costs, and improve health and behavioral health access, services and education to Idaho citizens. Videoconferencing equipment priority use is the need for telemedicine to expand psychiatric service access to prevent crises and maintain client stabilization, especially in rural and frontier areas.

During SFY 2009, equipment (i.e., the Polycom HDX 7000 Series with high definition video, voice and content sharing capabilities, Sony Bravia HDTVs and flat panel audiovisual carts with locking cabinets) was installed and tested at Central Office, State Hospital South, State Hospital North and each of seven regions. As of September 2008, eleven high definition videoconferencing sites were available for site to site use. Sites included regional main offices, central office and three state hospitals (State Hospital South, State Hospital North and Idaho State School and Hospital). Since that time, the system was expanded to allow multi-site videoconferencing. As of May 2009, up to eight sites could participate simultaneously. Alternatively, four sites could simultaneously videoconference in high definition.

Although installed for less than a year, the videoconferencing equipment has been used for a multitude of purposes by a variety of agencies. Purposes include availability to coordinate statewide communications in the event of a disaster, provision and enhancement of psychiatric services, site reviews, hospital discharge planning, statewide meetings, supervision, training and education. The Behavioral Health program has expanded access to psychiatric care and services to adults with a serious mental illness in rural and frontier areas through high definition videoconferencing. The Self Reliance program used this system to facilitate implementation of the Idaho Benefits Information System. Medicaid found it useful for provider trainings on new mental health rules. Idaho State School and Hospital used the system to evaluate drug wholesalers. The State

Planning Council on Mental Health has found videoconferencing to be an effective way to extend their budget while continuing to have meetings to address mental health issues. The Second District Drug Court has used it for training and education. The Idaho Supreme Court has offered team training sessions on topics such as child protection and drug court.

The federal government recently indicated interest in piloting the use of videoconferencing to conduct mental health block grant review meetings with up to five states. Idaho expressed interest in participating in such a pilot project. If successful, this process would save state employee time and federal money that has historically been directed to allow staff to travel to another state for block grant defense.

As of May 2009, three contracted psychiatrists were providing telemedicine from the Boise Central Office. From September 2008 through May 2009, Region 2 estimated that 360 clients received psychiatric services through this system. Region 7 began using these services in February 2009, with an estimated 180 clients benefitting through May 2009.

Idaho is primarily a rural and frontier state with all Idaho counties designated as mental health professional shortage areas. Psychiatric coverage is difficult to ensure across the State. Travel costs can be expensive. In a lean economic climate, all methods of cost reduction without compromising services are critical. Use of videoconferencing technology reduces costs with a high return on investment. High definition equipment allows for the provision of telemedicine, education, site reviews and meetings without the requirement of travelling to a central location for a face to face meeting.

Use of the videoconferencing equipment began slowly from September through December 2008, but increased rapidly from January 2009. From September through December 2008, the recognized cost savings was \$15,485. From January through May 2009, the cost savings for all users totaled \$182,388. The cost savings related to the TSI project as measured by reduction in travel costs (i.e., mileage, airfare, staff time to travel, per diem, hotel and other miscellaneous costs accrued in the course of travel to attend face to face meetings) has exceeded installation costs in less than a year. The total equipment costs of \$189,000 included cameras, monitors, carts, routers and a Multi-Channel Unit (MCU) device that enables simultaneous linkages to more than two connections. From September 2008 through May 2009, the total savings across all users was \$197,873.

#### **4. Parenting with Love and Limits®**

The CMH program research models of evidence-based Parent Management Training that could be utilized in Idaho to treat an ever increasing population of youth with behavioral disorders that are being ordered to the CMH system by the courts. After evaluating several programs, the Parenting with Love and Limits (PLL) program was selected. Surprisingly, the program was more successful than anticipated in the first year. Results demonstrate that approximately 75% of families that begin the 6 six to eight week voluntary program graduate. Approximately 51% of families are closed following the PLL intervention, with statistically valid reductions aggressive behaviors, rule breaking,

conduct disorder, oppositional defiant behavior, externalizing behavior, and internalizing behavior. The program is being delivered in collaboration with juvenile justice when possible and has been delivered with a parent co-facilitator in one region.

#### **5. Court Rule 19**

The Idaho Supreme Court through the Idaho Legislature modified court rules to require all youth being considered for commitment to the Department of Juvenile Corrections to be staffed by a multi-disciplinary group that includes the county juvenile justice, mental health, and other relevant individuals to determine if the commitment can be diverted and the youth served in the community.

#### **6. Medicaid Rule Modifications**

The Idaho Medicaid program, Idaho largest payer of public mental health services, has implemented several changes to their Mental Health program. These changes include a reduction in the number of “automatically” authorized hours of psychosocial rehabilitation (however additional hours are available with prior authorization based on medical necessity), adding additional detail to the service categories under the umbrella of psychosocial rehabilitation, adding a benefit to fund substance use disorders services, and Medicaid is requiring providers that are not licensed to acquire national certification in the field of psychosocial rehabilitation.

# Idaho

## Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

## 2010 Legislative Initiatives and Changes

Regarding Medicaid, the legislature passed **HB 123**, which amended "...existing law relating to public assistance and welfare to provide for Medicaid reduction." This bill directs that the quarterly rate at skilled care facilities will be decreased two and seven-tenths percent (2.7%) from July 1, 2009 through June 30, 2010, with the exception of nursing facilities at Idaho State veteran's homes. Legislators approved \$20.1 million for completion of the Medicaid Management Information System (MMIS) which is targeted to start in 2010. This system will include claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals.

**HB 321** authorized \$846,600 "...of ongoing funding within the Mental Health Grants Program for the Region 4 Dual Diagnosis Crisis Intervention beds...[and]... \$1,165,000 base ongoing funding to be continued in fiscal year 2010 for the Region 7 grant project that was selected in fiscal year 2008." The Region 7 project referred to provides mental health and substance use treatment at the jail in Bonneville County. While the 2009 economic downturn has not allowed for funding for a new round of mental health community development grant projects, the opportunity to develop such projects in previous years (see descriptions of HB 651 and SB 1143 below) continues to positively impact the mental health service delivery system through other previously developed programs as well (e.g., transitional housing, CIT training).

**SB 1065** addresses Regional Mental Health Boards. It revises the board to reflect 17 members instead of 14. Membership representation is to include "...three (3) county commissioners; two (2) department of health and welfare employees who represent the mental health system within the region; two (2) parents of children with a serious emotional disturbance, as defined in section 16-2403, Idaho Code, provided each parent's respective child is no older than twenty-one (21) years of age at the time of appointment; a law enforcement officer; three (3) adult mental health services consumer representatives, advocates or family members; a provider of mental health services within the region; a representative of the elementary or secondary public education system within the region; a representative of the juvenile justice system within the region; a physician or other licensed health practitioner from within the region; a representative of a hospital within the region; and a member of the regional advisory substance abuse authority." Select regional mental health board members provide regional representation on the State Planning Council for Mental Health.

**SB 1158** states that it "Amends and adds to existing law relating to the medically indigent to provide certain Department of Health and Welfare responsibilities for the Medically Indigent Program; to revise county and administrator responsibilities for the program; and to provide legislative intent." This legislation directs counties to pay costs of confinement, plus medical care and expenses while confined. This legislation defines medically indigent as "...any person who is in need of necessary medical services and who...does not have income and other resources available...to pay for necessary medical services." Additionally, the "Powers and Duties of the Department" are also outlined in SB 1158. Among other things, the Department is responsible to "(1) Design and manage

a utilization management program and third party recovery system for the medically indigent program... (3) Implement a Medicaid eligibility determination process for all potential applicants. (4) Develop and implement by July 1, 2010, in cooperation with the Idaho association of counties and the Idaho hospital association, a uniform form to be used for both the initial review, pursuant to section 31-3503E, Idaho Code, and the application for financial assistance pursuant to section 31-3504, Idaho Code.”

**HB 106** amends law related to mental health examinations of defendants. According to HB 106, “If there is reason to believe the mental condition of the defendant will be a significant factor at sentencing ... the court shall appoint at least one (1) psychiatrist, licensed psychologist or other professional determined by the court to be qualified to examine the defendant’s mental condition to examine and report upon the mental condition of the defendant.”

Three IDAPA rules focused on Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD). **IDAPA 16.04.03.08.01** adopts rules governing fees for Community Mental Health Services. **IDAPA 16.03.05.08.01** adopts pending rules that align AABD eligibility with “... federal regulations allowing special immigrants eligibility for benefits under this program.” Specifically, this adds coverage for Afghan and Iraqi Special Immigrants. **IDAPA 16.03.05.08.02** amends pending rule “... so that the census income is excluded from Medicaid only.” This allows temporary income exemption for short-term employees hired to assist with Census 2010 efforts, which “... will allow low income individuals who are eligible for assistance through AABD to earn additional income and gain job experience on a temporary basis without jeopardizing their Medicaid benefits.”

Several pieces of legislation related to the economy. HB 321, HB 268, HB 314, HB 316 and HB320 stated that, “An emergency existing therefore, which emergency is hereby declared to exist...” These bills directed state salary reductions of 5% such that “... agencies and institutions shall reduce all salaries of classified and nonclassified employees, regardless of fund source, by three percent (3%) for fiscal year 2010... Agencies shall use personnel cost savings, furloughs, and a reduction in force to manage the remaining two percent (2%) in funding reductions.” SB 1227 Section 15 later directed that “It is the intent of the Legislature that the provision of any act appropriating moneys which contains a three percent (3%) reduction in salaries of classified and nonclassified employees regardless of fund source is null, void and of no force and effect.” As a result of this later legislation, the Division of Behavioral Health did not cut salaries to meet the 5% budget cut. Instead this cut was managed by vacancy savings, layoffs and a mandatory four days of furlough for each full time state employee.

The Idaho Supreme Court through the Idaho Legislature modified court rules to require all youth being considered for commitment to the Department of Juvenile Corrections to be staffed by a multi-disciplinary group that includes the county juvenile justice, mental health, and other relevant individuals to determine if the commitment can be diverted and the youth served in the community.



# Idaho

## Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

The Children's Mental Health Program and the Adult Mental Health Program have been integrated to create the Division of Behavioral Health. This is a combined response between Adult and Children's Mental Health programs. Please see the Adult section for Idaho's response.

# Idaho

## Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

# Idaho State Planning Council on Mental Health

Pete T. Cenarrusa Building, 3<sup>rd</sup> Floor  
P.O. Box 83720  
Boise, ID 83720-0036

June 30, 2009

## MEMBERSHIP

Robert Bishop  
Rep. Sharon Block  
Stan Calder  
Shirley Clark  
Martha Ekhoﬀ  
Kathie Garrett  
Patricia Guidry  
Gary Hamilton  
Barbara Harkins  
Bill Harger  
Linda Hatzenbuehler  
Angela Hicks  
John Hill  
Michael Hinman  
Pam Hirsch  
Rick Huber  
Linda Johann  
Barbara Kauffman  
Lisa Koltes, MD  
Courtney Lester-Santillan  
Christina Lymberopoulos  
McCurdy, Cynthia  
Judge Brent Moss  
Mary Perrien  
Michael Stayner  
Rose Marie Tiffany  
Kim Wherry Toryanski  
Lynne Whiting  
Julie Williams  
Teresa Wolf  
Corinna Wolfe-Stiles

The Honorable C. L. "Butch" Otter  
Office of the Governor  
Statehouse Box 83720  
Boise, Idaho 83720-0034

Subject: 2009 Report from the Idaho State Planning Council on  
Mental Health

Dear Governor Otter:

On behalf of the Idaho State Planning Council on Mental Health it  
is my pleasure to submit to you the Council's Annual Report to the  
Governor for 2009 on the status of mental health services in Idaho.

The State Planning Council membership worked collectively in  
providing information and expertise in forming this report for your  
review. We hope you find our report informative and look forward  
to any comments that you may have.

Sincerely,

The Idaho State Planning Council on Mental Health

  
Teresa Wolf, Chair  
P.O. Box 896  
Lewiston, Idaho 83501

# Mental Health Report



**2009**

**Idaho State Planning Council on Mental Health**

**Report to the Governor & Legislature**

## **Our Goal:**

Our goal is for everyone in Idaho to be offered treatment that is not only consumer and family driven, but effective and recovery oriented so that persons and families affected by mental illness can participate fully in their communities.

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# Idaho State Planning Council on Mental Health

Pete T. Cenarrusa Building, 3<sup>rd</sup> Floor  
P.O. Box 83720  
Boise, ID 83720-0036

## Annual Report to the Governor and State Legislature

June 30, 2009, Boise, Idaho

### Executive Summary

The Idaho State Planning Council on Mental Health (SPCMH) provides a voice and advocacy for children, youth, adults, and families on a broad range of mental health issues. Our annual report is designed to provide a clear overview of the vast array of accomplishments of the SPCMH, Regional Mental Health Boards, and the Division of Behavioral Health. It is essential to the success of Idaho's Mental Health System of Care to improve access to treatment, expand system collaboration, and continue to strengthen community partnerships.

Our report includes accomplishments, opportunities captured, and challenges left to address. A sampling of the issues contained in the annual report is listed below:

- Improved communication and centralized reporting with the Governor, Legislature, and the Regional Mental Health Boards.
- Transformation of Idaho's Mental Health System in conjunction with WICHE and the Governor's Transformation Workgroup, Medicaid Reform, inclusion of the Wellness Recovery Action Plan to assist Peer Specialists, Parenting with Love and Limits, and increased focus on housing issues.
- Supporting adult and juvenile court collaboration and provide needed resources to many citizens seeking treatment.
- A number of issues surrounding Idaho's Mental Health system continue to challenge us and include:
  - ❖ Development of a Consumer/Family Driven System of Care
  - ❖ Recovery as a focus
  - ❖ Access to Community Based Services
  - ❖ Support for a Statewide Suicide Prevention Hotline

### **What to Expect in 2009/2010 from the Idaho State Planning Council on Mental Health:**

- **Continued Improvement of Communication Methods**
  - Information sharing with affiliates and other agencies on current issues and events is one key to a successful system
  - Encouraging the Regional Mental Health Boards to report centrally promotes distribution of information, ideas, and successes

- **Committee Involvement and Project Development**
  - Children's, Transformation/Housing, Membership, Legislative, and Education/Communication subcommittees are accountable for forming guidelines and responsibilities, goal setting, and project development.
  
- **Further Strengthen Collaborative Efforts with all Related Agencies and Affiliates**
  - Be more accessible
  - Clarify and advance our mission and direction
  - Become more visible
  - Develop sustainable partnerships

**Information sharing is a key component to a successful system.**

Using the SPCMH as a hub for distributing information by and between Regional Mental Health Boards will improve the system as a whole. This distribution will allow successful ideas and projects to be replicated throughout Idaho.

**By requiring the State Planning Council subcommittees to focus on our mission and direction, the Council will become more visible to our partners, and the mission clarified.**

The SPCMH will become more visible to the public and associate agencies by participating in active ways in local issues, communicating goals, visions and values, and being a robust voice for Idahoans living with mental health issues.

**Being a viable part of the mental health system promotes cooperation and collaboration.**

The SPCMH plays a key role in the mental health system of care. We are charged with serving as an advocate, advising, and providing guidance, monitoring and evaluating the system, and ensuring access. Our mission is to serve as a vehicle for policy and program development and to report on those achievements and system impacts. The SPCMH is dedicated to achieving those responsibilities with which we have been entrusted.

## INTRODUCTION

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### **Background:**

The State Planning Council on Mental Health (SPCMH) was organized in Idaho pursuant to Public Law 99-660, which established a Federal mental health block grant program to states and territories in the 1980's. The public law requires that the majority of membership of the SPCMH be made up of individuals affected by mental illness and their families, as well as representatives from key state agencies which provide services to this population.

In addition to meeting the Federal membership requirements, Idaho's SPCMH also has excellent representation from across the state. Each of the seven Regional Mental Health Boards is represented within our membership.

The federal law requires the SPCMH to oversee the annual plan for Federal block grant dollars that have been awarded to states to assist them in the development of mental health services, to monitor those mental health services funded through both state and federal dollars and to serve as advocates for the improvement of mental health services within the state.

In 2006, the Idaho Legislature placed the SPCMH into Idaho Code 39-3125. The SPCMH is directed to:

*"... serve as an advocate for adults with a severe mental illness and for seriously emotionally disturbed children and youth; to advise the state mental health authority on issues of concern, policies and programs and provide guidance to the mental health authority in the development and implementation of the state mental health systems plan; to monitor and evaluate the allocation and adequacy of mental health services within the state on an ongoing basis; to ensure that individuals with severe mental illness and serious emotional disturbances have access to treatment, prevention and rehabilitation services including those services that go beyond the traditional mental health system; to serve as a vehicle for intra-agency and interagency policy and program development; and to present to the Governor and the Legislature by June 30 of each year a report on the council's achievements and the impact on the quality of life that mental health services has on citizens of the state..."*

The SPCMH provides a consumer voice for publicly funded mental health services available to our residents (this was a key recommendation of The President's New Freedom Commission on Mental Health – Achieving the Promise: Transforming Mental Health Care in America published in July, 2003). We are here to assure that Idaho's public mental health system continues to move forward in quality and efficiency.

The membership of the SPCMH is committed to developing a public mental health system in Idaho in which recovery from mental illness is expected, programs to prevent mental illness are consumer and family driven and are available in all parts of the state. We stand ready to assist in whatever may be necessary to accomplish this end.

## **ENDORSED GOALS**

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### **The President's New Freedom Commission on Mental Health – Achieving the Promise: Transforming Mental Health Care in America' goals endorsed by the SPCMH.**

In a transformed Mental Health System:

1. Americans Understand that Mental Health Is Essential to Overall Health.
2. Mental Health Care Is Consumer and Family Driven.
3. Disparities in Mental Health Services Are Eliminated.
4. Early Mental Health Screening, Assessment and Referrals to Services Are Common Practice.
5. Excellent Mental Health Care is Delivered and Research Is Accelerated.
6. Technology Is Used to Access Mental Health Care and Information.

## IDAHO STATE PLANNING COUNCIL ACCOMPLISHMENTS

### **1. Influencing change to Mental Health Board membership**

- a. The SPCMH was kept well informed by the membership on legislative issues and was able to provide the needed support for addition of children's representation and clarification of membership on the Regional Mental Health Boards. With the loss of the Children's Mental Health Councils it was imperative that each regional board continued to address children's issues.
- b. Our representative gave a report to the House Health and Welfare Committee during this legislative session on the concerns, gaps and needs identified by the SPCMH.
- c. The SPCMH formed a subcommittee to keep us apprised on all legislative activity and issues of concern that affect our legally mandated responsibilities. The information was communicated to the membership to insure inclusion of the regional mental health boards.

### **2. Informing Legislators regarding housing and the need to recognize recovery as issues of high importance to the citizens of Idaho at the Annual Legislative Breakfast and other times throughout the year**

- a. The SPCMH membership met with each Legislator in attendance at our legislative breakfast to discuss the importance of the need to continue to make suitable, stable and affordable housing a priority for persons with mental illness and their families, as this is key to their recovery. The housing shortage in Idaho is at a critical level and needs to remain a top priority for the regions and the Legislature. We have formed a subcommittee to continue to keep the SPCMH apprised of the housing issues in Idaho so that we may assist others in their quest to solve regional problems.
- b. The membership regularly provides legislators up-to-date information regarding mental health issues to assist them in making informed decisions.

### **3. Functioning with minimal cost and no financial increases**

- a. The SPCMH understands and has risen to the challenge to keep expenses at a minimum and within our allotted budget. We have utilized videoconferencing, teleconferencing, and e-mail whenever possible. We have reduced the number of members and are currently reviewing the membership for further efficiencies. While still fulfilling our legally mandated responsibilities, we are trying to maintain and insure statewide representation. While costs have risen

dramatically over the last decade, our budget has not had a single increase in that time.

**4. Adopted Suicide Prevention council as subcommittee**

- a. The SPCMH recognizes the importance of the Suicide Prevention Council's efforts and voted to include them as a subcommittee of the SPCMH to keep us informed of their activities and educational efforts across the state.

**5. Development of a State Planning Council Brochure**

- a. A brochure was developed to provide more visibility for the SPCMH. This brochure gives a brief overview of our purpose and contact information. The brochure forged new partnerships with Idaho State Independent Living Council, who volunteered to print the brochure and the Office of Consumer Affairs offered use of their website for a resource link to assist in information distribution.

**6. Idaho state law (Title 39-3124) expanded our membership to include representatives from the Legislature and Judiciary**

- a. This change has enhanced our communication efforts to keep the Legislature informed of changes, gaps and needs in the mental health system. It has also given the Judiciary the opportunity to bring forth issues and identify additional resources available.

**7. Centralized reporting to the Council of regional council activities**

- a. Each council member is encouraged to report on the activities of their Regional Mental Health Board to share their successes and challenges so that all may benefit.
- b. The SPCMH has established an email list of the membership of the Regional Mental Health Boards (RMHB) to encourage continued communication, sharing information and mutual appraisal of current issues and concerns.

**8. Serving as a vehicle for intra-agency and interagency policy and program development.**

- a. The chair for this body has served on the Behavioral Health Transformation Workgroup this year.

## OPPORTUNITIES

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1. **The Idaho Mental Health and Substance Abuse System Redesign Project, otherwise known as the WICHE Report, offers Idaho a great opportunity to transform the current mental health system.**

The WICHE Report was commissioned and funded by the Legislature in 2007 through SCR 105. The findings and recommendations of the WICHE Report were presented to the Legislature via the Health Care Task Force. The report was strongly endorsed by that group's Mental Health Subcommittee. The report identified the need to create a statewide "transformation workgroup" to identify and address barriers to transformation. In January 2009 a Governor issued Executive Order created the Behavioral Health Transformation Workgroup. In his Executive Order No. 2009-04 the Governor stated "Idaho citizens and their families should have appropriate access to quality services through the public mental health and substance abuse system that are coordinated, efficient and accountable." The Legislature has appropriated \$250,000 to support the mission of this Workgroup. The Workgroup is to develop a plan for a coordinated, efficient state behavioral health infrastructure and present a plan to the Governor by December 2009 and the Legislature in 2010.

2. **The WICHE report has identified increasing accountability through information and data as a priority.**

According to the report, "Idaho's mental health data system did not appear to be robust, with a solid, valid set of statewide data available on program specifics, including outcomes. There appeared to be more data available for the substance abuse program, however, there remain gaps in the ability to track service delivery and outcomes in that system also (page 37)." A more robust data system will help the Department of Health and Welfare to provide oversight of providers, track services and outcomes and lead to more evidence based practices. Experience of the substance abuse treatment programs, Office of Drug Policy and Interagency Committee on Substance Abuse (ICSA) has demonstrated that outcome data is the key to policy maker's support of programs. Policy makers and Legislators want to see that the programs they support with funding are having positive outcomes.

3. **Continued work and refinement of Medicaid Reform.**

Medicaid reform has seen significant cuts in hours of PSR (not heavily utilized) and Partial Care services (the current model has not proven to be recovery oriented) along with significant changes in requirements for Community Providers. Medicaid should continue to work with Community Providers to make sure that the transition to a system that is based on the new requirements is both manageable and productive. Medicaid should continue their efforts on a reform package that offers services with an emphasis on recovery.

#### 4. Enhancing the Efficiency of the State's Hospital Capacity

**Recommendation 5.1:** Conduct a review of State Hospital utilization data (both sites) to identify:

1. Valid mean (average) and median lengths of stay by region over a year;
2. The number of individuals who would benefit from community-based services and the type(s) of service(s) required;
3. The cost accrued per day by these individuals in the state hospitals; and,
4. The potential State Hospital cost avoidance that could be realized by decreasing inpatient stay and increasing community tenure.

**Recommendation 5.2:** Allocate specific, acute bed capacity to the regional behavioral health authorities.

**Recommendation 5.3:** Achieve and maintain accreditation for **both** state hospitals.

**Recommendation 5.4:** Utilize deliberate planning and program development in secure facilities. This will ensure that civilly committed persons treated in these facilities are served in the least restrictive environment based upon their clinical and legal circumstances.

## PUBLIC MENTAL HEALTH ACCOMPLISHMENTS (STATE)

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### **1. Training Program.**

The first statewide Wellness Recovery Action Plan (WRAP) training occurred this fiscal year. WRAP plans help clients to understand recovery from mental illness is possible. They also serve to help clients understand warning signs, symptoms, and serve as a plan to follow when signs and symptoms of mental illness begin to exacerbate. This training was in preparation of the roll out of the peer specialist certification program.

### **2. Peer Specialist Certification Program has benefited virtually every region in the state.**

Peer Specialists started being placed on regional ACT teams in March of this year. Their purpose is to model recovery and resiliency for individuals receiving services through the ACT team model. Although Peer Specialists may have additional responsibilities that vary from region to region, they bring their own unique talents and special interests that serve to enhance the success of the ACT teams.

### **3. Youth Suicide Prevention.**

SPAN is active in some regions providing community and civic presentations. There was a town hall meeting in Idaho Falls on suicide prevention.

### **4. Medicaid Developments.**

Statewide assessment tools, to assist individuals with substance abuse problems, have been adopted. Benefits are now in place for substance use disorder treatment in Substance Abuse agencies and in primary care providers' offices. New requirements also increase participants' rights, promote parental involvement in children's treatment, restrict the use of seclusion and restraint, ensures diagnostic assessments are available to all who need them, require certification of unlicensed PSR workers, and ensure services that are developmentally appropriate for children. Additionally, 69% of Medicaid-reimbursed mental health agencies in Idaho have now been credentialed or are in the process.

### **5. Community Collaboration Grant funding for Crisis Intervention Training.**

For three years in a row, the Legislature has allocated funds for collaborative community projects, at the local level, to improve mental health services. Through the Development Grant process, the Division provided funding to allow Crisis Intervention Team (CIT) training for law enforcement officials in two regions. With the chronic under-funding of our state system it is critical that first responders have knowledge of mental health issues and community resources. Communities throughout the state are supporting Crisis Intervention Team (CIT) Training for law enforcement.

**6. Youth Programs: Parenting With Love and Limits (PLL)**

PLL, an evidence-based intervention for children and families has been implemented in each region. For the non-criminal justice population, utilization of costly residential treatment has been decreased in favor of more effective family-based therapy (PLL, for example).

**7. The first responder video was completed and distributed statewide, to groups such as: law enforcement, paramedics, mental health professionals, and others.**

This DVD has also generated interest from several law enforcement agencies and advocacy organizations across the country. This video uses scenarios to teach first responders how to appropriately respond to juveniles who are experiencing mental health crisis situations.

**8. Increased focus on housing.**

The community collaboration grant which has been exhausted helped the Idaho Falls community see the need for crisis housing. Transitional/supportive housing is being developed, at the local level, in many communities in Idaho. The process for accessing Shelter Plus Care beds has been standardized, leading to an increased level of regional involvement with these housing vouchers. The CATCH program, a program in Region 4 that mobilizes community resources to help address homelessness, is expanding to Region 3.

**9. Assertive Community Treatment (ACT)**

Ten ACT team sites were assessed for fidelity to the ACT model according to the Dartmouth Assertive Community Treatment Scale (DACTS). The results were favorable and were used to identify strengths and opportunities for improvement.

**10. Mental health court is now available in all regions.**

This program provides access to treatment for persons with mental illness who have been charged with a crime, it also fosters evidence-based treatment (Assertive Community Treatment is available in all regions). Mental Health Court utilization has increased to 90% since its inception.

**11. Clinicians in county juvenile detention centers.**

This model has been adopted in all detention centers. By screening all incoming adolescents, mental health issues are being identified and treated. All juveniles in detention facilities are now screened for mental health issues.

**12. Video conferencing equipment installed in each Region, State Hospital North, State Hospital South, and Idaho State Hospital and School.**

This equipment was procured to help compensate for a statewide shortage of psychiatrists. The technology has been used to allow psychiatrists based in Boise to see patients in Idaho Falls (Region 7) and Lewiston (Region 2). This equipment is also used for meetings while avoiding costly travel arrangements. For fiscal year 2009 to date, the Department has avoided approximately \$198,000 in travel costs as a result of installing this equipment. Doctors, patients and the court system feel this is an excellent alternative to transporting a handcuffed patient to the courthouse for commitment hearings.

**13. "Home Recovery Team" (HRT)**

This program provides in-home support, treatment, and resource development for individuals at risk of out of home placement in higher levels of care. Although this program is new, early results have been promising.

**14. Psychiatric residency program in Idaho is continuing to progress.**

A Forensic Psychiatrist was recruited and hired to work in Region 4. Because of the increasing caseload of clients from the criminal justice system, this has been a tremendous asset to the Division.

**15. The Continuous Quality Improvement (CQI) process in Children's Mental Health (CMH) has been standardized.**

This process has resulted in the development and implementation of corrective action plans to help ensure standards are adhered to.

**16. Patient Assistance Program (PAP) software package was purchased for approximately \$50,000.00.**

This software automates the application process for indigent benefits offered by many pharmaceutical companies. The automation frees up staff time and offers benefits to more clients. Costs of the medications received at not cost calculated at average wholesale price (AWP) indicate benefit received by the clients for February 2009 alone exceeds \$800,000.

**17. The Client Level Reporting Project (CLRP).**

Idaho was one of nine states awarded the CLRP to explore definitions and protocols for use in reporting the National Outcome Measures (NOMS) used in Federal Mental Health Block Grant processes. This will allow Idaho to capture client level data in participating Regions 1, 5 and 6. Idaho was asked to present its experiences in collecting and reporting that data at the Data Infrastructure Grant (DIG) Conference in Washington, DC in April 2009.

## CHALLENGES

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### **Challenge 1: Idaho's mental health system is not Recovery focused or fully consumer/family driven.**

All publicly-funded mental health systems need to be more recovery/strength based. The mental health system should focus on recovery and discovery of the individual's strengths. "The National Consensus Conference on Mental Health Recovery and Mental Health Systems, Transformation, convened by SAMSHA, identified 10 fundamental elements of recovery: self-direction, individualized and person-centered care, empowerment, holistic care, non-linear growth (continual growth and occasional setbacks), strength-based models, peer support, respect, responsibility and hope."

**Issue 1a:** The WICHE group noted that there was "significant bifurcation of systems between adults and children". Idaho needs one system of care and treatment not multiple agencies with an array of different rules and regulations resulting in individuals giving up or forgoing necessary treatment.

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There is a great deal of concern for both adults and children. One of the concerning trends in the state is the increased involvement of individuals affected by mental illness and their families in the court system. The ability to access mental health services is very limited for Idahoans without mental health insurance that do not qualify for Medicaid. Hence, court involvement is often their entry point into Idaho's publicly funded mental health system.

**Issue 2a:** Access to mental health service needs to include non-serious mental illness diagnoses. People that have insufficient access to community services and/or Medicaid simply do not receive needed treatment until they decline to the point of needing costly inpatient care and services.

**Issue 2b:** Due to budget and service cuts there are less community based service providers available. Several agencies have closed or pulled out of rural areas leaving communities and families with no alternatives for community treatment. The WICHE report shows Idaho as 49<sup>th</sup> in the Nation on spending for community based services (page 25).

**Issue 2c:** PSR and Partial Care services have been significantly cut. The results and impact of these cuts are uncertain at this time. Medicaid is a claim driven system and is therefore unable to monitor the clients who either dropped their services or had their service provider

discontinue services. They will only resurface (within the system) as a claim is made. The provider can take up to one year to generate a claim, for these reasons this will be a difficult situation to monitor.

**Challenge 3: Adult and juvenile transition services are underdeveloped.**

Reentry issues for adults and juveniles coming out of incarceration or institutions continue to be a major problem both with housing issues and with needed follow-up services.

**Challenge 4: Idaho lacks a statewide suicide prevention hotline.**

The Joint Finance and Appropriation Committee (JFAC) cut the Community Collaboration Grant program by half from one million to \$500,000. In February we were notified that the Idaho Suicide Prevention Hotline Grant would be terminated effective March 3, 2009. *Suicide is the second leading cause of death for Idaho's youth.* Idaho is one of only three states without a suicide hotline. Having a suicide crisis hotline in Idaho is especially important to citizens in rural areas where access to mental health services are limited. There is currently a call center in another state that is taking these calls. This is a Band-Aid solution. The regional call center does not have access to resources that are local to the calling parties.

**Challenge 5: Re-establish community resource workers in Idaho's 114 school districts.**

The resource workers helped to identify the unmet needs of children and families by providing information and support in seeking available community resources for families and should be re-established. Evidence shows that linking families to support systems reduces unnecessary stressors.

**Challenge 6: Minimal access to substance use/abuse and mental health treatment is currently available outside the criminal justice system in Idaho.**

Director Armstrong's report entitled "A Profile: Substance Use Disorders in Idaho SFY 2009" states that "currently, almost all adolescents entering treatment are involved with the juvenile justice system".

**Challenge 7: Publicly-funded hospitals in Idaho should be accessible voluntarily.**

Currently, the majority of individuals hospitalized are court committed. Voluntary admissions should be the norm, not the exception. Idaho needs to identify and provide a payment source for indigent patients to include short-term Medicaid and help insure the least restrictive and most appropriate treatment settings are available.

**Challenge 8: Early intervention and detection programs need to be developed.**

Recommendation 4.1 in the WICHE Report states “amend eligibility criteria for public mental health and substance abuse services to support access to screening, assessment, early intervention, and recovery” – all of which the State Planning Council supports. The National Mental Health Information Center reports that about two-thirds of the young people needing mental health services in the United States are not getting them. Providing early intervention can result in less children moving into the juvenile justice system requiring mental health treatment.

**Challenge 9: Lack of trainings available to school resources who serve children with mental health needs.**

*This need is at a critical point and must be addressed.*

**Challenge 10: State Hospital beds need to be accredited.**

State Hospital North continue to seek accreditation in order to attract competent and quality staff to serve the needs of Idaho citizens.

**Challenge 11: Strengthen voice of the Regional Mental Health Boards.**

Idaho needs to explore better ways to connect the Regional Mental Health Boards with the State Planning Council by using the State Planning Council as the “hub” for information sharing across the state. This would allow each Regional Mental Health Board insight into what is working well in other regions.

**Challenge 12: Oversight for the quality of public mental health services in Idaho is lacking.**

The WICHE Report identified this as a priority. Recommendation 1.1 of the WICHE report suggests transforming the Division of Behavioral Health into a Division that directly and promptly improves the quality of care at the ‘point of care’. This transformation will include:

1. Becoming a guarantor of care rather than a deliverer of care by administering, monitoring and ensuring the quality of care;
2. Leading collaborative efforts that include key community stakeholders and other departments divisions and agencies to improve systems; and,
3. An integration of operations within DBH; across divisions within the Department; and amongst executive branch agencies, including the Office of Drug Policy. Transforming the role of DBH is not a small or simple recommendation. There currently is almost no quality assurance or monitoring of mental health and substance abuse services. No one agency appears to be responsible for ensuring that treatment services are provided appropriately or that they ‘work’. Moreover, there is no agency overseeing the DBH-provided direct services to ensure that their services are necessary, appropriate and beneficial. This situation results

in a relatively high risk for the state. These risks are not present in most states, as their mental health (and substance abuse) authorities do not provide direct care services in the community. In most states, the mental health authority provides oversight and technical assistance, and monitors service contracts with community providers.

**Challenge 13: Veterans returning to Idaho from military service currently lack adequate services and information regarding resources through Idaho's Veterans Administration.**

Returning Veterans are not always aware of, or have access to the services in their areas. The Veterans Administration needs to provide more information to returning Veterans regarding mental health and general health care services available in both Idaho and Washington.

**Challenge 14: Loss of Community Incentive Grant.**

The loss of the community grants has severely impacted the development of identified regional resources that are specific to the needs of each of the individual regions. The grant projects helped develop collaboration and a sense of community involvement in solving the gaps in services. Idaho needs to consider restoring this program in better economic times.

