

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State SAPT DUNS Number

Number 825201486

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Idaho Department of Health and Welfare

Organizational Unit Division of Behavioral Health

Mailing Address POB 83720/3rd

City Boise

Zip Code 83720-0036

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Richard

Last Name Armstrong

Agency Name Idaho Department of Health and Welfare

Mailing Address 450 West State Street

City Boise

Zip Code 83720-0036

Telephone 208-334-5500

Fax 208-334-6558

Email Address OsbornJ@dhw.idaho.gov

State CMHS DUNS Number

Number 825201486

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Idaho Department of Health and Welfare

Organizational Unit Division of Behavioral Health

Mailing Address POB 83720/3rd

City Boise

Zip Code 83720-0036

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Richard

Last Name Armstrong

Agency Name Idaho Department of Health and Welfare

Mailing Address 450 West State Street

City Boise

Zip Code 83720-0036

Telephone 208-334-5500

Fax 208-334-6558

Email Address OsbornJ@dhw.idaho.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

Submission Date 8/31/2015 5:34:30 PM

Revision Date 3/14/2016 1:40:42 PM

V. Contact Person Responsible for Application Submission

First Name Terry

Last Name Pappin

Telephone 208-334-6452

Fax 208-334-5998

Email Address pappint@dhw.idaho.gov

Footnotes:

Anne Bloxham is the lead for the Mental Health portion of this application. Her phone number is 208-5527. Her email address is BloxhamA@dhw.idaho.gov. Terry Pappin is the lead for the Substance Abuse Prevention and Treatment portions of this application

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2017

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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. §5794), 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 Costal 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.): (a)

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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. 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). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Richard Armstrang

Signature of CEO or Designee¹: _____

Title: Director, Department of Health and Welfare

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.
Idaho

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2017

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
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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).
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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).

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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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Richard Armstrong

Signature of CEO or Designee¹: _____

Title: Director, Idaho Department of Health and Welfare

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	Richard Armstrong
Title	Director
Organization	Idaho Department of Health and Welfare

Signature: _____ Date: _____

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2016 Planning Period End Date: 6/30/2017

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$6,163,400	\$0	\$28,791,100	\$0	\$0
6. Other 24 Hour Care		\$0	\$0	\$0	\$4,210,300	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$2,070,873	\$635,325	\$4,500,778	\$32,356,893	\$0	\$0
8. Mental Health Primary Prevention**		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)		\$243,632	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$121,816	\$0	\$0	\$838,184	\$0	\$0
11. Total	\$0	\$2,436,321	\$6,798,725	\$4,500,778	\$66,196,477	\$0	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2016

Planning Period End Date: 9/30/2018

Expenditure Category	FY 2016 SA Block Grant Award	FY 2017 SA Block Grant Award
1. Substance Abuse Prevention* and Treatment	\$6,502,239	\$6,641,482
2. Substance Abuse Primary Prevention	\$1,812,999	\$1,813,000
3. Tuberculosis Services		\$1,000
4. HIV Early Intervention Services**		
5. Administration (SSA Level Only)	\$220,600	\$80,356
6. Total	\$8,535,838	\$8,535,838

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2016 Planning Period End Date: 9/30/2018

Strategy	IOM Target	FY 2016	FY 2017
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	\$349,651	\$304,784
	Selective		
	Indicated		
	Unspecified		
	Total	\$349,651	\$304,784
Education	Universal	\$831,549	\$695,806
	Selective	\$9,409	\$178,778
	Indicated		\$30,851
	Unspecified		
	Total	\$840,958	\$905,435
Alternatives	Universal	\$47,700	\$47,787
	Selective	\$7,128	\$16,620
	Indicated		
	Unspecified		
	Total	\$54,828	\$64,407
Problem Identification and Referral	Universal		
	Selective		\$27,231
	Indicated	\$96,388	\$130,400
	Unspecified		
	Total	\$96,388	\$157,631

Community-Based Process	Universal	\$82,678	\$8,649
	Selective		\$6,480
	Indicated		
	Unspecified		
	Total	\$82,678	\$15,129
Environmental	Universal	\$58,783	\$64,024
	Selective		
	Indicated		
	Unspecified		
	Total	\$58,783	\$64,024
Section 1926 Tobacco	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total	\$0	\$0
Other	Universal		
	Selective		
	Indicated	\$128,257	
	Unspecified	\$201,456	\$103,824
	Total	\$329,713	\$103,824
Total Prevention Expenditures	\$1,812,999	\$1,615,234	
Total SABG Award*	\$8,535,838	\$8,535,838	
Planned Primary Prevention Percentage	21.24 %	18.92 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Please note, the Primary Prevention Total on this table does not include the planned Primary Prevention Resource Development expenditures

reported on Table 6a. When the resource development expenditures are included in Primary Prevention calculation, the total planned expenditure is \$1,813,000 which is 21.24% of the estimated award.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2016 Planning Period End Date: 9/30/2018

Targeted Substances	
Alcohol	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>
Cocaine	<input type="checkbox"/>
Heroin	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>
Synthetic Drugs (i.e. Bath salts, Spice, K2)	<input type="checkbox"/>
Targeted Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input type="checkbox"/>
LGBTQ	<input type="checkbox"/>
American Indians/Alaska Natives	<input checked="" type="checkbox"/>
African American	<input type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>
Homeless	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input type="checkbox"/>
Asian	<input type="checkbox"/>
Rural	<input checked="" type="checkbox"/>
Underserved Racial and Ethnic Minorities	<input checked="" type="checkbox"/>

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2016 Planning Period End Date: 9/30/2018

Activity	FY 2016 SA Block Grant Award				FY 2017 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$42,002			\$42,002	\$42,627	\$34,894		\$77,521
2. Quality Assurance	\$52,918	\$754,812		\$807,730	\$54,375	\$69,790		\$124,165
3. Training (Post-Employment)	\$15,751			\$15,751	\$15,985	\$34,895		\$50,880
4. Education (Pre-Employment)	\$5,251			\$5,251	\$5,328	\$34,895		\$40,223
5. Program Development	\$18,962			\$18,962	\$15,985	\$453,632		\$469,617
6. Research and Evaluation	\$31,666			\$31,666	\$32,733	\$69,790		\$102,523
7. Information Systems	\$29,666	\$75,000		\$104,666	\$30,733	\$201,843		\$232,576
8. Total	\$196,216	\$829,812	\$0	\$1,026,028	\$197,766	\$899,739	\$0	\$1,097,505

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2016 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	\$20,000
MHA Administration	\$121,816
MHA Data Collection/Reporting	\$39,000
MHA Activities Other Than Those Above	\$635,220
Total Non-Direct Services	\$816036
<p>Comments on Data:</p> <p>MHA Activities Other Than Those Above:</p> <ul style="list-style-type: none"> Consumer & Family Empowerment \$160,700 MH Peer Specialist Training \$100,000 Suicide Prevention Hotline \$50,000 Suicide Prevention Council \$10,000 Certified Family Support Partner Training \$115,400 Family Run Organization \$199,120 	
<p>Footnotes:</p>	

22. State Behavioral Health Planning/Advisory Council Input on the Mental Health/Substance Abuse Block Grant Application

Overview:

The Legislature of the State of Idaho passed the Regional Behavioral Health Services (39-3100) statute in 2014. This legislation established integrated mental health and substance abuse prevention and treatment Behavioral Health Boards in each of Idaho's seven service regions. The legislation also established an integrated Behavioral Health Planning Council.

The Planning Council membership was developed using the CMHS required members as the foundation. Once those positions had been established, additional members were included to ensure that consumers, family members, community organizations and agencies, and positions representing the continuum of care were included. The Planning Council consist of consumer and family representatives as well as members representing the mental health and substance use disorder recovering communities, the mental health clinical, recovery support and medical communities, primary prevention providers, community coalitions, state agencies such as judicial/corrections, education, human services, vocational rehabilitation and housing, Native American, Hispanic and LGBTQ communities, and advocacy organizations for children and adults with a mental disorder.

The Planning Council has established mission and goal statements, principles that guide their work and bylaws which ensure compliance with state and federal requirements. The fist three items are included below. The by laws are available on the Planning Council website. The address for the website is found in the paragraph below.

VISION: We envision an accessible system that cultivates and supports healthy lives and communities.

MISSION: Promote advocacy, collaboration, education and policy development to create a seamless behavioral health delivery system.

PRINCIPLES

- We believe prevention is key
- Recovery and resiliency is possible or everyone
- An informed system is an effective system
- Advocacy is all-inclusive
- Services should be accessible throughout the lifespan
- Services are provided in the least restrictive environment.
- Early intervention is cost effective and evidence-based
- System is accountable, transparent and sustainable
- Whole person whole health
- Recognize the rights and responsibilities of individuals and families

In an effort to ensure the work of the Planning Council remains transparent and inclusive they have developed a webpage which includes information identified above as well as Planning Council meeting dates, agendas and minutes, the enabling legislation, annual reports to the governor and legislature, state and federal grant applications and reports and other resources. The webpage is located on the internet and open to the public, no password is required. The webpage is located on the State of Idaho's website at - <http://healthandwelfare.idaho.gov/Medical/MentalHealth/BehavioralHealthPlanningCouncil/tabid/320/Default.aspx>

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

Under Idaho code, the Planning Council is "to serve as an advocate for children and adults with behavioral health disorders; to advise the state behavioral health authority on issues of concern, on policies and on programs and to provide guidance to the state behavioral health authority in the development and implementation of the state behavioral health systems plan; to monitor and evaluate the allocation and adequacy of behavioral health services within the state on an ongoing basis; to monitor and evaluate the effectiveness of state laws that address behavioral health services; to ensure that individuals with behavioral health disorders have access to prevention, treatment and rehabilitation services; to serve as a vehicle for policy and program development; and to present to the governor, the judiciary and the legislature by June 30 of each year a report on the council's activities and an evaluation of the current effectiveness of the behavioral health services provided directly or indirectly by the state to adults and children." This legislation also established seven Regional Behavioral Health Boards, which encompass multiple adjoining counties. The Regional Boards are responsible to "advise the state behavioral health authority and the state planning council on local behavioral health needs of adults and children within the region."

Annually the Planning Council requires each Regional Board to submit a report of gaps and needs within the region. These reports form the foundation of the Planning Council's annual report to the governor and legislature. (The reports can be accessed on the Planning Council's website.) The reports provide an "on-the-ground" assessment of need for the Division of Behavioral Health. The information covers service gaps, un/under served populations and emerging behavioral health issues in each of the seven regions. This information is combined with client, criminal justice, education and public health data to identify new or emerging concerns, areas of greatest need and populations at risk and develop state service plans. The combined FY 15 Regional Board report and FY 16 State Planning Council report are attached to this response. Please note, the combined FY 16 Regional Board report is not yet completed.

