

Idaho

**UNIFORM APPLICATION
2011**

**STATE PLAN
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT**

OMB - Approved 08/06/2008 - Expires 08/31/2011

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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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FACE SHEET
FISCAL YEAR/S COVERED BY THE PLAN
X FY2011

STATE NAME: Idaho
DUNS #: 82-520-1486

I. AGENCY TO RECEIVE GRANT

AGENCY: Idaho Department of Health and Welfare
ORGANIZATIONAL UNIT: Division of Behavioral Health
STREET ADDRESS: 450 W. State St.

CITY: Boise STATE: ID ZIP: 83720-0036

TELEPHONE: 208-334-6997 FAX: 208-332-7291

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Richard M Armstrong TITLE: Director
AGENCY: Idaho Department of Health and Welfare
ORGANIZATIONAL UNIT: Division of Behavioral Health
STREET ADDRESS: 450 W. State St.

CITY: Boise STATE: ID ZIP CODE: 83720-0036

TELEPHONE: (208) 334-5500 FAX: (208) 334-6558

III. STATE FISCAL YEAR

FROM: 07/01/2010 TO: 06/30/2011

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Cynthia Clapper TITLE: Program Specialist
AGENCY: Idaho Department of Health and Welfare
ORGANIZATIONAL UNIT: Division of Behavioral Health
STREET ADDRESS: 450 W. State St.

CITY: Bosie STATE: ID ZIP: 83720-0036

TELEPHONE: 208.334.5527 FAX: 208.332.5998 EMAIL: clapperc@dhw.idaho.gov

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, quality assurance and technical assistance to regional service programs.

The Idaho Community Mental Health Block Grant Application is a one-year plan (FFY 2011) 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 Idaho State Planning Council on Mental Health and the children's and adult mental health programs. The Idaho State Planning Council on Mental Health 2010 Report to the Governor and State Legislature (July 2010) is also an important source of direction for the FFY 2011 Plan. The children's program plan for FFY 2011 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.

The priority service population for adults in SFY 2011 will be adults with a serious mental illness who are in crisis and individuals who qualify according to statutory mandates. These include adults referred by a judge under Idaho Code Section 19-2524, which 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, 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 is subject to modification by the court.

A major emphasis of the adult plan is system transformation in order to create an outcome driven system of care for persons with serious mental illness and substance use disorders. Maintaining and integrating funding for community mental health services and for consumer and family empowerment are also priority areas of the adult plan, as well as an emphasis of the themes of (a) accountability, and (b) better integration of treatment for substance use disorders. Both plans address development of information systems and outcomes measures for improved accountability and continuous quality improvement.

Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2011

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 State¹ 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 2011, 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:

²¹. 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.

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.)

1. Type of Federal Action: <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	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: Prime _____ Subawardee _____ Tier _____, if known: Congressional District, if known: _____		5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known: _____
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, if applicable: _____	
8. Federal Action Number, if known:	9. Award Amount, if known: \$ _____	
10. a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i>	b. Individuals Performing Services <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i>	
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.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____	
Federal Use Only:		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, re- gulations and policies governing this program.

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

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.

The draft of the SFY 2011 Mental Health Block Grant was uploaded to WebBGAS on August 3, 2010. An e-mail notification of the completed draft with instructions to access this document on WebBGAS was e-mailed on that date to the State Planning Council, to the Administrator of the Division of Behavioral Health and to the hospital administrators. Similar information was sent to the regional program managers. The members of the Planning Council were responsible to disseminate the information through regional boards. Comments were reflected in revisions to the plan and these were re-uploaded. The planners discussed the plan with the Planning Council face to face at their August 18 meeting, and feedback was incorporated into revisions that were uploaded into WebBGAS.

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 2009	Estimate/Actual FY 2010
<u>\$538,391</u>	<u>\$7,267,500</u>	<u>\$6,279,600</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 Actual FY Actual/Estimate FY

2008	2009	2010
<u>\$30,935,028</u>	<u>\$23,293,500</u>	<u>\$20,430,000</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

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
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

TABLE 1.

List of Planning Council

Members

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

TABLE 1.

List of Planning Council

Members

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. Manitaba 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:	bkauffman1951@q.com
Koltes, MD, Lisa	State Employees	Mental Health	1660 11th Ave. North Nampa, ID 83687 PH:208.453.9470 FAX:	koltesl@dhw.idaho.gov
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
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

TABLE 1.

List of Planning Council

Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
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	State Employees	Other	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
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

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	23	
Consumers/Survivors/Ex-patients(C/S/X)	4	
Family Members of Children with SED	3	
Family Members of adults with SMI	3	
Vacancies(C/S/X and Family Members)	2	
Others(not state employees or providers)	5	
TOTAL C/S/X, Family Members and Others	15	65.22%
State Employees	7	
Providers	1	
Vacancies	3	
TOTAL State Employees and Providers	8	34.78%

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.

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.

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.

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 strives to maintain 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 Native American communities are also represented on the Council.

In SFY 2010, the Idaho State Planning Council experienced some challenges with respect to maintaining the desired ratio of consumer and family member representation. One family member did not attend meetings and was released of her membership. One consumer and his mother filled both a consumer and a family member role. They moved and these positions have not yet been filled. The Council also lost several professional members during the past year. Judge Moss passed away. The corrections representative resigned after taking another position. A representative of a private provider advocacy group also resigned. There have not been many applications to replace these positions. The Council's recruitment subcommittee is charged with efforts to fill all vacant positions and they have been working on this.

The SFY 2010 funding for Council meetings was \$20,000, and efforts were made to save money through use of fewer face to face meetings, thereby reducing travel costs. This past year, the Council conducted business through one teleconference meeting, two face to face meetings, phone conference calls and interim subcommittee meetings.

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 traditionally 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. 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 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. In SFY 2010 and projected through SFY 2011, the State Planning Council on Mental Health plans to increase Regional Mental Health Board input into their efforts to identify mental health system strengths, weaknesses, unmet needs and strategies to address those needs.

The Council maintains five standing subcommittees. The Legislative/Advocacy & Education subcommittee, the Suicide Prevention 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.

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 the State System

The Idaho Department of Health and Welfare (IDHW) operates within the Executive Branch of Idaho state government. IDHW is composed of the Divisions of Public Health, Behavioral Health, Family and Community Services, Welfare, Medicaid, Information Technology, and Operational Services. The Division of Behavioral Health's Central Office includes Adult Mental Health, Children's Mental Health, Substance Use Disorders and a Data Unit. The Central Office component of the Division of Behavioral Health provides system coordination and leadership, policy and standards development, rule promulgation and interpretation, technical assistance, training, consultation, funding application and regulation, and quality assurance monitoring.

The Department of Health and Welfare is designated by statute (Idaho Code Section 39-3124) as the State Mental Health Authority (SMHA). Most of the SMHA responsibilities are carried out by the Division of Behavioral Health with IDHW.

The Division of Behavioral Health (DBH) includes the Adult Mental Health program, the Children's Mental Health program, and the Substance Use Disorders program. Idaho's two (2) state psychiatric hospitals, State Hospital North and State Hospital South, are also under the jurisdiction of the DBH Administrator. State Hospital North serves adults only while State Hospital South serves both adults and adolescents.

Adult and Children's Mental Health services are provided through state operated community mental health centers (CMHC's) located in each of the seven (7) IDHW geographically defined Regions. Historically, each of the regions was under the supervision of a Regional Behavioral Health Program Manager, and all seven (7) Regional Behavioral Health Program Managers reported to the Bureau Chief in the Division of Behavioral Health. The Bureau Chief reported to the Division Administrator.

Idaho Code Section 19-2524, effective in SFY 2007, gives judges additional sentencing options for felons with substance abuse and mental illness diagnoses. The law allows a judge to order a substance abuse assessment and/or a mental health examination for felons and felony parole violators that appear before the court. Based on the results of an assessment or examination, a judge may order, as a condition of probation, that the defendant undergoes treatment consistent with a treatment plan contained in the assessment or examination report. A treatment plan is subject to modification by the court.

The Division of Behavioral Health has formed strong collaborations with regional Mental Health Courts, and these courts refer individuals to treatment through ACT programs. Budget cuts in SFY 2009 and SFY 2010 resulted in reduced regional staff and closure of nine rural offices. The priority adult treatment populations to be served through the public mental health service system for SFY 2011 will be adults who are in crisis or subject to involuntary commitment to DBH and those individuals under statutory mandates related to court ordered services. This includes individuals who are court

ordered under Idaho Code Sections 19-2524, 18-211/212, and 66-329. While regional programs may continue to retain some eligible individuals who have Medicaid and who are unable to be served in the private sector because of challenging needs or behaviors, efforts are being made to refer all Medicaid eligible individuals to private community resources.

Additional organizational changes are planned for DBH in SFY 2011. Effective July 1, 2010, the seven (7) Regions are being organized into three service areas or “hubs.” The Behavioral Health Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). For now, the Program Managers in Region 3, Region 4, and Region 5 will report to the Mental Health Bureau Chief in DBH central office (southwestern hub). A legislative decision unit has been drafted to submit to the 2011 Idaho Legislature to fund a hub Administrator for the southwestern hub.

The projected SFY 2011 organizational structure for DBH will consist of an Administrator with oversight over five major areas: Mental Health Policy and Programs Bureau for AMH and CMH Policies and Programs; a Substance Use Disorders Program; a Quality Assurance Program; a Data Unit and Mental Health Services composed of the three service hubs. The proposed management team for the Division of Behavioral Health for SFY 2011 will be formed from the hub heads and the unit leads.

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 negatively impacted by the recession in SFY 2009 and SFY 2010. Several companies laid off employees, with serious layoffs in construction, retail and manufacturing. One of Idaho's largest manufacturing employers, Micron, laid off over 3,000 employees between October 2008 and February 2009.

Idaho Department of Labor statistics indicate that the June 2009 unemployment rate of 8.3 percent was a 25-year high, and is reflective of a June 2009 figure of over 62,000 unemployed compared to a June 2008 number of less than 36,000. According to the State of Idaho Department of Labor (article 'Idaho jobless rate drops again as labor force declines' at <http://labor.idaho.gov/news/Press>), the June 2010 unemployment rate "... was forecast at 8.8 percent, matching the rate for October 2009 when unemployment across Idaho was climbing to a peak of 9.5% this February. While down substantially from that peak, the rate is still the highest prior to this recession since July 1983." The June 2010 number of unemployed was estimated at 66,700. Hiring levels for manufacturing, leisure and business were normal in June 2010, but the Department of Labor reports that "Government cut jobs by nearly triple the percentage typically shed in June, reflecting cuts made to accommodate tax revenues slashed by the recession." County unemployment rates ranged from a low of 4.9% in Teton County to a high of 12.6% in Power County.

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. The eligibility rules that prevented those with assets over \$2,000 from qualifying for food assistance were temporarily suspended on June 1, 2009. The Idaho Statesman reported (June 4, 2010; Idaho food stamp surge tops nation) that in the last half of SFY 2010, the Department of Health and Welfare "...processed an average of 8,500 applications for food stamp assistance per month." As of July 2010, Idaho had an estimated 200,000 citizens who were receiving food stamps (7/6/2010, Idaho Food Stamp Use Doubles National Increase; fox12idaho.com).

In response to concerns about increasing Medicaid cost, the 2009 Idaho Legislature passed House Bill 123 (2009), which reduced reimbursement rates to several categories of providers (including hospitals, nursing homes, intermediate care facilities, physicians and dentists) and removed non-emergency transportation from the program's basic plan. The 2010 Idaho Legislature set forth detailed directions in legislative intent language attached to the SFY 2011 appropriation (House Bill No. 701 (2010)) on the processes for Medicaid to follow in making any further reductions in payments or benefits. Those processes included reducing Medicaid rates to Medicare rates, negotiating rate reductions with providers, implementing additional managed care contracts, and exploring waivers for services, including mental health services. In an effort to invite public input to "...address a projected \$247 million budget deficit for SFY 2011.." the Idaho Division of Medicaid launched the (www.MedicaidNeedsYourIdeas.dhw.idaho.gov) website in May

2010. Medicaid also held a series of public meetings in May 2010 to gather information from providers before determining strategies, policy changes and temporary rules to recommend to the 2011 Legislature.

Idaho also implemented a new Medicaid Management Information System (MMIS) which began operation on June 7, 2010. This system includes claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals. The implementation has added to difficulties being experienced in the Medicaid program that could impact clients. As of July 2010, some private providers reported that cuts in Medicaid payments and payment delays for services presented challenges to staying in business.

Idaho has had limited success in taking advantage of funds available through the American Recovery and Reinvestment Act of 2009. 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 match 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 initial approval for approximately 3,136 employees in SFY 2009, 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 layoffs of 23 people of whom 12.5 were from DBH; an additional required four days of furlough for all state employees; vacancy savings from keeping an additional 27 positions open of which 16 were in DBH; and a transfer of budget funds from operations to personnel.

The Department of Health and Welfare experienced additional cuts in SFY 2010. Furloughs for all staff were established from January 2010 through June 2010 on every other Friday. In response to SFY 2011 budget cuts, nine offices were closed in May 2010 in rural areas and 126 employees were laid off in an effort to save \$7 million.

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).

In 2007, 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.

Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with 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, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision and Goals:

Vision

Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery.

Goals

1. Increase availability of and access to quality services
2. Establish an infrastructure with clear responsibilities and actions
3. Create a viable regional and/or local community delivery system
4. Efficiently use existing and future resources
5. Increase accountability for services and funding
6. Seek and include input from stakeholders and consumers

Using a number of subcommittees the BHTWG developed a proposed organizational structure and core services for the transformed state behavioral health system. During the late summer and early fall of 2010, the BHTWG will be soliciting feedback on its proposals in preparation for a report to the Governor and 2011 Legislature on its recommendations, including next steps.

3. Mental Health Data System Activities

The Division of Behavioral Health was awarded a Client Level Reporting Project (CLRP) grant in the winter/spring of 2008. This award allowed 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).

During SFY 2009, the two State Hospitals (North and South) completed basic activities related to 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 CLRP data element definitions of the NOMS. This was completed by June 2009, with implementation and training for AMH in October 2009. Efforts continued during SFY 2010 to train users and enhance the WITS system to eventually support report extraction for all NOMS and URS. Implementation of the VistA system in the State Hospitals is also nearing completion. A data warehouse is anticipated to be completed in SFY 2011. The data warehouse will facilitate data storage and report extraction. Central Office is working on a WITS manual that will facilitate training and allow increased consistency and standardization of data entry into the WITS system for AMH. In addition, DBH is assessing the feasibility of converting children's mental health data to the WITS system.

4. Patient Assistance Program (PAP)

A Patient Assistance Program (PAP) software package was purchased for approximately \$50,000 in SFY 2009. 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. Estimated PAP cost savings for the first three quarters of SFY 2010 was \$9,694,973.

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, Idaho State School and Hospital 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.

Installed for over 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 that Idaho would be included in the list of states that will use videoconferencing to conduct mental health block grant review meetings in the fall of 2010. This process will save state employee time and federal money that has historically been directed to allow staff to travel to another state for block grant defense.

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. In May 2009, contracted psychiatrists were providing telemedicine from the Boise Central Office, with Region 2 estimating 360 clients receiving these services from 9/08 through 5/09. Region 7 used these services for an estimated 180 clients from 2/09 through 5/09. A total of 740 scheduled appointments (duplicative client count) were made for Region 2 clients from throughout the Region from July 7, 2009 through June 30, 2010. These services were provided through video equipped offices in Lewiston and Orofino.

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. In SFY 2010 (July 2009 to June 2010), the total estimated savings across all users was \$465,706.

6.Forensics

Idaho Code Section 19-2524, effective in SFY 2007, allows judges broadened sentencing options for felons with substance abuse and mental health disorders. The law allows a judge to order a substance abuse assessment and/or a mental health examination for felons and felony parole violators who appear before the court. Based on the results of an assessment or examination, 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 is subject to modification by the court.

DBH has formed strong collaborations with regional Mental Health Courts, and these courts refer individuals to DBH for treatment. The model used to support mental health court referrals are ACT teams that work with court representatives to develop an individualized treatment plans for court clients. The treatment plans are intended to help participants to stabilize and learn additional life management skills such as taking necessary medications, ending drug and alcohol abuse and avoiding criminal activities that brought them into the legal system. Regional AMH programs 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, and this was similar in SFY 2010.

Budget cuts in SFY 2009 and SFY 2010 resulted in reduced regional staff and closure of nine rural offices. The priority adult treatment populations to be served through the public mental health service system for SFY 2011 will be adults who are in crisis as determined by designated examinations and those individuals under statutory mandates related to court ordered services. This includes individuals who are court ordered under 19-2524, 18-211/212, and 66-329. While regional programs may continue to retain some clients who are voluntary without any insurance or other resources and some eligible individuals who have Medicaid and who are unable to be served in the private sector because of challenging needs or behaviors, efforts are being made to refer to private community resources.

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 demonstrated significant cost savings through

hospital diversion and high reports of participant satisfaction, it was terminated in May 2010 because of lack of funds.

8. Wood Pilot Project

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, funds were allocated to support similar one-time projects. Additional funds in the amount of \$1,240,000 were allocated to support one Multi-year Development Grant project. The Multi-Year Development grant was awarded to the Bonneville County's Substance Abuse/Mental Health Treatment Program, aka the Wood Pilot Project. The Wood Pilot Project continues to operate with a focus on implementation of a Substance Abuse and Mental Health treatment program for male and female offenders who are likely to be sentenced to corrections facilities. Treatment services include assessments, drug testing, treatment curriculum and treatment staff. This project also included purchase of Client Reporting Software (i.e., WITS). The state funding for SFY 2011 was reduced by the Legislature to \$1,083,400 because of budget holdbacks.

9. Detoxification Center

The Allumbaugh House opened in Boise, Idaho on May 1 2010 as a resource to Idaho citizens in Region 4. Services provided by this facility include crisis mental health, medically monitored chemical detoxification and sobering stations. Operations are managed by Terry Reilly Health Services. An estimated 100 people per month were served in the first three months of operation, with an average length of stay of three to four days. Referrals to the sobering station must be from health care providers or local law enforcement. Mental health service referrals may be from public or private health care providers. The detoxification program accepts self referrals and referrals from public and private health care providers. Terry Reilly indicates that one of the biggest challenges and successes relates to the diversity of players (e.g., private groups, city, county, state government) that collaborated to create the Allumbaugh House. The state was originally scheduled to contribute \$900,000 annually to the project. However, this amount was reduced by the Legislature to \$787,400 for SFY 2011.

10. 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 in 2009. This project was funded with Mental Health Block Grant dollars. As of June 2010, there were 47 Peer Specialists who completed the training and passed the certification exam. The Office of Consumer Affairs supervises placement of seven certified Peer Specialists; 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.

11. Housing and Homelessness

An SFY 2009 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. While PATH funds were distributed to each of seven regional behavioral health centers in SFY 2010, plans for SFY 2011 are to offer a Request for Proposals for PATH service delivery across the State of Idaho.

The Charitable Assistance to Community's Homeless (CATCH) program that mobilizes community resources to help address homelessness operated in Region 3 and Region 4 in SFY 2010. The process for accessing Shelter Plus Care beds was standardized in SFY 2009, leading to an increased level of regional involvement with these housing vouchers.

12. Behavioral Health Restructuring

Additional organizational changes are planned for DBH in SFY 2011. Effective July 1, 2010, the seven (7) Regions are being organized into three service areas or "hubs." The Behavioral Health Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). For now, the Program Managers in Region 3, Region 4, and Region 5 will report to the Mental Health Bureau Chief in DBH central office (southwestern hub). A legislative decision unit has been drafted to submit to the 2011 Idaho Legislature to fund a hub Administrator for the southwestern hub.

The projected SFY 2011 organizational structure for DBH will consist of an Administrator with oversight over five major areas: Mental Health Policy and Programs Bureau for AMH and CMH Policies and Programs; a Substance Use Disorders Program; a Quality Assurance Program; a Data Unit and Mental Health Services composed of the three service hubs. The proposed management team for the Division of Behavioral Health for SFY 2011 will be formed from the hub heads and the unit leads.

Adult - Legislative initiatives and changes, if any.

Relevant 2010 Idaho Legislative Changes

There were several relevant pieces of 2010 legislation pertaining to **appropriations**. These House Bills (HB) and Senate Bills (SB) described allowed transfers between personnel costs and operating expenditures; limited transfers of trustee and benefit payments, authorized expenditure of collected receipts and reappropriation of General Funds, cost containment measures and limitations in the number of full time equivalent positions. They also described reductions for FY 2010 and set appropriation amounts for FY 2011 (i.e., Medical Assistance, HB 701; Mental Health Services, HB715; Medically Indigent Administration, HB 716; and Psychiatric Hospitalization, SB 1434). Among other things, House Bill (HB) 701 also provided legislative intent for Medicaid program flexibility for FY 2011. The approved \$2 billion budget for the Department of Health and Welfare reflected 5.6% less general funds than the original SFY 2010 appropriation, with almost 20% less general funds for personnel and operating than what was allocated two years earlier. SB 1445 "Authorizes the transfer of Economic Recovery Reserve Fund moneys, Budget Stabilization Fund moneys and other dedicated fund moneys to the General Fund in fiscal year 2010; authorizes the transfer of Budget Stabilization Fund moneys and Economic Recovery Reserve Fund moneys to the General Fund in fiscal year 2011; authorizes the transfer of Budget Stabilization Fund moneys, Economic Recovery Reserve Fund moneys and Permanent Building Fund moneys to the General Fund in fiscal year 2010 under certain conditions."

Senate Bill 1330 related to "**Archaic Statutory Language**" pertaining to persons with disabilities. This bill amended and added to "...existing law relating to archaic statutory language to revise terminology; to remove redundant language; to remove obsolete language; and to provide legislative intent on respectful language." House Bill 537 addressed qualifications of staff providing services. HB 537 revised **licensing qualifications for social workers**.

House Bill 391 was passed to amend "...existing law relating to health and safety to establish the **Idaho Health Freedom Act**; and to provide for enforcement and to revise the duties of the Attorney General." HB 391, 39-9003, Statement of Public Policy states (1) The power to require or regulate a person's choice in the mode of securing health care services, or to impose a penalty related thereto, is not found in the Constitution of the United States of America, and is therefore a power reserved to the people pursuant to the Ninth Amendment, and to the several states pursuant to the Tenth Amendment. The state of Idaho hereby exercises its sovereign power to declare the public policy of the state of Idaho regarding the right of all persons residing in the state of Idaho in choosing the mode of securing health care services. (2) It is hereby declared that the public policy of the state of Idaho...is that every person within the state of Idaho is and shall be free to choose or decline to choose any mode of securing health care services without penalty or threat of penalty. (3) The policy stated herein shall not be applied to impair any right of contract related to the provision of health care services to any person or group."

House Bill 738 was passed to mandate the establishment of the **Idaho Health Quality Planning Commission** (IHQPC) to coordinate and implement health information technology. The eleven member committee was selected by the Governor's office and included representation from Medicaid, Blue Cross, Regence Blue Shield, local hospitals and practitioners.

House Bill 681 amended Idaho Code pertaining to procedures and services available to Idaho citizens who require services and who are **medically indigent**. Among other things, HB 681 revised definitions, terminology and "...the powers and duties of the county commissioners. It also described intent "...to provide payment procedures...to provide for the prorating of a first lien and to ...revise the services for which payment is to be made."

Relevant Idaho Code changes in SFY 2010 pertained to rules governing Medicaid. The 2010 Idaho State Legislature approved **Rules Governing Medicaid Cost-Sharing** (IDAPA Chapter 16.03.18) that describes the sliding scale, premium payments and premium waivers. As noted on page 26, "The cost savings for this rulemaking for SFY 2010 is estimated at \$210,000 in state general funds." Medicaid Omnibus Bill (HB 708) continued pricing freezes from SFY 2010 through SFY 2011; this bill allowed additional budget reductions that included mandates for pharmacies to participate in periodic cost surveys. Senate Bill 1321 created a notice requirement to allow the Department of Health and Welfare to **track property transfers of Medicaid recipients of long-term-care** to identify where transfer proceeds should be used to either repay Medicaid or pay for the individual's long term care costs. Effective February 1, 2010, the HB 430 legislation created statute governing **Third Party Health Plan Administration**.

The Criminal History Unit submitted rule changes (IDAPA Chapter 16.05.06, **Criminal History and Background Checks to the DHW Board**) as temporary rule, effective July 1, 2010. The purpose of this rule change is to "...remove confusion between the Department's program rules and the CHC rules...to remove definitions and only reference the Department's chapter of rules where an individual is required to have a criminal history and background check."

Additional legislation pertained to Eligibility for Aid to the Aged, Blind and Disabled (AABD), and Minimum Standards for Nonhospital, Medically Monitored Detoxification/Mental Health Diversion Units. The 2010 Idaho Legislature adopted temporary rules described in IDAPA 16.03.05, **Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)**. According to the 2010 Temporary Rule, p. 43, this rule is in response to the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, and "These rules align the Medicare Savings Program for Qualified Medicare Beneficiary (QMB) the Specified Low-Income Medicare Beneficiary (SLMB), and the Qualifying Individual (QI) for Medicare Part B with the Full Benefit Low-Income Subsidy (LIS) Program resource limits."

IDAPA 16.07.50 temporary **Rules and Minimum Standards Governing Nonhospital Medically-Monitored Detoxification/Mental Health Diversion Units** were amended

by the 2010 Idaho Legislature. Amendments (p. 206) included “Allowing a facility with both detoxification and mental health diversion units to divide an employee’s time between the two units,” and amending areas related to medical and general liability insurance, visitation policy, and meal provision. IDAPA 16.07.50 further states on p. 206 that “Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule.”

Relevant 2009 Idaho Legislative Changes

HB 123 amended “...existing law relating to public assistance and welfare to provide for Medicaid reduction.” This bill directed that the quarterly rate at skilled care facilities 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 was implemented in May 2010. This system includes 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 2009/2010 economic downturn did not allow for funding for a new round of grant projects, the opportunity to develop such projects in previous years continued to positively impact the mental health service delivery system through other previously developed programs (e.g., transitional housing, CIT training).

SB 1065 addressed revision of Regional Mental Health Boards 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 stated 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 amended 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 adopted rules governing fees for Community Mental Health Services. IDAPA 16.03.05.08.01 adopted pending rules that aligned 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 amended pending rule “...so that the census income is excluded from Medicaid only.” This allowed 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

House Bill 626 provided 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 allowed for appropriation of funds to the Department of Health and Welfare for state fiscal year 2009 for Community Mental Health Service provision, to continue the Region VII Multi-Year Development grant correctional alternative pilot project and to "...establish dual diagnosis crisis intervention beds in Region 4 that will be contractually operated by Ada County."