**Idaho State Planning Council on Mental Health - 2009**

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Rep. Sharon Block 12/31/10	Agency	Legislature	1093 Lakewood Dr. Twin Falls, ID 83301 208-734-6360 sblock@house.idaho.gov
VACANT 12/31/09	Agency	Department of Education	P.O. Box 83720 Boise, ID 83720 208-332-6917  @sde.idaho.gov
Kathie Garrett 12/31/10	Agency	Idaho Council on Suicide Prevention	2281 W. Trestle Dr. Meridian, ID 83646 208-344-5838 kgarrettidaho@aol.com
Pat Guidry 12/31/09	Agency	Division of Medicaid	3232 Elder St. Boise, ID 83720 208-346-1813 guidryp@dhw.idaho.gov
Gary Hamilton 12/31/10	Agency	Department of Vocational Rehabilitation	2025 W. Park Place, #101 Coeur d'Alene, ID 83814-2699 208-769-1441 ghamilton@vr.idaho.gov
Robert Bishop 12/31/09	Agency	State Mental Health Agency	2195 Ironwood Court Coeur d'Alene, ID 83814 208-769-2739 bishopR@dhw.idaho.gov
Judge Brent Moss 12/31/10	Agency	Judicial	P.O. Box 389 Rexburg, ID 83440 208-356-6880 bmoss@co.madison.id.us
Mary Perrien 12/31/10	Agency	Criminal Justice	IDOC 1299 N. Orchard St., Ste. 110 Boise, ID 83706 208-658-2144 mperrien@idoc.idaho.gov
Julie Williams 12/31/10	Agency	Housing	P.O. Box 7899 Boise, ID 83707-1899 208-331-4758 juliew@ihfa.org
Teresa Wolf Chair 12/31/09	Agency	Social Services	PO Box 896 Lewiston, ID 83501 208-799-3095 teresawolf@co.nezperce.id.us
Corinna Wolfe-Stiles 12/31/10	Agency	CO-AD	4477 Emerald St., Ste. B100 Boise, ID 83706 208-336-5353 x19 Corinnaw@cableone.net
Kim Wherry Toryanski 12/31/10	Agency	Aging	3380 Americana Terrace, Ste. 120 Boise, ID 83720 208-334-3833 ktoryanski@aging.idaho.gov

Rose Marie Tiffany 12/31/10	Board Member	Region I MH Advisory Board	13191 E. Rosewood Dr. St. Maries, ID 83861 208-689-3603 tiffany83861@yahoo.com
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Lisa Koltes, MD 12/31/09	Board Member	Region III MH Advisory Board	3309 Hazelwood Circle Caldwell, ID 83605 208-453-9470 lkoltes@msn.com koltesL@dhw.idaho.gov
Courtney Lester-Santillan 12/31/09	Board Member	Region IV MH Advisory Board	1509 S. Roberts St., Ste. 101 Boise, ID 83705 208-433-8845 clester@idahofederation.org
Shirley Clark Membership Chair 12/31/10	Board Member	Region V MH Advisory Board	Star Route Box 20 Albion, ID 83311 208-673-5332 saclark@live.com
Linda Hatzenbuchler, Ph.D. Executive Committee 12/31/10	Board Member	Region VI MH Advisory Board	Idaho State University College of Health Related Professions Box 8090 – CD 186 Pocatello, ID 83209 208-282-3992 hatzlind@isu.edu must e-mail Suzzie Morris: morrus2@isu.edu
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Martha Ekhoﬀ 12/31/10	Consumer	Region IV Consumer	1607 W. Jefferson St. Boise, ID 83702 208-336-5333 x340 mekhoff@mtnstatesgroup.org
Rick Huber Executive Committee 12/31/09	Consumer	Region V Consumer	309 Pashermakay Court #7 Rupert, ID 83350 208-436-1841 rick2727272000@yahoo.com
VACANT	Consumer	Region VII Consumer	
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Linda Johann 12/31/09	Family	Region I Family	11655 W. Manitoba Court Post Falls, ID 83854 208-773-2778 208-665-5666 - work ljohann@svf.net
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Barbara Hill-Harkins 12/31/09	Family	Region III Family	3707 Pioneer Park Lane Homedale, ID 83628 208-337-4564 hillharkins@gmail.com

VACANT	Parent	Region IV Parent	
Angela Hicks 12/31/09	Parent	Region V Parent	205 Aspen Dr. Ketchum, ID 83340 208-726-9519 208-720-1514 - cell monarch83340@hotmail.com
Michael Stayner 12/31/09	Family	Region VI Family	911 N. 7 <sup>th</sup> Ave. Pocatello, ID 83206 208-234-6141 mstayner@pocatello.us
Lynne Whiting Executive Committee 12/31/10	Parent	Region VI Family	160 N. Shilling Ave. Blackfoot, ID 83221 208-403-9140 lynne@idahofederation.org
Cynthia McCurdy 12/31/10	Parent	Region VII	2546 W. 6300 St. Rexburg, ID 83440 208-356-4204 efitecyn@hotmail.com
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# Idaho

## Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

## Unmet Service Needs

In May and June 2009, the Idaho State Planning Council on Mental Health developed and prioritized the following unmet service needs, which are taken from their June 2009 report, the *2009 Idaho State Planning Council on Mental Health Report to the Governor and Legislature*.

### **Challenge 1: Idaho's mental health system is not Recovery focused or fully consumer/family driven.**

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# Idaho

## Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

### **Plan to Address Unmet Needs**

The SPCMH provides a consumer voice for publicly funded mental health services available to our residents (this was a key recommendation of The President's New Freedom Commission on Mental Health – Achieving the Promise: Transforming Mental Health Care in America published in July, 2003). We are here to assure that Idaho's public mental health system continues to move forward in quality and efficiency.

The membership of the SPCMH is committed to developing a public mental health system in Idaho in which recovery from mental illness is expected, programs to prevent mental illness are consumer and family driven and are available in all parts of the state. We stand ready to assist in whatever may be necessary to accomplish this end.

### **The President's New Freedom Commission on Mental Health – Achieving the Promise: Transforming Mental Health Care in America' goals endorsed by the SPCMH.**

In a transformed Mental Health System:

1. Americans Understand that Mental Health Is Essential to Overall Health.
2. Mental Health Care Is Consumer and Family Driven.
3. Disparities in Mental Health Services Are Eliminated.
4. Early Mental Health Screening, Assessment and Referrals to Services Are Common Practice.
5. Excellent Mental Health Care is Delivered and Research Is Accelerated.
6. Technology Is Used to Access Mental Health Care and Information.

### **Executive Summary**

The Idaho State Planning Council on Mental Health (SPCMH) provides a voice and advocacy for children, youth, adults, and families on a broad range of mental health issues. Our annual report is designed to provide a clear overview of the vast array of accomplishments of the SPCMH, Regional Mental Health Boards, and the Division of Behavioral Health. It is essential to the success of Idaho's Mental Health System of Care to improve access to treatment, expand system collaboration, and continue to strengthen community partnerships.

Our report includes accomplishments, opportunities captured, and challenges left to address. A sampling of the issues contained in the annual report is listed below:

- Improved communication and centralized reporting with the Governor, Legislature, and the Regional Mental Health Boards.
- Transformation of Idaho's Mental Health System in conjunction with WICHE and the Governor's Transformation Workgroup, Medicaid Reform, inclusion of the Wellness Recovery Action Plan to assist Peer Specialists, Parenting with Love and Limits, and increased focus on housing issues.
- Supporting adult and juvenile court collaboration and provide needed resources to many citizens seeking treatment.
- A number of issues surrounding Idaho's Mental Health system continue to challenge us and include:

- ❖ Development of a Consumer/Family Driven System of Care
- ❖ Recovery as a focus
- ❖ Access to Community Based Services
- ❖ Support for a Statewide Suicide Prevention Hotline

**What to Expect in 2009/2010 from the Idaho State Planning Council on Mental Health:**

- **Continued Improvement of Communication Methods**
  - Information sharing with affiliates and other agencies on current issues and events is one key to a successful system
  - Encouraging the Regional Mental Health Boards to report centrally promotes distribution of information, ideas, and successes
- **Committee Involvement and Project Development**
  - Children's, Transformation/Housing, Membership, Legislative, and Education/Communication subcommittees are accountable for forming guidelines and responsibilities, goal setting, and project development.
- **Further Strengthen Collaborative Efforts with all Related Agencies and Affiliates**
  - Be more accessible
  - Clarify and advance our mission and direction
  - Become more visible
  - Develop sustainable partnerships

**Information sharing is a key component to a successful system.**

Using the SPCMH as a hub for distributing information by and between Regional Mental Health Boards will improve the system as a whole. This distribution will allow successful ideas and projects to be replicated throughout Idaho.

**By requiring the State Planning Council subcommittees to focus on our mission and direction, the Council will become more visible to our partners, and the mission clarified.**

The SPCMH will become more visible to the public and associate agencies by participating in active ways in local issues, communicating goals, visions and values, and being a robust voice for Idahoans living with mental health issues.

**Being a viable part of the mental health system promotes cooperation and collaboration.**

The SPCMH plays a key role in the mental health system of care. We are charged with serving as an advocate, advising, and providing guidance, monitoring and evaluating the system, and ensuring access. Our mission is to serve as a vehicle for policy and program development and to report on those achievements and system impacts. The SPCMH is dedicated to achieving those responsibilities with which we have been entrusted.

In May and June 2009, the Idaho State Planning Council on Mental Health developed and prioritized the following opportunities with respect to meeting unmet service needs (taken from their June 2009 report, the *2009 Idaho State Planning Council on Mental Health Report to the Governor and Legislature*).

**1. The Idaho Mental Health and Substance Abuse System Redesign Project, otherwise know as the WICHE Report, offers Idaho a great opportunity to transform the current mental health system.**

The WICHE Report was commissioned and funded by the Legislature in 2007 through SCR 105. The findings and recommendations of the WICHE Report were presented to the Legislature via the Health Care Task Force. The report was strongly endorsed by that group's Mental Health Subcommittee. The report identified the need to create a statewide "transformation workgroup" to identify and address barriers to transformation. In January 2009 a Governor issued Executive Order created the Behavioral Health Transformation Workgroup. In his Executive Order No. 2009-04 the Governor stated "Idaho citizens and their families should have appropriate access to quality services through the public mental health and substance abuse system that are coordinated, efficient and accountable." The Legislature has appropriated \$250,000 to support the mission of this Workgroup. The Workgroup is to develop a plan for a coordinated, efficient state behavioral health infrastructure and present a plan to the Governor by December 2009 and the Legislature in 2010.

**2. The WICHE report has identified increasing accountability through information and data as a priority.**

According to the report, "Idaho's mental health data system did not appear to be robust, with a solid, valid set of statewide data available on program specifics, including outcomes. There appeared to be more data available for the substance abuse program, however, there remain gaps in the ability to track service delivery and outcomes in that system also (page 37)." A more robust data system will help the Department of Health and Welfare to provide oversight of providers, track services and outcomes and lead to more evidence based practices. Experience of the substance abuse treatment programs, Office of Drug Policy and Interagency Committee on Substance Abuse (ICSA) has demonstrated that outcome data is the key to policy maker's support of programs. Policy makers and Legislators want to see that the programs they support with funding are having positive outcomes.

**3. Continued work and refinement of Medicaid Reform.**

Medicaid reform has seen significant cuts in hours of PSR (not heavily utilized) and Partial Care services (the current model has not proven to be recovery oriented) along with significant changes in requirements for Community Providers. Medicaid should continue to work with Community Providers to make sure that the transition to a system that is based on the new requirements is both manageable and productive. Medicaid should continue their efforts on a reform package that offers services with an emphasis on recovery.

**4. Enhancing the Efficiency of the State's Hospital Capacity**

**Recommendation 5.1:** Conduct a review of State Hospital utilization data (both sites) to identify:

1. Valid mean (average) and median lengths of stay by region over a year;
2. The number of individuals who would benefit from community-based services and the type(s) of service(s) required;
3. The cost accrued per day by these individuals in the state hospitals; and,
4. The potential State Hospital cost avoidance that could be realized by decreasing inpatient stay and increasing community tenure.

**Recommendation 5.2:** Allocate specific, acute bed capacity to the regional behavioral health authorities.

**Recommendation 5.3:** Achieve and maintain accreditation for **both** state hospitals.

**Recommendation 5.4:** Utilize deliberate planning and program development in secure facilities. This will ensure that civilly committed persons treated in these facilities are served in the least restrictive environment based upon their clinical and legal circumstances.

# Idaho

## Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

## Recent Significant Achievements

The Adult Mental Health Program has realized significant progress towards the development of a comprehensive community-based system of care for adults with a serious and persistent mental illness. Highlights of these achievements during SFY 2009 include the following:

### 1. Idaho Mental Health Transformation

Mental Health Transformation is an ongoing focus for the State of Idaho. Efforts to address transformation have included initial developmental efforts of a transformation workgroup, a review of the mental health and substance use service delivery system by the Western Interstate Commission for Higher Education (WICHE) Mental Health Program, and the establishment of a new transformation workgroup.

Previously and under the direction of Governor Dirk Kempthorne, Idaho initiated the Idaho Mental Health Transformation Work Group (TWG) in early 2006 in response to the recommendations of the President's New Freedom Commission report (2003). Guided by a steering committee composed of local and state government leadership, professional associations, consumer groups and other stakeholders, the TWG met from 2006 until 2007 and delivered a *Comprehensive Statewide Mental Health Transformation Action Plan 2007: The First Steps* (December 2006). According to this plan, the goals of a transformed system in Idaho were to 1) "Effect a paradigm shift by transforming the way we as a community think about and embrace mental health, understanding that mental health is essential to overall health...[2] Achieve a consumer-driven system of care by transforming the mental health delivery system to one that is based on individual strengths and needs, emphasizes resiliency and recovery, and features accessibility...[3] Organize the structure to sustain the vision by transforming the manner in which resources are provided, coordinated and delivered." (p. 3).

According to Senate CR Number 108 (2007) and through the Legislative Health Care Task Force, the Idaho State Legislature directed implementation of a study to review Idaho's mental health and substance abuse treatment delivery system and to recommend system improvements. The Legislature contracted with the Western Interstate Commission for Higher Education (WICHE) Mental Health Program to conduct this study. Areas assessed included treatment capacity, cost, eligibility standards and areas of responsibility. The study process included five site visits, 150 stakeholder interviews and use of a web-based survey with responses from 550 Idaho stakeholders. The final written report with recommendations, *2008 Idaho Behavioral Health System Redesign*, was submitted in August 2008.

The Governor convened the Behavioral Health Transformation Workgroup in April 2009 to promote the legislature's interest in advancing the provision of core services from the regions to private provider community settings as outlined in the WICHE *2008 Idaho Behavioral Health System Redesign* report. This group includes representation from DHW, Boise State University, the Office of Drug Policy, the Department of Juvenile Corrections, the State Planning Council on Mental Health, the Bonneville County

Sheriff's Office, the courts, the Department of Education, private providers, business, the Association of Counties, and the Department of Correction. Recommended WICHE goals that are being considered include 1) Establish a coordinated, efficient state infrastructure with clear responsibilities and leadership authority and action, 2) Create a comprehensive, viable regional or local community delivery system, 3) Make efficient use of existing and future resources, 4) Increase accountability for services and funding, 5) Provide authentic stakeholder participation in the development, implementation and evaluation of the system, and 6) Increase the availability of, and access to, quality services.

## **2. Adult Mental Health Data System Activities**

The Behavioral Health (BH) Monthly Data Report was piloted in December 2006, using regional hand counts of each element that were submitted to Central Office, where they were manually tallied into a statewide monthly report. This report has continued to evolve since that time, as the Leadership Team refines data definitions and identifies either more effective means of data capture or additional elements that need to be tracked.

During SFY 2009, the two State Hospitals (North and South) completed Vista installation and implementation. The AMH program pursued the joint purchase and use of the WITS system by both the AMH and the Substance Use Disorders (SUD) programs. On the AMH side, the WITS system was programmed with the Client Level Reporting Project (CLRP; see paragraph below) data definitions of the NOMS. Development of WITS was completed by June 2009, and implementation and training activities are scheduled through SFY 2010 with the expectation of system use by October 2009.

The Division of Behavioral Health continues to pursue strategies to allow improved data infrastructure development for both the long and short-term data needs in the AMH program. The AMH program is currently working with data entry specialists from each region to identify data needs and training opportunities. The Data Infrastructure Grant (DIG) helps to support these efforts.

The Division of Behavioral Health was awarded a Client Level Reporting Project (CLRP) grant in the winter/spring of 2008. This award allows three regions (i.e., Regions 1, 5 and 6) to pilot the Data Dictionary and Protocol that were developed by the nine participating states in an effort to create increased consistency and standardization in data capture and reporting of the National Outcome Measures (NOMS). This project has completed a test case deliverable and a deliverable of FY 2008 service data with CLRP data definitions. It will complete the final deliverable of SFY 2009 NOMS data by the project end date in September of 2009.

## **3. Patient Assistance Program (PAP)**

A Patient Assistance Program (PAP) software package was purchased for approximately \$50,000. This software automates the application process for the indigent benefits offered by many pharmaceutical companies, allowing clients to receive needed medications at no cost. The automation frees up staff time and essentially offers these

benefits to more clients. If the costs of the medications received for free are calculated at average wholesale price (AWP), the benefit received by clients for February 2009 alone exceeds \$800,000.

#### **4. Telehealth Service Implementation (TSI) Project**

The Department of Health and Welfare established a Telehealth System Implementation (TSI) videoconferencing work group that produced a Strategy for Video Conferencing Plan in April 2008. The purpose of the TSI project was to use information technology to assist government efforts to increase efficiency, reduce costs, and improve health and behavioral health access, services and education to Idaho citizens. Videoconferencing equipment priority use is the need for telemedicine to expand psychiatric service access to prevent crises and maintain client stabilization, especially in rural and frontier areas.

During SFY 2009, equipment (i.e., the Polycom HDX 7000 Series with high definition video, voice and content sharing capabilities, Sony Bravia HDTVs and flat panel audiovisual carts with locking cabinets) was installed and tested at Central Office, State Hospital South, State Hospital North and each of seven regions. As of September 2008, eleven high definition videoconferencing sites were available for site to site use. Sites included regional main offices, central office and three state hospitals (State Hospital South, State Hospital North and Idaho State School and Hospital). Since that time, the system was expanded to allow multi-site videoconferencing. As of May 2009, up to eight sites could participate simultaneously. Alternatively, four sites could simultaneously videoconference in high definition.

Although installed for less than a year, the videoconferencing equipment has been used for a multitude of purposes by a variety of agencies. Purposes include availability to coordinate statewide communications in the event of a disaster, provision and enhancement of psychiatric services, site reviews, hospital discharge planning, statewide meetings, supervision, training and education. The Behavioral Health program has expanded access to psychiatric care and services to adults with a serious mental illness in rural and frontier areas through high definition videoconferencing. The Self Reliance program used this system to facilitate implementation of the Idaho Benefits Information System. Medicaid found it useful for provider trainings on new mental health rules. Idaho State School and Hospital used the system to evaluate drug wholesalers. The State Planning Council on Mental Health has found videoconferencing to be an effective way to extend their budget while continuing to have meetings to address mental health issues. The Second District Drug Court has used it for training and education. The Idaho Supreme Court has offered team training sessions on topics such as child protection and drug court.

The federal government recently indicated interest in piloting the use of videoconferencing to conduct mental health block grant review meetings with up to five states. Idaho expressed interest in participating in such a pilot project. If successful, this process would save state employee time and federal money that has historically been directed to allow staff to travel to another state for block grant defense.

As of May 2009, three contracted psychiatrists were providing telemedicine from the Boise Central Office. From September 2008 through May 2009, Region 2 estimated that 360 clients received psychiatric services through this system. Region 7 began using these services in February 2009, with an estimated 180 clients benefitting through May 2009.

Idaho is primarily a rural and frontier state with all Idaho counties designated as mental health professional shortage areas. Psychiatric coverage is difficult to ensure across the State. Travel costs can be expensive. In a lean economic climate, all methods of cost reduction without compromising services are critical. Use of videoconferencing technology reduces costs with a high return on investment. High definition equipment allows for the provision of telemedicine, education, site reviews and meetings without the requirement of travelling to a central location for a face to face meeting.

Use of the videoconferencing equipment began slowly from September through December 2008, but increased rapidly from January 2009. From September through December 2008, the recognized cost savings was \$15,485. From January through May 2009, the cost savings for all users totaled \$182,388. The cost savings related to the TSI project as measured by reduction in travel costs (i.e., mileage, airfare, staff time to travel, per diem, hotel and other miscellaneous costs accrued in the course of travel to attend face to face meetings) has exceeded installation costs in less than a year. The total equipment costs of \$189,000 included cameras, monitors, carts, routers and a Multi-Channel Unit (MCU) device that enables simultaneous linkages to more than two connections. From September 2008 through May 2009, the total savings across all users was \$197,873.

## **5. Forensics**

The Idaho Mental Health Court program is targeted to address the service needs of adults diagnosed with a severe and persistent mental illness and who have also plead guilty to misdemeanor or felony crimes. Eligible and accepted individuals must agree to participate in active treatment for the mental illness and/or co-occurring substance abuse issues. While engaged in active treatment the jail sentence is suspended. The mental health court process involves an intensive and collaborative effort between judges, prosecutors, public defenders, probation officers, substance abuse treatment providers, jail representatives, NAMI, the CMHC's Assertive Community Treatment (ACT) or Forensic Assertive Community Treatment (FACT) teams and regional crisis teams.

Regional AMH Program Managers continue collaborative efforts in response to increased requests for best practice services to mental health court referrals. During SFY 2009, Mental Health Court Utilization increased to approximately 90% of capacity. A Forensic Psychiatrist was hired in Region 4 to provide services to increased numbers of clients referred from the criminal justice system.

During the 2009 legislative session, HB 321 authorized \$846,600 "...of ongoing funding within the Mental Health Grants Program for the Region 4 Dual Diagnosis Crisis Intervention beds...[and]... \$1,165,000 base ongoing funding to be continued in fiscal

year 2010 for the Region 7 grant project that was selected in fiscal year 2008.” The Region 7 project referred to provides mental health and substance use treatment at the jail in Bonneville County.

In addition to collaborating with the courts and corrections to establish referral, assessment, monitoring and treatment procedures, regional AMH programs also review and revise treatment services as needed in an effort to provide best practice, efficient and effective services. Besides use of the CCISC model of treatment for co-occurring disorders, all regional programs also have access to the Eli-Lilly Wellness curriculum and the Eli-Lilly Differential Diagnosis materials.

#### **6. Crisis Services; Crisis Intervention Teams and Home Recovery Teams**

The 2006 Legislature allocated two million dollars in State Fiscal Year 2007 to fund collaborative regional projects designed to meet unmet service needs for adults and/or children diagnosed with a serious mental illness and/or substance abuse. One of these Service Plan Component projects provided for joint crisis training for law enforcement and mental health staff. In State Fiscal Year 2008, additional funds were allocated to support similar One-Time Development (i.e., \$2,000,000) projects. One award funded early intervention and crisis treatment (mental health, substance use, criminal involvement), including a transitional housing component. While the 2009 economic downturn has not allowed for funding for a new round of mental health community development grant projects, the opportunity to develop such projects in previous years continues to positively impact the mental health service delivery system through other previously developed programs as well (e.g., transitional housing, CIT training).

During SFY 2009, an innovative public-private partnership was formed in Region 4. The Home Recovery Team (HRT) provides in home support, treatment and resource development for individuals who are at risk of out of home placement in more restrictive levels of care. Although this program is new, results have been promising.

Idaho remains committed to educating staff in Risk Assessment for Violence and in methodologies to ensure safe and effective resolution of crisis situations. In April 2007, Idaho sponsored Dr. Phillip Resnick to come and train on Risk Assessment for Violence. Dr. Resnick offered a workshop to approximately 300 individuals in Twin Falls on one day and approximately 250 participants in Boise the following day. A June 2008 statewide Designated Training (DE) training session was videotaped and is available for use by the regions. Pat Shea, Deputy Director of the Office of Technical Assistance at NASMHPD presented the Creating Violence Free and Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint workshop at the Idaho State University extension center in Idaho Falls on July 7-8, 2009. Forty staff from State Hospital South, eleven from Idaho State School and Hospital, six from State Hospital North, and an assortment of state and private provider staff attended for a total of 115 participants. One of the goals of providing this training opportunity was to broaden the skills and values related to reducing seclusion and restraint among both state and private providers.

## **7. Peer Specialist Certification and Placement with ACT Teams**

Through a contract with the Division of Behavioral Health, the Office of Consumer Affairs took responsibility to develop and implement a Peer Specialist Certification program in Idaho. Fifteen consumers were trained in February 2009, with twelve passing the certification exam. Certified Peer Specialists are expected to complete their own Wellness Recovery Action Plans (WRAP) in addition to completing the Peer Specialist Certification training. Certification training is again scheduled for September 2009.

In SFY 2009, seven certified Peer Specialists were placed; one on each of seven regional Assertive Community Treatment (ACT) teams. In addition to receiving supervision and support from regional ACT supervisors and the Office of Consumer Affairs, those Peer Specialists who are enrolled with the Division of Vocational Rehabilitation (VR) are able to avail themselves of additional support from their VR staff as needed. The Division of Vocational Rehabilitation has also been open to discussing other placement possibilities for certified Peer Specialists.

## **8. Housing and Homelessness**

During SFY 2009, there were several activities directed to housing and homelessness. A federal audit of the Pathways in Transition from Homelessness (PATH) grant provided an opportunity for each region to use feedback to develop an action plan to reflect opportunities for improvement in efforts to provide outreach and prevent homelessness among adults diagnosed with a serious mental illness. The Charitable Assistance to Community's Homeless (CATCH) program that mobilizes community resources to help address homelessness was expanded to include Region 3 in addition to Region 4. The process for accessing Shelter Plus Care beds has been standardized, leading to an increased level of regional involvement with these housing vouchers.

# Idaho

## Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

## **Future Vision 2010**

In May and June 2009, the Idaho State Planning Council on Mental Health developed and prioritized the following vision for Idaho's mental health system, which is taken from their June 2009 report, the *2009 Idaho State Planning Council on Mental Health Report to the Governor and Legislature*.

### **Executive Summary**

The Idaho State Planning Council on Mental Health (SPCMH) provides a voice and advocacy for children, youth, adults, and families on a broad range of mental health issues. Our annual report is designed to provide a clear overview of the vast array of accomplishments of the SPCMH, Regional Mental Health Boards, and the Division of Behavioral Health. It is essential to the success of Idaho's Mental Health System of Care to improve access to treatment, expand system collaboration, and continue to strengthen community partnerships.

Our report includes accomplishments, opportunities captured, and challenges left to address. A sampling of the issues contained in the annual report is listed below:

- Improved communication and centralized reporting with the Governor, Legislature, and the Regional Mental Health Boards.
- Transformation of Idaho's Mental Health System in conjunction with WICHE and the Governor's Transformation Workgroup, Medicaid Reform, inclusion of the Wellness Recovery Action Plan to assist Peer Specialists, Parenting with Love and Limits, and increased focus on housing issues.
- Supporting adult and juvenile court collaboration and provide needed resources to many citizens seeking treatment.
- A number of issues surrounding Idaho's Mental Health system continue to challenge us and include:
  - ❖ Development of a Consumer/Family Driven System of Care
  - ❖ Recovery as a focus
  - ❖ Access to Community Based Services
  - ❖ Support for a Statewide Suicide Prevention Hotline

### **What to Expect in 2009/2010 from the Idaho State Planning Council on Mental Health:**

- **Continued Improvement of Communication Methods**
  - Information sharing with affiliates and other agencies on current issues and events is one key to a successful system
  - Encouraging the Regional Mental Health Boards to report centrally promotes distribution of information, ideas, and successes
- **Committee Involvement and Project Development**
  - Children's, Transformation/Housing, Membership, Legislative, and Education/Communication subcommittees are accountable for forming guidelines and responsibilities, goal setting, and project development.

- **Further Strengthen Collaborative Efforts with all Related Agencies and Affiliates**
  - Be more accessible
  - Clarify and advance our mission and direction
  - Become more visible
  - Develop sustainable partnerships

**Information sharing is a key component to a successful system.**

Using the SPCMH as a hub for distributing information by and between Regional Mental Health Boards will improve the system as a whole. This distribution will allow successful ideas and projects to be replicated throughout Idaho.

**By requiring the State Planning Council subcommittees to focus on our mission and direction, the Council will become more visible to our partners, and the mission clarified.**

The SPCMH will become more visible to the public and associate agencies by participating in active ways in local issues, communicating goals, visions and values, and being a robust voice for Idahoans living with mental health issues.

**Being a viable part of the mental health system promotes cooperation and collaboration.**

The SPCMH plays a key role in the mental health system of care. We are charged with serving as an advocate, advising, and providing guidance, monitoring and evaluating the system, and ensuring access. Our mission is to serve as a vehicle for policy and program development and to report on those achievements and system impacts. The SPCMH is dedicated to achieving those responsibilities with which we have been entrusted.

**The President’s New Freedom Commission on Mental Health – Achieving the Promise: Transforming Mental Health Care in America’ goals endorsed by the SPCMH.**

In a transformed Mental Health System:

1. Americans Understand that Mental Health Is Essential to Overall Health.
2. Mental Health Care Is Consumer and Family Driven.
3. Disparities in Mental Health Services Are Eliminated.
4. Early Mental Health Screening, Assessment and Referrals to Services Are Common Practice.
5. Excellent Mental Health Care is Delivered and Research Is Accelerated.
6. Technology Is Used to Access Mental Health Care and Information.

Specific recommendations from the Planning Council's report include the following:

**1. The Idaho Mental Health and Substance Abuse System Redesign Project, otherwise known as the WICHE Report, offers Idaho a great opportunity to transform the current mental health system.**

The WICHE Report was commissioned and funded by the Legislature in 2007 through SCR 105. The findings and recommendations of the WICHE Report were presented to the Legislature via the Health Care Task Force. The report was strongly endorsed by that group's Mental Health Subcommittee. The report identified the need to create a statewide "transformation workgroup" to identify and address barriers to transformation. In January 2009 a Governor issued Executive Order created the Behavioral Health Transformation Workgroup. In his Executive Order No. 2009-04 the Governor stated "Idaho citizens and their families should have appropriate access to quality services through the public mental health and substance abuse system that are coordinated, efficient and accountable." The Legislature has appropriated \$250,000 to support the mission of this Workgroup. The Workgroup is to develop a plan for a coordinated, efficient state behavioral health infrastructure and present a plan to the Governor by December 2009 and the Legislature in 2010.

**2. The WICHE report has identified increasing accountability through information and data as a priority.**

According to the report, "Idaho's mental health data system did not appear to be robust, with a solid, valid set of statewide data available on program specifics, including outcomes. There appeared to be more data available for the substance abuse program, however, there remain gaps in the ability to track service delivery and outcomes in that system also (page 37)." A more robust data system will help the Department of Health and Welfare to provide oversight of providers, track services and outcomes and lead to more evidence based practices. Experience of the substance abuse treatment programs, Office of Drug Policy and Interagency Committee on Substance Abuse (ICSA) has demonstrated that outcome data is the key to policy maker's support of programs. Policy makers and Legislators want to see that the programs they support with funding are having positive outcomes.

**3. Continued work and refinement of Medicaid Reform.**

Medicaid reform has seen significant cuts in hours of PSR (not heavily utilized) and Partial Care services (the current model has not proven to be recovery oriented) along with significant changes in requirements for Community Providers. Medicaid should continue to work with Community Providers to make sure that the transition to a system that is based on the new requirements is both manageable and productive. Medicaid should continue their efforts on a reform package that offers services with an emphasis on recovery.

**4. Enhancing the Efficiency of the State's Hospital Capacity**

**Recommendation 5.1:** Conduct a review of State Hospital utilization data (both sites) to identify:

1. Valid mean (average) and median lengths of stay by region over a year;
2. The number of individuals who would benefit from community-based services and the type(s) of service(s) required;
3. The cost accrued per day by these individuals in the state hospitals; and,
4. The potential State Hospital cost avoidance that could be realized by decreasing inpatient stay and increasing community tenure.

**Recommendation 5.2:** Allocate specific, acute bed capacity to the regional behavioral health authorities.

**Recommendation 5.3:** Achieve and maintain accreditation for **both** state hospitals.

**Recommendation 5.4:** Utilize deliberate planning and program development in secure facilities. This will ensure that civilly committed persons treated in these facilities are served in the least restrictive environment based upon their clinical and legal circumstances.

# Idaho

## Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

The Children's Mental Health Program and the Adult Mental Health Program have been integrated to create the Division of Behavioral Health. This is a combined response between Adult and Children's Mental Health programs. Please see the Adult section for Idaho's response.

# Idaho

## Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

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# Idaho

## Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

The Children's Mental Health Program and the Adult Mental Health Program have been integrated to create the Division of Behavioral Health. This is a combined response between Adult and Children's Mental Health programs. Please see the Adult section for Idaho's response.

# Idaho

## Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

## Recent Significant Achievements

### Planning Council Achievements

#### 1. Influencing change to Mental Health Board membership

- a. The SPCMH was kept well informed by the membership on legislative issues and was able to provide the needed support for the addition of children's representation and clarification of membership on the Regional Mental Health Boards. With the loss of the Children's Mental Health Councils it was imperative that each regional board continued to address children's issues.
- b. Our representative gave a report to the House Health and Welfare Committee during this legislative session on the concerns, gaps and needs identified by the SPCMH.
- c. The SPCMH formed a committee to keep us apprised on all legislative activity and issues of concern that affect our legally mandated responsibilities. The information was communicated to the membership to insure inclusion of the regional mental health boards.

#### 2. Informing Legislators regarding housing and the need to recognize recovery as issues of high importance to the citizens of Idaho at the Annual Legislative Breakfast and other times throughout the year

- a. The SPCMH membership met with each Legislator in attendance at our legislative breakfast to discuss the importance of the need to continue to make suitable, stable and affordable housing a priority for persons with mental illness and their families, as this is key to their recovery. The housing shortage in Idaho is at a critical level and needs to remain a top priority issue for the regions and the Legislature. We have formed a subcommittee to continue to keep the SPCMH apprised of the housing issues in Idaho so that we may assist others in their quest to solve regional problems.
- b. The membership regularly provides legislators up-to-date information regarding mental health issues, assisting them in making informed decisions.

#### 3. Functioned with minimal cost and no financial increases

- a. The SPCMH understands and has risen to the challenge to keep expenses at a minimum and within our allotted budget. We have utilized videoconferencing, teleconferencing, and e-mail whenever possible. We have reduced the number of members and are currently

reviewing the membership for further efficiencies. While still fulfilling our legally mandated responsibilities, we are trying to maintain and insure statewide representation. While costs have risen dramatically over the last decade, our budget has not had a single increase in that time.

**4. Adopted Suicide Prevention council as subcommittee**

- a. The SPCMH recognizes the importance of the Suicide Prevention Council's efforts and voted to include them as a subcommittee of the SPCMH to keep us informed of their activities and educational efforts across the state.

**5. Development of a State Planning Council Brochure**

- a. A brochure was developed to provide more visibility for the SPCMH. This brochure gives a brief overview of our purpose and contact information. The brochure forged new partnerships with Idaho State Independent Living Council, who volunteered to print the brochure and the Office of Consumer Affairs offered use of their website for a resource link to assist in information distribution.

**6. Idaho state law (Title 39-3124) expanded our membership to include representatives from the Legislature and Judiciary**

- a. This change has enhanced our communication efforts to keep the Legislature informed of changes, gaps and needs in the mental health system. It has also given the Judiciary the opportunity to bring forth issues and identify additional resources available.

**7. Centralized reporting to the Council of regional council activities**

- a. Each council member is encouraged to report on the activities of their Regional Mental Health Board to share their successes and challenges so that all may benefit.
- b. The SPCMH has established an email list of the membership of the Regional Mental Health Boards (RMHB) to encourage continued communication, sharing information and keeping each other apprised of current issues and concerns.

**Mental Health Authority Achievements**

1. **Peer Specialist Program.** The first statewide Wellness Recovery Action Plan (WRAP) training occurred this fiscal year. WRAP plans help clients to understand recovery from mental illness is possible. They also serve to help clients understand warning signs, symptoms, and serve as a plan to follow when

- signs and symptoms of mental illness begin to exacerbate. This training was in preparation of the roll out of the peer specialist certification program.
2. **Success of substance abuse program.** Statewide assessment tools, to assist individuals with substance abuse problems, have been adopted.
  3. **Youth Suicide Prevention.** SPAN is active in some regions providing community and civic presentations. There was a town hall meeting in Idaho Falls on suicide prevention.
  4. **Medicaid Developments:** Benefits are now in place for substance use disorder treatment in Substance Abuse agencies and in primary care providers' offices. New requirements also increase participants' rights, promote parental involvement in children's treatment, restrict the use of seclusion and restraint, ensures diagnostic assessments are available to all who need them, require certification of unlicensed PSR workers, and ensure services that are developmentally appropriate for children. Additionally, 69% of Medicaid-reimbursed mental health agencies in Idaho have now been credentialed or are in the process.
  5. **Community Collaboration Grant funding for Crisis Intervention Training.** For three years in a row, the Legislature has allocated funds for collaborative community projects, at the local level, to improve mental health services. Through the Development Grant process, the Division provided funding to allow Crisis Intervention Team (CIT) training for law enforcement officials in two regions. With the chronic under-funding of our state system it is critical that first responders have knowledge of mental health issues and community resources. Communities throughout the state are supporting Crisis Intervention Team (CIT) Training for law enforcement.
  6. **Youth Programs: Parenting With Love and Limits,** an evidence-based intervention for children and families has been implemented in each region. For the non-criminal justice population, utilization of costly residential treatment has been decreased in favor of more effective family-based therapy (PLL, for example).
  7. **The first responder video** was completed and distributed statewide, to groups such as: law enforcement, paramedics, mental health professionals, and others. This DVD has also generated interest from several law enforcement agencies and advocacy organizations across the country. This video uses scenarios to teach first responders how to appropriately respond to juveniles who are experiencing mental health crisis situations.
  8. **Increased focus on housing.** The community collaboration grant which has been exhausted helped the Idaho Falls community see the need for crisis housing. Transitional/supportive housing is being developed, at the local level, in many communities in Idaho. The process for accessing Shelter Plus Care beds has been standardized, leading to an increased level of regional involvement with these housing vouchers. The CATCH program, a program in Region 4 that mobilizes community resources to help address homelessness, is expanding to Region 3.
  9. **Juvenile alternative courts,** both for mental health and substance abuse are getting started. They are also committed to using wrap around treatment. The increase in wrap around in is funded by the court system and juvenile corrections.

- The first Juvenile Mental Health Court has been established in Region VII. Rule 19, which was constructed to provide for alternatives to commitment to the Department of Juvenile Corrections, was approved by the courts. The Division collaborated with Family and Community Services (FACS) as well as the court to develop an implementation plan and adjust for the anticipated impact.
10. **Mental health court** is now available in all regions. This is considered an accomplishment as it provides access to treatment for persons with mental illness who have been charged with a crime, it also fosters evidence-based treatment (assertive community treatment is available in all regions). Mental Health Court Utilization has increased.
  11. **Clinicians in county juvenile detention centers.** This model has been adopted in all detention centers. By screening all incoming adolescents, mental health issues are being identified and treated. All juveniles in detention facilities are now screened for mental health issues.
  12. **Video conferencing** equipment has been installed in each Region, State Hospital North, State Hospital South, and Idaho State School and Hospital. This equipment was procured to help compensate for a statewide shortage of psychiatrists. Among other things, this equipment has been used to allow psychiatrists based in Boise to see patients in Idaho Falls and Lewiston. This equipment is also being used for meetings to avoid travel costs. Utilization of this equipment is increasing. For fiscal year 2009 to date, the Department has avoided approximately \$198,000 in travel costs as a result of installing this equipment. To date the response from users has been overwhelmingly positive. For commitment hearings, doctors, patients and the court system feel this is an excellent alternative to handling the patient in handcuffs to the courthouse.
  13. **“Home Recovery Team” (HRT)** provides in-home support, treatment, and resource development for individuals at risk of out of home placement in higher levels of care. Although this program is new, early results have been promising..
  14. **Psychiatric residency program** in Idaho is continuing to progress. A Forensic Psychiatrist was recruited and hired to work in Region 4. Because of the increasing caseload of clients from the criminal justice system, this has been a tremendous asset to the Division.
  15. **The Continuous Quality Improvement (CQI)** process in Children’s Mental Health (CMH) has been standardized. This process has resulted in the development and implementation of corrective action plans to help ensure standards are adhered to.
  16. **Patient Assistance Program (PAP)** software package was purchased for approximately \$50,000. This software automates the application process for the indigent benefits offered by many pharmaceutical companies, allowing clients to receive needed medications at no cost. The automation frees up staff time and essentially offers these benefits to more clients. If the costs of the medications received for free are calculated at average wholesale price (AWP), the benefit received by the clients just for February 2009 alone exceeds \$800,000.