The Division of Behavioral Health regularly attends the Planning Council meetings to provide updates on services, new initiatives, expanding services, block grant planning etc.

The draft block grant documents are made available to the public by being posted on the Substance Use Disorders, Mental Health and Planning Council webpages. The Planning Council receives notice when new block grant documents have been posted on their website. This includes the draft Behavioral Health Block Grant applications and updates as well as SAPT and CMHS block grant reports prior to submission to SAMHSA. Likewise, Regional Behavioral Health Boards are also notified about draft block grant documents and locations where the document can be accessed. Requests for review and comment on the draft documents are sent to Planning Council members, Regional Behavioral Health Board members, Regional DBH staff and are included in the DBH weekly newsletter. Using this method, the Division ensures that representatives from the primary prevention, early intervention and the mental health and substance use disorders treatment and recovery communities have the opportunity to review and comment on the block grant documents.

2. What mechanism does the state use to plan and implement substance abuse services?

The Idaho Department of Health and Welfare's Division of Behavioral Health is responsible for management of the Prevention and Treatment portions of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. As indicated in the the response to question #1, the Division of Behavioral Health employs a variety of data sources to plan and implement substance use disorders treatment services.

The first step in developing the plan is to conduct a review of client records to identify the populations being served, the drug(s) of choice and the services needs. The second step is to conduct a targeted review to determine if the service needs of block grant priority treatment populations - pregnant women, women with dependent children, and IV drug users - are being met. Upon completion of those reviews, survey data, Planning Council and Region Behavioral Health Board input and key informant data are reviewed to identify emerging issues as well as un/underserved populations.

Based on the reviews of priority population needs, current clients served, new and emerging needs data and state designated populations, the Division of Behavioral Health established services priorities. Once priorities are set, the Division meets with Business Psychology Associates, the substance use disorder services intermediary, to develop an implementation plan to serve the identified populations and needs.

The Idaho's Office of Drug Policy manages the Primary Prevention portion of the SAPT block grant. The State of Idaho utilizes epidemiological and surveillance data as the two primary mechanisms for identifying priority populations, developing plans and implementing substance abuse primary prevention services. These tools help the Office of Drug Policy (ODP) to identify where the greatest need for the allocation of resources exists, allow for program specific, local level decisions, and inform efforts to strategically balance prevention services across our state.

The use of epidemiological and surveillance data makes available for consideration social, behavioral, medical, geographic, and other demographic characteristics. Idaho's State Epidemiological Outcomes Workgroup (SEOW) updates the State of Idaho Substance Abuse Prevention Needs Assessment annually, examining administrative data from state agencies. The SEOW currently has 19 members representing different organizations/agencies including: Local Community Coalitions, Idaho Department of Health and Welfare, Idaho National Guard, Idaho Department of Corrections, Idaho Office of Drug Policy, Idaho Department of Education, Idaho Department of Juvenile Corrections, Idaho Statistical Analysis Center at the Idaho State Police, and the Idaho Supreme Court.

Mechanisms and Specific Data Sources include:

Mechanisms	Specific Sources
Local Surveillance Data	Idaho Vital Statistics, Idaho Transportation Department Records, Idaho Statistical Analysis Center
Census Data	US Census Bureau
Front Line Experience	Multi-Stakeholder Workgroups,
Program Evaluation Data	Pre/Post Surveys
Community Consultation	Community Coalition Surveys
Research/Data Collection	Idaho Behavioral Risk Factor Surveillance System (BRFSS)
Youth Use Data	Idaho Youth Prevention Survey; Youth Risk and Behavior Survey, National Survey on Drug Use and Health

The State of Idaho Substance Abuse Prevention Needs Assessment is used to guide SABG funding decisions by identifying specific priority populations on which the state is focused. In Idaho, the priority populations identified are: Rural/Frontier; Native American; Hispanic; and, Veteran populations. ODP works hard to ensure those programs funded with SABG monies address these identified populations.

Additionally, multi-stakeholder workgroups have been formed to address data collection challenges and interpret data in support of planning, implementation and evaluation of primary prevention programs. ODP is committed to expanding our capacity building efforts to facilitate an increased sharing of information and delivery of best practice programs and have found the workgroups to be highly successful in this effort

Finally, ODP has standardized our data collection tools and survey methods to better identify and address priority populations. By tailoring prevention programs and services to meet the needs of Idaho's priority populations, the State contributes to the improvement of overall population health outcomes.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

The Mental Health Planning Council was reorganized in 2014 in response to the passage of the Regional Behavioral Health Services (39-3100) statute. This legislation made the Planning Council an independent body, not attached to any state agency. Members are appointed by the governor and serve for a two year term. The legislation ensured the required CMHS block grant participants were included in the new Behavioral Health Planning Council. The legislation also identified specific Idaho participants and gave the Planning Council the authority to identify additional populations, organizations and agencies needed to complete their responsibilities.

The Idaho Behavioral Health Planning Council is now a fully integrated behavioral health advisory and advocacy group. The attached "Idaho Planning Council Positions" matrix documents the membership type and the broad range of entities represented including mental health and substance use disorders consumers, block grant required mental health planning council participants, primary prevention participants, state and local governmental agencies and cultural groups.

One of the first priorities of the reorganized Planning Council was to seek detailed information on both the CMHS and SAPT block grants. Their purpose was to ensure that all members understood the scope and requirements of both grants, so that they could better advise the state. The Planning Council continues to have the Division of Behavioral Health provide this information to all new members. More information about the legislation integrating the Planning Council, their priorities and subcommittees can be found on the internet at

<http://healthandwelfare.idaho.gov/Medical/MentalHealth/BehavioralHealthPlanningCouncil/tabid/320/Default.aspx>

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

The Planning Council matrix, attached to this section, documents the population as well as organization and agency participants to be included. While the Planning Council does not include specific positions for individuals living in rural, suburban and urban areas, the actual membership comes from a range of Idaho communities including frontier areas to Idaho's largest population area, the Treasure Valley. The Planning Council does include dedicated positions for individuals representing Native American and Hispanic communities. The Planning Council also includes dedicated positions for the LGBTQ community as well as for an older adult, youth, transition-aged youth and family members of a youth with SED.

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

As reported in the FFY 16 Assessment and Plan, the duties of the Idaho Behavioral Health Planning Council are established in Idaho Code Title 39, Chapter 31 Regional Mental Health Services. The Planning Council responsibilities include advocating for children and adults with behavioral health disorders, advising the State Behavioral Health Authority on issues of concern, policies and programs; providing

guidance to the Mental Health Authority in the development and implementation of the state mental health systems plan; monitoring and evaluating the allocation and adequacy of mental health services within the state; and ensuring that individuals with behavioral health disorders have access to prevention, treatment and rehabilitation services.

The Planning Council also serves as a vehicle for policy and program development; and presents to the governor, the judiciary and the legislature by June 30 of each year, a report on the council's activities and an evaluation of the current effectiveness of the behavioral health services provided directly or indirectly by the state to adults and children.

The Idaho Behavioral Health Planning Council Membership Matrix

Federally Mandated	Family Member of a Youth Mental Health Client	Judicial Branch	Certified Peer Specialist	Hispanic	Veteran	Advocacy Organization
State Mandated	Adult with Serious Mental Illness	Youth Corrections	Peer Recovery Coach	Native American	Transition Aged Youth (18 - 25)	Counties
Peer Consumer	Corrections (Adult)	Behavioral Health	Certified Family Specialist	Lesbian, Gay, Bisexual, Transgender, Questioning	Suicide Survivor (self or family member)	Community Coalition
Specific Population	Medicaid	Education	Adult Substance Use Disorder	Youth (< 18)	Aging (+55)	
Provider State Employee	Vocational Rehabilitation	Housing	Office of Drug Policy	Substance Use Disorder Provider	Mental Health Provider	Primary Care Provider
Community Stakeholders	Social Services					

Multiple colors indicate position is mandated by both state and federal law.

State Behavioral Health Planning Council

FY2016 Report to the Governor, State Legislature, and Judiciary



*Supporting behavioral health systems that are coordinated,
efficient, accountable, and focused on recovery.*

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INTRODUCTION

The Council would like to express our gratitude for the supportive actions of the Governor and the Legislature regarding the state's behavioral health system this past year. We appreciate the passage of legislation developing an Office of Suicide Prevention, funds for two (2) additional crisis centers, funding support for establishing four (4) additional community recovery centers, and support for the Jeff D. agreement by funding respite services and the Child and Adolescent Needs and Strengths (CANS) tool.

Actions such as these do not go unnoticed by advocates and we are grateful for your support in the continued improvement of Idaho's behavioral health system.

Idaho Behavioral Health Planning Council

The Idaho Behavioral Health Planning Council (BHPC) was established through the passage of Senate Bill 1224 in 2014. This bill amended Idaho Code 39-3125, see Appendix One (1), and replaced the previous "Idaho State Planning Council on Mental Health" with the "State Behavioral Health Planning Council." It also expanded the focus of the newly established council to include both mental health and substance use disorder issues. The Behavioral Health Planning Council was formally established as a new body on July 1, 2014.

As defined in both state and federal law, the purpose of the Council is to:

- Serve as an advocate for children and adults with behavioral health disorders.
- Advise the state behavioral health authority on issues of concern, on policies and programs, and to provide guidance to the state behavioral health authority in the development and implementation of the state behavioral health systems plan.
- Monitor and evaluate the allocation and adequacy of behavioral health services within the state on an ongoing basis, as well as the effectiveness of state laws that address behavioral health services.
- Ensure that individuals with behavioral health disorders have access to prevention, treatment, and rehabilitation services.
- Serve as a vehicle for policy and program development.
- Present to the Governor, the Judiciary, and the Legislature by June 30 of each year a report on the Council's activities and an evaluation of the current effec-

tiveness of the behavioral health services provided directly or indirectly by the State to adults and children.

- Establish readiness and performance criteria for the Regional Behavioral Health Boards (BHB) to accept and maintain responsibility for family support and recovery support services.

In early 2014, the Planning Council began reorganizing its membership to cover the full-spectrum of mental health and substance use disorder services. This includes members from state agencies, private service providers and prevention programs, as well as consumers, family members, and others representing the diversity of Idaho citizens. This unique cross-section of individuals make up the Idaho Behavioral Health Planning Council (BHPC). A complete list of the membership is found in Appendix Two (2).

The diversity of the membership creates a broad knowledge base for the BHPC which allows us to work with and support many aspects of the behavioral health system. The bulk of the work done by the BHPC is completed by its workgroups. The BHPC workgroups include:

- Children's Mental Health,
- Crisis Centers and Recovery Centers,
- Prevention, Education and Legislation, and
- Regional Behavioral Health Board Support.