Rules changes affecting AMH services in 2008 included IDAPA 16.07.01 and IDAPA 16.07.33. Chapter 16.07.01 outlines rules governing Behavioral Health fee schedules, including charges for Adult Mental Health Services and Charges for Children's Mental Health Services. Chapter 16.07.33 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.

Relevant 2007 Idaho Legislative Changes

SB 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 Programs use the Common Assessment instrument and procedure to respond to this legislation. The Substance Use Disorders program uses the GAIN instrument for their assessments.

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.

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 Department of Health and Welfare is designated by statute (Idaho Code Section 39-3124) as the State Mental Health Authority (SMHA). Most of the SMHA responsibilities are carried out by the Division of Behavioral Health with IDHW. 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 (DBH) includes the Adult Mental Health program, the Children's Mental Health program, and the Substance Use Disorders program. Idaho's two (2) state psychiatric hospitals, State Hospital North and State Hospital South, are also under the jurisdiction of the DBH Administrator. State Hospital North serves adults only while State Hospital South serves both adults and adolescents.

Adult and Children's Mental Health services are provided through state operated community mental health centers (CMHC's) located in each of the seven (7) IDHW geographically defined Regions. Historically, each of the regions was under the supervision of a Regional Behavioral Health Program Manager, and all seven (7) Regional Behavioral Health Program Managers reported to the Bureau Chief in the Division of Behavioral Health. The Bureau Chief reported to the Division Administrator.

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 Behavioral Health (BH) Management Team met periodically in person and through conference calls during SFY 2010. These meetings were a primary vehicle for policy development, system coordination and system improvement. This leadership team was composed of seven regional BH program managers, the administrative directors of the two state hospitals, the Mental Health Bureau Chief, the Substance Use Disorders Bureau Chief, and the Children's Mental Health Program Manager.

Effective July 1, 2010, the seven (7) Regions are being organized into three service areas or "hubs." The Behavioral Health Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). For now, the Program Managers in Region 3, Region 4, and Region 5 will report to

the Mental Health Bureau Chief in DBH central office (southwestern hub. The purpose of this reorganization was to improve service integration and resource use. Target goals include reducing the need for more costly services such as hospitalization and enhancing service outcomes. A legislative decision unit has been drafted to submit to the 2011 Idaho Legislature to fund a hub Administrator for the southwestern hub.

Additional organizational changes are planned for DBH in SFY 2011. The projected SFY 2011 organizational structure for DBH will consist of an Administrator with oversight over five major areas: Mental Health Policy and Programs Bureau for AMH and CMH Policies and Programs; a Substance Use Disorders Program; a Quality Assurance Program; a Data Unit and Mental Health Services composed of the three service hubs. The proposed management team for the Division of Behavioral Health for SFY 2011 will be formed from the hub heads and the unit leads.

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.

Overview of the State System

The Idaho Department of Health and Welfare (IDHW) operates within the Executive Branch of Idaho state government. IDHW is composed of the Divisions of Public Health, Behavioral Health, Family and Community Services, Welfare, Medicaid, Information Technology, and Operational Services. The Division of Behavioral Health's Central Office includes Adult Mental Health, Children's Mental Health, Substance Use Disorders and a Data Unit. The Central Office component of the Division of Behavioral Health provides system coordination and leadership, policy and standards development, rule promulgation and interpretation, technical assistance, training, consultation, funding application and regulation, and quality assurance monitoring.

The Department of Health and Welfare is designated by statute (Idaho Code Section 39-3124) as the State Mental Health Authority (SMHA). Most of the SMHA responsibilities are carried out by the Division of Behavioral Health with IDHW.

The Division of Behavioral Health (DBH) includes the Adult Mental Health program, the Children's Mental Health program, and the Substance Use Disorders program. Idaho's two (2) state psychiatric hospitals, State Hospital North and State Hospital South, are also under the jurisdiction of the DBH Administrator. State Hospital North serves adults only while State Hospital South serves both adults and adolescents.

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Idaho Code Section 19-2524, effective in SFY 2007, gives judges additional sentencing options for felons with substance abuse and mental illness diagnoses. The law allows a judge to order a substance abuse assessment and/or a mental health examination for felons and felony parole violators that appear before the court. Based on the results of an assessment or examination, a judge may order, as a condition of probation, that the defendant undergoes treatment consistent with a treatment plan contained in the assessment or examination report. A treatment plan is subject to modification by the court.

The Division of Behavioral Health has formed strong collaborations with regional Mental Health Courts, and these courts refer individuals to treatment through ACT programs. Budget cuts in SFY 2009 and SFY 2010 resulted in reduced regional staff and closure of nine rural offices. The priority adult treatment populations to be served through the public mental health service system for SFY 2011 will be adults who are in crisis or subject to involuntary commitment to DBH and those individuals under statutory mandates related to court ordered services. This includes individuals who are court

ordered under Idaho Code Sections 19-2524, 18-211/212, and 66-329. While regional programs may continue to retain some eligible individuals who have Medicaid and who are unable to be served in the private sector because of challenging needs or behaviors, efforts are being made to refer all Medicaid eligible individuals to private community resources.

Additional organizational changes are planned for DBH in SFY 2011. Effective July 1, 2010, the seven (7) Regions are being organized into three service areas or “hubs.” The Behavioral Health Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). For now, the Program Managers in Region 3, Region 4, and Region 5 will report to the Mental Health Bureau Chief in DBH central office (southwestern hub). A legislative decision unit has been drafted to submit to the 2011 Idaho Legislature to fund a hub Administrator for the southwestern hub.

The projected SFY 2011 organizational structure for DBH will consist of an Administrator with oversight over five major areas: Mental Health Policy and Programs Bureau for AMH and CMH Policies and Programs; a Substance Use Disorders Program; a Quality Assurance Program; a Data Unit and Mental Health Services composed of the three service hubs. The proposed management team for the Division of Behavioral Health for SFY 2011 will be formed from the hub heads and the unit leads.

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

Children's Mental Health

New Developments and Issues

1. Economic Downturn

Idaho's economy was negatively impacted by the recession in SFY 2009 and SFY 2010. Several companies laid off employees, with serious layoffs in construction, retail and manufacturing. One of Idaho's largest manufacturing employers, Micron, laid off over 3,000 employees between October 2008 and February 2009.

Idaho Department of Labor statistics indicate that the June 2009 unemployment rate of 8.3 percent was a 25-year high, and is reflective of a June 2009 figure of over 62,000 unemployed compared to a June 2008 number of less than 36,000. According to the State of Idaho Department of Labor (article 'Idaho jobless rate drops again as labor force declines' at <http://labor.idaho.gov/news/Press>), the June 2010 unemployment rate "...was forecast at 8.8 percent, matching the rate for October 2009 when unemployment across Idaho was climbing to a peak of 9.5% this February. While down substantially from that peak, the rate is still the highest prior to this recession since July 1983." The June 2010 number of unemployed was estimated at 66,700. Hiring levels for manufacturing, leisure and business were normal in June 2010, but the Department of Labor reports that "Government cut jobs by nearly triple the percentage typically shed in June, reflecting cuts made to accommodate tax revenues slashed by the recession." County unemployment rates ranged from a low of 4.9% in Teton County to a high of 12.6% in Power County.

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. The eligibility rules that prevented those with assets over \$2,000 from qualifying for food assistance were temporarily suspended on June 1, 2009. The Idaho Statesman reported (June 4, 2010; Idaho food stamp surge tops nation) that in the last half of SFY 2010, the Department of Health and Welfare "...processed an average of 8,500 applications for food stamp assistance per month." As of July 2010, Idaho had an estimated 200,000 citizens who were receiving food stamps (7/6/2010, Idaho Food Stamp Use Doubles National Increase; fox12idaho.com).

In response to concerns about increasing Medicaid cost, the 2009 Idaho Legislature passed House Bill 123 (2009), which reduced reimbursement rates to several categories of providers (including hospitals, nursing homes, intermediate care facilities, physicians and dentists) and removed non-emergency transportation from the program's basic plan. The 2010 Idaho Legislature set forth detailed directions in legislative intent language attached to the SFY 2011 appropriation (House Bill No. 701 (2010)) on the processes for Medicaid to follow in making any further reductions in payments or benefits. Those processes included reducing Medicaid rates to Medicare rates, negotiating rate reductions with providers, implementing additional managed care contracts, and exploring waivers

for services, including mental health services. In an effort to invite public input to "...address a projected \$247 million budget deficit for SFY 2011.." the Idaho Division of Medicaid launched the (www.MedicaidNeedsYourIdeas.dhw.idaho.gov) website in May 2010. Medicaid also held a series of public meetings in May 2010 to gather information from providers before determining strategies, policy changes and temporary rules to recommend to the 2011 Legislature.

Idaho also implemented a new Medicaid Management Information System (MMIS) that began operation on June 7, 2010. This system includes claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals. The implementation has added to difficulties being experienced in the Medicaid program that could affect clients. As of July 2010, some private providers reported that cuts in Medicaid payments and payment delays for services presented challenges to staying in business.

Idaho has had limited success in taking advantage of funds available through the American Recovery and Reinvestment Act of 2009. 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 match 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 initial approval for approximately 3,136 employees in SFY 2009, 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 layoffs of 23 people of whom 12.5 were from DBH; an additional required four days of furlough for all state employees; vacancy savings from keeping an additional 27 positions open of which 16 were in DBH; and a transfer of budget funds from operations to personnel.

The Department of Health and Welfare experienced additional cuts in SFY 2010. Furloughs for all staff were established from January 2010 through June 2010 on every other Friday. In response to SFY 2011 budget cuts, nine offices were closed in May 2010 in rural areas and 126 employees were laid off in an effort to save \$7 million.

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).

In 2007, 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.

Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with 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, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision and Goals:

Vision

Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable, and focused on recovery.

Goals

1. Increase availability of and access to quality services
2. Establish an infrastructure with clear responsibilities and actions
3. Create a viable regional and/or local community delivery system
4. Efficiently use existing and future resources
5. Increase accountability for services and funding
6. Seek and include input from stakeholders and consumers

Using a number of subcommittees the BHTWG developed a proposed organizational structure and core services for the transformed state behavioral health system. During the late summer and early fall of 2010, the BHTWG will be soliciting feedback on its proposals in preparation for a report to the Governor and 2011 Legislature on its recommendations, including next steps.

3. Court Ordered Evaluation and Services

Two statutes have continued to significantly affect both capacity and population served by Children's Mental Health. The first statute, Rule 19 of Idaho Juvenile Rules, requires that a screening team must evaluate alternatives before a juvenile is committed to the custody of the Department of Juvenile Corrections. Children's Mental Health clinicians are required to attend screening teams and devote considerable time to those meetings. The expressed intent of Rule 19 was to decrease commitments to the Department of Juvenile Correction and that objective has been achieved. However, referrals to Children's Mental Health have increased in proportion to decreases in commitments to the Department of Juvenile Corrections. The second statute, I.C. 20-511a, gives the court authority to order the Department of Health and Welfare to submit mental health assessments and a plan of treatment for a child or youth under jurisdiction of the juvenile court. The court may accept recommendations by the Department of Health and Welfare, other members of a screening team, or make other orders. The Children's Mental Health program has been impacted by court orders to serve youth when the youth does not meet eligibility criteria for the Children's Mental Health program and when the court orders treatment, including alternate-care placement, that is in opposition to recommendations by Children's Mental Health. No additional funding or other resources were allocated to the Department of Health and Welfare to address the impact of these statutes.

4. Infant and Early Childhood Mental Health

For over five years, a workgroup composed of representative from the Idaho Infant Toddler Program, Boise State University, Children's Mental Health, the Developmental Disabilities Program, the Early Childhood Coordinating Council, the Idaho Federation of Families for Children's Mental Health, and private providers have met to discuss issues related to infant and early childhood mental health. During the past year, the workgroup has been involved in supporting the establishment of the Idaho Association for Infant and Early Childhood Mental Health and has sponsored consultation related to the accreditation of mental health providers serving infants and children up to the age of 5 years. An accreditation process and criteria has been purchased from Michigan and a strategic plan is being developed to implement the process. The objective is to increase the provider base of those with experience and training specific to providing mental health services to infants, young children, and parents.

6. 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.

Installed for over 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 and children with serious emotional disturbance 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 that Idaho would be included in the list of states that will use videoconferencing to conduct mental health block grant review meetings in the fall of 2010. This process will save state employee time and federal money that has historically been directed to allow staff to travel to another state for block grant defense.

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 traveling to a central location for a face-to-face meeting. In May 2009, three contracted psychiatrists were providing telemedicine from the Boise Central Office, with Region 2 estimating 360 clients receiving these services from 9/08 through 5/09. Region 7 used these services for an estimated 180 clients from 2/09 through 5/09. Psychiatric services were offered from three psychiatrists through March 2010, when one left and there were only two psychiatrists providing these services through Boise Central Office. Region 7 discontinued use of the videoconferencing for psychiatric services in SFY 2010. A total of 740 scheduled appointments (duplicative client count) were made for Region 2 clients from throughout the Region from July 7, 2009 through June 30, 2010. These services were provided through video equipped offices in Lewiston and Orofino.

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. In SFY 2010 (July 2009 to June 2010), the total estimated savings across all users was \$465,706.24.

6. Behavioral Health Restructuring

Effective July 1, 2010, oversight of the seven regional behavioral health programs was restructured. Three ‘hubs,’ were established. The Administrator of State Hospital North is now additionally responsible for behavioral health services delivered through State programs in Regions 1 and 2 (the northern hub). The Administrator of State Hospital South provides oversight for Regions 6 and 7 (the southeastern hub). The Mental Health Bureau Chief in Central Office is responsible for Regions 3, 4 and 5 (the southwestern hub).

7. Wraparound

Services using the Wraparound model are available, in all regions of the state, to families when a child and family are assessed as requiring that level of intervention. Children’s Mental Health clinicians receive training on the Mary Grealish wraparound model and use wraparound in working with families on their caseload. In addition, representatives from other agencies such as county probation, private providers of psychosocial rehabilitation, and the Department of Juvenile Corrections, have been trained by Children’s Mental Health central office staff on the wraparound model. Representatives from Children’s Mental Health and other agencies commonly co-facilitate wraparound meetings.

8. Parenting with Love and Limits (PLL)

Children’s Mental Health began providing Parenting with Love and Limits (PLL) in June of 2008 and continues to provide PLL in all regions of the state. Children’s Mental Health (CMH) has expanded the provision of PLL to youth and families involved in the juvenile justice system. Youth involved in the juvenile corrections system must have a behavioral disorder but can receive PLL even when they do not meet CMH eligibility criteria.

9. Court Rule 19 and Idaho Statute 20-511a (Juvenile Corrections Act)

The Idaho Supreme Court through the Idaho Legislature modified court rules effective January 2009, to require all youth being considered for commitment to the Department of Juvenile Corrections be staffed by a multi-disciplinary team. The multi-disciplinary team must include representatives from county juvenile probation, Children’s Mental Health, Juvenile Corrections, and other persons designated by the juvenile court. The role of the team is to make a recommendation related to the serving the youth in the community and diverting the commitment to the Department of Juvenile Corrections.

The Idaho Legislature passed Idaho Statute 20-511a as an addition to the Juvenile Corrections Act in 2005. 20-511a authorizes a judge, of any court, to order the Department of Health and Welfare to conduct mental health assessments and develop a plan of treatment for the court’s approval. Such orders are an option whenever a judge has reason to believe that a juvenile involved in a proceeding under the Child Protective Act or the Juvenile Corrections Act is: (1) Suffering a substantial increase or persistence of a serious emotional disturbance and (2) such condition has not been adequately

addressed. The statute authorizes the judge to accept recommendations for treatment or to designate specific treatment, including residential treatment, and the costs of the treatment to be born by the Department of Health and Welfare. Under this statute, services must be provided by Children's Mental Health according to the court order and without regard to the child meeting Children's Mental Health program eligibility criteria and without Children's Mental Health agreeing to the treatment plan.

Court Rule 19 and Idaho Statute 20-511a have both significantly affected both the workload and population served through the Children's Mental Health program. Rule 19 orders place an additional demand on Children's Mental Health clinicians to assess and participate in team meetings. Time spent in a team meeting can amount to several hours and 1 or 2 Children's Mental Health or Child Welfare staff participate in each meeting. A significant number of 20-511a orders involve placing the youth in a treatment facility without clear discharge criteria. In addition, the Children's Mental Health program is being court ordered to serve youth involved in criminal activity within a system designed to serve children and youth with serious emotional disturbance.

10. Rule change to allow DHW to limit and prioritize CMH services.

Temporary Rule changes went into effect in May 2010 that allow the Department of Health and Welfare to limit and prioritize Children's Mental Health Services, including eligibility. The change in Rule was necessary due to reductions in appropriations and will allow the Department to focus available resources on those who have the greatest clinical and financial needs. The change in rule was supported by House Bill (HB) 715 as well as other legislative action that reduced appropriations for the 2010 state fiscal year. House Bill 715 reduced the total amount appropriated for the Department of Health and Welfare's Mental Health Services Division (Behavioral Health) for fiscal year 2011 by 6.5% from the original 2010 appropriation. Section 8 of HB 715 provided that notwithstanding any other provisions of law, the intent of the Legislature is that the Department is required to provide those services authorized or mandated by law in each program, only to the extent of funding and available resources appropriated for each budgeted program.

Child - Legislative initiatives and changes, if any.

Relevant 2010 Idaho Legislative Changes

There were several relevant pieces of 2010 legislation pertaining to **appropriations**. These House Bills (HB) and Senate Bills (SB) described allowed transfers between personnel costs and operating expenditures; limited transfers of trustee and benefit payments, authorized expenditure of collected receipts and re-appropriation of General Funds, cost containment measures and limitations in the number of full time equivalent positions. They also described reductions for FY 2010 and set appropriation amounts for FY 2011 (i.e., Medical Assistance, HB 701; Mental Health Services, HB715; Medically Indigent Administration, HB 716; and Psychiatric Hospitalization, SB 1434). Among other things, House Bill (HB) 701 also provided legislative intent for Medicaid program flexibility for FY 2011. SB 1445 “Authorizes the transfer of Economic Recovery Reserve Fund moneys, Budget Stabilization Fund moneys and other dedicated fund moneys to the General Fund in fiscal year 2010; authorizes the transfer of Budget Stabilization Fund moneys and Economic Recovery Reserve Fund moneys to the General Fund in fiscal year 2011; authorizes the transfer of Budget Stabilization Fund moneys, Economic Recovery Reserve Fund moneys and Permanent Building Fund moneys to the General Fund in fiscal year 2010 under certain conditions.”

Two House Bills addressed **qualifications of staff** providing services. House Bill 537 revised licensing qualifications for social workers and added existing law requirements for licensing of psychosocial rehabilitation specialists.

House Bill 681 amended Idaho Code pertaining to procedures and services available to Idaho citizens who require services and who are **medically indigent**. Among other things, HB 681 revised definitions, terminology and “...the powers and duties of the county commissioners. It also described intent “...to provide payment procedures...to provide for the prorating of a first lien and to ...revise the services for which payment is to be made.”

Relevant Idaho Code changes in SFY 2010 pertained to rules governing Medicaid Cost Sharing, Eligibility for Aid to the Aged, Blind and Disabled (AABD), and Minimum Standards for Nonhospital, Medically Monitored Detoxification/Mental Health Diversion Units. The 2010 Idaho State Legislature approved **Rules Governing Medicaid Cost-Sharing** (IDAPA Chapter 16.03.18) that describes the sliding scale, premium payments and premium waivers. As noted on page 26, “The cost savings for this rulemaking for SFY 2010 is estimated at \$210,000 in state general funds.”

The 2010 Idaho Legislature adopted temporary rules described in IDAPA 16.03.05, **Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)**. According to the 2010 Temporary Rule, p. 43, this rule is in response to the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, and “These rules align the Medicare Savings Program for Qualified Medicare Beneficiary (QMB) the Specified Low-Income Medicare Beneficiary (SLMB), and the Qualifying Individual (QI) for Medicare Part B with the Full Benefit Low-Income Subsidy (LIS) Program resource limits.”

IDAPA 16.07.50 temporary **Rules and Minimum Standards Governing Nonhospital Medically-Monitored Detoxification/Mental Health Diversion Units** were amended by the 2010 Idaho Legislature. Amendments (p. 206) included “Allowing a facility with both detoxification and mental health diversion units to divide an employee’s time between the two units,” and amending areas related to medical and general liability insurance, visitation policy, and meal provision. IDAPA 16.07.50 further states on p. 206 that “Rather than keep the temporary rule in place while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions which have been made to the pending rule.”

Relevant 2009 Idaho Legislative Changes

HB 123 amended “...existing law relating to public assistance and welfare to provide for Medicaid reduction.” This bill directed that the quarterly rate at skilled care facilities 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 was implemented in May 2010. This system includes 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 2009/2010 economic downturn did not allow for funding for a new round of grant projects, the opportunity to develop such projects in previous years continued to positively impact the mental health service delivery system through other previously developed programs (e.g., transitional housing, CIT training).

SB 1065 addressed revision of Regional Mental Health Boards 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 stated 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 amended 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 adopted rules governing fees for Community Mental Health Services. IDAPA 16.03.05.08.01 adopted pending rules that aligned 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 amended pending rule “...so that the census income is excluded from Medicaid only.” This allowed 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

House Bill 626 provided 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 allowed for appropriation of funds to the Department of Health and Welfare for state fiscal year 2009 for Community Mental Health Service provision, to continue the Region VII Multi-Year Development grant correctional alternative pilot project and to “...establish dual diagnosis crisis intervention beds in Region 4 that will be contractually operated by Ada County.”

Rules changes affecting AMH services in 2008 included IDAPA 16.07.01 and IDAPA 16.07.33. Chapter 16.07.01 outlines rules governing Behavioral Health fee schedules, including charges for Adult Mental Health Services and Charges for Children’s Mental Health Services. Chapter 16.07.33 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.

Relevant 2007 Idaho Legislative Changes

SB 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 Programs use the Common Assessment instrument and procedure to respond to this legislation. The Substance Use Disorders program uses the GAIN instrument for their assessments.

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.

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

State Agency Leadership

The Department of Health and Welfare is designated by statute (Idaho Code Section 39-3124) as the State Mental Health Authority (SMHA). Most of the SMHA responsibilities are carried out by the Division of Behavioral Health with IDHW. 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 (DBH) includes the Adult Mental Health program, the Children's Mental Health program, and the Substance Use Disorders program. Idaho's two (2) state psychiatric hospitals, State Hospital North and State Hospital South, are also under the jurisdiction of the DBH Administrator. State Hospital North serves adults only while State Hospital South serves both adults and adolescents.

Adult and Children's Mental Health services are provided through state operated community mental health centers (CMHC's) located in each of the seven (7) IDHW geographically defined Regions. Historically, each of the regions was under the supervision of a Regional Behavioral Health Program Manager, and all seven (7) Regional Behavioral Health Program Managers reported to the Bureau Chief in the Division of Behavioral Health. The Bureau Chief reported to the Division Administrator.

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 Behavioral Health (BH) Management Team met periodically in person and through conference calls during SFY 2010. These meetings were a primary vehicle for policy development, system coordination and system improvement. This leadership team was composed of seven regional BH program managers, the administrative directors of the two state hospitals, the Mental Health Bureau Chief, the Substance Use Disorders Bureau Chief, and the Children's Mental Health Program Manager.

Effective July 1, 2010, the seven (7) Regions are being organized into three service areas or "hubs." The Behavioral Health Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). For now, the Program Managers in Region 3, Region 4, and Region 5 will report to

the Mental Health Bureau Chief in DBH central office (southwestern hub). The purpose of this reorganization was to improve service integration and resource use. Target goals include reducing the need for more costly services such as hospitalization and enhancing service outcomes. A legislative decision unit has been drafted to submit to the 2011 Idaho Legislature to fund a hub Administrator for the southwestern hub.

Additional organizational changes are planned for DBH in SFY 2011. The projected SFY 2011 organizational structure for DBH will consist of an Administrator with oversight over five major areas: Mental Health Policy and Programs Bureau for AMH and CMH Policies and Programs; a Substance Use Disorders Program; a Quality Assurance Program; a Data Unit and Mental Health Services composed of the three service hubs. The proposed management team for the Division of Behavioral Health for SFY 2011 will be formed from the hub heads and the unit leads.

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

For the purpose of responding to Idaho's 2011 Mental Health Block Grant, the Idaho System Strengths and Weaknesses section will be described according to the Idaho State Planning Council on Mental Health 2010 Report to the Governor and State Legislature: *the Cost of Not Providing Mental Health Treatment*. The content of this report is described below.

Idaho State Planning Council on Mental Health 2010 Report to the Governor and State Legislature: *The Cost of Not Providing Mental Health Treatment*

2010 Idaho State Planning Council on Mental Health Report

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Idaho State Planning Council on Mental Health

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*Cover photo provided by Beau Stiles Creative 2010 © 2010 Idaho State Planning Council on Mental Health
Report 2

EXECUTIVE SUMMARY

The Idaho State Planning Council on Mental Health ("Council") was established pursuant to Public Law 99-660 and was placed into Idaho Code in 2006¹. The Council directives include in part:

¹ See Appendix 1 Idaho Code 39-3125

- ⌘ Serve as an advocate for adults with a severe mental illness and for seriously emotionally disturbed children and youth;
- ⌘ Advise the state mental health authority on issues of concern, policies and programs;
- ⌘ Provide guidance to the mental health authority in the development and implementation of the state mental health systems plan;
- ⌘ Monitor, review and evaluate the allocations and adequacy of mental health services within the state on an ongoing basis;
- ⌘ Present to the Governor and Legislature the impact on the quality of life that mental health services has on citizens of the state.

The 2009/2010 state cuts to services for individuals with mental illness, have been significant. The Council has the firm belief that the current and anticipated cuts to services for people with mental illness will result in long term increased costs to local communities, the State, and the quality of life of citizens in the state.

A snapshot of budget cut impacts includes:

1. Increase in Idaho suicide rate
2. Increased utilization of law enforcement
3. Increased utilization of hospitals

Resulting in: reduced health and economic well-being of communities.

In Idaho, there is currently no continuum of mental health care that provides appropriate services and support recovery. Idaho's mental health system needs to be more than crisis intervention. Treating only people in crisis costs more dollars to local communities and the State, causes more personal disruption, and results in lost opportunities for recovery. This is not speculation. This is fact, as supported by this report.

As directed by Idaho Code, the Council plays a key role in the State's mental health system of care. In this capacity, the 2010 State Planning Council on Mental Health Report to the Governor and State Legislature provides for your consideration (1) valuable information about the state mental health system and its efforts through the Governor's Behavioral Health Transformation Workgroup, (2) the effect of budget cuts within the system, (3) opportunities for change and improvement, and (4) efforts by the Council to support change and improvement. 2010 Idaho State Planning Council on Mental Health Report 3

INTRODUCTION

The Idaho State Planning Council on Mental Health (“Council”) is an active advocate providing a voice for children, youth, adults, and their families on mental health issues. The Council membership² is comprised of dedicated volunteers who give their time, energy, expertise and experience to improve and advocate for a system of care that provides quality mental health service to the people of Idaho.