# Idaho

## Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

The Children's Mental Health Program and the Adult Mental Health Program have been integrated to create the Division of Behavioral Health. This is a combined response between Adult and Children's Mental Health programs. Please see the Adult section for Idaho's response.

# Idaho

## Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

### **Establishment of a System of Care**

Idaho Code section 39-3124 of the Regional Mental Health Services Act designates the Idaho Department of Health and Welfare as the State Mental Health Authority (SMHA). The State operated public mental health system is administered by the Idaho Department of Health and Welfare in the Division of Behavioral Health.

Comprehensive mental health services are provided through seven regional Community Mental Health Centers which include 22 field offices across the state. The **Regional Mental Health Centers (RMHC)** work closely with the **two state psychiatric hospitals**, State Hospital South in Blackfoot and State Hospital North in Orofino, and have primary responsibility for the development of a system of care that is both community-based and consumer-guided. Additionally, programs also work with corrections and the courts to address the needs of clients referred through Mental Health Courts.

Each Region has a **Regional Mental Health Board**. Membership as stipulated in SB 1065 revised the board to reflect 17 members instead of 14. Membership representation is to include "...three (3) county commissioners; two (2) department of health and welfare employees who represent the mental health system within the region; two (2) parents of children with a serious emotional disturbance, as defined in section 16-2403, Idaho Code, provided each parent's respective child is no older than twenty-one (21) years of age at the time of appointment; a law enforcement officer; three (3) adult mental health services consumer representatives, advocates or family members; a provider of mental health services within the region; a representative of the elementary or secondary public education system within the region; a representative of the juvenile justice system within the region; a physician or other licensed health practitioner from within the region; a representative of a hospital within the region; and a member of the regional advisory substance abuse authority." A representative from each of the seven Regional Mental Health Boards is appointed to the State Planning Council on Mental Health. The Regional Mental Health Boards advise the Division of Behavioral Health on local needs within the region, and they regularly provide input and recommendations regarding system improvements.

Beginning in State Fiscal Year 2007, the Idaho legislature allocated \$2,000,000 to support the development of **Service Plan Component grants** that proposed to meet an identified regional and unmet need pertaining to mental health and/or substance use disorders. In State Fiscal Year 2008, additional funds were allocated to support similar One-Time Development (i.e., \$2,000,000) and Multi-year Development Grant projects (i.e., \$1,240,000). State Fiscal Year 2009 saw a legislative allocation of \$900,000 to "...establish dual diagnosis crisis intervention beds in Region 4 that will be contractually operated by Ada County," with another allocation (HB 651) of \$1,000,000 for support of new Community Collaboration grant projects pertaining to identified mental health needs. Projects included law enforcement and mental health provider training in early intervention and crisis skills to treat adults diagnosed with mental health and substance use disorders; transitional housing; tele-health; construction of a hospital safe room; expansion of the respite care system for families with children diagnosed with serious

emotional disorders; a youth safe house/group home; an integrated model of care for adults with mental health, substance use and primary care needs; a mental health/substance use outpatient clinic in a rural area; training in traumatic sexual abuse of children; early intervention and crisis treatment (mental health, substance use, criminal involvement), including a transitional housing component; and one Multi-Year Development grant for the Bonneville County's Substance Abuse/Mental Health Treatment Program, aka the Wood Pilot Project. The Wood Pilot Project is focused on developing a Substance Abuse/Mental Health treatment program for male and female offenders who are likely to be sentenced to corrections facilities. Treatment services supported by the grant include assessments, drug testing, treatment curriculum and treatment staff. This project also includes purchase of Client Reporting Software (i.e., WITS). Although the economy prevented additional legislative funding of these collaborative, community development projects, many of the projects that were funded continue to provide needed services in their communities.

Recognizing the benefits of using **peer specialists** as integral members of the adult mental health service array, the Division of Behavioral Health contracted with the Office of Consumer Affairs in SFY 2009 to provide 1) consumer education and support, 2) family member education and support, and 3) peer specialist certification training of peer specialists in each region of the State. Fifteen consumers were trained as peer specialists in February 2009, and twelve passed the certification exam. Peer specialists are also expected to complete their own WRAP plan, and peer specialists also attended WRAP training. The Office of Consumer Affairs facilitated placement of one certified peer specialist on an Assertive Community Treatment (ACT) team in each of the seven regions, and she continues to supervise peer specialists that are offered peer specialist work opportunities through those CMHC work sites. The Office of Consumer Affairs, the Division of Behavioral Health and the Division of Vocational Rehabilitation have had some initial discussions regarding possible additional job opportunities for certified peer specialists in Idaho. The next peer specialist certification training session is scheduled for September 2009.

Idaho is primarily a rural and frontier state with all Idaho counties designated as mental health professional shortage areas. Psychiatric coverage is difficult to ensure across the State. Travel costs can be expensive. In a lean economic climate, all methods of cost reduction without compromising services are critical. Use of videoconferencing technology reduces costs with a high return on investment. In SFY 2009, **high definition videoconferencing equipment** was installed at Central Office, State Hospital South, State Hospital North and each of seven regions. This equipment allows for the provision of telemedicine, education, site reviews and meetings without the requirement of travelling to a central location for a face to face meeting. Videoconferencing equipment priority use is the need for telemedicine to expand psychiatric service access to prevent crises and maintain client stabilization, especially in rural and frontier areas. As of May 2009, three contracted psychiatrists were providing telemedicine from the Boise Central Office. From September 2008 through May 2009, Region 2 estimated that 360 clients received psychiatric services through this system. Region 7 began using these services in February 2009, with an estimated 180 clients benefitting through May 2009.

The model used to support mental health referrals as an alternative to jail is provision of intensive ACT services and collaboration with court representatives to develop an individualized treatment plan that allows participants to stabilize and learn additional life management skills such as taking necessary medications, avoiding drug and alcohol use and avoiding criminal activities that brought them into the legal system. Regional AMH Program Managers continue collaboration efforts in response to increased requests for best practice services to **mental health court** referrals. During SFY 2009, Mental Health Court Utilization increased to approximately 90% of capacity. A Forensic Psychiatrist was hired in Region 4 to provide services to increased numbers of clients referred from the criminal justice system.

In addition to collaborating with the courts and corrections to establish referral, assessment, monitoring and treatment procedures, regional AMH programs also review and revise treatment services as needed in an effort to provide best practice, efficient and effective services. Besides use of the **Comprehensive Continuous Integrated System of Care (CCISC) model of treatment for co-occurring disorders**, all regional programs also have access to the **Eli-Lilly Wellness curriculum and the Eli-Lilly Differential Diagnosis** materials.

During SFY 2009, an innovative public-private partnership was formed in Region 4. **The Home Recovery Team (HRT)** provides in home support, treatment and resource development for individuals who are at risk of out of home placement in more restrictive levels of care. Although this program is new, results have been promising.

# Idaho

## Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;  
Employment services;  
Housing services;  
Educational services;  
Substance abuse services;  
Medical and dental services;  
Support services;  
Services provided by local school systems under the Individuals with Disabilities Education Act;  
Case management services;  
Services for persons with co-occurring (substance abuse/mental health) disorders; and  
Other activities leading to reduction of hospitalization.

## **Available Services**

This section describes the three broad categories of health, mental health and rehabilitation services available in the state of Idaho to adults with serious mental illness. Core adult mental health services are provided by all seven regional community mental health centers.

Eligibility as defined under updated 2008 IDAPA 16.07.33 includes diagnoses under the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or subsequent version, which includes: schizophrenia, paranoia and other psychotic disorders, bipolar disorders (mixed, manic and depressive), major depressive disorders (single episode or recurrent), schizoaffective disorders and obsessive compulsive disorders. In addition, a substantial disturbance in role performance in at least two areas (i.e., vocational/educational, financial, social relationships, family, basic living skills, housing community/legal, health/medical) must be present over the previous six months. In addition, we also serve any individual 18 years of age or older who is experiencing an acute psychiatric crisis, including suicidal and/or homicidal behavior and who may end up in an inpatient psychiatric facility if mental health intervention is not provided promptly. Only short-term treatment or intervention, not to exceed 120 days, is provided to this population.

### **Regional Community Mental Health Center Services**

Core Mental Health Services include:

- (1) Screening: Screening for eligibility of services through Regional Mental Health Programs based on the above criteria. If an individual meets population criteria as defined above, he or she is accepted for services either on an ongoing basis or for short-term intervention. Individuals not meeting above criteria are referred out to appropriate community agencies.
- (2) Service Coordination (Targeted Case Management Services): Service Coordination services are provided to clients with a severe and persistent mental illness who meet our first criteria outlined above. Services include assessment, service plan development, monitoring and coordination of service delivery, referral and linkage with requisite services, client advocacy, and crisis support services.
- (3) Crisis Intervention Services: These services provide for the delivery of both center-based and community-based crisis intervention in psychiatric emergencies, including 24-hour crisis response intervention services. Community emergency resources and providers are mobilized in order to stabilize the crisis situation and to provide immediate and/or continuing treatment.
- (4) Psychosocial Rehabilitation Services (PSR): Psychosocial Rehabilitation Services (PSR) are consumer directed, recovery and outcome oriented services that are provided to assist consumers function maximally in their community settings. Services include individual and group psychosocial rehabilitation, pharmacological management and nursing services, assessment and service plan development, community crisis support intervention services, psychotherapy, education about illness (e.g., symptom management, medication) and skills development (e.g., education, vocational, independence, communication, activities of daily living).

(5) Assertive Community Treatment (ACT): An intensive service program delivered by the use of assertive outreach in the community. The majority of treatment and rehabilitation intervention takes place in the community in the consumer's natural environment. Services include PSR, "in vivo" skills training, 24-hour crisis availability, assistance with vocational reintegration and financial monitoring. All regions collaborate in the provision of best practice services to mental health court individuals. Clients referred by regional mental health courts receive supportive individual and group mental health and substance use disorders treatment services through the regional ACT or forensic ACT (FACT) teams. As of March 2009, a peer specialist was placed as staff with each main office ACT team.

(6) Psychiatric Services: These services include psychiatric evaluation, medication prescription and monitoring, consultation and education, and psychiatric nursing.

(7) Short-Term Mental Health Intervention: Short-term mental health treatment may be provided to individuals 18 and over who may not have a severe and persistent mental illness but who are nevertheless in a stage of acute psychiatric crisis, including experiencing symptoms of suicidal and/or homicidal behavior. Without an immediate mental health intervention, these individuals are at high risk of hospitalization. Such interventions are time limited and not to exceed 120 days. Services include short-term therapy, medication prescription and monitoring, psychiatric evaluation, referral to community agencies, provision of designated examinations and involuntary commitment dispositions, psychiatric nursing, and/or short term PSR services following discharge from state psychiatric inpatient facility. Short-term crisis services in Region 4 were enhanced in SFY 2009 by a contract with Mountain States Group to provide Home Recovery Team services.

Regional AMH Program Managers continue collaboration efforts in response to increased requests for best practice services for eligible mental health court referrals. The model used to support mental health referrals as an alternative to jail is provision of intensive ACT services and collaboration with court representatives to develop an individualized treatment plan that allows participants to stabilize and learn additional life management skills such as taking necessary medications, avoiding drug and alcohol use and avoiding criminal activities that brought them into the legal system. Region 7 is a designated national training site for these services.

In addition to collaborating with the courts and corrections to establish referral, assessment, monitoring and treatment procedures, regional AMH programs also review and revise treatment services as needed in an effort to provide best practice, efficient and effective services. Besides use of the CCISC model of treatment for co-occurring disorders, all regional programs also have access to the Eli-Lilly Wellness curriculum and the Eli-Lilly Differential Diagnosis materials.

### **Case Management Services**

Case management is provided to all individuals who meet the priority population definition and who are receiving substantial amounts of public mental health services. In practice, the intensity of case management provided varies from individual to individual, as needed and appropriate. The continuum of case management services varies in

intensity from the most intensive activities provided through ACT, community crisis response, and PSR to the provision of less intensive case management for those needing short term treatment and medication management services.

As identified previously, Idaho also has a Medicaid option for case management services referred to as service coordination (see (2) above). This option is available in both the public and private sector. Service Coordination services may be provided to clients who are diagnosed with a severe and persistent mental illness and who meet specific criteria as outlined in Medicaid rule. Service Coordination is limited to comprehensive assessment and service plan development, monitoring and coordination of services, linkage to needed services, client advocacy and crisis support services.

### **Crisis Support Services**

The Region 4 “24-hour” residential program, Franklin House, was discontinued in SFY 2009 because of cost. It was replaced by the Home Recovery Team, which provides crisis services in the client’s home as an alternative to hospitalization. These services have been well-received, and the practice is promising in Region 4.

The Adult Mental Health program continues to prioritize reduction of state psychiatric hospitalizations and decreasing the length of stay. Idaho continues to experience waiting lists for involuntary admissions to the two state hospitals. In an effort to develop additional community based alternatives to inpatient treatment, specific projects target the development of strategies for community based alternative placements. These include community hospitalization, as needed, and use of regional transitional beds that were established in response to previous years’ Service Plan Component, Development Grant and Community Collaboration project opportunities. Additionally, two regions have Crisis Intervention Team (CIT) trained law enforcement personnel.

Several strategies are used to reduce hospitalizations and decrease length of stay. Effective February 1, 2004, all discharge plans for individuals leaving State Hospital North or State Hospital South include: 1) a scheduled (no later than five working days from discharge) face to face screening with the regional mental health program; and 2) admission to the regional mental health program for follow-up care and treatment. Individuals discharged from a state hospital shall be admitted to DHW mental health services as part of the target population under the criteria of psychiatric crisis no matter what the primary reason or primary diagnosis was for admission to the hospital.

Regional mental health programs conduct any needed assessments, develop treatment plans, and provide ongoing mental health services. Individuals transitioned to a private mental health (or other behavioral health) service provider continue to receive regional mental health service delivery until a suitable treatment plan and community supports are in place. The treatment plan focuses on services and supports to maintain the individual in their community and to reduce the likelihood of re-hospitalization. The treatment plan also addresses transitional needs (public to private) to assure continuity of care. In most cases, regional mental health programs provide services to the individual for not less than 30 days.

State Hospital South (SHS) in Blackfoot and State Hospital North (SHN) in Orofino, collaborate and coordinate with the regional CMHC's to ensure a seamless, efficient delivery system of public mental health services, using a variety of methods. State Hospital North assigns a primary therapist for each client admitted to the hospital. The primary therapist is responsible for initiating weekly telephone contacts with regional CMHC staff to give progress reports, coordinate care, update discharge plans and arrange aftercare services. State Hospital South staff initiates monthly conference calls with all regional CMHC's who have clients admitted or in residence during the month. Content of the calls includes progress reports, treatment planning, discharge planning, and aftercare discussions. Every Regional CMHC has an identified Hospital Liaison who maintains regular contact between the institutions and the community programs. These Hospital Liaisons and their Regional Program Managers conference periodically with staff from both state hospitals to review admission and discharge protocols, discuss barriers to community placement, recommend service system improvement, identify areas for resource development, and discuss ongoing continuous quality improvement projects.

The Adult Mental Health Program Administration and Program Managers review quarterly and annualized utilization data. The data includes regional admission and discharge rates and regional hospital bed utilization patterns. Regional rates of discharged clients successfully keeping their first CMHC appointment and the 30-day readmission rates are also regularly shared and reviewed. In addition, problem cases identified as having barriers to prompt and/or successful community placement are reviewed at these meetings.

State Hospital administrators participate as equals at all levels of service system planning and development. The administrative directors of SHN and SHS attend the meetings of the State Planning Council on Mental Health.

### **State Hospital Services**

Idaho's two state psychiatric hospitals are located in Orofino (State Hospital North) and Blackfoot (State Hospital South). State Hospital North is a psychiatric hospital that is licensed for 60 beds however only 55 beds are available for patient care. In order to try to accommodate the need for inpatient beds, the space that was originally designed to house a Chemical Dependency Program was changed to house and treat committed patients who have more acute psychiatric symptoms and require a higher level of care than those that would be in a residential care facility. Because of this increased acuity, it has been necessary to limit the number of patients who are served on the unit to 20 in order to assure the safety of the patients and staff on the unit.

State Hospital South is JCAHO accredited and has a total of 90 adult beds on three adult units, 16 adolescent beds on an adolescent psychiatric unit and licensure to serve 30 clients on a skilled nursing unit. The hospital provides separate and distinct treatment programs depending upon the patient's age, legal status, and mental condition. Acute, intensive, inpatient psychiatric services are provided around the clock to stabilize symptoms of acute mental illness and prepare an individual to return to community-based

care. State Hospital South (SHS) also serves forensic clients. In SFY 2009, there were a total of 62 forensics clients served at SHS. The forensic psychologist treats forensic clients with a focus on restoring them to fitness to proceed and assist in their own defense.

In an effort to best meet the psychiatric needs of adult citizens who are diagnosed with a serious mental illness and who also have criminal charges, the State of Idaho is pursuing alternatives to jailing these individuals. Mental Health Courts work with regional ACT teams to provide least restrictive treatment service options to eligible referred clients. State Hospitals serve forensics clients in the general hospital population with a treatment focus on restoring them to fitness to proceed. Idaho is exploring the option of creating a secure, 16-bed forensics treatment facility, State Hospital West, on the campus of Idaho State School and Hospital.

### **Community Hospitalization**

When there is a need for hospitalization to avert danger to self or others and a bed is not available at one of the two state hospitals, a client may be hospitalized temporarily at a community hospital. Bed days at community hospitals are funded by dollars that are legislatively allocated each year.

### **Medicaid Reimbursable Mental Health Services**

In SFY 2008, there were two major changes in Medicaid eligibility. The scope of eligible telehealth service was changed such that physicians can perform telehealth in any setting in which they are licensed. A benefit was added to allow for family therapy without the client present.

The availability of mental health services in the private sector has been affected somewhat by the economy. As of July 2007, there were 171 different PSR providers operating in a total of 311 agency locations in the State of Idaho. There were 189 different Clinic providers operating in a total of 303 agency locations. Eight private hospitals in the state provide psychiatric inpatient services with approximately 215 beds available statewide. In comparison, as of July 2009, there were 185 different PSR providers operating in a total of 239 agency locations in the State of Idaho. There were 186 different clinic providers operating in a total of 239 agency locations. Eight private hospitals in the state provided psychiatric inpatient services in SFY 2009 with approximately 215 beds available statewide.

The Division of Medicaid implemented several strategies to control rising expenditures in Medicaid Mental Health services. Legislatively approved changes to clinic option rules included decreasing the number of partial care hours from 56 to 36 hours per week in 2004, with this benefit subsequently reduced to 12 hours per week. Psychosocial Rehabilitation (PSR) services were reduced from 20 to ten hours per week, and PSR crisis services were reduced from 20 to ten hours per week.

All Psychosocial Rehabilitation services were prior authorized by the Mental Health Authority Unit through the Division of Behavioral Health in State FY 2008. Because the

oversight services provided by the Mental Health Authority Unit were primarily Medicaid services, this unit was moved to the Division of Medicaid on July 1, 2008. As a part of Medicaid Modernization, Medicaid benefits were changed to be more reflective of participants' needs. Three benefits plans, the Medicaid Basic Plan Benefits, the Medicaid Enhanced Plan Benefits and the Medicare/Medicaid Coordinated Plan Benefits were effective as of July 1, 2006. The Medicaid Medicare Coordinated Plan has been in effect since April 1, 2007. Blue Cross of Idaho started with their plan on April 1, 2007 and United Health Care started with their plan on May 1, 2007. As of July 2008, there were approximately 1,100 dual eligible individuals participating in these insurance plans. This makes up about 7.4% of eligible duals in 24 counties in Idaho. As of July 2009, there were approximately 1,040 dual eligible individuals participating in these insurance plans. This makes up about 7.0% of eligible duals in 24 counties in Idaho.

Partial Care, Service Coordination and Psychosocial Rehabilitation mental health services are excluded from the Medicaid Basic Plan Benefits except for diagnostic and evaluation services to determine eligibility for these services. These services continue to be covered under the Medicaid Enhanced Plan Benefits. The services available in the Medicaid Enhanced Plan include the full range of services covered by the Idaho Medicaid program. Medicaid Basic Plan Benefit participants are limited to twenty-six (26) separate outpatient mental health clinic services annually and ten (10) psychiatric inpatient hospital days annually.

In the 2009 legislative session, the legislature passed HB 123, which amended "...existing law relating to public assistance and welfare to provide for Medicaid reduction." This bill directs that the quarterly rate at skilled care facilities will be decreased two and seven-tenths percent (2.7%) from July 1, 2009 through June 30, 2010, with the exception of nursing facilities at Idaho State veteran's homes. Legislators approved \$20.1 million for completion of the Medicaid Management Information System (MMIS) which is targeted to start in 2010. This system will include claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals.

### **Services for Persons with Co-Occurring (SA/MH) Disorders**

Another treatment approach in our state has been the development of dual diagnosis (i.e., co-occurring mental illness and substance abuse) services for persons who are experiencing both serious mental illness and substance abuse. National studies estimate that between 50% and 70% of persons with serious mental illness also have substance abuse problems. Each regional community mental health center program either offers services targeted to individuals with a dual diagnosis or has developed partnerships with community substance abuse treatment providers for services.

In an effort to further efforts to develop an integrated system of care for co-occurring disorders treatment, the Division of Behavioral Health consulted with Ken Minkoff and Christie Cline. Workgroups began in September 2006 and continued throughout 2008, with the last consultation on June 4, 2008. Dr. David Mee-lee began consulting in May 2008, and continued to do so throughout SFY 2009. The Division of Substance Use

Disorders contracted with Co-Occurring Center for Excellence (COCE) to provide technical assistance in efforts to develop statewide co-occurring, integrated care for adults diagnosed with a serious mental illness and a substance use disorder. John Challis and Andrew Homer came to Idaho to present at the Policy Institute on Co-Occurring Disorders in April 2008. Although the SAMHSA contract for technical assistance with COCE has been terminated, COCE agreed to conduct a co-occurring disorders train-the-trainer session for 25 people in Idaho in August 2008. Training 25 trainers facilitated efforts to develop sustainability of co-occurring, integrated practice to citizens diagnosed with serious mental illness and substance use disorders. Participants in this process included representatives from the Department of Health and Welfare, Department of Corrections, Department of Juvenile Corrections and the Supreme Court.

Greater efforts have been placed on improving coordination between the regional CMHC's and Idaho's Drug Courts. A protocol was developed and implemented between the Idaho Drug Courts and the Adult Mental Health program for the delivery of coordinated services in each region. Each regional ACT or FACT team provides treatment services to referred and eligible clients. Treatment services include the range of available ACT and crisis services, as well as group and individualized substance use disorder services. Curriculum that is used for dual diagnosis treatment includes MATRIX, Moral Reconciliation Therapy, Motivational Interviewing and Cognitive Self-Change.

Individuals who are involved in the Mental Health/Drug court are required to attend these groups. Other consumers of the CMHC are referred to these groups by the treating physician on an "as needed" basis. Individuals, who are already receiving substance abuse treatment from a community provider, usually continue with their on-going substance abuse treatment provider and work collaboratively with the regional programs. The Crisis Response Team (CRT) performs mental health screenings and is responsible to refer eligible individuals with a dual diagnosis to either a program at the CMHC or to an appropriate community based partner. Referrals may also be made to support services such as AA, inpatient detoxification programs or other support groups, as needed.

Regional Mental Health Centers work conjointly with the Substance Use Disorders programs to coordinate and optimize services for consumers who are receiving both mental health and substance abuse services. Due to the ongoing increase in the number of consumers with co-occurring treatment needs, the program provides substance abuse treatment (groups and some individual counseling) for individuals served through the mental health court system. While the program has some clinician staff certified as substance abuse counselors, other regional clinical staff have developed competencies in treating persons with co-occurring disorders.

Regional mental health staff attend mental health and drug court coordination team meetings. The CMHC provides consultation services pertaining to mental health issues as well as screening services for any referrals received from the court. Regions work closely with local substance use resources and substance use councils to improve the

accessibility of treatment for adults with a severe and persistent mental illness and a co-occurring substance use disorder.

### **Substance Use Disorder Services**

Substance Use Disorder services are administered by the Department of Health and Welfare within the Division of Behavioral Health's Substance Use Disorders Program, through a statewide Prevention Services Contractor and an intervention and treatment Management Services Contractor (MSC). Both contractors hire and manage a network of providers local to the area they serve, provide liaison to the Regional Substance Abuse Authorities (RSAA's) and their state Executive Council. They monitor the implementation of services models, including evidence-based prevention and treatment services, conduct utilization review and quality audits, manage the various funding streams, collect and report service and performance data, and participate in outcome studies. The Substance Use Disorders Program monitors contracts and provides system leadership and technical assistance. The Substance Use Disorders Program also conducts treatment program certification, DUI evaluator licensing, and tobacco sales permitting and youth tobacco sales enforcement.

### **Employment Services**

In addition to services provided statewide by the Division of Vocational Rehabilitation (VR) located in local communities, Idaho has developed a unique program of assigning vocational rehabilitation counselors to several regional CMHC assertive community treatment teams (ACT). Vocational Rehabilitation counselors provide vocational services to ACT consumers as well as other consumers participating in the regional mental health programs. Services include work skills assessments, career counseling, rehabilitation plan development, and referrals to vocational and educational services such as job coaching, transportation, job shadowing, adult education and literacy services (GED and college level courses), and transitional/sheltered work experiences.

Prior to July 1, 2004, the Department of Health and Welfare managed the funding for the Community Supported Employment program. The 2004 Idaho legislature moved funding for Community Supported Employment Services to individuals with developmental disabilities, mental health issues, traumatic brain injuries and serious learning disabilities from the Family and Community Services budget and moved the funding to the Idaho Department of Vocational Rehabilitation budget. As of July 1, 2004, Vocational Rehabilitation assumed the responsibility for administering the Community Supported Employment program.

During SFY 2009, the Interagency Agreement between the Division of Behavioral Health (BH) and the Division of Vocational Rehabilitation added the provision of on-site VR staff in Region 5, which meant that all regions had a dedicated, on-site VR person to provide employment services and supports to regional BH clients. The SFY 2009 Interagency Agreement also included initiation of monthly data reports, including reports of open cases, closures and service hours.

## **Housing Services**

Through the Bureau of Facility Standards, the Department of Health and Welfare licenses or certifies a variety of supportive/assistive residential facilities and homes that are available to persons with a serious mental illness in Idaho. These supportive housing options include licensed Residential and Assisted Living Facilities, Certified Family Homes and Semi-Independent Group Homes throughout the state.

Idaho also has a Shelter Plus Care Program, administered through Idaho Housing and Finance Association (IHFA). Shelter Plus Care is a rental assistance program for persons diagnosed with a serious and persistent mentally illness and who are also homeless. The program operates in each of the seven regions of the state, with funding support from the HUD Continuum of Care Awards. Each region has funding for rental assistance for 9 to 11 dwelling units. In addition to Shelter Plus Care, IHFA also manages the Section 8 Rental Assistance voucher program in Idaho. Julie Williams is the housing representative for the State Planning Council on Mental Health in Idaho.

The Department of Health and Welfare also participated (i.e., Adult Mental Health Program, Substance Abuse Program and Division of Medicaid) on the Governor's Policy Academy on Chronic Homelessness. This Governor appointed group was subsequently incorporated into the Idaho Homeless Coordination Network, which was sponsored by Idaho Homelessness Finance Association (IHFA). This group has been officially designated as the Idaho Homelessness Policy Council. Representation from both the State Mental Health Authority and Medicaid were required for the Policy Academy to assist in the development of a state plan to end chronic homelessness. The Council developed a ten-year "Plan to End Homelessness in Idaho." The Idaho Homelessness Coordinating Committee meets quarterly with representation from each region, from IHFA and from the Division of Behavioral Health. Regional programs are active in efforts to develop specific regional plans to ameliorate homeless. For example, Region 4 presented a "Ten Year Plan to Reduce and Prevent Chronic Homelessness" to the City Council in November 2007.

The need for assistance with accessing and maintaining housing is a required component of the comprehensive assessment for PSR and service coordination services. Both service options identify housing as a primary focus area, which may be addressed if a functional limitation is identified in the assessment process. Needed services would then be identified on the individualized treatment plan in order to assist a consumer access and maintain housing in their community.

During SFY 2009, there were several activities directed to housing and homelessness. A federal audit of the Pathways in Transition from Homelessness (PATH) grant provided an opportunity for each region to use feedback to develop an action plan to reflect opportunities for improvement in efforts to provide outreach and prevent homelessness among adults diagnosed with a serious mental illness. The Charitable Assistance to Community's Homeless (CATCH) program that mobilizes community resources to help address homelessness was expanded to include Region 3 in addition to Region 4. The process for accessing Shelter Plus Care beds has been standardized, leading to an increased level of regional involvement with these housing vouchers.

### **Educational Services**

In addition to the educational services described in the children's plan in Criterion I Available Services, Idaho also has three state universities, four state colleges, two private universities and two private colleges. Through the Vocational Rehabilitation program, consumers with an approved Vocational Rehabilitation plan may attend classes at these institutions as part of their own recovery. The need for referral to educational services is identified during the comprehensive assessment process and included in the individualized treatment plan.

### **Medical and Dental Services**

Medical and dental needs for consumers in the public mental health system are identified during the assessment process. The assessment is used to address the individual's medical history and current health problems and identify needs. Medical/Health is an area that can be included in the PSR service plan to assist a consumer with learning to access needed medical and dental services and develop skills to better manage their medical needs. Case management services provide assistance with coordination of and referrals to community medical and dental providers.

Access to medical and dental services for those without private insurance or Medicaid benefits is limited across the state. There are a few community providers such as the Terry Reilly Health Clinics that provide medical and dental services on a sliding fee scale in limited areas. There is also a very limited county indigent program that varies by county with what services are covered. The program is usually limited to one-time expenses.

The Idaho Medicaid program encourages recipients to sign up for Healthy Connections. Healthy Connections is Medicaid's managed care program. It provides a medical home for Medicaid clients by having one doctor responsible for the client's entire health care, referring a client to a specialist when necessary. The Department has implemented the Healthy Connections program in order to provide improved care and cost management.

In July 2006, Idaho Medicaid implemented benefit plans to support the Medicaid Modernization initiative. The benefit plans include Medicaid Basic Plan and Medicaid Enhanced Plan benefits. The Medicaid Basic Plan offers benefits for low-income children and adults with eligible dependent children. This plan provides complete health, prevention and wellness services for children and adults who don't have disabilities or other special health needs. The Medicaid Enhanced Plan includes all services covered

under the Medicaid Basic Plan Benefits, plus additional services to cover the needs of participants with disabilities or special health concerns. The services in this plan include the full range of services covered by the Idaho Medicaid program. Enrollment in one of these plans is determined by individual health needs.

Idaho also has seven public health districts that are the primary outlets for public health services. These districts work in close cooperation with the Department of Health and Welfare and numerous other state and local agencies. Each district has a board of health appointed by the county commissioners within that region. The districts are not part of any state agency. Each district responds to local needs to provide an array of services that may vary from district to district. Services range from community health nursing and home health nursing to environmental health, dental hygiene and nutrition programs. Many services are provided through contracts with the Department of Health and Welfare.

### **Mental Health Boards, Consumer/Family Advocacy and Education and Peer Specialists**

Each regional CMHC has a Regional Mental Health Board that participates directly in regional mental health policy and decision-making. Each Regional Mental Health Board consists of county commissioners, consumer/advocates, and other providers and stakeholders. These groups meet regularly to provide important input and recommendations for improvement of the system. Consumers and family members from all seven regions also serve on the Idaho State Planning Council on Mental Health, which meets quarterly.

In SFY 2009, the Division of Behavioral Health contracted with Mountain States Group for the Office of Consumer Affairs to provide technical assistance, coordination and support to local consumer and family groups across the state, and to develop a Peer Specialist certification program. This contract replaced a previous contract for consumer advocacy, education and empowerment with the Office of Consumer Affairs and for similar activities for family members through a contract with NAMI.

Regarding the peer specialist piece of the contract, trained and certified peer specialists placed with regional ACT teams are employees of the Office of Consumer Affairs, and they continue to receive support and supervision through that office in addition to the support and supervision received on their ACT teams. Peer specialists complete personal Wellness Recovery Action Plans (WRAP) in addition to completing a rigorous peer specialist training program.

# Idaho

## Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

**1. GENERAL DESCRIPTION OF THE SED POPULATION**

For purposes of estimating the prevalence of serious emotional disturbance and the scope of this public health problem among children and youth, Idaho continues to use the federal definition pursuant to section 1912 (c) of the Public Health Service Act as amended by Public Law 102-321 which includes those children and youth:

"From birth up to age 18, who currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV, that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. A substance abuse disorder or developmental disorder, alone, does not constitute a serious emotional disorder although one or more of these two disorders may co-exist with a serious emotional disorder. "

**2. IDAHO PREVALENCE ESTIMATES**

Serious emotional disturbance must be considered in a broad context, including and distinguishing among various degrees of emotional disturbance based on the levels of impairment. It is also important to show the relationships between these groups and Idaho's target population. To determine the prevalence of serious emotional disturbance among children and adolescents and their needs, the State of Idaho continues to use nationally obtained prevalence estimates.

Knowing the pervasiveness and persistence of a disorder is helpful in determining prevalence of serious emotional disturbance. Pervasiveness is usually measured by the degree of impairment to a child/youth's adaptive functioning or life skills. Most definitions of serious emotional disturbance require that, because of the mental illness, there be substantial or significant degrees of impairment in the youth's functioning in multiple life domains. The Center for Mental Health Services (CMHS) includes, as one component of its SED definition, "impairment such that there is substantial interference with a child's role or functioning in various life domains and adaptive skills" (Federal Register, May 20, 1993). Persistence or duration as a characteristic of a "serious" disorder is highlighted by Idaho Code. Idaho's Children's Mental Health Services Act includes, as one element of its SED definition, that the disorder "requires sustained treatment interventions" (Idaho Code, Title 16, Chapter 24, sections 2403).

The estimated number of children under 18 years with an SED in Idaho is 18,709 (see table below). This estimate is based on the 2007 US Census data and uses a conservative estimate of 5.0% of Idaho's children under the age of 18 years.

**Projected Population of Children with Serious Emotional Disturbance**  
**By DHW Region, FY2007**

	Regions							
	I	II	III	IV	V	VI	VII	TOTAL

<b>2007 Estimated 0 to 17 Population (2007 Census Data)</b>	47,444	20,220	64,527	98,949	45,806	46,021	51,213	<b>374,180</b>
<b>Estimated 0 to 17 Population with Serious Emotional Disturbance (5%)</b>	2,372	1,011	3,226	4,947	2,290	2,301	2,561	<b>18,709</b>

The public mental health system’s capacity and resources are limited. Some children with emotional disturbance will receive services from the private service sector. Others will receive services from the education system, the six Idaho Tribes, and from the juvenile corrections system. Most agree the public sector’s legitimate role in mental health service delivery is limited to the most seriously emotionally disturbed.

For purposes of service prioritization, a serious disorder is operationally triaged in order of priority:

- I.** The child is an imminent danger (risk to safety) to self or others (suicide/homicide) due to a substantial disorder of thought, mood or perception. This additionally includes the child who evidences an inability to meet basic needs for safety or evidences gross impairment in reality testing such as requiring 24 hour supervision and care and as indicated by DHW's assessment process.
- II.** Due to the presence of a serious emotional disturbance, the child is at risk of out-of-home placement, is currently in out-of-home placement, or is returning from a psychiatric inpatient or residential placement due to experiencing substantial multiple living problems including school, home, interpersonal or community, which are attributable to a substantial disorder of thought, mood, or perception.
- III.** Due to the presence of a serious emotional disturbance, the child evidences substantial impairment in functioning in family, school or community, as determined by standardized measures/criteria.

The Department has adopted the Child and Adolescent Functional Assessment Scale (CAFAS) as the method for determining substantial impairment. The operational definition of SED for the Department must include a DSM-IV diagnosis and a functional impairment as documented by the CAFAS. The complete definition is:

“An Axis I diagnosis according to the DSM-IV clinical criteria is required. A substance abuse disorder or developmental disorder alone does not by itself constitute a serious emotional disturbance, although one or more of these disorders may co-exist with a serious emotional disturbance. Co-existing

conditions require a joint planning process that crosses programs and settings. V-Codes are not considered an Axis I disorder for purposes of this definition. The Child Adolescent Functional Assessment Scale (CAFAS) will be used to determine the degree of functional impairment. The child/adolescent must have a full-scale score (using all 8 sub-scales) of 80 or above and “moderate” impairment in at least one of the following three scales: Self-Harmful Behavior; Moods/Emotions; Thinking.”

This definition is used to identify the targeted service population. The prevalence and general estimates use the federal definition. As services and resources expand, the Idaho service definition may be modified to be more inclusive. The Department will review the operational definition annually to determine the need for modification.

According to the National Prevalence figures prepared for MHSIP by the National Research Institute and distributed by CMHS, the following table describes Idaho’s 2005 prevalence of SED. Background details on these procedures have been published previously in Federal Register Notices. Current county estimates are not available; however, the methodology could be adapted to the county level.

State	Number of Youth 9 to 17	Age 5 - 17 Percent in Poverty	State Tier for % in Poverty	Level of Functioning Score=50		Level of Functioning Score=60	
				Lower Limit	Upper Limit	Lower Limit	Upper Limit
Idaho	191,326	12.9%	Mid	11,480	15,306	19,133	22,959

One change in the last year with the creation of the CMH rules discussed in the New Legislation category is the inclusion of children and youth with conduct disorders. The State of Idaho has not included Conduct Disorder in the list of approved diagnoses until the passage of these rules. The impact of this expansion is not yet fully realized, however, the Juvenile Justice Blue Print for Change identified that approximately 90% of adolescents diagnosed with conduct disorder meet the criteria for at least one other diagnosis.

### 3. ACCESS TO SERVICES FOR SPECIAL POPULATIONS

Two populations requiring special note are the highly rural and ethnic minority populations. Historically, these groups either do not have easy access to services, or if there is access the services are not relevant to their needs, strengths and contexts. Access to services for rural populations will be addressed in Criterion 4.

The dually diagnosed is another special population that requires a higher level of coordination and cooperation. The Idaho State School and Hospital (ISSH) is a state run institution that has historically served individuals with developmental disabilities. With the increasing identification of co-existing disorders, developmental disorders and mental illness, ISSH has expanded their capacity to include dually diagnosed. Additionally, Medicaid, Family and Community Services and the Division of Behavioral Health working together have developed an intensive community-based service called Intensive

Behavioral Interventions (IBI). IBI is designed to provide skill-based rehabilitative type services to children/youth that have a developmental disorder and for the dually diagnosed. See Criterion 1 for information on services to children with co-existing substance abuse and serious emotional disturbance.

**4. ETHNIC AND MINORITY POPULATIONS**

Idaho is predominately a Caucasian state. According to Year 2006 census data, 86% of Idaho’s population is white. The racial composition of the remaining 14% of Idaho’s population is as follows:

BLACK/ AFRICAN AMERICAN	NATIVE AMERICAN/ ALASKA NATIVE	ASIAN	NATIVE HAWAIIAN/ PACIFIC ISLANDER	LATINO/ HISPANIC
1.1%	1.6%	1.0%	0.5%	9.8%

Idaho’s largest ethnic minority, representing 9.8% of the state’s total population, is of Hispanic heritage. Region III and V especially have large concentrations of people who are Hispanic. (Appendix D)

Given that only 14% of the population is non-Caucasian, the system tends to be ethnocentric. This results in a general lack of development of services that are relevant to any group other than the dominant culture.

Planning for mental health services must more fully address access to culturally relevant services for this minority population. The Department of Health and Welfare has a liaison with a primary responsibility of coordinating with the Idaho tribes. The Department of Health and Welfare has ongoing networking activities with the six Idaho Indian tribes through the Idaho State and Indian Tribal Child Welfare Committee that meets quarterly. The Department continues to allocate \$200,000 in Social Service Block Grant funds to the six Idaho tribes for the enhancement of tribal child welfare services. Additionally, the ICCMH has chartered a Tribal Coordinating Council (TCC) to oversee mental health services to Native American youth. DHW has set aside \$15,000 as budget for this use.

# Idaho

## Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

## **Quantitative Targets**

### **Adult Mental Health – SFY 2009 and Projections for SFY 2010**

Tables in this section include quantitative targets for the number of adults with serious mental illness in Idaho served by Idaho's Public Mental Health System in SFY2009. Targets for SFY 2010 are maintenance or better of levels served during SFY2009.

In reviewing these tables, please remember that (a) These numbers represent Idaho's best estimate to date of incidence, treated prevalence, and quantitative targets. Any data in the Adult Plan represents our best estimates based on available data and reflects the limitations of our reporting and information systems. In some cases it is not possible to guarantee unduplicated counts. (b) These numbers represent publicly provided and/or funded (including Medicaid) mental health services rendered by the public sector. (c) Some individuals received services from both public mental health system and private sector providers during FY2009. (d) In Idaho, due to funding constraints, the target population is defined as adults diagnosed with a *serious and persistent mental illness*, a narrower subset of serious mental illness.

The State of Idaho is in the process of implementing the WITS data infrastructure system to support the needs of the AMH and SUD regional behavioral health service delivery systems. The anticipated target date for implementation is SFY 2010. The VistA system has already been installed and is now being implemented at the two state psychiatric facilities, State Hospital South (SHS) and State Hospital North (SHN) During this transitional period, accurate and unduplicated data capture continues to be challenging.

For the purpose of this report, the total number served is based on the Daily Activity Report (DAR) system numbers. In this report, enrolled clients are those opened for services in the public mental health system and included in the Department's ongoing caseload count. Non-enrolled clients served are those that received at least one Department provided adult mental health service but are not formally opened or included in the ongoing caseload count of individuals served.

Other data for tracking numbers related to types of services is derived from the Behavioral Health (BH) Monthly Data Report, which relies on regional manual counts that are submitted monthly to central office to compile into a statewide report. The Behavioral Health Monthly Data Report highlights some of the types and numbers of services provided in SFY 2009, however the total number recorded in these categories does not match the total number of clients as tracked through the DAR caseload count total. The BH report provides information on numbers served through ACT and Mental Health (MH) Court referred ACT, Outpatient Clinic, Psychosocial Rehabilitation/Case Management (Non-ACT); Designated Exam Holds, Hospital Diversions and PAP scholarships. The DAR provides numbers on Information and Referral.

The Office of Consumer Affairs provides monthly reports of services for Consumer and Family Advocacy/Education and Peer Specialist Certification. Service numbers of peer specialist and advocacy/education activities are also noted in the following tables:

**Served in SFY 2009 and Projected to be Served in SFY 2010**

**Projections for SFY 2010 will be maintenance of the same levels as numbers served in FY 2009.** See charts below for details on Services and numbers served in SFY 2009:

**AMH SERVICES BY SERVICE TYPE SFY 2009 (AS OF 7/24/2009)**

<b>DAR Caseload Count Report – SFY 2009</b>		<b>Region 1</b>	<b>Region 2</b>	<b>Region 3</b>	<b>Region 4</b>	<b>Region 5</b>	<b>Region 6</b>	<b>Region 7</b>	<b>Total</b>
<b>YTD Total # People Served by SMHA Resources</b>	<b>Beginning Caseload</b>	428	470	628	773	496	534	906	4,235
	<b>Total Through System</b>	933	341	992	618	940	708	939	5,471
	<b>Total</b>	<b>1361</b>	<b>811</b>	<b>1620</b>	<b>1391</b>	<b>1436</b>	<b>1242</b>	<b>1845</b>	<b>9,706</b>

**SERVICE TYPES AND NUMBERS SFY 2009 – BH REPORT AND DAR**

<b>SERVICE TYPE</b>	<b>SMHA SYSTEM</b>
Outpatient Clinic Services – BH report	3,460
Psychosocial Rehabilitation/Case Management (Non-ACT) - BH	1,101
ACT Team (353) and MH Court ACT (234) – BH report	587
MH Court ACT with Co-Occurring Disorders – BH report; tracked only November 2008-June 2009	1,357
Designated Exam Holds and Petitions – BH report	966
Holds Diverted from State Hospitalization – BH report	879
Clients receiving PAP med scholarships – BH report	4,274
Information & Referral (DAR report)	640
<b>CONTRACT W/OFFICE OF CONSUMER AFFAIRS (MONTHLY CONTRACT REPORT)</b>	
Peer Specialists Trained (February 2009)	15
Peer Specialists Certified (March 2009)	12
Peer Specialists Placed as of July 2009	7
Calls/consults/education (consumers or family members) (December 2008 through May 2009)	79

# Idaho

## Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

## **Outreach to Homeless**

The State of Idaho provides state funded and operated community based mental health care services through Regional Mental Health Centers (RMHC) located in each of the seven geographical regions of the state. Each RMHC provides mental health services through a system of care that is both community-based and consumer-guided. Individuals receiving mental health treatment through the RMHC continually need assistance with locating, maintaining, and stabilizing their housing.

The homeless population served through the mental health system in Idaho includes those individuals who are homeless or at risk of homelessness. Eligibility for mental health services, as defined under updated 2008 IDAPA 16.07.33, includes diagnoses under the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or subsequent version, which includes: schizophrenia, paranoia and other psychotic disorders, bipolar disorders (mixed, manic and depressive), major depressive disorders (single episode or recurrent), schizoaffective disorders and obsessive compulsive disorders. In addition, a substantial disturbance in role performance in at least two areas (i.e., vocational/educational, financial, social relationships, family, basic living skills, housing community/legal, health/medical) must be present over the previous six months.

The need for assistance with accessing and maintaining housing is a required component of the comprehensive assessment for PSR and service coordination services. Both service options identify housing as a primary focus area, which may be addressed if a functional limitation is identified in the assessment process. Needed services would then be identified on the individualized treatment plan in order to assist a consumer access and maintain housing in their community.

Outreach and services for homeless individuals with serious mental illness are provided in Idaho under the auspices of the Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program of the Center for Mental Health Services. PATH funds are used to provide services, basic housing essentials and emergency housing for eligible individuals. Specific PATH funded services in Idaho include outreach; screening and diagnostic treatment; community mental health; case management; referrals for primary health, and housing services. Idaho has participated in this federal grant program for the past sixteen years and was again awarded Project funding for FY 2009. PATH funding is distributed to each of the seven regional mental health centers responsible for providing these services. State general funds are used by each DHW Region to supplement PATH Grant allocations.

Other funds available to those who are homeless or at risk of homelessness are provided through funding from the Department of Housing and Urban Development (HUD). Idaho Housing and Finance Association (IHFA) and Boise City Ada County Housing Authority (BC/ACHA) apply for and administer grant funding received from HUD. Although the State of Idaho is not directly involved in the HUD Continuum of Care, the Division of Behavioral Health (DBH) does collaborate with both agencies to coordinate

and support homeless initiatives in Idaho. A representative from DBH participates in IHFA's Idaho Homeless Coordinating Committee on a quarterly basis and BC/ACHA's monthly meeting. Representatives from each RMHC work closely with the Regional Housing Coalitions and attend the regional meetings.

Julie Williams, Executive Director of Idaho Housing and Finance Authority (IHFA), is the housing representative on the State Planning Council for Mental Health. IHFA is integrally involved in housing issues in Idaho, and is primarily responsible to oversee HUD grants and shelter plus care. Shelter Plus Care housing is available in all regions of the state. This program assists in providing housing to those with a mental illness who are homeless. The Adult Mental Health program provides documentation of the mental health services match required for the Shelter Plus Care federal grant.

The Department of Health and Welfare (i.e., Adult Mental Health Program, Substance Abuse Program and Division of Medicaid) participated on the Governor's Policy Academy on Chronic Homelessness. This Governor appointed group was subsequently incorporated into the Idaho Homeless Coordination Network, which was sponsored by Idaho Homelessness Finance Association (IHFA). This group has been officially designated as the Idaho Homelessness Policy Council. Representation from both the State Mental Health Authority and Medicaid were required for the Policy Academy to assist in the development of a state plan to end chronic homelessness. The Council developed a ten-year "Plan to End Homelessness in Idaho." The Idaho Homelessness Coordinating Committee meets quarterly with representation from each region, from IHFA and from the Division of Behavioral Health. Regional programs are active in efforts to develop specific regional plans to ameliorate homeless. For example, Region 4 presented a "Ten Year Plan to Reduce and Prevent Chronic Homelessness" to the City Council in November 2007.

Through the Bureau of Facility Standards, the Department of Health and Welfare licenses or certifies a variety of supportive/assistive residential facilities and homes that are available to persons with a serious mental illness in Idaho. These supportive housing options include licensed Residential and Assisted Living Facilities, Certified Family Homes and Semi-Independent Group Homes throughout the state.

During SFY 2009, there were several activities directed to housing and homelessness, including the following:

- A federal audit of the Idaho PATH program provided an opportunity for each region to use feedback to develop an action plan to reflect opportunities for improvement in efforts to provide outreach and prevent homelessness among adults diagnosed with a serious mental illness.
- The Charitable Assistance to Community's Homeless (CATCH) program that mobilizes community resources to help address homelessness was expanded to include Region 3 in addition to Region 4.
- The process for accessing Shelter Plus Care beds was standardized, leading to an increased level of regional involvement with these housing vouchers.

- The State of Idaho was awarded 19.6 million from the 2008 Housing & Economic Recovery Act in SFY 2009 to distribute towards the acquisition and rehabbing of foreclosed or abandoned property in targeted areas throughout the state. Twenty percent (20%) of these funds were set aside for special needs housing. Housing representatives from the Division of Behavioral Health (DBH) attended the statewide discussions and regional discussions regarding use of earmarked funds and assisted with developing regional requests for funding. Many of the requests were to either establish Housing First programs or expand upon Housing First Programs statewide.
- Idaho participated in the HUD point in time count in January 2009 with a homeless stand-down event in Region 5.
- The Division of Behavioral Health is an active participant in the Community Conversations on Housing workgroup.

# Idaho

## Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

## **Rural Area Services**

### **Definition of Rural**

For the purposes of this document, we will conform to the classification system that is followed by the Federal Census Bureau. Under their classification, an urban county is defined as a county having a population center of greater than 20,000. A rural county is defined as a county having no population center of 20,000 or more, yet an average of six or more persons per square mile. A frontier county is defined as a county that averages less than six persons per square mile. Only 8 of Idaho's 44 counties are classified as "urban."

### **Population Density**

Idaho is a predominantly rural state. According to the U.S. Census Bureau, the total state population estimate for 2007 is 1,499,402. Idaho experienced an estimated 15.4% population increase from 2000 to 2007. Of the fifty states, Idaho ranks 13th in area size with 83,557 square miles and ranks 42nd in population. According to the Census Bureau, 66.4% of Idaho's population lived in urban areas, and 33.6% lived in rural and frontier areas in 2000.

The research team initially attempted to update this profile using the U.S. Census Bureau Civilian population; however, civilian population data is not broken down by county. Instead, the team is using residential population this year to allow for greater specificity at the county level. Due to the wide diversity of Idaho's counties, populations that allow for county level research provide a clearer portrayal of the state's needs and goals.

Idaho has a diverse geology and biology, containing large areas of alpine mountainous regions, vast desert plains, farmland valleys, and deep canyons and gorges. Many areas of the state have few roads. Some areas are vast wildernesses with no roads. Only five out of a total of 44 counties meet the criteria of a Metropolitan Statistical Area (MSA) as defined by the Federal Office of Management and Budget. The remaining 39 counties are classified as rural (at least 6 people per mile) or frontier (less than 6 people per square mile). Sixteen of Idaho's counties are considered frontier. These frontier areas comprise 59% of Idaho's total land area. Two thirds of Idaho's landmass consists of state and federal public lands.

In accordance with the 2006 estimates, there were an average of 15.6 persons per square mile in the state compared to the national average of 79.6 persons. Idaho counties with the largest populations include Ada, Canyon, Kootenai, Bonneville, Bannock and Twin Falls. There are 19 counties with a population under 10,000. The least populated counties, with under 5,000, include Camas, Clark, Butte, Adams, Lewis, Lincoln, Oneida, and Custer. Using 2000 population data, there are 8 counties classified as "urban," 20 as "rural" and 16 as "frontier."

### **Racial /Ethnic Composition**

Idaho is predominantly a Caucasian state. According to Year 2006 estimated census data, 95.2% of Idaho's population was white and 86.3% of Idaho's population is

classified as white, not Hispanic. The racial composition of the remaining 13.7% of Idaho's population is as follows:

Black/African American	Native American/Alaska Native	Asian	Native Hawaiian/Pacific Islander	Hispanic
0.7%	1.4%	1.1%	0.1%	9.5%

Idaho's largest ethnic minority, representing 9.5% of the state's total population, is of Hispanic heritage. Regions III and V contain the predominant concentrations of persons with Hispanic heritage. Up to 15% of the total population of these two regions is of Hispanic/Latino heritage and culture.

Given that 12.8% of the population is non-Caucasian, the system tends to be ethnocentric. This results in a general lack of development of services that are relevant to any group other than the dominant culture.

**Rural Mental Health Service Delivery in Idaho**

A rural service system must maintain resource flexibility and creativity while being as responsive as possible to individual, family and community needs. A review of the literature relating to human services delivery in rural areas in the United States identifies a range of social, psychological and economic factors that must be considered in delivering services in rural areas. These factors include:

- (1) Low population densities make it difficult to provide some services (for example, inpatient treatment) which require a "critical mass" of consumers to be economically and programmatically viable.
- (2) There can be difficulties associated with the availability of professionally trained staff in rural areas. In addition, it is often difficult to attract and retain qualified staff to move to rural areas to work. The State Office of Rural Health and Primary Care indicates that, in 2007, all areas of the State of Idaho have a federal designation as a Health Professional Shortage Area in the category of Mental Health. Additionally, State Hospital South has been designated as well.
- (3) The incidence of poverty is likely to be higher in rural areas.
- (4) In rural areas, long distances and lack of transportation options can be barriers to service access.
- (5) Social and geographical isolation can produce significant psychological difficulties for the individual and the family.

As indicated in the statistics stated above, Idaho is predominantly a rural state. Staff in the state-operated community mental health system have developed extensive skills and knowledge about how to effectively and efficiently deliver services to isolated rural communities and individuals.

Below are listed some of the ways in which the public adult mental health system in Idaho has attempted to address and reduce some of the inherent problems of rural service delivery.

1) The state has made and continues to make significant investments in technology, including personal computers and computer networks, laptop computers, cellular phones, electronic mail and fax machines. Telephone conference calls, with the ability to bring together ten or twelve individuals at a time from all over the state, are used extensively. In the area of electronic mail, we have a daily system of notification regarding admissions, discharges and problem cases at the state hospitals.

2) The Department of Health and Welfare established a videoconferencing work group that produced a Strategy for Video Conferencing Plan in April 2008. The purpose of this plan was to create video conferencing capability for all of the Divisions. Since that time, equipment has been installed at eleven locations (i.e., central office, SHS, SHN, Idaho State School and Hospital and seven regional main offices). The equipment was available for use in September 2008. Benefits of using this system include expanding the service array to rural and frontier areas and to those areas that need additional psychiatric services to meet the needs of clients; reduction of transportation costs; service delivery in the client's community setting; provision of educational opportunities; reduction in costs while maintaining high quality service options. Idaho Medicaid allows for reimbursement of tele-health services related to pharmacological management and psychotherapy. In SFY 2009, psychiatric monitoring services were provided through the high definition videoconferencing system to clients in Regions 2 and 7.

3) The state's support for consumer empowerment and self-help also extends the limited resources of our rural state to better serve adults diagnosed with a serious mental illness by developing a natural support system. This is further enhanced as a result of the Peer Specialist Training program, which allows certified peer specialists to provide supplemental adult mental health services through the ACT teams at regional centers.

4) As described previously, adult mental health services are delivered through the seven regional community mental health centers. In addition to the location of each CMHC in the seven major population centers, each region operates field offices (i.e., a state total of 22 field offices) that provide access to services for those living in the more remote areas of the state. Other methods of service extension include the development of networks of private providers under the Medicaid Rehabilitation Option.

# Idaho

## Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

### **Services to Older Adults**

The State of Idaho is committed to serving the mental health needs of its adult citizens, including those of older adults. Older adults who are eligible for mental health services are offered the full array of Community Mental Health Services that are available to all eligible adults (see Available Services section).

The Office on Aging is responsible to provide Adult Protective Services to older adults in Idaho. This agency also coordinates homemaker services. Regional Mental Health Center programs provide support, education, consultation and backup to the Office on Aging when mental health issues are identified. Occasionally, the Regional programs provide after hours services for those older adults who are in crisis.

According to Medicaid regulations, the Regional Mental Health Center programs are responsible to provide Qualified Mental Health Professionals (QMHP) to assess individuals referred to nursing home settings with the Patient Admission Screening and Annual Resident Review (PASARR) evaluation tool. Years ago, some mental health clients were admitted to nursing homes without physical disability diagnoses. This practice was revised such that a physician must make all referrals. Those indicating symptoms of mental health concerns (e.g., depression, anxiety, etc.) are evaluated accordingly. The Regional Medicaid Unit assesses physical reasons for nursing home admissions. Individuals with both physical reasons and mental health issues may be accepted into nursing home facilities. In these instances, the psychiatrist will review psychiatric medications and adjust as needed. The QMHP can order the nursing home facility to arrange for counseling or other mental health services, if such services are determined to be in the best interest of the client.

# Idaho

## Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

## Resources for Providers

### Financial Resources

The funding allocation for the Adult Mental Health Program is determined as part of the larger Idaho Department of Health and Welfare's budget. The State of Idaho uses a historical budget methodology based on the prior year's budget for the overall budget appropriation for the program. This includes the use of a historical budget based on the prior year's expenditures for allocating appropriated funds.

Each year the Adult Mental Health program budget is submitted to the State Legislature for the exact amount as in the prior year. Inflation factors are then added for personnel and for individual operating and trustee and benefit payment categories. The inflation amounts for the submission are set by the state's Division of Financial Management.

The prior year's approved budget plus the inflationary increases constitute the new fiscal year's base amount. To the base are added any program enhancements that are requested by the agency. This would include increased program funding requests, requests for additional personnel, etc. The final total is the program's annual budget submission.

After the budget is set by the legislature, the approved amount is allocated to the different program areas based on the prior year's expenditure level. This is not universal in the program in that personnel is set according to expected need based on the number of employees, salary and benefit rates.

The major categories of revenue available for Idaho's state community mental health program include state general funds, federal funds, and program receipts and are allocated for State FY2010 as follows:

Expenditures By Fund Detail	FY2010 Estimate
<b>State:</b>	
General Funds	\$14,802,900
Economic Recovery (State Funds)	0
Receipts- ongoing	\$600,000
<b>Subtotal State:</b>	<b>\$15,402,900</b>
<b>Federal:</b>	
CMHS Block Grant	1,100,000
DIG	98,000
PATH	243,900
Client Level Reporting	61,000
Olmstead Grant	60,000
Medicaid	0
TANF	0
Other Federal	0
<b>Subtotal Federal:</b>	<b>\$1,562,900</b>
<b>Total Estimated Expenditures</b>	<b>\$16,965,800</b>

**Resources - Staff**

The Department of Health and Welfare’s Division of Behavioral Health Program Managers reports the following distribution of established full time equivalent (FTE) staff as of 7/1/2009 in the Adult Mental Health Program statewide. Figures reflect budget cut layoffs in SFY 2009 and figures provided include existing forced vacancies. In comparison, the total FTE of all seven regions plus central office staff in SFY 2008 was 246.15.

**STATEWIDE DISTRIBUTION OF CMHC AMH STAFF as of 7/1/2009**

<b>Region</b>	<b>Total Established SMHA FTE’s</b>
<b>Region I</b>	29.08
<b>Region II</b>	23.85
<b>Region III</b>	37
<b>Region IV</b>	43.75
<b>Region V</b>	29.3
<b>Region VI</b>	32.33
<b>Region VII</b>	31.6
<b>Central Office</b>	8.00
<b>Total</b>	<b>234.91</b>

**Training Resources**

The Adult Mental Health Program continues to provide funding for identified training opportunities and needs for the regional CMHC staff. Additionally, each regional adult mental health program dedicates program funds to facilitate staff training. Each year the top training priorities are identified by the program managers and training is planned based those priorities.

The Division of Behavioral Health’s Adult Mental Health Program will continue in SFY 2010 to assume leadership in identifying the statewide training needs of the public mental health service delivery system. The Division has prioritized the need for improved statewide consistency and the development and implementation of program standards and competencies. The training priorities for SFY 2010 include training on use of the WITS data system, integrated co-occurring disorders competency and certification training in psychosocial rehabilitation. Additional training will focus on maximizing use of peer professionals within the context of the mental health service delivery system.

The WITS data system was developed at regional mental health centers and central office in June 2009. Training sessions were provided on the WITS system beginning in winter 2009 with a plan to continue training through implementation. The target date for beginning to use the WITS system is October 2009.

Specific training opportunities planned for SFY 2010 include the develop of an on-line training curriculum for Co-Occurring Disorders based on SAMHSA Tip 42 and training on psychosocial rehabilitation. The United States Psychiatric Rehabilitation Association (USPRA) is scheduled to provide a training opportunity on psychosocial rehabilitation in Idaho in September 2009. This training will be made available across the State of Idaho through high-definition videoconferencing to up to 120 staff and 100 private providers. USPRA has additionally chosen Boise, Idaho, as the site for their June 13-17, 2010 35th Annual Conference.

Common Assessment training was offered in all regions in January and February 2008. Designated Examiner and risk assessment training by an internal provider was held in June 2008 and videotapes of this session are available to all regions by request.

During SFY 2009, Dr. Ken Minkoff and Dr. Christine Cline, and Dr. Mee-Lee consulted with a wide range of professional staff on issues related to integrating co-occurring disorders of mental health and substance abuse in the State of Idaho. Interested regional staff were encouraged to pursue additional training and/or cross training certification in substance abuse and/or treatment of co-occurring disorders. Training and consultation in this area for SFY 2010 will depend on whether funds can be identified to defray costs.

A workshop on Preventing Violence, Trauma and the Use of Seclusion and Restraint in Mental Health Settings was offered on July 7-8, 2009. This training was sponsored by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the National Association of State Mental Health Program Directors Office of Technical Assistance and the Idaho Department of Health and Welfare, Division of Behavioral Health. Over 100 people participated, with representation from Regional Behavioral Health programs, corrections, substance abuse, hospitals and other stakeholders.

Also during SFY 2009 and through a Division of Behavioral Health contract with Mountain States Group Office of Consumer Affairs, Martha Ekhoft of the Office of Consumer Affairs offered a week of WRAP training to prospective peer specialist candidates, and an additional week in February 2009 of Peer Certification training to 15 peers from around the State of Idaho. Of these, 12 were certified and 7 were placed on regional ACT teams. Another Peer Certification training session is scheduled for September 2009. State Hospital South has set aside funds to support placement of a Certified Peer Specialist at their psychiatric facility.

# Idaho

## Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

## **Emergency Services Provider Training**

Ongoing training needs related to emergency medical services providers and law enforcement will continue to be identified in conjunction with the statewide mental health service providers training needs. The State Planning Council on Mental Health also endorses continued training efforts to provide training of law enforcement officers on the Police Pocket Guide developed by Children's Mental Health as well as first responder training to medical and law enforcements personnel.

A workshop on Preventing Violence, Trauma and the Use of Seclusion and Restraint in Mental Health Settings was offered on July 7-8, 2009. This training was sponsored by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the National Association of State Mental Health Program Directors Office of Technical Assistance and the Idaho Department of Health and Welfare, Division of Behavioral Health. Over 100 people participated, with representation from Regional Behavioral Health programs, corrections, substance abuse, hospitals and other stakeholders.

A staff member from Region III with expertise in performing Designated Examinations (DE) and disposition services offered statewide DE training June 2008. This training was videotaped and made available to all regions by request.

In 2002 a series of Critical Incident Response trainings was provided. The Adult Mental Health program sponsored a Risk Assessment for Violence training by Phillip Resnick, M.D. in March 2003, and again in April 2007. Targeted attendees included CMHC staff, private sector providers, physicians and law enforcement. The April 2007 training was offered in Twin Falls and again in Boise, so that a maximum number of people could attend from all areas of the State of Idaho.

Regional CMHC's provide ongoing training opportunities to their local law enforcement agencies on a regular basis. Training topics include risk assessment, mental hold protocols, available services, stigma and mental illness awareness education. Region 6 was awarded a Service Plan Component grant in the fall of 2006 that allowed law enforcement and mental health staff in Bingham County to receive Crisis Intervention Training (CIT) to enhance effective crisis response. As of January 2008, 35 officers and treatment providers had completed 24 hours of CIT in Region 6. Dual Diagnosis and CIT wraparound training was completed in Region 6 in May 2008, and this training was approved for 8 hours of Continuing Education Units by the POST law enforcement academy for law enforcement participants. Region 2 and Region 4 also have some CIT trained law enforcement personnel.

The Department of Health and Welfare and other agencies participated with the Idaho Bureau of Disaster Services in the development of the revised Idaho Emergency Operations Plan in 2007. The plan was revised to align Idaho's plan with the Federal Response Plan. The plan calls for mental health to assist in assessing mental health needs; provide disaster emergency mental health training materials for disaster

emergency workers; provide liaison with assessment, training, and program development activities by state and local officials and to administer the Emergency Crisis Counseling Program for the Bureau of Disaster Services. The Bureau of Disaster Services is the Governor's appointed representative for disaster response. The Division of Behavioral Health and Bureau of Disaster Services will continue to participate in joint coordination efforts. One Adult Mental Health and one Children's Mental Health representative from the Division of Behavioral Health attended the FEMA sponsored Disaster Response training in August 2008, and an AMH representative attended the Disaster Planning workshop in March/April 2009.

# Idaho

## Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

## Mental Health Block Grant Expenditure Manner – Adults and Children

Manner in which the State intends to expend the block grant for SFY 2010:

<b>Adult Mental Health</b>	<b>Federal Budget</b>
Adult Mental Health Services	\$1,205,898
Peer Specialist/Consumer/Family Empowerment	\$ 153,000
State Planning Council	\$ 20,000
Suicide Prevention	\$ 10,000
Quality Improvement System Development	\$25,000
<b><i>Total Adult Services FY 2010</i></b>	<b>\$1,413,898</b>
<b>Children’s Mental Health</b>	
CMH Special Projects:	\$ 312,121
-Contract with Family Run Organization	\$269,267
-Contract for Suicide Prevention Services	\$22,854
-Contract for Primary Care Physician Training	\$20,000
<b><i>Total Children Services FY2010</i></b>	<b>\$ 312,121</b>
Administration at 5%	<b>\$ 90,843</b>
<b><i>Totals; Adult Services, Children’s Services, Administration</i></b>	<b>\$ 1,816, 862</b>

It is expressly understood, as required by Public Law 102-321, that no Federal CMHBG funds are used for inpatient services. The following projects will be specifically funded with Federal Community Mental Health Block Grant (CMHBG) funds in FY2010:

**\$153,000** will be used to fund the contract with the Office of Consumer Affairs (through Mountain States Group) for Peer Specialist Training, Certification and supervision at regional ACT work sites. It will also include provision of advocacy and education to consumers and family members throughout Idaho.

**\$20,000** will be used to support the meetings and activities of the Idaho State Planning Council on Mental Health.

**\$10,000** will be used to contribute to funding a contact for suicide prevention.

**\$25,000** will be dedicated to provide funding for implementation of a quality improvement system to ensure best practice service delivery in all adult and children’s mental health services programs.

**\$1,205,898** in Federal CMHBG funds are placed in the Department of Health and Welfare's Mental Health Cost Pool and allocated to the seven regional CMHC budgets to fund various community mental health program categories by the use of a Random Moment Time Study.

**Table C. MHBG Funding for Transformation Activities  
State: Idaho**

	<b>Column 1</b>	<b>Column 2</b>	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the <i>actual</i> <b>or</b> <i>estimated</i> amount of MHBG funding that will be used to support this transformation goal in FY2010	
		<b>Actual</b>	<b>Estimated</b>
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	☒		10,000
GOAL 2: Mental Health Care is Consumer and Family Driven	☒		422,000
GOAL 3: Disparities in Mental Health Services are Eliminated	☒		20,000
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	☒		10,000
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	☒		1,200,000
GOAL 6: Technology Is Used to Access Mental Health Care and Information	☒		69,000
<b>Total MHBG Funds</b>	N/A	0	1,731,000

\*Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research ... Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

# Idaho

## Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State's transformation activities are described elsewhere in this application, you may simply refer to that section(s).

## **Description of Transformation Activities**

### **Goal 1: Americans Understand that Mental Health is Essential to Overall Health**

Mental Health Block Grant funds in the amount of \$1,205,898 will be dedicated to the provision of mental health services through the Adult Mental Health service system in the State of Idaho. In SFY 2009, a total amount of \$16,370,600 was spent on these activities (see MOE SFY 2009).

One of the activities provided through each regional adult mental health service program is the evidence based practice of Assertive Community Treatment (ACT). In addition to serving traditionally referred ACT clients, Regional Mental Health Centers also collaborate with Mental Health Courts to provide forensic ACT services to eligible individuals as a deterrent to jail. Region 7 is a national training site for the demonstration of the effectiveness of this partnership. One aspect of ACT services is the provision of treatment for co-occurring disorders.

In an effort to ensure that ACT services are provided according to best practice, the Dartmouth Assertive Community Treatment Scale (DACTS) was used for fidelity site reviews on four regional teams in SFY 2009. DACTS fidelity reviews will be conducted for at least three regional teams in SFY 2010.

Anti-stigma activities and social marketing are necessary to transform the mental health system because of the lack of understanding that mental health is essential to overall health. The Idaho Federation of Families led an effort in Idaho to hold mental health awareness artistic activities throughout the state. The first of these brought youth with SED together to express themselves through different types of art. These pieces of art were gathered, photographed and made into four large panels. This traveling art display was shown throughout the state in an effort to bring awareness to mental health. The Federation and the Department are partnered to do a similar effort with poetry, which was published into a book.

Idaho is currently contracting for the delivery of training to primary health care physicians/pediatricians on an ongoing basis. The training is part of a project to assist primary health care physicians and pediatricians to understand the symptoms and treatments of social and emotional disturbances in children and adolescents, thus foster competence in remaining the child/youth medical home. This is an important step in removing the stigma associated with mental illness and giving recognition of it as a medical condition that is treatable.

### **Goal 2: Mental Health Care is Consumer and Family Driven**

In SFY 2009, the Division of Behavioral Health contracted with the Office of Consumer Affairs through Mountain States Group to provide education and advocacy to consumers and family members across the State of Idaho, and to also establish a Peer Specialist training program. This contract included \$153,000 in block grant funds in SFY 2009. In February 2009, 15 consumers completed the Peer Specialist program and 12 of these passed the certification exam. Of these, seven were placed with regional ACT teams. The Office of Consumer Affairs provides ongoing support and supervision of placed peer specialists.

In addition to Peer Specialist training, peer specialists are also expected to complete Wellness Recovery Action Plan (WRAP) training and develop their own WRAP plans. The next Peer Specialist training is scheduled for September 2009, with another WRAP training scheduled

prior to that in August 2009. State Hospital South has set aside funds to support placement of a certified Peer Specialist at their facility following the completion of the September certification training session. The anticipated cost of this project is \$276,450 per year, with \$153,000 of this from 2010 Mental Health Block Grant funds.

The State Planning Council on Mental Health is instrumental in guiding the mental health service system in the State of Idaho. Consumers and family member are represented on this board, and \$20,000 of MHBG dollars will be directed to the support of this Council's efforts and activities. The annual Block Grant Planning submission is based on the State Planning Council on Mental Health's June report of identified mental health system strengths and weaknesses. The plan is reviewed at the August meeting of the State Planning Council, and their suggestions and revisions are incorporated into the final product. The State Planning Council on Mental Health is also responsible for oversight of continued transformation efforts in the State of Idaho.

The majority of the MH Block funds for CMH are used to contract with the Idaho Federation of Families for Children's Mental Health (IFFCMH) to assist and support parents in meeting the mental health needs of their children. All families that apply for mental health services through the Department are giving the opportunity to complete a referral/release form that is provided to the IFFCMH. This provides the family with the opportunity to learn from parents experiencing similar challenges.

Idaho has implemented the Wraparound approach to serving children with SED and their families. This process is driven by the families own voice and choice in the selection of a team to assist them in meeting the needs of their children. The inclusion of this as a service option in Idaho was driven in part by the advocacy of parents to move to a system that respects parents as the experts on their own families and capitalizing on that expertise to develop services that are strength-based and community-based. Idaho has, for many years, been moving to a system that is family centered, but youth consumer driven services and supports is relatively new. The youth movement was slow to come to Idaho, but is gaining momentum.

The State Planning Council on Mental Health includes a youth participant and many of the community CMH councils are beginning to realize the need and benefit of including youth as partners in the System of Care. The Idaho Federation of Families is working with youth statewide to develop leadership in this paradigm shift. Often, child serving agencies view their roles as very different from one another, which can lead to conflict between agencies. Idaho experience is that by focusing on the youth, the conflict resolves itself. Having strong youth leadership assists the agencies to keep the youth and family at the center and helps to avoid the conflict that can occur.

### **Goal 3: Disparities in Mental Health Services are Eliminated**

The block grant funds \$10,000 of the contract to address suicide prevention. In previous years, this contract was with the Suicide Prevention Action Network (SPAN). The Suicide Prevention Block Grant is now being administered by Benchmark.

The Idaho Suicide Prevention Research Project strives to support the volunteers, professionals and organizations in Idaho that are working to reduce the frequency of suicides and the impact of

suicide on survivors and communities. Through a DHW contract with Benchmark, the Suicide Prevention Research Project gathers and displays Idaho specific, user accessible data about the prevalence, circumstances and impact of suicide. Idaho specific data is available for special at risk populations that include teen males, Native American males, working age males and elderly males. All project data and reports will be accessible through a website dedicated to suicide research and data in Idaho. This website can be accessed at [www.IdahoSuicide.info](http://www.IdahoSuicide.info).

A Patient Assistance Program (PAP) software package was purchased for approximately \$50,000. This software automates the application process for the indigent benefits offered by many pharmaceutical companies, allowing clients to receive needed medications at no cost. The automation frees up staff time and essentially offers these benefits to more clients. If the costs of the medications received for free are calculated at average wholesale price (AWP), the benefit received by clients for February 2009 alone exceeds \$800,000.

The 2006 Idaho Legislature passed parity legislation for the first time in Idaho. The legislation requires parity in mental health services for all state employees and is intended to be a pilot. The bill will sunset in three years, but includes requirements for evaluation. The State Planning Council was in support of the legislation and is continuing to encourage a thorough evaluation of the impact of parity. The project continues and the results of the pilot will be shared with the planning council.

An important component to the Cooperative Agreement with SAMHSA awarded to Idaho for building Systems of Care was the creation of the Tribal Coordinating Council (TCC) that works with state leaders to increase awareness of and support for the tribes as they meet the mental health needs of their Native youth. Even with the end of the Cooperative Agreement, the TCC continues to work to coordinate services among the tribes and create a single forum to address the disparities in the mental health care of all Idahoans.

#### **Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice.**

In SFY 2010, the AMH program worked with regional Behavioral Health Program Managers to define caseload acuity for high, medium and low service needs. These acuity levels are programmed into the new WITS data system for AMH programs and applied to caseloads in all service areas. The LOCUS instrument was chosen to assist in determining acuity level for adult mental health services.

Regional AMH Program Managers continue collaboration efforts in response to increased requests for best practice services to mental health court referrals. During SFY 2009, Mental Health Court Utilization increased to approximately 90% of capacity. A Forensic Psychiatrist was hired in Region 4 to provide services to increased numbers of clients referred from the criminal justice system.

The model used to support mental health referrals as an alternative to jail is the provision of intensive ACT services and collaboration with court representatives to develop an individualized treatment plan that allows participants to stabilize and learn additional life management skills such as taking necessary medications, avoiding drug and alcohol use and avoiding criminal activities that brought them into the legal system.

In addition to collaborating with the courts and corrections to establish referral, assessment, monitoring and treatment procedures, regional AMH programs also review and revise treatment services as needed in an effort to provide best practice, efficient and effective services. Besides use of the CCISC model of treatment for co-occurring disorders, all regional programs also have access to the Eli-Lilly Wellness curriculum and the Eli-Lilly Differential Diagnosis materials.

Idaho is working with Georgetown University to begin using a Public Health approach to mental health in the area of prevention. Idaho is working with the Public Health Districts throughout the state to disseminate information on mental health. Specifically, Idaho is utilizing the “Bright Futures: What to Expect and When to Seek Help” brochures in the public health offices. This will allow public health professionals to assist in the early identification of children that have mental health needs and assist parents in accessing information that can prevent mental illnesses. This is a particularly important effort in the rural parts of Idaho and with the homeless population as individuals that are homeless and/or from rural Idaho are more likely to seek services for physical health needs than mental health needs. Public health districts are usually viewed as more accessible. Idaho is currently contracting for the delivery of training to primary health care physicians/pediatricians on an ongoing basis. The training is part of a project to assist primary health care physicians and pediatricians to understand the symptoms and treatments of social and emotional disturbances in children and adolescents, thus foster competence in remaining the child/youth medical home. This is an important step in removing the stigma associated with mental illness and giving recognition of it as a medical condition that is treatable.

#### **Goal 5: Excellent Mental Health Care is Delivered and Programs are Evaluated**

Mental Health Block Grant funds in the amount of \$25,000 will be allocated to Quality Improvement System Development. Specific activities directed to quality improvement include the development and implementation of policies and procedures to improve service consistency and standardization; use of instruments such as the OQ that was piloted in Region 6 to measure outcome quality of provided services from the customer perspective and conducting site visits to review service quality (e.g., DACTS fidelity review of ACT EBP, review of documentation, etc.).

During SFY 2009, an innovative public-private partnership was formed in Region 4. The Home Recovery Team (HRT) provides in home support, treatment and resource development for individuals who are at risk of out of home placement in more restrictive levels of care. Although this program is new, results have been promising.

With respect to the Children’s Mental Health (CMH) program, Idaho is currently utilizing two of the three evidence-based practices (EBP) approved by SAMHSA, Treatment Foster Care (TFC) and Functional Family Therapy (FFT). Idaho’s model of TFC is a state developed model that does not utilize any nationally recognized fidelity measures. Idaho’s model follows a set of standards that were developed to include training, support, and treatment services. Idaho is currently exploring the possibility of making TFC a Medicaid reimbursable service. This will require Idaho to adopt a more robust model. Currently, the Department is evaluating the newly developed Wraparound model of TFC and the Oregon Social Learning Center’s Multi-Dimensional TFC program.

Idaho contracts for FFT with the Idaho Youth Ranch. The Youth Ranch works directly with FFT Inc. to ensure fidelity to the model. This has been an important addition to Idaho's continuum of care. FFT and TFC serve children from multiple settings. These services are developed through true collaboration and determination. These services are integrated between juvenile justice, child welfare, and children's mental health.

The CMH program staff performed audits on all open CMH cases for the purposes of quality assurance. One clear theme came from the audits; approximately 70% of open cases had a primary or secondary presenting issue of disruptive behaviors. Research demonstrates that among the most effective treatments for disruptive behavior disorders is Parent Management Training. After a literature review on Parent Management Training programs available across the country, the CMH program settled on a program called Parenting with Love and Limits (PLL). This program is well researched and is included as a model program for OJJDP, SAMHSA, and the White House's Helping America's Youth rated PLL as achieving the highest level of evidence to support its effectiveness. PLL is a unique program based on the Parent Management Model that has both a group component, custom designed for parents of children and youth ages 10 to 17 years old with severe emotional and behavioral problems, and individual family therapy (coaching) sessions provided concurrent to the group sessions. PLL combines effective techniques from Motivational Interviewing, Wraparound, Functional Family Therapy, and Parent Management Training in a Solution Focused Approach to move families through the change stages toward better family functioning. The program was rolled out in June of 2008.

#### **Goal 6: Technology is Used to Access Mental Health Care and Information**

During SFY 2009, the two State Hospitals (North and South) completed VistaA installation and implementation. The AMH program pursued the joint purchase and use of the WITS system by both the AMH and the Substance Use Disorders (SUD) programs. On the AMH side, the WITS system was programmed with the Client Level Reporting Project (CLRP; see paragraph below) data definitions of the NOMS. Installation of WITS was completed by June 2009, and implementation and training activities are scheduled through SFY 2010 with the expectation of system use by September 2009.

The Division of Behavioral Health was awarded a Client Level Reporting Project (CLRP) grant in the winter/spring of 2008. This award allows three regions (i.e., Regions 1, 5 and 6) to pilot the Data Dictionary and Protocol that were developed by the nine participating states in an effort to create increased consistency and standardization in data capture and reporting of the National Outcome Measures (NOMS). This project has completed a test case deliverable and a deliverable of FY 2008 service data with CLRP data definitions. It will complete the final deliverable of SFY 2009 NOMS data by the project end date in September of 2009.

The Department of Health and Welfare established a Telehealth System Implementation (TSI) videoconferencing work group that produced a Strategy for Video Conferencing Plan in April 2008. The purpose of the TSI project was to use information technology to assist government efforts to increase efficiency, reduce costs, and improve health and behavioral health access, services and education to Idaho citizens. Videoconferencing equipment priority use is the need for telemedicine to expand psychiatric service access to prevent crises and maintain client stabilization, especially in rural and frontier areas.

During SFY 2009, equipment was installed and tested at Central Office, State Hospital South, State Hospital North and each of seven regions. As of September 2008, eleven high definition videoconferencing sites were available for site to site use. Sites included regional main offices, central office and three state hospitals (State Hospital South, State Hospital North and Idaho State School and Hospital). Since that time, the system was expanded to allow multi-site videoconferencing.

Although installed for less than a year, the Behavioral Health program has expanded access to psychiatric care and services to adults with a serious mental illness in rural and frontier areas through high definition videoconferencing. The State Planning Council on Mental Health has found videoconferencing to be an effective way to extend their budget while continuing to have meetings to address mental health issues. The Second District Drug Court has used it for training and education. The Idaho Supreme Court has offered team training sessions on topics such as child protection and drug court.

Idaho is primarily a rural and frontier state with all Idaho counties designated as mental health professional shortage areas. Psychiatric coverage is difficult to ensure across the State. Travel costs can be expensive. In a lean economic climate, all methods of cost reduction without compromising services are critical. As of May 2009, three contracted psychiatrists were providing telemedicine from the Boise Central Office. From September 2008 through May 2009, Region 2 estimated that 360 clients received psychiatric services through this system. Region 7 began using these services in February 2009, with an estimated 180 clients benefitting through May 2009.

Use of the videoconferencing equipment began slowly from September through December 2008, but increased rapidly from January 2009. From September through December 2008, the recognized cost savings was \$15,485. From January through May 2009, the cost savings for all users totaled \$182,388. The cost savings related to the TSI project as measured by reduction in travel costs (i.e., mileage, airfare, staff time to travel, per diem, hotel and other miscellaneous costs accrued in the course of travel to attend face to face meetings) has exceeded installation costs in less than a year. The total equipment costs of \$189,000 included cameras, monitors, carts, routers and a Multi-Channel Unit (MCU) device that enables simultaneous linkages to more than two connections. From September 2008 through May 2009, the total savings across all users was \$197,873.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	8,707	10,356	8,600	8,700	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:** Persons with a serious and persistent mental illness will have access to SMHA services. While a small number will have Medicaid, the majority served do not have access to Medicaid or other forms of insurance

**Target:** Provide state public mental health service access to at least 8,700 eligible persons.

**Population:** Adults with SMI who are served by the SMHA. While some have Medicaid, the majority do not have access to Medicaid or other forms of insurance.

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

**Indicator:** Total number of persons who received services through the state operated mental health system.

**Measure:** Total number of persons receiving state operated mental health services.

**Sources of Information:** DAR, Manual Count (Behavioral Health Monthly Data Report), WITS

**Special Issues:** Due to transitions from our old data system to the WITS system, we are unable to guarantee unduplicated client counts for SFY 2010. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 22 field offices across the state. Idaho's target population is defined as serious and persistent mental illness. The Department counts both enrolled and non-enrolled clients when determining the total persons served. Enrolled clients are those opened for services in the public mental health system and included in the Department's ongoing caseload count. Non-enrolled clients served are those that received at least one Department provided adult mental health service but are not formally opened or included in the ongoing services caseload count. These services include Consumer Activities, Advocacy & Development, Designated Exams, Disposition and Court services, and Information & Referral services. Projections for total adults served for State FY 2010 will be at least 8,700.

**Significance:** National Outcome Measure.

**Action Plan:** The data reported on this measure will rely on access data for eligible adult individuals in the SMHA. The Adult Mental Health program is not able to capture the data of those persons with a serious and persistent mental illness who receive services from private providers.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	2.30	.22	3.80	5	N/A
Numerator	13	1	--	--	--
Denominator	566	457	--	--	--

Table Descriptors:

- Goal:** Adults with a serious and persistent mental illness will be re-hospitalized less often as they will be able to access community based mental health services.
- Target:** Achieve a rate not to exceed 5% for re-admission to the two State Psychiatric Hospitals within 30 days of discharge.
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of persons who are re-admitted to a psychiatric hospital within thirty days of a state hospital discharge.
- Measure:** Numerator-Number of persons readmitted within thirty days of state hospital discharge.  
Denominator- Number of persons discharged from a state hospital.
- Sources of Information:** State hospital data system - VistA
- Special Issues:** This objective supports the Planning Council's priority on quality, continuum of care and community supports and is a required NOM. The 5% target reflects concerns about increased stressors on Idaho citizens related to the economy, as well as possible repercussions of budget cuts to staff in the mental health service delivery system.
- Significance:** National Outcome Measure.
- Action Plan:** An adult mental health program policy requiring that all persons discharged from a state psychiatric hospital will be opened for follow up services by the regional CMHC for not less than 30 days in most cases allows for consistent and coordinated discharge planning between the hospitals and the CMHC's. A post discharge survey is conducted by the regional CMHC staff on all persons discharged from a state psychiatric hospital. The surveys are then sent to State Hospital South for data tabulation. Implementation of the VistA data infrastructure system at both state hospitals and upgrades to the pharmacy management data system will significantly improve our ability to provide state hospital related data.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	7.42	3.94	6	7	N/A
Numerator	42	18	--	--	--
Denominator	566	457	--	--	--

Table Descriptors:

- Goal:** Adults diagnosed with a serious and persistent mental illness will be re-hospitalized less often as they will be able to access community based mental health services.
- Target:** Achieve a rate not to exceed 7% for re-admission to the two State Psychiatric Hospitals within 180 days of discharge.
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of persons re-admitted to a state psychiatric hospital within 180 days of discharge from a state psychiatric hospital.
- Measure:** Numerator- Number of person readmitted within 180 days of discharge. Denominator- Total number of discharges.
- Sources of Information:** State hospital data system
- Special Issues:** The VistA data system was implemented during FY09 for the two state psychiatric hospitals, which should improve Idaho's reporting of the NOMS. We were unable to report FY 2008 data without duplication because state hospital data system was only able to report the total number of readmission occurrences and could not unduplicate between the two hospitals or a single person with several re-admission episodes. The 7% target reflects concerns about increased stressors on Idaho citizens related to the economy, as well as possible repercussions of budget cuts to staff in the MH service delivery system.
- Significance:** National Outcome Measure.
- Action Plan:** A policy implemented in the adult mental health program requires that all persons discharged from a state psychiatric hospital be opened for follow up services by the regional CMHC for not less than 30 days allows for consistent and coordinated discharge planning between the hospitals and the CMHC's. A post discharge survey is conducted by the regional CMHC staff on all persons discharged from a state psychiatric hospital. The surveys are then sent to State Hospital South for data tabulation. Efforts to implement the VistA data infrastructure system in both of the state hospitals during SFY 2009 is anticipated to significantly improve our future ability to provide state hospital related data.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	3	3	4	4	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:** Persons with a serious and persistent mental illness will have increased access to evidence based mental health services.

**Target:** Maintain the number of Evidence-Based Practices in Idaho and increase the number of persons served by those programs during SFY 2010.

**Population:** Adults with SMI

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

**Indicator:** Total number of evidence based practices provided by the SMHA.

**Measure:** Total number of evidence based practices that are implemented by the adult mental health program.

**Sources of Information:** Regional reports through the Behavioral Health Monthly Data Report form, Vocational Rehabilitation.

**Special Issues:** Evidence based practices currently being implemented by the SMHA for adults with a serious and persistent mental illness include Assertive Community Treatment,Supported Housing, Supported Employment and Integrated Treatment of Co-Occurring Disorders (MISA).

**Significance:** This is a required National Outcome Measure.

**Action Plan:** Assertive Community Treatment services are available in each of the seven service regions of the Department of Health and Welfare's Adult Mental Health Program. Each region provides traditionally referred and mental health court referred ACT services; Community Supported Employment, Integrated Treatment of Co-Occurring Disorders and Supported Housing. In SFY 2009, certified peer specialists were placed with regional ACT teams across the state. Fidelity to the ACT model is measured through use of the DACTS for at least 3 regions per year.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	85	85	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** The goal is to increase independence and housing stability for adult Idaho citizens with SMI who are receiving supportive services from the SMHA and who are also living in Shelter Plus Care housing.
- Target:** During SFY 2010, at least 85% of adults with SMI who are living in Shelter Plus Care housing and receiving supportive services from the SMHA will maintain their housing stability for at least 9 months.
- Population:** Adults with SMI who are living in Shelter Plus Care housing and receiving supportive services from the SMHA. The percentage will not include those who move out of state or move into other permanent housing in the reporting period.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of adults with SMI who are living in Shelter Plus Care housing and receiving SMHA supportive services who maintain their housing stability for at least 9 months. Numerator - Number maintaining housing for 9 months. Denominator - Total number in Shelter Plus housing and receiving SMHA supportive services.
- Measure:** Percentage of adults with SMI who are living in Shelter Plus Care housing and receiving SMHA supportive services who maintain their housing stability for at least 9 months.
- Sources of Information:** Manual counts from regional Shelter Plus Care Coordinators.
- Special Issues:** Six of seven regions collaborate with Idaho Housing and Finance Association (IHFA) to identify eligible Shelter Plus Care individuals. Those who receive Shelter Plus Care housing and who meet SMHA eligibility also receive mental health services (e.g., case management, counseling and other supportive services) from the SMHA. The number of eligible Shelter Plus Care slots is fixed. The SFY 2010 goal reflects an outcome measure related to the percentage of individuals that are able to benefit from SMHA services and maintain stability in their Shelter Plus Care housing for at least 9 months.
- Significance:** Adults with SMI that are able to maintain supported housing for at least 9 months tend to have increased stability in other aspects of their lives as well.
- Action Plan:** Provide supportive housing services to eligible Shelter Plus Care housing recipients. Track numbers of service participants who maintain stable housing for at least 9 months during SFY 2010.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	155	156	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** The Divisions of Behavioral Health (BH) and Vocational Rehabilitation (VR) collaborate to improve community supported employment (CSE) services and data capture for SMI adults served through the DHW SMHA service system.
- Target:** The SFY 2010 target is to provide CSE services to at least 156 adults with a serious mental illness served through the 7 CMHC service sites.
- Population:** Adults with a serious mental illness who are receiving BH and VR services through regional service programs.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** At least 156 eligible adults served through BH and VR regional programs will receive CSE services and be employed in SFY 2010.
- Measure:** VR reports of CSE services provided to BH clients whose cases were either closed (Rehab Closed, Employed) or open and employed from 7/1/2009 through 6/30/2010.
- Sources of Information:** VR data on shared VR and BH clients who received CSE services and who are 1) employed and either closed in SFY 2010 or 2) still open as of 6/30/2010.
- Special Issues:** The Divisions of Behavioral Health and Vocational Rehabilitation collaborate to identify methods to improve CSE data capture and services to eligible adults served through both programs. During SFY 2010, IDVR will provide monthly service reports to BH on vocational services provided to shared clients. IDVR regional staff will attend at least one weekly ACT meeting in each region.
- Significance:** Ongoing collaboration and enhanced data capture will improve supported employment service and access to Idaho adult citizens with a serious mental illness receiving services from regional CMHC's.
- Action Plan:** The Divisions of VR and BH will collaborate to provide best practice services to eligible Idaho adult citizens served through both programs in all regions. During SFY 2010, at least 156 shared clients will receive CSE services and be either 1) still open and employed by June 30, 2010 or 2) rehab closed and employed.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	547	N/A	587	590	N/A
Numerator	N/A	525	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** Persons with a serious and persistent mental illness diagnosis have access to assertive community treatment and forensic assertive community treatment services.
- Target:** Provide ACT services to at least 590 persons as measured by total number of traditionally referred ACT served plus total number of Mental Health Court ACT served during SFY 2010.
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Total number of persons receiving Assertive Community Treatment Services (i.e., total ACT plus total MH Court ACT) from the SMHA.
- Measure:** Total number of persons receiving ACT services.
- Sources of Information:** Regional reports through the Behavioral Health Monthly Data report.
- Special Issues:** This is a required NOM. Assertive Community Treatment teams in Idaho serve traditionally referred ACT clients as well as Mental Health Court (MHC) referred clients. In SFY 2009, there were a total of 587 ACT clients served; 353 of these were non-MHC referred and 234 were MHC referred. Idaho implemented a Peer Specialist Certification program in SFY 2009. As a result, certified peer specialists have been placed with ACT teams across the State.
- Significance:** Idaho continues to support the implementation of ACT teams in the public mental health system as a strategy to decrease psychiatric hospitalizations and to maintain persons in their communities with necessary supports. Idaho ACT teams provide services to eligible traditionally referred clients and to those eligible individuals referred through regional Mental Health Courts.
- Action Plan:** ACT staff will continue to serve traditionally referred ACT clients as well as mental health court referred clients in each region. In SFY 2009, certified peer specialists were placed with ACT teams across the state. This will continue in an effort to model best practice as well as recovery and resilience.

**ADULT - GOALS TARGETS AND ACTION PLANS**

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

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:** Implement the WITS data system in SFY 2010 and begin to track the number of adults with SPMI served by the SMHA who receive Family Psychoeducation to establish a baseline.

**Target:** Establish a baseline.

**Population:** Adults with SPMI served through the regional SMHA.

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

**Indicator:** Numbers of adults with SPMI receiving Family Psychoeducation services through the SMHA.

**Measure:** Numbers of adults with SPMI receiving Family Psychoeducation services through the SMHA.

**Sources of Information:** WITS data system, regional reports.

**Special Issues:** The data infrastructure system in Idaho has been inadequate to track services. The implementation of the WITS data system in SFY 2010 should help to track the numbers of adults with SPMI who are receiving Family Psychoeducation services through the SMHA.

**Significance:** This is a required NOM.

**Action Plan:** Implement the WITS data system. Establish a baseline of adults with SPMI receiving Family Psychoeducation through the SMHA is SFY 2010

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	160	180	N/A
Numerator	N/A	256	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** Provide co-occurring, integrated treatment to adults with co-occurring mental illness and substance use disorders to at least 180 adults receiving SMHA services June 30, 2010.
- Target:** The target for SFY 2010 is to provide co-occurring, integrated SMHA treatment services to at least 180 eligible adults.
- Population:** Eligible adults with co-occurring mental health and substance use disorders receiving SMHA treatment services.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Provision of co-occurring, integrated treatment services to at least 180 individuals with mental illness and substance use disorders receiving SMHA treatment services.
- Measure:** see Indicator.
- Sources of Information:** Regional counts, court data, Behavioral Health Adult Mental Health Monthly Data Report, WITS.
- Special Issues:** Idaho has worked to standardize the process to capture system data from mental health and substance use programs. Regional ACT teams provide dual diagnosis groups and other dual diagnosis services to adults referred through mental health courts. In SFY 2008, 201 mental health court referred clients were served by regional ACT teams; approximately 140 of these individuals received dual diagnosis services. In SFY 2009, approximately 181 mental health court ACT and 161 ACT were diagnosed as co-occurring with at least 160 receiving co-occurring services. The WITS data system is being implemented in SFY 2010, and it is anticipated that data capture will improve. Regions continue to work on becoming co-occurring capable in the delivery of treatment services; therefore the 2010 goal will be to provide these services to 180 eligible adults served by ACT, MH Court referred ACT and also Clinic services.
- Significance:** National Outcome Measure. Idaho is developing and implementing a best practice model of integrated treatment to serve those with co-occurring substance use and mental health diagnoses.
- Action Plan:** Provide dual diagnosis services to at least 180 eligible adult SMHA clients with co-occurring diagnoses.

**ADULT - GOALS TARGETS AND ACTION PLANS**

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

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** Implement the WITS data system in SFY 2010 and begin to track the number of adults with SMI served by the SMHA who receive Illness Self Management to establish a baseline.
- Target:** Establish a baseline of adults with SMI served by the SMHA who receive Illness Self Management.
- Population:** Adults with a serious and persistent mental illness served through the SMHA.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Numbers of adults with SPMI receiving Illness Self Management through the SMHA.
- Measure:** Numbers of adults with SPMI receiving Illness Self Management through the SMHA.
- Sources of Information:** WITS data system, regional reports.
- Special Issues:** The data infrastructure system in Idaho has been inadequate to track services. The implementation of the WITS data system in SFY 2010 should help to track the numbers of adults with SPMI who are receiving Illness Self Management through the SMHA.
- Significance:** This is a required NOM.
- Action Plan:** Implement the WITS data system. Establish a baseline of adults with SPMI receiving Illness Self Management services through the SMHA in SFY 2010.

**ADULT - GOALS TARGETS AND ACTION PLANS**

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

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** Implement the WITS data system in SFY 2010 and begin to track the number of adults with SPMI served by the SMHA who receive Medication Management to establish a baseline.
- Target:** Establish a baseline of adults with SPMI served by the SMHA who receive Medication Management.
- Population:** Adults with SPMI served through the regional SMHA system.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Numbers of adults with SPMI receiving Medication Management services through the SMHA.
- Measure:** Numbers of adults with SPMI receiving Medication Management services through the SMHA.
- Sources of Information:** WITS data system, regional reports.
- Special Issues:** The data infrastructure system in Idaho has been inadequate to track services. The implementation of the WITS data system in SFY 2010 should help to track the numbers of adults with SPMI who are receiving Medication Management services through the SMHA.
- Significance:** This is a required NOM.
- Action Plan:** Implement the WITS data system. Establish a baseline of adults with SPMI receiving Medication Management services through the SMHA in SFY 2010.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	88	84.68	84.97	85	N/A
Numerator	704	763	--	--	--
Denominator	800	901	--	--	--

Table Descriptors:

**Goal:** Persons receiving SMHA services will report a positive perception of care received from the SMHA.

**Target:** To achieve an 85% or higher approval rating in consumer's positive satisfaction with services.

**Population:** Adults with SMI

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

**Indicator:** Percentage of consumers receiving DHW provided mental health services who rate positive satisfaction with services.

**Measure:** Numerator- Number of consumers who rate positive satisfaction with services Denominator- Number of completed consumer satisfaction surveys

**Sources of Information:** DS2k+ Website, MHSIP Adult Consumer Survey

**Special Issues:** This is a required NOM.

**Significance:** Measurement of consumer satisfaction is an important component in assessing the overall quality and appropriateness of services. This supports the Planning Council's priorities related to Quality.

**Action Plan:** Beginning in October 2003, Idaho adopted and implemented the use of the MHSIP Adult Consumer Satisfaction Survey. The survey is offered annually and at discharge to all persons receiving ongoing public provided adult mental health services for 30 days or more. Consumers are asked to voluntarily complete the survey. Completed paper surveys are sent to central office where they are data entered into the DS2K+ website by support staff. The goal for SFY 2010 is to maintain at least an 85% report of positive client perception of care on the MHSIP survey.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	110	112	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:** Provide increased and/or retained employment for adults receiving SMHA services.

**Target:** Provide employment services to at least 16 persons per region for a total of at least 112 persons.

**Population:** Eligible adults with a serious mental illness who are able to work.

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

**Indicator:** Number of adults able to work who are receiving SMHA services and who are employed.

**Measure:** Number of adults able to work who are receiving SMHA services and who are employed.

**Sources of Information:** Division of Vocational Rehabilitation, Regional information

**Special Issues:** The Division of Behavioral Health has an Interagency Agreement with Idaho Division of Vocational Rehabilitation (IDVR) to provide vocational services to SMHA adults with a serious and persistent mental illness. This year, the agreement includes additional data capture and reporting. It also includes increased IDVR presence during weekly ACT team meetings. These changes are anticipated to improve accurate data capture of persons employed and improve employment opportunities and services.

**Significance:** National Outcome Measure.

**Action Plan:** The SMHA and IDVR will collaborate to increase and retain the number of adults with SMI able to work and that are working and retaining jobs.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	4	85.90	88.86	86	N/A
Numerator	31	542	--	--	--
Denominator	775	631	--	--	--

Table Descriptors:

- Goal:** Adults receiving SMHA services will report decreased arrests in the prior 12 month period on the MHSIP Consumer Survey.
- Target:** To achieve 14% or less in arrests reported through MHSIP system for the previous 12 month period for clients in service at least 12 months.
- Population:** Adults served by regional community mental health programs with SMI and also with criminal justice involvement.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Numbers of arrests reported by adults with SMI with criminal justice involvement on MHSIP; self report for previous 12 months by clients who have been receiving services for at least the past 12 months.
- Measure:** Adults with SMI with criminal justice involvement who have been receiving services for at least 12 months; self report on MHSIP consumer survey of arrests in previous 12 month period.
- Sources of Information:** MHSIP Consumer Survey; Regional data sources, courts, corrections
- Special Issues:** Completion of the MHSIP Consumer Surveys is voluntary and anonymous; the reported numbers therefore capture only a subset of the total number of clients served through the mental health service system.
- Significance:** National Outcome Measure.
- Action Plan:** Continue to track reported arrests through MHSIP. Continue efforts to develop an internal data infrastructure system to capture arrest data related to clients receiving SMHA services.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	70	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** Increase stability in housing among adults receiving SMHA services who have been homeless or at risk of homelessness.
- Target:** At least 10 persons per each of 7 regions who have received homeless services through the SMHA will retain stable housing for at least 3 months; total served SFY 2010 will be 2010.
- Population:** Adults with a serious mental illness (SMI).
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Adults receiving SMHA services who have been homeless or at risk of becoming homeless will retain stable housing (i.e., permanent housing) for at least 3 months.
- Measure:** Adults receiving SMHA services who have been homeless or at risk of becoming homeless will retain stable housing (i.e., permanent housing) for at least 3 months.
- Sources of Information:** Regional data sources.
- Special Issues:** The AMH system has been challenged with an inadequate data capture system that requires regional hand counts. The National PATH Program had indicated plans to initiate PATH outcome data tracking through Homeless Information Management system (HMIS) in SFY 2009. The HMIS system did not become available to Idaho PATH programs in SFY 2009, so Idaho's SFY 2009 goal to use HMIS to track 3 month housing stability was not feasible without PATH access to the HMIS system. For this reason, the SFY 2010 goal to track stability in housing will rely on manual, regional counts of PATH clients that maintain stable housing for at least 3 months. Another factor that resulted in decreased numbers served than originally projected for SFY 2009 related to the economic downturn. As a result of the economy, there was a decreased amount of state dollars that were directed to the provision of homeless services and an increased number of people requiring emergency short-term services. While Idaho applied for ARRA and Neighborhood Stabilization Program (NSP) funds, receipt of those funds went to IHFA, and IHFA distributed those funds to the private providers, not to the SMHA.
- Significance:** National Outcome Measure.
- Action Plan:** Add a manually counted, regional outcome measure to track 3 month stability in housing for regional clients served by the PATH program. The SFY 2010 goal will be that at least 10 PATH clients served by the SMHA in each of 7 regions will maintain housing for at least 3 months.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	63.50	64.24	67	N/A
Numerator	N/A	548	--	--	--
Denominator	N/A	863	--	--	--

Table Descriptors:

**Goal:** Adults receiving SMHA services will report a stronger sense of social connectedness.

**Target:** To achieve a 67% or higher rating on social connectedness.

**Population:** Adults with a serious mental illness (SMI).

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

**Indicator:** Responses on consumer survey (MHSIP).

**Measure:** Responses on consumer survey (MHSIP).

**Sources of Information:** Consumer survey (MHSIP).

**Special Issues:** The Adult Mental Health program is in the process of assessing and developing a data infrastructure system capable of reliably capturing data to allow reporting on NOMS.

**Significance:** National Outcome Measure.

**Action Plan:** Encourage completion and submission of MHSIP consumer surveys. Achieve a rating of at least 67% on MHSIP Consumer Survey positive reports of Social Connectedness in SFY 2010.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	64.77	66	67	N/A
Numerator	N/A	559	--	--	--
Denominator	N/A	863	--	--	--

Table Descriptors:

- Goal:** Adults receiving SMHA services will report an improved level of functioning as a result of treatment services provided.
- Target:** To achieve at least 67% or higher report of improved functioning.
- Population:** Adults with a serious mental illness (SMI).
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services  
4:Targeted Services to Rural and Homeless Populations
- Indicator:** Subjective report of improved functioning; objective regional reports of increased functioning in areas of psychiatric stability, work, housing, family, etc.
- Measure:** Subjective report of improved functioning; objective regional reports of increased functioning in areas of psychiatric stability, work, housing, family, etc.
- Sources of Information:** Consumer survey (MHSIP) and regional data submissions.
- Special Issues:** The Adult Mental Health program is in the process of assessing and developing a data infrastructure system capable of tracking and monitoring data necessary to report on NOMS.
- Significance:** National Outcome Measure.
- Action Plan:** The goal for SFY 2009 was to establish a baseline of improved functioning. Based on subjective report of improved functioning on the MHSIP Consumer Survey, 64.77% in 2008 and 66% in 2009 reported improved functioning. The goal for SFY 2010 is to increase subjective MHSIP Consumer Survey reports of improved functioning to 67% or more.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** ACT Outcomes and Fidelity Measurement

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	7	6	4	3	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** The State will continue to develop and fund innovative projects, enhance service delivery, provide training as well as provide adequate funding to provide accessible, high quality and evidence based mental health services.
- Target:** The Adult Mental Health Program will conduct ACT fidelity assessment on no less than three existing ACT or forensic ACT teams in SFY 2010.
- Population:** Adults with SMI who are receiving ACT or forensic ACT (FACT) services from regional SMHAs.
- Criterion:** 5:Management Systems
- Indicator:** The number of completed ACT or FACT fidelity assessments.
- Measure:** Total number of completed ACT or FACT fidelity assessments conduct during SFY 2010.
- Sources of Information:** Adult Mental Health Program DACTS scores/review, regional information, Behavioral Health Monthly Data Report.
- Special Issues:** This objective supports the State Planning Council's priorities on quality and continuum of care. While the Dartmouth Assertive Community Treatment Scale (DACTS) is used for determining fidelity, the DACTS does not completely and accurately reflect ACT services in rural and frontier areas, or effectiveness of services provided to mental health court referred clients. For example, one item on the DACTS encourages a low graduation rate. Mental health court referred clients are successful when they graduate from the program.
- Significance:** ACT teams provide community based services to adults with a serious and persistent mental illness who require intensive services to maintain in a least restrictive, community setting and forensic ACT services to eligible adults referred through regional Mental Health Courts. Fidelity assessments help to determine fidelity to the model and provide an opportunity for both feedback and sharing of information on best practice service delivery.
- Action Plan:** Data relating to ACT services and to MH Court ACT services is manually counted through the Behavioral Health Monthly Data Report form. The Adult Mental Health Program has selected the DACTS Fidelity Scale as the assessment tool to be used to measure the fidelity of the ACT program in Idaho. Assessments will be conducted on at least three regional ACT teams by a team led by the Division office with a peer reviewer from another region. Results of the fidelity assessments will be utilized by Division administration in the planning process to improve the ACT service delivery system in Idaho.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** AMH Data System

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	1	1	1	1	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** Provide standardized, accurate and timely outcome based data reports for the Adult Mental Health Program.
- Target:** Implement the WITS data infrastructure systems (regions) that was developed in SFY 2009.
- Population:** Adults with SMI
- Criterion:** 2:Mental Health System Data Epidemiology
- Indicator:** AMH WITS system implementation for by June 30, 2010.
- Measure:** The AMH will implement the WITS system in the regions by June 30, 2010.
- Sources of Information:** ITSD, Division of Behavioral Health, State Hospitals
- Special Issues:** Regions piloted a December 2006 interim method of manually capturing critical data through the Behavioral Health Monthly Data Report. The Adult Mental Health program explored requirements in SFY 2008, and installed the WITS data system in SFY 2009.
- Significance:** It is critical that the SMHA accurately report and identify the populations being served and the outcomes of services provided. Reliable and valid data is necessary for informed decision making by Health and Welfare, the State Planning Council on Mental Health and the Idaho Legislature.
- Action Plan:** The Division of Behavioral Health developed the WITS system in regions and at central office in June 2009. The WITS system will be implemented for electronic health record data collection in the seven regions of the State of Idaho by June 30, 2010.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Attend Medication Appointment After State Hospital Discharge

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	70.70	67.60	75.40	70	N/A
Numerator	323	261	--	--	--
Denominator	457	386	--	--	--

Table Descriptors:

- Goal:** Persons with serious mental illness discharged from a state hospital will have ready access to community-based mental health services.
- Target:** Achieve a rate of 70 % or higher for persons discharged from a state psychiatric hospital who attend their scheduled first medication follow-up appointment with their physician or physician extender.
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of persons discharged from a state hospital who keep their first medication follow-up appointment with a physician or physician extender at their community mental health provider.
- Measure:** Numerator- Number of persons who keep their first medication follow-up appointment with a physician after discharge Denominator- Number of persons discharged from a state hospital as measured by total number of discharge survey results.
- Sources of Information:** State Hospital data bases, discharge survey
- Special Issues:** This objective supports the Planning Council's objective on quality, continuum of care and community supports.
- Significance:** Attending the first medication follow-up appointment in the community is a key indicator of successful community reintegration and treatment compliance.
- Action Plan:** All persons discharged from a state hospital have a medication follow up appointment with their community mental health provider scheduled prior to their being discharged from the state hospital. Additionally, a policy has been implemented in the adult mental health program which strongly encourages that all persons discharged from a state psychiatric hospital will be opened for follow up services by the regional CMHC for a minimum of 30 days. This will allow for consistent and coordinated discharge planning between the hospitals and the CMHC's. A post discharge survey is conducted by the regional CMHC staff on all persons discharged from a state psychiatric hospital. The surveys are then sent to SHS for data tabulation.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Co- Occurring Disorders Training

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	3	2	2	1	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** Idaho is working to implement a best practice model of integrated treatment to serve those with co-occurring substance use and mental health diagnoses.
- Target:** The Adult Mental Health Program will provide at least one (1) training opportunity for CMHC staff on treatment strategies for co-occurring disorders.
- Population:** Adults with SMI
- Criterion:** 5:Management Systems
- Indicator:** Co-occurring treatment training provided through on-line course covering Tip 42.
- Measure:** The number of training opportunities provided and completed.
- Sources of Information:** Adult Mental Health Program, number of training opportunities on integrated treatment for co-occurring disorders.
- Special Issues:** A primary emphasis of the ACT teams in Idaho is provision of collaborative services to participants in the Idaho Mental Health Court programs. One of the the essential core components is the ability to provided integrated treatment for persons with co-occurring disorders. In an effort to ensure cost-effective training during a context of budget cuts, DHW will develop a course based on Tip 42 that will be accessible by regional SMHA MH and SUD staff before 6/30/09.
- Significance:** This objective supports the Planning Council's priorities on continuum of care as well as the President's New Freedom Recommendations related to Goal 5. This has also been identified as a system training priority by the Adult Mental Health Program Managers. MH and SUD providers in all 7 regions completed their DDCAT baseline in SFY 2009. Also in SFY 2009, there were two training opportunities by June 30, 2009. Each of 7 regions (SUD & MH) implemented Tip 42 training. Additional training was provided at the Idaho Conference on Alcohol and Drug Dependence (ICADD; 5/2009).
- Action Plan:** The Adult Mental Health Program will facilitate the development of an on-line co-occurring treatment course based on Tip 42 for regional CMHC and SUD staff SFY 2010. The course will include an evaluation component and a certificate for each section completed.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Follow Up Appointment Within 7 Days of Discharge

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	92.20	89.10	85.79	85	N/A
Numerator	412	344	--	--	--
Denominator	457	386	--	--	--

Table Descriptors:

- Goal:** Adults diagnosed with a serious mental illness who are discharged from a state hospital will have ready access to community based mental health services.
- Target:** Achieve a rate of 85% or higher for the number of persons seen for a first face to face appointment at their community mental health provider within 7 days of discharge from an Idaho state hospital.
- Population:** Adults with SMI
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of persons seen at their community mental health provider within 7 days of discharge from an Idaho state hospital.
- Measure:** Numerator: Number of persons seen by their community mental health provider within 7 days of discharge from a state hospital.  
Denominator: Number of persons discharged from a state psychiatric hospital as measured by discharge survey results.
- Sources of Information:** State hospital database, discharge survey
- Special Issues:** None
- Significance:** Timely follow-up in the community is a significant indicator for successful community integration and reduction of re-hospitalization. This objective supports the Planning Council priorities on quality, continuum of care and community supports.
- Action Plan:** An adult mental health policy requires that persons discharged from a state psychiatric hospital be opened for follow up services by the regional CMHC for a minimum of 30 days to allow for consistent and coordinated discharge planning between the hospitals and CMHC's. A post discharge survey is conducted by regional CMHC staff on all persons discharged from a state psychiatric hospital, with surveys sent to SHS for data tabulation.

# Idaho

## Child - Establishment of System of Care

Child - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

Idaho Code section 16-2404(1) states that "The department of health and welfare shall be the lead agency in establishing and coordinating community supports, services and treatment for children with serious emotional disturbance and their families, utilizing public and private resources available in the child's community. Such resources shall be utilized to provide services consistent with the least restrictive alternative principle, to assist the child's family to care for the child in his home and community whenever possible. The state department of education shall be the lead agency for educational services."

Section 16-2404(2) states that "The department of health and welfare, the state department of education, the department of juvenile corrections, counties, and local school districts shall collaborate and cooperate in planning and developing comprehensive mental health services and individual treatment and service plans for children with serious emotional disturbance making the best use of public and private resources to provide or obtain needed services and treatment."

The Department of Health and Welfare is organized so that the children's mental health service responsibility resides within the same division as Adult Mental Health and Substance Use Disorders Programs. State Hospital South has an adolescent unit for in-patient care and also falls under the same Division. Medicaid is a separate Division within the Department of Health and Welfare. Child Welfare services are also located in the same Department, but in a separate division, the Division of Family and Community Services.

The Department, through the Division of Behavioral Health, provides children's mental health services through seven regional service centers. A variety of Behavioral Health employees staff these regional field offices. This network of field offices extends into all counties providing at least minimum access to departmental services across the state.

The State of Idaho is developing, implementing, promoting and evaluating an integrated system of care that is community-based and family focused for children with SED. This development is lead by Idaho's youth consumers and families in partnership with the Department's Behavioral Health Division, but is supported and is collaboratively implemented by state and local Juvenile Justice, Education, the Idaho Federation of Families for Children's Mental Health, the Child Welfare system, Medicaid, and other public and private agencies that serve Idaho's youth. The details of this transformation will be detailed in the sections that follow.

# Idaho

## Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;  
Employment services;  
Housing services;  
Educational services;  
Substance abuse services;  
Medical and dental services;  
Support services;  
Services provided by local school systems under the Individuals with Disabilities Education Act;  
Case management services;  
Services for persons with co-occurring (substance abuse/mental health) disorders; and  
Other activities leading to reduction of hospitalization.

## -HEALTH, MENTAL HEALTH, REHABILITATION SERVICES

The system of care for children and youth with serious emotional disturbance encompasses those services provided through the Department of Health and Welfare and services provided by other public agencies, non-profit agencies and the private service sector.

Private providers of mental health services exist throughout the state. Private provider services range from outpatient clinic services and psychosocial rehabilitation services to residential and inpatient care. Services may be paid through Medicaid, private insurance, self-pay, and contracts. Comprehensive services exist within the state, but not in all areas of the state or in sufficient quantity.

The Department has developed service definitions and measures for the following services within the comprehensive system of care:

- Assessment
- Case management
- Respite Care
- Family Support
- Therapeutic foster care
- Crisis response
- School Mental Health Services
- Outpatient treatment
- Residential Treatment
- Inpatient Hospitalization

These definitions will provide for consistency of services throughout the state, measure services provided, identify gaps in services, and clearly describe the comprehensive array of services. The Department has developed CMH Core Service Standards for the 10 core services that give direction to each of the 7 Department regions. These standards provide direction in the development of the core services in each of the regions. The state is moving towards statewide consistency in the application of these services in order to best meet the needs of children with SED and their families.

The State of Idaho, through the Department of Health and Welfare, Division of Behavioral Health, operates one psychiatric inpatient unit for adolescents, State Hospital South Adolescent Unit (SHSAU). This unit has the capacity for 16 adolescents (ages 12 - 17 years of age).

The role of the SHSAU within the state's system of care is to provide inpatient stabilization and treatments requiring intermediate lengths of stay that average 45 to 90 days. Brief, short-term emergency/acute inpatient care must occur at a local level, not at the State Hospital level. Longer term care and treatment following stabilization at the State Hospital is a function of treatment families, residential treatment and group care.

In 1997, Idaho implemented the Rehabilitation Option as part of its Medicaid Plan. The intent of Idaho's Rehabilitation Option is to provide community-based services to children with serious emotional disturbance and to adults with serious and persistent mental illness. The SED definition used to determine Rehabilitation Option service eligibility is consistent with the federal definition pursuant to section 1913 (c) of the Public Health Service Act as amended by Public Law 102-321.

One key feature of Idaho's Rehabilitation Option is the recognition that Medicaid Rehabilitation Option funding is a public resource and should be expended on that population for which the public has service responsibility, the child with a serious emotional disturbance. The Rehabilitation Option is a vehicle through which public Medicaid resources can flow to the private sector enabling them to assist in serving the target population. The Medicaid Prior Authorization Unit, through their service provider system, accomplishes this. Medicaid continues to build provider networks by forming public-private partnerships with providers who want to access Medicaid funds under the Rehabilitation Option. Interested providers negotiate and sign provider agreements through Medicaid. It is important to note that not all children are Medicaid eligible and therefore, the Department's Behavioral Health Division provides these same services through other funding sources to ensure equal access.

DHW's strategic plan guides the delivery of all the services offered by the Department. The mission of DHW is to "Promote and protect the health and safety of all Idahoans." This is reflected in the CMH program's approach to services for children with SED. In order for children with SED to live and participate fully in their communities, the overall health of the child is an important consideration. Each child presented to DHW for determination of service eligibility receives an assessment which identifies not only the mental health needs of the children, but their overall health needs concurrently.

## EMPLOYMENT SERVICES

Employment services and transition services are a major responsibility of the State Department of Education (SDE). SDE was recently awarded a federal grant to improve secondary transition services by increasing the ability to gather data regarding performance indicators of post secondary school students. Additionally, the Department of Health and Welfare has in place a requirement of transition planning for any child receiving services by their 16th birthday. This includes both transition to adult mental health services and transition to adulthood and employment.

Youth in transition additionally have access to vocational rehabilitation services through Idaho Vocational Rehabilitation (IVR). This is accessed through their school or through direct referrals. IVR has its own eligibility criteria for services. Children that have been in placement for 90 consecutive days through a voluntary placement agreement also have access to Independent Living funds.

The Department's Behavioral Health division additionally participates on the statewide Policy Council for Secondary Transition established through the State Department of

Education. The council acts as a steering committee to assist the State of Idaho in planning for all youth with disabilities during their transition to adulthood and therefore higher education and employment.

## HOUSING SERVICES

Idaho Code identifies services to children and youth as only being delivered to children whose parents have provided informed consent to the services. Typically the parents of the child have the responsibility to provide housing to children receiving community based services. However, every child whose parent has provided informed consent and applies for CMH services receives an assessment. The child's clinical case manager has a responsibility to assess the child and family's housing needs and assists the family in finding appropriate housing to care for their family.

Idaho Housing is a statewide agency that provides subsidized housing for low income families. Idaho also maintains a statewide toll-free phone number, called the Idaho Housing Information and Referral Center, to assist families in addressing their housing needs. This information can also be obtained through Idaho's 211 Health and Resources center, called the Idaho CareLine. Families with children are a priority group for Idaho Housing.

The only way that an Idaho youth can be emancipated is through marriage and with their parent's consent, therefore there has been little need to assist with the housing needs to children served with the exception of transition. Please refer to Criterion 4 for additional information on services for homeless children and families.

## EDUCATIONAL SERVICES

The State Department of Education (SDE) provides federal and state funding to 114 independent local school districts and several charter schools. Services provided under the Individuals with Disabilities Education Act are provided by the local school districts based upon the child's need and identified through the Individual Education Plan. Services are provided according to state and federal IDEA requirements. Education faces some of the same barriers as other child serving systems in Idaho. One of the major factors is the rural nature of Idaho and access to services in local communities. More children would be served in schools with the development of more local resources. The Bureau of Special Populations of the State Department of Education utilizes an advisory board, called the Special Education Advisory Committee, to provide guidance to education professionals as they work towards meeting the requirements of the No Child Left Behind Act.

School mental health services to students with SED are delivered through a partnership between local school districts and the Department of Health and Welfare. These services range from school companion services to intensive day treatment services. The State Department of Education and the Department of Health and Welfare have collaborated to

create Student Support Standards that can be used to ensure that children with emotional and behavioral disturbance have the necessary supports to allow them academic success.

For additional information, please see the section below related to services provided under the Individuals with Disabilities Education Act.

## SUBSTANCE ABUSE SERVICES

The Department's Substance Use Disorders program is within the same division, the Division of Behavioral Health, as mental health. Division administration is focused on the integration of substance abuse services and mental health. The majority of substance abuse services are delivered by contractors located across the state and range from preventative services to outpatient and intensive inpatient services. The following are the guiding principles expected of each substance abuse treatment provider:

- Are based on consumer needs;
- Involve communities in program development mental health. and oversight;
- Have measurable outcomes;
- Provide easy access and facilitate smooth transitions from service to service and provider to provider;
- Provide for a full continuum of services;
- Are managed by leaders who create a culture of quality, effectiveness and efficiency;
- Are staffed by qualified people committed to providing quality services in the most cost-effective and efficient manner possible; and
- Have fair and objective systems to manage consumer complaints and concerns and assess responsibility for those problems and concerns.

The Department maintains one statewide contract for substance abuse services with Business Psychology Associates (BPA). BPA then subcontracts in each region for individual services providers. Outpatient and inpatient services are available to every region in the state, but not necessarily located in every region of the state. Youth 15 years and under are required to have parental consent for services, while 16 and older can access services without parental consent.

Division of Behavioral Health's is developing its ability to meet the needs of individuals with co-occurring substance and mental health disorders. It is based on Dr. Minkoff's nationally recognized model and Idaho is the initial stages of implementation. The Division is committed to developing a treatment system for individuals with co-occurring disorders. The Idaho Legislature lead an effort to coordinate with all substance use disorder providers by utilizing the same instrument, the GAIN series of screening and evaluation.

## MEDICAL AND DENTAL SERVICES

Medical benefits to Children with SED may be provided through Medicaid, Children's Health Insurance Program (CHIP), private insurance, the county system and/or other

private systems. Eligible children and families have access to medical and preventative health services through Health Districts. Idaho's seven health districts are primary outlets for public health services. These districts work in close cooperation with the Department of Health and Welfare and numerous other state and local agencies. Each district has a Board of Health appointed by the county commissioners within that region. Each district responds to local needs to provide an array of services that may vary from district to district. Services range from community health nursing and home health nursing to environmental health, dental hygiene and nutrition programs. Many services are provided through contracts with the Department of Health and Welfare. Additionally, the Children's Health Insurance Plan (CHIP) has had steady increase in enrollment.

Although there have been considerable measures taken to reduce Medicaid spending, children's dental services are still covered. However, Idaho has very few dental service providers that will accept Medicaid insurance. Especially impacted by this shortage are the rural communities. The Idaho Dental Association has implemented an educational dental hygiene program that, in cooperation with schools, works toward increasing awareness of dental care. Additionally, a collection of dentists in the state are donating time to provide free dental care for children to low income families.

Idaho Medicaid is working toward enrolling all individuals with Medicaid or CHIP in the Healthy Connections Program. The Healthy Connections Program is a managed care model that requires a physician's referral for non-emergent health services. This has the potential to increase the overall quality of health care for Idaho's children with public health insurance. Healthy Connections referrals require physicians to give regular check-ups to children and be involved and informed of their mental health services, which improves the coordination between medical and mental health services.

House Bill 376 was passed by the 2003 legislature to provide medical coverage for children and adults with income between 150-185% of the Federal Poverty Guidelines. CHIP-B, in response to this legislation, is low cost health coverage for Idaho children who don't have insurance and don't qualify for Idaho Medicaid or regular CHIP.

Quality health care is more difficult to ensure for children without public health insurance. However, as part of the Comprehensive Assessment that is completed by the Mental Health Authority on every child receiving services, the medical history and current status is evaluated and, if needs are apparent, they can be included in treatment planning.

Idaho has, in recent years, been a national leader in identifying Medicaid modernization activities. Idaho Medicaid has implemented a tiered system that provides that right coverage to the population needing that coverage. The system is divided into a basic plan that includes most physical health care services and an enhanced plan that is directed at those in need of disability specific services. As with all state, Idaho is trying to control cost increases while simultaneously providing high quality health care coverage to Idaho citizens. Early indications demonstrate that this model is achieving both outcomes.

## SUPPORT SERVICES

It is clear from the analysis of the target population and the prevalence figures of SED in children and youth (as provided in Criterion #2) that a considerable number of children with major mental health problems are not served by the public agencies. The majority of children with a SED who do not qualify to receive mental health services through the public sector, either are not served or are served through the private sector and/or school special education system. In addition, as the 1999 Needs Assessment points out, many of Idaho's children with a SED are served through the Juvenile Corrections system. While often inappropriate, this may be the only resource families have available to meet their children's mental health needs. A much larger private mental health system does exist and is comprised of various providers. Whether the private mental health service system has the capacity to serve the number of children and youth having serious emotional disturbance effectively is difficult to determine. The true capacity of the private provider system is unknown and there is currently no data system(s) which can determine an unduplicated count of the number of SED population who receive services from providers in the private service sector. This should be less of an issue as the Division of Behavioral Health moves into the "managed care" role and develops more private provider contracts.

Additionally, as part of DHW's Core Children's Mental Health services, family support services and respite care are offered to families served by the system. Family support services include family preservation services, individual and marital counseling to the parent/guardians of children with SED, transportation services, parent skills training and education, flexible funding to assist families in meeting their needs related to the health and well-being of their child, and peer support. DHW also maintains a contract with the Idaho Federation of Families for Children's Mental Health for family support and advocacy on behalf of children with SED and their families. A primary responsibility of the Federation under this contract is the development of a statewide family to family support network.

Respite is another service offered to families needing a temporary break from their care giving responsibilities. It is important to allow the parents and siblings of children with SED a break as that can often allow the family time to recover from the intensity of caring for a child with a SED. The Department contracts with the Idaho Federation of Families for Children's Mental Health to provide a statewide respite information and referral center and to recruit and train respite care providers. The Federation receives an incentive of \$50 for every provider recruited in a urban area and \$100 for recruits from a rural area.

## SERVICES PROVIDED BY LOCAL SCHOOL SYSTEMS UNDER IDEA

There are 114 independent local school districts in Idaho, all of whom are required to make the necessary considerations available to children on Individualized Educational Plans under IDEA if the child is determined qualified for special education. These

services are detailed in the following outline as prepared and approved by the Idaho Association of School Administrators, Special Education Directors:

- A. Individuals with Disabilities Education Act (IDEA)
  - i. Each district is required to identify individual students as disabled and deliver appropriate educational services:
    - 1. Child Find/Referral processes
    - 2. Evaluation/Eligibility processes
      - a. 15 Categories of disability type with evaluation and eligibility criteria for each. SDE provides the evaluation and eligibility criteria for each category. There must be substantial 'Educational Affect.'
      - b. Eligibility is a decision of the IEP Team with parent as a member.
    - ii. Specially Designed Instruction- outlined as goals and objectives on an Individualized Education Plan (IEP)
    - iii. Related Services - assist in meeting IEP goals. Listed on the IEP with goals/objectives. (Includes such services as speech and language therapy, occupational therapy, physical therapy, counseling, etc.)
    - iv. Least Restrictive Environment - as close to classroom setting as possible. Decision is made by the IEP team with parents as partners.
    - v. Review and Re-evaluation- Decisions regarding program are made annually. Eligibility- annually or at least every 3 yrs.
    - vi. Transition Requirements- At the age of 14, the school district is required to assist the student and his/her family with transition to life outside of school. Includes planning high school coursework and graduation requirements; offering career exploration and opportunities for work experience; and, perhaps teaching independent living skills. The district must contact and refer students and families to outside agencies such as Health and Welfare and Vocational Rehabilitation that can assist the student in transitioning to that life after school.
    - vii. Behavior- required to consider behavior management for students whose behavior interferes with theirs or others education program.
      - 1. Evaluation- Individualized functional behavior assessment
      - 2. Behavior Plan is part of IEP
      - 3. Usually includes training in social skills, anger management, etc.
    - viii. The decision whether to use outside providers to deliver special education or related services is the districts'. Decision to allow private providers to deliver services during school day is also district specific.

## CASE MANAGEMENT SERVICES

Stroul and Friedman (1986) refer to case management as the "backbone of the system of care" and as the cohesive element that holds the system of care together. Case management plays a key role in the coordination of services to children and families in the system of care. The children and families encountering the Department demonstrate a multiplicity of needs. These multiple needs, in turn, result in multiple service/agency involvement. Since no one type of service or program element is sufficient to meet all

needs of the child and family, case management is essential and includes several functions:

- Mental Health Assessment
- Service Planning
- Service Implementation
- Service Coordination
- Monitoring and Evaluation
- Advocacy

Clinical case management is the process of facilitating, linking, monitoring, and advocating for children and their families to ensure that multiple services, designed to meet a family's and a child's need for care are delivered in a coordinated and therapeutic manner. Clinical case management should be child centered and family focused to meet the goals of treatment outcomes, to be culturally sensitive, community-based, and provided in the least restrictive, most appropriate and most cost-effective setting with the needs of the child and family dictating the types of services provided. Clinical case managers are trained mental health professionals who have a clinical knowledge of human behavior theories and psychopathology, as well as a thorough knowledge of the philosophy of various therapeutic approaches. Clinical case managers are able to provide accurate assessments, create and coordinate service plans, and know when and how to intervene.

One of the essential features of effective case management is the manager's ability to access a broad array of services on behalf of the child and family. Equally important is the case manager's ability to help develop an individualized service plan with the child and family. Effective case managers must acknowledge parents as equal partners in the treatment program. This means parents having a voice in all decision making regarding their children. Ideally, the parents are co-case managers. An effective case management system makes flexible funds available and easily accessible to the case manager and family.

Idaho's children's mental health program currently relies very little on receipts to fund services. Staffing of services, especially case management, continues to be accomplished through a mix of general and block grant funds. One of the recommendations in the court-approved plan is to explore the feasibility of billing Medicaid for case management. Another is to develop standards for case management to be applied consistently across the state. Clinical case management is the primary service that is delivered directly by Department clinicians. Case management may be this service system's greatest strength. However, while case management is a strength of the system, the system cannot meet the case management needs of all children and youth experiencing serious emotional disturbances due to capacity issues.

Children and youth with serious emotional disturbance who are Medicaid-eligible and are receiving services from the private service sector can access case management (called service coordination) through Medicaid's Early Periodic Screening Diagnosis and

Treatment Program (EPSDT). Service Coordination provided by private practice Service Coordinators is a Medicaid-reimbursable service.

The Children's Mental Health program has implemented Wraparound services. Wraparound is typically considered a highly effective, but resource intensive service and is therefore reserved for the most difficult cross system cases. Wraparound is also utilized to avoid expensive out-of-home placements.

## SERVICES TO CHILDREN WITH CO-OCCURRING DISORDERS

Children and youth with co-occurring serious emotional disturbance and substance abuse disorders can access services for both, if they qualify, concurrently. Services are delivered by two different programs within the same division of the Department of Health and Welfare, the Division of Behavioral Health. Most services for both mental health and substance abuse are delivered by private providers; however, these services are expected to be delivered through a collaborative service model. The first step in the intake process for Children's Mental Health is to provide a comprehensive assessment to each child applying for services and substance abuse is assessed as an area for inclusion in recommendations for additional services. The Department is using the GAIN-Q as the screening instrument for co-occurring disorders.

As stated above, Idaho is currently toward being co-occurring ready by enhancing the Division of Behavioral Health's ability to meet the needs of individuals with co-occurring substance and mental health disorders. Dr. Minkoff's model is nationally recognized and Idaho is the initial stages of implementation.

It is important to point out that there is another class of co-occurring disorders, which is that of mental health and developmental disabilities. This is an ever growing population as families struggle to find appropriate serves for their children. The two Divisions within the Department that provide services to children with SED and developmental disability services collaborate to provide coordinated services. Wraparound teams frequently include developmental disability providers as well. However, this continues to be one of the most difficult populations to serve.

## ACTIVITIES TO REDUCE HOSPITALIZATIONS

The ability of a system of care to reduce restrictive inpatient placements is dependent upon that system's ability to provide alternative intensive community-based services. One strategy that the Division employs to help expand community-based services and reduce inpatient placements is to continue channeling financial resources from traditional out-of-home contracts to community-based contract services.

The Children's Mental Health Services Act provides guidelines for accessing community-based services. The Act, in the purpose and legislative intent language, emphasizes that the mental health system be community-based. The law requires that services occur when the child is in the home whenever possible. It limits out-of-home placement to

circumstances in which safety may be jeopardized or there is risk of substantial mental or physical deterioration without treatment out of the home. The law also prescribes guidelines for least restrictive treatment principles and safeguards and review processes to determine the necessity for initial and continued out-of-home care. The continued expectation is that this comprehensive Act, passed in 1997, will be fully implemented.

In 1998, the Department instituted Medicaid Reform for children by allowing Medicaid payments for services in all licensed inpatient psychiatric hospitals. Previously, only psychiatric units attached to general medical and surgical centers could receive Medicaid reimbursement. Services in 'free standing' psychiatric facilities or Institutes for Mental Disease (IMD's) were not Medicaid-reimbursable. Often the lack of available local acute intensive services in the community has contributed to a commitment and placement in the state hospital facility -- a facility often located hundreds of miles from the youth's home. In some instances, it has been necessary to make a voluntary inpatient placement away from the child's home and community. In rare cases, placement has been made out of state in a Medicaid-reimbursable unit. By making all inpatient psychiatric hospital services Medicaid reimbursable, more children and youth have access to shorter-term, acute inpatient services closer to their homes and families. This feature of the state's Medicaid plan fills a gap in several local systems of care by providing emergency stabilization and averting penetration into 'deeper end' levels of care. Implementation of a prior authorization and concurrent review process ensures there is a need for all admissions and continued stays.

The Division is committed to reduction of out-of-home placements while taking into account issues of risk/safety. Children are placed outside the home only when necessary as indicated by risk factors and/or the inability of the community-based service system to provide adequate services to assure safety. The Division uses regional placement review teams including the child and their parent(s)/guardian(s) as a mechanism for quality assurance, placement gate keeping, and intensive screening. All out-of-home placements (except for traditional foster care services) are reviewed to ensure that (a) out-of-home services are needed and (b) reasonable efforts have been made to prevent such placement. Following placement, a review process is used which focuses on (1) progress towards goal attainment while tracking determined measurable outcomes, (2) further planning (3) continued need for placement services, and (4) planning toward return to home or other less restrictive care. It is expected that this review process, as well as all treatment and transition plans, be done in conjunction with the child and his/her family members. Providers must demonstrate family involvement as part of their contract criteria.

The Medicaid Division has a contract with Qualis Health Care to provide prior authorization of psychiatric hospitalization placements. This contract includes an agreement with the regional CMH programs to review the intake assessment and history to make a determination of lesser restrictive placement options. Every time a determination is made, the CMH program sends a letter to the parents of the admitted child notifying them of services available from DHW to avoid further hospitalization. The CMH program has also developed standards for inpatient services that outline the requirements for discharge planning and follow up.

Additionally, a modification in the Medicaid rules allows all children coming out of hospitalization to have access to 120-days of Psychosocial Rehabilitation services to assist in transition and skill building to avoid re-admissions.

# Idaho

## Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

**1. GENERAL DESCRIPTION OF THE SED POPULATION**

For purposes of estimating the prevalence of serious emotional disturbance and the scope of this public health problem among children and youth, Idaho continues to use the federal definition pursuant to section 1912 (c) of the Public Health Service Act as amended by Public Law 102-321 which includes those children and youth:

"From birth up to age 18, who currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV, that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. A substance abuse disorder or developmental disorder, alone, does not constitute a serious emotional disorder although one or more of these two disorders may co-exist with a serious emotional disorder. "

**2. IDAHO PREVALENCE ESTIMATES**

Serious emotional disturbance must be considered in a broad context, including and distinguishing among various degrees of emotional disturbance based on the levels of impairment. It is also important to show the relationships between these groups and Idaho's target population. To determine the prevalence of serious emotional disturbance among children and adolescents and their needs, the State of Idaho continues to use nationally obtained prevalence estimates.

Knowing the pervasiveness and persistence of a disorder is helpful in determining prevalence of serious emotional disturbance. Pervasiveness is usually measured by the degree of impairment to a child/youth's adaptive functioning or life skills. Most definitions of serious emotional disturbance require that, because of the mental illness, there be substantial or significant degrees of impairment in the youth's functioning in multiple life domains. The Center for Mental Health Services (CMHS) includes, as one component of its SED definition, "impairment such that there is substantial interference with a child's role or functioning in various life domains and adaptive skills" (Federal Register, May 20, 1993). Persistence or duration as a characteristic of a "serious" disorder is highlighted by Idaho Code. Idaho's Children's Mental Health Services Act includes, as one element of its SED definition, that the disorder "requires sustained treatment interventions" (Idaho Code, Title 16, Chapter 24, sections 2403).

The estimated number of children under 18 years with an SED in Idaho is 18,709 (see table below). This estimate is based on the 2007 US Census data and uses a conservative estimate of 5.0% of Idaho's children under the age of 18 years.

**Projected Population of Children with Serious Emotional Disturbance**  
**By DHW Region, FY2007**

	Regions							
	I	II	III	IV	V	VI	VII	TOTAL

<b>2007 Estimated 0 to 17 Population (2007 Census Data)</b>	47,444	20,220	64,527	98,949	45,806	46,021	51,213	<b>374,180</b>
<b>Estimated 0 to 17 Population with Serious Emotional Disturbance (5%)</b>	2,372	1,011	3,226	4,947	2,290	2,301	2,561	<b>18,709</b>

The public mental health system’s capacity and resources are limited. Some children with emotional disturbance will receive services from the private service sector. Others will receive services from the education system, the six Idaho Tribes, and from the juvenile corrections system. Most agree the public sector’s legitimate role in mental health service delivery is limited to the most seriously mentally ill.

For purposes of service prioritization, a serious disorder is operationally triaged in order of priority:

- I.** The child is an imminent danger (risk to safety) to self or others (suicide/homicide) due to a substantial disorder of thought, mood or perception. This additionally includes the child who evidences an inability to meet basic needs for safety or evidences gross impairment in reality testing such as requiring 24 hour supervision and care and as indicated by DHW's assessment process.
- II.** Due to the presence of a serious emotional disorder, the child is at risk of out-of-home placement, is currently in out-of-home placement, or is returning from a psychiatric inpatient or residential placement due to experiencing substantial multiple living problems including school, home, interpersonal or community, which are attributable to a substantial disorder of thought, mood, or perception.
- III.** Due to the presence of a serious emotional disorder, the child evidences substantial impairment in functioning in family, school or community, as determined by standardized measures/criteria.

The Department has adopted the Child and Adolescent Functional Assessment Scale (CAFAS) as the method for determining substantial impairment. The operational definition of SED for the Department must include a DSM-IV diagnosis and a functional impairment as documented by the CAFAS. The complete definition is:

“An Axis I diagnosis according to the DSM-IV clinical criteria is required. A substance abuse disorder or developmental disorder alone does not by itself constitute a serious emotional disturbance, although one or more of these disorders may co-exist with a serious emotional disturbance. Co-existing conditions require a joint planning process that crosses programs and settings. V-

Codes are not considered an Axis I disorder for purposes of this definition. The Child Adolescent Functional Assessment Scale (CAFAS) will be used to determine the degree of functional impairment. The child/adolescent must have a full-scale score (using all 8 sub-scales) of 80 or above and “moderate” impairment in at least one of the following three scales: Self-Harmful Behavior; Moods/Emotions; Thinking.”

This definition is more narrowly defined than the federal definition as it excludes stand alone conduct disorder. This definition is used to identify the targeted service population. The prevalence and general estimates use the federal definition. As services and resources expand, the Idaho service definition may be modified to be more inclusive. The Department will review the operational definition annually to determine the need for modification.

According to the National Prevalence figures prepared for MHSIP by the National Research Institute and distributed by CMHS, the following table describes Idaho’s 2005 prevalence of SED. Background details on these procedures have been published previously in Federal Register Notices. Current county estimates are not available; however, the methodology could be adapted to the county level.

State	Number of Youth 9 to 17	Age 5 - 17 Percent in Poverty	State Tier for % in Poverty	Level of Functioning Score=50		Level of Functioning Score=60	
				Lower Limit	Upper Limit	Lower Limit	Upper Limit
Idaho	191,326	12.9%	Mid	11,480	15,306	19,133	22,959

One change in the last year with the creation of the CMH rules discussed in the New Legislation category is the inclusion of children and youth with conduct disorders. The State of Idaho has not included Conduct Disorder in the list of approved diagnoses until the passage of these rules. The impact of this expansion is not yet fully realized, however, the Juvenile Justice Blue Print for Change identified that approximately 90% of adolescents diagnosed with conduct disorder meet the criteria for at least one other diagnosis.

### 3. ACCESS TO SERVICES FOR SPECIAL POPULATIONS

Two populations requiring special note are the highly rural and ethnic minority populations. Historically, these groups either do not have easy access to services, or if there is access the services are not relevant to their needs, strengths and contexts. Access to services for rural populations will be addressed in Criterion 4.

The dually diagnosed is another special population that requires a higher level of coordination and cooperation. The Idaho State School and Hospital (ISSH) is a state run institution that has historically served individuals with developmental disabilities. With the increasing identification of co-existing disorders, developmental disorders and mental illness, ISSH has expanded their capacity to include dually diagnosed. Additionally, Medicaid, Family and Community Services and the Division of Behavioral Health

working together have developed an intensive community-based service called Intensive Behavioral Interventions (IBI). IBI is designed to provide skill-based rehabilitative type services to children/youth that have a developmental disorder and for the dually diagnosed. See Criterion 1 for information on services to children with co-existing substance abuse and serious emotional disturbance.

**4. ETHNIC AND MINORITY POPULATIONS**

Idaho is predominately a Caucasian state. According to Year 2006 census data, 86% of Idaho’s population is white. The racial composition of the remaining 14% of Idaho’s population is as follows:

BLACK/ AFRICAN AMERICAN	NATIVE AMERICAN/ ALASKA NATIVE	ASIAN	NATIVE HAWAIIAN/ PACIFIC ISLANDER	LATINO/ HISPANIC
1.1%	1.6%	1.0%	0.5%	9.8%

Idaho’s largest ethnic minority, representing 9.8% of the state’s total population, is of Hispanic heritage. Region III and V especially have large concentrations of people who are Hispanic. (Appendix D)

Given that only 14% of the population is non-Caucasian, the system tends to be ethnocentric. This results in a general lack of development of services that are relevant to any group other than the dominant culture.

Planning for mental health services must more fully address access to culturally relevant services for this minority population. The Department of Health and Welfare has a Program Manager with a primary responsibility of coordinating with the Idaho tribes. The Department of Health and Welfare has ongoing networking activities with the six Idaho Indian tribes through the Idaho State and Indian Tribal Child Welfare Committee that meets quarterly. The Department continues to allocate \$200,000 in Social Service Block Grant funds to the six Idaho tribes for the enhancement of tribal child welfare services. Additionally, the ICCMH has chartered a Tribal Coordinating Council (TCC) to oversee mental health services to Native American youth. DHW has set aside \$15,000 as budget for this use.

# Idaho

## Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

The estimated number of children under 18 years with an SED in Idaho is 18,709. This estimate is based on the 2007 US Census data and uses a conservative estimate of 5.0% of Idaho's children under the age of 18 years.

The public mental health system's capacity and resources are limited. Some children with emotional disturbance will receive services from the private service sector. Others will receive services from the education system, the six Idaho Tribes, and from the juvenile corrections system. Most agree the public sector's legitimate role in mental health service delivery is limited to the most seriously mentally ill.

Because of the service system's limited capacity, the target population (18,709) must be differentiated from the state's service goal -- those children who actually will receive public services. The target population (18,709) is the 'pool' of youth estimated to have a serious emotional disorder with significant and chronic impairment from which those receiving services will originate. It is estimated that 40% will need publicly funded mental health services and therefore, Idaho's service goal is 40% of the target population or 7,484 children and youth. This number is Idaho's target planning goal that, in turn, will drive public service system capacity development. This service goal includes children and youth with serious emotional disturbance served by Medicaid and/or the Mental Health Authority.

The Department's quantitative target is identified in the table below.

	<b>I</b>	<b>II</b>	<b>III</b>	<b>IV</b>	<b>V</b>	<b>VI</b>	<b>VII</b>	<b>TOTAL</b>
<b>2007 Quantitative Targets for Children/Youth with SED</b>	949	404	1,291	1,979	916	920	1,024	<b>7,484</b>

# Idaho

## Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;  
Educational services, including services provided under the Individuals with Disabilities Education Act;  
Juvenile justice services;  
Substance abuse services; and

Health and mental health services.

## INTEGRATED SYSTEM OF CARE MODEL

Idaho's system of care is a state-operated public mental health system administered through the Department of Health and Welfare with direct services provided through seven service regions. As stated in Criterion 1, the Department of Health and Welfare is the lead agency in the coordination of mental health services. To understand Idaho's system for children's mental health services, one must be familiar with the integrated children's service system model.

The Georgetown University CASSP Technical Assistance Center (Stroul and Friedman, NIMH 1986) has developed a system of care model that outlines the various dimensions comprising a total system of care. That model is function-specific rather than agency-specific and includes the following dimensions:

1. Mental health services
2. Social services
3. Educational services
4. Health services
5. Vocational services
6. Recreational services
7. Family Support services

Idaho's system of care model views these same dimensions, in addition to family organizations, juvenile corrections and substance abuse, as the important service components comprising a system of care. Idaho has organized its service delivery model according to the philosophy of integrated services. Children with serious emotional disturbance have multiple service needs. Their multiple needs cross traditional agency boundaries. Because of cross-agency involvement, coordination of services is a major issue for the family who has a child with a serious emotional disorder. Without such coordination, the potential for fragmentation of services is great. This occurs as gaps form between the boundaries of the separate programs. Families fall through these service gaps unless special bridges are formed to join the service functions. The integrated service model is an attempt to reduce the separation and resultant fragmentation between the services. Case management is the mechanism for coordinating and integrating the various services and service providers.

Since most service functions are provided by different child-serving agencies, both public and private, the Department seeks to develop interdepartmental agreements that provide for jointly operated and funded mental health services. The Department of Health and Welfare has developed, with the State Department of Education, the Department of Juvenile Corrections and the Department of Correction, a Children's Mental Health Interagency Agreement. The purpose of this agreement is to foster collaboration in planning, developing and providing services to children who are eligible for mental health services and to clarify financial responsibilities and develop methods to collaboratively use existing resources. The goal is to provide services that meet the child's need in the least restrictive setting without compromising the safety of the family or community.

## SOCIAL SERVICES:

In the current Children's Mental Health program, within the Department of Health and Welfare, children's mental health coordinates closely with child protective services, adoption/foster care services, Indian Child Welfare, and other child welfare functions. Within these programs, unlike more traditional programs, there are few boundaries and little separation of programs. Integration of services for children involved in the child protection system and who present with serious emotional disturbance can more easily occur.

The Department of Health and Welfare has organized a program called Service Integration. The goal of the program is to assist families in navigating a system that can lack internal cross system coordination. The Service Integration model recognizes that a major criticism of the Department is the number of different programs that work independent of one another and the struggle for a family or individual to access services in a large bureaucracy. The program has recently incorporated external systems, supports, and services. Additionally, the service integration program is closely connected to Idaho's Health Information and Referral center called Idaho CareLine. These is Idaho's 211 resources. The intent is that if a family's needs are met in a comprehensive way, they will avoid the need for long-term intensive services. The program has the entire array of services under its scope, including;

- Social Services
  - Medicaid
  - Health and Injury Prevention
  - Self-Reliance/Financial Support (Welfare)
  - Substance Abuse
  - Adult Mental Health
  - Developmental Disabilities
  - Infant and Toddler Program
  - Child Welfare
  - Children's Mental Health
- And coordinates with:
- Parent Run Organizations
  - Housing
  - Vocational Rehabilitation

## EDUCATIONAL SERVICES (INCLUDING SERVICES UNDER IDEA):

As one attempt to integrate children's services, the Departments of Health and Welfare and Education created an interdepartmental agreement. This agreement provides for the development and implementation of collaborative and jointly operated community-based intensive school-based programs. All regions of the state coordinate with local school districts to meet the needs of children with SED. These programs blend a combination of resources from Children's Mental Health, State Department of Education, and local school district. These programs range from traditional day treatment program models to

classroom-based program models. The eligible population for these jointly-sponsored, intensive school-based programs includes children and youth identified as seriously emotionally disturbed according to the educational system's criteria and students identified by Children's Mental Health Services criteria. It is recognized that the capacity of these programs falls short of meeting current needs.

The Idaho State Department of Education and the Department of Health and Welfare provide health, mental health and educational services under the requirements of IDEA. These services are delivered primarily by local school districts and through collaborations with other child/youth serving agencies.

#### JUVENILE JUSTICE SERVICES:

Idaho has implemented many programs and pilots to better meet the needs of youth in the juvenile justice system. First was the creation of the Juvenile Justice/Children's Mental Health Collaborative Workgroup. This group includes administrative and frontline personnel with a primary purpose of collaborating to determine the best models to meet the needs of this population of youth.

Some of the projects include, a Youth Mental Health Court. Currently the court is only providing services to three counties, but there is statewide interest in expansion. The Juvenile Mental Health Court has had tremendous success with youth offenders and utilizes the Wraparound process to facilitate treatment planning and coordination. The Department has provided one Wraparound Specialist for this court and the county has recently hired and is funding two additional Wraparound Specialists for the Juvenile Mental Health Court. The Wraparound model has been so successful that the County is now beginning to utilize it in the Juvenile Drug Courts.

Another project includes the placement of a contracted mental health professional at a juvenile detention center to assist with evaluations, referrals to services, and follow up to assist the family in accessing services outside of the center. This began as a pilot project in one detention center, but because of the success of the project, the Department has partnered with the Department of Juvenile Corrections to fund clinicians in all 13 of Idaho Juvenile Detention Centers.

#### SUBSTANCE ABUSE SERVICES:

The Substance Use Disorders (SUD) program and the Mental Health Programs for the Department of Health and Welfare are organized in the same Division. The SUD system is lead by the Interagency Council on Substance Abuse (ICSA) and the Governor's Office on Drug Policy. Locally, SUD is guided by Region Advisory Committees (RACs). The RACs include providers, consumers, state and local agencies, and include cross representation from the MH system.

Substance Use Disorders services are delivered through a statewide managed care contractor. This contractor subcontracts with several outpatient and inpatient providers

throughout the state for service delivery. Members from the state system, the managed care contractor, and the direct service providers collaborate with the mental health system to arrange and coordinate services to youth with co-occurring disorders. Idaho continues to work toward a co-occurring ready mental health and substance abuse system that is based on the Dr. Kenneth Minkoff model. Dr. Minkoff has been to Idaho several times to provide technical assistance as Idaho moves toward this model.

Idaho has initiated the Idaho Meth Project. The project takes a controversial approach to educate Idaho citizens about methamphetamines, by advertising in very graphic television and print depictions of meth users and situations. Early evidence demonstrates that the campaign has been effective in reducing first time use by youth.

#### HEALTH AND MENTAL HEALTH SERVICES:

The Division of Behavioral Health has now established a partnership with Public Health for the promotion of mental health and early intervention opportunities. The partnership is still forming, but public health districts statewide have agreed to assist clients in accessing mental health services and in preventative mental wellbeing activities. The Division of Behavioral Health has provided materials to the Health Districts for distribution that inform consumers about the signs of depression and other symptoms of mental illnesses.

The Children's Mental Health program has been working with the TA Center at Georgetown to begin utilizing a public health approach in work with health districts. The Department has received authorization to reprint the Bright Futures Developmental Tools and has distributed those to public health, child welfare, and Idaho's 0-3 agency, the infant/toddler program.

Idaho is currently evaluating the latest research on the utilization of a Public Health approach to mental health services. There is promising practices to this approach and Idaho will continue to evolve further evidence regarding this approach is validated.

Research is showing that the average age at death for individuals identified as having mental illness is approximately 20 years less than that of the general population. Idaho is in the early stages of planning how best to care for the overall health of consumers and not just the mental health. A general focus on wellness seems to be gaining interest of a federal level and Idaho is looking at how that impacts state service systems.

#### ADDITIONAL INTEGRATED SERVICES AND ACTIVITIES

##### Regional Mental Health Boards

Each region of the state maintains and supports a Regional MH Board that advises and supports improvement to the MH system throughout the state. Idaho used to maintain two separate systems of adult and child MH advisory councils. The Regional MH Boards had responsibility over the adult and children's systems, but primarily focused on the

adult system. The CMH system had Regional CMH councils and local MH councils that were developed strictly for focus on CMH and lead by the Idaho Council on Children's Mental Health (ICCMH). This created a lack of consistency and uniformity amount the voices speaking on behalf of mental health consumers and their families. The ICCMH was created under Executive Order of the Governor, but that Executive Order expired in September of 2008. The ICCMH's duties, and the Councils that it chartered, were folded into the State Planning Council on Mental Health and the Regional MH Boards. The majority of the Region MH Boards created CMH subcommittees to maintain the increased focus on children, youth, and families. Additionally, the statute that created the Regional MH Boards was modified to include two parents/families members of children with SED, a representative from the Juvenile Justice system, and a representative from the education system. This will allow the committees to have equal representation from both the adult and child MH systems.

# Idaho

## Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

Idaho is 83,557 square miles, which ranks as the 13th largest State in the Country. There are 44 counties in Idaho and approximately 130 Local Independent school districts. The Department of Health and Welfare has a central or administrative office and seven (7) regional service areas. The development of the Idaho System of Care is a statewide initiative and although there are only 37 Local CMH Councils, each county of the state is covered by a regional council. (Please see the above section for additional information regarding the Regional and Local Councils.) Each Regional Office is located in the highest populated city in the Region, but in addition to the Regional Office there are field (or satellite) offices in each region to service the rural parts of the state. (Please see Criterion 4 for a description of the rural and frontier areas in Idaho.) Each Region has a responsibility to meet the needs of children with SED and their families throughout the Region. While all 10 of the Department's CMH core services are not located in every community of the state, children and families from those areas have access to the services. A challenge that continues to make community-based services inaccessible is the distance that many families face in order to access services. However, with the increase in the private provider base, the available services to families have continued to increase.

As previously stated, Idaho operates a state-run mental health system. There is a concerted effort in Idaho to ensure statewide consistency in the provision of services, but also enough flexibility to allow for regional prerogative. Through this effort, Idaho is dedicated to making the system of care available to children and families across the state.

# Idaho

## Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

A survey of Idaho's primary homeless and runaway youth programs identified the following as the major mental health needs of runaway and homeless youth:

- Family conflict situations;
- Depression;
- Suicide ideation;
- Substance abuse; and
- Trauma associated with history of physical and/or sexual abuse.

Children who are homeless and youth with serious emotional disturbance comprise two broad groups: (1) those who have no family, including runaways or those discarded from their families; and (2) those youth that have families but whose parents are they themselves homeless. Each of these two broad groupings of homeless youth, those living with family and those living apart from family, can access needed mental health services through a number of pathways. However, traditionally the service system has had difficulty providing accessible mental health and other related services to this population. One barrier is that services in Idaho require the informed consent of the parent or guardian. It is often difficult for youth without a family to access service because of this.

The following are initiatives and projects that the Department either sponsors or has linkages with in order to provide outreach and access to homeless youth with serious emotional disturbance.

a. Crisis/shelter system

Idaho has few homeless shelters. Those that do exist are clustered around larger communities; i.e., Boise and Pocatello, and most serve primarily adult males. In Boise, Idaho's capital city, there are a few shelters that provide housing to families. These shelters have access to mental health services for families and children provided by the Department of Health and Welfare offices through established referral and intake mechanisms and through the shelter homes own service provider.

There are two federal funding grantees within the state system that provide a variety of services to homeless/runaway youth: the Bannock Youth Foundation in Pocatello and Hays Shelter Home in Boise. Besides providing crisis and emergency shelter, both offer a variety of in-house, short-term and crisis mental health services to their client population. When necessary, these programs refer clients to the local Family and Children's regional office for more intensive mental health services. Additionally, local CMH offices contract with these two agencies for various services, such as shelter care and family reconciliation.

Several communities have domestic abuse shelters that serve women and their children. Many of these women have mental health needs of a crisis nature. Depending upon the shelter, there may be limited in-house capacity to address mental health crisis needs. The Department of Health and Welfare, through its Division of Behavioral Health, serves the more intensive and/or longer term mental health needs of this population. These services

are accessed through the emergency response system or by the shelter making a referral through established mechanisms.

b. Community Mental Health Emergency Response System

In Idaho, the most frequently occurring entry point for mental health services for homeless youth is through the crisis system. The Department of Health and Welfare, Children's Mental Health program, maintain statewide emergency systems. The Department facilitated the development of Emergency Response protocols that cover every region of the state. Community agencies that have contact with homeless youth needing mental health services frequently access these emergency services. The various community agencies that serve the homeless have ready access to emergency mental health services.

c. Community Agencies

Various community agencies come into contact and identify homeless youth in need of mental health services. These include county social services, crisis/emergency shelters, emergency rooms, schools, Community Action Programs, and Health and Welfare eligibility determination offices.

d. Community Action Program (CAP) offices exist throughout the state in all seven Health and Welfare regions. The State Economic Opportunity Office allocates federally derived funds to each CAP for identified homeless clients.

e. Community-based hospital emergency rooms are a frequent point of access for crisis services for the homeless youth and his/her family. The public emergency mental health system, the Children's Mental Health program, networks and links with this hospital resource. Community hospitals work in conjunction with their local CMH offices to provide mental health services when they have identified homeless youth with mental health needs.

f. County Social Services refer identified homeless clients to their local regional Division of Behavioral Health offices for children's mental health services.

g. The Department of Health and Welfare has statutory responsibility to provide child protective services for the state. When a child protective services worker identifies a homeless youth with mental health needs, mental health services are offered within the same Department.

The Department of Health and Welfare co-locates eligibility offices with its regional Division of Behavioral Health offices in many regions of the state. These services are not always in the same office building, but typically in the same general location. When families apply for services and assistance for their family/children and it is determined that they are homeless and that a child in the family has a mental health need, a referral for child mental health services is made to the Service Integration navigator previously explained.

h. Churches may identify homeless families who have children experiencing mental health difficulties. Church authorities know how to refer and access their local CMH office for screening and service needs.

i. Community House Program

In Boise, all the major community agencies serving the needs of the homeless population have formed The Homeless Coalition. The Department of Health and Welfare, through its Region IV service center, has been an essential member of this group. This lead group helped to create Community House. Community House is designed to be the central access point for homeless families in the Treasure Valley and provides a full service program. Community House offers shelter to homeless families as well as having on site treatment and case management provided as part of the program. Case managers help coordinate and access other identified services as part of a client's plan. The services may include job training, childcare, social services, mental health services, and medical services to homeless families. With the development of Community House, services for the homeless population are more easily accessed. Community House is an example of a locally based partnership that is funded by a blending of private and public resources, including on-site mental health screenings for clients in the shelter and availability of mental health services as indicated by the screening.

# Idaho

## Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

Idaho is primarily a rural/frontier state. Low population densities in many service areas make it impractical to dedicate large amounts of resources/funding on predetermined categorical programs, which may only be indicated for a few individuals. This is especially true for programs such as inpatient and residential, which require large amounts of 'up-front' resources to develop and support the program.

The availability of professionally trained staff is very limited in many areas of Idaho. In the more rural areas of the state, families and children are less likely to have access to trained mental health professionals. Recruiting and maintaining staff is also a difficult task for the Department as well as private providers and agencies.

An additional complication for the service delivery system is that the incidence of poverty is greater in Idaho's highly rural areas. Since the percentage of families living in poverty is high, private sector treatment providers avoid investing resources and provide few services in such areas due to the decreased potential for covering their incurred costs. Consequently, service delivery in rural areas becomes the primary responsibility of the public service sector.

In large expanses of rural area, distances and lack of transportation can become barriers to service access. It is not practical to have a full service office in every small town. The Department does maintain offices that cover all counties. In order to best provide access to services at the local level and to make services available in rural areas, the Idaho Department of Health and Welfare has decentralized its service delivery system by organizing into seven service regions. Each of the seven service regions is subdivided further to facilitate localized service capacity. The Division of Behavioral Health maintains a total of 33 service centers, field offices and satellite offices throughout the state system.

Recognizing the needs of children and families living in rural and frontier geographic areas of the state, the Department has developed core service standards. The standards are intended to achieve statewide consistency in the development and application of CMH Core services and shall be implemented in the context of all applicable laws, rules and policies. Regardless of the rural nature of the community where the child lives, the intent of the standards is to ensure that the array of services are available to all Idaho children and families that need the service. While all these services cannot be available in every community of the state, each regional service center is required to build the capacity to meet the need of their region.

The Department is partnering with a group of primary care physicians (PCPs) to build on the idea of maintaining the PCPs as the medical home by offering initial evaluation and ongoing consultation from a Board Certified Children/Adolescent psychiatrist and ongoing targeted educational opportunities for PCPs. This model has proven successful in the largest populated area of Idaho, the Treasure Valley, and is now being evaluated for expansion statewide.

Recently, Idaho has dramatically expanded its ability to meet the psychiatric needs of clients statewide by purchasing and utilizing tele-medicine technology. For example, the CMH program used to fly a psychiatrist from the largest population center of Idaho, Boise 300 miles to the Region 2 office. The psychiatrist's available time was cut in half because of the airport and flight time. Now, the psychiatrist comes to the Boise office and provides services to the Region 2 office through video conference. This has effectively doubled the amount of actual time spent with clients at no additional cost.

# Idaho

## Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

## FINANCIAL RESOURCES

In the 2005 session, the Idaho Legislature pulled Children's Mental Health funding out of the larger children's services funding pool. The Children's Mental Health budget can now be better identified and tracked. In the Department's present configuration, the target population can be served by entering the system through several referral pathways. Therefore, children who meet the target population definition can receive services that focus on their needs and the needs of their family. Providing services in this way enables a more flexible use of available funding, reducing gaps and overlaps in the process, and provides the opportunity to serve more of Idaho's population in need of service.

Historically, all residential care funding for both children's mental health and child welfare was appropriated to the Children Mental Health Program. During the 2007 legislative session, the Idaho Legislature separated the budgets for residential care into the respective program budgets. This realized a more than \$5,000,000 reduction in the CMH budget, but the funding continues to be utilized for children with emotional disturbance regardless if they are served in the CMH program or the child welfare program.

The following breaks down the funding estimate for Idaho's Children's Mental Health Program for SFY2010 by amount and funding source.

Social Services Block	\$ 1,288,500
State General Funds	\$ 8,086,500
State Residential Care Funds (CW)	\$ 254,800
IV-E Funds (Foster care)	\$ 656,900
IV-E Adoption	\$ 146,600
TANF/Emergency Assistance	\$ 1,554,100
MH Block Grant	\$ 299,000
Children's Mental Health Initiative	\$ 0
Miscellaneous	\$ 855,100
Receipts	\$ 90,000
Total	\$ 13,231,500

This level of funding provides for personnel, operating, and other expenses for the delivery of services by the Department in the Children's Mental Health Program. The above information does not include the budgetary expenditures of the State Hospital South Adolescent Unit, which is estimated to be an additional \$2,850,000.

## STAFFING OF THE SYSTEM

The Children's Mental Health Authority has approximately 65 fulltime positions dedicated to the provision of clinical services to children and youth with serious emotional disturbance. The clinician position qualifications include a Master's degree in social work, psychology, marriage and family counseling, marriage and family therapy,

psychosocial rehabilitation counseling, psychiatric nursing, or very closely related field of study. These positions do not include staffing of the State Hospital South Adolescent Unit, clinical supervisors, Chiefs of Children's Mental Health, Program Managers, or clerical support or administrative support. The Department additionally has one central office CMH Program Manager, two CMH Program Specialists positions, one administrative assistant, and one training specialist for the entire Division.

It is important to note that the majority of the services delivered in Idaho are delivered by private providers. Medicaid funds the bulk of publicly funded services in Idaho. The providers in these private agencies vary in the qualifications based on the services provided. Psychotherapy can only be delivered by licensed clinical professionals, but skill building in the rehabilitation program can be staffed by individuals with bachelor's degrees.

The CMH program has recently completed a Workforce Development Plan that includes activities for recruitment, retention, and training of professional staff. Every county in Idaho is designated a mental health workforce shortage area. Idaho does not have a medical school and therefore it is particularly difficult to attract Board Certified Child and Adolescent Psychiatrists. Toward this end, Idaho recently began a partnership with the University of Washington for a Psychiatric Residency program through the Veteran's Hospital.

#### TRAINING-

- The Department adapted a Police Pocket Guide to assist law enforcement when working with youth that having emotional and behavioral disorders and expanded the training to all first responders. This includes train the trainer workshops to sustain the training.
- The Mental Health system continues to have a short period of time to present on critical issues in working with mentally ill clients at the new officer academy.
- The Department worked with the Juvenile Justice system to develop training on how to work with juveniles with emotional and behavioral disorders at the Probation and Detention new officer academy.
- The CMH program has completed a Children's Mental Health Practice Manual to guide clinicians in their practice.
- FACS Policy Memorandum 01-03 requires that all children's mental health staff receive training annually by parents and family members of children with serious emotional disturbance. This training helps staff to recognize the challenges that families have to struggle with every day.
- The Department currently contracts with a parent-run organization for family support and advocacy in Idaho. The contract requires the contractor to provide

ongoing training to staff and families served by the Department on advocacy, self-case management and consumer training. In the past fiscal year, the Idaho Federation of Families for Children's Mental Health conducted training in all seven regions of the state.

- Private providers of mental health services were provided training on assessment and service planning and trained on the CAFAS in every region of the state.
- Training has been delivered to emergency mental health responders on how to assess for needs, safety planning, and community referrals. Training also includes how to conduct Designated Exams for determining if involuntary treatment is necessary.
- The Department purchased rights to Grealish's curriculum and has used it to train parents, facilitators, juvenile justice, private providers, and communities on the approach.
- The Department contracts with St Luke's Children's Hospital to conduct monthly CMH training for primary care physicians on a variety of topics. The intent is, because Idaho has a severe shortage in child and adolescent psychiatrists, to assist primary care physicians in gaining the knowledge and skills to meet the mental health needs of their patients as well as the physical health needs. These training sessions are available in person or via teleconferencing. Additionally, St Luke's conducts an annual CMH conference for physicians.
- The CMH program has trained juvenile justice and mental health providers around the state on a strength-based approach to work with families and children. This was developed because of legislation requiring a strength-based approach on children staffed under a change in court rules in the JJ system.

## DATA AND INFORMATION SYSTEM DEVELOPMENT

The Division has completed implementation of its Family Oriented Community User System (FOCUS) information system. The first phase of this implementation began July 1, 1998, in Region V. Staff training and conversion of cases from the old data system took place region by region. The system was fully implemented October 1, 2000. The FOCUS information system is an electronic system including an electronic clinical record. This system encompasses child protective services, child mental health services, foster care and licensing, adoptions, interstate compacts, as well as invoicing and payment for child welfare and children's mental health services. This system will provide the information on the number of children and the resources used through the CMH program. The FOCUS system has the capability to report on a number of data elements reported in this plan. Idaho is working to enhance this system to report on all of the elements required for the implementation plan and has received the Data Infrastructure Grant to assist in this enhancement. FOCUS now has the ability to report some of the Uniform Data requirements and the National Outcome Measures. The

FOCUS system also now has the ability to track all CAFAS information and generate reports.

Additional data is gathered through the Medicaid fiscal system (AIMS). The AIMS system was developed for fiscal purposes and is also used to extract data on utilization and expenditures. These reports are gathered through a system call the IDEA reports viewer. Idaho participates in the utilization of the MHSIP Satisfaction Survey for Families.

The adult MH system in Idaho is beginning implementation of a new data system called Web Infrastructure for Treatment Services or WITS. The CMH program is requesting funding to switch to the WITS system and if approved, the CMH system will discontinue use of the CW FOCUS system and join with adult MH and substance use disorders programs by utilizing WITS.

Idaho is currently utilizing the CALOCUS, CBCL, and YOQ in parts of the CMH program, but not universally. These outcome and evaluation instruments assist in determining the effectiveness of different core services that the Department provides.

#### QUALITY ASSURANCE AND PROGRAM ACCOUNTABILITY

A number of efforts and activities are occurring to help initiate and continue assuring program accountability, outcomes and quality assurance/improvement. The Division of Behavioral Health is currently implementing a Continuous Quality Improvement system in the Children's Mental Health Program. This system has three (3) major components:

- External Reviews
- Internal Reviews
- Case Reviews

The Department, with the intent to become more proficient at conducting uniform assessments with measurable outcomes, has begun using the Child Adolescent Functional Assessment Scale (CAFAS) as a statewide uniform assessment tool. CAFAS scores are recorded in a data base to track progress of the child's functioning over time. The CAFAS is administered initially at application for services for eligibility purposes and every 120-days as an outcome measure. The CAFAS is assisting the Department in measuring the success of our own services and our service providers. The Department has implemented a Case Review Instrument for the Children's Mental Health program to measure adherence to regulations and best practice standards.

The Children's Mental Health program continues to emphasize the need for program evaluation that includes input and feedback from families. All families receiving services have the opportunity to complete a Family Satisfaction Survey. Families are given the opportunity to provide feedback in a voluntary and confidential way in the following categories:

- Access

- Appropriateness
- Inclusion/Empowerment
- Effectiveness
- Cultural Competence

The information and data gathered will be added to overall system evaluation efforts. Input from families and family advocacy organizations (such as The Idaho Federation of Families for Children's Mental Health) are also invaluable in assisting with planning of the mental health service system. Parents and advocates input are gathered through their involvement in policy and program development.

The Children's Mental Health Subcommittee, a standing committee of the State Planning Council on Mental Health, plays a role in monitoring the adequacy of the mental health system for children. It also assists in establishing the system priorities and monitoring of the system's responsiveness to those priorities.

Medicaid Rehabilitation Option is developing the process to collect information regarding outcomes. The data will be used for comparison purposes to aid in determining service effectiveness. The CMH program recognizes that this outcome and service evaluation data is needed for all children and families receiving publicly funded services, not just those receiving services under the Rehabilitation Option. Client evaluation will focus on the 8-scales of client functioning specifically identified on the CAFAS.

The Children's Mental Health Authority is utilizing a case review instrument. The instrument and process of case review is similar to those state reviews in the child welfare system called the Child and Family Services Review. The outcomes for these reviews measure achievement in:

- Access to Services;
- Appropriateness of Services;
- Effectiveness of Services; and
- Family Inclusion/Involvement

Lastly, the Division of Behavioral Health recently moved toward more emphasis on Quality Assurance by creating and filling a Quality Assurance/Utilization Program Manager position. This position is tasked with Division wide quality improvement process to develop policies, standards, and procedures.

# Idaho

## Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

The Department is statutorily the lead for the development and implementation of children's mental health services in Idaho. As the lead agency, the Department believes that it has a role in the education of first responders in issues related to mental health. The Department's Mission is to Promote and Protect the Health and Safety of All Idahoans. This includes assisting other agencies in how best to respond to situations that are exacerbated by a emergency responder's lack of knowledge in dealing with person that have a mental illness. The following are examples of the activities that the Department has implemented to meet this need.

- The Department adapted a Police Pocket Guide to assist law enforcement when working with youth that having emotional and behavioral disorders.
- The Department has delivered training to First Responders in multiple locations in the state, for which the police academy gave continuing education credits.
- The Children's Mental Health program was approved by the Idaho Police Officers Standards and Training (POST) academy to offer continuing education credits for the First Responder's training.
- The CMH program developed a training video that utilizes real law enforcement on de-escalation skills for emergency responses. This video is being utilized as part of the first responders training.
- The Mental Health system continues to have a short period of time to present on critical issues in working with mentally ill clients at academy.
- The Department has worked with the Juvenile Justice system to develop training on how to work with juveniles with emotional and behavioral disorders at the Probation and Detention new officer academy.
- Training has been delivered to emergency mental health responders on how to assess for needs, safety planning, and community referrals. Training also includes how to conduct Designated Exams for determining if involuntary treatment is necessary.
- The CMH program partnered with POST and the Ada County Sheriff's office to deliver several train the trainer workshops. This effort will sustain the training and allow it to be delivered in smaller communities across the state in these difficult financial times.
- The Adult and Children's programs continue to offer Crisis Response Training (CRT) with law enforcement across the state when requested.

# Idaho

## Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Below is a description of how the Children’s Mental Health Authority intends on spending the FY2010 SAMHSA Block Grant:

**MENTAL HEALTH BLOCK GRANT**

<b>Adult Mental Health</b>	<b>Federal Budget</b>
Adult Mental Health Services	\$1,205,898
Peer Specialist/Consumer/Family Empowerment	\$ 153,000
State Planning Council	\$ 20,000
Suicide Prevention	\$ 10,000
Quality Improvement System Development	\$25,000
<b><i>Total Adult Services FY 2008</i></b>	<b>\$1,413,898</b>
<b>Children’s Mental Health</b>	
CMH Special Projects:	\$ 312,121
-Contract with Family Run Organization	\$269,267
-Contract for Suicide Prevention Services	\$22,854
-Contract for Primary Care Physician Training	\$20,000
<b><i>Total Children Services FY2010</i></b>	<b>\$ 312,121</b>
Administration at 5%	<b>\$ 90,843</b>
<b><i>Totals; Adult Services, Children’s Services, Administration</i></b>	<b>\$ 1,816, 862</b>

The above information shows how the state will load the 2010 SAMHSA block grant funds into its budget structure for the Children’s Mental Health Program. This is based off of the allotment schedule from FY2009. This assures that all block grant funds pertaining to children’s mental health obtained through SAMHSA and in accordance with PL 102-321 was expended for community-based programming. Historically, the Department utilized a portion of the Block Grant in the general cost pool for treatment services and personnel cost. This has been a source of criticism at peer reviews and site visits. Therefore, the entire Children’s Mental Health portion of the Block Grant will be allocated for special projects. Of this amount, an estimated **\$269,267** is allocated to a contract with the Idaho Federation of Families for Children’s Mental Health; **\$20,000** is allocated for training primary care physicians on the needs of children with mental illnesses; **\$22,854** is directed toward a contact for suicide prevention services.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	3,050	3,155	2,500	2,500	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:** Provide an array of mental health services to children representing the target population.

**Target:** To serve no less than 2,500 children/youth in the Department's Children's Mental Health Authority Program.

**Population:** Children with SED

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

**Indicator:** The number of children/youth served by DHW's CMH Authority Program

**Measure:** Unduplicated count of children with serious emotional disturbance served by the Mental Health Authority children's program.

**Sources of Information:** FOCUS information systems

**Special Issues:** This table has been updated to reflect the change in organizational structure and will no longer include children/youth that are served solely through the Medicaid program. This includes updating prior years data to reflect the accurate measure.

**Significance:** National Outcome Measure

**Action Plan:** The Uniform Data Tables will report this information broken down by gender and age as requested. This table does not allow this data to be reported in that fashion. The target is set at 2,500 because of a lack in funding and personnel growth in the children's program. The children's mental health authority will continue to seek methods of creating a more efficient mental health program, including seeking additional evidence-based programs, and will hopefully increase access to services in the future.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	0	0	3	3.80	N/A
Numerator	0	0	--	--	--
Denominator	79	80	--	--	--

Table Descriptors:

**Goal:** Ensure that an array of community-based services are available to children with SED and their families to decrease psychiatric hospitalization.

**Target:** Readmissions of youth to State Hospital South Adolescent Unit will not exceed 3% at 30 days and 9% at 180 days.

**Population:** Children with SED

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

**Indicator:** The number of children/youth readmitted to SHS at 30 and 90 days.

**Measure:** Numerator: persons, 0-17, who are reasmitted to SHS within 30 and 180 days. Denominator: persons, 0-17, who are discharged from SHS during the past year.

**Sources of Information:** SHS information system

**Special Issues:** Idaho has only one adolescent state hospital unit, which is a 16 bed facility.

**Significance:** National Outcome Measure

**Action Plan:** SHS continues to work toward the reduction of readmissions through thorough discharge planning. The regional CMH program is a gatekeeper for the SHS unit. In order for a child/youth to be placed at SHS, they must be evaluated and followed by a CMH clinician. These clinicians are engaged in case management throughout the placement and assist the child and family with transition. By increasing the access to community-based services upon discharge, the child has a better chance of successful transition.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	5.06	5	8.50	8.50	N/A
Numerator	4	4	--	--	--
Denominator	79	80	--	--	--

Table Descriptors:

**Goal:** Ensure that an array of community-based services are available to children with SED and their families to decrease psychiatric hospitalization.

**Target:** Readmissions of youth to State Hospital South Adolescent Unit will not exceed 3% at 30 days 9% at 180 days.

**Population:** Children with SED

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

**Indicator:** The number of children/youth readmitted to SHS at 30 and 90 days.

**Measure:** Numerator: persons, 0-17, who are reasmitted to SHS within 30 and 180 days. Denominator: persons, 0-17, who are discharged from SHS during the past year.

**Sources of Information:** SHS information system

**Special Issues:** Idaho has only one adolescent state hospital unit, which is a 16 bed facility.

**Significance:** National Outcome Measure

**Action Plan:** SHS continues to work toward the reduction of readmissions through thorough discharge planning. The regional CMH program is a gatekeeper for the SHS unit. In order for a child/youth to be placed at SHS, they must be evaluated and followed by a CMH clinician. These clinicians are engaged in case management throughout the placement and assist the child and family with transition. By increasing the access to community-based services upon discharge, the child has a better chance of successful transition.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	1	2	2	2	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** Provide an array of community-based services that are evidence-based and that demonstrate achievement of treatment outcomes.
- Target:** Maintain the number of Evidence-Based Practices utilized in Idaho and increase the number of youth served in those programs.
- Population:** Children with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** The number of EBPs utilized by the Idaho CMH System of Care
- Measure:** The number of EBPs that are used by the Idaho Children's Mental Health system to serve children and youth with SED.
- Sources of Information:** CMH Information System: FOCUS and Regional self-report
- Special Issues:** Idaho has two EBPs currently in use by the Department of Health and Welfare. One is Treatment or Therapeutic Foster Care and the other is Functional Family Therapy. Idaho does not follow fidelity to the EBP model in TFC, but has quality assurances for the implementation and utilization of the Idaho model. Idaho contracts with the Idaho Youth Ranch for FFT and that program adheres to the fidelity of that model.
- Significance:** National Outcome Measure
- Action Plan:** Idaho's Treatment/Therapeutic Foster Care program is an Idaho developed system and does not necessarily adhere to the fidelity of the EBP model. The fidelity of Idaho's TFC system is connected to a set of practice standards that were developed based off of best practices. The adherence to these standards are measured through the use of a case review instrument and quality assurance practices. Please refer to Criterion 5 for an overview of the CQI system in Idaho. Idaho also utilizes Functional Family Therapy. This is delivered through a contract with the Idaho Youth Ranch. Currently, the service is only available through DHW in 6 of the seven regions, however it is available through juvenile justice in every region of the state. DHW will be working to expand FFT to the last region.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	129	4.94	5	5	N/A
Numerator	N/A	156	--	--	--
Denominator	N/A	3,155	--	--	--

Table Descriptors:

- Goal:** Provide an array of community-based services that are evidence-based and that demonstrate achievement of treatment outcomes.
- Target:** Maintain the number of youth/children that receive TFC in Idaho.
- Population:** Children with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** The number of children receiving treatment foster care services.
- Measure:** The total number of children/youth with SED that are placed in treatment foster care by the CMH program
- Sources of Information:** CMH Information system, FOCUS
- Special Issues:** The treatment foster care program in Idaho does not follow the fidelity of the EBP program, but has a quality assurance system in place to ensure quality. Treatment foster care is available in each region of the state, though not at adequate levels to support the need and not in every community within each region.
- Significance:** National Outcome Measure
- Action Plan:** Idaho's Therapeutic Foster Care program is an Idaho developed system and does not necessarily adhere to the fidelity of the EBP model. The fidelity of Idaho's TFC system is connected to a set of standards that guide the delivery of services. The adherence to these standards are measured through use of a case review instrument and on through on going quality assurance practices. Please refer to Criterion 5 for an overview of the CQI system used in Idaho. Additionally, Idaho utilizes the Wrap-Around model of service planning and delivery which is a EBP and recommend this be considered in the future for inclusion in the EBP's recognized by CMHS.

**CHILD - GOALS TARGETS AND ACTION PLANS**

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

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

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

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	82	2.19	2	2	N/A
Numerator	N/A	69	--	--	--
Denominator	N/A	3,155	--	--	--

Table Descriptors:

- Goal:** Provide an array of community-based services that are evidence-based and that demonstrate achievement of treatment outcomes.
- Target:** Maintain the number of children/youth that receive FFT in Idaho.
- Population:** Children with SED.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** The number of children/youth receiving Functional Family Therapy.
- Measure:** The total number of children/youth with SED that are provided Functional Family Therapy.
- Sources of Information:** Provider contract reports.
- Special Issues:** The FFT program that Idaho offers is delivered is by the Idaho Youth Ranch, a contractor. The contractor utilizes the FFT measures of fidelity, the Department requires this as part of the contract.
- Significance:** National Outcome Measure
- Action Plan:** Currently, FFT is available in all seven regions of the state through the Idaho Department of Health and Welfare and/or the Department of Juvenile Corrections. The Department of Health and Welfare has the service available in six of the seven regions and is actively seeking to expand the service into the other region.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	51.19	50.45	50	50	N/A
Numerator	172	112	--	--	--
Denominator	336	222	--	--	--

Table Descriptors:

**Goal:** Ensure that families of children with SED are full partners in developing, implementing, and evaluating the System of Care

**Target:** To remain above an average satisfaction scores of 50% with the MHSIP Youth Services Survey for Families.

**Population:** Children with SED

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

**Indicator:** The average score on the Family Satisfaction Survey.

**Measure:** Numerator: the number of families responding to the survey that positively rate their perception of care.  
  
Denominator: the number of families responding to the survey

**Sources of Information:** MHSIP satisfaction survey database, questions 16, 17, 18, 19, 20, and 21.

**Special Issues:** Idaho has historically surveyed families every 120-days. Beginning in SFY2008, the children's mental health program has implemented a new standard that surveys families once a year on July 1st and every family upon discharge from services.

**Significance:** National Outcome Measure

**Action Plan:** As of July 1, 2005, Idaho began using the MHSIP Client Satisfaction Survey for Families. Additionally, in July of 2007, Idaho has implemented a standard that requires families survey on July 1st of each year. The children's mental health program is working on a full implementation of Wraparound services as a philosophical approve to the delivery system. The is a child and family-centered practice that empowers the family and will therefore increase family satisfaction with services. We will continue to evaluate the results and the return rate to implement methods for increasing both.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	88.16	85.53	75	75	N/A
Numerator	134	65	--	--	--
Denominator	152	76	--	--	--

Table Descriptors:

**Goal:** Children with Serious Emotional Disturbance are provided necessary mental health services that allow them to return/stay in school.

**Target:** 75% of children/youth will return to/stay in school.

**Population:** Children with SED

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

**Indicator:** The number of children with SED that returned/stayed in school as reported in the MHSIP Youth Satisfaction Survey for Families (YSSF).

**Measure:** Numerator: The number of families reporting that their child returned/stayed in school on the MHSIP YSSF.  
  
Denominator: The total number of families reporting on whether their child returned/stayed in school on the MHSIP YSSF.

**Sources of Information:** MHSIP Youth Satisfaction Surveys for Families Reports from the Decision 2000+ Idaho Website

**Special Issues:** This will be the second year that Idaho has collected this data. Therefore, this year will be the first year that Idaho has a target. Based off of one year's data, it is difficult to hold a state to 100% compliance when there are not multiple years data to establish the target.

**Significance:** National Outcome Measure

**Action Plan:** Idaho has recently created new practice standards for surveying families with the latest MHSIP YSSF. It is anticipated that this will increase the return rate and therefore yield more reliable data. The surveys will be sent out to all families that are currently receiving services from the CMH program on July 1st each year. Additionally, every family that is discharged from services will also receive a survey. Each survey will include a self-addressed, pre-posted envelope. The surveys will be sent to the Central Office and entered into the MHSIP site. This relieves the burden from the regional offices. This information will be used throughout the year as a management instrument, but also reported annually as a NOM in the MH Block Grant.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	75	41.54	40	35	N/A
Numerator	48	27	--	--	--
Denominator	64	65	--	--	--

Table Descriptors:

**Goal:** Children with Serious Emotional Disturbance are provided necessary mental health services that decreases their criminal justice involvement

**Target:** 70% of children/youth served will avoid increased Juvenile Justice involvement.

**Population:** Children with SED

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

**Indicator:** The number of children with SED that have decreased involvement with criminal justice as reported in the MHSIP YSSF

**Measure:** Numerator: The number of families reporting decreased involvement with criminal justice as reported in the MHSIP YSSF  
  
Denominator: The total number of families reporting on criminal justice involvement in the MHSIP YSSF

**Sources of Information:** MHSIP Youth Satisfaction Surveys for Families Reports from Decision 2000+ Idaho Website

**Special Issues:** This will be the second year that Idaho has collected this data. Therefore, this year will be the first year that Idaho has a target. Based off of one year's data, it is difficult to hold a state to 100% compliance when there are not multiple years data to establish the target.

**Significance:** National Outcome Measure

**Action Plan:** Idaho has recently created new practice standards for surveying families with the latest MHSIP YSSF. It is anticipated that this will increase the return rate and therefore yield more reliable data. The surveys will be sent out to all families that are currently receiving services from the CMH program on July 1st each year. Additionally, every family that is discharged from services will also receive a survey. Each survey will include a self-addressed, pre-posted envelope. The surveys will be sent to the Central Office and entered into the MHSIP site. This relieves the burden from the regional offices. This information will be used throughout the year as a management instrument, but also reported annually as a NOM in the MH Block Grant.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	1	1	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:** Children with Serious Emotional Disturbance are provided necessary support to increase their stability in living arrangements.

**Target:** To maintain less than a 1% homeless rate among the children/youth served.

**Population:** Children with SED

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

**Indicator:** The number of children with SED that have increased stability in housing as reported in the MHSIP Youth Satisfaction Survey for Families (YSSF).

**Measure:** Numerator: The number of families reporting their living situation as homeless.  
  
Denominator: The total number of families receiving services.

**Sources of Information:** The CMH information system called FOCUS

**Special Issues:** Idaho has a low rate of homelessness traditionally and particularly with children and youth in the CMH system. The target will be established at a low rate, but due to the current economic conditions it is difficult to predict the overall increase potential in the homeless population.

**Significance:** National Outcome Measure

**Action Plan:** This is the first year that this National Outcome Measure will be implemented. Idaho has a low rate of homelessness traditionally and has attempted several campaigns to reach out to the homeless population of children/youth with SED and their families, but has yet to dramatically reach the homeless population. Therefore, the Department will continue to work with providers of services to homeless families including shelters, first responders, and city/county officials to partner in outreach efforts.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

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

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	73.60	65	65	N/A
Numerator	N/A	131	--	--	--
Denominator	N/A	178	--	--	--

Table Descriptors:

**Goal:** Children with Serious Emotional Disturbance are provided necessary mental health services to increase social supports/social connectedness

**Target:** To have at least 65% of families report increasing social supports/social connectedness

**Population:** Children with SED

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

**Indicator:** The number of children with SED that increased social supports/social connectedness as reported in the MHSIP Youth Satisfaction Survey for Families (YSSF)

**Measure:** Numerator: The number of families reporting that their child has increased social supports/social connectedness on the MHSIP YSSF.  
  
Denominator: The total number of families reporting on whether their child has increased social supports/social connectedness on the MHSIP YSSF.

**Sources of Information:** MHSIP Youth Satisfaction Surveys for Families Reports from the Decision 2000+ Idaho Website

**Special Issues:** This will be the second year that Idaho has collected this data. Therefore, this year will be the first year that Idaho has a target. Based off of one year's data, it is difficult to hold a state to 100% compliance when there are not multiple years data to establish the target.

**Significance:** National Outcome Measure

**Action Plan:** Idaho has recently created new practice standards for surveying families with the latest MHSIP YSSF. It is anticipated that this will increase the return rate and therefore yield more reliable data. The surveys will be sent out to all families that are currently receiving services from the CMH program on July 1st each year. Additionally, every family that is discharged from services will also receive a survey. Each survey will include a self-addressed, pre-posted envelope. The surveys will be sent to the Central Office and entered into the MHSIP site. This relieves the burden from the regional offices. This information will be used throughout the year as a management instrument, but also reported annually as a NOM in the MH Block Grant.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	50.45	50	50	N/A
Numerator	N/A	112	--	--	--
Denominator	N/A	222	--	--	--

Table Descriptors:

**Goal:** Children with Serious Emotional Disturbance are provided necessary mental health services to improve their level of functioning

**Target:** To maintain at least 50% of families report improved levels of functioning

**Population:** Children with SED

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services  
4:Targeted Services to Rural and Homeless Populations

**Indicator:** The number of children with SED that have improved levels of functioning as reported in the MHSIP Youth Satisfaction Survey for Families (YSSF)

**Measure:** Numerator: The number of families reporting that their child has improved levels of functioning on the MHSIP YSSF.  
  
Denominator: The total number of families reporting on whether their child has improved levels of functioning on the MHSIP YSSF.

**Sources of Information:** MHSIP Youth Satisfaction Surveys for Families Reports from the Decision 2000+ Idaho Website

**Special Issues:** This will be the third year that Idaho has collected this data. Therefore, this year will be the second year that Idaho has a target. Based off of two year's data, it is difficult to hold a state to 100% compliance when there are not multiple years data to establish the target.

**Significance:** National Outcome Measure

**Action Plan:** Idaho has recently created new practice standards for surveying families with the latest MHSIP YSSF. It is anticipated that this will increase the return rate and therefore yield more reliable data. The surveys will be sent out to all families that are currently receiving services from the CMH program on July 1st each year. Additionally, every family that is discharged from services will also receive a survey. Each survey will include a self-addressed, pre-posted envelope. The surveys will be sent to the Central Office and entered into the MHSIP site. This relieves the burden from the regional offices. This information will be used throughout the year as a management instrument, but also reported annually as a NOM in the MH Block Grant.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** CAFAS Outcomes

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	50	67	50	50	N/A
Numerator	81	215	--	--	--
Denominator	105	323	--	--	--

Table Descriptors:

- Goal:** Provide an array of community-based services to children with SED and their families.
- Target:** Achieve a target of at least 50% of children/youth receiving two or more CAFAS evaluations that indicate a decrease in the functional impairment.
- Population:** Children with SED.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percent of children/youth with a positive change in the CAFAS score over time.
- Measure:** Numerator: Number of children/youth receiving services with an improved CAFAS score.  
Denominator: Total number of children receiving an initial CAFAS and a closure CAFAS following the delivery of services.
- Sources of Information:** Service Evaluation Database/FOCUS information system
- Special Issues:** CAFAS is a method to measure a child's overall functional impairment. While the overall score may improve, a child may still experience difficulties in specific functional areas. Families and children may drop out of services prior to 120 days making a second CAFAS score difficult to accomplish.
- Significance:** Improved functioning demonstrates the effectiveness of service interventions and leads to successful community integration of children with SED.
- Action Plan:** The Department will strive to meet the target by continuing to implement the continuous quality improvement (CQI) system that addresses the effectiveness of services by measuring the reduction of functional impairment. The CAFAS will continue to be used to measure functional impairment. To increase the effectiveness of services the Department is also making modifications to the psychosocial rehabilitation program (PSR). Historically, the Regional Mental Health Authority (RMHA) closely monitored the accesses and usage of PSR, which has limited the opportunity to increase the quality assurance with private providers of the service. One action of the Department will be to transition to a system that spends resources to increase the quality of services, rather than guarding the access to those services. Both in the PSR program and throughout the CMH program, the Department is moving toward an outcomes driven model.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Expenditures on Community-Based Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	92	89	75	75	N/A
Numerator	69,789,340	51,854,370	--	--	--
Denominator	75,748,250	58,247,862	--	--	--

Table Descriptors:

- Goal:** Prioritize funding for community-based services to ensure appropriate resource allocation of the community-based system, and to ensure continuous quality improvement of the service system.
- Target:** 75% of all funding for CMH services by DHW will be spent on community-based services.
- Population:** Children with SED
- Criterion:** 5:Management Systems
- Indicator:** Percentage of total CMH funding, including block grant funds, expended on community-based services.
- Measure:** Numerator: Amount of children's mental health funding for community based programs (non-hospital care and expenditures). Denominator: Total funds spent on all children's mental health services including State Hospital South and other hospitalizations funded by Medicaid or contracts.
- Sources of Information:** Divisional information systems, Division of Management Services information systems, and Medicaid system information.
- Special Issues:** Many/most hospitalizations are most appropriately considered community-based, especially if the hospital is located in the child's home community and if the admission is for short-term crisis stabilization. However, in Idaho, many of the inpatient units receiving public funds (Medicaid) are long distances from the child's home and some of the stays are longer than short-term crisis stabilization. The data system cannot differentiate which admissions may be local and short term versus distant and longer term. Subsequently, for purposes of this performance indicator, community-based services are defined as outpatient services that clearly are community-based and are less restrictive.
- Significance:** A community-based service system is a core value for the state as well as being a standard for the field. Community-based services have been shown to be the most normalized, the most effective and the most cost efficient services. Data systems are needed which address not only client encounter and funding data parameters, but also quality and service effectiveness measures. This objective relates to the State Planning Council's CMH priority: Enhancing community-based efforts at all levels within the community.
- Action Plan:** The Department is dedicated to serving children in their own communities whenever possible. It is recognized that often children may require services that are not community-based, but the focus has been on developing the array of core services in each region of the state. The Department is monitoring the utilization of residential and inpatient care, including the development of reports that provide information on multiple hospitalizations, in order to provide the necessary community-based services to avoid further need for out-of-community care. The Department will continue to expand the use of Local Councils as resources to families. There are multiple anecdotal examples of the Local Councils use of creative resources to maintain children in their own communities and avoid more restrictive levels of care. Technical assistance and community resources development will be used to assist Local Councils in their efforts to increase community-based care options.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Local Council Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	153	148	150	150	N/A
Numerator	153	148	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

**Goal:** Provide a system of integrated social services, educational services, juvenile justice services, and substance abuse services together with mental health services.

**Target:** Maintain the number of families receiving Wraparound.

**Population:** Children with SED

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

**Indicator:** Number of children participating in the Wraparound Process

**Measure:** Unduplicated count of children/youth served through the Wraparound process.

**Sources of Information:** FOCUS information system and Wraparound Specialist's monthly activity reports

**Special Issues:** Wraparound is a Evidence-Based Practice and the Idaho State Planning Council on Mental Health has continued to recommend in it's annual letter that it be recognized as such in the Block Grant. The title of this indicator refers to Local Councils, which have evolved into a subcommittee of the Regional Mental Health Boards. Wraparound is typically delivered by Department staff. There are some contract providers of Wraparound, but this indicator only pertains to Department delivered Wraparound.

**Significance:** Interagency collaboration and consumer/family driven services at the local level will ensure a comprehensive community based system of care for children. This objective relates to the State Planning Council's CMH priority: Expand and refine collaboration and remove barriers to coordination.

Additionally, this indicator was selected as the TRANSFORMATION INDICATOR for the children's plan because it is the Wraparound process with is family and consumer driven. This related to the President's New Freedom Commission Report Goal #2, "Mental Health Care is Consumer and Family Driven."

**Action Plan:** Wraparound will be the chosen model for all children, youth, and families with high severity, at risk of out of home care, and that are multi-system involved. Additionally, the CMH program is working with courts on Juvenile MH courts in three counties. These courts have selected Wraparound as the coordination model for the youth under jurisdiction.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Medicaid Mental Health Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	17,332	17,431	17,000	16,500	N/A
Numerator	N/A	17,431	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

- Goal:** To provide youth/children with emotional disturbance access to outpatient mental health services through Medicaid.
- Target:** To provide mental health services to no less than 16,500 children with emotional disturbance through the Medicaid's outpatient mental health programs.
- Population:** Children with Emotional Disturbance
- Criterion:** 2:Mental Health System Data Epidemiology
- Indicator:** The number of children/youth that receive Medicaid funded mental health services.
- Measure:** The total unduplicated number of children/youth with emotional disturbance that receive a Medicaid funded outpatient mental health service.
- Sources of Information:** Medicaid's datawarehouse reports viewer
- Special Issues:** The Medicaid outpatient mental health services array includes services that do not require an SED to obtain. Therefore, some of the unduplicated count of children/youth that are receiving these services may not be SED, though all have a mental health diagnosis and are emotionally impaired.
- Significance:** This is an important measure because Medicaid is the largest funder of mental health services in Idaho. It is necessary to track services and continue to provide effective mental health services to children in Idaho that are SED and those that have not been determined SED. An critical component to any system of care is the ability to provide early intervention and early identification. The Medicaid programs often prevent children/youth from having to move deeper in the system.
- Action Plan:** Medicaid is currently working with a stakeholder group, including the Division of behavioral health, on the improving the behavioral health service delivery package that it offers. Medicaid has heavily funded psychosocial rehabilitation historically and has done so with little control over the quality of care. This system redesign is intended to move the system further toward best practices. One important component that has been missing in Medicaid has been the ability to provide services to a child/youth's family because of the rigidity of the medical model. Medicaid is reviewing models of Parent Management Training and has already begun to fund services that include Functional Family Therapy and Multi-systemic Therapy.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Services to rural populations

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	26.30	25	25	25	N/A
Numerator	957	785	--	--	--
Denominator	3,050	3,155	--	--	--

Table Descriptors:

- Goal:** Ensure that families residing in rural areas have access to services for their children with a serious emotional disturbance.
- Target:** Twenty five percent of children served by Department programs are from rural areas.
- Population:** Children with SED
- Criterion:** 4:Targeted Services to Rural and Homeless Populations
- Indicator:** The percentage of children receiving CMH services from the MHA that reside in rural areas. The number of children served in a rural service area is defined as those children served from counties and field offices other than the county in which the primary regional service center is located.
- Measure:** Numerator : The number of children/youth served from rural areas. Denominator: The total number of children/youth served across all counties/field offices.
- Sources of Information:** Divisional information system database.
- Special Issues:** The figures reflecting numbers of children served represent youth receiving community-based services through DHW's regional Programs.
- Significance:** Idaho is a very rural state. A large percentage of Idaho citizens reside in rural areas. It is important for citizens that they have access to services in rural areas. Rural service delivery is a requirement of federal law if states are to receive federal block grant monies. This objective relates to the State Planning Council's CMH priority: Increasing services, increase continuous access to these services and removal of barriers in rural areas of the state.
- Action Plan:** The Department is maintaining the previously established target for this performance indicator. This target becomes increasingly difficult to achieve as it involves the expansion of services in rural areas of the state to be consistent with the delivery of services in the urban areas. Obviously it is more difficult to build and sustain a provider based in a rural geographical area. The Department is going to increase efforts to develop, recruit, and maintain a service delivery base in rural areas of the state in order to maintain this target. It is a challenge to gather consistently accurate data from the information system for this performance requirement. Because Idaho is a state-run system information is gathered based on where the clinical case manager serving the child is located, not where the child lives. The Department will be working on developing a report to pull this information consistently and accurately.

# Idaho

## Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

# Idaho State Planning Council on Mental Health

Pete T. Cenarrusa Building, 3<sup>rd</sup> Floor  
P.O. Box 83720  
Boise, ID 83720-0036

## MEMBERSHIP

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Lynne Whiting  
Julie Williams  
Teresa Wolf  
Corinna Wolfe-Stiles

August 20, 2009

Barbara Orlando  
Office of Program Services, Division of Grant Management  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Road, Room 7-1091  
Rockville, Maryland 20857

RE: State of Idaho Application for 2010 Federal Community Mental Health Block Grant

Dear Ms. Orlando:

The Idaho State Planning Council on Mental Health (SPCMH) appreciated the opportunity to review, discuss, and provide comment on the Federal Block Grant for 2010 at our meeting on August 11-12, 2009. We are pleased to offer our support and approval of the Federal Block Grant request.

Idaho, like other states, has faced many challenges from the recent economic downturn. The SPCMH continues to monitor the impact of budget reductions and the reorganization of services for children, families, and individuals.

Providing appropriate mental health services to individuals in Idaho remains a constant challenge for our State and we offer the following suggestions as they relate to Idaho's Mental Health care system.

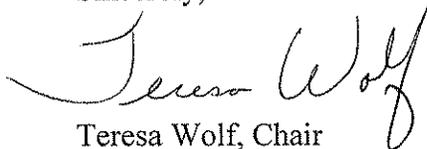
- The actual population receiving services in our State is better reflected by using the definition SPMI. We believe that SMI implies a much broader population than is being served.
- We endorse ongoing education for school resource workers who serve children with mental health needs and their families.
- "Homeless" as defined under the Federal Block Grant does not adequately describe the reality of children, youth, families and adults who are experiencing homelessness in Idaho. The true picture of being, or becoming, homeless can be a slow decline into being unable to function in Activities of Daily Living, or more sudden with an economic reverse or socially inappropriate behavior that results in eviction or outcast. The Council favors all efforts put forth in addressing homelessness and believes this issue is of critical importance in Idaho.

- The limited budget for the SPCMH has been and continues to be a topic of importance to our Council as we work diligently to meet our requirements under the guidance of the Federal Block Grant.

The SPCMH appreciates the opportunities made available by the Federal Block Grant. Idaho has made great strides in improving the system of care providing services to the mentally ill and their families. Included in this array of improved services is the Peer Specialist Certification Program which has benefited nearly every region within the State. A Peer Specialist position is to be placed at one of the two (2) State Hospitals by the end of 2009. This is a positive step for clients as well as an identified priority for our Council in discharge planning. Another achievement is the first statewide Wellness Recovery Action Plan (WRAP) training for consumers which occurred this year. This program has become an invaluable tool in supporting and educating consumers on the principles and practices of recovery. The SPCMH fully supports recovery-based programs and encourages training for all seven regions of our State. Idaho plans to implement the WITS system in the State operated clinics as an electronic medical record collection program on October 1, 2009. These improvements continue to advance the data collection efforts and improving service provision. The SPCMH fully supports these efforts to supply reliable data, critical for verification of need when considering additional system enhancements in coming years. Another area of improvement is the Client Level Reporting Project. Three (3) regions in Idaho have helped develop and are using a data dictionary to assist other regions; this demonstrates the willingness to promote consistency across the State.

The SPCMH continues to advocate and monitor the array of available services and to provide a voice for those without a voice. We strive to keep the Governor and State Legislature apprised of the need for providing quality mental health services to our citizens. We are committed to improving services for all individuals affected by mental illness.

Sincerely,



Teresa Wolf, Chair  
Idaho State Planning Council on Mental Health

# Idaho

## Appendix A (Optional)

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



C. L. "BUTCH" OTTER  
GOVERNOR

August 27, 2009

Ms. LouEllen Rice  
Grants Management Officer  
Division of Grants Contract Management  
OPS, SAMHSA  
5600 Fishers Lane, Room 13-103  
Rockville, MD 20857

Dear Ms. Rice:

I hereby delegate authority to make application to the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services, for Idaho's FY2010 Community Mental Health Block Grant to the Director of the Department of Health and Welfare, Richard M. Armstrong.

This delegation of authority is effective immediately. It extends to any changes or additions to the grant, including assurances required by Congress or the Executive Branch.

As Always – Idaho, "Esto Perpetua"

A handwritten signature in black ink, appearing to read "C. L. Butch Otter".

C. L. "Butch" Otter  
Governor of Idaho

CLO:/sns



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER - GOVERNOR  
RICHARD M. ARMSTRONG - DIRECTOR

OFFICE OF THE DIRECTOR  
450 W. State Street, 10th Floor  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-5500  
FAX 208-334-6558

August 21, 2009

A. Kathryn Power, M.Ed., Director  
Center for Mental Health Services  
Substance Abuse and Mental Health Services Admin.  
5600 Fishers Lane  
Rockville MD 20857

Dear Ms. Power:

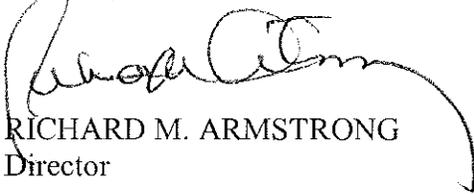
**RE: State of Idaho, FFY 2010 Federal Community Mental Health Services Block  
Grant Application**

I am pleased to submit to you Idaho's FFY2010 Community Mental Health Services Block Grant application.

This is a one-year plan. As in previous years, it is a single, integrated plan and application covering both adult and children's services.

Thank you for consideration of this application and your ongoing support of our efforts to improve the lives of adults with serious mental illness and children with serious emotional disturbance in Idaho.

Sincerely,



RICHARD M. ARMSTRONG  
Director

RMA/re

**Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT  
FUNDING AGREEMENTS**

FISCAL YEAR 2010

I hereby certify that Idaho agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

**Section 1911:**

Subject to Section 1916, the State<sup>1</sup> will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

**Section 1912**

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

**Section 1913:**

(a)(1)(C) In the case for a grant for fiscal year 2010, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

---

<sup>21</sup>. The term State shall hereafter be understood to include Territories.

- (A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

**Section 1914:**

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

- (A) the principle State agencies with respect to:
  - (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
  - (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
- (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
- (C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
- (D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

- (A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

**Section 1915:**

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

**Section 1916:**

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

**Section 1941:**

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

**Section 1942:**

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

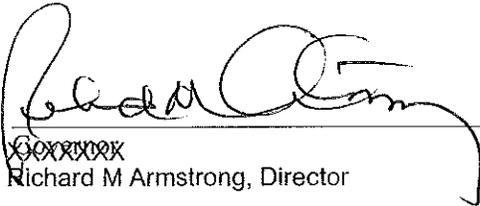
- (1) make copies of the reports and audits described in this section available for public inspection within the State; and
- (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

**Section 1943:**

(a) The State will:

- (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
- (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
- (2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
- (3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

  
~~XXXXXX~~  
Richard M Armstrong, Director

8/21/2009  
Date

## CERTIFICATIONS

### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
  - (1) The dangers of drug abuse in the workplace;
  - (2) The grantee's policy of maintaining a drug-free workplace;
  - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

- point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management  
 Office of Grants Management  
 Office of the Assistant Secretary for Management and Budget  
 Department of Health and Human Services  
 200 Independence Avenue, S.W., Room 517-D  
 Washington, D.C. 20201

### 3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

### 4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

**5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL 	TITLE Director
APPLICANT ORGANIZATION Idaho Department of Health and Welfare	DATE SUBMITTED 8/21/2005

**DISCLOSURE OF LOBBYING ACTIVITIES**

Approved by OMB  
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352  
(See reverse for public burden disclosure.)

<b>1. Type of Federal Action:</b>  <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<b>2. Status of Federal Action</b>  <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	<b>3. Report Type:</b>  <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change  <b>For Material Change Only:</b> Year _____ Quarter _____  date of last report _____
<b>4. Name and Address of Reporting Entity:</b>  Prime _____ Subawardee _____  Tier _____, if known:  Congressional District, if known: _____		<b>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b>    Congressional District, if known: _____
<b>6. Federal Department/Agency:</b>	<b>7. Federal Program Name/Description:</b>  CFDA Number, if applicable: _____	
<b>8. Federal Action Number, if known:</b>	<b>9. Award Amount, if known:</b> \$ _____	
<b>10. a. Name and Address of Lobbying Entity</b> (if individual, last name, first name, MI):	<b>b. Individuals Performing Services</b> (including address if different from No. 10a.) (last name, first name, MI):	
<b>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</b>		
Signature: _____  Print Name: _____  Title: _____  Telephone No.: _____ Date: _____		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)
<b>Federal Use Only:</b>		

## INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.  
  
(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

**ASSURANCES - NON-CONSTRUCTION PROGRAMS**

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

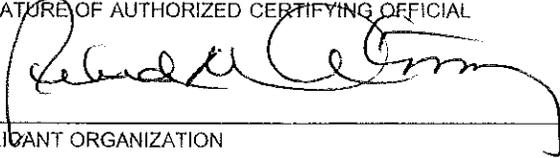
**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.**

**Note:** Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age;
- (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL 	TITLE Director	
APPLICANT ORGANIZATION Idaho Department of Health and Welfare		DATE SUBMITTED 8/21/2009



# IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER - GOVERNOR  
RICHARD M. ARMSTRONG - DIRECTOR

OFFICE OF THE DIRECTOR  
450 W. State Street, 10th Floor  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-5500  
FAX 208-334-6558

August 21, 2009

Admiral Eric Broderick, DDS, MPH  
SAMHSA  
1 Choke Cherry Rd., Rm. 8-1065  
Rockville, MD 20580

Dear Admiral Broderick:

**RE: Idaho's Community Mental Health (MH) Block Grant Request for Maintenance of Effort (MOE) Waiver**

The State of Idaho, like many states, has fallen victim to the national economic crisis. The impact to the state economy has required reductions in state funding for all publicly funded services and supports. The Mental Health system in Idaho shares in the state's budgetary challenge to meet the State's Constitutional mandate to maintain a balanced budget.

The State of Idaho is requesting a WAIVER based on Extraordinary Economic Conditions for the 2010 Community MH Block Grant's Maintenance of Effort (MOE) requirement because the State of Idaho will not meet its MOE obligation. It is the first time the State of Idaho has requested the MOE WAIVER. Over the past seven (7) years, the Mental Health system in Idaho has realized steady growth; however, this year is an unfortunate and predictable exception.

This request for a WAIVER is based on the reduction in state funding for mental health services, both in the adult and children's programs. Please see the description below that will outline the circumstances which necessitate this request.

SFY2007	SFY2008	SFY2009
State Expenditures	State Expenditures	State Expenditures
\$ 29,859,900	\$ 30,935,028	\$ 23,293,500

State expenditures on mental health services in Idaho were reduced \$7,641,528 from SFY2008 to SFY2009. This resulted in a 23.37% overall reduction in spending for SFY2009 from the average of the prior two years. Attached, please see the MOE Expenditures Record spreadsheet for further information regarding expenditure data.

In order to qualify for the WAIVER, the state must meet the requirements for Extraordinary Economic Conditions. As explained in the FY2009-FY2011 Community MH Services Block Grant Application Guidance and Instructions, Extraordinary Economic Conditions are defined as financial crisis that results in a minimum one and one half (1½%) percentage decline in total state tax revenue and an increase in unemployment by one (1%) percentage point.

The Idaho Division of Financial Management, the state agency responsible for reporting on Idaho's economy and budget (including tax revenue), reports that the State of Idaho's total State General Funds revenue in SFY2008 was \$2,909.4 million and the total State General Funds revenue in SFY2009 was \$2,465.6 million. This is a decline of \$443.8 million or 15.3%.

The Idaho Department of Labor, the state agency responsible for reporting on Idaho's employment and unemployment, reports that Idaho's unemployment rate is at its highest level since 1983. The unemployment rate in June of SFY2008 was 4.7% compared to 8.4% in June of SFY2009. The result is a 3.7% increase in unemployment from SFY2008 to SFY2009.

Attached to this letter of request for a WAIVER to the MOE requirement for the State of Idaho are published reports from the Idaho Division of Financial Management and the Idaho Department of Labor that details the above stated information.

In Idaho, as with many states, the global financial crisis has greatly impacted state economy and mental health system budget. Idaho has, and continues to take every possible precaution to deal with the budget challenges in a way that limits the effect on mental health consumers and their families. We believe Idaho is poised to rebound from these difficult economic times and the result will be a leaner and stronger economy.

Thank you for your consideration of this request for a WAIVER from the MOE requirement for the FY2010 Community Mental Health Block Grant for the State of Idaho.

Sincerely,



RICHARD M. ARMSTRONG  
Director

RMA/re

c: Barbara Orlando  
Holly Berilla  
Kathleen P. Allyn  
Laurie Hancock

**Idaho Division of Behavioral Health  
Community Mental Health Services Expenditure History  
SFY 2002 thru SFY 2010**

App.	SFY	Expenditure	Two-Year Average	\$ Difference	% Diff.	BG Amount	Service Level
2000	1999						
2001	2000						
2002	2001						
2003	2002	\$ 16,928,500					
2004	2003	\$ 16,987,700					
2005	2004	\$ 17,322,600					
2006	2005	\$ 19,878,800	\$ 17,155,150	\$ 2,723,650	15.88%		
2007	2006	\$ 26,382,900	\$ 18,600,700	\$ 7,782,200	41.84%		
2008	2007	\$ 29,859,900	\$ 23,130,850	\$ 6,729,050	29.09%		
2009	2008	\$ 30,935,028	\$ 28,121,400	\$ 2,813,628	10.01%		
2010	2009	\$ 23,293,500	\$ 30,397,464	\$ (7,103,964)	-23.37%		

# IDAHO OUTLOOK

## NEWS OF IDAHO'S ECONOMY AND BUDGET

C.L. "Butch" Otter, Governor  
Wayne L. Hammon, Administrator

Michael H. Ferguson, Chief Economist  
Derek E. Santos, Economist

DIVISION OF FINANCIAL MANAGEMENT

JULY 2009 VOLUME XXXII NO. 1

We are not alone. The U.S. economy is in a recession, but so are most of its trade partners. As the table prepared by IHS Global Insight shows, five of the seven covered foreign economies are expected to contract this year. China's output is projected to advance 7.2%, but even at this pace, it too is in a recession. The global economy is forecast to shrink 2.6% this year.

The global slowdown will suppress trade. Real exports, which began shrinking in late 2008, are expected to continue contracting through most of this year. Specifically, they fall at a 30.6% annual rate in the first quarter of 2009, by 11.8% in the second quarter, and 1.1% in the third quarter. Interestingly, real imports into the U.S. are more impacted during the first half of this year than exports. They fall at a 36.4% annual clip in the first quarter of 2009 followed by a 17.5% drop in the second quarter. As a result, the real net export (export less imports) deficit actually slips just below \$300 billion in the first quarter and falls further to \$262 billion in the second quarter, which is its low point for the next few years. The U.S. trade deficit grows in this

year's second half as rising domestic demand boosts imports.

On an annual basis, the real net exports deficit is forecast to improve from \$390 billion in 2008 to \$317 billion in 2009. The deficit jumps to \$406 billion the next year. But after this increase, the real net exports deficits are expected to drop to \$402 billion in 2011 and to \$389 billion in 2012, as growing demand in recovering foreign economies causes real exports to grow faster than real imports. As a result, net exports will be less of a drag on the U.S. economy than they had been in the recent past.

Real net exports will largely be determined by how well our trade partners' economies recover. Each will have its own shape and its own risks. Europe is expected to have an "L-shaped" recovery. There are growing fears that Europe's recovery will not only start after the U.S. recovery, but it will be weaker. There are several reasons for this disappointing outlook. First, because this economy is much more dependent than the U.S. on exports, its recession will be deeper. Second, banking problems in Europe are

as bad, if not worse, than in the U.S. In addition, they are not nearly as far as the U.S. toward solving their financial troubles. Third, the region's fiscal and monetary response to its recession has been more measured than in the U.S.

China is at risk of experiencing a "W-shaped" recovery. While China has been the first major economy to improve, the recent softening of exports suggest it may still face challenges. In fact, after rebounding strongly, China's purchasing managers' index has begun to flatten out in recent months. The large government stimulus program has had a strong impact on capital spending, but almost no impact on retail sales and consumer spending. The liquidity injections into the economy have helped out but are beginning to moderate. China is forecast to grow 7.2% this year and 8.3% next year. Nevertheless, it remains vulnerable to a "double-dip" recession if growth falters when the massive stimulus wears off, consumer demand does not grow rapidly, and exports fail to expand at a double-digit pace.

Japan's economy must clear several high hurdles in the near future. Its recession probably ended this spring. However, the second and third quarters of 2009 are likely to be flat. Domestic demand remains weak, with fixed investment and construction spending falling, and consumer spending moving sideways. In addition, deflation still plagues the world's second largest economy. While its government has promised large amounts of fiscal stimulus, in reality it is only likely to amount to 2.0% to 2.5% of its GDP. Japan's real output is expected to drop 6.8% this year and rise just 0.9% next year. Even after the global business cycle improves, continued structural problems in Japan will threaten an extended period of anemic growth.

Projected Real GDP			
	2008	2009	2010
United States	1.1%	-2.8%	1.5%
Canada	0.4%	-2.3%	2.3%
Japan	-0.7%	-6.8%	0.9%
Europe	0.6%	-4.6%	0.1%
Mexico	1.4%	6.0%	2.4%
South America	4.9%	-1.0%	2.6%
Asia except Japan	5.7%	3.2%	5.7%
China	9.0%	7.2%	8.3%
World	2.2%	-2.6%	2.0%

Source: IHS Global Insight

# Idaho General Fund Update

As of June 30, 2009

\$ Millions				
Revenue Source	FY 2008 Actual	FY 2009 Executive Estimates Jan. 2008	FY 2009 Executive Estimates Feb. 2009 <sup>1</sup>	FY 2009 Actual
Individual Income Tax	1,430.2	1,423.4	1,222.6	1,167.9
Corporate Income Tax	189.3	187.8	156.5	141.0
Sales Tax	1,142.5	1,249.3	1,041.6	1,022.2
Product Taxes <sup>2</sup>	26.8	37.7	29.7	29.7
Miscellaneous	120.7	113.7	110.1	104.7
<b>TOTAL GENERAL FUND<sup>3</sup></b>	<b>2,909.4</b>	<b>3,011.9</b>	<b>2,560.4</b>	<b>2,465.6</b>

<sup>1</sup> Executive estimate as adjusted for 2008 legislative action  
<sup>2</sup> Product Taxes include beer, wine, liquor, and cigarette taxes  
<sup>3</sup> May not total due to rounding

General Fund revenue finished FY 2009 \$94.8 million lower than expected based on the February 2009 Executive Revenue Forecast. The month of June contributed a net of -\$19.7 million to this weak finish. June's weakness was across the board, with each of the five main revenue categories coming in lower than expected. The bulk of June's weakness was spread across the big three—individual and corporate income tax and sales tax. Only the product tax category managed to complete the full fiscal year ahead of the forecast—by a tiny \$0.1 million margin. Over half of the fiscal year revenue shortfall was due to weakness in the individual income tax (-\$54.7 million), but the corporate income tax and sales tax each contributed substantially to the shortfall as well.

Individual income tax revenue was \$8.2 million lower than expected in June, and finished the fiscal year \$54.7 million below the February 2009 forecast. Instead of falling by 14.5% (per the February 2009 forecast), individual income tax receipts finished FY 2009 18.3% below the FY 2008 level. This

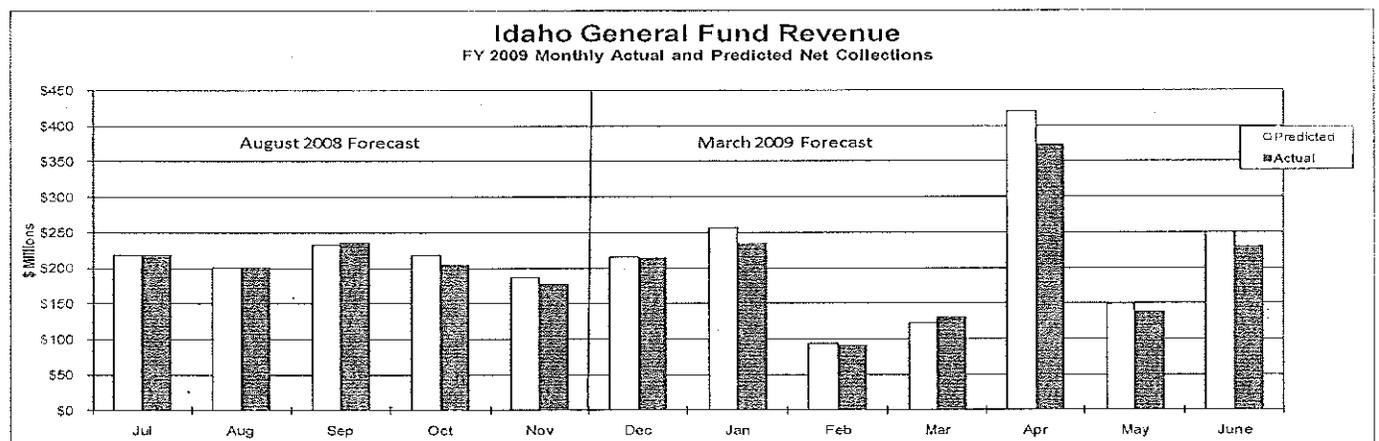
outcome was due to a combination of filing collections that were down 25.8% (versus a forecasted decline of 24.6%), withholding collections that were down 6.2% (versus a forecasted decline of 3.8%), and refunds that were up 13.3% (versus a forecasted increase of 5.2%). FY 2009 actual individual income tax collections fell below the levels attained in each of the preceding three fiscal years.

Corporate income tax revenue was \$4.5 million below expectations in June and finished the fiscal year \$15.4 million below the February 2009 forecast. Instead of falling by 17.3% (per the February 2009 forecast), corporate income tax revenue actually fell by 25.5% in FY 2009. This outcome was due to a combination of filing collections that were down 27.6% (versus a forecasted decline of 10.2%), estimated payments that were down 13.3% (versus a forecasted decline of 14.0%), and refunds that were up 42.2% (versus a forecasted increase of 25.8%). This is the third consecutive year of decline. FY 2009 actual corporate income tax collections fell below the levels attained in each of the preceding three fiscal years (and barely

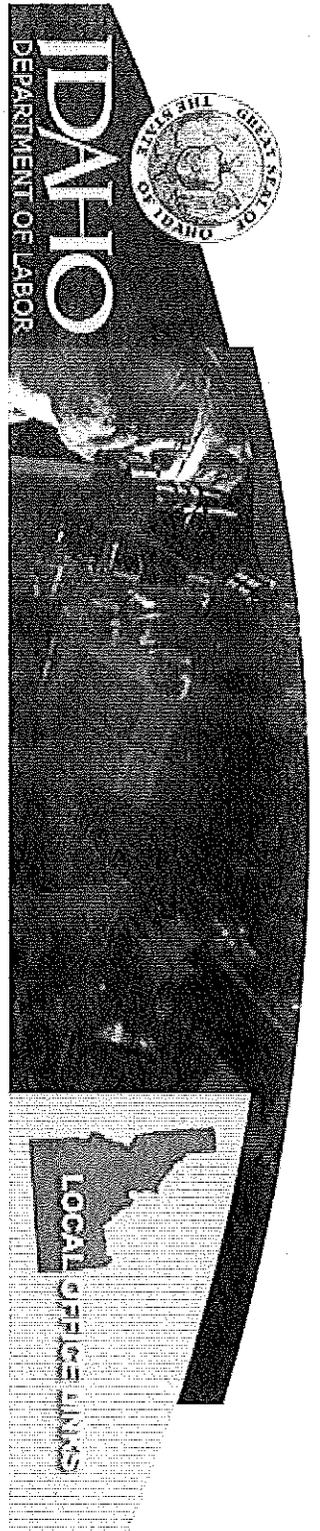
exceeded the FY 2005 level by a mere \$1.5 million).

Sales tax revenue was \$3.9 million lower than expected in June, and finished the fiscal year \$19.4 million below the forecasted amount. Instead of falling by 8.8% (per the February 2009 forecast), sales tax revenue actually fell by 10.5% in FY 2009. This is the second year of decline for the sales tax on a normalized basis (i.e., adjusted for rate and distribution changes), and as in the case of the income taxes, the FY 2009 level of sales tax was lower than each of the past three fiscal years.

Product taxes were slightly behind target (\$0.1 million) in June and slightly ahead of the forecast (\$0.1 million) for the full fiscal year. Miscellaneous revenues were \$3.1 million lower than expected in June and finished the fiscal year \$5.4 million lower than forecast. Within the miscellaneous category interest earnings were \$3.2 million lower than expected in June and \$5.3 million lower than the forecast for the full fiscal year.



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## Press Release

Date: 7/10/2009

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### U.S. Labor Department Boosts Idaho's June Jobless Rate to 8.4%

The U.S. Department of Labor readjusted Idaho's forecasted unemployment rate on Friday, adding another point to put the seasonally adjusted rate for June at 8.4 percent, compared to 7.8 percent for May and 4.7 percent a year ago.

Idaho's revised rate remained the highest unemployment rate the state has recorded since September 1983. This is the fourth time Idaho's forecasted rate has been adjusted in the past year, but the first time it's been adjusted upward.

Federal analysts determined Idaho's labor force – the number of workers with jobs or looking for jobs – did not decline as significantly from May as earlier believed and reduced the decline from 2,900 to 1,600. While that increased total employment for the month to 686,500, still the lowest employment level since March 2005, it added 500 to the number of unemployed, pushing it to 62,700. Total unemployment for the state of Idaho has set a record in eight of the last nine months including June.

**C.L. "BUTCH" OTTER,**  
**GOVERNOR**  
 Roger B. Madsen, Director  
 Equal Opportunity Employer