These workgroups are working on several projects including respite education, naloxone training, and supporting the regional Behavioral Health Boards (BHBs) during their transition to stand-alone boards.

The BHPC looks forward to continued active participation in the improvement of Idaho's Behavioral Health System. The membership is eager to partner with all of the system's stakeholders by sharing our knowledge, expertise, and lived experience in order to improve the lives of all Idahoans.

Regional Behavioral Health Boards

The Regional BHBs are a critical component to Idaho's transformed Behavioral Health System. The BHPC continues to support and encourage effective communication between the BHPC and each of the BHBs. Below are brief updates about the activities of each of the BHBs from the past fiscal year.

Region 1 Behavioral Health Board

The Region 1 BHB partnered with the Panhandle Health District and was approved by the BHPC as a stand-alone board in September 2015. During the course of the past year, the Board supported the opening of the Crisis Center for North Idaho in Coeur d'Alene, partnered with community organizations to provide Trauma Informed Care trainings to over 700 providers, and helped fund the regional Crisis Intervention Training for law enforcement personnel. They look forward to continued partnerships within the community as they work with local organizations to support the opening of the Kootenai Recovery Community Center in their region.

Region 2 Behavioral Health Board

In early 2016, the Region 2 BHB partnered with the North Central District Public Health. Highlights of the past year for Region 2 include the opening of the Latah County Recovery Center, successful Crisis Intervention Training for law enforcement personnel from across the region, and Youth Mental Health First Aid trainings conducted in several communities. The board is grateful for community partnerships that continue to support the future opening of the Nez Perce County Recovery Center in Lewiston later this year. They continue to advocate for increased use of Telehealth services, as well as a crisis center for Region 2.

Region 3 Behavioral Health Board

In the past year, the Region 3 BHB partnered with the Southwest District Health. The Board is also actively working with the Southwest District Health Statewide Health Innovation Plan (SHIP) Manager to create Patient Centered Medical Homes. The Board created Provider and Children's Mental Health subcommittees and their members are actively working with the Region 3 BHB Executive Board to address the needs and gaps in the region. More recently, the Board put together a Crisis Center subcommittee to

work collaboratively with community organizations to support placement of the next crisis center in Region 3. The Region 3 BHB sponsored scholarships to the Idaho Conference on Alcohol and Drug Dependency conference, supported Crisis Intervention Team trainings, participated in the Children's Mental Health Awareness Week poster contest, supported a golf program for youth in the juvenile justice system, and promoted Recovery Day.

Region 4 Behavioral Health Board

The Region 4 BHB partnered with the Central District Health Department to serve the behavioral health needs of Ada, Boise, Elmore and Valley counties. The board made great strides in its organization and houses three (3) active committees including a Wellness and Recovery Committee, Youth Behavioral Health Committee, and Provider Committee. With representation by a diverse group of skilled individuals, the board plans to implement a comprehensive data collection process that will determine ways in which the region's needs and gaps can be addressed. This is a motivated board that plans to actively seek grants and affect positive change for Region 4 consumers of behavioral health services.

Region 5 Behavioral Health Board

Over the past year, the Region 5 BHB filled all of its board positions and completed a board orientation process. They also supported mental health awareness activities in the Twin Falls, Wood River Valley, and Mini Cassia areas. A strong working relationship has been established with South Central Public Health. The Region 5 BHB looks forward to being able to support and partner with a new behavioral health crisis center in their region during the next year.

Region 6 Behavioral Health Board

The Region 6 BHB continues to move toward supporting recovery in their region by educating the public about mental health issues and encouraging communication between service and support providers within their region. Their children's mental health (CMH) subcommittee is reaching out to local school districts through a newsletter. Behavioral health board members seek to educate legislators and other government officials on behavioral health issues within the state and the region. The Region 6 BHB seeks

greater connections between all providers of behavioral health services and a reduction of silos in order to increase support for those in recovery.

Region 7 Behavioral Health Board

In September 2015, the Region 7 BHB, through a contract from Idaho Department of Health and Welfare's (IDHW), Division of Behavioral Health (DBH), partnered with Eastern Idaho Public Health (EIPH) for the provision of administrative and support services to the board. This partnership is working well. In December, a grant of nearly \$15,000 from the Blue Cross Foundation for Health was awarded to the Region 7 BHB/EIPH for a regional community engagement project focusing on children's mental health issues, allowing the board to facilitate education to individuals throughout the region and connect them with resources to assist children with mental health needs. This outreach occurred in Clark, Bonneville, and Teton Counties, with events scheduled in Lemhi, Bingham, and Butte Counties in the coming months. The Region 7 BHB is also excited about the funding awarded to support the recovery center (Center for HOPE) in Eastern Idaho and continues to work to support its efforts to serve as a resource to individuals with mental health or substance use issues in Eastern Idaho.

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SUCCESSSES DURING 2015-2016

Crisis Centers

In 2014, the Idaho Legislature awarded funding for one crisis center to be located in Idaho Falls. The following year, additional funding was awarded and a crisis center opened in Coeur d’Alene. During the 2016 session, the legislature awarded funding for two additional centers, one in Twin Falls and the other in Boise. While the most recent additions are still in the planning/implementation phase and the doors have not yet opened, the original centers have provided crisis services for hundreds of Idahoans, helping them avoid incarceration or a visit to the emergency department. These diversions have helped individuals through moments of crisis, preserving their dignity, and have saved Idahoans significant tax dollars in circumvented legal and medical costs.

The chart below represents the number of people served in the crisis centers. These figures represent an unduplicated count.

	Idaho Falls	Coeur d’Alene*	Combined
Dec 1, 2014-June 30, 2015	377		377
July 1, 2015-April 30, 2016	506	307	873
Unique clients (unduplicated)	873	307	

*The Coeur d’Alene center did not open until December, 2015.

Recovery Centers

Four (4) recovery centers were funded with Millennium Funding during the 2015 session. Those centers, located in Moscow, Emmett, Caldwell, and Boise, opened in 2015 and continue to serve individuals seeking recovery. These centers operate on a shoe-string budget, heavily utilizing volunteers to provide day-to-day services. The centers all received additional financial support during the 2016 session (again, Millennium fund-

ing) and each center is actively pursuing alternative sustainable funding. Also during this session, Millennium Funding was granted for four (4) new centers:

- Coeur d'Alene,
- Lewiston,
- Pocatello and
- Idaho Falls.

All four communities are working hard to open their doors during 2016.

Respite Funding

The 2016 Legislature demonstrated its support of the Jeff D. settlement agreement by increasing the respite budget for CMH to almost \$1 million. Respite is defined in Idaho Administrative Procedures Act (IDAPA) 16.07.37 Children's Mental Health Services as "time-limited care provided to children" during "circumstances which require short term, temporary care of a child by a caregiver different from his usual caregiver. The duration of an episode of respite care ranges from one (1) partial day up to fourteen (14) consecutive days."

During the process of writing the Jeff D. agreement and implementation plan it was noted that current respite services are not adequate for families of children with serious emotional disturbance (SED). This additional funding provides opportunities for changes to be made to the current respite model that will allow respite services to be accessible and effective for all families of children with SED in Idaho.

Office of Suicide Prevention

Thanks to the 2015 and 2016 Legislatures and the Governor, suicide prevention in Idaho received a boost in funding and awareness. The 2015 Legislature tasked the Health Quality Planning Commission (HQPC), headed by Dr. Robert Polk, with finding a way to reduce the state's suicide rates. After inviting commentary from various prevention groups and reviewing efforts nationwide, the HQPC asked for, and received, an appropriation of nearly \$1 million. This appropriation will:

- Fund 60% of the Idaho Suicide Prevention Hotline (ISPH),
- Create the Office of Suicide Prevention in the IDHW, Division of Public Health,

- Provide suicide prevention training for middle and high schools, and
- Produce suicide prevention awareness campaigns.

Naloxone Education

During the 2015 legislative session, a law passed that increases the accessibility of opioid antagonist medications that literally reverses overdoses caused by opiates. It is not often we can point to a policy and say with certainty that it will save lives, but that is exactly what this new law will do. This year, the Office of Drug Policy (ODP) and Idaho's Prescription Drug Workgroup worked diligently to educate prescribers, pharmacists, and the public about the new law through trainings, newsletters, on-line videos, print materials and the media. Discussions were also held with law enforcement agencies and schools regarding Naloxone programs and how they may be incorporated into and benefit these types of organizations. These education and awareness efforts will continue throughout the next year.

Children's Mental Health Reform Project (CMHR)

On May 17, 2016, the United States District Court of Idaho approved the Jeff D. Implementation Plan. The approval of the Implementation Plan was the first step in the Jeff D. Settlement Agreement that was approved by the court in June 2015. The plan, which is the foundation for Idaho's CMHR Project, outlines the steps that will be taken to improve access to mental health services for approximately 9,000 children with SED in Idaho. Some of the highlights of the plan include:

- a Child and Family Team approach to treatment planning (a process which increases parent and child voice,
- improving communication between all professionals involved in the child's treatment),
- new services designed to provide a complete spectrum of community-based treatment for children and families,
- increased parent and youth involvement in system design and improvement, and
- new strengths-based assessment process.

At the system-level, the plan creates cross-system partnerships that will develop a new infrastructure for communication and collaboration on children's mental health cases.

This will allow all of the systems which touch a child to operate in-sync in order to facilitate and coordinate ongoing services and supports for as long as the child and family need them. The results will be a system that more efficiently uses state dollars while more effectively serving children and families.

CHILDREN'S MENTAL HEALTH

Prevention

Training and Education

Many of the Regional BHBs across Idaho supported educational and training opportunities on various children's mental health topics during the past fiscal year. Some of these trainings included Youth Mental Health First Aid, Trauma-Informed Care, and educational programs using a unique format to bring regional experts on a variety of CMH topics into rural communities. The Idaho Federation of Families (IFOFF) for CMH continues to host monthly webinars on topics related to CMH that are available for parents and professionals to view from their home or office.

Respite Funding

The additional funding for respite that was approved during the 2016 Legislative Session will allow regions to provide more comprehensive and family-driven respite services. Previously respite services were only available to families whose child had an open case with CMH. Recent changes made to the respite process, as well as the additional funding provided by the legislature, will allow any child with a SED to access funding for respite services. Removing this barrier and increasing access to these services is a huge support for Idaho families.