² See Appendix 2 Membership

The Council appreciates and embraces the opportunity to participate on the Governor’s Behavioral Health Transformation Workgroup. The Council has reviewed the work to date, and provided input to establish the Transformation Workgroup’s goals, values and direction. We are excited by this group’s identified future efforts, and we welcome the opportunity to help work through the challenges that transformation will bring to the system. The Council will continue to address needed changes through its active role on the Governor’s Behavioral Health Transformation Workgroup and support of transformation efforts.

2010 Accomplishments

- ✘ Developed and implemented a media campaign raising awareness of impending budget cuts and the impact of those cuts on individuals with mental illness;
- ✘ Improved communication of regional mental health efforts to the State level;
- ✘ Service on the Governor’s Behavioral Health Transformation Workgroup;
- ✘ Use by the Regional Mental Health Boards of the Council’s website to post and share minutes with other Regional Boards;
- ✘ Hosted annual legislative event and award ceremony (February 2010). This year’s event titled “YOUTH: Our Greatest Resource” focused on children’s mental health issues. Panel members included youth and family members who discussed their challenges and successes within the mental health system. Awards were presented to recipients from the media, the judiciary, law enforcement, the legislature and a community advocate.

The Future

The Council will continue increasing awareness of mental health issues and the impact of budget cuts on recovery. The Council will support the Substance Abuse & Mental Health Services Administration (SAMHSA) 2010 strategic initiatives that support “prevention works, treatment is effective, and people recover from mental and substance abuse disorders.” SAMHSA has set forth: Behavioral health is an essential component of health service systems and community-wide strategies that work to improve health status and lower costs for families, businesses, and governments.

The Council will continue to serve as an advocate for Idahoans with mental illness. 2010 Idaho State Planning Council on Mental Health Report 4

SNAPSHOT: Increase in Idaho Suicide Rate

Death by suicide is a serious public health issue in Idaho. Suicide devastates Idaho families and communities. Access to mental health and substance abuse treatment is an identified prevention to suicide.

- Data from the Centers for Disease Control and Prevention (2006) ranks Idaho as 10th highest in the nation for number of completed suicides per capita and 3rd highest for suicide among adolescents and young adults.
- Deaths by suicide in Idaho increased by 14% in 2008 (251 deaths) and increased again by 19% in 2009 (300 deaths). This is one death every 29 hours.
- In the last 5 years (2004-2008), Idaho lost 65 students age 10-18 to suicide; 15 of those were between 10 and 14 years old.
- Boise City Police data shows in the first 83 days of 2010 officers responded to 13 attempted suicides, 193 threatening suicides, 104 overdoses, and 3 suicide deaths. These numbers are trending upward.
- The average total hospital cost for treating people who attempt suicide in Idaho is approximately \$8.2 million per year. Average work lost by suicide attempters is \$7.8 million per year.

Cost versus Lives

We need to ask ourselves:

Is decreasing mental health services the right choice?

Teresa Wolf, Council Chair

Idaho is the only state without a suicide crisis hotline.

Idaho does not have a nationally certified hotline. The national Lifeline crisis centers accept Idaho calls at Lifeline's expense as a temporary measure and professional courtesy.

Idaho's Lifeline calls have nearly tripled since 2007

The State Planning Council on Mental Health believes suicide is a serious but preventable public health crisis that requires high profile recognition at the state level and a high priority on the state health agenda.

The State Planning Council on Mental Health recommends State leadership identify sustainable funding for an Idaho Suicide Prevention Hotline to avert the human suffering of suicides and attempts and resulting economic costs. 2010 Idaho State Planning Council on Mental Health Report 5

SNAPSHOT: Increased Utilization of Law Enforcement

“Not providing adequate mental health treatment places additional burdens on law enforcement. Because there will be fewer mental health treatment resources, law enforcement will have fewer options for the mentally ill. This may result in more incarcerations in local jails which are exactly what we, in law enforcement, have been working hard to prevent. This will present a great disservice to the mentally ill and the community as a whole.”

*Major Michael Stayner
Deputy Chief of Police
Pocatello Police Department
Council Member*

Increasingly, as budget cuts reduce services, local and State law enforcement is called to be the first responders to crisis involving individuals with mental illness. This places an enormous strain on public funding at the state, county and city levels and increases risk to non-trained law enforcement officers. Training to officers that teaches how to effectively interact with people in mental health crisis or anyone in emotional distress, is critical. Involvement with law enforcement often results in: an overburdened law enforcement, increased juvenile detention, increased adult incarceration, loss of housing, loss of employment, loss of education opportunity and loss of community.

The City of Boise Community Ombudsman issued an Ombudsman’s Special Report in December 2006 that recommended Crisis Intervention Teams (CIT) in response to homeless persons with mental illness. A CIT is a collaboration between law enforcement, mental health providers, family and consumer advocates. CIT equips officers to interact with individuals experiencing a psychiatric crisis by helping them learn to recognize the signs of psychiatric distress and how to de-escalate a crisis – avoiding officer injuries, consumer deaths and tragedy for the community. In addition, CIT officers learn how to link people with appropriate treatment, which has a positive impact on fostering recovery and reducing recidivism.

Officers trained in CIT rate their program as more effective at meeting the needs of people with mental illness, minimizing the amount of time they spend on “mental disturbance” calls, and maintaining community safety, than officers who rely on a mobile crisis unit or in-house social worker for assistance with “mental disturbance” calls.³

³ See Appendix 3 References

The State Planning Council on Mental Health believes cuts to mental health treatment place law enforcement and people with mental illness at risk.

The State Planning Council on Mental Health recommends State leadership support re-establishing full funding for mental health services and place a priority on Crisis Intervention Training (CIT) for law enforcement. 2010 Idaho State Planning Council on Mental Health Report 6

SNAPSHOT: Increased Utilization of Hospitals

Over utilization of emergency rooms by individuals in mental health crisis, is epidemic. Unfortunately, with the current budgeting levels, the system will continue to force its citizens into emergency rooms for treatment. In addition, placements at State hospitals will continue to increase if the lack of preventative services is not addressed.

It is well established that the cost of a clinician is far lower than the cost of even one day in a facility. In FY 2008, it was reported the state of Idaho's average cost to Medicaid per client accessing community based mental health services was \$4,003. In FY 2008, the average cost per client for hospitalizations related to mental health needs, was \$30,304.⁴

⁴ Presentation by Kathleen Allen to Transformation Workgroup, June 2009

⁵ See Appendix 4 BHTWG Core Services draft: March 10, 2010

⁶ "Thousands in Idaho can't access drug abuse treatment" Idaho Statesman, May 31, 2010

The Behavioral Health Transformation Workgroup (BHTWG) addresses these concerns by proposing a meaningful and efficient system of care. This system of care features availability and access to an array of behavioral health services on as local a level as possible. The intent is to provide a "floor" of services, available in each region, that span prevention, intervention, treatment and recovery so that coordinated efforts are enabled to redirect supports from the more expensive emergent and medically necessary services, to more effective and less costly prevention, intervention and recovery services.⁵

A lack of community services forces many people with mental illness to access services any way they can. According to Dr. Charles Novak, a psychiatrist who is president-elect of the psychiatric staff at St. Alphonsus, more people are showing up in the emergency room and being hospitalized against their wishes because they are judged to be a threat to themselves or other people. That costs taxpayers more than treating patients outside of hospitals.⁶

"Mental Illness is not a crime. It should not be treated as one. Desperate people take desperate actions. Not providing treatment, forces people to act out of the recklessness of despair!!"

Rick Huber

Council Member

The State Planning Council on Mental Health believes due to a lack of alternatives, existing services are exploited, over-used, miss-used and become a "catch all" to cover every possible mental health condition.

The State Planning Council on Mental Health recommends the state should apply the resources necessary to develop a full continuum of mental health care that can provide appropriate services with the various levels of care necessary to treat people with mental illness in their own communities, prevent costly hospitalizations and support recovery. 2010

Idaho State Planning Council on Mental Health Report 7

CONCLUSION

The vision of the Governor's Behavioral Health Transformation Workgroup: Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable, and focused on recovery. The Idaho State Planning Council on Mental Health believes in this vision. Clearly, the Transformation Workgroup believes in this vision. We now need State leadership to believe in this vision.

The Council's 2010 Report to the Governor and State Legislature has provided an overview of the issues and problems resulting from cuts to the state mental health system. The report highlights and voices the concerns provided by individuals across the state regarding *the cost of not providing mental health treatment*.

The impact of budget cuts in the area of mental health services include:

1. Increase in Idaho suicide rate
2. Increased utilization of law enforcement
3. Increased utilization of hospitals

Resulting in: reduced health and economic well-being of communities.

As previously stated, Idaho's mental health system needs to be more than crisis intervention. Treating only people in crisis costs more dollars to local communities and the State, causes more personal disruption, and results in lost opportunities for recovery. This is not speculation. This is fact.

The State Planning Council on Mental Health will fulfill its mandate on behalf of people with mental illness in Idaho. This will include education, advocacy, continued advisement and guidance to the mental health authority, and ensuring that individuals with severe mental illness and serious emotional disturbance have access to treatment, prevention and rehabilitation services including those services that go beyond the traditional mental health system⁷.

⁷ See Appendix 1 Idaho Code 39-3125

"The cost of mental health services for us, at times, have been a choice of either getting help for our son or putting food on the table. We eventually took loans out & went deeply in debt to pay for the services he needed. Our reason was that the cost of the 11 lives on his "hit list" was far greater than the devastating cost to us financially. If we had not had the resource/assistance of DHW we would never have been able to pay for the services, or we would have had to relinquish our rights as his parents."

~~ Elaine Sonnen Greencreek, ID ~~ 2010 Idaho State Planning Council on Mental Health Report 8

APPENDIX

Appendix 1 – Idaho Code 39-3125

TITLE 39

HEALTH AND SAFETY

CHAPTER 31

REGIONAL MENTAL HEALTH SERVICES

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. 2010 Idaho State Planning Council on Mental Health Report 9

**Appendix 2 – Membership
Name**

**Agency or Organization
Represented**

City

Teresa Wolf Chair	Social Services	Lewiston
Pam Hirsch Vice-Chair	Region II MH Advisory Board	Lapwai
Linda Hatzenbuehler, Ph.D. Executive Committee	Region VI MH Advisory Board	Pocatello
Rick Humber Executive Committee	Region V Consumer	Rupert
Lynn Whiting Executive Committee	Region VII Family	Blackfoot
Stan Calder Executive Committee	Region I Consumer	Coeur d'Alene
Shirley Clark Membership Chair	Region V MH Advisory Board	Albion
Corinna Stiles Education Chair	DisAbility Rights Idaho	Boise
Rep. Sharon Block VACANT	Legislature	Twin Falls
Kathie Garrett	Department of Education Idaho Council on Suicide Prevention	Meridian
Pat Guidry	Division of Medicaid	Boise
Gary Hamilton	Department of Vocational Rehabilitation	Coeur d'Alene
Judge Brent Moss In Remembrance VACANT	Judicial	Rexburg
Julie Williams	Criminal Justice Housing	Boise
Kim Wherry Toryanski	Aging	Boise
Robert Bishop	State Mental Health Agency	Coeur d' Alene
Rose Marie Tiffany	Region I MH Advisory Board	St. Maries
Lisa Koltes, MD	Region III MH Advisory Board	Nampa

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 2010, the Idaho State Planning Council on Mental Health developed and prioritized the following unmet service needs, which are taken from their June 2010 report, the *Idaho State Planning Council on Mental Health 2010 Report to the Governor and State Legislature: the Cost of Not Providing Mental Health Treatment*.

This report (p. 2) states the following:

“The 2009/2010 state cuts to services for individuals with mental illness have been significant. The Council has the firm belief that the current and anticipated cuts to services for people with mental illness will result in long term increased costs to local communities, the State, and the quality of life of citizens in the state.

A snapshot of budget cut impacts includes:

1. Increase in Idaho suicide rate
2. Increased utilization of law enforcement
3. Increased utilization of hospitals

Resulting in: reduced health and economic well-being of communities.

In Idaho, there is currently no continuum of mental health care that provides appropriate services and support recovery. Idaho’s mental health system needs to be more than crisis intervention. Treating only people in crisis costs more dollars to local communities and the State, causes more personal disruption and results in lost opportunities for recovery.”

The State Planning Council’s 2010 Report to the Governor and Legislature (see System Strengths and Weaknesses section for entire report) identifies three major unmet needs. These are identified in snapshot format, with narrative descriptions of data that supports each snapshot. Highlights of these identified snapshot areas of unmet needs are described below:

Snapshot: Increase in Idaho Suicide Rate (p. 4)

“Death by suicide is a serious public health issue in Idaho. Suicide devastates Idaho families and communities. Access to mental health and substance abuse treatment is an identified prevention to suicide.” This report adds that “Idaho does not have a nationally certified hotline. The national Lifeline crisis centers accept Idaho calls at Lifeline’s expense as a temporary measure and professional courtesy. Idaho’s lifeline calls have nearly tripled since 2007.”

The report states that, “**The State Planning Council on Mental Health believes** suicide is a serious but preventable public health crisis that requires high profile recognition at the state level and a high priority on the state health agenda.”

Snapshot: Increase Utilization of Law Enforcement (p. 5)

“Increasingly as budget cuts reduce services, local and State law enforcement is called to be the first responders to crisis involving individuals with mental illness. This places an enormous strain on public funding at the state, county and city levels and increases risk to non-trained law enforcement officers. Training to officers that teaches how to effectively interact with people in mental health crisis or anyone in emotional distress, is critical.

Involvement with law enforcement often results in: an overburdened law enforcement, increased juvenile detention, increased adult incarceration, loss of housing, loss of employment, loss of education opportunity and loss of community.”

The report states that, “**The State Planning Council on Mental Health believes** cuts to mental health treatment place law enforcement and people with mental illness at risk.”

Snapshot: Increased Utilization of Hospitals (p. 6)

“Overutilization of emergency rooms by individuals in mental health crisis is epidemic. Unfortunately, with the current budgeting levels, the system will continue to force its citizens into emergency rooms for treatment. In addition, placements at State hospitals will continue to increase if the lack of preventative services is not addressed.” The report adds, “A lack of community services forces many people with mental illness to access services any way they can. According to Dr. Charles Novak, a psychiatrist who is president-elect of the psychiatric staff at St. Alphonsus, more people are showing up in the emergency room and being hospitalized against their wishes because they are judged to be a threat to themselves or other people. That costs taxpayers more than treating patients outside of hospitals.”

The report states that, “**The State Planning Council on Mental Health believes** due to a lack of alternatives, existing services are exploited, over-used, miss-used and become a ‘catch all’ to cover every possible mental health condition.”

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

Plan to Address Unmet Needs

In May and June 2010, the Idaho State Planning Council on Mental Health developed and prioritized the following unmet service needs, which are taken from their June 2010 report, the *Idaho State Planning Council on Mental Health 2010 Report to the Governor and State Legislature: the Cost of Not Providing Mental Health Treatment*. The Planning Council's Report to the Governor is available in its entirety in the System Strengths and Weaknesses section of this report.

The Planning Council's Report to the Governor (p. 2) states the following:

“The 2009/2010 state cuts to services for individuals with mental illness have been significant. The Council has the firm belief that the current and anticipated cuts to services for people with mental illness will result in long term increased costs to local communities, the State, and the quality of life of citizens in the state.

A snapshot of budget cut impacts includes:

1. Increase in Idaho suicide rate
2. Increased utilization of law enforcement
3. Increased utilization of hospitals

Resulting in: reduced health and economic well-being of communities.

In Idaho, there is currently no continuum of mental health care that provides appropriate services and support recovery. Idaho's mental health system needs to be more than crisis intervention. Treating only people in crisis costs more dollars to local communities and the State, causes more personal disruption and results in lost opportunities for recovery.”

The State Planning Council's 2010 Report to the Governor and Legislature (see System Strengths and Weaknesses section for entire report) identifies three major unmet needs. These are identified in snapshot format, with narrative descriptions of data that supports each snapshot. Highlights of these identified snapshot areas of unmet needs are described below:

Snapshot: Increase in Idaho Suicide Rate (p. 4)

“Death by suicide is a serious public health issue in Idaho. Suicide devastates Idaho families and communities. Access to mental health and substance abuse treatment is an identified prevention to suicide.” This report adds that “Idaho does not have a nationally certified hotline. The national Lifeline crisis centers accept Idaho calls at Lifeline's expense as a temporary measure and professional courtesy. Idaho's lifeline calls have nearly tripled since 2007.”

The report states that, “**The State Planning Council on Mental Health believes** suicide is a serious but preventable public health crisis that requires high profile recognition at the state level and a high priority on the state health agenda.”

The Planning Council includes a recommendation to address this unmet need, as described below:

“The State Planning Council on Mental Health recommends State leadership identify sustainable funding for an Idaho Suicide Prevention Hotline to avert the human suffering of suicides and attempts and resulting economic costs.”

Snapshot: Increase Utilization of Law Enforcement (p. 5)

“Increasingly as budget cuts reduce services, local and State law enforcement is called to be the first responders to crisis involving individuals with mental illness. This places an enormous strain on public funding at the state, county and city levels and increases risk to non-trained law enforcement officers. Training to officers that teaches how to effectively interact with people in mental health crisis or anyone in emotional distress, is critical.

Involvement with law enforcement often results in: an overburdened law enforcement, increased juvenile detention, increased adult incarceration, loss of housing, loss of employment, loss of education opportunity and loss of community.”

The report states that, **“The State Planning Council on Mental Health believes** cuts to mental health treatment place law enforcement and people with mental illness at risk.”

The Planning Council includes a recommendation to address this unmet need, as described below:

“The State Planning Council on Mental Health recommends State leadership support re-establishing full funding for mental health services and place a priority on Crisis Intervention Training (CIT) for law enforcement.”

Snapshot: Increased Utilization of Hospitals (p. 6)

“Overutilization of emergency rooms by individuals in mental health crisis is epidemic. Unfortunately, with the current budgeting levels, the system will continue to force its citizens into emergency rooms for treatment. In addition, placements at State hospitals will continue to increase if the lack of preventative services is not addressed.” The report adds, “A lack of community services forces many people with mental illness to access services any way they can. According to Dr. Charles Novak, a psychiatrist who is president-elect of the psychiatric staff at St. Alphonsus, more people are showing up in the emergency room and being hospitalized against their wishes because they are judged to be a threat to themselves or other people. That costs taxpayers more than treating patients outside of hospitals.”

The report states that, **“The State Planning Council on Mental Health believes** due to a lack of alternatives, existing services are exploited, over-used, miss-used and become a ‘catch all’ to cover every possible mental health condition.”

The Planning Council includes a recommendation to address this unmet need, as described below:

“The State Planning Council on Mental Health recommends the state should apply the resources necessary to develop a full continuum of mental health care that can provide appropriate services with the various levels of care necessary to treat people with mental illness in their own communities, prevent costly hospitalizations and support recovery.”

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

Highlights of significant achievements during SFY 2010 include the following:

1. Idaho Mental Health Transformation

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.

Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with 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, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision and Goals:

Vision

Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery.

Goals

1. Increase availability of and access to quality services
2. Establish an infrastructure with clear responsibilities and actions
3. Create a viable regional and/or local community delivery system
4. Efficiently use existing and future resources
5. Increase accountability for services and funding
6. Seek and include input from stakeholders and consumers

Using a number of subcommittees the BHTWG developed a proposed organizational structure and core services for the transformed state behavioral health system. During the late summer and early fall of 2010, the BHTWG will be soliciting feedback on its proposals in preparation for a report to the Governor and 2011 Legislature on its recommendations, including next steps.

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. Use of the BH Monthly Data Report was discontinued in July 2010 because AMH data was captured through the WITS system. Enhancements to the WITS system to allow report extraction for the NOMS/URS and other state and federal reports are expected through SFY 2011.

The Division of Behavioral Health was awarded a Client Level Reporting Project (CLRP) grant in the winter/spring of 2008. This award allowed 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 completed a test case deliverable, an FY 2008 service data deliverable with CLRP data definitions and a final deliverable of SFY 2009 NOMS data by the project end date in September of 2009.

During SFY 2009, the two State Hospitals (North and South) completed Vista installation and began 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 above) data definitions of the NOMS. Development of WITS was completed by June 2009, and the system 'went live' for AMH in SFY 2010 (October 2009). Implementation and training activities occurred throughout SFY 2010. While the basic AMH WITS system is implemented, efforts will continue through SFY 2011 to work with the vendor (FEI) to enhance WITS to allow

relevant report extraction and to support other system features relating to mental health service delivery. The Data Infrastructure Grant (DIG) helps to support these efforts.

3. Patient Assistance Program (PAP)

A Patient Assistance Program (PAP) software package was purchased for approximately \$50,000 in SFY 2009. 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 exceeded \$800,000. In SFY 2010, the monthly number of patients receiving PAP ranged from a low of 549 to a high of 828. The total monthly number of orders (new and renewed) ranged from a low of 916 to a high of 1,212. The estimated value of PAP medications received in SFY 2010 was \$13,119,671.

4. Telehealth Service Implementation (TSI) Project

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.

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 a little over 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.

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. In SFY 2010 (July 2009 to June 2010), the total estimated savings across all users was \$465,706.24.

In SFY 2010, psychiatric services from Boise Central Office were offered using videoconferencing to rural and frontier areas of the State of Idaho. A total of 740 scheduled appointments (duplicative client count) were made for Region 2 clients from throughout the Region from July 7, 2009 through June 30, 2010. These services were provided through video equipped offices in Lewiston and Orofino.

The federal government recently indicated interest in use of videoconferencing to conduct mental health block grant review meetings. Idaho is scheduled for a videoconferenced block grant review process on October 27, 2010. If successful, this process should save state employee time and federal money that has historically been directed to allow staff to travel to another state for block grant defense.

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 use 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 and this was maintained in SFY 2010. A Forensic Psychiatrist hired in Region 4 to provide services to increased numbers of clients referred from the criminal justice system has since resigned.

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 4 project refers to Allumbaugh House (see 7, Detoxification Center) and the Region 7 project referred to provides mental health and substance use treatment at the jail in Bonneville County (see 8, Wood Pilot Project).

The courts report that there were twelve treatment courts in Idaho in SFY 2010. Ten of these were post adjudication courts that provided coordinated treatment and probation supervision and two were diversion courts that diverted participants into treatment on a pre-adjudication basis. In SFY 2010, 348 individuals were served through post adjudication courts and 52 received services through diversion courts for a total of 400 served. The courts indicated that the court budget for this time period was \$590,810, with additional treatment funds covering the costs of treatment provided through the Division of Behavioral Health. The courts reported expenditures of \$90,750 for substance use disorder treatment that was provided separately from services that were provided through State Mental Health programs.

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

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 and 2010 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) provided in home support, treatment and resource development for individuals who are at risk of out of home placement in more restrictive levels of care. Certified Peer Specialists were employed as equal members of this team. Although there was demonstrated cost savings and reports of consumer satisfaction, this program was terminated in May 2010 due to budget cuts.

7. Detoxification Center

The Allumbaugh House opened in Boise, Idaho on May 1 2010 as a resource to Idaho citizens in Region 4. Services provided by this facility include crisis, mental health, medically monitored chemical detoxification & sobering stations. Operations are managed by Terry Reilly Health Services. An estimated 100 people per month were served in the first three months of operation, with an average length of stay of three to four days. Referrals to the sobering station must be from health care providers or local law enforcement. Mental health service referrals may be from public or private health care providers. The detoxification program accepts self referrals and referrals from public and private health care providers. Terry Reilly indicates that one of the biggest challenges and successes relates to the diversity of players (e.g., private groups, city, county, state government) that collaborated to create the Allumbaugh House.

8. Wood Pilot Project

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, funds were allocated to support similar one-time projects. Additional funds in the amount of \$1,240,000 were allocated to support one Multi-year Development Grant project. The Multi-Year Development grant was awarded to the Bonneville County's Substance Abuse/Mental Health Treatment Program, aka the Wood Pilot Project. The Wood Pilot Project continues to operate with a focus on implementation of a Substance Abuse and Mental Health treatment program for male and female offenders who are likely to be sentenced to corrections facilities. Treatment services include assessments, drug testing, treatment curriculum and treatment staff. This project also included purchase of Client Reporting Software (i.e., WITS).

9. 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 in 2009. This project was funded with Mental Health Block Grant dollars. As of June 2010, there were 47 Peer Specialists who completed the training and passed the certification exam. The Office of Consumer Affairs supervises placement of seven certified Peer Specialists; 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. 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.

10. Housing and Homelessness

During SFY 2010, there were several activities directed to housing and homelessness. Following the recommendations of a federal audit of the Pathways in Transition from Homelessness (PATH) services in SFY 2009, Idaho plans to implement a Request for Proposals (RFP) process for PATH funds and services in SFY 2011. The Charitable Assistance to Community's Homeless (CATCH) program that mobilizes community resources to help address homelessness continued operations in both Region 3 and Region 4. On 2/18/10, several Idaho housing service providers from across the State came together to advocate for Idaho's homeless on Idaho Public Television. St. Vincent de Paul's Coeur d'Alene emergency shelter partnered with the City of Coeur d'Alene in SFY 2010 to open the meeting room behind the Coeur d'Alene Thrift Store to unsheltered homeless individuals when the temperature dropped to 15 degrees or below.

11. Internship Programs

Region VI mental health has actively recruited and cultivated an internship program that draws interdisciplinary students from across the state of Idaho and from multiple nations. Students are expected to perform research, individual and group therapy, couples counseling, family therapy, substance abuse interventions, and psychological assessment. Each student receives one-on-one supervision, and many also receive group supervision. All interns receive a weekly psycho-educational didactics series in evidenced based practices. During SFY 2010, a doctoral residency/internship program was established in Region VI in clinical psychology. This program generated over 80 applicants for three positions, and drew students from the United States and Canada. Region VI hopes to expand and pool resources to draw interns across regions.

12. Quality Assurance/Utilization Program

The Division of Behavioral Health (DBH) is committed to promoting and protecting the health and safety of Idahoans by ensuring that programs within the Division provide

clinically necessary services that are cost effective and that demonstrate achievement of client-center health outcomes. The vehicle to accomplish the level of continuous feedback necessary to achieve this is the Division's Quality Assurance (Q/A) Program.

The Quality Assurance/Utilization (QA/U) Program was established in the Division of Behavioral Health in June 2009, and a Program Manager was hired in Central Office to manage this program. The QA/U program incorporates five (5) components that create a comprehensive Quality Management structure. These components are 1) Comprehensive Local/Statewide Quality Management; 2) Quality Assurance(QA)/Continuous Quality Improvement (CQI); 3) Corrective Action; 4) Performance Improvement; and 5) Stakeholder Review Systems. The intent of the QA/U Program is to implement the five components by using systematic approaches to identify effective and ineffective practices, successful and unsuccessful client outcomes, compliance and non-compliance with regulatory requirements.

The local/statewide Quality Management (QM) structure involves oversight of regional compliance, corrective action, and performance improvement. The Division's QA/U Program Manager provides oversight to the statewide system. The local QM committees feed results of quality assurance reviews to the QA Manager who works with the region on corrective action where this is necessary.

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

Future Vision

In May through July 2010, 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 July 2010 report, the *Idaho State Planning Council on Mental Health 2010 Report to the Governor and State Legislature: the Cost of Not Providing Mental Health Treatment*.

Executive Summary

The Idaho State Planning Council on Mental Health ("Council") was established pursuant to Public Law 99-660 and was placed into Idaho Code in 2006. The Council directives include in part:

- Serve as an advocate for adults with a severe mental illness and for seriously emotionally disturbed children and youth;
- Advise the state mental health authority on issues of concern, policies and programs;
- Provide guidance to the mental health authority in the development and implementation of the state mental health systems plan;
- Monitor, review and evaluate the allocations and adequacy of mental health services within the state on an ongoing basis;
- Present to the Governor and Legislature the impact on the quality of life that mental health services has on citizens of the state.

The 2009/2010 state cuts to services for individuals with mental illness, have been significant. The Council has the firm belief that the current and anticipated cuts to services for people with mental illness will result in long term increased costs to local communities, the State, and the quality of life of citizens in the state.

A snapshot of budget cut impacts includes:

1. Increase in Idaho suicide rate
2. Increased utilization of law enforcement
3. Increased utilization of hospitals

Resulting in: reduced health and economic well-being of communities.

In Idaho, there is currently no continuum of mental health care that provides appropriate services and support recovery. Idaho's mental health system needs to be more than crisis intervention. Treating only people in crisis costs more dollars to local communities and the State, causes more personal disruption, and results in lost opportunities for recovery. This is not speculation. This is fact, as supported by this report.

As directed by Idaho Code, the Council plays a key role in the State's mental health system of care. In this capacity, the 2010 State Planning Council on Mental Health Report to the Governor and State Legislature provides for your consideration (1) valuable information about the state mental health system and its efforts through the Governor's Behavioral Health Transformation Workgroup, (2) the effect of budget cuts within the system, (3) opportunities for change and improvement, and (4) efforts by the Council to support change and improvement.

INTRODUCTION

The Idaho State Planning Council on Mental Health (“Council”) is an active advocate providing a voice for children, youth, adults, and their families on mental health issues. The Council membership is comprised of dedicated volunteers who give their time, energy, expertise and experience to improve and advocate for a system of care that provides quality mental health service to the people of Idaho.

The Council appreciates and embraces the opportunity to participate on the Governor’s Behavioral Health Transformation Workgroup. The Council has reviewed the work to date, and provided input to establish the Transformation Workgroup’s goals, values and direction. We are excited by this group’s identified future efforts, and we welcome the opportunity to help work through the challenges that transformation will bring to the system. The Council will continue to address needed changes through its active role on the Governor’s Behavioral Health Transformation Workgroup and support of transformation efforts.

2010 Accomplishments

- Developed and implemented a media campaign raising awareness of impending budget cuts and the impact of those cuts on individuals with mental illness;
- Improved communication of regional mental health efforts to the State level;
- Service on the Governor’s Behavioral Health Transformation Workgroup;
- Use by the Regional Mental Health Boards of the Council’s website to post and share minutes with other Regional Boards;
- Hosted annual legislative event and award ceremony (February 2010). This year’s event titled “YOUTH: Our Greatest Resource” focused on children’s mental health issues. Panel members included youth and family members who discussed their challenges and successes within the mental health system. Awards were presented to recipients from the media, the judiciary, law enforcement, the legislature and a community advocate.

The Future

The Council will continue increasing awareness of mental health issues and the impact of budget cuts on recovery. The Council will support the Substance Abuse & Mental Health Services Administration (SAMHSA) 2010 strategic initiatives that support “prevention works, treatment is effective, and people recover from mental and substance abuse disorders.” SAMHSA has set forth: Behavioral health is an essential component of health service systems and community-wide strategies that work to improve health status and lower costs for families, businesses, and governments.

The Council will continue to serve as an advocate for Idahoans with mental illness.

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

The State Planning Council on Mental Health believes suicide is a serious but preventable public health crisis that requires high profile recognition at the state level and a high priority on the state health agenda.

The State Planning Council on Mental Health recommends State leadership identify sustainable funding for an Idaho Suicide Prevention Hotline to avert the human suffering of suicides and attempts and resulting economic costs.

The State Planning Council on Mental Health believes cuts to mental health treatment place law enforcement and people with mental illness at risk.

The State Planning Council on Mental Health recommends State leadership support re-establishing full funding for mental health services and place a priority on Crisis Intervention Training (CIT) for law enforcement.

The State Planning Council on Mental Health believes due to a lack of alternatives, existing services are exploited, over-used, miss-used and become a 'catch all' to cover every possible mental health condition.

The State Planning Council on Mental Health recommends the state should apply the resources necessary to develop a full continuum of mental health care that can provide appropriate services with the various levels of care necessary to treat people with mental illness in their own communities, prevent costly hospitalizations and support recovery.

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

For the purpose of responding to Idaho’s 2011 Mental Health Block Grant, the Idaho System Strengths and Weaknesses section will be described according to the Idaho State Planning Council on Mental Health 2010 Report to the Governor and State Legislature: the Cost of Not Providing Mental Health Treatment. The content of this report is described below.

Idaho State Planning Council on Mental Health 2010 Report to the Governor and State Legislature: *The Cost of Not Providing Mental Health Treatment*
2010 Idaho State Planning Council on Mental Health Report.

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EXECUTIVE SUMMARY

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- ☒ Serve as an advocate for adults with a severe mental illness and for seriously emotionally disturbed children and youth;
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The 2009/2010 state cuts to services for individuals with mental illness, have been significant. The Council has the firm belief that the current and anticipated cuts to services

for people with mental illness will result in long term increased costs to local communities, the State, and the quality of life of citizens in the state.

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Resulting in: reduced health and economic well-being of communities.

In Idaho, there is currently no continuum of mental health care that provides appropriate services and support recovery. Idaho's mental health system needs to be more than crisis intervention. Treating only people in crisis costs more dollars to local communities and the State, causes more personal disruption, and results in lost opportunities for recovery. This is not speculation. This is fact, as supported by this report.

As directed by Idaho Code, the Council plays a key role in the State's mental health system of care. In this capacity, the 2010 State Planning Council on Mental Health Report to the Governor and State Legislature provides for your consideration (1) valuable information about the state mental health system and its efforts through the Governor's Behavioral Health Transformation Workgroup, (2) the effect of budget cuts within the system, (3) opportunities for change and improvement, and (4) efforts by the Council to support change and improvement. 2010 Idaho State Planning Council on Mental Health Report 3.

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SAMHSA has set forth: Behavioral health is an essential component of health service systems and community-wide strategies that work to improve health status and lower costs for families, businesses, and governments.

The Council will continue to serve as an advocate for Idahoans with mental illness. 2010.

SNAPSHOT: Increase in Idaho Suicide Rate

Death by suicide is a serious public health issue in Idaho. Suicide devastates Idaho families and communities. Access to mental health and substance abuse treatment is an identified prevention to suicide.

- Data from the Centers for Disease Control and Prevention (2006) ranks Idaho as 10th highest in the nation for number of completed suicides per capita and 3rd highest for suicide among adolescents and young adults.
- Deaths by suicide in Idaho increased by 14% in 2008 (251 deaths) and increased again by 19% in 2009 (300 deaths). This is one death every 29 hours.
- In the last 5 years (2004-2008), Idaho lost 65 students age 10-18 to suicide; 15 of those were between 10 and 14 years old.
- Boise City Police data shows in the first 83 days of 2010 officers responded to 13 attempted suicides, 193 threatening suicides, 104 overdoses, and 3 suicide deaths. These numbers are trending upward.
- The average total hospital cost for treating people who attempt suicide in Idaho is approximately \$8.2 million per year. Average work lost by suicide attempters is \$7.8 million per year.

Cost versus Lives

We need to ask ourselves:

Is decreasing mental health services the right choice?

Teresa Wolf, Council Chair

Idaho is the only state without a suicide crisis hotline.

Idaho does not have a nationally certified hotline. The national Lifeline crisis centers accept Idaho calls at Lifeline’s expense as a temporary measure and professional courtesy. Idaho’s Lifeline **calls have nearly tripled since 2007. The State Planning Council on Mental Health believes** suicide is a serious but preventable public health crisis that requires high profile recognition at the state level and a high priority on the state health agenda.

The State Planning Council on Mental Health recommends State leadership identify sustainable funding for an Idaho Suicide Prevention Hotline to avert the human suffering of suicides and attempts and resulting economic costs.

SNAPSHOT: Increased Utilization of Law Enforcement

“Not providing adequate mental health treatment places additional burdens on law enforcement. Because there will be fewer mental health treatment resources, law enforcement will have fewer options for the mentally ill. This may result in more incarcerations in local jails which are exactly what we, in law enforcement, have been working hard to prevent. This will present a great disservice to the mentally ill and the community as a whole.”

*Major Michael Stayner
Deputy Chief of Police
Pocatello Police Department
Council Member*

Increasingly, as budget cuts reduce services, local and State law enforcement is called to be the first responders to crisis involving individuals with mental illness. This places an enormous strain on public funding at the state, county and city levels and increases risk to non-trained law enforcement officers. Training to officers that teaches how to effectively interact with people in mental health crisis or anyone in emotional distress, is critical. Involvement with law enforcement often results in: an overburdened law enforcement, increased juvenile detention, increased adult incarceration, and loss of housing, loss of employment, loss of education opportunity and loss of community.

The City of Boise Community Ombudsman issued an Ombudsman’s Special Report in December 2006 that recommended Crisis Intervention Teams (CIT) in response to homeless persons with mental illness. A CIT is a collaboration between law enforcement, mental health providers, family and consumer advocates. CIT equips officers to interact with individuals experiencing a psychiatric crisis by helping them learn to recognize the signs of psychiatric distress and how to de-escalate a crisis – avoiding officer injuries, consumer deaths and tragedy for the community. In addition, CIT officers learn how to link people with appropriate treatment, which has a positive impact on fostering recovery and reducing recidivism. Officers trained in CIT rate their program as more effective at meeting the needs of people with mental illness, minimizing the amount of time they spend on “mental disturbance” calls, and maintaining community safety, than officers who rely on a mobile crisis unit or in-house social worker for assistance with “mental disturbance” calls.

The State Planning Council on Mental Health believes cuts to mental health treatment place law enforcement and people with mental illness at risk.

The State Planning Council on Mental Health recommends State leadership support reestablishing full funding for mental health services and place a priority on Crisis Intervention Training (CIT) for law enforcement.

SNAPSHOT: Increased Utilization of Hospitals

Over utilization of emergency rooms by individuals in mental health crisis, is epidemic. Unfortunately, with the current budgeting levels, the system will continue to force its citizens into emergency rooms for treatment. In addition, placements at State hospitals will continue to increase if the lack of preventative services is not addressed. It is well established that the cost of a clinician is far lower than the cost of even one day in a facility. In FY 2008, it was reported the state of Idaho's average cost to Medicaid per client accessing community based mental health services was \$4,003. In FY 2008, the average cost per client for hospitalizations related to mental health needs, was \$30,304.⁴

⁴ Presentation by Kathleen Allen to Transformation Workgroup, June 2009

⁵ See Appendix 4 BHTWG Core Services draft: March 10, 2010

⁶ "Thousands in Idaho can't access drug abuse treatment" Idaho Statesman, May 31, 2010

The Behavioral Health Transformation Workgroup (BHTWG) addresses these concerns by proposing a meaningful and efficient system of care. This system of care features availability and access to an array of behavioral health services on as local a level as possible. The intent is to provide a "floor" of services, available in each region, that span prevention, intervention, treatment and recovery so that coordinated efforts are enabled to redirect supports from the more expensive emergent and medically necessary services, to more effective and less costly prevention, intervention and recovery services.⁵

A lack of community services forces many people with mental illness to access services any way they can. According to Dr. Charles Novak, a psychiatrist who is president-elect of the psychiatric staff at St. Alphonsus, more people are showing up in the emergency room and being hospitalized against their wishes because they are judged to be a threat to themselves or other people. That costs taxpayers more than treating patients outside of hospitals.⁶

"Mental Illness is not a crime. It should not be treated as one. Desperate people take desperate actions. _ providing treatment, forces people to act out of the recklessness of despair!!"

Rick Huber

Council Member

The State Planning Council on Mental Health believes due to a lack of alternatives, existing services are exploited, over-used, miss-used and become a "catch all" to cover every possible mental health condition.

The State Planning Council on Mental Health recommends the state should apply the resources necessary to develop a full continuum of mental health care that can provide appropriate services with the various levels of care necessary to treat people with mental illness in their own communities, prevent costly hospitalizations and support recovery.

CONCLUSION

The vision of the Governor's Behavioral Health Transformation Workgroup: Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are

coordinated, efficient, accountable, and focused on recovery. The Idaho State Planning Council on Mental Health believes in this vision. Clearly, the Transformation Workgroup believes in this vision. We now need State leadership to believe in this vision. The Council's 2010 Report to the Governor and State Legislature has provided an overview of the issues and problems resulting from cuts to the state mental health system. The report highlights and voices the concerns provided by individuals across the state regarding *the cost of not providing mental health treatment*

The impact of budget cuts in the area of mental health services include:

1. Increase in Idaho suicide rate
2. Increased utilization of law enforcement
3. Increased utilization of hospitals

Resulting in: reduced health and economic well-being of communities.

As previously stated, Idaho's mental health system needs to be more than crisis intervention. Treating only people in crisis costs more dollars to local communities and the State, causes more personal disruption, and results in lost opportunities for recovery. This is not speculation. This is fact.

The State Planning Council on Mental Health will fulfill its mandate on behalf of people with mental illness in Idaho. This will include education, advocacy, continued advisement and guidance to the mental health authority, and ensuring that individuals with severe mental illness and serious emotional disturbance have access to treatment, prevention and rehabilitation services including those services that go beyond the traditional mental health system⁷.

⁷ See Appendix 1 Idaho Code 39-3125

"The cost of mental health services for us, at times, have been a choice of either getting help for our son or putting food on the table. We eventually took loans out & went deeply in debt to pay for the services he needed. Our reason was that the cost of the 11 lives on his "hit list" was far greater than the devastating cost to us financially. If we had not had the resource/assistance of DHW we would never have been able to pay for the services, or we would have had to relinquish our rights as his parents."

~~ Elaine Sonnen Greencreek, ID

APPENDIX

Appendix 1 – Idaho Code 39-3125

TITLE 39

HEALTH AND SAFETY

CHAPTER 31

REGIONAL MENTAL HEALTH SERVICES

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 intraagency 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.

Appendix 2 – Membership

Name Agency or Organization Represented

Teresa Wolf, Chair Social Services Lewiston

Pam Hirsch, Vice-Chair Region II MH Advisory Board Lapwai

Linda Hatzenbuehler, Ph.D. Executive Committee Region VI MH Advisory Board
Pocatello

Rick Humber, Executive Committee Region V Consumer Rupert

Lynn Whiting, Executive Committee Region VII Family Blackfoot

Stan Calder, Executive Committee Region I Consumer Coeur d'Alene

Shirley Clark, Membership Chair Region V MH Advisory Board Albion

Corinna Stiles, Education Chair DisAbility Rights Idaho Boise

Rep. Sharon Block, Legislature Twin Falls

VACANT Department of Education

Kathie Garrett, Idaho Council on Suicide Prevention Meridian

Pat Guidry, Division of Medicaid Boise

Gary Hamilton, Department of Vocational Rehabilitation Coeur d'Alene

Judge Brent Moss, In Remembrance Judicial Rexburg

VACANT Criminal Justice

Julie Williams, Housing Boise

Kim Wherry Toryanski, Aging Boise

Robert Bishop, State Mental Health Agency Coeur d' Alene

Rose Marie Tiffany, Region I MH Advisory Board St. Maries

Lisa Koltes, MD Region III MH Advisory Board Nampa

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.

Please refer to response under Adult section.

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

Please refer to response under Adult section.

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

Highlights of significant achievements during SFY 2010 include the following:

1. Idaho Mental Health Transformation

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 with 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. The Behavioral Health Transformation Workgroup (BHTWG) meeting minutes for June 11, 2010 (p. 9) describes the proposed mental health and substance abuse core services as "...community based, emergent, medically necessary, and required by law. The intent is to provide a 'floor' of services, or a framework, which is available in each region. This framework is intended to span prevention, intervention, treatment and recovery so that coordinated efforts are enabled to redirect supports from the more expensive emergent and medically necessary services to more effective and less costly prevention, intervention and recovery services. Core services will be provided in accordance with statewide standards which will include, at minimum, monitoring for quality, consistency

and timeliness. These services will be delivered from a client-centered perspective. Effectiveness of service delivery will be determined by examining quality of life measures as well as other standardized outcome-based instruments. "

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. Use of the BH Monthly Data Report was discontinued in July 2010 because AMH data was captured through the WITS system. Enhancements to the WITS system to allow report extraction for the NOMS/URS and other state and federal reports are expected through SFY 2011.

The Division of Behavioral Health was awarded a Client Level Reporting Project (CLRP) grant in the winter/spring of 2008. This award allowed 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 completed a test case deliverable, an FY 2008 service data deliverable with CLRP data definitions and a final deliverable of SFY 2009 NOMS data by the project end date in September of 2009.

During SFY 2009, the two State Hospitals (North and South) completed Vista installation and began 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 above) data definitions of the NOMS. Development of WITS was completed by June 2009, and the system 'went live' for AMH in SFY 2010 (October 2009). Implementation and training activities occurred throughout SFY 2010. While the basic AMH WITS system is implemented, efforts will continue through SFY 2011 to work with the vendor (FEI) to enhance WITS to allow relevant report extraction and to support other system features relating to mental health service delivery. The Data Infrastructure Grant (DIG) helps to support these efforts.

3. Patient Assistance Program (PAP)

A Patient Assistance Program (PAP) software package was purchased for approximately \$50,000 in SFY 2009. 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 exceeded \$800,000. In SFY 2010, the monthly number of patients receiving PAP ranged from a low of 549 to a high of 828. The total monthly number of orders (new and

renewed) ranged from a low of 916 to a high of 1,212. The estimated value of PAP medications received in SFY 2010 was \$13,119,671.

4. Telehealth Service Implementation (TSI) Project

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.

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 a little over 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.

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. In SFY 2010 (July 2009 to June 2010), the total estimated savings across all users was \$465,706.24.

In SFY 2010, psychiatric services were offered from three psychiatrists through March 2010, when one left and there were only two psychiatrists providing these services through Boise Central Office. Region 7 discontinued use of the videoconferencing for psychiatric services in SFY 2010. A total of 740 scheduled appointments (duplicative client count) were made for Region 2 clients from throughout the Region from July 7, 2009 through June 30, 2010. These services were provided through video equipped offices in Lewiston and Orofino.

The federal government recently indicated interest in use of videoconferencing to conduct mental health block grant review meetings. Idaho is scheduled for a video-conferenced block grant review process on October 27, 2010. If successful, this process should save state employee time and federal money that has historically been directed to allow staff to travel to another state for block grant defense.

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 use 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 and this was maintained in SFY 2010. A Forensic Psychiatrist hired in Region 4 to provide services

to increased numbers of clients referred from the criminal justice system has since resigned.

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.

The courts report that there were twelve treatment courts in Idaho in SFY 2010. Ten of these were post adjudication courts that provided coordinated treatment and probation supervision and two were diversion courts that diverted participants into treatment on a pre-adjudication basis. In SFY 2010, 348 individuals were served through post adjudication courts and 52 received services through diversion courts for a total of 400 served. The courts indicated that the court budget for this time period was \$590,810, with additional treatment funds covering the costs of treatment provided through the Division of Behavioral Health. The courts reported expenditures of \$90,750 for substance use disorder treatment that was provided separately from services that were provided through State Mental Health programs.

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

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 and 2010 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) provided in home support, treatment and resource

development for individuals who are at risk of out of home placement in more restrictive levels of care. Certified Peer Specialists were employed as equal members of this team. Although there was demonstrated cost savings and reports of consumer satisfaction, this program was terminated in May 2010 due to budget cuts.

7. Detoxification Center

The Allumbaugh House opened in Boise, Idaho on May 1 2010 as a resource to Idaho citizens in Region 4. Services provided by this facility include crisis, mental health, medically monitored chemical detoxification & sobering stations. Operations are managed by Terry Reilly Health Services. An estimated 100 people per month were served in the first three months of operation, with an average length of stay of three to four days. Referrals to the sobering station must be from health care providers or local law enforcement. Mental health service referrals may be from public or private health care providers. The detoxification program accepts self referrals and referrals from public and private health care providers. Terry Reilly indicates that one of the biggest challenges and successes relates to the diversity of players (e.g., private groups, city, county, state government) that collaborated to create the Allumbaugh House.

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 in 2009. This project was funded with Mental Health Block Grant dollars. As of June 2010, there were 47 Peer Specialists who completed the training and passed the certification exam. The Office of Consumer Affairs supervises placement of seven certified Peer Specialists; 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. 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.

9. Housing and Homelessness

During SFY 2010, there were several activities directed to housing and homelessness. Following the recommendations of a federal audit of the Pathways in Transition from Homelessness (PATH) services in SFY 2009, Idaho plans to implement a Request for Proposals (RFP) process for PATH funds and services in SFY 2011. The Charitable Assistance to Community's Homeless (CATCH) program that mobilizes community resources to help address homelessness continued operations in both Region 3 and Region 4. On 2/18/10, several Idaho housing service providers from across the State came together to advocate for Idaho's homeless on Idaho Public Television. St. Vincent de Paul's Coeur d'Alene emergency shelter partnered with the City of Coeur d'Alene in SFY 2010 to open the meeting room behind the Coeur d'Alene Thrift Store to unsheltered homeless individuals when the temperature dropped to 15 degrees or below.

10. Internship Programs

Region VI mental health has actively recruited and cultivated an internship program that draws interdisciplinary students from across the state of Idaho and from multiple nations. Students are expected to perform research, individual and group therapy, couples counseling, family therapy, substance abuse interventions, and psychological assessment. Each student receives one-on-one supervision, and many also receive group supervision. All interns receive a weekly psycho-educational didactics series in evidenced based practices. During SFY 2010, a doctoral residency/internship program was established in Region VI in clinical psychology. This program generated over 80 applicants for three positions, and drew students from the United States and Canada. Region VI hopes to expand and pool resources to draw interns across regions.

11. Quality Assurance/Utilization Program

The Division of Behavioral Health (DBH) is committed to promoting and protecting the health and safety of Idahoans by ensuring that programs within the Division provide clinically necessary services that are cost effective and that demonstrate achievement of client-center health outcomes. The vehicle to accomplish the level of continuous feedback necessary to achieve this is the Division's Quality Assurance (Q/A) Program.

The Quality Assurance/Utilization (QA/U) Program was established in the Division of Behavioral Health in June 2009, and a Program Manager was hired in Central Office to manage this program. The QA/U program incorporates five (5) components that create a comprehensive Quality Management structure. These components are 1) Comprehensive Local/Statewide Quality Management; 2) Quality Assurance(QA)/Continuous Quality Improvement (CQI); 3) Corrective Action; 4) Performance Improvement; and 5) Stakeholder Review Systems. The intent of the QA/U Program is to implement the five components by using systematic approaches to identify effective and ineffective practices, successful and unsuccessful client outcomes, compliance and non-compliance with regulatory requirements.

The local/statewide Quality Management (QM) structure involves oversight of regional compliance, corrective action, and performance improvement. The Division's QA/U Program Manager provides oversight to the statewide system. The local QM committees feed results of quality assurance reviews to the QA Manager who works with the region on corrective action where this is necessary.

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

Future Vision

In May through July 2010, 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 July 2010 report, the *Idaho State Planning Council on Mental Health 2010 Report to the Governor and State Legislature: the Cost of Not Providing Mental Health Treatment*.

Executive Summary

The Idaho State Planning Council on Mental Health ("Council") was established pursuant to Public Law 99-660 and was placed into Idaho Code in 2006. The Council directives include in part:

- Serve as an advocate for adults with a severe mental illness and for seriously emotionally disturbed children and youth;
- Advise the state mental health authority on issues of concern, policies and programs;
- Provide guidance to the mental health authority in the development and implementation of the state mental health systems plan;
- Monitor, review and evaluate the allocations and adequacy of mental health services within the state on an ongoing basis;
- Present to the Governor and Legislature the impact on the quality of life that mental health services has on citizens of the state.

The 2009/2010 state cuts to services for individuals with mental illness, have been significant. The Council has the firm belief that the current and anticipated cuts to services for people with mental illness will result in long term increased costs to local communities, the State, and the quality of life of citizens in the state.

A snapshot of budget cut impacts includes:

1. Increase in Idaho suicide rate
2. Increased utilization of law enforcement
3. Increased utilization of hospitals

Resulting in: reduced health and economic well-being of communities.

In Idaho, there is currently no continuum of mental health care that provides appropriate services and support recovery. Idaho's mental health system needs to be more than crisis intervention. Treating only people in crisis costs more dollars to local communities and the State, causes more personal disruption, and results in lost opportunities for recovery. This is not speculation. This is fact, as supported by this report.

As directed by Idaho Code, the Council plays a key role in the State's mental health system of care. In this capacity, the 2010 State Planning Council on Mental Health Report to the Governor and State Legislature provides for your consideration (1) valuable information about the state mental health system and its efforts through the Governor's Behavioral Health Transformation Workgroup, (2) the effect of budget cuts within the system, (3) opportunities for change and improvement, and (4) efforts by the Council to support change and improvement.

INTRODUCTION

The Idaho State Planning Council on Mental Health (“Council”) is an active advocate providing a voice for children, youth, adults, and their families on mental health issues. The Council membership is comprised of dedicated volunteers who give their time, energy, expertise and experience to improve and advocate for a system of care that provides quality mental health service to the people of Idaho.

The Council appreciates and embraces the opportunity to participate on the Governor’s Behavioral Health Transformation Workgroup. The Council has reviewed the work to date, and provided input to establish the Transformation Workgroup’s goals, values and direction. We are excited by this group’s identified future efforts, and we welcome the opportunity to help work through the challenges that transformation will bring to the system. The Council will continue to address needed changes through its active role on the Governor’s Behavioral Health Transformation Workgroup and support of transformation efforts.