Idaho Lives

The Idaho Lives Project (ILP) is a program of the Idaho State Department of Education and Suicide Prevention Action Network of Idaho (commonly known as SPAN Idaho), funded from a three-year Substance Abuse and Mental Health Services Administration (SAMHSA) Garrett Lee Smith (GLS) grant. Over three years the project trained 38 secondary schools with Sources of Strength, the only peer-based best-practice program proven to reduce all types of risky behaviors over the lifespan, including suicidal behavior. Sources are listed on SAMHSA's National Registry of Evidence-based Programs and Practices. Another portion of the program addressed clinical training in Assessing and Managing Suicide Risk as most university programs and licensing boards do not require mental or medical professionals to have any suicide-specific training. The trainer, Dr. David Rudd, well known for his work nationally with the military, provided training to over 1,600 Idaho providers. In addition to these two (2) programs, the ILP trained juvenile justice centers in awareness and intervening with suicidal juveniles. This project

will continue for the next few years in a reduced capacity to train secondary schools with Sources of Strength.

Idaho Youth M.O.V.E. (Motivating Others through Voices of Experience)

Idaho Youth M.O.V.E. is a state-wide group of diverse, motivated youth who wish to make a positive change in their communities. They advocate for youth rights and are the voice for mental health and the need for services in the systems where they serve. They work towards empowering youth to be equal partners to enact change. Idaho Youth M.O.V.E. has grown and now has chapters in Boise, Pocatello, Gooding, and Nampa as of 2016, with plans to establish groups in Northern Idaho in the upcoming summer. The groups help develop leadership, advocacy, pro-social behavior, and community.

Intervention

Child and Adolescent Needs and Strengths (CANS)

As part of the Jeff D. Implementation plan, Idaho will utilize a new tool in the assessment for children with a SED. The CANS is a communication tool that is used by various child-serving systems in all 50 states. It is designed to support decision-making in the child's treatment plan, as well as assist in quality improvement measures for the system. Idaho will implement an electronic version of the CANS that can be utilized across child-serving systems. While full implementation of the CANS tool will not occur until 2018, training of clinicians and creation of the digital platform are already beginning.

Trauma-Informed Efforts in Foster Care

Over the past several years, the DHW has been focused on enhancing their practice in assessing and treating trauma. Through the Title IV-E Child Welfare Waiver Demonstration project, they have implemented research-based programs and strategies to serve children, youth, and families involved in the child welfare system. These efforts will assist the program in improving overall well-being, reduce length of time in care, increase placement stability, achieve more timely permanency, and reduce congregate care for children and families served. These researched-based programs include the implementation of the Nurturing Parent Program and the CANS tool, and the expansion of Family Group Decision Making that includes fidelity measures.

Idaho Department of Juvenile Corrections

In the past twenty years, there have been significant steps to strengthen collaboration and coordination in Idaho's juvenile justice system under Idaho's Juvenile Corrections Act. The success of this collaboration is most apparent in the numbers we have seen. As the 10- to 17-year-old population increases, there has been a decline in arrests, bookings, and commitments to state custody. This is tangible evidence of the ongoing efforts to take a strong developmental approach to juvenile justice through increased understanding of adolescent development and building services in communities.

Treatment

Idaho Caregivers Alliance

The largest workforce caring for people with mental illness, particularly children with emotional disturbance, is family members. These caregivers are often unrecognized and invisible, in spite of saving the state millions of dollars each year. The unseen cost of this caregiving is the toll it can take on family members. While they generally welcome their responsibilities, sometimes the demands are so overwhelming that the related stress causes problems with health, employment and family dynamics, and relationships. Access to critical information or an occasional break from caregiving means the difference between providing a stable and nurturing environment or one that can break a family apart. The strength of these family caregivers is impressive but it also has limits.

There are various resources that can inform and sustain family caregivers:

- Information about available services for their child or family member, provided in easy to understand terminology.
- Assistance from a person knowledgeable about the service system that can help guide families through the first steps or when a crisis occurs.
- Training for the caregivers themselves on strategies they can use to take care of themselves.
- Occasional time away from 24/7 caregiving to refuel and recharge their batteries.
- Flexibility at work that can accommodate caregiver demands, particularly those that are unexpected.

Pockets of support are available in some Idaho communities but these are isolated, fragmented, and may have narrow eligibility requirements. A framework that adequately supports family members to meet their caregiving responsibilities is needed. The BHPC works in partnership with the Idaho Caregiver Alliance, the SHIP and others to develop plans and seek funding and resources to build that framework.

Family Support Services

As of May 2016, Family Support Services is a Medicaid billable service that will benefit families of children with a mental health disorder. The IFOF conducted three (3) 40-hour trainings across Idaho in which 71 parents/care takers with “lived experience” were trained and recommended to IDHW, DBH for certification as Certified Family Support Partner (CFSP). These individuals will be employed in the community by mental health provider agencies. The role of a CFSP is to support, educate and mentor parents that are navigating various systems as they seek appropriate care for their children.

Jeff D. Implementation Plan

The approval of the Jeff D. Implementation Plan in May 2016 was a huge step forward for Idaho’s Children’s Mental Health system. This plan outlines the services that will comprise a complete spectrum of care for children with a SED, with a focus on community-based services. While the State will be using a phased-in approach to rolling out the new and enhanced services across the state, these services can be expected as early as 2017, beginning with enhanced respite care and a newly developed partial hospitalization service.

Next Steps for Children’s Mental Health

- There are limited services and supports in Idaho for **transitional age youth**...those between the ages of 16 and 24 who will lose (or have already lost) their services through CMH. This transitional age is challenging for any young adult, and those struggling with emotional and behavioral challenges are at risk for more serious mental health and substance use issues without appropriate support and treatment.

- The approval of the Implementation Plan for the Children's Mental Health Reform Project (Jeff D.) was undoubtedly an exciting step forward for Idaho's children and families. This new system relies heavily on the involvement of parents, professionals, and other stakeholders. Because of this, **education about and engagement in the CMH Reform Project** is a critical next step in order to ensure the success of the project in the coming years.
- Idaho continues to experience a shortage of child and adolescent psychiatrists. And while this shortage is found nationwide, in Idaho we continue to see families driving up to four hours from their home to access needed psychiatric services. By continuing to create a solid foundation for consistent and responsive **psychiatric Telehealth services**, we can increase the accessibility of this service.

ADULT MENTAL HEALTH

Prevention

Training and Education

Many of the Regional BHBs across Idaho supported educational and training opportunities on various adult mental health topics during the past fiscal year. Some of these trainings included Crisis Intervention Training for local law enforcement officers, Mental Health First Aid training, and a variety of suicide prevention trainings.

Idaho Suicide Prevention Hotline

In 2015, the ISPH answered 4,866 calls from Idahoans; of these callers, 1,015 were from young people age 10-24. Because of the high number of youth callers, a limited pilot project was added that allows for text and chat; funding provided from the Legislature will allow text and chat to be available throughout Idaho this fall. Approximately 617 of the hotline calls 2015 were from Idaho military members or their families. In addition to taking calls from people in crisis or needing help for someone who is in crisis, the ISPH began work with St. Alphonsus to make follow up calls to suicidal patients after their release from the emergency room or the hospital. Research has proven that follow up after a hospital visit can save suicidal patients' lives. The ISPH also offers free posters and cards that show the call number and the warning signs for suicide.

Recovery Centers

The Community Recovery Centers that have been supported through Millennium Funds provide opportunities for those in recovery from a mental health crisis to find services that will continue to help support them in their recovery journey. These services include National Alliance on Mental Illness support groups, sober entertainment (movies, game nights, bowling, etc.), phone banks, veteran support groups, smoking cessation, crisis support for families, grief support, art therapy, free counseling, and peer mentorship. They also offer referrals to and assistance accessing housing, medical assistance, transportation, and employment.

Intervention

Crisis Centers

Crisis centers are currently open in Idaho Falls and Coeur d'Alene, with additional centers in Boise and Twin Falls planning on opening in the coming months. These centers have provided crisis services for hundreds of Idahoans over the past two years. They have helped individuals avoid incarceration or a visit to the emergency department, and these diversions not only save Idahoans significant tax dollars, but also preserve the dignity of the individual experiencing the crisis.

Treatment

Peer Support Specialists

Peer Support Specialists are individuals who use their own lived experience with mental illness to provide empowerment and encouragement to support the recovery of others experiencing mental health disorders. Peer support is based on the belief that recovery is possible for everyone. It is a strengths focused, peer-driven, highly effective non-clinical service provided to individuals in recovery from mental illness. Peer Specialists have the unique opportunity to share their own recovery story in their professional setting, which contributes to a strong and trusting relationship with those they serve. There are currently 170 trained and certified peer support specialists in Idaho and 75 peers are trained each year. Peer support is an evidence-based practice that helps prevent individuals from returning to jail and/or state hospitals, and the behavioral health system could greatly benefit from increased training availability.

SHIP

The DBH staff conducted onsite surveys on behalf of the SHIP Behavioral Health Integration Workgroup between October 14 and December 14, 2015. Forty-seven patient-centered medical homes (PCMH) enrolled in the Idaho Medicaid Health Home Program participated. A majority of these primary care clinics offered co-located or semi-integrated behavioral health services. The survey highlighted a solid foundation for behavioral health integration throughout the state, as well as opportunities to further extend integration as clinics transition to PCMH practices in the months and years to come.

Next Steps for Adult Mental Health

- Idaho's rural and frontier areas continue to struggle with a lack of access to psychiatric care. Creating stable **psychiatric Telehealth programs** should be a priority for supporting Idaho's behavioral health system.
- There has been much discussion about the "coverage gap" - the 78,000 Idahoans who lack any form of health insurance coverage. They do not qualify for traditional Medicaid and earn too little to qualify for assistance on Idaho's insurance exchange. Many in this "coverage gap" struggle with treatable behavioral health issues, but due to their lack of insurance are not able to access treatment that supports their recovery. This lack of consistent mental health treatment leads to crisis situations that not only cost significant taxpayer money but also create trauma for the individual and make recovery difficult. Finding a **solution for the "coverage gap"** will improve access to care for many adults with mental illness.

Every region of the state expressed the need to resolve Idaho's limited access to **affordable, suitable, and sustainable housing**. They have identified problem areas that are especially critical in rural communities such as the lack of crisis beds, transitional, supportive and traditional housing. Housing is necessary to help assure success for those individuals who are or have been in treatment for behavioral health issues. Limited housing affects many aspects of the population including woman, children and individuals who are being released from the State Hospitals.

Shelter is a basic essential need that can assist individuals in their journey towards recovery, acceptance and success.

- Idahoans who are **lesbian, gay, bisexual, and transgender** are not a protected population and face the risk of being denied services, employment, and housing based on their gender identity or sexual orientation. Without these protections, Idahoans who are gay and transgender are more susceptible to behavioral health issues but can be denied services when seeking help; this creates an accessibility concern. All Idaho families need to be able to earn a living and provide for their families, have access to services and housing without fear of being turned away.