2010 Accomplishments

- Developed and implemented a media campaign raising awareness of impending budget cuts and the impact of those cuts on individuals with mental illness;
- Improved communication of regional mental health efforts to the State level;
- Service on the Governor’s Behavioral Health Transformation Workgroup;
- Use by the Regional Mental Health Boards of the Council’s website to post and share minutes with other Regional Boards;
- Hosted annual legislative event and award ceremony (February 2010). This year’s event titled “YOUTH: Our Greatest Resource” focused on children’s mental health issues. Panel members included youth and family members who discussed their challenges and successes within the mental health system. Awards were presented to recipients from the media, the judiciary, law enforcement, the legislature and a community advocate.

The Future

The Council will continue increasing awareness of mental health issues and the impact of budget cuts on recovery. The Council will support the Substance Abuse & Mental Health Services Administration (SAMHSA) 2010 strategic initiatives that support “prevention works, treatment is effective, and people recover from mental and substance abuse disorders.” SAMHSA has set forth: Behavioral health is an essential component of health service systems and community-wide strategies that work to improve health status and lower costs for families, businesses, and governments.

The Council will continue to serve as an advocate for Idahoans with mental illness.

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

The State Planning Council on Mental Health believes suicide is a serious but preventable public health crisis that requires high profile recognition at the state level and a high priority on the state health agenda.

The State Planning Council on Mental Health recommends State leadership identify sustainable funding for an Idaho Suicide Prevention Hotline to avert the human suffering of suicides and attempts and resulting economic costs.

The State Planning Council on Mental Health believes cuts to mental health treatment place law enforcement and people with mental illness at risk.

The State Planning Council on Mental Health recommends State leadership support re-establishing full funding for mental health services and place a priority on Crisis Intervention Training (CIT) for law enforcement.

The State Planning Council on Mental Health believes due to a lack of alternatives, existing services are exploited, over-used, miss-used and become a 'catch all' to cover every possible mental health condition.

The State Planning Council on Mental Health recommends the state should apply the resources necessary to develop a full continuum of mental health care that can provide appropriate services with the various levels of care necessary to treat people with mental illness in their own communities, prevent costly hospitalizations and support recovery.

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.

Mental health services are provided through seven regional Community Mental Health Centers which included 22 field offices across the state until budget cuts resulted in the closure of nine of those rural offices across the state in May 2010. 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 public system of care that is both community-based and consumer-guided. Programs 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. Project examples 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; 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; early intervention and crisis treatment with a transitional housing component (mental health, substance use, criminal involvement); 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 included 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 used Block Grant funds to contract with the Office of Consumer Affairs (OCAFA) in SFY 2009 and SFY 2010 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. Peer specialists are also expected to attend Wellness Recovery Action Plan (WRAP) training and to complete their own WRAP plans. As of July 9, 2010, OCAFA provided WRAP training to 40 Certified Peer Specialists, 19 consumers, and four professional staff. There are 19 Certified WRAP Facilitators in Idaho; 15 are Certified Peer Specialists, one is a consumer and three are DHW staff. There were 55 consumers who attended Certified Peer Specialist training opportunities (2/09, 10/09 and 5/10), with 45 who passed the certification exam and five who have not yet taken it.

The Office of Consumer Affairs facilitated placement and supervision of one certified peer specialist on an Assertive Community Treatment (ACT) team in each of the seven regions. As of July 9, 2010, there were two regional ACT teams that were looking for another Certified Peer Specialist. There were four Certified Peer Specialists employed on ACT teams who were also graduates of Idaho Mental Health Court programs.

During SFY 2009, an innovative public-private partnership was formed in Region 4. **The Home Recovery Team (HRT)** provided in home support, treatment and resource development for individuals who are at risk of out of home placement in more restrictive levels of care. Certified Peer Specialists were employed as equal members of this team. Although results were positive and there was demonstrated cost savings related to these services, budget cuts resulted in termination of this pilot project in May 2010.

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. As of May 2010, there were two psychiatrists providing telehealth services from Central Office to clients in Region 2, where services could be accessed through either the Lewiston or Orofino sites. The estimated cost savings as a result of using the videoconferencing equipment for SFY 2010 is \$465,706.

There are mental health courts in each region of the State. The model used to support mental health court 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 and this continued into SFY 2010. A Forensic Psychiatrist hired in Region 4 to provide services to increased numbers of clients referred from the criminal justice system in SFY 2009, but he has since resigned.

The courts report that there were twelve treatment courts in Idaho in SFY 2010. Ten of these were post adjudication courts that provided coordinated treatment and probation supervision and two were diversion courts that diverted participants into treatment on a pre-adjudication basis. In SFY 2010, 348 individuals were served through post adjudication courts and 52 received services through diversion courts for a total of 400 served. The courts indicated that the court budget for this time period was \$590,810, with additional treatment funds covering the costs of treatment provided through the Division of Behavioral Health. The courts reported expenditures of \$90,750 for substance use disorder treatment that was provided separately from services that were provided through State Mental Health programs.

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.

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 diagnosed with serious and persistent mental illness (SPMI). While those individuals with private insurance or Medicaid may choose from a variety of private mental health service providers, the Idaho Department of Health and Welfare's (DHW) Division of Behavioral Health (DBH) has historically been responsible to provide these services to adults who do not have Medicaid or other forms of insurance or payment, and to those who may have Medicaid but whose needs are too complicated for private providers to manage effectively.

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.

A range of adult mental health services have historically been provided by all seven regional community behavioral health centers. In SFY 2011, available services provided through regional behavioral health centers may be reduced in response to budget cuts. Additional changes in SFY 2011 may reflect the direction of the Governor's Behavioral Health Transformation Work Group (BHTWG).

Budget Cuts and Public SMHA Service Priority Populations

Budget cuts in SFY 2009 and SFY 2010 resulted in reduced regional staff and closure of nine rural offices. During SFY 2010, Idaho State Department of Health and Welfare (DHW) budget shortfalls resulted in furlough days for all DHW staff, 126 permanent layoffs of DHW staff and closure of nine rural DHW offices. In May 2010, a total of nine DHW offices were closed in Jerome, Orofino, Bellevue, Rupert, Bonners Ferry, Soda Springs, Emmett, McCall and American Falls.

The priority adult treatment populations to be served through the public mental health service system for SFY 2011 will be adults who are in crisis as determined by designated examinations and those individuals under statutory mandates related to court ordered services. This includes individuals who are court ordered under 19-2524, 18-211/212, and 66-329. While regional programs may continue to retain some clients who are voluntary without any insurance or other resources and some eligible individuals who have Medicaid and who are unable to be served in the private sector because of

challenging needs or behaviors, efforts are being made to refer to private community resources.

Referrals from Mental Health Courts and Judges

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 in SFY 2007. 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.

Regional AMH programs continue collaboration efforts in response to increased requests for best practice services to mental health court referrals. The model used to support mental health court 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. During SFY 2009, Mental Health Court Utilization increased to approximately 90% of capacity, and this was similar in SFY 2010. A Forensic Psychiatrist hired in Region 4 in SFY 2009 to provide services to increased numbers of clients referred from the criminal justice system has since resigned.

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.

Crisis and Hospitalization Services

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.

Regional Behavioral Health programs offer crisis services to adults who are at risk of harming themselves or others, or who are determined to be gravely disabled. Crisis services include designated examinations and short term stabilization. Regional mental health programs conduct assessments, develop treatment plans, and provide ongoing mental health services. Individuals transitioned to a private 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.

The Region 4 “24-hour” residential program, Franklin House, was discontinued in SFY 2009 because of cost. It was replaced by an innovative public-private partnership, the Home Recovery Team (HRT). This team included Certified Peer Specialists as equal staff members who provided in home support, treatment and resource development for individuals who were at risk of out of home placement in more restrictive levels of care. Although this program demonstrated significant cost savings through hospital diversion and high reports of participant satisfaction, budget cuts resulted in HRT termination in May 2010.

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 behavioral health services. State Hospital North assigns a primary therapist for each client admitted to the hospital. The primary therapist initiates 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 for the purpose of discussing progress reports, treatment planning, discharge planning, and aftercare.

Efforts to reduce state psychiatric hospitalizations and decrease the length of stay are expected to be enhanced as a result of the July 1, 2010 restructuring into three geographical service hubs. 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 targeting community based alternative placements include as needed community hospitalization, use of regional transitional beds, and Crisis Intervention Team (CIT) trained law enforcement personnel in two regions. Additionally, all discharge plans for individuals leaving SHN or SHS include a scheduled (no later than five working days from discharge) face to face screening with, and admission to, the regional mental health program for follow-up care and treatment. Individuals discharged from a state hospital are 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.

The Behavioral Health 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 (SHN) and Blackfoot (SHS). 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. Separate and distinct treatment programs are provided according to 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. The forensic psychologist treats forensic clients served at SHS with a focus on restoring them to fitness to proceed and assist in their own defense.

State Hospital North is licensed for 60 beds however only 55 beds are available for patient care. While State Hospital North is not JCAHO accredited, every effort has been made to adopt the policies and procedures used and JCAHO approved at State Hospital South. State Hospital North had two recent positive reviews from Facility Standards and they continue to follow State licensure laws and best practice standards identified through both JCAHO and Center for Medicare Services (CMS) Certification. State Hospital North is pursuing CMS certification.

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.

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.

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 in 2009. This project was funded with Mental Health Block Grant dollars. As of July 9, 2010, there were 55 Peer Specialists who completed the training, with 45 who passed the certification exam and five who had not yet taken the exam. The Office of Consumer Affairs facilitates and supervises placement of seven certified Peer Specialists; 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.

Housing and Homelessness

An SFY 2009 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. While PATH funds were distributed to each of seven regional behavioral health centers in SFY 2010, plans for SFY 2011 are to offer a Request for Proposals for PATH service delivery across the State of Idaho.

The Charitable Assistance to Community's Homeless (CATCH) program that mobilizes community resources to help address homelessness operated in Region 3 and Region 4 in SFY 2010. The process for accessing Shelter Plus Care beds was standardized in SFY 2009, leading to an increased level of regional involvement with these housing vouchers.

Regional Community Mental Health Center Services as of July 2010

As of July 2010, Core Adult Mental Health Services provided through Regional Behavioral Health centers included the following:

- (1) Screening: Screening for eligibility of services through Regional Mental Health Programs based on the above criteria. If an individual meets eligibility criteria as defined above, he or she is accepted for services either on an ongoing basis or for short-term intervention. Individuals not meeting eligibility 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 (SPMI) who meet eligibility 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: 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 Certified Peer Specialist (CPS) was placed as staff with each main office ACT team, with supervision of these placements provided through a contract with the Office of Consumer Affairs.

(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.

Case Management Services

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.

Medicaid Reimbursable Mental Health Services

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 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 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. Medicaid data on private sector resources is not yet available for SFY 2010.

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.

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.

There were several pieces of legislation and relevant Idaho Code changes in SFY 2010 that pertained to rules governing Medicaid. House Bill (HB) 701 provided legislative intent for Medicaid program flexibility for FY 2011. The 2010 Idaho State Legislature approved Rules Governing Medicaid Cost-Sharing (IDAPA Chapter 16.03.18) that describes the sliding scale, premium payments and premium waivers. As noted on page 26, "The cost savings for this rulemaking for SFY 2010 is estimated at \$210,000 in state general funds." Medicaid Omnibus Bill (HB 708) continued pricing freezes from SFY 2010 through SFY 2011; this bill allowed additional budget reductions that included mandates for pharmacies to participate in periodic cost surveys. Senate Bill 1321 created a notice requirement to allow the Department of Health and Welfare to track property transfers of Medicaid recipients of long-term-care to identify where transfer proceeds should be used to either repay Medicaid or pay for the individual's long term care costs.

The 2010 Idaho legislature directed Medicaid to negotiate pricing and service changes with Medicaid providers to meet the projected \$247 million budget deficit for SFY 2011. In response, Medicaid scheduled provider group meetings in May 2010 to solicit input about service reductions. They also established a website for this purpose; the site address is www.MedicaidNeedsYourIdeas.dhw.idaho.gov. This Medicaid savings website included dates of provider meetings, the budget status for Idaho Medicaid, the provider cost share of the Medicaid shortfall, the 2010 legislative direction to deal with the budget shortfall and surveys to gather cost savings input and ideas. Public input will be used to initiate policy changes through temporary rules prepared for the 2011 legislative session.

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.

In an effort to continue to provide co-occurring, integrated disorders training in a cost-effective and efficient manner, SAMHSA's Tip 42 describing best practice treatment for integrated, co-occurring disorders was put on the Department of Health and Welfare's Knowledge Learning Center website in SFY 2010. All Department of Health and Welfare employees have access to this website, and Continuing Education Credits are available for completion of each module of the Tip 42 training.

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.

Employment and Educational 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 Interagency Agreement continued through SFY 2010 and will continue through SFY 2011. This Agreement includes the provision of monthly data reports of clients served, including reports of open cases, closures and service hours.

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.

Housing Services

Through the Bureau of Facility Standards, the DHW 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.

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.

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. Available community providers, such as the Terry Reilly Health Clinics, provide medical and dental services on a sliding fee scale in limited areas. There is also a limited county indigent program that varies by county with respect to covered services and that is usually limited to one-time expenses. The Idaho Medicaid program encourages recipients to sign up for its managed care program, Healthy Connections. This program 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.

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 DHW 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 by district. Services range from community health nursing and home health nursing to environmental health, dental hygiene and nutrition programs.

The State of Idaho Department of Insurance issued a News Release July 8, 2010 that described a new pre-existing condition insurance plan. According to the news release, "As of July 1, 2010, Idaho residents are able to apply for a new Pre-Existing Condition Insurance Plan administered by the Department of Health and Human Services... To qualify for coverage... Idahoans must have been uninsured for at least six months, have been unable to obtain health coverage because of a health condition and be U.S. citizens or reside in the United States legally."

Mental Health Boards, Consumer/Family Advocacy and Education and Peer Specialists
Each Regional Mental Health Board includes representation from county commissioners, consumer/advocates and other providers and stakeholders. Consumers and family members from these boards are represented on the State Planning Council. Regional boards meet regularly to provide important input and recommendations for mental health system improvement.

In SFY 2009, the Division of Behavioral Health used mental health block grant funds to contract 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. These activities continued through SFY 2010 and are anticipated to be continued through SFY 2011.

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. As of July 9, 2010, there were 55 trained Peer Specialists.

Behavioral Health Restructuring

Additional organizational changes are planned for the Idaho State Mental Health Authority (SMHA) in SFY 2011. Effective July 1, 2010, the seven (7) Regions were divided into three (3) "hubs." The Behavioral Health Program Managers in Region 1 and Region 2 report to the Administrator of State Hospital North (northern hub). The Program Managers in Region 6 and Region 7 report to the Administrator of State Hospital South (southeastern hub). Initially, the Program Managers in Region 3, Region 4, and Region 5 were to report to the Behavioral Health Bureau Chief in the Division of Behavioral Health central office (southwestern hub), but the Mental Health Bureau Chief resigned in July 2010. A legislative decision unit has been drafted to request two positions; one position would fund a hub Administrator for the southwestern hub, and another would fund a Central Office position responsible to support the three hub Administrators.

The projected SFY 2011 organizational structure for the Division of Behavioral Health would include a Division of Behavioral Health Administrator with oversight over five major areas. These areas are projected to be the Mental Health Policy and Programs Bureau for AMH and CMH Policies and Programs; a Substance Use Disorders Bureau; a Quality Assurance and Utilization Program; a Data Unit and the Mental Health Services Bureau as defined by the three hubs. The proposed management team for the Division of Behavioral Health for SFY 2011 may be redefined as the hub heads and the unit heads.

Behavioral Health Transformation Work Group

Established in 2008 by Governor Butch Otter, the Behavioral Health Transformation Work Group's (BHTWG) appointed membership includes the Director of the Department of Health and Welfare and representation from the Office of Drug Policy, the Boise State University's Institute for the Study of Addiction, the Department of Juvenile Corrections, the Bonneville County Sheriff's Office, the Association of Counties, the Drug and Mental Health Court Coordinating Committee, the State Planning Council on Mental Health, a local psychiatrist and a legislator.

The May 12, 2010 BHTWG meeting minutes describe a “Draft Framework” that “...outlines action to integrate mental health and substance abuse systems..” (p. 1). The BHTWG Vision is described on p. 14 as, “Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery.” Described goals include “1. Increase the availability of and access to quality services, 2. Establish a coordinated, efficient state and community infrastructure throughout the entire mental health and substance abuse system with clear responsibilities and leadership authority and action, 3. Create a comprehensive, viable region or local community delivery system, 4. Make efficient use of existing and future resources, 5. Increase accountability for services and funding, 6. Provide authentic stakeholder participation in the development, implementation and evaluation of the system.”

The May 12, 2010 minutes also proposed several action strategies (pp. 14-17) to transform Idaho’s system. Action strategies include 1) generating Regional Behavioral Health Community Development Boards that combine existing Regional Mental Health Boards (focus on mental health) and Regional Advisory Committees (focus on substance use issues), 2) through legislation, creating the State Behavioral Health Planning Council to replace the State Mental Health Planning Council with a focus on both mental health and substance use disorders, 3) through legislation, creating a Statewide Behavioral Health Interagency Cooperative composed of “...government entities that are purchasers and users of services” that are responsible “...to actively coordinate the transformation of the behavioral health system on behalf of their respective and collective consumers needs...and their respective agency requirements” (p. 15), 4) appointing a Transformation Champion/Project Manager that reports to the governor and is responsible to manage the State Behavioral Health Interagency Cooperative’s transformation activities, 5) assigning the Department of Health and Welfare as the Guarantor of Care, and 6) supporting Regional Provider Networks. The BHTWG additionally defined their vision of core services (Services, March 10, 2010) as “...an array of services including those that are community based, emergent, medically necessary, and required by law. The intent is to provide a ‘floor’ of services, available in each region, that span prevention, intervention, treatment and recovery so that coordinated efforts are enabled to redirect supports from the more expensive emergent and medically necessary services to more effective and less costly prevention, intervention and recovery services. Core services will be provided in accordance with statewide standards which will include, at minimum, monitoring for quality, consistency and timeliness. These services will be delivered from a client-centered perspective. Effectiveness of service delivery will be determined by examining quality of life measures as well as other standardized outcome-based instruments.”

As of July 2010, the BHTWG (Services, June 9, 2010, pp. 1-10) was in the process of defining what they recommend for an array of core services for behavioral health. These services included 1) Assertive Community Treatment (ACT), Intensive Case Management and Wraparound, 2) Assessment and Evaluation, 3) Case Management/Service Coordination, 4) Designated Examinations and Dispositions, 5) Intensive Outpatient Treatment

(includes Home-Based Mental Health Services, Intensive Outpatient Substance Use Disorder Treatment), 6) Illness Self-Management and Recovery Services, 7) Inpatient Psychiatric Hospitalization, 8) Medication Management (includes Medication Management/Pharmacotherapy, Medication Administration/Monitoring and Laboratory Tests), 9) Peer Support Services, 10) Prevention Services, 11) Early Intervention Services for Children and Adolescents, 12) Psychiatric Emergency and Crisis Intervention Services (includes Crisis Intervention/Mobile Crisis and Crisis Residential Treatment/Respite Care Services), 13) Psychotherapy (includes Individual Psychotherapy, Group Psychotherapy and Family Psychotherapy for Children and Adolescents, 14) Alcohol and Drug Residential Treatment, 15) Supported Employment (includes Supported Employment and Job Preparedness), 16) Supported Housing, 17) Transportation, 18) 24-Hour Out of Home Treatment Interventions for Children and Adolescents (includes Residential Treatment and Treatment Foster Care), and 19) Day Treatment/Partial Care Services for Children and Adolescents, and Partial Hospitalization for Adults.

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

Estimate of Prevalence

The State of Idaho uses the estimation methodology for adults required by the Substance Abuse Service Administration's Center for Mental Health Services (CMHS). According to the National Prevalence figures prepared for MHSIP by the National Research Institute and distributed by CHHS, the following table describes Idaho's 2008 estimated prevalence of SMI and SPMI. Updated figures are based on the 2008 U.S. Census Bureau information. Background details on the definition for SMI were published previously in the Federal Register on May 20, 1993. Estimation methodologies for SMI were published in the Federal Register on June 24, 1999.

According to the U.S. Census Bureau data for 2008, Idaho total population estimate of age 18 and over was **1,111,176**. Based on this estimate and the CMHS estimation methodology establishing prevalence at 5.4% for SMI and a prevalence rate of 2.6% for SPMI, it may be concluded that there are **60,004** adults in the state of Idaho with serious mental illness and **28,891** adults in the state of Idaho with serious and persistent mental illness.

According to information provided from NRI (URS Table 1: Number of Persons with Serious Mental Illness, age 18 and older, by State 2009; July 6, 2010), the 2009 civilian population 18 and older estimate for Idaho is 1,121,809. The estimated civilian population with a diagnosis of a serious mental illness (5.4%) is 60,578, with a lower limit of estimate (3.7%) of 41,507 and an upper limit of estimate (7.1%) of 79,648.

The following table shows breakdowns by Region based on 2008 census population estimates.

	2008 Estimated Adult (age 18 and over) SMI/SPMI Populations By Region							
	Region I	Region II	Region III	Region IV	Region V	Region VI	Region VII	Total
2008 Adult Population	161,853	81,216	173,662	313,891	127,597	114,052	138,905	1,111,176
Estimated Adult SMI Population (5.4%)	8,740	4,386	9,378	16,950	6,890	6,159	7,501	60,004
Estimated Adult SPMI Population (2.6%)	4,208	2,112	4,515	8,161	3,318	2,965	3,612	28,891

Source: US Census Bureau
Annual Estimates of the Resident Population by Selected Age Groups and Sex for Counties: April 1, 2000 to July 1, 2008.

<http://www.census.gov/popest/counties/asrh/CC-EST2008-agesex.html>

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

Quantitative Targets

Adult Mental Health – SFY 2010 and Projections for SFY 2011

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 SFY 2010. Targets for SFY 2011 are maintenance of levels served during SFY2010.

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 FY2010. (d) In Idaho, due to funding constraints, the target population in SFY 2010 was defined as adults diagnosed with a *serious and persistent mental illness*, a narrower subset of serious mental illness.

The State of Idaho began implementation of data entry into the WITS data infrastructure system on October 1, 2009 to support the needs of the AMH regional behavioral health service delivery systems. During this transitional period, accurate and unduplicated data capture continued to be challenging, and the Behavioral Health Monthly Data Report information continued to track key data elements as a backup to the WITS system throughout SFY 2010. Efforts to enhance system features and develop report extraction capability for WITS will continue throughout SFY 2011 as funds allow. The Vista system is the system used at the two state psychiatric facilities, State Hospital South (SHS) and State Hospital North (SHN).

For the purpose of this report, the total number served is based on the Daily Activity Report (DAR) billing 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 provided in SFY 2010 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 2010, 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 provided 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. Because many of the mental health services provided

through the SMHA are provided to a core ongoing caseload of the same people from one month to the next and because monthly numbers on the BH Monthly Data Report do not track new or closed clients, data provided for ACT, outpatient clinic and psychosocial rehabilitation/case management are estimated from the highest monthly count in each category in each region for SFY 2010. Use of the Behavioral Health Monthly Data Report was discontinued in July 2010, and SFY 2011 data will be based on reports from the WITS system.

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 activities are also noted in the following tables:

Served in SFY 2010 and Projected to be Served in SFY 2011

Projections for SFY 2011 will be maintenance of the same levels as numbers served in FY 2010. See charts below for details on Services and numbers served in SFY 2010:

AMH SERVICES BY SERVICE TYPE SFY 2010 (AS OF 7/24/2010)

DAR Caseload Count Report – SFY 2010		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Total
YTD Total # People Served by SMHA Resources	Beginning Caseload	431	439	648	578	455	565	700	3,816
	Total Through System	411	191	700	137	690	518	700	3347
	Total	842	630	1348	715	1145	1083	1400	7163

SERVICE TYPES AND NUMBERS SFY 2010 – BH REPORT AND DAR

SERVICE TYPE	SMHA SYSTEM
Outpatient Clinic Services – BH report	2,557
Psychosocial Rehabilitation/Case Management (Non-ACT) - BH	899
ACT Team (266) and MH Court ACT (242) – BH report	508
MH Court ACT with Co-Occurring Disorders – BH report; July 1, 2009 through June 30, 2010	193
Designated Exam Holds and Petitions – BH report	3,905
% Holds Diverted from State Hospitalization – BH report	86.26%
Clients receiving PAP med scholarships – BH report (duplicated)	7,841
CONTRACT W/OFFICE OF CONSUMER AFFAIRS (MONTHLY CONTRACT REPORT)	
Peer Specialists Trained (as of July 2010)	55
Peer Specialists Certified (as of July 2010)	45
Peer Specialists Placed as of July 2010	6

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 2010. PATH funding has historically been distributed to each of the seven regional mental health centers responsible for providing these services, with state general funds used to supplement PATH grant allocations. Following the recommendations of a federal audit of the PATH services in SFY 2009, Idaho plans to implement a Request for Proposals (RFP) process for PATH funds and services in SFY 2011.

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 Special Needs grants, including Housing for Persons with AIDS/HIV (HOPWA), Emergency Shelter Grants-Stewart B. McKinney (ESG), Supportive Housing Program-Stewart B. McKinney (SHP), Shelter Plus Care Program (S+C) and Homeless Assistance. Idaho Housing and Finance Authority searches out and acts on other grant opportunities that best serve the housing needs of limited income Idahoans. They have received funding to provide technical assistance to nonprofit housing sponsors and allocations of Section 8 funding designated for special need populations. They have also assisted community efforts to obtain private foundation grant funds to help serve homeless individuals. Idaho Housing and Finance Authority recently secured federal and other funding for housing for persons diagnosed with AIDS. Efforts are underway to obtain equipment and software to help build the technological capabilities of nonprofit housing organizations.

Shelter Plus Care housing is available in all regions of the State of Idaho. This program assists in providing housing to those who are diagnosed with a mental illness and who are also 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.

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.

Highlights of SFY 2010 activities directed to housing and homelessness include the following:

- The Charitable Assistance to Community's Homeless (CATCH) program that mobilizes community resources to help address homelessness continued operations in both Region 3 and Region 4.
- The Division of Behavioral Health is an active participant in the Community Conversations on Housing workgroup.
- On 2/18/10, several Idaho housing service providers from across the State came together to advocate for Idaho's homeless on Idaho Public Television.
- St. Vincent de Paul's Coeur d'Alene emergency shelter partnered with the City of Coeur d'Alene to open the meeting room behind the Coeur d'Alene Thrift Store to unsheltered homeless individuals when the temperature dropped to 15 degrees or below.

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 (2009), the total state population estimate for 2009 is 1,545,801. Idaho experienced an estimated 19.5% population increase from April 2000 to July 2009. Of the fifty states, Idaho ranks 13th in area size with 82,747.21 square miles.