SUBSTANCE USE DISORDERS

Prevention

Office of Drug Policy

Substance abuse prevention in Idaho has seen continued growth and success during the past year. Seventeen (17) Idaho communities are now receiving funds through the Office of Drug Policy's Strategic Prevention Framework (SPF) Grants program to implement population level prevention strategies. The SPF program also provides funds for six (6) law enforcement agencies to conduct operations to enforce underage drinking laws and curb prescription drug misuse. In addition, 46 prevention providers statewide were awarded funding from the Substance Abuse Prevention and Treatment block grant to deliver evidence-based prevention programs in their communities.

Recovery Centers

The Community Recovery Centers that have been supported through Millennium Funds provide opportunities for those in recovery from a substance use disorder to find services that will continue to help support them in their recovery journey. These services include life skills training, smoking cessation, drug testing, recovery coaching, case management, childcare, help accessing safe and sober housing, and support in finding Substance Use Disorders (SUD) treatment options.

Youth Drug and Alcohol Prevention Coalitions in Idaho

There were 14 Idaho prevention coalitions that attended the Community Anti-Drug Coalitions of America Coalition Academy and graduated in Washington, D.C. this year. This is an extensive three-week training that was held over the course of a year, in Boise. Eleven (11) additional coalitions just completed the course and will graduate in February 2017. There are currently 29 active prevention coalitions that are working with the Community Coalitions of Idaho (CCI), a statewide coalition of coalitions, and the Idaho Office of Drug Policy, to address youth substance abuse.

The CCI members are working to address the growing problem of prescription drug misuse, alcohol use and marijuana use among youth. Several coalitions will be addressing the prescription drug misuse problem by providing prescription drug collection programs and educating physicians of the importance of using the Prescription Monitoring System. They will also use media, billboards, and social media to raise awareness

of this increasing issue and implementing a variety of activities in communities across the state. Our coalitions have been effectively implementing strategies to decrease underage drinking, marijuana use, vaping, and many other drug related trends.

Intervention

Naloxone

The education and awareness efforts surrounding the use of Naloxone to treat opioid overdose continues to positively impact the potential of this policy to save lives. The Office of Drug Policy (ODP) and Idaho's Prescription Drug Workgroup continues to educate prescribers, pharmacists, and the public about the new law various methods. These efforts to educate all of the individuals and organizations that could potentially benefit from the understanding of Naloxone will continue throughout the next year.

Treatment

In FY 16, DHW's Division of Behavioral Health managed nearly \$7 million in combined federal block grant and state dollars for treatment and recovery support services. This money served different populations, including Intravenous Drug Users, Pregnant Women and Women with Children, Adolescents, State Hospital patients returning to the community, Supervised Misdemeanants, parents involved with child protection, mental health clients, and certain problem-solving courts ("drug courts"). This year, the DHW was able to provide services to a new category: Idahoans who fall under 100% of federal poverty guidelines. These services helped bridge the Idaho's Medicaid expansion gap. However, demand outweighed supply and services for this population were terminated before year's end.

Other highlights include:

- Telehealth SUD services in the publically funded network were made available this year.
- There has been an increase in the numbers of individuals accessing treatment who claim heroine/opioids as their primary drug of choice, indicating a rise in use of these drugs in our state.
- Recovery Coaching is now a reimbursable service in this system."

Idaho Department of Corrections (IDOC)

The IDOC budget for direct SUD services in FY16 is \$7,062,100. These funds provide community-based drug and alcohol treatment services for adult felons through a statewide private provider network. At the start of FY16, available treatment services included assessment, outpatient/intensive outpatient care and recovery support services (case management, drug testing, safe/sober housing, life skills and transportation). To improve offender outcomes, in January 2016, the IDOC added a 28-day residential treatment option to the service matrix. As the end of FY16 approaches, it is estimated that the private provider network will serve approximately 4,300 IDOC offenders.

Recovery Coaches

Efforts to increase the number of Idaho Recovery Coaches continue. To date, more than 400 coaches have been trained. Recovery Centers and treatment providers are beginning to employ coaches as they see the value of providing peer-to-peer services. Many, but not all, public funders of treatment are supporting the service. The Idaho Board of Alcohol/Drug Counselor's Certification now offers a certification for Recovery Coaching.

Next Steps for Substance Use Disorder Treatment

Medication Assisted Treatment (MAT)

In terms of DHW and next steps for MAT, the DHW is currently exploring options for funding this service using block grant and state dollars. Without additional funding, the introduction of MAT into our cadre of services will result in others not receiving treatment due to lack of funds. The Obama administration is promoting significant funding for states to combat the opioid crisis. Idaho continues to watch that proposal closely. Idaho currently has some MAT providers across the state and while some are receiving federal grant monies (from grants they have independently applied for), none are receiving state funding at this time.

IDENTIFIED BARRIERS

Each year the Regional BHBs submit a report to the BHPC detailing their successes, as well as the needs and gaps within their regions. Upon reviewing the reports, the BHPC recognized many statewide trends regarding barriers to both accessing services and maintaining recovery.

Barriers to Accessing Services

- Lack of consistent, reliable **Telehealth** services.
- Lack of **providers** (psychiatrists, as well as other behavioral health providers), especially in rural areas.
- Lack of access to services for **non-criminal justice, at-risk youth and adults**
- Lack of **collaboration among providers** about mental health and physical health needs (often due to system limitations, not the choice of the professional).
- Lack of access to insurance coverage for the **"gap" population**.

Barriers to Maintaining Recovery

- Lack of **housing**, including traditional housing (especially for women and families) and models with more supervision for high risk patients with complex medical and co-occurring conditions transitioning out of hospital settings.
- Lack of consistent, reliable **transportation**.
- Lack of **supported employment** for those with the most serious mental health challenges.
- **Stigma** often limits access to opportunities that are currently available.
- Lack of **family engagement** for youth during treatment (due to a variety of issues including not being able to take off time from work, lack of transportation for parents, lack of understanding about the treatment process, etc.).

CONCLUSION

In closing, the Council would like to once again thank the Governor and the Legislature for their supportive actions with regards to the behavioral health system this past year. Your support allows for the continued improvement of Idaho's behavioral health system.

As we look forward to the next fiscal year and beyond:

- The BHPC supports increased numbers of problem-solving courts which provide alternatives and treatment for those facing criminal charges complicated by their mental health diagnosis or substance use disorder.
- The BHPC supports collaboration with the Courts, Juvenile and Adult Corrections, and County probation to better meet the needs of those with a mental health diagnosis or substance use disorder in the criminal justice system.
- The BHPC supports the work of the regional BHBs and their collaboration with their local community networks to provide the mental health and SUD supports for adults, children, and families.
- The BHPC supports the investment in prevention programs and activities to reduce substance abuse and protect the health, safety and quality of life for all, especially Idaho's youth.
- The BHPC supports the work of crisis and recovery centers that provide resources to those seeking treatment and supports to aid their recovery.
- The BHPC supports the new system of care within CMH, which will more efficiently and effectively meet the mental health needs of Idaho's children diagnosed with a serious emotional disturbance.
- The BHPC supports efforts to decrease the "silos" within the behavioral health system and increase opportunities for shared communication, treatment, and recovery support for both children and adults.
- The BHPC supports increased use of peer support services within all aspects of Idaho's Behavioral Health system; including recovery support coaches, peer support specialists, and family support partners.
- The BHPC supports the continued development of consistent, sustainable Telehealth services within behavioral health.

There is much work left to do, but the Council remains hopeful that by working together we can continue to transform Idaho's behavioral health system into one that is responsive and effective.

Appendix

Statute – IC 39-3125

TITLE 39
HEALTH AND SAFETY
CHAPTER 31

REGIONAL BEHAVIORAL HEALTH SERVICES

39-3125. STATE BEHAVIORAL HEALTH PLANNING COUNCIL. (1) A state behavioral health planning council, hereinafter referred to as the planning council, shall be established to serve as an advocate for children and adults with behavioral health disorders; to advise the state behavioral health authority on issues of concern, on policies and on programs and to provide guidance to the state behavioral health authority in the development and implementation of the state behavioral health systems plan; to monitor and evaluate the allocation and adequacy of behavioral health services within the state on an ongoing basis; to monitor and evaluate the effectiveness of state laws that address behavioral health services; to ensure that individuals with behavioral health disorders have access to prevention, treatment and rehabilitation services; to serve as a vehicle for policy and program development; and to present to the governor, the judiciary and the legislature by June 30 of each year a report on the council's activities and an evaluation of the current effectiveness of the behavioral health services provided directly or indirectly by the state to adults and children. The planning council shall establish readiness and performance criteria for the regional boards to accept and maintain responsibility for family support and recovery support services. The planning council shall evaluate regional board adherence to the readiness criteria and make a determination if the regional board has demonstrated readiness to accept responsibility over the family support and recovery support services for the region. The planning council shall report to the behavioral health authority if it determines a regional board is not fulfilling its responsibility to administer the family support and recovery support services for the region and recommend the regional behavioral health centers assume responsibility over the services until the board demonstrates it is prepared to regain the responsibility.

(2) The planning council shall be appointed by the governor and be comprised of no more than fifty percent (50%) state employees or providers of behavioral health services. Membership shall also reflect to the extent possible the collective demographic characteristics of Idaho's citizens. The planning council membership shall include representation from consumers, families of adults with serious mental illness or substance use disorders; behavioral health advocates; principal state agencies and the judicial branch with respect to behavioral health, education, vocational rehabilitation, adult correction, juvenile justice and law enforcement, 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 or substance use disorders, and related support services; and the regional behavioral health board in each department of health and welfare region as provided for in section 39-3134, Idaho Code. The planning council may include members of the legislature.

(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.

History:

[39-3125, added 2006, ch. 277, sec. 3, p. 849; am. 2014, ch. 43, sec. 7, p. 109.]