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

According to the Census Bureau, a 2008 estimate is that 94.6% of Idaho citizens self-identify as white with 85% white/not Hispanic; .9% black; 1.5% American Native/Alaska Native; 1.1% Asian; .1% Pacific Islander and 10.2% Hispanic/Latino origin. See below:

Black/African American	Native American/Alaska Native	Asian	Native Hawaiian/Pacific Islander	Hispanic
0.9%	1.5%	1.1%	0.1%	10.2%

Idaho's largest ethnic minority, representing 10.2% 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 a very small percentage 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). Use of this system allows expansion of 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. Region 2 continued to provide these services to clients throughout the region through videoconferencing sites at Lewiston and Orofino in SFY 2010.

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 operated field offices (i.e., a state total of 22 field offices) that provided access to services for those living in the more remote areas of the state for most of SFY 2010. Budget cuts necessitated the closure of nine (9) rural offices in May 2010. Other methods of service extension include the development of networks of private providers under the Medicaid Rehabilitation Option.

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 regional mental health services through the Division of Behavioral Health 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. The Idaho Commission on Aging is another resource. Their mission is “To improve quality of life for all older Idahoans, vulnerable adults, and their families through education, advocacy, accountability and service; to provide opportunity for all to live independent, meaningful and dignified lives within communities of their choice.

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.

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 FY2011 as follows:

Expenditures By Fund Detail	SFY 2011 Estimate
State:	
General Funds	13,472,000
Economic Recovery (State Funds)	
Receipts- ongoing	600,000
Subtotal State:	14,072,000
Federal:	
CMHS Block Grant	1,100,000
DIG	142,200
PATH	300,000
Olmstead Grant	0
Medicaid	0
TANF	0
Other Federal	1,056,200
Subtotal Federal:	2,598,400
Total Estimated Expenditures	16,670,400

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 7/1/2010 in the Adult Mental Health Program statewide. Figures reflect budget cut layoffs in SFY 2009 and SFY 2010 and figures provided include existing forced vacancies. In comparison, the total Established FTE in SFY 2008 was 246.15 and the total Established FTE in SFY 2009 was 234.91.

STATEWIDE DISTRIBUTION OF CMHC AMH STAFF as of 7/1/2010

Region	Total Established SMHA FTE's	Vacant FTE
Region I	31.08	6.08
Region II	24.35	3.6
Region III	36.5	4
Region IV	45	8
Region V	28.1	6.5
Region VI	27.74	4.56
Region VII	34.1	5.7
Central Office	8	0
Total	234.87	38.44

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 2011 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 2011 include training on use of the WITS data system and training related to the provision of services to the SFY 2011 priority population of crisis services and statutory mandates (e.g., court ordered).

Several training modules were developed in SFY 2009 and SFY2010 for online use through the Department of Health and Welfare's Knowledge Learning Center (KLC). The KLC provides a variety of training modules for both online learning and for scheduled ground classes. Continuing Education Units (CEUs) are available for many of these courses, and this feature is helpful to Idaho clinical and social work staff who have

requirements for at least 20 CEUs per year. Training modules that are especially pertinent to Idaho Behavioral Health staff include SAMHSA's TIP 42 for treatment of integrated co-occurring disorders competency; cultural competency modules and ethics. Division of Behavioral Health Policies and Procedures are available through the KLC, and all staff are required to complete these courses. The KLC tracks courses and whether participants complete and pass each course taken. Regional supervisors are responsible to ensure that their staff complete and pass required KLC modules to provide mental health services.

The WITS data system was implemented for data entry at regional mental health centers and central office in October 2009. Enhancements to WITS for additional clinical features and for report extraction continue as funds are available.

Specific training opportunities that were offered in SFY 2010 in addition to courses on the KLC included training on psychosocial rehabilitation. The United States Psychiatric Rehabilitation Association (USPRA) chose Boise, Idaho as the location for their 2010 35th Annual National Conference (June 13-17, 2010). This training was well attended, and Certified Peer Specialists helped to facilitate logistics and track attendance at each workshop. An Idaho State USPRA training on psychosocial rehabilitation was provided in September 2009. This training was made available across the State of Idaho through high-definition videoconferencing to up to 120 Department 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 on an ongoing basis 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.

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. An assortment of Emergency Services Provider Training events were held throughout SFY 2010 in each of the regions (see Emergency Services Provider Training for specifics).

Also during SFY 2009 and SFY 2010, and through a Division of Behavioral Health contract with Mountain States Group Office of Consumer Affairs, Martha Ekhoﬀ of the Office of Consumer Affairs oﬀered WRAP and Certified Peer Specialist training to prospective peer specialist candidates. Certified Peer Specialist trainings were held in February 2009, in October 2009 and in May 2010, with a total of 55 consumers attending the training sessions. Of those 55, 45 passed the certification exam. Fifteen Certified Peer Specialists were trained as Certified Wellness Recovery Action Planning (WRAP) facilitators as of July 9, 2010 and one Certified Peer Specialist qualified as an advanced level WRAP facilitator. Also as of July 2010, there were six Certified Peer Specialists employed and placed on Regional Assertive Community Treatment teams, and one unpaid volunteer who worked at State Hospital South.

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 on an ongoing basis to all regions by request.

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. By 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.

During SFY 2010, regions provided an array of emergency provider training opportunities. Highlights of SFY 2010 trainings include the following:

In Region 2, approximately 30 people (e.g., law enforcement, prosecutors, private providers) attended an Emergency Response Protocol/First Responders Training on May 19, 2010 in Latah County. This training reviewed statutory rules and how they applied to emergency situations with respect to the civil commitment protocol. Adult Mental Health staff provided an overview of the designated examiner process and protocol to hospital emergency room physicians, primary care physicians and private practice physicians in the Moscow community. Partnering with the prosecutor, this training covered relevant rules, protocols, court processes and liabilities. Designated examiner training was also offered to physicians who thought it would add value to their practice. These training opportunities attracted the interest of a group of physicians who expressed interest in future training to prepare them to be designated examiners. Mental Status Examination training for first responders and private providers will be offered in conjunction with the Designated Examiner training opportunity.

Region 2 uses the video conferencing equipment located at State Hospital North to provide psychiatric oversight for clients, primarily those who are indigent and those referred from Mental Health Court. Of these, 29 live in Clearwater County, which is 40 miles from available doctors' offices. Clearwater County has the highest unemployment rate in the State of Idaho and the video conferencing equipment allowed service provision to a population that otherwise would not be served. This same equipment is used for weekly staff meetings, avoiding cost and time associated with travel for clinical staff.

In Region 3, the Chief of Social Work for Children's Mental Health takes the training lead on the crisis team that provides the mental health response for emergency services and first responders. Training needs are identified through requests from the community. In May 2010, Region 3 provided training to ten Payette city police officers, fifteen Payette County sheriffs, nine Fruitland City police officers and six staff at Valley Crisis Center. Additional training was provided to twenty Washington county sheriff officers and Weiser City police officers in November 2009. In April 2010, training was offered to 24 Emmett police officers, Gem County sheriffs and 8 staff at Weiser Memorial Hospital. In October 2009, 45 Canyon County Sheriffs officers were trained, and twelve Caldwell police officers were trained in September 2009. Emergency services training was offered to Nampa police officers in December, January, February and March, with an estimated 40 officers attending each training. Additional trainings were offered to 25 ER staff at West Valley Medical Center and 15 ER staff at Mercy Medical Center (August 2010); three staff at the CATCH program and 22 staff from Canyon County probation and parole (June 2010); 15 adult protection staff (February 2010) and 90 social work and nursing students from three universities (November 2009 and July 2010). Two designated examiner trainings were offered (October 2009 and May 2010) to a total of 30 participants.

The monthly Region 3 stakeholder meeting with representation from local law enforcement, hospitals, the prosecutor's office, the developmental disabilities program, adult protection and transportation services continues to operate and review all problematic cases each month. This group reviews procedures and cases to assure that an appropriate response is provided for persons with a mental illness. Information from this meeting is shared to assure ongoing efficiency and professionalism is maintained in the crisis system for emergency responders.

In SFY 2010, the Ada County Meeting met monthly with approximately 25 representatives from law enforcement, emergency rooms, psychiatric inpatient hospitals, Veterans Administration, Allumbaugh House, mobile crisis, Ada County Prosecutors, Suicide Prevention and other interested parties. The focus of these meetings is to staff cases and resolve systems issues between agencies, to provide up-to-date information to community partners, and to foster and maintain open relationships and flow of information between agencies. The Ada County Meeting will continue through SFY 2011, with new community partners (e.g., representatives from the Governor's Transformation Workgroup and Taskforce on Suicide in Idaho, Mental Health Board members, and private providers).

Region 4 Adult Mental Health staff maintains a representative on the statewide CIT curriculum committee and they also provided 4 hours of the 40 hour CIT training to approximately 40 local police officers July 19-23. Region 4 provided three hours of crisis training (e.g., mental illness, mental hold assessment, accessing mobile crisis) to 50 Ada County Sheriff- Gold Team officers on July 14, 2010, with additional training scheduled for 50 Red Team officers in August 2010. Region 4 provided Mental Health identification and de-escalation training to 20 employees of the Boise City Public Library on July 19, 2010. Region 4 provided Designated Examiner training (May 2010) to 65 participants from Region 4 Counties, the Ada County Jail, Corrections, psychologists, Children's and Adult Mental Health and local hospitals. Multiple trainings were provided throughout the fiscal year to approximately 15 staff (e.g., court staff, judge, probation officer, vocational rehabilitation, Ada County Mental Health Court Agencies). Mobile Crisis provided training to 40 people from Boise State University; 15 medical/social work staff at St. Alphonsus and other community service providers (e.g., About Balance, El-Ada, Access Behavioral Health, Head Start, and Pioneer Health Services).

In SFY 2010, Region 5 provided mental health training to approximately 15 law enforcement personnel during quarterly Protective Custody Task Force meetings. Region 6 implemented a CIT training, held a monthly interagency task force meeting, offered community workshops on suicide and crisis training, and went to every county to train county representatives on crisis matters and protocols.

Region 7 offered de-escalation training (2/3-2/5) to 30 participants from Bonneville County Sheriff's Office, Pocatello City Police, Idaho Falls Police, Dispatch and the Behavioral Health Center. They also provided a 40 hour CIT Academy (10/19-10/23), with approximately 30 participants from Idaho Falls Police Department, Bonneville County, Caribou County, Fremont County, Jefferson County, juvenile corrections,

advocacy groups and the Department of Health and Welfare. Ongoing meetings were held with representation from local law enforcement, courts, advocacy groups, housing, hospitals, prosecutors, public defenders and the jail to network and discuss issues. Region 7 participates in a quarterly 19-2524 meeting with the judge.

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

The State intends to expend the block grant for SFY 2011 as follows:

Adult Mental Health	Block Grant Funds
Adult Mental Health Services	\$1,196,478
Peer Specialist/Consumer/Family Empowerment	\$ 153,000
State Planning Council	\$ 20,000
Suicide Prevention	\$ 10,000
Quality Improvement System Development	\$25,000
<i>Total Adult Services FY 2011</i>	\$1,404,478
Children’s Mental Health	
CMH Special Projects:	
-Contract with Family Run Organization	\$269,267
-Contract for Suicide Prevention Services	\$22,854
-Contract for Primary Care Physician Training	\$20,000
<i>Total - Children Services FY2011</i>	\$ 312,121
Administration (5%)	\$ 90,347
<i>Total- Adult Services, Children’s Services, & Administration</i>	\$ 1,806,946

It is understood, as required by Public Law 102-321, that no Federal CMHBG funds are to be used to pay for inpatient services.

The following projects will be funded using federal Community Mental Health Block Grant (CMHBG) funds in FY2011:

\$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 the 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.

\$32,854 will be used to contribute toward the funding of a contact for Suicide Prevention. This total reflects \$10,000 from the Adult Mental Health allocation and \$22,854 from the Children’s Mental Health allocation.

\$25,000 will be dedicated toward funding the implementation of a Quality Improvement System to ensure best practice service delivery in adult and children's mental health services programs.

\$269,267 will be used to fund the contract with a Family Run Organization.

\$20,000 will be used to fund a contract to train Primary Care Physicians on treating patients with mental health disorders.

\$1,196,478 will be 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

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the <i>actual or estimated</i> amount of MHBG funding that will be used to support this transformation goal in FY2011	
		Actual	Estimated
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	<input checked="" type="checkbox"/>		10,000
GOAL 2: Mental Health Care is Consumer and Family Driven	<input checked="" type="checkbox"/>		422,000
GOAL 3: Disparities in Mental Health Services are Eliminated	<input checked="" type="checkbox"/>		20,000
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	<input checked="" type="checkbox"/>		10,000
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	<input checked="" type="checkbox"/>		1,200,000
GOAL 6: Technology Is Used to Access Mental Health Care and Information	<input checked="" type="checkbox"/>		69,000
Total MHBG Funds	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.

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

Mental Health Transformation has been 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.

Governor Butch Otter convened the Behavioral Health Transformation Work Group (BHTWG) in April 2009 with 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, a private citizen, the Association of Counties, and the Department of Correction. The BHTWG began its work by adopting the following Vision and Goals:

Vision

Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable and focused on recovery.

Goals

1. Increase availability of and access to quality services
2. Establish an infrastructure with clear responsibilities and actions
3. Create a viable regional and/or local community delivery system
4. Efficiently use existing and future resources
5. Increase accountability for services and funding
6. Seek and include input from stakeholders and consumers

Transformation activities that pertain to specific goals are described below:

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.

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 were conducted for three regional teams in SFY 2010. DACTS fidelity reviews will be conducted for two regional teams in SFY 2011.

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 partnered to do a similar effort with poetry, and results of this effort were 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 and SFY 2010, 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. As of July 2010, 55 consumers attended the Certified Peer Specialist training events and 45 of these passed the certification exam. There are seven Certified Peer Specialist Training Curriculum Trainers. Certified Peer Specialists were employed through the Office of Consumer Affairs and were placed on Regional ACT teams in six regions. One Certified Peer Specialist was volunteering at State Hospital South. 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. As of July 2010, 40 Certified Peer Specialists completed WRAP, and 15 Certified Peer Specialists were trained as WRAP facilitators. One Certified Peer Specialist is qualified as an advanced level WRAP facilitator. There are \$153,000 in 2011 Mental Health Block Grant funds directed to this project.

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 July 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.

Goal 3: Disparities in Mental Health Services are Eliminated

The block grant funds \$20,000 of the contract to address suicide prevention. In previous years, this contract was with the Suicide Prevention Action Network (SPAN). The Suicide Prevention contractor is now 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.

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 exceeded \$800,000. Estimated PAP cost savings for the first three quarters of SFY 2010 was \$9,694,973.

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

In SFY 2010, the Behavioral Health Program defined a method to determine caseload acuity for high, medium and low service needs for both the adult and children's programs. These acuity levels are programmed into the information systems and applied to caseloads in all service areas. The LOCUS and CALOCUS instruments were chosen to assist in determining acuity level for mental health services.

Regional MH 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 and this continued into SFY 2010. A Forensic Psychiatrist was hired in Region 4 to provide services to increased numbers of clients referred from the criminal justice system, but he has since resigned.

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.

The children's mental health program continues to work with the courts and juvenile justice systems. Regional CMH staff provide screenings and assessments to at risk juveniles during the juvenile court proceedings either through parental consent or court orders. These assessments or

screenings result in recommendations and referrals for services if needed. Additionally, the Department provides a portion of the funding to the Idaho Department of Juvenile Corrections to contract with mental health professionals to provide screenings and assessments to youth in county juvenile detention facilities. These screenings and assessments also lead to referrals for follow up services when indicated.

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 (eg., 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 demonstrated cost savings through diversion from hospitalization and reports of participant satisfaction, it was discontinued in May 2010 because of budget cuts.

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 effect 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 research 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

The Division of Behavioral Health was awarded a Client Level Reporting Project (CLRP) grant in the winter/spring of 2008. This award allowed 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).

During SFY 2009, the two State Hospitals (North and South) installed and implemented the VistA system for electronic health records. 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 CLRP data element definitions of the NOMS. Installation of WITS for Adult Mental Health (AMH) use was completed by June 2009 and regions began data entry for AMH into the WITS system in October 2009. Implementation and training activities were held for AMH programs throughout SFY 2010.

While the WITS system can be used to input data, extraction of that data for reporting purposes is not yet possible. As funds are available, the Division of Behavioral Health will pursue enhancements to WITS for data collection and data extraction and reporting purposes throughout SFY 2011. If funds can be identified, the Division would also like to use the Client Level Reporting Project data elements for Children's Mental Health (CMH) to build CMH capacity in the WITS system. If funds cannot be identified, the CMH program will continue to use the existing FOCUS system.

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 2009, 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 two years, the Behavioral Health program has expanded access to psychiatric care and services to adults with a serious mental illness and children with serious emotional disturbance 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 with a Region 2 estimate that 360 clients received these services from 9/08 through 5/09.

In May 2009, contracted psychiatrists were providing telemedicine from the Boise Central Office, with Region 2 estimating 360 clients receiving these services from 9/08 through 5/09. Region 7 used these services for an estimated 180 clients from 2/09 through 5/09. A total of 740 scheduled appointments (duplicative client count) were made for Region 2 clients from throughout the Region from July 7, 2009 through June 30, 2010. These services were provided through video equipped offices in Lewiston and Orofino.

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. In SFY 2010 (July 2009 to June 2010), the total estimated savings across all users was \$465,706.24.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	10,356	8,209	7,163	7,000
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 7,000 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. The SFY 2011 priority population is adults with SMI in crisis and statutory mandate (court ordered).
- 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, WITS
- Special Issues:** The WITS system was implemented for AMH 10/1/09; SFY 2011 will be the first full year of AMH data capture from this system. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court ordered). 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. Projections for total adults served for State FY 2011 will be at least 7,000.
- 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. The SMHA will provide public mental health services to at least 7,000 eligible adults in SFY 2011.

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	.22	2.71	6.07	6
Numerator	1	18	--	--
Denominator	457	663	--	--

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 6% 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 6% target reflects concerns about increased stressors on Idaho citizens related to the economy and an SFY 2011 priority population for individuals in crisis and for those under statutory mandate (i.e., court ordered). In October 2009, the state hospitals changed practice guidelines in order to accept committed patients and have those patients transferred to the state hospital facility within 24 hours of commitment.

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.

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	3.94	9.05	11	11
Numerator	18	60	--	--
Denominator	457	663	--	--

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 11% 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. The 11% target reflects concerns about increased stressors on Idaho citizens related to the economy and an SFY 2011 priority population of those in crisis and those eligible under statutory mandate (i.e., court ordered). The state hospitals responded to a 2008 analysis of the Idaho mental health system by shortening length of stay in the hospital setting. This has also resulted in an increase in 180 day readmissions.
- 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.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	1	5	6	5
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 evidence based mental health services.

Target: Maintain the number of Evidence-Based Practices in Idaho during SFY 2011.

Population: The priority population for SFY 2011 is adults with SPMI in crisis and adults served by statutory mandate (e.g., court ordered).

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, WITS, Vocational Rehabilitation.

Special Issues: Evidence based practices (EBP) implemented by the SMHA for adults with a serious and persistent mental illness in SFY 2010 included ACT,Supported Employment, Supported Housing, Medication Management, Illness Self Management and Integrated Treatment of Co-Occurring Disorders. All regions provide ACT; not all provide all other EBPs. EBP fidelity is measured only for ACT (DACTS). Supported employment is provided through an Interagency Agreement with the Idaho Division of Vocational Rehabilitation. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court ordered).

Significance: This is a required National Outcome Measure.

Action Plan: Assertive Community Treatment (ACT) services are available in each of the 7 service regions of the Department of Health and Welfare's Adult Mental Health Program. Each region provides mental health court referred ACT services and Supported Employment. Most regions provide Co-Occurring, Integrated Treatment. Some provide Supported Housing, Medication Management and Illness Self Management. In SFY 2009 and 2010, certified peer specialists were placed with regional ACT teams across the state; this is also planned for SFY 2011.

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	69.75	65
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 2011, 65% 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. During SFY 2010, 69.75% of adults with SMI who were living in Shelter Plus Care housing and receiving supportive services from the SMHA maintained their housing stability for at least 9 months. The SFY 2011 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. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court

ordered).

- 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 2011.

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	54.07	270	270
Numerator	N/A	146	--	--
Denominator	N/A	270	--	--

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 2011 target is to provide CSE services to at least 270 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 270 eligible adults served through BH and VR regional programs will receive CSE services and be employed in SFY 2011.
- Measure:** VR reports of CSE services provided to BH clients whose cases were either closed (Rehab Closed, Employed) or open and employed from 7/1/2010 through 6/30/2011.
- 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 2011 or 2) still open as of 6/30/2011.
- 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 2011, 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. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court ordered).
- 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 2011, at least 270 shared clients will receive CSE services and be either 1) still open and employed by June 30, 2011 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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	7.15	508	250
Numerator	525	587	--	--
Denominator	N/A	8,209	--	--

Table Descriptors:

- Goal:** Priority population persons with a serious mental illness will have access to assertive community treatment services.
- Target:** Provide ACT services to at least 500 persons as measured by total number of ACT clients served during SFY 2011.
- 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 from the SMHA.
- Measure:** Total number of persons receiving ACT services.
- Sources of Information:** Regional reports through the WITS system and courts.
- 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 2010, there were an estimated 508 ACT clients served; 266 of these were non-MHC referred and 242 were MHC referred. Idaho implemented a Peer Specialist Certification program in SFY 2009 and certified peer specialists were placed with ACT teams across the State. The SFY 2011 target reflects changes in the SMHA. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court ordered).
- 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.
- Action Plan:** ACT staff will primarily serve priority population clients (i.e., crisis and court ordered)clients in each region. Certified peer specialists will continue placements with ACT teams across the state 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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	2.29	193	193
Numerator	256	188	--	--
Denominator	N/A	8,209	--	--

Table Descriptors:

Goal:	Provide co-occurring, integrated treatment to adults with co-occurring mental illness and substance use disorders to at least 193 adults receiving SMHA services by June 30, 2011.
Target:	The target for SFY 2011 is to provide co-occurring, integrated SMHA treatment services to at least 193 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 193 individuals with mental illness and substance use disorders receiving SMHA treatment services.
Measure:	see Indicator.
Sources of Information:	Regional counts, court data, 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 2010, approximately 193 mental health court ACT were diagnosed and received treatment for co-occurring disorders. The WITS data system was implemented October 1, 2009, and report extraction enhancements will continue through SFY 2011 in an effort to improve data capture and reporting. Regions continue to work on becoming co-occurring capable in the delivery of treatment services; therefore the 2011 goal will be to provide these services to 180 eligible adults served by ACT and MH Court referred ACT. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court ordered).
Significance:	National Outcome Measure.
Action Plan:	Provide dual diagnosis services to at least 193 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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	12.69	500	500
Numerator	N/A	1,042	--	--
Denominator	N/A	8,209	--	--

Table Descriptors:

- Goal:** At least 500 adults receiving SMHA services will also receive Illness Self Management.
- Target:** Provide Illness Self Management to at least 500 adults with SMI served by the SMHA.
- 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 WITS data system will be used in SFY 2011 to track the numbers of adults with SPMI who are receiving Illness Self Management through the SMHA. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court ordered).
- Significance:** This is a required NOM.
- Action Plan:** Track the numbers of adults receiving Illness Self Management services through the SMHA in SFY 2011 through the WITS system. Provide Illness Self Management services to at least 500 individuals in SFY 2011.

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	15.91	500	500
Numerator	N/A	1,306	--	--
Denominator	N/A	8,209	--	--

Table Descriptors:

- Goal:** Provide Medication Management services through the SMHA to at least 500 adults with SPMI in SFY 2011.
- Target:** Provide Medication Management services through the SMHA to at least 500 adults with SPMI in SFY 2011.
- 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 WITS data system in SFY 2011 should help to track the numbers of adults with SPMI who are receiving Medication Management services through the SMHA. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court ordered).
- Significance:** This is a required NOM.
- Action Plan:** Use the WITS data system to track the number of adults with SPMI receiving Medication Management services through the SMHA in SFY 2011. Provide Medication Management services through the SMHA to at least 500 adults with SPMI in SFY 2011.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	84.68	84.97	90	84
Numerator	763	656	--	--
Denominator	901	772	--	--

Table Descriptors:

- Goal:** Persons receiving SMHA services will report a positive perception of care received from the SMHA.
- Target:** To achieve an 84% or higher approval rating in MHSIP reports of 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 on the MHSIP survey.
- 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. MHSIP data for Idaho has historically been entered into the DS2K+ website. Efforts will be made in SFY 2011 to develop an internal resource for this.
- 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:** Idaho began using the MHSIP Adult Consumer Satisfaction Survey in October 2003. The survey is offered for voluntary completion at discharge and annually to all persons receiving ongoing public provided adult mental health services for 30 days or more. Completed paper surveys are sent to central office where they were data entered into the DS2K+ website by support staff; SFY 2011 efforts will include developing an internal site for this. The goal for SFY 2011 is to maintain at least an 84% 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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	54.07	112	112
Numerator	N/A	146	--	--
Denominator	N/A	270	--	--

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. The agreement includes data capture and reporting. It also includes IDVR presence during weekly ACT team meetings. The SMHA's priority population for SFY 2011 will be adults with SMI who are in crisis and those referred through statutory mandate (i.e., court ordered).
- 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. At least 112 persons served through the SMHA and by IDVR will be employed.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	85.90	92.97	89	86
Numerator	542	463	--	--
Denominator	631	498	--	--

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. In SFY 2010,508 of 566 consumers in service for at least 12 months reported no arrests within the past year (.897%); 176 consumers who began MH services during the past 12 months out of a total of 196 respondents indicated no arrests during the past year (.897%). The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court ordered).

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	81.11	90	90
Numerator	N/A	365	--	--
Denominator	N/A	450	--	--

Table Descriptors:

Goal: Increase stability in housing among adults receiving SMHA services who have been homeless or at risk of homelessness.

Target: At least 90 persons who have received homeless services through PATH funds will retain stable housing for at least 3 months; total served SFY 2011 will be 90.

Population: Adults with a serious mental illness (SMI).

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

Indicator: Adults receiving PATH funded 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 PATH funded 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 FY 2011 PATH dollars will be awarded to a contractor with the best response to a Request for Proposals. The SFY 2011 goal to track stability in housing will rely on contractor reported counts of PATH clients that maintain stable housing for at least 3 months. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court ordered).

Significance: National Outcome Measure.

Action Plan: The SFY 2011 goal will be that a total of at least 90 PATH clients served through a contract with a private provider will maintain housing for at least 3 months as measured by contractor reports.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness
(Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	63.50	64.25	65	65
Numerator	548	478	--	--
Denominator	863	744	--	--

Table Descriptors:

- Goal:** Adults receiving SMHA services will report a stronger sense of social connectedness.
- Target:** To achieve a 65% 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. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court ordered).
- Significance:** National Outcome Measure.
- Action Plan:** Encourage completion and submission of MHSIP consumer surveys. Achieve a rating of at least 65% on MHSIP Consumer Survey positive reports of Social Connectedness in SFY 2011.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	64.77	66.89	67	67
Numerator	559	497	--	--
Denominator	863	743	--	--

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% 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 as measured by MHSIP; objective regional reports of increased functioning in areas of psychiatric stability, work, housing, family, etc.

Measure: Subjective report of improved functioning (MHSIP); 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 public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court ordered).

Significance: National Outcome Measure.

Action Plan: Based on subjective report of improved functioning on the MHSIP Consumer Survey, 64.77% in 2008 and 66% in 2009 reported improved functioning. The projected percentage for SFY 2010 is 67%. The goal for SFY 2011 is for subjective MHSIP Consumer Survey reports of improved functioning of at least 67%.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: ACT Outcomes and Fidelity Measurement

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

Table Descriptors:

- Goal:** The State will continue to provide Assertive Community Treatment (ACT) services and measure fidelity to the model of service for this evidence based practice.
- Target:** The Adult Mental Health Program will conduct ACT fidelity assessment on no less than two existing ACT or forensic ACT teams in SFY 2011.
- 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 2011.
- Sources of Information:** Adult Mental Health Program DACTS scores/review, WITS, regional information
- 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. The public mental health system provides adult mental health services through 7 regionally based community mental health centers which includes 13 field offices (9 closed in SFY 2010) across the state. Budget cuts in 2009 and 2010 resulted in reduced staff and fewer field offices. Idaho's priority service population for SFY 2011 is adults with serious and persistent mental illness in crisis and those referred through statutory mandate (e.g., court ordered).
- Significance:** ACT teams provide community based services to adults with a serious mental illness who require intensive services to maintain in a least restrictive, community setting. 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 will be tracked through WITS in SFY 2011. 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 two 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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	1	1	1	1
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:** Enhance report extraction capability in SFY 2011 from the WITS data infrastructure systems (regions) that was implemented for AMH October 1, 2009.
- Population:** Adults with SMI
- Criterion:** 2:Mental Health System Data Epidemiology
- Indicator:** AMH WITS system report extraction capability for NOMS/URS by June 30, 2011.
- Measure:** The AMH will extract data for NOMS/URS for adults receiving community SMHA services from the WITS system by June 30, 2011.
- Sources of Information:** ITSD, Division of Behavioral Health, State Hospitals
- Special Issues:** The Adult Mental Health program explored requirements in SFY 2008, and began use of the WITS data system for AMH in October 2009. While data can be entered, reports cannot yet be extracted. Report extraction capability is anticipated for SMHA community services related to AMH NOMS/URS in SFY 2011.
- 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 implemented data entry into the WITS system for community SMHA services to adults in October 2009. Report extraction capability for AMH NOMS/URS from the WITS system will be implemented by June 30, 2011.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Attend Medication Appointment After State Hospital Discharge

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	67.60	75	80	80
Numerator	261	414	--	--
Denominator	386	549	--	--

Table Descriptors:

- Goal:** Persons with serious mental illness discharged from a state hospital will have access to community-based mental health services.
- Target:** Achieve a rate of 80% 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. This has been a special focus of the SMHA. The state hospitals and community programs have collaborated to improve continuity of care and to refine discharge procedures.
- 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: Follow Up Appointment Within 7 Days of Discharge

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	89.10	88.90	85	85
Numerator	344	471	--	--
Denominator	386	549	--	--

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:** Existing challenges for state hospitals include out of state discharges. Typically, the other state will not schedule an appointment with a person planning to discharge until that person is actually in their state. This makes it more difficult to ensure a timely follow up.
- 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.

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

Establishment of System of Care - Child

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 through the Division of Behavioral Health.

Idaho Code section 16-2404(1) states, “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.”

Idaho Code section 2404(2) states, “The Department of Health and Welfare, the state Department of Education, the Department of Juvenile Correction, counties, and local school districts shall collaborate and cooperate in planning and delivering 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 provides children’s mental health services through mental health centers located in seven geographical regions. The regional mental health centers work closely with State Hospital South in Blackfoot and have primary responsibility for the development of a public system of care. Regional programs work with juvenile corrections and the courts to address the needs of children and youth involved in the corrections system.

Each Region has a Regional Mental Health Board. By law, board membership 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 related to system improvement.

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. 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 travel. As of May 2010, two psychiatrists were providing telehealth services from Boise central office to clients in Region 2, where services could be accessed through either the Lewiston or Orofino sites.

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.

Available Services – Child

The system of care for children and youth with serious emotional disturbance encompasses those services provided through the Department of Health and Welfare (DHW) Children's Mental Health (CMH) program and services provided by other public agencies, non-profit agencies and the private for-profit sector.

Mental health services are provided by private for-profit individual and agency providers throughout the state. Private provider services range from outpatient clinic services, including psychosocial rehabilitation services, to residential and inpatient care. Payment for services may be made by Medicaid, private insurance, self-pay, or contract with the CMH program. Comprehensive services exist within the more populated areas of the state. The more rural areas of the state may have few available mental health services regardless of the funding source.

The CMH program has developed service definitions and measures for the following ten (10) services within the comprehensive system of care:

1. Assessment
2. Case management
3. Respite Care
4. Family Support
5. Therapeutic foster care
6. Crisis response
7. School Mental Health Services
8. Outpatient treatment
9. Residential Treatment
10. Inpatient Hospitalization

Defining these definitions provides for consistency of service provision throughout the state, a measure for services to be provided, a means of identifying gaps in services, and a clear description of each service. Core Service Standards have been developed to address each of the 10 core services and to give direction to each of the 7 DHW regions. These standards also provide direction to regional staff on the development of core services in each region. CMH is moving towards statewide consistency in the application of services in an effort to best meet the needs of children with SED and their families.

The Department of Health and Welfare, Division of Behavioral Health, operates the only publicly operated 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 is to provide inpatient stabilization and treatment requiring lengths of stay averaging 45 to 90 days. Brief, short-term emergency/acute inpatient care must occur at a local level in a privately operated hospital. Longer-term care and treatment, following stabilization at State Hospital South, is provided by foster parents, treatment foster parents, and residential treatment facilities.

In 1997, Idaho implemented the Rehabilitation Option as part of the state Medicaid Plan. The intent of implementing the Rehabilitation Option was to provide community-based services to children with serious emotional disturbance and to adults with serious and persistent mental illness. In implementing the Rehabilitation Option, Idaho recognized that Medicaid funding is a public resource and should be expended on that population for which the public has service responsibility including children with a serious emotional disturbance. The Rehabilitation Option is a vehicle through which public Medicaid resources can flow to the private sector enabling that sector to assist in serving the target population. Medicaid, through their service provider system, continues to build provider networks by forming public-private partnerships. Recognizing that not all children are Medicaid eligible, CMH provides services that would be funded by Medicaid to those children through provider contracts.

EMPLOYMENT SERVICES

Employment services and transition services are a major responsibility of the State Department of Education (SDE). In addition, CMH has a requirement to develop a transition plan for any child, 16 years of age and older, receiving CMH services. This requirement includes both transition to adult mental health services and transition to independent living.

In addition, youth in transition have access to vocational rehabilitation services through Idaho Vocational Rehabilitation (IVR). Youth accessed IVR services through their school or through direct referrals. Children that have been in foster or residential care for 90 cumulative days have access to Independent Living funds through the Child Welfare program.

HOUSING SERVICES

For children receiving CMH services, the child's clinical case manager is responsible to assess the child and family's housing needs and assist the family in finding housing.

The Idaho Housing Agency provides subsidized housing for low-income families. Idaho also maintains a statewide toll-free phone number for the Idaho Housing Information and Referral Center. This center assists families in addressing their housing needs. Idaho's 211 CareLine also provides referral information on resources related to housing.

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 student's 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 for students with SED were delivered through a partnership between local school districts and the Department of Health and Welfare for the school 2009-2010 school year. These services ranged from school companion services to intensive day treatment services.

For additional information, please see the section below related to services provided under the Individuals with Disabilities Education Act.

SUBSTANCE USE TREATMENT SERVICES

The Department's Substance Use Disorders program is within the same division, the Division of Behavioral Health, as Adult and Children's Mental Health. Most substance abuse services are delivered by private 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 use treatment provider:

- Services are based on consumer needs
- Involve communities in program development mental health. and oversight
- Services 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
- Treatment agencies are managed by leaders who create a culture of quality, effectiveness and efficiency
- Treatment agencies are staffed by qualified people committed to providing quality services in the most cost effective and efficient manner possible
- Agencies 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 subcontracts in each region with individual service providers. Outpatient and inpatient services are available to residents in 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 treatment services without parental consent.

MEDICAL AND DENTAL SERVICES

Medical services for children with SED may be funded by Medicaid, Children's Health Insurance Program (CHIP), private insurance, the county welfare services, private

insurance, and private pay. 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 district. Each district responds to local service needs and the corresponding array of services may vary from district to district. Services range from community health nursing and home health nursing to environmental health, dental hygiene and nutrition programs.

Idaho Medicaid continues to cover children's dental services. However, Idaho has very few dental service providers that will accept Medicaid. 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 and low-income families.

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.

SUPPORT SERVICES

The majority of children with SED who do not qualify to receive public mental health services, either are not served or are served through the private sector. In addition, many of Idaho's children with SED are served through the Juvenile Corrections system. Oftentimes, this may be the only resource a family may have to meet their child's mental health treatment needs.

A large private mental health provider system does exist in addition to the public provider system. The actual capacity of the private provider system is unknown and there is currently no data system(s) that can determine an unduplicated count of the number of children with receiving services from private sector providers.

Core CMH services include family support and respite care. 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 core service offered to families needing a temporary break from their care giving responsibilities. 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 a monetary incentive for every provider recruited from an urban or rural area.

SERVICES PROVIDED BY LOCAL SCHOOL SYSTEMS UNDER IDEA

There are 114 independent local school districts in Idaho, all of which 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 district's. Decision to allow private providers to deliver services during school day is also district specific.

CASE MANAGEMENT SERVICES

Children and youth with serious emotional disturbance who are Medicaid-eligible can access case management (service coordination) through a private provider of mental health services. Service Coordination provided by private service coordinators is a Medicaid-reimbursable service.

The Children's Mental Health program has implemented Wraparound services. Wraparound is a highly effective but resource intensive service. Wraparound is therefore reserved for the most difficult cases and those where the child is involved with more than one agency or system. Oftentimes, Wraparound is used in an attempt to avoid expensive out-of-home placements.

Clinical case management is the primary service delivered directly by CMH clinicians. Case management may be the service system's greatest strength. However, the system cannot meet the case management needs of all children and youth experiencing serious emotional disturbances due to capacity limitations.

SERVICES TO CHILDREN WITH CO-OCCURRING DISORDERS

Services for children and youth with SED and those with a substance use disorder are delivered by two different programs within the Department of Health and Welfare Division of Behavioral Health. The completion of a comprehensive assessment on each child receiving CMH services does include an assessment of substance use and recommendations for services. While the vast majority of mental health and substance use treatment services are delivered by private providers, all providers are expected to deliver services using a collaborative service model.

Developing and accessing services for children and youth with co-occurring SED and a developmental disability presents an ever-increasing challenge. Within the Department of Health and Welfare, the Division of Division of Family and Community Services is responsible for providing services to the developmentally disabled. The Division of Family and Community Services and the Division of Behavioral Health collaborate to provide coordinated services. In addition, Wraparound teams frequently include developmental disability providers. Serving those with co-occurring disorders of SED and developmental disability presents unique challenges and this population is one of the most difficult to serve.

ACTIVITIES TO REDUCE HOSPITALIZATIONS

The Children's Mental Health Services Act (CMHSA) emphasizes that the mental health system be community-based. The CMHSA requires that services be provide in the child's home whenever possible. The law limits out-of-home placement to circumstances in which safety may be jeopardized or when there is risk of substantial mental or physical deterioration without treatment out of the home. Further, the law includes least

restrictive treatment principles, safeguards, and review processes to determine the necessity for initial and continued out-of home care. The expectation is that this 1997 law 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. The implementation of this change included a requirement that all psychiatric inpatient hospitalizations funded by Medicaid be reviewed prior to payment. The review consists of a determination of least restrictive services to determine if hospitalization of the child meets both severity of illness and intensity of services criteria. In addition, Medicaid rule allows all children being discharged from psychiatric inpatient hospital to have access to 120-days of Psychosocial Rehabilitation services to assist in transition and skill building to avoid re-admission.

The Children's Mental Health program is committed to the reduction of hospitalization and out-of-home placements. Children are hospitalized or placed out the family home only when indicated by the inability of the community-based service system to provide services to ensure safety and meet treatment needs. CMH, in partnership with Child Welfare, uses regional placement review teams that include the child and their parent(s)/guardian(s). All out-of-home placements, except general foster care, are reviewed to ensure that (a) out-of-home services are needed and (b) reasonable efforts have been made to prevent the placement. Following placement, a review process is used which focuses on (1) progress toward goal attainment and measurable outcomes, (2) further planning, (3) continued need for placement services, and (4) planning toward transitioning the child home or to other less restrictive care. This review of all out-of-home placements contributes to reducing recommendations for hospitalization.

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

Estimate of Prevalence

The State of Idaho uses the estimation methodology for children required by the Substance Abuse Service Administration's Center for Mental Health Services (CMHS). According to the National Prevalence figures prepared for MHSIP by the National Research Institute and distributed by CHHS, the table below provides Idaho's 2009-estimated prevalence of Serious Emotional Disturbances (SED) for individuals under 18 years of age. Updated figures are based on the 2009 U.S. Census Bureau estimates. Background details on the definition for SED were published previously in the Federal Register on May 20, 1993. Estimation methodologies for SED were published in the Federal Register on June 24, 1999.

According to the U.S. Census Bureau data for 2009, Idaho total population estimate is 1,545,801. Using the 2008 percent of persons under 18 years of age, we can estimate that 27.1% of the estimated 2009 population is under 18 years of age. Given this methodology, we can estimate that more than 418, 483 individuals in Idaho are under 18 years of age. Using the estimate that 5 to 9 percent of children meet the definition of SED, it may be concluded there are at least 20,921 children in Idaho with SED.

The following table shows population breakdown by Region based on 2009 census population estimates and the percent of persons under 18 years of age according to the 2008 census:

	2009 Estimated Children (under 18 years of age) SED Populations By Region							
	Region I	Region II	Region III	Region IV	Region V	Region VI	Region VII	Total
2009 Estimated 0 to 17 y/o Population	50,101	21,374	75,321	113,388	49,787	34,397	74,115	418,483
2009 Estimated 0 to 17 y/o Population with SED (5%)	2,505	1,068	3,766	5,669	2,489	1,719	3,705	20,921

Source:

US Census Bureau

Annual Estimates of the Resident Population by Selected Age Groups and Sex for Counties: April 1, 2000 to July 1, 2008.

<http://www.census.gov/popest/counties/asrh/CC-EST2008-agesex.html>

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

Quantitative Targets – Child

The estimated number of children in Idaho under 18 years of age with a serious emotional disorder (SED) is 20,921. This estimate is based on 2009 U.S. Census data and uses a conservative estimate of 5.0% of all children in Idaho having a SED.

Some children with a SED will receive services from private providers. Others will receive services through the school system, the six Idaho tribes, the juvenile corrections system, and through the Children’s Mental Health program. The role of the public sector is to serve the most seriously mentally ill and those without other resources.

The estimated total SED population of 20,921 children must be differentiated from the estimated number of children with SED projected to receive mental health services through the public system. It is estimated that 40% of children with SED will require publicly funded mental health services. Using this percentage, Idaho’s quantitative target in the implementation of the system of care is **8,368** children and youth. This service goal includes children and youth with SED receiving mental health services funded by Medicaid

The Quantitative Target is detailed by Region in the following chart:

Region	1	2	3	4	5	6	7	Total
Quantitative Target (number of children/youth)	1002	427	1506	2268	996	687	1482	<u>8368</u>

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.

System of Integrated Services – Child

MENTAL HEALTH

Idaho's system of care is a state-operated public mental health system administered through the Department of Health and Welfare using a system of seven (7) geographic regions. In addition to services provided by or through the Department of Health and Welfare Children's Mental Health (CMH) program, the Department of Health and Welfare is designated as the lead agency in the coordination of mental health services for the state.

Idaho subscribes to an integrated service delivery system composed of service components including mental health services, social services, educational services, health services, vocational services, and juvenile corrections. Recognizing that services are provided by multiple child-serving agencies, both public and private, the CMH program continues to seek cooperative agreements with other departments and agencies. The need for child and family agencies to work together is emphasized by the fact that many of the children served in the CMH program are also served by other agencies or systems.

SOCIAL SERVICES

The CMH program works closely with the Child Welfare program. Both programs are under the umbrella of the Department of Health and Welfare and prior to 2006, both were in the same Division. A memorandum of understanding between CMH and Child Welfare program on how the two programs will serve children involved in both programs. The memorandum details the process of making referrals to the other program, how to coordinate the placement of children in alternate care placements, and other details of coordinating between the two programs.

The Department of Health and Welfare (DHW) established a Service Integration program with the goal of assisting families in navigating the various DHW programs. The DHW recognized that a major criticism is the difficulty a family or individual may experience in accessing services in a large bureaucracy. The Service Integration program is closely connected to Idaho's Health Information and Referral center also referred to as the 211-Idaho CareLine. The 211-CareLine provides referral information and can be accessed statewide by dialing 211.

EDUCATION

The Departments of Health and Welfare and the Department of Education have worked together with local school districts in establishing and operating community-based intensive school-based programs. The Department of Health and Welfare through the CMH program provided funding for day treatment programs during the 2009-2010 school year. These school programs ranged from traditional day treatment models to classroom-based models. The eligible population for these jointly sponsored, intensive

school-based programs included children and youth identified as emotionally disturbed according to the educational system's criteria and students meeting diagnostic criteria for SED.

JUVENILE JUSTICE

Idaho has implemented many programs and pilots in an effort to better meet the needs of youth in the juvenile justice system. The first example was the creation of the Juvenile Justice/Children's Mental Health Collaborative Workgroup. This group includes administrative and direct service personnel. The primary purpose of the group is to collaborate in resolving obstacles to cooperatively serving youth with a SED that are involved in the juvenile justice system. One project sponsored by the group was the establishment of a Youth Mental Health Court. The court is operating in only three counties, but there is statewide interest in expansion. The Youth Mental Health Court has been successful with youth offenders and uses the Wraparound process to facilitate treatment planning and coordination. DHW has provided one wraparound specialist for this court and provides training to other agencies, including juvenile probation officers. Another project includes the placement of a clinician in juvenile detention centers to assist with evaluations, referrals to services, and to assist families in accessing community services.

SUBSTANCE USE

The Substance Use Disorders (SUD) program and the Children's Mental Health Program are organized in the same division within the Department of Health and Welfare. 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 representation from the MH system.

Substance Use Disorders services are delivered through a statewide managed care contractor. This contractor subcontracts with 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 for youth with co-occurring disorders.

Child - Establishes defined geographic area for the provision of the services of such system.

Geographic Area Definition – Child

Idaho ranks as the 14th largest state by land area with a geographic area of 83,570 square miles. With an area larger than all of New England, Idaho is a mostly mountainous state. Idaho is surrounded by the states of Washington, Oregon, Nevada, Utah, Wyoming, Montana, and the Canadian Province of British Columbia. The landscape is rugged with some of the largest unspoiled natural areas in the United States. The northern portion of the state is mountainous and forested with the southern part of the state considered high desert.

Idaho is divided into 44 counties and there are approximately 130 independent school districts. There are seven (7) Department of Health and Welfare regions in the state that generally correspond to seven (7) judicial districts. The seven (7) Department of Health and Welfare regions cover all areas of the state. Starting at the northern tip of the state with Region 1 and moving down the state with Region 6 at the southeastern tip of the state and Region 7 to the north of Region 6. A regional office is located in the highest populated city in each region. Field offices are located in the more rural areas of the regions.

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

OUTREACH TO HOMELESS – CHILDREN

Children classified as homeless can be placed within two groupings: (1) those who are living independent from family, including runaways or those expelled from their family, and (2) those youth that are living with their family who themselves are homeless. Information provided by The National Center on Family Homelessness provided data that in 2008, there were 3,488 homeless children in Idaho. Of this total, 1339 were under the age of 6 years; 1295 children were enrolled in school in grades K-8; and 554 were enrolled in school in grades 9-12. The age and school status of the remaining 300 children was not identified in The National Center on Family Homelessness 2008 report.

Idaho Code 33-1404 states: “Homeless children and youth may attend any school district or school within a district without payment of tuition when it is determined to be in the best interest of that child.”

Children in need of Children’s Mental Health (CMH) services are frequently identified by school personnel. While the CMH program will record information provided by a third party, such as a school counselor, an application for services must be made by the child’s parent or legal guardian. Children living with their homeless family will be served through the CMH office in the geographical area of the child’s school of attendance. If the child is without adult care and supervision, a referral is made to Child Welfare for investigation and assessment of need. Upon confirmation that the child is without adult care and supervision, the child falls under the purview of the Child Protective Act and will be placed into foster care. Children in foster care and in the custody of the State will be referred for a mental health assessment and needed services by the assigned child protection case manager.

There are two federally funded grantees with the state that provide services to homeless/runaway youth: Bannock Youth Foundation in Pocatello and Hays Shelter Home in Boise. In addition to crisis and emergency shelter, both programs offer a variety of short-term and crisis mental health services to residents. Both programs work closely with Children’s Mental Health and Child Welfare in addressing both mental health and care and supervision needs of children in residence.

Child - 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 (2009), the total state population estimate for 2009 is 1,545,801. Idaho experienced an estimated 19.5% population increase from April 2000 to July 2009. Of the fifty states, Idaho ranks 13th in area size with 82,747.21 square miles.

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

According to the Census Bureau, a 2008 estimate is that 94.6% of Idaho citizens self-identify as White with 85% White/not Hispanic; 9% Black; 1.5% American Native/Alaska Native; 1.1% Pacific Islander and 10.2% Hispanic/Latino origin. See below:

Black/African American	Native American/Alaska Native	Asian	Native Hawaiian/Pacific Islander	Hispanic
0.9%	1.5%	1.1%	0.1%	10.2%

Idaho's largest ethnic minority, representing 10.2% 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 a very small percentage 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). Use of this system allows expansion of 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. Region 2 continued to provide these services to clients throughout the region through videoconferencing sites at Lewiston and Orofino in SFY 2010.

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 earlier, adult and children's mental health services are delivered through the seven regional community mental health centers. In addition to the location of mental health centers in each of the seven major population centers, for most of SFY 2010, each region operated field offices (i.e., a state total of 22 field offices) that provided access to services for those living in the more remote areas of the state. Budget cuts necessitated the closure of nine (9) rural offices in May 2010. Other methods of service extension include the development of networks of private providers under the Medicaid Rehabilitation Option.

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

Resources for Providers – Child

Financial Resources

The budget for Children’s Mental Health (CMH) program was separated from the larger children’s services funding pool in 2005 by the Idaho Legislature. With this separation, CMH does continue to access funding sources such as IV-E and the Social Services Block Grant that are primarily accessed by the Child Welfare program. The following reflects the CMH budget allocation for SFY 2010 and SFY 2011:

FUNDING SOURCE	SFY 2010	SFY 2011
Social Services Block Grant	\$1,288,500	\$ 371,300
State General Funds	\$8,086,500	\$ 8,902,300
State Residential Care	\$ 254,800	
IV-E	\$ 656,900	
IV-E Adoption	\$ 146,600	
TANF/EA	\$1,554,100	
MH Block Grant	\$ 299,000	\$ 299,000
CMH Initiative	\$ 0	
Misc	\$ 855,100	\$ 1,478,800
Receipts	\$ 90,000	\$ 70,000
Total	\$13,231,500	\$11,121,400

Staffing the System

For FY 2010, the Children’s Mental Health (CMH) program was authorized 89.30 full-time equivalent (FTE) positions. Those positions include clinicians, supervisors, administrative assistants, and other classifications within the CMH program. The FTE were allocated according to the following chart:

	Central Office	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Total
FTE Established	7	10	9.20	12.30	15	10.40	9.55	11.60	85.05
Vacant FTE	0	2	2	3.5	1	2	2.15	3	15.65

As noted above, on 7/01/10, 15.65 FTE were vacant which amounted to a vacancy rate of 17.53%. In addition to the FTE recorded above, there are 261.85 FTE established for State Hospital South, the only state operated hospital providing services to those under 18 years of age.

Of the CMH positions filled on 7/01/10, 53 were clinicians providing direct services to children and youth with serious emotional disturbance. Required qualifications for the clinician position include a Master’s degree in social work, psychology, marriage and

family counseling, marriage and family therapy, psychiatric nursing, psychosocial rehabilitation counseling, or a Master's degree in a closely related field of study.

It is important to note that the majority of children's mental health services are delivered by private providers. Medicaid funds the majority of publicly funded mental health services in Idaho. The private providers of outpatient mental health treatment vary in qualifications based on services they provide. Psychotherapy can only be provided by licensed clinical professionals while skill building can be provided by individuals with a Bachelor's degree.

Training

- The Children's Mental Health program has developed a Children's Mental Health Practice Manual to guide CMH clinicians in their practice.
- Policy Memorandum 01-03 requires that all CMH staff receive training annually on working with parents and family members with children with SED.
- CMH contracts with a family-run organization to provide support and advocacy for families in Idaho. The contract requires the contractor to provide ongoing training to staff and families served by CMH on advocacy, self-case management, and being a consumer of services.
- Ongoing training is provided in each region to CMH staff on how to assess for needs, safety planning, and community referrals. Training also includes how to conduct Designated Examinations to determine if involuntary treatment is warranted.
- Ongoing training is provided by central office to regional staff and partner agencies on providing Wraparound services using the Mary Grealish model. Those trained on the model include representatives from juvenile corrections, private providers, as well as parents.
- CMH contracts with St. Luke's Hospital for the provision of monthly trainings for physicians and other medical professionals on a variety of topics related to service children with mental illness. The intent of training provided under this contract is to assist primary care practitioners in gaining the knowledge and skills necessary to meet the mental health needs of their patients. Training primary care practitioners on treating mental health concerns is necessitated because Idaho has a severe shortage of psychiatrists; especially those treating children and adolescents. The contract requires the recording of the training and making DVD's available to medical practitioners upon request.
- CMH staff have trained juvenile justice staff in various locations around the state on using a strength-based approach in working with youth and families.

Child - 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 on an ongoing basis to all regions by request.

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. By 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.

During SFY 2010, regions provided an array of emergency provider training opportunities. Highlights of SFY 2010 trainings include the following:

In SFY 2010, Region I held Crisis Intervention Training (CIT) for 30 law enforcement officers in Sagle (March 2010). Crisis Intervention Training is now at the statewide committee level for curriculum and sustainability and law enforcement has bought in at the state level as well. The law enforcement's Post Academy is considering options to incorporate more CIT content into the academy training as well as the field training.

In Region 2, approximately 30 people (e.g., law enforcement, prosecutors, private providers) attended an Emergency Response Protocol/First Responders Training on May 19, 2010 in Latah County. This training reviewed statutory rules and how they applied to emergency situations with respect to the civil commitment protocol. Adult Mental Health staff provided an overview of the designated examiner process and protocol to hospital emergency room physicians, primary care physicians and private practice physicians in the Moscow community. Partnering with the prosecutor, this training covered relevant rules, protocols, court processes and liabilities. Designated examiner training was also offered to physicians who thought it would add value to their practice. These training opportunities attracted the interest of a group of physicians who expressed interest in future training to prepare them to be designated examiners. Mental Status Examination training for first responders and private providers will be offered in conjunction with the Designated Examiner training opportunity.

Region 2 uses the video conferencing equipment located at State Hospital North to provide psychiatric oversight for clients, primarily those who are indigent and those referred from Mental Health Court. Of these, 29 live in Clearwater County, which is 40 miles from available doctors' offices. Clearwater County has the highest unemployment rate in the State of Idaho and the video conferencing equipment allowed service provision to a population that otherwise would not be served. This same equipment is used for weekly staff meetings, avoiding cost and time associated with travel for clinical staff.

In Region 3, the Chief of Social Work for Children's Mental Health takes the training lead on the crisis team that provides the mental health response for emergency services and first responders. Training needs are identified through requests from the community. In May 2010, Region 3 provided training to ten Payette city police officers, fifteen Payette County sheriffs, nine Fruitland City police officers and six staff at Valley Crisis Center. Additional training was provided to twenty Washington county sheriff officers and Weiser City police officers in November 2009. In April 2010, training was offered to 24 Emmett police officers, Gem County sheriffs and 8 staff at Weiser Memorial Hospital. In October 2009, 45 Canyon County Sheriffs officers were trained, and twelve Caldwell police officers were trained in September 2009. Emergency services training was offered to Nampa police officers in December, January, February and March, with an estimated 40 officers attending each training. Additional trainings were offered to 25 ER

staff at West Valley Medical Center and 15 ER staff at Mercy Medical Center (August 2010); three staff at the CATCH program and 22 staff from Canyon County probation and parole (June 2010); 15 adult protection staff (February 2010) and 90 social work and nursing students from three universities (November 2009 and July 2010). Two designated examiner trainings were offered (October 2009 and May 2010) to a total of 30 participants.

The monthly Region 3 stakeholder meeting with representation from local law enforcement, hospitals, the prosecutor's office, the developmental disabilities program, adult protection and transportation services continues to operate and review all problematic cases each month. This group reviews procedures and cases to assure that an appropriate response is provided for persons with a mental illness. Information from this meeting is shared to assure ongoing efficiency and professionalism is maintained in the crisis system for emergency responders.

In SFY 2010, the Ada County Meeting met monthly with approximately 25 representatives from law enforcement, emergency rooms, psychiatric inpatient hospitals, Veterans Administration, Allumbaugh House, mobile crisis, Ada County Prosecutors, Suicide Prevention and other interested parties. The focus of these meetings is to staff cases and resolve systems issues between agencies, to provide up-to-date information to community partners, and to foster and maintain open relationships and flow of information between agencies. The Ada County Meeting will continue through SFY 2011, with new community partners (e.g., representatives from the Governor's Transformation Workgroup and Taskforce on Suicide in Idaho, Mental Health Board members, and private providers).

Region 4 Adult Mental Health staff maintains a representative on the statewide CIT curriculum committee and they also provided 4 hours of the 40 hour CIT training to approximately 40 local police officers July 19-23. Region 4 provided three hours of crisis training (e.g., mental illness, mental hold assessment, accessing mobile crisis) to 50 Ada County Sheriff- Gold Team officers on July 14, 2010, with additional training scheduled for 50 Red Team officers in August 2010. Region 4 provided Mental Health identification and de-escalation training to 20 employees of the Boise City Public Library on July 19, 2010. Region 4 provided Designated Examiner training (May 2010) to 65 participants from Region 4 Counties, the Ada County Jail, Corrections, psychologists, Children's and Adult Mental Health and local hospitals. Multiple trainings were provided throughout the fiscal year to approximately 15 staff (e.g., court staff, judge, probation officer, vocational rehabilitation, Ada County Mental Health Court Agencies). Mobile Crisis provided training to 40 people from Boise State University; 15 medical/social work staff at St. Alphonsus and other community service providers (e.g., About Balance, El-Ada, Access Behavioral Health, Head Start, and Pioneer Health Services).

In SFY 2010, Region 5 provided mental health training to approximately 15 law enforcement personnel during quarterly Protective Custody Task Force meetings. Region 6 implemented a CIT training, held a monthly interagency task force meeting,

offered community workshops on suicide and crisis training, and went to every county to train county representatives on crisis matters and protocols.

Region 7 offered de-escalation training (2/3-2/5) to 30 participants from Bonneville County Sheriff's Office, Pocatello City Police, Idaho Falls Police, Dispatch and the Behavioral Health Center. They also provided a 40 hour CIT Academy (10/19-10/23), with approximately 30 participants from Idaho Falls Police Department, Bonneville County, Caribou County, Fremont County, Jefferson County, juvenile corrections, advocacy groups and the Department of Health and Welfare. Ongoing meetings were held with representation from local law enforcement, courts, advocacy groups, housing, hospitals, prosecutors, public defenders and the jail to network and discuss issues. Region 7 participates in a quarterly 19-2524 meeting with the judge.

Child - 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

The State intends to expend the block grant for SFY 2011 as follows:

Adult Mental Health	Block Grant Funds
Adult Mental Health Services	\$1,196,478
Peer Specialist/Consumer/Family Empowerment	\$ 153,000
State Planning Council	\$ 20,000
Suicide Prevention	\$ 10,000
Quality Improvement System Development	\$25,000
<i>Total Adult Services FY 2011</i>	\$1,404,478
Children’s Mental Health	
CMH Special Projects:	
-Contract with Family Run Organization	\$269,267
-Contract for Suicide Prevention Services	\$22,854
-Contract for Primary Care Physician Training	\$20,000
<i>Total - Children Services FY2011</i>	\$ 312,121
Administration (5%)	\$ 90,347
<i>Total- Adult Services, Children’s Services, & Administration</i>	\$ 1,806,946

It is understood, as required by Public Law 102-321, that no Federal CMHBG funds are to be used to pay for inpatient services.

The following projects will be funded using federal Community Mental Health Block Grant (CMHBG) funds in FY2011:

\$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 the 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.

\$32,854 will be used to contribute toward the funding of a contact for Suicide Prevention. This total reflects \$10,000 from the Adult Mental Health allocation and \$22,854 from the Children’s Mental Health allocation.

\$25,000 will be dedicated toward funding the implementation of a Quality Improvement System to ensure best practice service delivery in adult and children's mental health services programs.

\$269,267 will be used to fund the contract with a Family Run Organization.

\$20,000 will be used to fund a contract to train Primary Care Physicians on treating patients with mental health disorders.

\$1,196,478 will be 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.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	23,358	3,072	2,610	1,697
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 that 1,697 children/youth through the Department's Children's Mental Health program.

Population: Children with SED and meeting eligibility criteria for the CMH program.

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

Indicator: The number of children/youth served by DHW's CMH Program

Measure: Unduplicated count of children served through the Mental Health Authority Children's Mental Health program.

Sources of Information: FOCUS information system

Special Issues: The reduction in the target number for FY2011 is in response to a reduction in funding for the Children's Mental Health program, the closure of 9 field offices, and a reduction in the number of CMH staff. The calculation of the FY 2011 target of 1,697 children served was made by reducing the Fy 2010 projected number of 2,610 children by 35%. The 35% was chosen given that approximately 70% of children served during FY2010 were Medicaid eligible and efforts are underway to assist families requiring lower intensity services to access services through the private sector using Medicaid.

Significance: National Outcome Measure

Action Plan: The children's mental health authority will explore methods of assisting children and families in accessing community mental health services funded by Medicaid and other third party payers.

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	0	0	2.50	3
Numerator	0	0	--	--
Denominator	80	87	--	--

Table Descriptors:

Goal: Ensure that an array of community-based services are available to children with SED and their families to decrease psychiatric hospitalization and readmissions.

Target: Readmissions of youth to State Hospital South Adolescent Unit will not exceed 3% at 30 days after discharge.

Population: Children with SED discharged from State Hospital South.

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

Indicator: The number of children/youth readmitted to SHS at 30 days after discharge.

Measure: Numerator: children (0-18 years) who are readmitted to SHS within 30 days after discharge from SHS. Denominator: total number of children (0-18 years) discharged from SHS during the past year.

Sources of Information: SHS data.

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. For a child/youth to be placed at SHS, the child must be evaluated and followed by a CMH clinician. These clinicians are engaged in case management throughout the hospitalization and assist the child and family with transition. By increasing access to community-based services upon discharge, the child has an improved chance of successful transition back to their home community.

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	5	5.75	3.75	9
Numerator	4	5	--	--
Denominator	80	87	--	--

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 9% at 180 days after discharge.

Population: Children with SED hospitalized in SHS.

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

Indicator: The number of children/youth readmitted to SHS at 180 days after discharge.

Measure: Numerator: children (0-18 years)readmitted to SHS within 180 days after discharge. Denominator: children (0-18 years)discharged from SHS during the year.

Sources of Information: SHS data

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. Children/youth placed in SHS 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 back to their home community.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

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

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

Table Descriptors:

Goal: Provide community-based services that are evidence-based.

Target: Maintain a minimum of 2 Evidence-Based Practices available in Idaho.

Population: Children with SED

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

Indicator: The number of EBPs available through the Idaho CMH System of Care

Measure: The number of EBPs that are available through 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 (2) EBPs available through the CMH program that are recognized by SAMHSA. One is Treatment or Therapeutic Foster Care and the other is Functional Family Therapy. Even though Idaho does not follow fidelity to a EBP model for TFC, Idaho does have quality assurances for the use of the Idaho model. Idaho contracts with the Idaho Youth Ranch (IYR) for FFT and IYR does adhere to the fidelity of the FFT model. Two additional services Parenting with Love and Limits and Wraparound are available in Idaho and are considered to be EBPs by some(not SAMHSA).

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 is measured through the use of a case review instrument and quality assurance practices.

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	4.90	3.87	2	2
Numerator	156	119	--	--
Denominator	3,182	3,072	--	--

Table Descriptors:

- Goal:** Provide an array of community-based services that are evidence-based and that demonstrate achievement of treatment outcomes.
- Target:** Maintain a minimum percentage of 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 percentage of children receiving Children's Mental Health services that receive treatment foster care services.
- Measure:** Numerator: The total number of children/youth that are placed in treatment foster care by the CMH program. Denominator: The total number of children/youth with SED that receive services through 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. Idaho has adopted a definition/standard of treatment foster care and begun a training of staff and contractors throughout the state. The target for this indicator is being reduced given the change in the definition of treatment foster care and the change in the population served through the CMH program.
- 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 is measured through use of a case review instrument and through ongoing quality assurance practices.

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	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: Multi-Systemic Therapy is not available in Idaho.

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)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	5.53	5.73	2.60	2
Numerator	176	176	--	--
Denominator	3,182	3,072	--	--

Table Descriptors:

- Goal:** Provide an array of community-based services that are evidence-based and that demonstrate achievement of treatment outcomes.
- Target:** Maintain (or increase) the percentage of children/youth that receive FFT in Idaho at a minimum of 2%..
- Population:** Children with SED.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The percentage of children/youth receiving Functional Family Therapy.
- Measure:** Numerator: The number of children/youth with SED that receive Functional Family Therapy.
Denominator: The total number of children receiving CMH services.
- Sources of Information:** Reports by contractor.
- Special Issues:** The FFT program provided in Idaho is delivered by the Idaho Youth Ranch, a contractor. The contractor complies with the FFT measures of fidelity as required in the contract.
- Significance:** National Outcome Measure
- Action Plan:** FFT is available in all seven regions of the state through a contract with the Idaho Youth Ranch. FFT is made available to both CMH and the Department of Juvenile Corrections.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

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

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	50.45	82.72	64.70	50
Numerator	112	158	--	--
Denominator	222	191	--	--

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 at or above an average satisfaction score of 50% with the MHSIP Youth Services Survey for Families (YSS-F).
- Population:** Children with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The percentage of positive responses to questions related to perception of care on the MHSIP YSS-F.
- Measure:** Numerator: the number of families responding to the MHSIP YSS-F that rate their perception of care as positive.
Denominator: the total number of families responding to the perception of care section of the MHSIP YSS-F.
- Sources of Information:** MHSIP database (questions 16, 17, 18, 19, 20, and 21).
- Special Issues:** Beginning in SFY2008, the children's mental health program implemented a standard that surveys families once a year on July 1st and upon case closure.
- Significance:** National Outcome Measure
- Action Plan:** Idaho uses the MHSIP YSS-F. Surveys are sent to parents of children with an open case on July 1st of each year or upon closure if the case is closed prior to July 1.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	85.53	72.19	84.90	75
Numerator	65	122	--	--
Denominator	76	169	--	--

Table Descriptors:

- Goal:** Children with Serious Emotional Disturbance are provided necessary mental health services that support their return to/continuation in school.
- Target:** A minimum of 75% of children/youth will return to/remain in school.
- Population:** Children with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The percentage of children with SED that returned/remained in school during and after receiving CMH services as reported on the MHSIP YSS-F.
- Measure:** Numerator: The number of families reporting that their child returned to/remained in school on the MHSIP YSS-F. Denominator: The total number of families completing the school section of the MHSIP YSS-F.
- Sources of Information:** MHSIP YSS-F
- Special Issues:** Beginning in SFY2008, the children's mental health program implemented a standard that surveys families once a year on July 1st and upon case closure.
- Significance:** National Outcome Measure
- Action Plan:** Surveys are sent to all families that are receiving services from the CMH program on July 1st each year. Additionally, if a case is closed prior to July 1, a survey is sent to the family at the time of case closure. This information is used throughout the year as a management instrument and reported annually as a NOM.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	41.54	52.05	45.40	35
Numerator	27	38	--	--
Denominator	65	73	--	--

Table Descriptors:

- Goal:** Children with Serious Emotional Disturbance are provided necessary mental health services that decreases their criminal justice involvement
- Target:** At least 35% of children/youth served through the Children's Mental Health program will have a reduced involvement with the juvenile justice system.
- Population:** Children with SED
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The percentage of children with SED that have reduced involvement with criminal justice as reported in the MHSIP YSS-F.
- Measure:** Numerator: The number of families reporting on the MHSIP YSS-F that their child had reduced involvement with criminal justice. Denominator: The total number of families reporting on criminal justice involvement in the MHSIP YSS-F.
- Sources of Information:** MHSIP YSS-F
- Special Issues:** Idaho law allows for a judge to order the Department of Health and Welfare to provide Children's Mental Health services to youth involved in the juvenile justice system. It can be anticipated that the percentage of youth served through the Children's Mental Health program that have criminal justice involvement will increase. With that increase, it can be anticipated that the percentage of youth with additional involvement with the criminal justice system could increase. In addition, this will be the third year that Idaho has collected this data. Last year was the first year Idaho identified a target. The target for this indicator is being adjusted given additional data and changes in Idaho law related to providing mental health services to children/youth involved in the criminal justice system.
- Significance:** National Outcome Measure
- Action Plan:** Surveys are sent to all families receiving services from the CMH program on July 1st each year and at case closure. This information is used throughout the year as a management instrument and reported annually as a NOM.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Child - Increased Stability in Housing (Percentage)

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

Table Descriptors:

- Goal:** Children with Serious Emotional Disturbance are provided support to increase stability in their living situation.
- Target:** To maintain a homeless rate of less than a 1% among the children/youth served through the Children's Mental Health program.
- Population:** Children with SED.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The percent of children served through the Children's Mental Health program that are reported as homeless on the MHSIP YSS-F.
- Measure:** Numerator: The number of families reporting their living situation as homeless on the MHSIP YSS-F. Denominator: The total number of families responding to the living situation section of the MHSIP YSS-F.
- Sources of Information:** The MHSIP YSS-F
- Special Issues:** Idaho has a low historical rate of homelessness and particularly with children and youth in the CMH system. The target will be established at a low rate, but considering the current economic conditions, it is difficult to predict the likelihood of an increase in the homeless population.
- Significance:** National Outcome Measure
- Action Plan:** This is the second year this National Outcome Measure will be implemented. Idaho has a low rate of homelessness, historically. Idaho 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.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness
(Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	73.60	73.40	67	65
Numerator	131	138	--	--
Denominator	178	188	--	--

Table Descriptors:

- Goal:** Children with Serious Emotional Disturbance are provided mental health services that support increased social supports/social connectedness.
- Target:** At least 65% of families receiving Children's Mental Health services will report increased social supports/social connectedness for their child on the MHSIP YSS-F.
- Population:** Children with SED.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
- Indicator:** The percentage of children with SED experiencing increased social supports/social connectedness as reported on the MHSIP YSS-F.
- Measure:** Numerator: The number of families reporting that their child has increased social supports/social connectedness on the MHSIP YSS-F. Denominator: The total number of families responding to the social supports/social connectedness section on the MHSIP YSS-F.
- Sources of Information:** MHSIP YSS-F
- Special Issues:** This is the third year Idaho has collected this data. This indicator is being adjusted to reflect economic conditions and changes in the system of care.
- Significance:** National Outcome Measure
- Action Plan:** Surveys are sent to all families receiving services from the CMH program on July 1st each year and at the time of case closure. This information is used throughout the year as a management instrument and reported annually as a NOM.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	50.45	58.06	55	50
Numerator	112	108	--	--
Denominator	222	186	--	--

Table Descriptors:

- Goal:** Children with Serious Emotional Disturbance are provided mental health services that support an improved level of functioning.
- Target:** A minimum of 50% of families receiving CMH services will report improved levels of functioning for their child.
- 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 percentage of parents reporting that their child demonstrated improved levels of functioning after receiving CMH services.
- Measure:** Numerator: The number of families reporting on the MHSIP YSS-F that their child had improved levels of functioning. Denominator: The total number of families completing the level of functioning section on the MHSIP YSS-F.
- Sources of Information:** MHSIP YSS-F
- Special Issues:** This will be the fourth year Idaho has collected this data and the third year Idaho had a target.
- Significance:** National Outcome Measure
- Action Plan:** Surveys are sent to all families receiving services from the CMH program on July 1st each year and at the time of case closure. This information is used throughout the year as a management instrument and reported annually as a NOM.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: CAFAS Outcomes

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	67	66	72.90	50
Numerator	215	404	--	--
Denominator	323	608	--	--

Table Descriptors:

- Goal:** Provide an array of effective community-based services to children with SED and their families.
- Target:** At least 50% of children/youth receiving two or more CAFAS evaluations will reflect a decrease in functional impairment.
- Population:** Children with SED.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percent of children/youth with a CAFAS score reflecting decreased functional impairment over time.
- Measure:** Numerator: Number of children/youth receiving services with CAFAS scores indicating a decrease in functional impairment.
Denominator: Total number of children receiving an initial CAFAS and at least one additional CAFAS following the delivery of services.
- Sources of Information:** 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. Additionally, services may terminate prior to the administration of a second CAFAS.
- Significance:** Improved functioning demonstrates the effectiveness of service interventions that lead to successful community integration.
- Action Plan:** CMH will strive to meet the target by continuing to implement a continuous quality improvement (CQI) program that addresses the effectiveness of services. The CAFAS will continue to be used to measure functional impairment.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:]

Name of Performance Indicator: Expenditures on Community-Based Systems

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	89	92	75	75
Numerator	51,854,370	70,904,962	--	--
Denominator	58,247,862	77,187,319	--	--

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:** At least 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 CMH contracts.
- Sources of Information:** FOCUS information system, Division of Management Services information systems, SHS data, and Medicaid system information.
- Special Issues:** Existing data systems cannot differentiate from hospitalizations that are local and short term versus distant and longer term. For the purposes of this indicator, community-based services are defined as children's mental health services that are less restrictive than hospitalization.
- Significance:** A community-based service system is a core value for the state as well as being a standard of practice for the field of mental health. Community-based services have been shown to be the most normalized, the most effective, and the most cost effective services.
- Action Plan:** The Department is dedicated to serving children in their home communities whenever possible. Even though children may require services that are not community-based, the focus has been on developing an array of core services in each region of the state.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ⌋

Name of Performance Indicator: Medicaid Mental Health Services

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	6,594	17,858	16,500	16,500
Numerator	6,594	17,858	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

- Goal:** To provide youth/children with emotional disturbance access to outpatient mental health services funded by Medicaid.
- Target:** To provide mental health services to no less than 16,500 children with emotional disturbance through outpatient mental health programs funded by Medicaid.
- 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 that receive a Medicaid funded outpatient mental health services.
- Sources of Information:** Medicaid data
- Special Issues:** Outpatient mental health services funded by Medicaid do not require a SED or specific mental health diagnosis. As a result, some of the unduplicated count of children/youth receiving services may not be SED, though all have a mental health diagnosis and are emotionally impaired.
- Significance:** 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.
- Action Plan:** Medicaid is a major source of payment for community mental health services. As mental health services provided through public agencies are impacted by current economic factors, the number of children and families accessing Medicaid funded services will be expected to increase.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Services to rural populations

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	25	26.40	33.70	25
Numerator	785	834	--	--
Denominator	3,182	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: A minimum of twenty-five percent (25%) of children served by the Children's Mental Health program will be from rural areas of the state.

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 receiving services through DHW field offices other than the primary regional office.

Measure: Numerator : The number of children/youth receiving Children's Mental Health Services through field offices located in rural areas of the state. Denominator: The total number of children/youth receiving Children's Mental Health services (through all Department of Health and Welfare field offices).

Sources of Information: FOCUS Information System

Special Issues: The Department of Health and Welfare has previously calculated the number of families residing in rural areas by adding cases served through field offices located in rural areas of the state. Given the recent closure of 9 field offices located in rural areas, this calculation is becoming more difficult. This target becomes increasingly difficult to achieve as it involves the maintenance of the same level of services when rural offices have been closed due to budget limitations. 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.

Significance: A significant percentage of Idaho citizens reside in rural areas of the state.

Action Plan: The Department is working on developing a report to pull this information consistently and accurately especially given the reassignment of staff previously working in rural field offices that have been closed.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Wraparound Services

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	148	110	86	75
Numerator	148	110	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

- Goal:** Provide a system of integrated social services, educational services, juvenile justice services, and substance use services in combination with mental health services.
- Target:** A minimum of 75 families will receive Wraparound services.
- Population:** Children with SED.
- Criterion:** 3:Children's Services
- Indicator:** Number of families receiving Wraparound services through the CMH program.
- Measure:** Unduplicated count of families served through the Wraparound process.
- Sources of Information:** FOCUS information system and reports from Wraparound specialists.
- Special Issues:** The target for this indicator is being reduced given the projected reduction in total cases served through the CMH program. While Wraparound is considered an Evidence-Based Practice (EBP) by some, it is not listed as an EBP by SAMHSA.
- Significance:** The Wraparound model emphasizes interagency collaboration and consumer driven services. This indicator was selected as the Transformation Indicator considering the consumer and family driven components.
- Action Plan:** Wraparound will be the chosen model for all children, youth, and families with high service needs, those at risk of out-of-home placement, and families with children involved in multiple systems.

Upload Planning Council Letter for the Plan

Idaho State Planning Council on Mental Health

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Boise, ID 83720-0036

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Lynne Whiting
Julie Williams
Teresa Wolf

August 24, 2010

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 2011 Federal Community Mental Health Block Grant

Dear Ms. Orlando:

The opportunity to review, discuss and provide comments to the Federal Block Grant by the Idaho State Planning Council on Mental Health (SPCMH) is greatly appreciated. The Block Grant Report was a topic of great discussion at our meeting on August 17- 19, 2010.

In reviewing the Federal Block Grant we must consider the fact that the economic downturn continues to plague many states and Idaho is no exception. It is an important time for all State Planning Councils to diligently monitor the legislature as they struggle with decisions impacting our most vulnerable populations. The SPCMH has been attentive in monitoring budget reductions and reorganization of services for children, youth, families, and individuals. We believe our role as SPCMH members is more important then ever as we inform and educate our elected officials.

Providing appropriate mental health services to individuals in Idaho is a perennial challenge for our State and we offer the following information related to Idaho's Mental Health system of care.

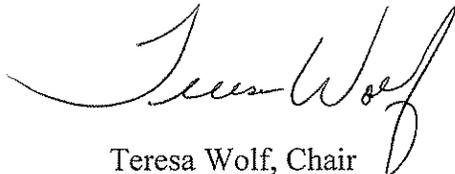
- The SPCMH launched a media letter writing campaign to inform and raise awareness of the impending budget cuts and the impact on individuals with mental illness. The purpose was to inform the public of the reduction in staff and services affecting our mental health population and to keep the impacts of these cuts fresh in the minds of the public. Our goal was to raise awareness of the outcome those cuts have on our citizens, neighbors, family and friends.
- Improved communication of regional mental health efforts to the State level was an important milestone for the Council. The development of a website for use by the Regional Mental Health Boards to share

minutes and developments with other regions has had a positive impact on our communication efforts. The ability to post minutes of the SPCMH meetings and regularly send correspondence to the Regional Mental Health Boards for distribution helps expand our education and awareness efforts.

- The SPCMH recognizes the importance of evidence based practices, and demonstration of data about those practices specific to mental health services in our State. We encourage and support the sharing of data with all interested parties to identify services that fit in frontier, rural, and urban Idaho. With the installation of the WITS system we are hopeful about continued improvement in data collections.
- The SPCMH encourages and appreciates the efforts of the Governor's Mental Health Transformation Workgroup in blending Mental Health and Substance Abuse in the overall system of care for Idaho citizens. The Council has a representative that participated in the meetings of the Transformation Workgroup and this representative keeps the Council apprised of the process. The SPCMH particularly applauds the public forums sponsored by the Transformation Workgroup throughout the State. We embrace their goals to increase availability of quality services and to create localized service delivery systems with local input from consumers and stakeholders.
- Hosting the annual legislative event and award ceremony expands our opportunity to inform and educate the public and our elected officials. "Youth: Our Greatest Resource" was the title of this year's event. The focus was on children's mental health issues which included a panel discussion on the challenges and success of youth within the mental health system. Awards were presented to recipients from the media, the judiciary, legislators, law enforcement, and community advocates for their exemplary work.

The Idaho State Planning Council on Mental Health is comprised of a dedicated group of champions providing a voice for many of our citizens. Our goal is to keep the Governor and State Legislature acutely aware 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

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.