BHPC Membership by Region

Name	Position	Region	Email
Sandra McMichael	Consumer/SUD	1	smcmichael@bmc.portland.ihs.gov
Angela Palmer	Treatment Provider/SUD	1	angela.palmer@sequelyouthservices.com
Tammy Rubino	Community Coalitions	1	communitycoalitionsofidoaho@gmail.com
Abraham Broncheau	Tribal	2	abebwolfis@gmail.com
Jennifer Griffis	Parent of Child/Adolescent	2	jengriffis@gmail.com
Elda Catalano	Hispanic	3	ecatalano@canyonco.org
Judy Gabert	SPAN Idaho	3	jgabert@spanidaho.org
Rosie Andueza	Division of Behavioral Health	4	AnduezaR@dhw.idaho.gov
Evangeline (Van) Beechler	LGBTQ	4	ebeechler@gmail.com
Carol Dixon	Certified Family Specialist	4	cdixon@idahofederation.org
Jane Donnellan	Vocational Rehab	4	jane.donnellan@vr.idaho.gov
Jen Haddad	Family and Child Services	4	HaddadJ@dhw.idaho.gov
Magni Hamso	Physician	4	mhamso@trhs.org
Marianne King	Office of Drug Policy	4	marianne.king@odp.idaho.gov
Tiffany Kinzler	Medicaid	4	KinzlerT@dhw.idaho.gov
Greg Lewis	Corrections/Adult	4	glewis@idoc.idaho.gov
James Meers	Veteran	4	jmeers99@gmail.com
Julie Mitchell	Housing	4	juliew@ihfa.org
Jason Stone	Corrections/Youth	4	Jason.stone@idjc.idaho.gov
Rick Huber	Consumer/MH	5	rick2727272000@yahoo.com
Susan Hepworth	Consumer/Senior Adult	6	skhepworth53@gmail.com
Holly Molino	Treatment Provider/MH	7	holly@accesspointkids.com
Jon Shindurling	Judiciary	7	jshindurling@co.bonneville.id.us

Acronyms

Acronym	Meaning
BHB	Behavioral Health Board
BHPC	Behavioral Health Planning Council
CANS	Child and Adolescent Needs and Strengths Assessment
CCI	Community Coalitions of Idaho
CFSP	Certified Family Support Partner
CHMR	Children's Mental Health Reform Project
CMH	Childrens Mental Health
DBH	Division of Behavioral Health
DHW	Department of Health and Welfare
EIPH	Eastern Idaho Public Health
GLS	Garrett-Lee Smith grant
HQPC	Health Quality Planning Commission
IDAPA	Idaho Administrative Procedures Act
IDHW	Idaho Department of Health and Welfare
IDOC	Idaho Department of Corrections
IFOF	Idaho Federation of Families
ILP	Idaho Lives Project
ISPH	Idaho Suicide Prevention Hotline
MAT	Medication Assisted Treatment
ODP	Office of Drug Policy
PCMH	Patient-Centered Medical Homes
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SHIP	Southwest District Health Statewide Health Innovation Plan
SPF	Strategic Prevention Framework

Regional Behavioral Health Board

Gaps and Needs Analysis

2015

Please provide a brief description for each of the columns listed. Include additional information as needed.

Identified Regional Service Needs and Gaps <i>Relating to Prevention, Treatment and Rehabilitation Services</i>	Short Falls and Challenges	Project Proposals and Progress <i>Including those related to Family Support Services and Recovery Support Services</i>	Improvement and Strategy Measures
MH/SUD Crisis Services Detox Regions – 1,2,3,4,5,7	<ul style="list-style-type: none"> • Lack of crisis services with health care status and 24 hour availability • Lack of general and intensive outpatient providers in rural areas • Lack of capacity for local ERs to identify/manage/address/acute crisis needs • Lack of SUD prevention, early intervention services and residential options • Lack of case management services • Better crisis response plan • High demand on crisis center and additional centers are needed • Increased need for diversion 	<ul style="list-style-type: none"> • Continue to survey stakeholders to prioritize needs • Research results submitted to legislature • All Substance Abuse Providers need to be certified to treat dual diagnosis • Adults: Community Recovery Centers to assist those in recovery • Improve communication about hospital actions that limit bed availability and result in diversion to other hospitals out of region • Engage the new BHC Director in community planning • Explore options for sub-acute detoxification services 	<ul style="list-style-type: none"> • CDA selected as site of crisis center 23 hour voluntary holds • Collect data from primary and secondary consumers on perception of their needs for services • Latah County NAMI assisting with WSU data collections for Region 2 • Searching for funding that incorporates individuals with dual diagnosis legislature need to pass/approve Medicaid • Expansion/Restructuring Youth: Data/outcomes from Shelter Care, Prevention data/outcomes from schools,

	<p>programs</p> <ul style="list-style-type: none"> • Need to de-criminalize substance use disorders • Additional resources for community supervision • Lack of local detox facilities 	<ul style="list-style-type: none"> • Increase number of beds available for adults and youth • Alternative resources for the waiting period until a bed becomes available • Create transportation options to transport to nearest available bed or crisis center • Have a crisis center open and running 24/7 in all Regions • Community support and awareness • Utilization of existing buildings to house the facility • Further support for community recovery centers • Provide for additional probation officers based on per capita populations • Establish subsidized respite care program • Provide training for first responders on mentally ill children and their families 	<p>decrease in youth hospitalizations and referrals to juvenile probation</p> <ul style="list-style-type: none"> • Adults: decrease in Probation and Parole, incarceration, hospitalization, client holds, and increase in case management. • Address psychiatric beds at the quarterly PCH (protective custody hold) Meetings. • Create a list of what is currently available with a payment source and seek funding opportunities • Create a list of what is being used now for detox • Enhance communications between provider and law enforcement to create a more efficient process • Increase awareness and promote the need for a Crisis Center
<p>Access to Psychiatric Services for both Adults and Children Regions 1,2,4,5,7</p>	<ul style="list-style-type: none"> • Funding for Tel-Health/ Insurance and the structure is inadequate • Best use of existing TH facilities • PCP not willing to prescribe psychotropic RX • Lack of Psychiatric Providers who can subscribe • Limited staff at BHC on weekends. • Lack of dependable access to 	<ul style="list-style-type: none"> • Increased uses of Psych NP • Continue use of tele-health in outlying areas and provide state-subsidies for professionals willing to work in outlying areas. Load re-payment options and identify a facility/site to house the equipment • Psychiatric Mid-level providers • Use of existing facilities and 	<ul style="list-style-type: none"> • ACA increased access • Advocate for local tele-health services and change IDAPA SUD regulations to allow clinical supervision via Tele-health • Partner with North-West Children's Home for psychiatric services • Acquire data on frequency of use of ERs for Behavioral

<p>Financial help with Medications for both Children and Adults Regions 1,5</p>	<p>psychiatric beds</p> <ul style="list-style-type: none"> • Lack of understanding around medical necessity determination for CBRS • Mental health services for families in rural areas • Inability to access reimbursement for prevention or treatment • SOAR needs faster accessibility to Medicaid approval • Lack of available child psychiatrists • No short-term acute services for youth • Expand services for infant & toddlers • Psych-education for agencies, school personnel, & juvenile justice system on Trauma-Informed Care • Post adoption services for children with SED • Use of evidence-based practices for children & for parent education • Better pay for psychiatrists • School loan repayment for physicians • Increase Medicaid payments • Person to apply for aid from drug companies • Complicated paperwork requiring assistance to prepare • Demand exceeds availability 	<p>building that are not currently being used to house Community Recovery Center, Centers for Community Health, and as satellite sites for providers</p> <ul style="list-style-type: none"> • Provider Trainings – Demonstration of medical necessity for care to include CBRS • Support Medicaid expansion or Health Plan Idaho. • Increase SOAR trained professionals in the area. <p>Decrease time frame for those in need to access services.</p> <ul style="list-style-type: none"> • Children’s Mental Health Planning Council • Psychiatric Mid-level Providers • Children’s mental health first responder training 	<p>Health Services</p> <ul style="list-style-type: none"> • Research and seek out funding sources and programs that support tele-health initiatives such as – The Healthcare Connection Fund – Agency for Healthcare Research and Quality Small Research Grant program • Start a “mobile clinic” to take MH services to patients in remote areas • Engage and educate community leaders and private businesses about the positive effects that enhanced access to behavioral health has on communities • Reopen regional satellite office. • Collect data on psychiatrist’s salaries • Publicize the loan repayment program
		<ul style="list-style-type: none"> • Use a 340 B drug program for the community • Increase access to medication management to reduce avoidable readmissions • Enhance communication with 	<ul style="list-style-type: none"> • Create awareness and provide accurate information about what medication management is • Engage and include community providers in the

<p>Sustainable Housing for the Homeless and Transitional Populations Regions 1,2,3,4,5,7</p>	<ul style="list-style-type: none"> • Community acceptance, stigma • Limited funding for housing • Lack of Safe and Sober Housing for males/females • For both Adults and Juveniles • Lack of shelter, transitional, residential or supportive care facilities insufficient for the demand and need 	<p>care-givers across the continuum of care</p> <ul style="list-style-type: none"> • Improve the perception of “Med. Management” and why it is a necessary component of care • Apply for ID Housing monies • Housing for felons • PATH therapeutic foster care • Address housing policies that • Establish an Emancipation Home type of program • Develop temporary residential housing and treatment for youth with mental illness who are unable to remain in homes • Well-managed, clean transitional housing units • Housing opportunities that “screen in” individuals rather than “screen out” individuals • Engage more housing providers in case management of existing/potential residents, connect to Community Recovery Centers and peer/Recovery supports • Address policy of requiring 24 hours homelessness for those leaving institutions (jail, hospital) before eligible for shelter • Develop additional partnerships and linkages to increase housing options 	<p>conversations addressing this need</p> <ul style="list-style-type: none"> • Increase access to medications by addressing cost and affordability • Develop sustainable housing for men, women, youth; group homes or secure homes • Explore grant opportunities for housing • Create Housing committee on Regional Boards • Partner with local colleges to research grants and work on data collection • Decrease risk of homelessness to this vulnerable population • Have a housing representative educate the RBHB regarding statistics and housing options for the behavioral health population. • Engage our community members while educating about the social and fiscal benefits of crisis/transitional housing • Capture sources of funding for first-month rent and deposits • Research functioning housing models in other regions/states and address hurdles
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			<ul style="list-style-type: none"> encountered during state-up Research and collaborate regarding the opportunity to renovate and use existing vacant dwellings/structures.
Respite/Therapeutic Foster Care for both Children and Adults Regions 1,2,4 CMH Day	<ul style="list-style-type: none"> Funding to provide training Lack of available affordable respite care Funding for services Licensure for Day Treatment Increase number of therapeutic foster homes 	<ul style="list-style-type: none"> Train volunteer families to accept referrals on temp basis PATH therapeutic foster care Youth: Shelter Care, a form of short-term intervention, residential respite care 	
Suds/MH Parent Education, Training and Services for both Children and Adults to include Intervention & Prevention Regions 1,3,4,5	<ul style="list-style-type: none"> Family education needed Community education, survey of what is needed in specific communities Parenting classes are available – need to help insure people know it is available Community Acceptance; stigma Individual SD Resistance Funding from MH and SUD groups and connecting of current available resources Idaho does not have DEC Alliance protocol in place; need system in place to identify kids at risk. 	<ul style="list-style-type: none"> Expansion of behavioral health youth mentoring program, connecting provides with needs in the community Develop a resource for employers that addresses common questions in an effort to support success for both parties Expand Mental Health First Aid training Normalize the concept of attending parenting classes in effort to boost attendance and provide valuable tools for families More afterschool programs with the assistance of applications for the State Dept. of Education 21st Century Grant, Increase school participation in Prevention Block Grant 	<ul style="list-style-type: none"> Use resources of advocacy groups to start: NAMI, IFFCMH Data/outcomes of referrals through judicial system, adult/juvenile probation and hospitalization. Public education about behavioral health and community wellness issues Seek funding sources for promotion and delivery of educational material Collaborate with OPTUM to promote and expand the Mental health First Aid Trainings to a broader audience Work towards evaluating why parenting classes have low attendance and consider re-evaluating QPR Training

<p>Transportation for MH/SUD Clients Regions 1,2,3,4,5,</p>	<ul style="list-style-type: none"> • Currently no transportation in rural areas • Limited City Link bus routes • Taxi services are unaware of available funding to transport individuals with SUD • Limited access to transportation to access needed appointments and employment 	<ul style="list-style-type: none"> • Engage Mayor's Youth Advisory Councils to promote healthy youth involvement, • Engage BHB to assist in the writing of grant funding opportunities • Address needs of children in dangerous drug environments • Formation of community-based partnerships with agencies across multiple disciplines • Support state services and local communities to develop efficient/effective strategies/for avocation of victims • Implement more prevention programs within schools. • Establish a state supported bus pass program for MH/SUD individuals to attend treatment, medical, probation and other related appointments • Combine and coordinate individual vehicle fleets from multiple organizations/agencies/provides to offer efficient public transport from a single transit organization/central dispatch • Consider the use of existing transportation sources to provide services to 	<ul style="list-style-type: none"> • Overall reduction of recidivism, incarceration, and hospitalization by changing environmental strategies • Identify drug endangered children the dangers they face. • Offer ongoing education, support and linking services
		<ul style="list-style-type: none"> • Improve access to car/services/supports and decrease no show rates • Investigate rural transportation models that have proved successful in areas with similar geographic/populations make up • Seek expanding the use of Section 5311 funds to communities with populations less than 50,000 • Telehealth reduces need for transportation services • Need for continued reform of 	

		rural/frontier areas	shackling policy <ul style="list-style-type: none"> Explore use of Virtual Behavioral Health Care to meet local mental health needs
Education for Law Enforcement and First Responders about MH and SUD issues Regions 4,5	<ul style="list-style-type: none"> Increase funding for CIT Training Time for officers to attend training Resistance by LE Administration Difficult for smaller areas to attend full trainings and keep staffed during that time 	<ul style="list-style-type: none"> CIT trainings are offered and well-received by local law enforcement, however many rural areas are unable to coordinate due to the length of the course 	<ul style="list-style-type: none"> More CIT training Propose the idea of shorter mini-training sessions to reach locations that are unable to attend the week-long training in one block
Specialty Court Client Issues – including youth Mental Health Court Regions 1,2,3	<ul style="list-style-type: none"> Case Management services are underutilized and in high need. Housing is an issue Funding, lack of grant writing experience (opportunities exist), engaging judicial involvement 	<ul style="list-style-type: none"> Offer housing and case management Engage BHB to assist in the writing of grant funding opportunities, engage judicial system and juvenile probation. Review models in other regions with date review. 	<ul style="list-style-type: none"> Data/outcomes of referrals through judicial system, juvenile probation, and hospitalization. Need for approval by Idaho Drug and MH Coordinating Committee Funding
Access to Services without criminal involvement Regions 3,4	<ul style="list-style-type: none"> Funding, a successful model(school disciplinary hearings), parental/caregiver involvement Schools in more rural areas do not have the resources to provide services needed for children/families with mental illness Lack of training and resource to hire within. These services are currently contracted out which limits response and resources 	<ul style="list-style-type: none"> Research funding sources such as the Juvenile Justice Commission, develop a model for schools/communities to refer at-risk youth, engage parents/caregivers in family supports (family therapy/groups) Work with DHW for crisis services (law enforcement, schools, parents, caregivers). Engage in community training such as trauma informed care, 	<ul style="list-style-type: none"> Decrease in referrals to juvenile probation, outcomes/data from successful model implementation and crisis calls deferred, and increase in parental/caregiver involvement in family supports Adult Corrections accessing funds through Justice Reinvestment Act Identify specific need for

	<p>for the school</p> <ul style="list-style-type: none"> Minimal Trauma informed care and strengthening families training opportunities Support for children of incarcerated parents Limit incarceration terms, reassess risk levels Increase services for this population Difficulty in obtaining services under children's mental health unless involved in the system. 	<p>suicide prevention, at-risk youth behavioral education.</p> <ul style="list-style-type: none"> Establish and/or support these training opportunities Establish a state-wide system, at the court level, to identify children of parents being incarcerated; provide professional to engage them in prevention interventions immediately. Establish diversion programs in lieu of incarceration. Develop Grant writing partnerships 	<p>recovery in each region</p> <ul style="list-style-type: none"> Legislature need to pass/approve Medicaid Expansion/Restructuring
<p>Optum Idaho SUD Referrals Regions 1,2,3,4,5</p>	<ul style="list-style-type: none"> Lack of SUD diagnosis and internal referral processes Policy barriers to qualify care and accessibility: H0001 code attached facility instead of license No reimbursement from contractors for paperwork required from providers Currently no path in place within contractors referral system to refer clients to a SUD Provider when a need is identified Issues with Co-Occurring referrals Establish a culture of collaboration with Medicaid provider and contractor. Increase oversight of Medicaid contractor, increase 	<ul style="list-style-type: none"> Engage Optum to provide data reports, monitoring/enforcing that providers are operating within their scope of practice, using evidenced based practices, appropriate referral of co-occurring clients. Better communication between Medicaid/Behavioral Health division lines Policy changes that allow for assessments to be conducted based on licenses not facility approval Better oversight by Medicaid contractor to identify clients with SUD needs and conversely push toward drug Dependent Epidemiology (DDE) programs for all SUD providers 	<ul style="list-style-type: none"> Increase diagnosis and treatment of SUD and co-occurring Request enhanced data reports and measures to ensure providers operate within scope of practice Improved service provision and patient outcomes. Maintain capacity (provider networks). Reimbursement rates are below average Collaborate with Optum for Fall/Winter PCP/Provider Collaboration Education

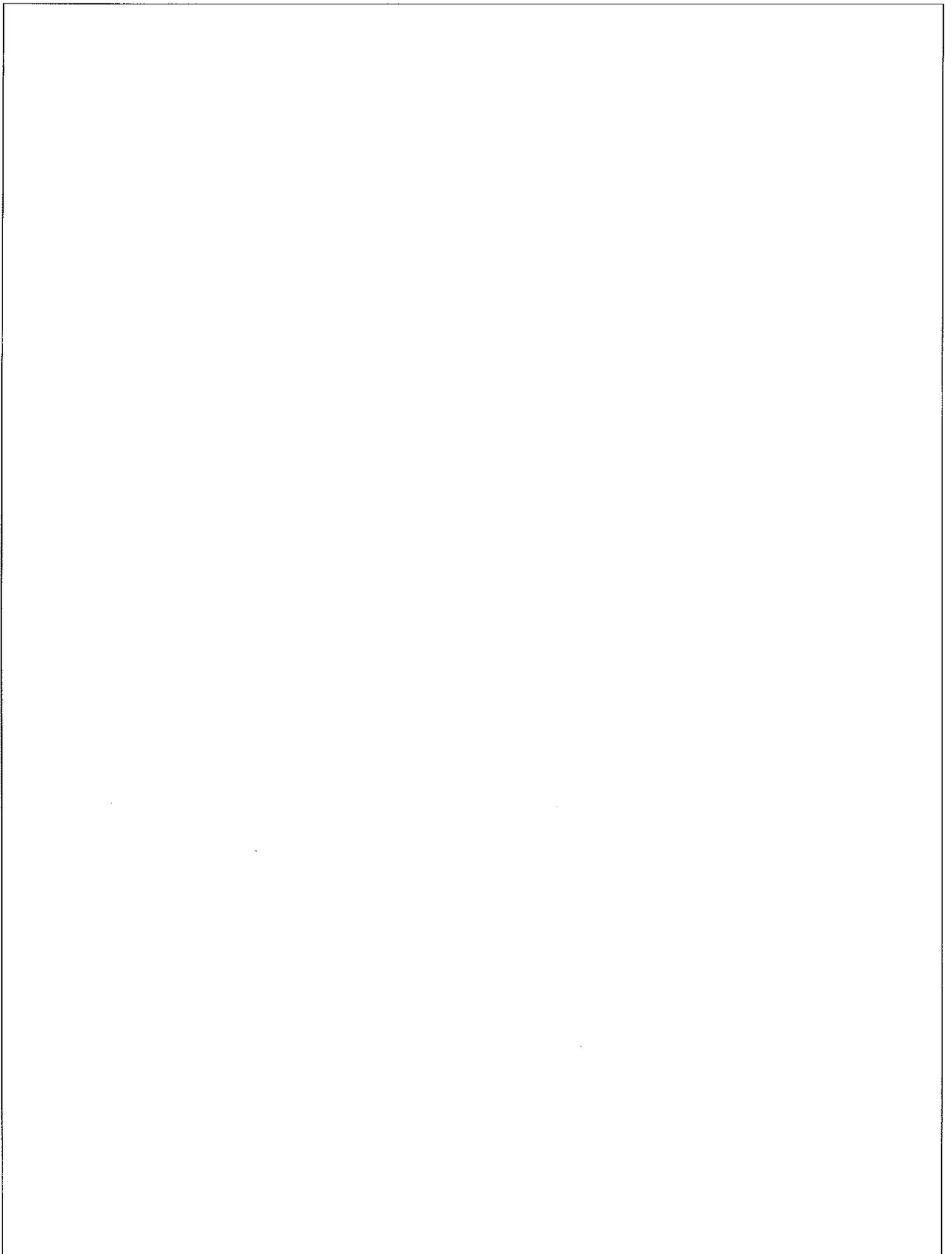
	communication across lines.	<ul style="list-style-type: none"> • Incorporation of American Society of Addiction Medicine (ASAM) in Medicaid paperwork allowances in the billing matrix to bill for communication. • Develop system to track co-occurring client referrals • Increase SUD Provider network • Service Provider Contractors should reflect sub-categories being treated 	
Interpreters/translators Regions 3,4,5	<ul style="list-style-type: none"> • Lack of training and availability of service 	<ul style="list-style-type: none"> • Increase training • Increase access to care • Improve quality of care and outcomes 	<ul style="list-style-type: none"> • Increase the number of available providers • Promote and educate regarding the need for this type of service in the regions • Seek funding sources that aim to address this need by promoting training, certification, and community education
Systems Issues Region 4	<ul style="list-style-type: none"> • Policy and legislation requirements are often redundant and in conflict with current licensing standards • Need for better communication and consistency across division lines • Need for better communication with contract managers • Need to create funding stream for gaps in care • Offender re-entry • Patients released for IDOC/SHS 	<ul style="list-style-type: none"> • Establish and communicate measurable goals for state mental health/SUD system, in a fashion that incorporates input from all levels • Establish working relationship with licensing boards so that policy and legislation are written with current licensing standards in mind. • Division lines (Behavioral Health and Medicaid) collaborate, measure goals/ 	<ul style="list-style-type: none"> •

	<ul style="list-style-type: none"> • Medicaid expansion populations • Legislative support of program needs 	<p>outcomes of both populations concurrently, drill down with contract managers and into provider network.</p> <ul style="list-style-type: none"> • Support of legislation related to proposed mental and behavioral health services and programs. 	
<p>Data Collection and Data Sharing Issues: Region 7</p>	<ul style="list-style-type: none"> • There is a need for a database that would allow multiple agencies to share information on persons with mental illness in order to provide better response and ongoing care. 	<ul style="list-style-type: none"> • Identify core performance indicators and collection points. • Determine a mechanism to be able to appropriately share critical information across those systems with a need to know (database) 	<ul style="list-style-type: none"> • Continue to collaborate with OPTUM/Medicaid for data sharing • Compile a data request list to submit to Optum.
<p>Primary Care Regions 1,2,7</p>	<ul style="list-style-type: none"> • Ongoing funding for Federally Qualified Health Centers • Move towards holistic model • Often times clients are in need of medical, psychiatric, dental and vision services – but don't have access if they do not have insurance or benefits • Urgent care centers are not connected to the mental health system (but treat many individuals for mental health issues) • Lacking for clients not on Medicare, Medicaid or Private Insurance • Idaho needs to make use of Medicaid realignment funds • Clinics treating the uninsured 	<ul style="list-style-type: none"> • Lack of medical insurance • Develop better linkages between mental health and primary medical care including physical health , dental care and vision care • Explore access barriers • Assist with necessary application for various medical assistance benefits • Expand community collaboration 	<ul style="list-style-type: none"> • Collaborate with the 211 care line to ensure it accurately covers resources available in each of the regions • Create a cover letter to distribute to primary care providers throughout the region with information on how to access the newly updated 211 care line • ACA • SHIP Program • Legislature need to pass/approve Medicaid Expansion/Restructuring

<p>Peer Support and Recovery: Coaches Region 7</p>	<p>need increased funding and resources</p> <ul style="list-style-type: none"> • Region would benefit from a broader availability of peer support and recovery coaches. All agencies need to have access to peer support and recovery coaches • Need to expand use of Peer support and Recovery coaches in the community to probation and parole 	<ul style="list-style-type: none"> • Expand the availability and use of peer support and recovery coaches 	<ul style="list-style-type: none"> • Develop a Community recovery Center • Provide more opportunities for peer Support/Recovery coach training in the region • Connect and collaborate with Optum's peer and family support • Create and maintain a current list of all recovery coaches and peer support specialists in the region
<p>Accomplishments and Progress</p> <ul style="list-style-type: none"> • Kootenai Co had two orgs present to BHB about group homes • Legislation passed ID House/Senate HB 264 • Legislation passed to offer loan repayment to Psych MDs to work at State Hospitals • Children's Mental Health Planning Council • Children's mental health first responder training • Developed Iris House/transitional housing with 1 crisis bed • Parenting with Love and Limits/Logic available • NAMI Family to Family 	<p>Accomplishments and Progress</p> <ul style="list-style-type: none"> • Abbadly House in Cottonwood • Transitional Housing Funds from IDOC • Shelter Plus Care is available • NAMI Family to Family • FFCMH Building Stronger Families; online courses, seminars • CMH ACE training in April 2015 • QPR Suicide Prevention Training • ACE (Adverse Childhood Experience) workshop April 30th, 2015 • April 10 Presentation Building a Trauma Informed Care Community at Kroc • 2014 Legislation approved loan repayment for physicians at state hospitals 	<p>Accomplishments and Progress</p> <ul style="list-style-type: none"> • SHIP Program to focus on Patient Centered Medical Home • CIT Training for First Responders • Progress: Have requested data and measures to ensure SUD referrals • ACA increased access to needed care • CDA selected as site of crisis center 23 hours voluntary holds • Provided 5 scholarships to ICADD for providers • QPR Training in Silver Valley 	<p>Accomplishments and Progress</p> <ul style="list-style-type: none"> • IFFCMH Building Stronger Families; online courses, seminars • CMH ACE training in April • QPR Suicide Prevention Training • CIT trainings, youth mentoring programs • Providing training (eating disorders, PLL Parent Support Groups • BH meeting with housing authorities to provide on-site BH referrals

- Region 3 was a pilot for Vallivue and Nampa School Districts that utilized funding to deter youth from the criminal justice system. Potential to follow that pilot model/outcomes. CIT Trainings within the schools, youth mentoring program
- Progress/Youth: Working with Juvenile Probation to develop Shelter Care Model, increase transportation services to needed behavioral health services, increase individual/family group therapy, add full ACT options with Optum
- Progress/Adult: Increase transportation services to needed behavioral health services, increase individual/family group therapy, youth mentoring programs
- Shackling legislation passed in 2014 Session
- Prescription drop-off boxes in the communities
- Drug courts
- FQHC's (Federally Qualified Health Centers) established in Idaho.

- State Healthcare Innovation Plan funded by Feds and awarded to DHW
- Idaho Health Insurance Exchange
- BH provided training to medical staff, schools and law enforcement
- Region 2 Developed of Respite Care Training Curriculum
- Adult Mental Health provide Designated Examiner Training for Psychologists
- Improved relationships with Tribal representatives
- Mental Health First Aid Training
- Recovery Center in Latah County
- Establishment of Children's Mental Health subcommittees
- Children's Mental Health Council provided information, training for schools and public established support groups
- ATR4 – allows for homeless SUD (substance use disorder) population to access needed services.



Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016 End Year: 2017

Type of Membership	Number	Percentage
Total Membership	25	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	1	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	4	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	13	52.00%
State Employees	9	
Providers	2	
Federally Recognized Tribe Representatives	1	
Vacancies	0	
Total State Employees & Providers	12	48.00%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Persons in recovery from or providing treatment for or advocating for substance abuse services	3	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Idaho Behavioral Health Planning Council was notified via email, that the FY 17 Application Update was posted on their website for review and comment. (<http://healthandwelfare.idaho.gov/Medical/MentalHealth/BehavioralHealthPlanningCouncil/tabid/320/Default.aspx>) Because the FY 17 Application update only covers SSA and MHA planned expenditures and information on the Planning Council, a conference call was not held. However, the chairman of the Planning Council did encourage members to review the document and contact her if they had concerns. The chairman summarized their comments in her letter of support for the combined application. The letter is attached to this section.

Footnotes:

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016 End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Rosie Andueza	State Employees	Division of Behavioral Health	450 W State St Boise ID, 83702 PH: 208-334-5934	anduezar@dhw.idaho.gov
Evangeline Beecher	Others (Not State employees or providers)		3314 N 32nd St Boise ID, 83703 PH: 208-353-7896	eebechler@gmail.com
Abraham Broncheau	Federally Recognized Tribe Representatives		803 Hill Street Kamiah ID, 83536 PH: 208-935-8028	abeebwolfis@gmail.com
Elda Catalano	Others (Not State employees or providers)		Canyon County Caldwell ID, 83605 PH: 208-454-7300	ecatalano@canyonco.org
Carol A. Dixon	Others (Not State employees or providers)		704 N 7th St Boise ID, 83702 PH: 208-433-8845	cdixon@idahofederation.org
Jane Donnellan	State Employees	Vocational Rehabilitation	650 W State ST Boise ID, 83702 PH: 208-834-3390	jane.donnellan@vr.idaho.gov
Judy Gabert	Others (Not State employees or providers)		SPAN Idaho Nampa ID, 83687 PH: 208-866-1703	jpgabert@spanidaho.org
Jennifer Griffis	Parents of children with SED		155 Cheyenne Drive Grangeville ID, 83815 PH: 208-983-0513	jengriffis@gmail.com
Jennifer Haddad	State Employees		POB 83720/5th Boise ID, 83720 PH: 208-334-6953	haddadj@dhw.idaho.gov
Magni Hamso	Leading State Experts		300 E. Highland View Drive Boise ID, 83701 PH: 208-391-3245	jagni.hamso@gmail.com
Susan Hepworth	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		823 Northgate Drive Pocatello ID, 83201	skhepworth53@gmail.com
Rick Huber	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		309 Pasher Makay Court #7 Rupert ID, 83350 PH: 208-436-1841	rick2727272000@yahoo.com
Marriane C. King	State Employees	Office of Drug Policy	Bosie ID, 83702 PH: 208-854-3043	marianne.king@odp.idaho.gov
			Medicaid	

Tiffany Kinzler	State Employees	Medicaid	Boise ID, 83705 PH: 208-346-1813	KinzlerT@dhw.idaho.gov
Gregory Lewis	State Employees	Idaho Department of Correction	2400 N 36th St Boise ID, 83703 PH: 208-658-2034	glewis@idoc.idaho.gov
Sandra McMichael	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 388 Plummer ID, 83851 PH: 208-686-1449	
James Meers	Individuals in Recovery (from Mental Illness and Addictions)		4325 E. Stonebridge Dr Meridian ID, 83642 PH: 208-602-3184	jmeers99@gmail.com
Julie Mitchell	State Employees		4125 Hillcrest Drive Boise ID, 83705 PH: 208-867-8914	juliew@ihfa.org
Holly Molino	Providers		422 Napa Dr Idaho Falls ID, 83404 PH: 208-705-6758	holly@accesspointkids.com
Angela Palmer	Providers		1200 Ironwood Dr, Ste 101 Coeur d'Alene ID, 83814 PH: 208-667-2979	angela.palmer@sequelyouthservices.com
Tammy Rubino	Family Members of Individuals in Recovery (to include family members of adults with SMI)		10617 N Lakeview Dr Hayden ID, 83835 PH: 208-651-6335	communitycoalitionsofidaho@gmail.com
Judge Jon Schinderling	State Employees		PH: 208-589-2604	jshindurling@co.bonneville.id.us
Jason Stone	State Employees		POB 83720/DJC Boise ID, 83720 PH: 208-334-5100	jason.stone@idjc.idaho.gov

Footnotes: