WICHE

MENTAL HEALTH PROGRAM

Idaho Behavioral Health System Redesign

Findings and Recommendations for the Idaho State Legislature

2008

Western Interstate Commission for Higher Education
3035 Center Green Drive Suite 200
Boulder, CO 80301-2204
303.541.0200 PH 303.541.0297 FX

www.wiche.edu

Table of Contents

List of Tables

Executive Summary

The Legislature of the State of Idaho passed Senate Concurrent Resolution Number 108 in 2007, implementing a review of Idaho's current mental health and substance abuse treatment delivery system, and the development of recommendations to improve the system. The legislative Health Care Task Force is the oversight body for the study, and is responsible for reporting back to the full legislature on this project. This report is a result of that review.

The legislature's intent to provide a comprehensive review of the public behavioral health system is indicative of an evolving understanding among public policy makers that the current mental health and substance abuse systems are falling short in their ability to effectively meet the needs of adults, children and their families. This effort offers Idaho the opportunity to promote the transformation of its behavioral health system to enhance its ability to meet the needs of Idaho residents with behavioral health care needs.

The Western Interstate Commission for Higher Education's Mental Health Program (WICHE) was selected to complete this project. Founded in 1953, WICHE is a collaborative Interstate Compact with 15 western states, and a regional governmental entity. The WICHE Mental Health Program, established in 1955, is one of the oldest WICHE programs, having been established in 1955. Idaho was a founding member of the WICHE Interstate Compact.

Idaho's mental health and substance abuse systems are severely fragmented, with a significant lack of clarity – and consensus – regarding the roles and responsibilities of various system stakeholders. This fragmentation exists between the child and adult systems; between the Medicaid and non-Medicaid eligible; between mental health and substance abuse systems; and between executive branch agencies. This review of the system has identified some of the main challenges (or weaknesses) facing Idaho's public mental health and substance abuse systems, as well as some of the opportunities (or strengths) that exist.

Over the past seven months of this study, these findings and recommendations in this report were supported by information obtained during key stakeholder interviews and communications, as well as from quantitative and qualitative data gathered through a web-based survey.

Challenges

While every state has some degree of fragmentation, Idaho's system is uniquely challenged in several ways:

- Numerous recent and new initiatives aimed at reform in a number of allied systems, which are not necessarily part of a larger, strategic plan;
- A long history of failed – or perceived failure of – collaborations or discussions regarding improving or transformation of the related systems;
- Lack of a coordinated, comprehensive, community operated, accountable community mental health system;
- Significant system distinctions and differences between adult and children's mental health, as well as that between the mental health and substance abuse systems;
- A large amount of risk to the State, particularly due to the following:
  - Legal: State employees are a key part of both deciding which persons are involuntarily admitted to the state hospitals, and, particularly for adults, for delivering the care in the community. This risk is exceptionally high regarding those persons who were receiving services from the state employees – services that may not have met the person's clinical needs. There is no clear oversight of the quality of services delivered by the State, which in itself is an exposure to risk. Further, there is almost no oversight of other community providers; and,
  - Cost: There is a significant amount of cost shifting between public systems, where the cost of failing to provide adequate services (or to provide quality services at the most appropriate time) results in a person accruing costs in more than one publicly funded system. Examples of some of the major costs shifts, in addition to those between the public mental health and substance abuse systems and the criminal and juvenile justice systems, include that of State to the counties for services to the non-Medicaid eligible who are not involuntarily treated; from the counties to the State, when someone cannot access preventative care or early intervention services and the costs of treatment exceeds the 'coverage' cap of the Catastrophic Health Care Fund (CAT Fund); as well as a cost shift from one part of the State (community mental health) to the State hospitals as a person is transferred from a

community service to a State hospital and then back again;
- Varied confidence in the ability of the executive branch to collaborate and lead in the area of behavioral health;
- A history and culture of legislative action to create fixes or solutions to identified problems, including new executive branch or other governmental bodies.

Opportunities

In contrast to these challenges, Idaho's structure and overall system has strengths, on which a foundation for transformation may be built. Some of the major strengths identified include:

- A notable number of legislators who are interested in these issues, and a legislative branch that has shown willingness to act to solve issues identified by their constituents (which includes counties);
- A proven track record of implementing certain mental health or substance abuse programs and services, such as mental health courts and the Office of Drug Policy;
- A foundation of community involvement, including various established and functioning regional entities, boards and other governmental bodies in many regions that involve most key stakeholders; and,
- The executive branch restructuring of mental health and substance abuse programs, which supports activities to integrate services for persons with co-occurring disorders, thereby improving outcomes for this population.

Vision, Goals and Recommendations

This report is tructured to provide recommendations in a context for the foundation of a strategic plan. As such, many recommendations for change will be proposed in this report, most of which are interconnected with other recommendations. The overall goal of these recommendations is to create a state-community partnership, one that promotes a higher level of local authority for governance, administration, and operations of the public mental health and substance abuse systems. Additionally, achieving this goal will create an environment that promotes cost-sharing versus cost-shifting.

As in a strategic plan, these recommendations are structured to achieve goals, which, in turn, will result in achieving the following vision:

> "Idaho citizens and their families have appropriate access to quality services provided through the public mental health and substance abuse systems that are coordinated, efficient and accountable."

The goals identified for this strategic plan approach are broad to due to the complexity of providing these recommendations in a 'strategic' format. The proposed goals are:

1. Establish a coordinated, efficient state infrastructure with clear responsibilities and leadership authority and action.
2. Create a comprehensive, viable regional or local community delivery system.
3. Make efficient use of existing and future resources.
4. Increase accountability for services and funding.
5. Provide for authentic stakeholder participation in the development, implementation and evaluation of the system.
6. Increase the availability of, and access to, quality services.

These recommendations are associated in this report with an identified "Issue Area" and a "Goal". The "Issue Areas" have been identified as the following:

a. Executive Branch Structure/ Transforming the Structure and Roles of the Division of Behavioral Health
b. Creating Regional Authorities
c. Identifying Gaps in the Intersection of the Justice Systems
d. Increasing Access to Care through Eligibility and Waivers
e. Enhancing the Efficiency of the State's Hospital Capacity
f. Increasing Accountability through Data
g. Enhancing Workforce Capacity

Recommendations

Issue Area	Recommendation
Executive Branch Structure/ Transforming the Structure and Roles of the Division of Behavioral Health	**Recommendation 1.1:** Transform the Division of Behavioral Health (DBH) into a Division that directly and promptly improves the quality of care at the 'point of care'. This transformation will include: 1. Becoming a guarantor of care rather than a deliverer of care by administering, monitoring and ensuring the quality of care; 2. Leading collaborative efforts that include key community stakeholders and other departments, divisions and agencies to improve systems; and, 3. An integration of operations within DBH; across divisions within the Department; and amongst executive branch agencies, including the Office of Drug Policy. **Recommendation 1.2:** Create a statewide 'transformation workgroup' to identify and address barriers to transformation by utilizing an existing collaborative, such as the Interagency Substance Abuse Prevention and Treatment Committee. **Recommendation 1.3:** Consolidate statutory requirements regarding designated evaluations for involuntary commitment into a single-step, community-based evaluation and determination process. **Recommendation 1.4:** Establish new staff positions to invest in a transformed Division: 1. Clinical: A medical director (psychiatrist or licensed psychologist), either as a state employee or on contract; and additional clinical staff; 2. Policy planning; and, 3. Data/evaluation. **Recommendation 1.5:** Formalize the criteria for the current community grants, which must include an official method for selecting programs; and adjust the community grants program to ensure its use as a mechanism for funding innovative programs and practices.
Creating Regional Authorities	**Recommendation 2.1:** Create a regionally operated, integrated mental health and substance abuse authority – or district – in each of the existing seven regions to plan, administer, and manage and/or deliver services for children and adults. **Recommendation 2.2:** Ensure that the boards of the regional behavioral health authorities/ districts comprise members who represent the various stakeholders; and ensure that the membership of the boards does not exceed fifty percent elected officials, providers and other professionals. **Recommendation 2.3:** Collaboratively establish a statewide, prioritized package of services to be delivered within regional behavioral health authorities/districts. **Recommendation 2.4:** Transform the existing county behavioral health funding (e.g., CAT and general funds currently expended on behavioral health services) into a fixed match that preserves a maintenance of the current funding for the regional behavioral health authorities. **Recommendation 2.5:** Use a transformed DBH to fund regional behavioral health authorities utilizing formulized funding, based on factors including historical utilization and population.
Identifying Gaps in the Intersection of the Justice Systems	**Recommendation 3.1:** Review the mental health and substance abuse programs within the criminal and juvenile justice systems to ensure integration with regionally-based behavioral health authorities. **Recommendation 3.2:** Collect and share regional practices that have resulted in providing appropriate care to children in the custody of juvenile corrections.
Increasing Access to Care through Changes to Financing, Eligibility and the Use of Waivers	**Recommendation 4.1:** Identify clinical and financial eligibility criteria that support the delivery of timely, quality, cost-effective screening, assessment, early intervention and prevention services. **Recommendation 4.2:** Amend eligibility criteria for public mental health and substance abuse services to support access to screening, assessment, early intervention, and recovery.

	Recommendation 4.3: Continue the current effort to identify possible waiver or demonstration programs, including those that will result in integrated providers (mental health and substance abuse); in continuing these efforts, conduct a study of the per capita costs of providing appropriate services, basing this study on any new eligibility criteria and including services funded by Medicaid. **Recommendation 4.4:** Integrate the current efforts towards credentialing providers with the transformed DBH and regionally-based behavioral health authorities. **Recommendation 4.5:** Consider reinstituting targeted funds for the school-based counseling program. **Recommendation 4.6:** Revise the existing eligibility screening and service delivery contracts for substance abuse to: 1. Create an adequate, risk-based contract for service delivery, preferably a capitated style contract with more local planning and control of service delivery; 2. Clarify eligibility requirements by removing any uncertainty on eligibility decisions; and, 3. Separte the eligibility determination function from the service assessment, planning and financing functions.
Enhancing the Efficiency of the State's Hospital Capacity	**Recommendation 5.1:** Conduct a review of State Hospital utilization data (both sites) to identify: 1. Valid mean (average) and median lengths of stay by age group and by region over a year; 2. The number of individuals who would benefit from community-based services and the types of services required; 3. The costs accrued per day by these individuals in the state hospitals; and, 4. The potential State Hospital cost avoidance that could be realized by decreasing inpatient stays and increasing community tenure. **Recommendation 5.2:** Allocate specific, acute bed capacity to the regional behavioral health authorities. **Recommendation 5.3:** Achieve and maintain accreditation for both state hospitals. **Recommendation 5.4:** Utilize deliberate planning and program development in secure facilities, ensuring that civilly committed persons treated in these facilities are served in the least restrictive settings based on their clinical and legal circumstances.
Increasing Accountability through Information and Data	**Recommendation 6.1:** Fully implement the recent budget initiative to design and implement a statewide data system that: 1. Has utility at the 'point of care' (e.g., is helpful in clinical planning and treatment); 2. Collaboratively addresses and incorporates 'legacy' (systems in use currently by providers and other public agencies) systems currently in use by stakeholders; and, 3. Supports the implementation of electronic medical records. **Recommendation 6.2:** Conduct a study to determine 'population in need', i.e. those who have serious mental illness or substance abuse/use disorder who are in need of publicly funded, community services. **Recommendation 6.3:** Revamp and improve the accessibility and utility of the DHW website. **Recommendation 6.4:** Implement a system of evaluation and reporting for transformation activities, with an emphasis on identifying and analyzing the impacts of change on service recipients.
Enhancing Workforce Capacity	**Recommendation 7.1:** Create a Workforce Collaborative to manage and coordinate a statewide behavioral health workforce study which will inform the development of a statewide strategic workforce plan. **Recommendation 7.2:** Design and implement applied mental health and substance abuse educational programs that translate into a job in the workforce system. **Recommendation 7.3:** Increase availability of applied training opportunities in behavioral health professional settings. **Recommendation 7.4:** Provide incentives for the recruitment and retention of behavioral health professionals trained to deliver evidence-based treatment interventions.

In assessing which recommendations or actions will be adopted or taken, it is recommended that the following potential policy and implementation questions be asked:

- What are the strengths and weaknesses of a particular recommendation, including an analysis of opportunities and threats?
- What are key considerations prior to adopting (or rejecting) recommendations?
- How will key stakeholder input be gathered and incorporated?
- What examples from other states exist to support the recommendation?
- What are the steps towards implementation, and in what order should they be taken?

Introduction

To conduct this project, WICHE utilized a multi-component process of technical assistance to the legislative Health Care Task Force. This process included meetings in Idaho with key stakeholders, and the dissemination of a web-based survey to all identified stakeholders. Comparisons with other similar western states are also provided in the individually targeted issue areas. Using a coordinated approach with the legislative Task Force and others, reviews, assessments and recommended changes occurred in the following issue areas:

1. Management structure;
2. Existing efforts of system integration and transformation;
3. Delivery systems, including access to services and system capacity for adults and children;
4. System accountability;
5. State hospital and forensic mental health bed needs and capacity;
6. Data systems and information sharing;
7. Financing; and
8. Workforce

As part of the overall project approach, meetings were held in various regions across the state, including Orofino, Lewiston, Idaho Falls, Blackfoot and Boise (six times). These meetings were with stakeholders in the mental health and substance abuse systems, including legislators and legislative staff, Department of Health and Welfare (DHW) leadership and staff, other DHW and state agencies, counties, consumers and family members, regional mental health board (RMHB) and Regional Advisory Council (RAC) members, providers and other system partners and agencies.

The web-based survey was designed and provided to legislative and department staff for comment and suggestions. After incorporation of these comments and suggestions, WICHE published the survey and disseminated it widely. The dissemination list included all contacts provided by legislative staff, as well as to Idaho's professional associations (those who were likely to deliver services to persons with mental illness or substance abuse disorders).

This report is structured to provide the reader with concise findings, recommendations, "decision points" or considerations and, in many areas, potential action steps.

Recommendations

There are thirty key recommendations highlighted in this report. Of these, the firt ten – recommendation sections 1 and 2 – should be considered the primary ones, as they target system-wide transformation. One of the key questions of the Idaho legislature was to address the need for a separate agency to direct the mental health and substance abuse systems:

> " b. Determine whether there is a lead agency in Idaho responsible for paying for and coordinating services regardless of where an individual enters the mental health or substance abuse system and study the possibility of restructuring the current system via the creation of a separate agency combining mental health and substance abuse services in Idaho."[1]

This review found that the creation of separate state agencies or other governmental bodies to address problems has occurred previously in Idaho, notably with the creation of the Departments of Corrections and Juvenile Corrections, as well as that of the Office of Drug Policy.

Despite this history, this review does not result in a recommendation that Idaho create a new, separate agency as the primary means to achieve the desired system improvements. That is, Idaho may achieve its vision and goals within the current departmental structure. Restructuring state government engages significant resources and alone, will not result in the desired system improvements; and in fact can be so disruptive that it diverts the focus from more transformative system changes, including those that improve the system for communities, consumers and families. However, significant changes to the Idaho behavioral health system are recommended, and it may be determined that the most efficient way to embark on system transformation for Idaho would be restructuring and the creation of a new department, but we emphasize that this should not be the primary action identified to improve the system.

Findings from the survey indicated that respondents felt relatively neutral about the recent restructuring of the mental health and substance abuse programs within the DHW (see chart, below).

However, respondents felt somewhat negatively about the ability of the current administrative structure to carry out its duties (see chart, below), suggesting that stakeholders may be open to changes that would increase the quality and efficiency of service delivery.

1 Executive Branch Structure/ Transforming the Structure and Roles of the Division of Behavioral Health

Recommendation 1.1: Transform the Division of Behavioral Health (DBH) into a Division that directly and promptly improves the quality of care at the 'point of care'. This transformation will include:

1. Becoming a guarantor of care rather than a deliverer of care by administering, monitoring, and ensuring the quality of care;
2. Leading collaborative efforts that include key community stakeholders and other departments, divisions and agencies to improve systems; and,
3. An integration of operations within DBH; across divisions within the Department; and amongst executive branch agencies, including the Office of Drug Policy.

Recommendation 1.2: Create a statewide 'transformation workgroup' to identify and address barriers to transformation by utilizing an existing collaborative, such as the Interagency Substance Abuse Prevention and Treatment Committee.

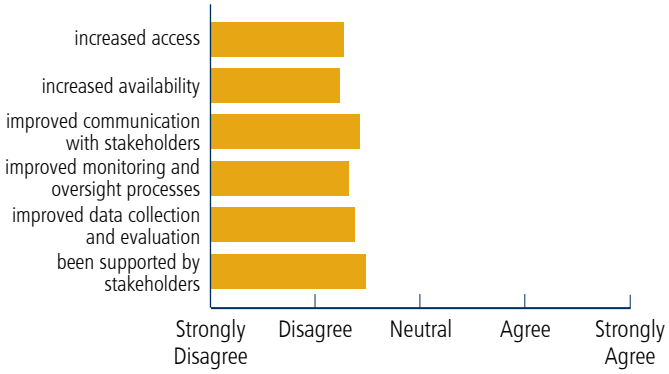
Recommendation 1.3: Consolidate statutory requirements regarding designated evaluations for involuntary commitment into a single-step, community-based evaluation and determination process.

Recommendation 1.4: Establish new staff positions to invest in a transformed Division;

1. Clinical: A medical director (psychiatrist or licensed psychologist), either as a state employee or on contract; and additional clinical staff.
2. Policy planning; and,
3. Data/evaluation.

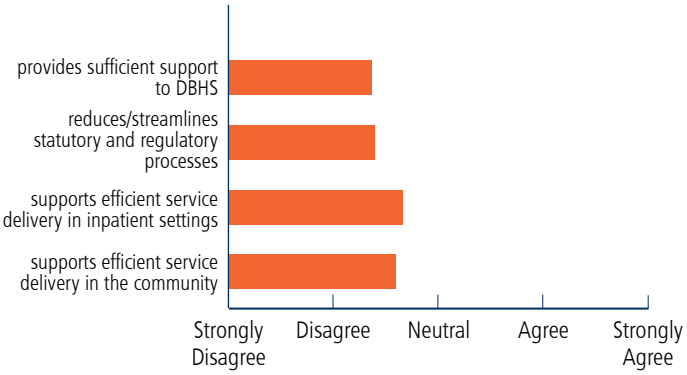
Recommendation 1.5: Formalize the criteria for the current community grants, which must include an official method for selecting programs; and adjust the commuity grants program to ensure its use as a mechanism for funding innovative programs and practices.

The restructuring/integration of the mental health and substance abuse programs has ...



In the words of one Community Mental Health Center employee, "Most of the changes we have seen have been administrative in nature thus having no direct impact on improving the system or financial in nature... Neither aspect has improved the delivery of existing services nor expanded the variety of available services."

The department's current administrative structure ...



During our visits with key stakeholders, it was apparent that:

- Idahoans appeared more at ease with the creation of new departments or other agencies than is found in some other states;
- A clear lack of trust in the Department of Health and Welfare to truly collaborate with other stakeholders, and in the ability of the Department to lead any efforts to change; and,
- There was a very favorable perception about the success of some of the separations created previously, predisposing stakeholders to believe that such an action is a potential solution.

It is strongly recommend, however, that any consideration of creating a new department begin with a strategic planning process to determine whether such a change will result in a positive, relatively immediate benefit to the citizens who are receiving public mental health and substance abuse services. That is, any restructuring should be done to create the most benefit at the "point of care" rather than being focused on "moving boxes" amongst state agencies. Generally, large, departmental restructuring efforts – even if well planned and that achieve the stated goals – detract staff from the day to day responsibilities that often directly impact those most in need of care. In Idaho, this would be particularly true for adults and those involuntarily committed given the current role of the DBH to be a provider of services.

Strengths and Weaknesses of Departmental Restructuring

Some of the strengths and weaknesses of either approach (restructuring or status quo) are outlined below. While there are any number of individual divisions or functions that could be combined within a new department – or have been discussed previously – for purposes of this section, the option of restructuring the Department is considered to be that of including DBH (with the Bureau of Substance Abuse) and Medicaid within one new "umbrella" Department. Table 1 shows a comparison between the two restructuring options, juxtaposed with five potential 'goals'. In the Strength and Weakness area, we note brief comments about how certain factors may impact the ability of that option to achieve the particular goal.

However, there are instances where the opposite is also true, where both options share a particular strength. To a large degree, the way either option is implemented will bear heavily on its eventual success. Also, this is true between a strength and a weakness for one option, where the 'strength' might only be realized if implemented properly, else the 'weakness' be realized.

Recommendation 1.1: Transform the Division of Behavioral Health into a Division that directly and promptly improves the quality of care at the 'point of care'. This transformation will include:

Table 1. Strengths and Weaknesses of Departmental Restructuring

	Create New Department		Maintain Current Structure	
Goal	**Strength**	**Weakness**	**Strength**	**Weakness**
Increase in coordination, access and quality at the "Point of Care"	Easier to set one standard for multiple systems	Adds additional 'silo' to bureaucracy	Covers all age groups in various systems (e.g. child protection)	Few formal, trusted internal mechanisms for coordination
Improved community perceptions and collaboration with stateholders	'One-stop' agency; more singular focus – and may improve communication	Restructuring may improve internal collaboration, but alone will not impact collaboration with other stakeholders	More accessible to stakeholders	Too little leverage within executive branch
Enhance financial efficiency	Due to smaller size, may be easier to integrate budgeting, contracting functions	Financially more efficient to be part of larger (DHW) financial services – economy of scale	Allows for 'braiding' of resources with other agencies within DHW, benefit from economy of scale with financial services	Higher overall costs of care due to inefficient coordination of care
Integrate oversite/ quality assurance roles	Integration, cross training of staff due to larger number of staff	Increased specialization, variability amongst staff	More complete integration due to smaller staff	Major systems not integrated (i.e., Medicaid), although could become integrated within DHW
Overall costs	May realize certain administrative efficiencies	Significant direct and indirect costs to combine	More certainty of costs; fewer additional costs	'Opportunity costs' greater, i.e., fewer resources free for innovation

1. Becoming a guarantor of care rather than a deliverer of care by administering, monitoring and ensuring the quality of care;
2. Leading collaborative efforts that include key community stakeholders and other departments, divisions and agencies to improve systems; and,
3. An integration of operations within DBH; across divisions within the Department; and amongst executive branch agencies, including the Office of Drug Policy.

Transforming the role of DBH is not a small or simple recommendation. There currently is almost no quality assurance or monitoring of mental health and substance abuse services. No one agency appears to be responsible for ensuring that treatment services are provided appropriately or that they 'work'. Moreover, there is no agency overseeing the DBH-provided direct services to ensure that their services are necessary, appropriate and beneficial. This situation results in a relatively high risk for the state. These risks are not present in most states, as their mental health (and substance abuse) authorities do not provide direct care services in the community. In most states, the mental health authority provides oversight and technical assistance, and monitors service contracts with community providers.

The financial risk of persons being hospitalized – in private and state facilities – is being borne largely by the state. After 24 hours, the cost of hospitalizing citizens is charged to the state, and, as noted above, this cost is high due to long lengths of stay. Further, those adults who are not eligible for Medicaid (and some who are) will be treated by the state in the community at state cost.

Some of the efficiencies that might be gained by state-run services, such as consistency across the state, statewide policy development and planning, improved relationships with other state agencies (e.g., Medicaid) do not appear to been attained in Idaho. Of note here are the remarks by many DBH state staff regarding their frustration in working with and billing Medicaid.

The following are broad considerations that, while applicable to the entire 'transformation' process, are especially important regarding the Department's structure and DBH's role:

1. Maintaining a focus on improving the system at the 'point of care' is crucial as energy expended on transformation is energy or resources potentially lost to serve citizens who are receiving care.
2. Relatively more resources are required to restructure a department.
3. Any transformation – and the outcomes resulting from any change – are very dependent on the persons or leaders involved. That is, making changes to structures may or may not have the intended impact if the leadership and staff involved are not "bought into" the change.
4. The real transformation of the system necessary should occur regardless of the overall, departmental or executive branch structure. So, even with a separate department, a true state level monitoring/quality assurance agency is necessary in Idaho, as well as a regionally-operated mental health and substance abuse delivery system.

As is seen in other states (and other issue areas), it is likely that an adequate, private, community-based provider system will be more efficient than one operated by the state.

The President's New Freedom Commission and the Need for System Transformation

In July 2003 after more than a year of research and testimony from key stakeholders, The President's New Freedom Commission on Mental Health (NFC) released its final report, Achieving the Promise: Transforming Mental Health Care in America. The six goals identified in this report supporting a transformed mental health system include:

1) Americans understand that mental health is essential to overall health.
2) Mental health care is consumer and family driven.
3) Disparities in mental health services are eliminated.
4) Early mental health screening, assessment, and referral to services are common practice.
5) Efficient mental health care is delivered and research is accelerated.
6) Technology is used to access mental health care and information.

Although this report focuses on mental health, the recommendations are applicable to substance abuse as well, especially in states that have combined these agencies into a behavioral health system, such as Idaho.

The NFC report clearly articulates the need for comprehensive system transformation to overcome

the fragmented service delivery systems in the states, instead of just focusing on one or even a few of the six goals. The report also identifies the need for adequate resources to support persons dealing with mental illnesses and suggests that the system be responsible for service coordination, instead of placing that burden on consumers and family members. Another focus is on delivering services in integrated settings and whenever possible, in communities instead of institutions. A clear vision, effective leadership, accountability and alignment are essential to the success of system transformation efforts.

Vision

The vision should represent a shared image of what is desired in the future, not a strategic plan, but the inspiration that will motivate people to create such a plan and take the necessary effort to achieve it.[2] A successful vision encompasses a sense of urgency to overcome stakeholder complacency. A well-defined vision clarifies the general direction for change, motivates people to take action in the right direction, and helps coordinate people's actions.[3] Earlier in this report a suggested vision is drafted, however the development of a clear vision that is embraced by the people of Idaho will be an essential early step toward transforming the behavioral health system.

Leadership

Transformation efforts require exceptional, effective leadership abilities. Leaders must have the capability to formulate a compelling vision and the skills to organize and direct the change processes. Additionally, leadership's responsibilities involve developing a coherent transformation plan, maintaining a focus on key transformation goals, and managing external changes to complement internal ones.[4] Transformation is a complex, revolutionary, and continuous process that demands fundamental changes in the organizational structures and systems through which products are developed and services are delivered. In this process, laws may need to be modified; values reassessed; and systems of service delivery and finance may need to be changed. Guided by visionary leadership, transformative change can gather momentum until it reaches "a tipping point" where it will spread like an epidemic throughout the many intertwined systems and dramatically alter how organizations and systems operate.[5] Clearly defining the leadership structure and hierarchy in Idaho will be paramount to successfully implementing improvements to the mental health and substance abuse systems.

Accountability

"Accountability is to organizations what breathing is to bodies".[6] Clear responsibilities and expectations are essential to system accountability. Communication and trust are also vital to implementing system transformation and holding all stakeholders accountable for their role in supporting and operationalizing the vision of the behavioral health system.

Alignment

The Crossing the Quality Chasm: A New Health System for the 21st Century[7], identified four essential strategies for large-scale alignment to support system transformation:

- finance reform;
- retraining of human resources;
- developing performance measures and information technology; and
- identification and implementation of evidence-based practices.

Alignment within and across state and regional entities will be a key component to system transformation in Idaho and are discussed later in this report. Transformation of the behavioral health system in Idaho will need to be very strategic and methodological. There will be a clear vision and starting point, however to be successful, it will need to be a continuous process with celebrated achievements along the way, but without an identified end point. To identify an end point would be accepting status quo and not embracing true system transformation.

The recommendations contained in this report range from the more simple to the more complex. Regardless of which recommendations are chosen for implementation, an overall 'transformation' strategy that will serve to guide the planning, implementation and evaluation components of any system change efforts is necessary. This strategy would be premised on the principle of collaboration, which was found to be present on the regional level, in fact thriving in some regions; however, similar efforts at collaboration were found to have often failed at broader system and state levels. We suggest that a deliberate strategy to collaborate amongst all stakeholders, which can be the foundation for transforming the behavioral health system in Idaho.

Table 2. Five State Structural/Organizational Comparison						
Questions	**ID**	**AK**	**CO**	**OR**	**UT**	**WA**
Does the SMHA Director sit as a member of the Governor's cabinet?	No	No	No	No	No	No
Not counting the SMHA Director or Governor, how many formal organizational layers exist between the SMHA Director and the Governor?	2	1	2	1	1	2
Is the responsibility for the operation of state mental hospitals within the same state agency responsible for the funding and/or delivery of community-based mental health services?	Yes	Yes	No	Yes	Yes	Yes
Is the SMHA located within another state agency or is it an independent department/agency?	Health & Welfare	Human Services	Human Services	Human Services	Human Services	Social & Health Services
Responsibility of the SMHA in administering children and youth mental health services.	Yes	Yes	Yes	Yes	Yes	Yes
Responsibility of the SMHA in administering elderly mental health services.	Shared	Yes	Yes	Yes	Yes	Yes
Responsibility of the SMHA in administering Alzheimer disease and organic brain syndrome services.	No	Shared	No	Shared	No	Shared
Responsibility of the SMHA in administering adult forensic mental health services.	Yes	Shared	No	Yes	Yes	Yes
Responsibility of the SMHA in administering brain impaired services.	No	Shared	No	Shared	Shared	No
Responsibility of the SMHA in administering court evaluation of mental health status.	Shared	Shared	Shared	Shared		Yes
Responsibility of the SMHA in administering services to persons with mental illness in prison/jail.	Shared	Shared	Shared			Yes (Local)
Responsibility of the SMHA in administering sex offender services.	No	Shared	No	Yes	No	No
Responsibility of the SMHA in administering state mental hospitals.	Yes	Yes	No	Yes	Yes	Yes
Responsibility of the SMHA in administering community mental health programs.	Yes	Yes	Yes	Yes	Yes	Yes
Responsibility of the SMHA in administering criminal justice mental health services.	Shared	Shared	Shared	Shared	Shared	Shared
Responsibility of the SMHA in administering juvenile justice mental health services.	Shared	Shared	Shared	Shared	Shared	No
Number of SMHA-operated state psychiatric hospitals.	2	1	2	2	1	3
Total number of community mental health providers.	7	76	24	114	11	126
Has the MH/SA been relocated/reorganized within state government in the last 4 years?	Yes	Yes	Yes	No	No	No
Are community mental health programs being given control over the utilization or budgets of state mental hospitals and other state-operated programs?	No	No	No	No	No	No
SMHA directly provides funds, but does not operate local community-based agencies.	No for Adults	Yes	Yes	Yes	Yes	Yes
Does the SMHA have an office or coordinator position established for co-occurring mental health and substance abuse services?	No	Yes	Yes	Yes	No	Yes
Does the SMHA have an office of consumer affairs?	Yes	No	Yes	No	Yes	Yes

Recommendation 1.2: Create a statewide 'transformation workgroup' to identify and address barriers to transformation by utilizing an existing collaborative, such as the Interagency Substance Abuse Prevention and Treatment Committee.

The effort to transform the behavioral health system in Idaho will require the collaborative efforts of many key stakeholders. A 'transformation workgroup', similar in structure to such workgroups being implemented by various states (including Washington) for the federal Transformation grants from the Substance Abuse and Mental Health Services Administration, allows for all stakeholders to review, receive public input, study and propose an overall strategic plan, as well as specific 'action steps', for implementing these recommendations. Also, this workgroup, through various subcommittees, will be critical in developing and proposing the details for implementing the recommendations related to creating a regional or local behavioral health authority/district. For example, this workgroup would be the body charged with assisting the Department in designing a request for proposal (RFP) to implement a demonstration or pilot program at the regional level, as well as an advisory body to the Department during its more internal transformation.

The key stakeholders will come from the three branches of the state government, including the Department, the Departments of Corrections and Juvenile Correction, counties and municipalities, consumers and families, the state's Mental Health Planning and Advisory Council, providers, hospitals, local law enforcement agencies, and perhaps other groups identified as important to the process. The Interagency Committee (ICSA), whose charge generally is to advise the Office of Drug Policy, is the one existing committee or workgroup found that could serve in this role. Additional representation will be necessary, such as counties (perhaps municipalities), and statutory changes may be required to ensure this adequate representation and additional authority and reporting requirements. The state's Mental Health Planning and Advisory Council also must be represented on the workgroup to ensure coordination between the two; this representation may or may not be a new member, although the Council should have a representative who can represent the Council itself, including children's issues.

Moreover, the ICSA, if it is to be an effective body, will likely require additional resources, namely financial and personnel. There were comments made during the review for this report indicating that ODP could use additional staff to perform its functions; a change to a transformation workgroup of the ICSA will clearly require more FTE to implement.

Review of Idaho's Mental Health and Substance Abuse State Management Structure

The Idaho Division of Behavioral Health Services (DBH) is located in the Department of Health and Welfare (DHW), under Health Services. Also included in Health Services is the Division of Medicaid and the Division of Public Health. Idaho has seven (7) state-operated regional, geographically-defined, community mental health centers (CMHCs) that provide services to children and adults. Each of the CMHCs has a Regional Mental Health Board that consists of key stakeholders who offer input and recommendations to improve the service delivery system.

The Division of Behavioral Health also operates two (2) state psychiatric hospitals, State Hospital North in Orofino and State Hospital South in Blackfoot. Additionally, the Division of Behavioral Health is responsible for the state Substance Abuse Program.

Idaho Code 16-2404 identifies DHW as the lead agency for the development and delivery of children's mental health services. It also requires DHW, the Department of Juvenile Corrections, Department of Education, counties, and local school districts to collaborate in the planning for mental health services for children with serious emotional disorders. Additionally, Idaho has seven (7) Regional Mental Health Boards and thirty-four (34) Local Children's Mental Health Councils.

As noted from the 2008 Idaho Mental Health Block Grant (MHBG) Application, the central office within the Division of Behavioral Health provides:

- System coordination;
- Development of policies, standards and best practice procedures;
- Rule promulgation and interpretation;
- Federal grant applications and oversight;
- Contract development and monitoring; and
- Training and technical assistance to support and expand an organized, community-based statewide system of care that is consumer and family driven.

The Idaho Planning Council on Mental Health is statutorily authorized to advocate for mental health transformation with the Governor and Legislature.

Comparison of Western State Structures

When comparing Idaho's behavioral health structure to other state systems, no other state is identical in scope of responsibility and authority to Idaho. However, there are some states that are more similar to Idaho than others, including having mental health and substance abuse functions within the same agency and within one authority. The five Western states selected for comparison to Idaho are Alaska, Colorado, Oregon, Utah, and Washington. These states were selected by using data from the National Association of State Mental Health Program Directors' Research Institute (NRI). The WICHE MH Program examined information from the NRI's State Mental Health Profiles to compare and contrast the structure of DHW/DBH with that of other Western States. The State Profiles data are provided annually by states to NRI, and, while there is some variability in the data provided, it represents the only such national database in the country.

The Organization/Structure component of the profile includes multiple questions covering the following domains:

- Location and functions of SMHA within State Government;
- Types of Programs Managed by SMHAs;
- Relationships with other State Agencies to Deliver MH Services;
- Relationship to Cities, Counties, and Other Community MH Providers; and
- Reorganization of SMHA within State Government.

Table 2 illustrates the structure and organization questions that were part of the NRI Survey. The most recent published information is from 2005; however, some of the key responses were updated by WICHE based on more recent information.

Comparable States' Mission, Purpose and Structure

The narrative provided below summarizes the information obtained through state web pages and provided through interviews by the five comparison states; Alaska, Colorado, Oregon, Utah and Washington.

The persons in these states who were interviewed and/or provided information for this project were:

- Alaska: Melissa Stone, Director, Behavioral Health, Department of Health and Social Services
- Colorado: Janet Wood, Director and Charles Smith, Deputy Director – Behavioral Health Services
- Oregon: Bob Nikkel, Assistant Director, Addictions & Mental Health Division
- Utah: Mark Payne, Director, and Janina Chilton, Division of Substance Abuse and Mental Health
- Washington: Judy Hall, Director, Planning, Performance and Accountability; and Kathleen Lizee, Mental Health Program Administrator for Co-Occurring Programs; Department of Health and Social Services

Alaska

Responsibility for the Alaska public behavioral health (mental health and substance abuse) system is held by the Department of Health and Social Services (DHSS), Division of Behavioral Health (Behavioral Health). Integration of the former divisions of Mental Health and Alcohol and Drug Abuse began in July 2003, and has continued since. Behavioral Health, as described in Alaska's 2008 Community Mental Health Services Block Grant Plan:

> "administers the statewide system of community mental health programs for delivery of residential and community-based treatment and recovery services; manages the state's only public psychiatric hospital; administers grants to the state's network of local community mental health programs; and coordinates with other government, tribal and private providers of mental health services to ensure the provision of comprehensive mental health services to Alaska residents. Behavioral Health works closely with the Alaska Mental Health Board (AMHB--the state's mental health planning council) on system planning and evaluation. The AMHB provides public forums at their quarterly meetings for discussion of matters pertinent to the budgeting process and the mental health block grant. It also reports to the Legislature, the Governor and the Commissioner of DHSS, and advocates before the executive and legislative branches of government on behalf of persons served by Alaska's mental health programs."[8]

In addition to Behavioral Health, the Alaska Mental Health Trust Authority (and its advisory boards) plays a significant role in system planning and funding. The Authority is mandated to administer the Trust, with a specific requirement to: "enhance and protect the Trust and to provide leadership in advocacy, planning, implementing and funding of a comprehensive integrated mental health program to improve the lives and circumstances of its beneficiaries. The beneficiaries of the Trust are Alaskans who experience: mental illness, developmental disabilities, chronic alcoholism, Alzheimer's disease and related dementia."[9]

Colorado

The Colorado Department of Human Services (DHS) is charged with the administration and supervision of all non-medical public assistance and welfare activities of the State, including assistance payments, food stamps, child welfare services, rehabilitation programs, alcohol and drug treatment programs, and programs for the aging. The Department operates two Mental Health Institutes, three Regional Centers for persons with developmental disabilities, and ten institutions for juvenile delinquents. The Department also provides funding for indigent persons with mental illness, funds Community Centered Boards for the Developmentally Disabled, and contracts for the supervision and treatment of delinquent juveniles.

Office of Behavioral Health and Housing:

This section of the Department of Human Services includes largely non-Medicaid funded Mental Health Community Programs, the Mental Health Institutes, the Alcohol and Drug Abuse Division, Supportive Housing and Homelessness Programs, and funds for central administration of these programs. Behavioral Health Services oversees the Division of Mental Health and the Alcohol and Drug Abuse Division.

The Division of Mental Health administers non-Medicaid community mental health services for people with serious emotional disturbance or serious mental illness of all ages, through contracts with six specialty clinics and seventeen private, nonprofit community mental health centers. The Division of Mental Health strives to ensure high quality, accessible mental health services for Colorado residents, by reviewing community mental health programs; adopting standards, rules and regulations; providing training and technical assistance; and responding to complaints from non-Medicaid consumers. The Division of Mental Health also receives and administers federal grants focused on improving services as the state mental health agency.

The **Alcohol and Drug Abuse Division** contains appropriations for alcohol and drug abuse prevention, intervention, and treatment services. Treatment, prevention, and detoxification services are provided primarily through six managed service organizations, each of which is responsible for managing the provision of services to residents of a specified geographic area of the State. The Division also funds and oversees involuntary commitments to detoxification facilities and substance abuse treatment programs.

In the spring of 2006, the Director of the Office of Behavioral Health and Housing reorganized the Division of Mental Health and the Alcohol and Drug Abuse Division under a new entity called **Behavioral Health Services, which has since been renamed the Division of Behavioral Health**. Since that last restructuring, the finance and data/evaluation sections of the two divisions have experienced the greatest amount of integration. At this time, the clinical and regulatory functions of the two divisions remain generally separate.

Oregon

The Oregon Department of Human Services is made up of five divisions: Children, Adults and Families Division, Addictions and Mental Health Division, Public Health Division, Division of Medical Assistance Programs, and Seniors and People with Disabilities Division. They are supported by the Director's Office, Administrative Services Division, Finance and Policy Analysis and Office of Financial Services.

The Addictions and Mental Health Division (AMH) of the Oregon Department of Human Services is responsible for delivering adult and children's mental health and addiction services. Mental health services are delivered locally through community mental health departments and organizations, as well as through state-operated psychiatric hospitals in Salem, Portland and Pendleton. The division is responsible for delivering addiction prevention and treatment services in the areas of alcohol, tobacco, other drugs and problem gambling. The DHS Administrative Services Division serves the entire department with functions that include contracting, facilities, financial services, forms and document management, human resources and information systems. Finance and Policy Analysis

provides budget and forecasting services, monitors federal and state policies for their impact on the department's budget, and develops the rates paid to providers in DHS programs.

Utah

The Utah Department of Human Services (DHS) provides direct and contracted services to their most vulnerable children, families and adults. The Division of Substance Abuse and Mental Health (DSAMH) ensures substance abuse and mental health prevention and treatment services are available statewide, monitors outpatient and residential treatment programs and provides inpatient care, at Utah State Hospital for persons with serious mental illness.

Utah's Division of Substance Abuse and Mental Health is authorized under the Utah State statute 62A-15-103 to be the substance abuse and mental health authority for the state. As the mental health authority, the Division is charged with maintenance and oversight of the State Hospital and the responsibility to contract with local mental health authorities who administer public mental health care through community mental health centers. The Division is one of eight divisions and offices under the Department of Human Services, but falls under the policy direction of the governor appointed Board of Substance Abuse and Mental health. Under Utah State statute Section 17-43-301 local mental health authorities are responsible for the provision of mental health services to their citizens. A local mental health authority is generally the governing body of a county. Several of Utah's rural and frontier counties have joined together to provide mental health services through single community mental health center. Utah has eleven community mental health centers with four of the centers organized as private non-profit corporations, and seven organized under inter-local agreements. (http://mentalhealth.samhsa.gov/cmhs/Stateplanning/)

Washington

The Mental Health Division (MHD) is a division within the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services (DSHS). The Secretary of DSHS is appointed by the Governor to this Cabinet-level position, overseeing several other administrations within DSHS including; the Aging and Disability Services Administration, the Children's Administration, the Economic Services Administration, and the Juvenile Rehabilitation Administration. HRSA sister agencies to MHD include the Division for Alcohol and Substance Abuse and the Medical Assistance Administration.

In 1989, the Washington State Legislature enacted the Mental Health Reform Act; a measure which consolidated responsibility and accountability for the provision and oversight of community mental health treatment with the creation of 14 Regional Support Networks (RSNs).

The RSNs are under direct contract with MHD to ensure quality outpatient services for individuals with mental illness, including crisis response and management of the involuntary treatment program.

Beginning in October 1993 through 1996, MHD implemented a capitated managed care system for community outpatient mental health services through a federal Medicaid waiver, thereby creating prepaid health plans operated by the Regional Support Networks. In 1996, the waiver was amended to include community inpatient psychiatric care and, by 1999, all Regional Support.
Networks were responsible for management of inpatient community mental health care in addition to outpatient services.

The current community mental health system operates under Chapters 71.24, 71.05, 38.52, 74.09 and 71.34 of the Revised Code of Washington (RCW) and under a 1915b Medicaid waiver from the federal Centers for Medicare and Medicaid Services (CMS). The waiver allows the state to operate a managed care model. Within the managed care framework, RSNs operate under two contracts with MHD; one contract is a Prepaid Inpatient Health Plans (PIHPs) for Medicaid enrollees and the other as a State funded contract for non-Medicaid services. Under both contracts the RSNs are to ensure the provision of community inpatient and outpatient services. The RSNs accomplish this by contracting directly with community providers who then actually deliver the services. (http://www1.dshs.wa.gov/pdf/hrsa/mh/2006_MHBG_Plan_FINAL_for_PUBLIC.pdf)

Organizational Changes in the Comparison States

Utah reported that they combined the state administration of mental health and substance abuse approximately five to six years ago, Oregon in 2002, Alaska in 2003 and Colorado in 2006. Over time, these states have been moving from a parallel organization

to being integrated under the same authority, however none of these states created a new department as part of their restructuring. Consistently, the states reported that the integration has been an iterative process, and has taken more time than was initially expected.

In Washington, one of the program sections under the Secretary of the Department of Social and Health Services is the Health and Recovery Services Administration (HRSA). Mental Health Alcohol and Substance Abuse are two of the ten entities included in HRSA and are not integrated into one entity. Although the state mental health and substance abuse authorities are not integrated, they do have a designated mental health staff responsible for integrated co-occurring projects, who works closely with Alcohol and Substance Abuse staff. One example of such a project is their Integrated Crisis Response Project. "The Engrossed Second Substitute Senate Bill 5763 (E2SSB-5763) was passed in 2005. The bill required additional chemical dependency treatment services for adults and children; established a new "enhanced resources facility" to serve people with complex cases; provided for suspension rather than termination of Medicaid benefits during incarceration; authorized the establishment of three pilot projects to provide mental health and or chemical dependency services; and authorized counties to impose a 1/10 of one percent sales tax to fund new mental health, chemical dependency or therapeutic court services." (http://www.mhtransformation.wa.gov/pdf/mhtg/SSB-5763Summary.pdf)

Oregon commented that they have focused on keeping mental health or substance abuse activities and initiatives separate when they ought to be separate and integrated when they ought to be integrated. They did not intend to completely integrate all functions and programs, instead determined which sectors would benefit more from integration and focused their efforts on those areas, while at the same time preserving the mental health and substance abuse specialty areas.

Some data, reporting and monitoring activities have been integrated in the states that have integrated mental health and substance abuse; however, none of the states have completely integrated these functions. The states included in this review have community agencies providing both mental health and substance abuse services in some parts of the state, while having different providers for these services in other parts of the state. Funding streams have continued to be separate in these states except for a few specific programs.

The current Behavioral Health structure in Alaska includes a director and the following program areas: Alaska Psychiatric Institute, Prevention and Early Intervention, Treatment and Recovery, Policy and Planning, Program Integrity and the Alcohol Safety Action Program. Organizationally, Alaska has integrated staff from the mental health and substance abuse programs more than that of the other comparative states

Within the organizational structure of the comparative state integrated behavioral health authorities, all states have separate reporting lines for the mental health and substance abuse program areas, except Alaska. Similarly, substance abuse prevention and early intervention are generally separate from treatment (except in Washington). Utah commented that although they continue to support behavioral health integration, they also believe it is important to continue to have subject matter experts for the separate mental health and substance abuse program areas, as well as for different target populations (e.g., child, adult, and older adult). In fact, Utah and Colorado both indicated they utilize subject matter experts as well as back-up staff to address content and population-specific issues. These states noted that the community providers have found it particularly helpful to know which staff to contact for information about specific populations or clinical needs.

Relationship with Providers in the Comparison States

Colorado, Oregon, Utah and Washington all use contracts for distribution and accountability of funding to community providers. These contracts are non-competitive and are negotiated with the providers. All four states reported that they are moving toward more performance-based contracts over time. Utah's providers are required to submit three-year plans and the state staff monitor adherence to the plans as well as to statutory requirements. Oregon's providers submit biennial plans to the state, most of which are approved as submitted. Colorado's contract requirements are determined through an annual negotiations with providers who are selected by their peers to be part of this process. Colorado does not require providers to submit plans. Alaska currently uses a grant process for the distribution of funds to community providers,

however is currently considering moving toward performance-based contracts.

Accreditation/Monitoring Process in the Comparison States

None of the comparison states require providers to be nationally accredited, although some providers have chosen to do so. Colorado (for mental health; substance abuse providers are reviewed roughly every three years) and Utah have an annual monitoring cycle for providers, and Oregon has a two to three year cycle for their program reviews. Alaska focuses on the development of grant request for proposals, reviewing the grants submitted and then the subsequent reports, while placing less emphasis on the direct monitoring of providers.

When the providers are the same for both mental health and substance abuse services, some of the states are trying to conduct integrated/joint monitoring of the programs. However, Washington and Alaska do not currently have joint monitoring for their mental health and substance abuse providers.

States reported that they have engaged in some cross-training of staff, however, have also kept program specific expertise in both areas and believe that this is important as well. Utah noted that they currently have mental health and substance abuse staff jointly monitor the providers that are licensed to provide both mental health and substance abuse services.

Staffing in the Comparison States

Alaska Behavioral Health has 86 full-time equivalent positions (FTEs), which includes 26 FTEs in a Court Monitoring/Enforcement Unit. None of the comparative states have FTEs associated with the court monitoring and enforcement function located within the state behavioral health authority. Other states' behavioral health systems have slightly different responsibilities and are structured somewhat differently, however it is reasonable to exclude the 26 FTEs for a net of 60 FTEs in Alaska when comparing behavioral health authority resources, in order to improve the comparability across the states.

Utah has approximately 40 FTEs and stated that they are adequately staffed at the state level to fulfill their mental health and substance abuse responsibilities. However, if they were able to get additional staff, their greatest need would be for data collection and reporting functions. Typically, they move staff from one project to another depending on agency priorities. They have struggled some in the data and reporting area due to staff turnover and increased reporting requests and requirements.

Oregon has approximately 150 FTEs, which include 35 FTEs in Operations and Contracts and 15 FTEs related to new facility construction, and they do not believe that the Addictions and Mental Health Division is adequately staffed. Their greatest needs are for additional staff for licensing/certification and training, especially in the area of mental health and substance abuse prevention. They did recently receive 15 additional staff to assist with activities related to the replacement of the state hospitals. These new facilities will be called Treatment and Recovery Centers.

Colorado currently has approximately 67 FTEs, which includes 12 discretionary grant positions, and has historically reported that they do not have sufficient staff to adequately address their responsibilities. However, they recently received approval for a few new positions and once they are fully staffed, they will be reassessing their specific staffing needs. They expect that they will continue to need additional resources for data and evaluation, as well as for program monitoring. Washington has approximately 58 FTEs in the Division of Mental Health, including the directors of three [3] state hospitals and 74 FTEs in the Division of Alcohol and Substance Abuse, for a combined total of 132 FTEs. The staff for the Division of Alcohol and Substance Abuse includes six regional administrators and administrative staff support for the regions. Idaho has 35 FTEs plus four [4] research/information systems staff, that are organized as 1) Adult Mental Health/Children's Mental Health Field Program Managers [7], 2) State Hospitals [2], 3) Adult Mental Health [4], Children's Mental Health [8] and 4) Substance Abuse [13] This count does not include the fifteen FTEs [15], recently transferred to the Medicaid Division for oversight and quality monitoring functions for Medicaid-funded behavioral health services.

Table 3 illustrates the approximate breakouts of FTEs in Idaho and the five comparison states. Note: The breakout of these FTEs is an approximation based on interpretation of organizational charts and job titles from each of the states.

Table 3. Comparative FTEs						
Functional Area	**Idaho FTEs**	**Alaska FTEs**	**Colorado FTEs**	**Oregon FTEs**	**Utah FTEs**	**Washington FTEs**
Administrative Support, Finance, Grants/Contracts	7.55 / 4.85	13**	12	38	14	18 / 19
Treatment & Recovery	1.2 / 3.2	23		55		18 / 23
Prevention & Early Intervention	.15 / .75	8***	6	5		
Program Integrity	.65 / .85	4	33	6	19	9 / 11
Policy & Planning	2.45 / .35	4	1	5		8 / 8
Data, Evaluation, Info Systems	4~ / 3~	6	12	13	4	3 / 4
Director, Deputy(s), State Hospital and Regional Mgrs.	10*	2	3	4	3	5 / 6****
Total	26 / 13 **39**	**60**	**67**	**126**	**40**	58 / 74 **132**

Note: Separate numbers are provided for Idaho and Washington representing Mental Health FTE/Substance Abuse FTE.

Idaho
* Includes the 7 Regional Managers
~ Each include 2 FTE for Information Systems/Research not directly assigned to DBH
Of note here is that the numbers above reflect a total addition of FTE resources commited to each functional area, meaning that some areas do not have one, dedicated FTE but are shared amongst several.

Alaska
** Includes the 13 FTEs that are formally centralized, but assigned to DBH
*** Excludes the 26 FTEs for the Court Monitoring/Enforcement Unit

Oregon – The positions below were not included in Table above to improve comparability:
3 FTE Gambling staff
4 FTE Workforce Development staff
15 FTE Hospital Replacement staff

Washington
**** Includes the 5 regional managers

All six states reported that their ancillary/support staff are centralized, either within their department or other parts of state government (information technology, human resources, budget/finance, purchasing, grants/contacts).

None of the comparison states believe that the centralization of these functions was advantageous for the program areas, although it was noted that the centralization probably has improved consistency of these functions across the department/state. It was reported that the change to centralized services was sometimes chaotic for states. Processes tend to be more bureaucratic with centralized services, turn-around time for requests is slower, and clear communication is critical. Frequently the centralized staff are not co-located with the programs, so efforts to educate the centralized staff about the program needs and priorities is important, especially when there is staff turnover. Developing good, respectful relationships along with a clear recognition of each others' needs seem to improve the centralization process.

Colorado, Oregon and Utah have separate reporting lines for mental health and substance abuse program areas, while combining some support areas such as data and evaluation, finance and grants/contracts management. Alaska has integrated most mental health and substance abuse functions, and Washington operates with two separate divisions within the same department. Additionally, all five states have separate distinct functional areas for child and adult mental health program areas. Leadership staff in these states believe maintaining separate areas for these functions supports ensuring continued staff expertise for these populations.

Also of note is the fact that in Idaho, staff responsibilities in both the mental health and substance abuse areas are spread across many of the functional areas. And although this likely occurs to some extent in most states, it is more pronounced in Idaho, and is likely due to insufficient resources to dedicate staff to more specific functions.

Clinical Comparison

In isolating the clinically-focused positions noted in the table below, Idaho has significantly fewer staff than any of the comparative states. And although the mental health and substance abuse FTEs are combined in these tables, it is noteworthy that the other states tend to have a stronger focus on quality improvement/accountability for community providers, which has been less of a focus for DBH, especially since it directly provides a bulk of the adult community mental health services. A number of stakeholders commented during interviews about the lack of clinical strength in DBH and based on the staffing information, this appears to be an accurate perception. DBH does not have an identified medical director, which is a key position within a state mental health authority serving to assist with critical, clinical issues, and to provide technical assistance to community providers and other state entities. It was noted that 15 clinical FTEs were recently transferred from DBH to the Division of Medicaid for the oversight of Medicaid-funded programs and services. However, there continues to be a need for oversight of other publicly-funded behavioral health services, which could be accomplished by transferring all or a portion of the 15 clinical FTEs that were recently transferred to the State Medicaid Division and, or the addition of new FTEs.

The comparative states mostly monitor regional, comprehensive, community-based providers, along with a few specialty providers. Idaho is structured with seven regional service areas however, the state provides most of the adult mental health services and has a much greater mix and total numbers of comprehensive and specialty providers for children and substance abuse services. This structure contributes to needing more resources for monitoring and accountability functions than what the comparison states may need and, as noted previously, the structure also raises the concern that the State is both directly providing services and monitoring the quality and accountability of the services they provide. This is part of the basis for the recommendation to consider the development of a regionally-managed community-based system of care for the public behavioral health system, with a stronger DBH focus on monitoring, oversight and technical assistance functions, which can improve the consistency of the implementation of rules and regulations across the State. If this focus does change, then it may also be feasible for the seven current Regional Managers to provide clinical oversight and program/contract monitoring functions, if they are no longer have regional program management operational responsibilities.

Administrative Comparison

For the administrative functional area including support

staff, finance and grants/contracts, Idaho staffed comparably to the other states, as noted in the table below. However, it is important to note that unlike the comparative states, many of the staff in Idaho have responsibilities in this functional area as well as other areas, such as the clinical areas or policy and planning. This is why Table 5 shows many staff functions as percentages in Idaho, unlike in other states. Therefore, while Idaho's overall FTE count is similar to the other states, it has fewer individuals dedicated to this functional area.

If DBH receives new FTEs as recommended in this report, additional administrative support will likely be needed.

Data, Evaluation and Information Management System Comparison

Colorado, Utah and Alaska have expressed that one of their greatest needs for additional resources was in the area of data and evaluation, which is also a key need for Idaho. Of the three FTEs noted in this functional area for mental health, two of the FTEs focus on information systems, compared with 0.2 FTE for substance abuse. Given the current differences in data systems and capacity this may be reasonable. However, mental health does not have sufficient resources to capture and report data to stakeholders and implement data-based decisions to enhance the mental health system. Additionally, Idaho will need to dedicate additional resources to its recently funded data system project in order to ensure its success as it is fully implemented across the state, which ideally will support a common data platform across all age groups and for both mental health and substance abuse services. Idaho has struggled with reporting consistent and accurate data for many years, compromising comparisons with others states, as well as national reporting. Efforts to move toward data-driven decision making and evaluation of system changes on service delivery will be enhanced if adequate infrastructure and resources are dedicated to this. In the end, it is the behavioral health consumers, family members and citizens in Idaho who will benefit from having access to timely, accurate data.

Table 4. Comparative FTEs for Clinical Positions

Functional Area	Idaho FTEs	Alaska FTEs	Colorado FTEs	Oregon FTEs	Utah FTEs	Washington FTEs
Clinical MH/SA Positions – Assumes Treatment & Recovery, Prevention & Early Intervention and Program Integrity staff have clinical training/backgrounds.	7.8	35	39	66	20	66

Table 5. Comparative FTEs for Administrative Positions

Functional Area	Idaho FTEs	Alaska FTEs	Colorado FTEs	Oregon FTEs	Utah FTEs	Washington FTEs
Administrative Support, Finance, Grants/Contracts.	12.4	13	12	38	14	37

Table 6. Comparative FTEs for Data, Evaluation, and Information Management Systems

Functional Area	Idaho FTEs	Alaska FTEs	Colorado FTEs	Oregon FTEs	Utah FTEs	Washington FTEs
Data, Evaluation, Information Systems	3 / 3	6	12	13	4	3 / 4

Policy and Planning Comparison

Idaho clearly dedicates fewer resources for policy and planning efforts than the comparative states. Resources in this area generally facilitate the development of a strategic, comprehensive system of care based on resiliency and recovery for persons with mental health and substance abuse disorders. The successful planning, development and implementation of such a system requires input from a variety of stakeholders such as other state agencies, local public and private providers, planning and advisory councils, advocates, consumers and family members. This input fosters the commitment of the stakeholders to support system changes and improvements identified through policy development and planning initiatives.

Limited resources in this area can hinder the capacity to engage stakeholders in a meaningful way, which may impact the adoption and implementation of policies, rules, regulations and system improvements. Additionally, not having adequate resources in this area can impede relationships with various agencies, providers and other stakeholders. Two comments that illustrate this are, "Rules and regulations are not well-defined, interpreted differently by different agencies, difficult to implement…Rules are confusing and enforced arbitrarily".

Adequate resources in this functional area will be critical to the success of future behavioral health system development initiatives and collaborative efforts with other agencies, divisions and stakeholders.

Director, Deputy(s), State Hospitals and Regional Managers Comparison

The states reviewed have from two to six 'management' staff, not including the Regional Managers. Idaho and Washington have regional managers as part of their central office staffing, including seven of these FTE in Idaho and five in Washington. In Washington, these staff function as regional administrators for the Division of Alcohol and Substance Abuse Services and do not provide or manage direct services. Whereas in Idaho, these staff directly operate adult mental health services in the seven regions.

The state operation of community-based adult mental health services adds to the complexity of the role for the Division of Behavioral Health. Serving as both the provider and guarantor of quality public services can blur the priorities and accountability of such an agency. Additionally, with the critical responsibilities associated with direct service provision, other management and systemwide leadership initiatives such as implementing system improvements, provider credentialing, developing data systems may languish. As noted in survey comments DBH requires 'more regulations and paperwork from providers – to make up for their inability to more strategically monitor and provide oversight of services and programs', which is a common issue when agencies are under-resourced. Therefore, although the actual FTEs devoted to DBH management activities are comparable with the other states; this is off-set by the diversity and complexity of its current responsibilities.

Table 7. Comparative FTEs for Policy and Planning

Functional Area	Idaho FTEs	Alaska FTEs	Colorado FTEs	Oregon FTEs	Utah FTEs	Washington FTEs
Policy and Planning	2.8	10	13	18	4	16

Table 8. Comparative FTEs for Director, Deputy, State Hospitals, and Regional Managers

Functional Area	Idaho FTEs	Alaska FTEs	Colorado FTEs	Oregon FTEs	Utah FTEs	Washington FTEs
Director, Deputy(s), State Hospital and Regional Managers	10 (9.66 MH)	2	3	4	3	11

The Division of Behavioral Health, as the state mental health and substance abuse authority, needs to be resourced and empowered to provide leadership for the behavioral health system. One stakeholder commented, "Regulations are outmoded, fail to incentivize quality services, and provide no real vision or leadership environment". Comments from other stakeholders addressed the 'lack of a mental health, substance abuse or behavioral health system' and stated that they have not witnessed system improvements since the DHW's restructuring and creation of the DBH. Further, there were comments regarding the number and function of the deputy directors within the Department, particularly regarding the effectiveness of having a diversified management structure. If the current structure or number of deputy directors reduces the ability of the Division to lead in the behavioral health system, then changes to the deputy director structure should occur. As part of the consideration for the adequate number of deputy directors, one factor to consider is how many direct reports each has, and the impact too many direct reports has on the ability of the deputy director and their managers to both lead strategically and manage the day to day operations.

An increased focus on the development of a comprehensive system of care and system transformation highlight the importance of ensuring quality services through the implementation of evidence-based and promising practices. The success of leadership activities and system improvements will require dedicated leadership and adequate resources for implementation and sustainability.

Recommendation 1.3: Consolidate statutory requirements regarding designated evaluations for involuntary commitment into a single-step, community-based evaluation and determination process.

As part of implementing the recommendations regarding DBH structure, and that of creating regional authorities/districts, the responsibility for conducting designated evaluations needs to be transferred to the local level. It was clear from the review conducted for this report that the current system of designated evaluations is problematic on many levels, notably for the quality of care for individuals and families and on a risk basis. The designated evaluations should also be streamlined into a more consumer- and family-friendly process, including possibly eliminating the second evaluation or narrowing the statutory requirements for conducting one. It is important to remember that the behavioral health system in Idaho has a significant focus or emphasis on access to care on an involuntary basis, or through the justice systems. The current designated evaluation process tends to exacerbate this situation.

Successfully implementing this change will also reduce the risk to which the State (through the Department) is exposed as it serves the service provider (for many adults); the agency primarily responsible for financing involuntary hospitalization at private facilities; the 'gatekeeper' for access to the State Hospitals; and the administrator of the State Hospitals. A well-designed regional authority/district that is responsible for the continuum of care for individuals will alleviate much of this risk as care--from crisis/emergency to hospitalization to transition back to the community--is coordinated and delivered at the local level.

Suggested Functions of New FTE

The following are general descriptions of some of the functions, or roles and responsibilities, that new FTE may assume:

Clinical FTEs

- Provide program oversight and monitoring activities for community-based programs for compliance with contractual requirements;
- Provide guidance and technical assistance regarding programmatic issues, policy clarification, and the implementation and fidelity monitoring of evidenced-based practices;
- Provide oversight of regional providers' complaint systems and practices for investigating and responding to complaints, determine compliance with contractual requirements regarding the handling of complaints, and provide technical assistance to to providers on complaint systems and advocacy efforts;
- Foster quality improvement activities across regions, including information and data sharing to enhance provider performance and outcomes across the State; and
- Provide technical assistance and support to other agencies and divisions regarding behavioral health practices.

Policy and Planning FTEs

- Coordinate policy and planning efforts across the behavioral health system including other state agencies and divisions as well as local providers
- Facilitate broad stakeholder input into policy and planning activities working closely with the Mental Health Planning and Advisory Council and other consumer and advocacy networks and organizations; and
- Foster collaboration with clinical and data/ evaluation staff to use clinical data to understand current practices and inform planning and policy initiatives.

Data and Evaluation FTEs

- Develop and implement common reporting practices and performance measures across regions and the state hospitals;
- Collecting, analyze, and disseminate data, including data on client demographics, level of functioning, diagnoses, and service utilization.
- Oversight of regional provider data systems and data reporting. This includes verifying that systems produced valid data, and ensuring that data were submitted according to contractual requirements
- Monitor data integrity and provide periodic reports of trends, issues and outcomes;
- Publish 'report cards' for the regions and state hospitals using identified performance measures and share finding with stakeholders, using a quality improvement, performance improvement focus.

Medical Director Responsibilities:

- Collaborate on clinical issues with the administrative Director of DBH,
- Identify emerging clinical issues impacting the DBH, public mental health service delivery system and other agencies and divisions that address behavioral health issues;
- Provide advice, guidance and technical assistance to DBH staff, the Interagency Committee and community providers on best practices and policy for these issues;
- Provide forums to encourage providers to share planning, programming, and research and evaluation findings to improve public mental health service in Idaho; and
- Promote peer-to-peer information sharing, and encourage collaborative responses to identified technical assistance needs in Idaho.

Administrative Support Responsibilities:

- Provide clerical and administrative support to behavioral health staff;
- Organize and provide support for meetings and conferences; and
- Ensure DHW administrative procedures are communicated to staff and ensure that procedures are followed.

Recommendation 1.4 Establish new staff positions to invest in a transformed Division:

1. **Clinical FTE: A medical director (psychiatrist or licensed psychologist), either as a state employee or on contract; and additional clinical staff;**
2. **Data/evaluation FTE; and,**
3. **Policy planning FTE.**

Suggested Structural Function of the Division of Behavioral Health

Developing a structure that clearly identifies key staff leads and functions, while also supporting communication and reducing silos can happen in a variety of ways. In fact, some of this can be accomplished within almost any organizational structure. Before embarking on structural reorganization, it is important that the goals for any change be clearly identified and articulated, and that internal staff and key stakeholders understand the basis for planned changes.

Numerous respondents to the survey noted the problems with oversight that arise due to state employees providing adult mental health services. One respondent summarized these concerns by stating, "H&W… will not enforce even basic ethics for providers…the credentialing process is so marginal it's a waste of state money." Respondents were concerned the "lack of quality control and oversight makes it unclear whether services are evidence-based," and concerned there is "lack of a shared vision as to what would constitute quality."

One provider noted, "We remain faced with 4 mental health services choices: counseling, service coordination, Partial Care and Psychosocial Rehabilitation. These choices are not supported by well-written rules or by careful oversight." However, even if there were clear guidelines as to what constitutes quality mental health services, respondents noted there

are "few incentives to pursue quality services." Even when quality trainings are available, they are often "difficult for providers to attend due to high cost." Separating service provision from the DHW's oversight responsibilities would enable DHW to develop a more stringent credentialing process, provide continual monitoring of mental health service providers for quality assurance purposes, provide technical assistance to community providers, and offer financial incentives for providers to pursue additional training to ensure they provide high quality, evidence-based services to mental health consumers.

Recommendation 1.5: Formalize the criteria for the current community grants, which must include an official method for selecting programs, and adjust the program to ensure its use as a mechanism for funding innovative programs and practices.

This recommendation has two primary elements. First, there were numerous comments provided through the online survey and in key stakeholder interviews regarding what is perceived as the uncertain nature of how decisions regarding the grants are made, namely that of selecting which programs are to be funded. Most importantly, respondents expressed concern that the criteria for selection were largely unknown to the applicants, or that the decisions were made arbitrarily. The recommendation for this element is to clearly publish the application and selection criteria for the grants. For the best results, this recommendation should be integrated with earlier ones that create a 'transformation' workgroup and create regional authorities/districts.

The recommendation for the second element is to alter the purpose of the grants to enhance innovation and best practice at the local level. Many stakeholders referred to these grants as "capacity building", where the funding from these grants is serving to establish (or maintain) services that should be provided through other, regular state funding mechanisms. Some grants already fit in an "innovative" category, such as tele-psychiatry. This recommendation should be implemented in conjunction with the creation of regional authorities/districts, where the primary financing for community care can be consolidated at the local level.

State Mental Health Authority (SMHA) Expenditure Data

Table 9 illustrates the SMHA Mental Health Controlled Per Capita Expenditures For State Mental Hospital Inpatient Services, Community Services (State Hospital and Other Community-based), Research, Training and Administration, FY 2005 (the most recent national available at this time) for the 15 Western States. The National Median and National Mean noted in the last two rows of the table include data from all 50 states and the District of Columbia. Based on the data from NRI FY 2005 State Mental Health Agency Revenue and Expenditure Study, **Idaho ranked 47th in the nation for the per capita expenditures spent on mental health services**. Idaho's reported 2005 state mental health authority expenditures were $37.81 per capita, while the national average was $99.54 and the national median was $89.19. The comparison states were:

Colorado:	$ 54.53
Oregon:	$ 87.54
Utah:	$ 45.51
Washington:	$ 93.96

Alaska: (Data not included because they included substance abuse expenditures)

Idaho ranked 44th in the nation for reported state mental health authority expenditures for state psychiatric hospitals with $10.10 per capita, while the national mean was $27.35 and the national median is $27.57. However, Idaho also spent 43% of its expenditures on state psychiatric hospitals compared with a national mean of 27 % and national median of 29%. Therefore, while the per capita expenditures for Idaho ranked low compared with the rest of the nation, the proportion of funding spent on state psychiatric hospitals when compared to community-based services was significantly higher than most states. This comparison does not include the additional dollars spent in Idaho and other states for private psychiatric hospitalizations.

The range in the 15 western States for the percent of funds spent on community-based versus state inpatient services ranged from 37% (South Dakota) to 91% (Arizona). Idaho ranked 49th at 57%, while the national mean was 70% and the median was 68%.

The higher proportion of expenditures in Idaho for state psychiatric services may be reflective of Idaho's more

narrow focus on adults with serious and persistent mental illness (SPMI), where most states also serve persons without persistent mental illness (SMI), in additional to providing some early intervention and prevention services. Persons with SPMI are more likely to require hospitalization than person with less persistent disorders. Additionally, these data may indicate the lack of a comprehensive community-based system of care; therefore persons are hospitalized when they could have been treated in the community, had an appropriate array of services been available.

Idaho did not report specific funding for Prevention,

Table 9. NRI FY 2005 State Mental Health Agency Revenue and Expenditure Study

Community Services (State Hospital and Other Community-based), Prevention, Research, Training, and Administration, FY2005

	State Psychiatric Hospital		Community-Based		Prevention, Research, & Training		SMHA		Total SMHA	
STATE	**Inpatient**	**Rank (%)**	**Services**	**Rank (%)**		**Rank (%)**	**Admin.**	**Rank (%)**	**Expend.**	**Rank**
Alaska	**$30.04**	**19 (11%)**	**$232.10**	**1 (86%)**	**$1.51**	**6 (1%)**	**$5.99**	**4 (2%)**	**$269.64**	**2**
Arizona	$10.55	49 (7%)	$133.43	6 (91%)	$0.17	15 (0%)	$2.07	17 (1%)	$146.22	8
California[b]	$21.24	37 (18%)	$96.53	9 (81%)			$0.88	33 (1%)	$118.65	17
Colorado	**$19.46**	**39 (26%)**	**$54.53**	**29 (73%)**			**$0.28**	**42 (0%)**	**$74.28**	**32**
Hawaii	$42.86	8 (27%)	$106.73	8 (68%)			$7.08	3 (5%)	$156.67	7
Idaho	**$16.10**	**44 (43%)**	**$21.70**	**49 (57%)**					**$37.81**	**47**
Montana	$23.07	33 (17%)	$106.77	7 (80%)	$0.15	16 (0%)	$4.05	8 (3%)	$134.03	12
Nevada	$14.94	45 (24%)	$46.31	32 (74%)			$1.37	28 (2%)	$62.62	40
New Mexico[ac]	$11.33	48 (47%)	$12.90	51 (53%)					$24.23	51
North Dakota	$29.80	20 (40%)	$44.53	35 (60%)			$0.06	44 (0%)	$74.39	31
Oregon	**$28.53**	**23 (24%)**	**$87.54**	**15 (73%)**			**$3.41**	**10 (3%)**	**$119.48**	**15**
South Dakota	$45.19	7 (63%)	$26.19	43 (37%)					$71.38	35
Utah	**$18.39**	**40 (29%)**	**$45.51**	**33 (71%)**	**NA**	**NA**	**$0.44**	**40 (1%)**	**$64.34**	**39**
Washington	**$28.45**	**24 (30%)**	**$63.46**	**25 (68%)**	**$0.08**	**18 (0%)**	**$1.97**	**19 (2%)**	**$93.96**	**24**
Wyoming	$29.51	21 (30%)	$67.68	24 (69%)	NA	NA	$1.60	25 (2%)	$98.79	21
WICHE Average **WICHE Median** **National Average** **National Median**	**$24.91** **$25.76** **$27.35** **$27.57**	24% 27% 27% 29%	**$76.34** **$65.57** **$70.00** **$58.14**	74% 68% 70% 68%	**NA** **$1.06**	NA 1%	**$2.26** **$1.60** **$1.96** **$1.46**	2% 2% 2% 2%	**$103.21** **$96.38** **$99.54** **$89.19**	

NA = Services provided but exact expenditures unallocatable.

Note: "Community Services" includes expenditures from state mental hospitals for ambulatory and residential services.

a = Medicaid Revenues for Community Programs are not included in SMHA-Controlled Expenditures.

b = SMHA-Controlled Expenditures include funds for mental health services in jails or prisons.

c = Children's Mental Health Expenditures are not included in SMHA-Controlled Expenditures.

Research and Training, or Administration; therefore no comparisons for these categories with the other states are possible.

Trends in substance abuse expenditures at a national level are described below. The only state-level comparisons found were limited to the Substance Abuse Prevention and Treatment Block Grants awarded to the states from the Substance Abuse and Mental Health Services Administration. Since this grant is distributed to the states on a formula basis and does not include other funding sources, comparisons would not be beneficial for the purpose of this project, and therefore are not included. However, the information below does address, from a national perspective, the need for adequate funding for substance abuse services.

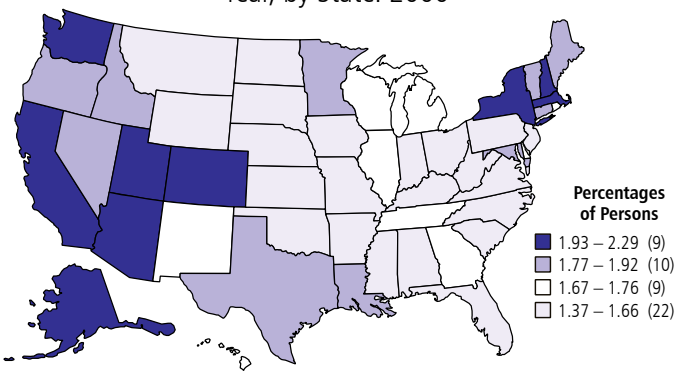
National Trends in Substance Abuse Expenditures – Excerpt from: State Spending on Substance Abuse Treatment by Anna Scanlon, December 2002[10]

Although the treatment gap is growing, the annual growth rate in expenditures for mental health and substance abuse treatment is lower than the annual growth rate for all health care expenditures. An article in the July/August 2000 *Health Affairs* reported that the growth in substance abuse and mental health expenditures was 6.8 percent between 1987 and 1997, compared to 8.2 percent for all health expenditures. During this time period, there was a 10 percent decrease in hospital expenditures and a 5 percent decrease in nursing home expenditures. The drop in inpatient treatment may be indicative of managed care cost saving efforts.

Between 1987 and 1997, substance abuse spending increased very slowly, at a rate of 2.5 percent compared to 4 percent for mental health and 5 percent for all health spending. Other health benefits increased at a faster rate than mental health benefits in private health insurance plans. The responsibility of funding substance abuse treatment noticeably shifted to public payers between 1987 and 1997. According to a study published in Health Affairs, public funding of substance abuse services increased from 50 percent to more than 60 percent in the 10-year period. Private insurance spending for substance abuse spending actually declined during the same period at a rate of 0.6 percent annually. In contrast private insurance spending on substance abuse increased only 1.9 percent annually. The Medicare and Medicaid share of spending increased rapidly compared to private payers with annual growth rates of 10 percent and 11 percent, respectively, for substance abuse treatment. However, the spending increases in Medicaid declined overall for substance abuse spending.

Chart 1. SAMHSA Unmet Substance Abuse Need

Percentages of Persons Aged 12 or Older Needing but Not Receiving Treatment for an Illicit Drug Problem in the Past Year, by State: 2000[11]



Although it is important for states to finance substance abuse treatment and help close the treatment gap, trends in health care spending are challenging state efforts. Trends show marked discrepancies in the financing of health services. Substance abuse treatment spending has not increased at the rate of other health expenditures, and the burden is increasingly placed on public payers to fund substance abuse treatment. As budgets tighten and health care costs increase, states will be increasingly challenged to find ways to fund substance abuse treatment services.

As reflected from a national perspective above, it is likely that the financing for behavioral health including for mental health, substance abuse and co-occurring populations will be a challenge in Idaho.

2 Creation of Regional Authorities

Recommendation 2.1: Create a regionally operated, integrated mental health and substance abuse authority – or district – in each of the existing seven regions to plan, administer, and manage and/or deliver services for children and adults.

Recommendation 2.2: Ensure that the boards of the regional behavioral health authorities/districts comprise members who represent the various stakeholders; and ensure that the membership of the boards does not exceed fifty percent elected officials, providers and other professionals.

Recommendation 2.3: Collaboratively establish a statewide, prioritized package of services to be delivered within regional behavioral health authorities/districts.

Recommendation 2.4: Transform the existing county behavioral health funding (e.g., CAT and general funds currently expended on behavioral health services) into a fixed match that preserves a maintenance of the current funding for the regional behavioral health authorities.

Recommendation 2.5: Use a transformed DBH to fund regional behavioral health authorities utilizing formulized funding, based on factors including historical utilization and population.

The current system is most fragmented at the community level, closest to the point of treatment need. Such specialization into separate governance, administrative, and service delivery systems is especially problematic in rural/frontier areas. The resources required, both fiscal and human, to operate such a split system so diffuses resources that is not enough economy of scale for any one segment to effectively operate optimally. This situation in only compounded by human resource shortages and limited financial resources. Simply put, the rural behavioral health marketplace is not robust enough to support or sustain multiple systems, and it is suspect as to whether more metropolitan settings can truly succeed in such an environment either.

One of the strengths of the Idaho system is, however, its well established regions, and, in a number of regions, the work of the Regional Mental Health Board. These boards are statutorily authorized, and are charged with the following eight duties:[12]

"(1) Shall advise the state mental health authority through the state planning council on local mental health needs within the region;
(2) Shall assist in the formulation of an operating policy for the regional service;
(3) Shall interpret the regional mental health services to the citizens and agencies of the region;
(4) Shall advise the state mental health authority and the state planning council of the progress, problems and proposed projects of the regional service;
(5) Shall collaborate with the regional advisory substance abuse authorities and the regional children's mental health councils to develop appropriate joint programs;
(6) Shall promote improvements in the delivery of mental health services and coordinate and exchange information regarding mental health programs in the region;
(7) Shall identify gaps in available services including, but not limited to, services listed in section 39-3128, Idaho Code, and recommend service enhancements that address identified needs for consideration to the state mental health authority;
(8) Shall assist the state planning council on mental health with planning for service system improvement. The state planning council shall incorporate the recommendation to the regional mental health boards into the annual report provided to the governor by June 30 of each year. This report shall also be provided to the legislature; and
(9) May develop, or obtain proposals for, a service plan component for consideration by the state mental health authority."

Recommendation 2.1: Create a regionally operated, integrated mental health and substance abuse authority – or district – in each of the existing seven regions to plan, administer, and manage and/or deliver services for children and adults. Like that of transforming DBH, this is a primary recommendation of this report.

Recommendation 2.2: Ensure that the boards of the regional behavioral health authorities/ districts comprise members who represent the various stakeholders; and ensure that the membership of the boards does not exceed fifty percent elected officials, providers and other professionals.

These first two recommendations are critical to the overall transformation being recommended in this report. That is, creation of regional "behavioral" health authorities and changes to the requirements for the expenditure of CAT funds are expected to occur as the DBH transitions from delivering direct care to that of a monitoring/quality assurance/technical assistance role. The regional mental health board statute will require amendment to add the authority to expend resources. It is recommended that DBH distribute these resources through performance-based contracts within a statewide service plan. It is also recommended that DBH/DHW maintain the responsibility for allocating funding to the regional authorities, so there should not be direct budget/appropriations proposals from the regional authorities directly to the legislature. Further, it is recommended that a 'demonstration' or pilot program approach be considered. For example, two or three regions could be allowed to apply through a request for proposal/qualification process. This demonstration would entail a region developing a plan to:

- Establish one regional board, which will include collapsing of several existing boards;
- Develop an operational plan for the board, including a binding or contractual agreement amongst the board members; and,
- Create a service plan that either will allow for the board to directly provide care, or how the board will contract out for care with community providers.

In reviewing the Idaho code and during stakeholder interviews and discussions, the public health district model has been raised as a possible model for this regionalization. The current public health district statute, however, would require several changes to be adapted for this purpose (and the regional mental health board statute would need to be repealed). The primary areas for changes would be in board membership (public health district boards do not reflect the breadth or diversity of mental health and substance abuse stakeholders) and in the charge of the boards. Integrating mental health and substance abuse into the public health model does offer potential benefits, and, if done well, would achieve the first goal of the NFC: "Americans understand that mental health is essential to overall health.". It would provide a potential benefit to consider, in the short- or long-term, the inclusion of mental health and substance abuse care within the public health district model.

These new regional authorities/districts would be responsible for all services, and would receive funding for all services within their continuum of care. This 'envelope' funding, where all the funds are placed in one pool for use by the regional body, would include those funds allocated by DBH, and would also mean that the regional bodies would have 'control' over a determined amount of bed capacity at the State Hospitals and the private hospital funding (for involuntary care). The allocation of these statewide funds will have to be based on historical utilization, population, the 'population in need' (the expected number of persons who need services in a region) and other factors.

A sample of the statutory requirements for a community (or regional) authority's board composition from Michigan:

"330.1222 Board; composition; residence of members; exclusions; approval of contract; exception; size of board in excess of § 330.1212; compliance.

Sec. 222. (1) The composition of a community mental health services board shall be representative of providers of mental health services, recipients or primary consumers of mental health services, agencies and occupations having a working involvement with mental health services, and the general public. At least 1/3 of the membership shall be primary consumers or family members, and of that 1/3 at least 1/2 of those members shall be primary consumers. All board members shall be 18 years of age or older.

(2) Not more than 4 members of a board may be county commissioners, except that if a board represents 5 or more counties, the number of county commissioners who may serve on the board may equal the number of counties represented on the board, and the total of 12 board memberships shall

be increased by the number of county commissioners serving on the board that exceeds 4. In addition to an increase in board memberships related to the number of county commissioners serving on a board that represents 5 or more counties, board memberships may also be expanded to more than the total of 12 to ensure that each county is entitled to at least 2 board memberships, which may include county commissioners from that county who are members of the board if the board represents 5 or more counties. Not more than 1/2 of the total board members may be state, county, or local public officials. For purposes of this section, public officials are defined as individuals serving in an elected or appointed public office or employed more than 20 hours per week by an agency of federal, state, city, or local government."

The establishment of regional bodies should result in better utilization of local (and state) resources, and in better coordination of the two systems (child and adult). Care must be given to ensuring that there is adequate representation of child issues on the RMHBs.

Recommendation 2.3: Collaboratively establish a statewide, prioritized package of services to be delivered within regional behavioral health authorities/districts.

As with most of these recommendations, this recommendation should be integrated with the others regarding transformation of DBH and the creation of regional authorities. Particularly, the 'transformation' workgroup should serve to provide comment and advice on the development of this package of services, and in its prioritization.

Conceptually, this package of services should provide care along the continuum, from prevention to crisis/emergency care to early intervention to treatment (voluntarily and involuntarily). While regions may decide to provide more services in one category, or to tailor the package to local needs, there should be a prioritization of which of these services from what is always available to what is, depending on resources, considered optional. Also, this package of services should be as similar for those without Medicaid eligibility as for those who are Medicaid eligible.

Further, the service package should have an emphasis on evidence-based or other, quality services that have a definite, proven outcomes. Services should also maintain the focus on the system for providing care in the least restrictive manner, and improving consumer's and families' opportunities for recovery.

Using the Michigan example, the following are the statutorily defined services:

" 330.1206 Community mental health services program; purpose; services.

Sec. 206. (1) The purpose of a community mental health services program shall be to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay. The array of mental health services shall include, at a minimum, all of the following:

(a) Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service that is prepared to respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.
(b) Identification, assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services.
(c) Planning, linking, coordinating, follow-up, and monitoring to assist the recipient in gaining access to services.
(d) Specialized mental health recipient training, treatment, and support, including therapeutic clinical interactions, socialization and adaptive skill and coping skill training, health and rehabilitative services, and pre-vocational and vocational services.
(e) Recipient rights services.
(f) Mental health advocacy.
(g) Prevention activities that serve to inform and educate with the intent of reducing the risk of severe recipient dysfunction.
(h) Any other service approved by the department.

(2) Services shall promote the best interests of the individual and shall be designed to increase independence, improve quality of life, and support community integration and inclusion. Services for children and families shall promote the best interests of the individual receiving services and shall be

designed to strengthen and preserve the family unit if appropriate. The community mental health services program shall deliver services in a manner that demonstrates they are based upon recipient choice and involvement, and shall include wraparound services when appropriate."

In the survey, 59% of respondents disagreed or strongly disagreed with the statement that community stakeholders have sufficient input or voice into current initiatives and activities of the Division of Behavioral Health Services. In their comments, almost all respondents noted their feelings that the Department "does not appreciate or value the opinions of the community or providers," and is unwilling to "let providers have input into their agendas." One respondent effectively summarized these comments: "I continue to see a clear and persistent disconnect between the needs of the community, the members who require services, the providers, and human services. Human services repeatedly ignores the voices of the counties, communities, providers, families, and clients they serve in lieu of a 'we know what you need' attitude." Including community members and providers on local planning and advisory committees, and making use of their input, may alleviate some of these concerns, and allow DBH to more effectively serve the mental health and substance abuse needs of each community by tailoring services to particular regions.

Recommendation 2.4: Transform the existing county behavioral health funding (e.g., CAT and general funds currently expended on behavioral health services) into a fixed match that preserves a maintenance of the current funding for the regional behavioral health authorities.

As an element of implementing regional authorities/districts, the current CAT funding mechanism must be changed to adapt to the new structure. There is not enough data on behavioral health expenditures for every county to accurately determine how much, in total, of the current allocation of funds should be dedicated to the regional bodies on a county by county basis. For example, some counties do not report CAT expenditures for behavioral health services (there was a clear lack of consensus--evinced by the ongoing legal actions--regarding whether the CAT statute calls for, funds or otherwise allows for these funds to be expended in this manner.) Or, some counties may not report all of their behavioral health expenditures.

However, the recommendation here is that a specific amount of existing CAT funding be allocated through the counties towards the behavioral health services either delivered or financed by regional behavioral health authorities/districts. This can be characterized as a 'fixed match', whereby counties have some certainty on expenditures on an annual basis. This match will vary by county (region), and data will have to be collected to better determine the amount of this match. The match can be indexed against inflation in future years. This match, however, is not intended to relieve counties of their responsibilities as "board members" of a regional authority/district for financial risk that is taken on by the regional body.

Idaho's unique county-based funding system for 'indigent' adults is, at best, anachronistic. It forces citizens to seek care, often the most expensive (e.g., crisis or hospitalization services), then apply to have any costs reimbursed. While the onset of mental illness cannot be predicted, citizens could be allowed to apply for treatment funds before a crisis occurs. Also, while counties often have contracts with regional DHW/DBH providers for designated evaluator (DE) services, the system does not have enough flexibility for counties to contract with indigency dollars for community-based, preventative/early intervention services.

Recommendation 2.5: Use a transformed DBH to fund regional behavioral health authorities utilizing formulized funding, based on factors including historical utilization and population.

Key stakeholders commented – through the survey and interviews – on their uncertainty or disagreement with how funds are allocated currently. These concerns were often in the context of how the Department allocates funding and other resources (e.g., staff) by region; however, any changes to DBH's role and the structure of the local system will also be impacted by decisions of how to allocate funds and resources across the state.

In conjunction with the transformation of DBH and the creation of regional authorities/districts, the funding to be provided to the regional bodies must be formally set utilizing standard criteria, such as historical utilization and population. It is recognized that there is likely insufficient data currently to determine many elements of historical utilization, although that data or acceptable 'proxy' data will be required to implement

this recommendation. Or, the data may be obtained as part of the recommended "cost study".

It is important to emphasize here that the new regional bodies would be responsible for managing all levels of care, including inpatient hospitalization. Because of this, this recommendation includes allocating to the regional bodies funding based on their historical use of State Hospital beds. The data in this case are more readily available, however, care must be given regarding historical usage as counties/regions have had inequitable access to State Hospital beds. That is, communities that have utilized fewer beds historically would be disadvantaged in this allocation, unless the allocation is combined with population and 'population in need' data.

3 Identifying Gaps in the Intersection of the Justice Systems

Recommendation 3.1: Review the mental health and substance abuse programs within the criminal and juvenile justice systems to ensure integration with regionally-based behavioral health authorities.

Recommendation 3.2: Collect and share regional practices that have resulted in providing appropriate care to children in the custody of juvenile corrections.

With the growth in mental health and drug courts, Idaho would benefit from identifying how to divert more persons from the criminal/juvenile justice systems (Idaho's local ACT programs, which differ from region to region, are one tool for preventing persons from reentering the system). Using the courts (and, subsequently, inpatient hospitals) as the primary entry point for persons with SMI/SPMI/SED is not an efficient use of resources.

Some key stakeholders commented that there were few, if any, mental health or substance abuse services available to juveniles. (Since this review began, however, there has been an initiative to add a mental health staff in each of the 12 detention facilities.) Additionally, it was noted that the system is in critical need of services for youth before they become involved with detention, as well as for follow up services upon their release from detention.

4 Increasing Access to Care through Changes to Financing, Eligibility and the Use of Waivers

Recommendation 4.1: Identify clinical and financial eligibility criteria that support the delivery of timely, quality, cost-effective screening, assessment, early intervention and prevention services.

Recommendation 4.2: Amend eligibility criteria for public mental health and substance abuse services to support access to screening, assessment, early intervention, and recovery.

Recommendation 4.3: Continue the current effort to identify possible waiver or demonstration programs, including those that will result in integrated providers (mental health and substance abuse); in continuing these efforts, conduct a study of the per capita costs of providing appropriate services, basing this study on any new eligibility criteria and including services funded by Medicaid.

Recommendation 4.4: Integrate the current efforts towards credentialing providers with the transformed DBH and regionally-based behavioral health authorities.

Recommendation 4.5: Consider reinstituting targeted funds for school-based counseling program.

Recommendation 4.6: Revise the existing eligibility screening and service delivery contracts for substance abuse to:

1. Create an adequate, risk-based contract for service delivery, preferably a capitated style contract with more local planning and control of service delivery;
2. Clarify eligibility requirements by removing any uncertainty on eligibility decisions; and,
3. Separte the eligibility determination function from the service assessment, planning and financing functions.

Idaho is expending crucial resources by restricting 'front door' (or voluntary) access to services thus paying for expensive bed days, both in private facilities and in the state hospitals. This has created a 'catch-22' whereby people have to wait in private facilities because no state

beds are available, and people have insufficient access to community services and/or Medicaid and thus are held at the state hospitals.

Idaho needs to address the significant costs expended through inpatient hospitalization of persons who otherwise could be treated in the community, or who could benefit from shorter stays in inpatient settings. Because of the relatively stringent Medicaid eligibility standards, most adults with a SMI or acute crisis (but not SPMI) will likely only receive treatment through the court or hospital system.

A majority of respondents to the survey felt that the current funding is insufficient to provide quality services. This feeling may be due, in part, to the belief that the current funding is not being used to maximum efficiency, and many are being left untreated due to current restrictions on how mental health services are paid for (in particular, the priority given to individuals in the court systems). Many respondents echoed the statement made by an adult corrections employee: "There is not enough access to drug treatment or mental health treatment…if you are not a felon and do not have insurance, or money, you do not get help." However, even felons were noted to have problems with accessing mental health services upon their return to the community: "…connecting offenders returning to society with mental health services has been a challenge.

There are those who don't qualify for services because they aren't homeless and yet they don't have the funds or the health coverage to continue their medication without assistance." Allowing more flexibility in how mental health funds are used may alleviate these concerns that only certain populations are able to access services. In particular, allowing for prevention services would address the problem that "people have to be incredibly ill or in prison to get services." Crisis services (and ensuing hospitalizations) are substantially more costly than prevention services. Allowing residents to apply for funding and receive services prior to the development of a crisis would enable more money to be used to expand mental health services, which many respondents viewed as insufficient to meet Idaho's current mental health needs.

It is important to note that making changes to the State Plan are not recommended due to the current environment at CMS, unless the overall 'transformation' effort must include a State Plan Amendment. Of those waivers that have been identified in key stakeholder interviews:

1. Home and Community Based waiver (1915C): This waiver allows States to provide services in the community to persons who would otherwise be eligible or need inpatient care. This waiver would be an extension of the Benchmark plan in offering additional community services to those with serious mental illness.
2. 1915 B waiver: This is a "managed care" waiver, which allows for waiving of certain parts of the federal law, i.e., "statewide-ness", choice, populations. This approach would perhaps be best served if applied in urban settings and maintaining a fee for service approach in more rural areas. Utah and Colorado have such waivers. Here is a brief description of the waiver:

"States may request Section 1915(b) waiver authority to operate programs that impact the delivery system of some or all of

Recommendation 4.6: Revise the existing eligibility screening and service delivery contracts for substance abuse to:

1. **Create an adequate, risk-based contract for service delivery, preferably a capitated style contract with more local planning and control of service delivery;**
2. **Clarify eligibility requirements by removing any uncertainty on eligibility decisions; and,**
3. **Separate the eligibility determination function from the service assessment, planning and financing functions.**

During this review, there were comments by key stakeholders regarding the existing substance abuse delivery system, including that of the statewide contracts for eligibility screening and financing. The concerns expressed at both the local and state levels. A number of state and private providers noted how difficult it was to obtain prior authorization, including making several calls to staff located in the Boise area. Moreover, providers report that they are given a 'set' amount of services for a person over a calendar year, and cannot deviate from that approved plan and expect reimbursement.
The primary concern expressed on the local level was that of intrusion of the 'system' into the consumer-provider relationship, particularly with care decisions.

Specifically, there were what would be considered 'normal' concerns about decisions being made "in the central office" or "in Boise" regarding the care of clients who had only been seen in-person in the community. While it is understandable that providers may have concerns with a prior authorization process, the recommendation here is similar to that for the whole system: Push the responsibility and decision-making on care to the local level ("point of care"). An example of this is to establish performance-based contracts with individual providers that allow for care to be better targeted, as well as increasing the ability of providers to plan and budget over a longer term.

From the state level, the review found that there were issues with the service contract, including the perception that eligibility criteria decisions were subject to change, and that there was a lack of sufficient controls of, and incentives to manage, the overall budget. Transitioning the current contractual relationship to one that is more risk-based is recommended here. The intent is to have a clearer understanding of the criteria surrounding eligibility, and greater clarity on the processes the State and the contractor will use to make decisions (or to handle appeals of decisions). Moreover, a risk-based contract would reduce the overall risk currently held by the State (e.g., the responsibility for providing utilization management) by shifting that to a contractor. Importantly, this change would require data that may not be readily available, particularly regarding the number of clients expected to be eligible year to year, the per service costs, and the outcomes services. An additional factor to consider is whether more than one contractor for the entire state is appropriate in the long term. This factor may be of more importance if the change to risk-based contracting attracts bidders who currently are not interested in competing under the existing model.

Further, the review highlighted an issue that there was no separation of responsibility between the entity responsible for determining a client's eligibility from that of the entity responsible for initial assessment/care planning and financing. As noted above, there is not a known, large pool of potential contractors for either of these contracts, which complicates implementing change. Regardless, it appeared through this review that consideration should be given to ensuring that there is a clear delineation of responsibilities such that there is no risk that eligibility decisions will be impacted by the financing of the care to be delivered.

5 Enhancing the Efficiency of the State's Hospital Capacity

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

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

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

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

Recommendation 5.4: Utilize deliberate planning and program development in secure facilities, ensuring that civilly committed persons treated in these facilities are served in the lease restrictive settings based on their clinical and legal circumstances.

Discussion of Options for Addressing State Hospital Utilization

Service Utilization Rates

Idaho's overall and community utilization rates per 100,000 population are lower than the Western States and US, while the state hospital utilization is within the range of the Western and US rates. These data reflect the focus of Idaho's adult mental health services on persons with serious and persistent mental illnesses (SPMI), a subset of the persons with serious mental illnesses (SMI) served in most states. However, Idaho's Other Psychiatric Inpatient Utilization per 100,000 Population rate is 0.36 compared with 1.42 for the US. Therefore, compared with the other states, Idaho relies more on state hospital inpatient services than other inpatient resources. This may at least in part, be related to the lack of availability of non-state hospital inpatient beds in Idaho. According to the DHW statewide listing of hospital beds, Idaho has 143 non-state, psychiatric hospital beds, of which 34 serve older adults. Persons

with SPMI are more likely than those with SMI and other less serious disorders to require hospitalization, especially in a state hospital.

The ability of states to serve more persons in the community instead of state hospitals varies significantly across the country and is dependent on the capacity of comprehensive community-based service systems. One stakeholder commented, "Patients get stuck in the state hospital because they don't have suitable places to go, even though they no longer need inpatient treatment".

Idaho has been investing in mental health and substance abuse courts, and assertive community treatment programs, which can be effective for persons with SPMI and/or criminal justice involvement. However this is only a subset of the persons in need of services. Delaying treatment until a disease is persistent, often requires more intensive, costly services and jeopardizes the potential for successful outcomes. There have been numerous advances in the treatment of persons with mental illnesses in the past 15-20 years, however even with these advancements, the best outcomes occur when treatment begins at the onset of symptoms.

State Hospital Length of Stay and Readmission Rates

The average length of stay for persons discharged in calendar year 2007 from the State Hospital South was about 70 days. This includes adults served on the admissions unit, which had an average length of stay (ALOS) of about 29 days, adults served on the longer-term units, which had ALOSs of 114 and 156 days, as well as the adolescent unit, which had an ALOS of 69.4 days. The State Hospital North reports for state fiscal year 2007 an overall discharge ALOS of 70 days also.

For comparison purposes, the average discharge length of stay data for the two State Hospitals in Colorado were used because Colorado implemented programmatic changes in the past five years in an attempt to decrease lengths of stay, while monitoring the readmission rates. This initiative was driven by budget cuts during FY 2003/2004, whereby State Hospital beds were reduced and the cost savings were transferred to community providers that were interested in reducing their use of the State Hospitals, while enhancing their community-based services. From FY 2003 to FY 2007, the Adolescent ALOS at one

Table 10. Service Utilization and Readmission Rates following Discharge for Civil, Non-Forensic Clients

Discussion of Options for Addressing State Hospital Utilization

Service Utilization and Readmission Rates following Discharge for Civil, Non-Forensic Clients (2006 CMHS Uniform Reporting System Data – Output Tables)

	Idaho Rate	West Rate	US Rate
Service Utilization Rates			
Total Persons Served per 100,000 Population	15.41	18.91	19.88
Community Utilization per 100,000 Population	13.95	18.20	18.58
State Hospital Utilization per 100,000 Population	0.49	0.30	0.59
Other Psychiatric Inpatient Utilization per 100,000 Population	0.36	NR	1.42
Readmission Rates			
State Hospital Readmissions within 30 Days	0.7%	6.3%	9.1%
State Hospital Readmissions within 180 days	3.1%	15.3%	19.3%
State Hospital Readmissions within 30 Days - Adults	0.9%	NR	9.4%
State Hospital Readmissions within 180 days - Adults	4.0%	NR	19.6%
State Hospital Readmissions within 30 Days - Children	NR	NR	6.4%
State Hospital Readmissions within 180 days - Children	NR	NR	14.2%

NR = Not Reported

hospital went from 19.52 days to 11.15 days and 25 days to 16 days at the other hospital. The Adult ALOS (not including adults over age 64) during the same time period went from 68.43 days to 40.60 days at one hospital and from 75 days to 48 days at the other hospital. Both hospitals monitor their readmission rates while continuing to reduce their length of stay, when clinically indicated. The changes implemented in Colorado supported the Olmstead V. L. C. Supreme Court Decision (98-536) 527 U.S. 581 (1999), and allowed for persons to be returned to their home communities more quickly, with less disruption to their lives.

Idaho's state hospital readmission rates for both 30 and 180 days are significantly lower than the rates of the Western States and the US. Idaho did not report state hospital readmission data specifically for children in the same source document as the other data. However, based on the readmission rates for all persons served and for the adults served, it is clear that the readmission rates for children are lower than those of adults, which makes them substantially lower than the US rate as well. A review of discharge length of stay data is useful to help determine if the extremely low readmission rates for Idaho are related to efficient inpatient services and subsequent community follow-up, or relatively long inpatient stays – thereby reducing the need for a readmission – but removing persons from their community for longer periods than is necessary, if the inpatient stay was brief, focused on discharge and the community-based service system had adequate capacity.

State hospital services are a critical part of the continuum of services, however should only be used when less restrictive community-based services are not appropriate to safely treat persons with serious mental illnesses. The development of a comprehensive community-based system of care for children and adults allows for persons to remain in their local communities while receiving treatment, which is less disruptive to the lives of persons needing treatment, was well as their families; and is also more cost-effective for the behavioral health system.

Considerations

In looking at the combined 1) low service utilization data, 2) 70 day ALOS, 3) and the remarkably low 30 and 180 day readmission rates in Idaho, there appears to be an opportunity to increase the flow of patients through the State Hospitals. Some specific observations and opportunities to consider include:

- Expanding community-based-services, as well as providing services to persons with less persistent serious mental illnesses and those in need of early intervention and prevention is an investment opportunity for the health of Idahoans.
- The balance between length of stay and readmissions is complex and although low readmission rates are desirable; when they become extremely low, they may be an indicator that many persons are hospitalized longer than necessary. This clinical judgment is compounded by the availability or lack of availability, of community services and supports for persons after they are discharged from a hospital. However, given the current lengths of stay, there may be internal practices within the State Hospitals that could be modified to increase the 'churn' of the population, thereby freeing up more bed days in order to serve more persons. This would allow for more persons to be served in the State Hospitals, at a lower daily rate, than private hospitals. The cost-offset from this type of a shift could be used to enhance community-based services and supports.

Secure Mental Health Facility Considerations

Idaho clearly needs designated secure mental health inpatient capacity, beyond what is available in the prison system. As stated in the Statement of Purpose for House Concurrent Resolution (HCR) NO. 56, "This resolution declares the policy that the State of Idaho should not use prison facilities for the treatment or confinement of people with mental illness who have not been convicted of a crime or charged with commission of a violent crime, and that a secure facility for treatment persons with serious mental illness should be established under the administration of the Department of Health and Welfare, separate from the secure facility proposed by the Department of Corrections."

It is understood that HCR 58 provides authorization for the Board of Correction to build a secure mental health treatment facility and the Board of Correction will establish, operate, and maintain a program for persons displaying evidence of mental illness or psychosocial disorders and requiring diagnostic services and treatment in a maximum security setting, and for other criminal commitments.

As noted in HCR 58, under current law, standards for appropriate mental health treatment in the Idaho Security Medical Program shall be jointly developed by the Department of Correction and the Department of Health and Welfare. Additionally, the Department of Correction is authorized to receive and admit patients of any institution or facility under the jurisdiction of the Department of Health and Welfare to the Idaho Security Medical Program if they have been determined by a court to be both dangerous and mentally ill as defined in Section 66-1305, Idaho Code. Patients admitted to the Idaho Security Medical Program may originate from civil commitments by the courts as:

- unfit to proceed;
- referrals by the courts for psychosocial diagnosis and recommendations as part of the pretrial or pre-sentence procedure of determination of mental competency to stand trial;
- adult prisoners with mental illness from city, county and state correctional institutions for diagnosis, evaluation or treatment;
- civil commitments by the courts (Persons coming to the Idaho Security Medical Program on the basis of a civil commitment must first be found to be both dangerous and have a mental illness); and
- criminal commitments of the Idaho Department of Correction requiring some form of specialized program not otherwise available.

During the 2007 legislative session the Interim Committee on Mental Health and Substance Abuse endorsed a proposal by the Department of Correction to build a 300-bed treatment facility. An appropriation of $3 million was provided to begin the planning process for a secure mental health facility. This facility has been designed jointly by the Department of Correction and the Department of Health and Welfare. Funding in the amount of $70 million was included in the Governor's recommendation for the Building Fund Advisory Council in the Department of Administration.

Given the time it will take to construct the new 300 bed facility, it is understood that plans are underway to convert one facility on the campus of the Idaho State Hospital and School (ISHS) as an interim secure treatment facility with 16-20 beds. This facility is expected to be ready early in 2010 and will serve as an interim secure facility until the new facility is constructed, which is expected to take three to four years. Additionally, opportunities to develop a few secure beds in hospitals and other facilities across the State is being explored as well.
In the September 2007 Idaho State School and Hospital, Nampa Idaho Facility Review completed by WICHE, the following was stated.

> "When bringing a forensic population to a campus that primarily serves the function of an Intermediate Care Facility for the Mentally Retarded; safety and security issues for the residents, staff and local community must be considered. The possible patients to be housed in a secure facility are at significant risk of causing harm to themselves or other patients and/or staff, present a risk for escape, and require high levels of supervision and treatment."

It is suggested that Idaho proceed with cautious diligence as it develops secure mental health capacity. Deliberate planning and programs must acknowledge the differences in persons residing in secure facilities who have civil rather than criminal commitments and respect the individual rights of such persons, while also ensuring they are treated in the least restrictive setting based on their clinical and legal circumstances.

6 Increasing Accountability through Information and Data

Recommendation 6.1: Fully implement the recent budget initiative to design and implement a statewide data system that:

1. Has utility at the 'point of care' (e.g., is helpful in clinical planning and treatment);
2. Collaboratively addresses and incorporates 'legacy' (systems in use currently by providers and other public agencies) systems currently in use by stakeholders; and,
3. Supports the implementation of electronic medical records.

Recommendation 6.2: Conduct a study to determine 'population in need', i.e. those who have serious mental illness or substance abuse/use disorder who are in need of publicly funded, community services.

Recommendation 6.3: Revamp and improve the accessibility and utility of the DHW website.

Recommendation 6.4: Implement a system of evaluation and reporting for transformation activities, with an emphasis on identifying and analyzing the impacts of change on service recipients.

- Information from interviews conducted illustrated that some persons are court-ordered to a State Hospital and while waiting for a bed to become available are successfully treated and stabilized in a private hospital. However, since the court order is for the person to go to a State Hospital, often these stabilized persons are still transferred in order to comply with the court order. This practice needs to be addressed, possibly by the court ordering treatment/stabilization, without identifying that this occurs in a State Hospital.

Idaho's mental health data system did not appear to be robust, with a solid, valid set of statewide data available on program specifics, including outcomes. There appeared to be more data available for the substance abuse program, however, there remain gaps in the ability to track service delivery and outcomes in that system, too.

Through the web-based survey and during meetings with key stakeholders, participants were asked to provide any reports and/or data that showed the success of specific programs, including the various implementations of the Assertive Community Treatment programs in the various regions.

During the process of this review, the legislature has funded an initiative to implement a data system for adult mental health.

In the process of identifying whether more persons should be made eligible for services (Recommendation 5.1), a determination of the prevalence of serious mental and substance abuse disorders is recommended. Specifically, the state could benefit from statistically identifying how many persons may become eligible for community-based, voluntary services prior to taking any steps towards expanding eligibility. Such studies, sometimes referred to as a "population in need" study, have been performed in a number of states, including several in the West.

Finally, key stakeholders informed this review that it was difficult to use the DHW website. Providers expressed concern that they were not able to easily and quickly navigate to key sections of the website, notably regulations and forms.

Review of Workforce Capacity

Idaho is one of the many western states projected to have fewer people entering the workforce than leaving it by 2025 (see Table 11). According to the WICHE Workforce Brief:

> Employment in Idaho (including hourly and salaried jobs and self-employment) is projected to grow by 24 percent from 2002 to 2012, adding 144,520 new jobs to the state's economy and growing the workforce from 610,640 to 755,160. The rate of growth is much higher than the 15 percent increase projected for the nation as a whole.

7 Enhancing Workforce Capacity

Recommendation 7.1: Create a Workforce Collaborative to manage and coordinate a statewide behavioral health workforce study which will inform the development of a statewide strategic workforce plan.

Recommendation 7.2: Design and implement applied mental health and substance abuse educational programs that translate into a job in the workforce system.

Recommendation 7.3: Increase availability of applied training opportunities in behavioral health professional settings.

Recommendation 7.4: Provide incentives for the recruitment and retention of behavioral health professionals trained to deliver evidence-based treatment interventions.

However, Idaho's retirement population is growing at a significantly higher rate than its workforce population (156.6% vs. 20%).

Only Alaska and Utah have higher retirement growth projections. Currently, according to the 2006 American Community Survey for Idaho[13], the statewide labor force participation was 65.8%. Ada was the highest county at 69.5%. The unemployment rate in Idaho is 5.3%. The lowest rate was in Twin Falls County (3.9%) and the highest was in Kootenai County (7.3%). Bannock County had the highest poverty rates in the state (11.5% of families and 14.8% of the people). The state poverty averages were 9.3% for families and 12.6% for individuals.

The states in the Western Region are some of the most rural in the nation. Behavioral health data for comparing the states are drawn from the Bureau of Labor Statistics (BLS) website. The BLS maintains data for each of the 50 states regarding 11 behavioral health disciplines, including Clinical, Counseling, and School Psychologists; Substance Abuse and Behavioral Disorder Counselors; Educational, Vocational, and School Counselors; Marriage and Family Therapists; Mental Health Counselors; Child, Family, and School Social Workers; Medical and Public Health Social Workers; Mental Health and Substance Abuse Social Workers; Psychiatrists; Psychiatric Technicians; and Psychiatric Aides. Some professionals are grouped together even though they may have some differences in professional focus or activities (e.g., Clinical, Counseling, and School Psychologists). There was no data for Idaho regarding four professions, Psychologists, All Other, Substance Abuse and Behavioral Disorder Counselors, Child, Family, and School Social Workers, and Psychiatrists. These professions will not be included in the table. Table 12 presents data from the Bureau of Labor Statistics for each of these disciplines in Idaho for 2006, including the number of employed professionals, number of professionals per 100,000 persons in the state, as well as the ranking of a given profession among the thirteen Western states. In terms of professionals per 100,000, Idaho ranks, on average, 7th in the West on professions with available data. The best rankings (2nd) are for Clinical, Counseling, and School Psychologists, and Psychiatric Technicians, while the lowest ranking (11th) was for Mental Health Counselors.

Several caveats should be kept in mind when considering these rankings. First, these comparisons are among the 13 Western states and rankings might be different if looking at the whole country. Second, data was not available for given professions (e.g., Psychiatrists) in all states, which could also affect rankings.

Although Idaho may rank highly for a given behavioral health occupation within the Western region, the trends of the state (based on data presented in earlier sections) suggests a decreasing workforce ratio, increasing number of people with mental health and/or substance use problems, and a fairly large percent of unmet need (i.e., the number of those estimated to

Table 11. Projections of the Working and Retirement Age Populations from 2000 to 2025[14]

State	Actual Pop. Ages 18-64 (2000)	Projected Population Ages 18-64 (2025)	% Change 2000 to 2025	Actual Pop. Ages 65+ (2000)	Projected Population Ages 65+ (2025)	% Change 2000 to (2025)	Entering (+) vs Leaving (-) workforce by 2025
CA	21,026,161	28,352,207	34.8	3,595,658	6,424,090	78.7	+4,497,614
HI	755,169	1,040,295	37.8	160,601	288,581	79.7	+157,146
NM	1,098,247	1,458,993	32.8	212,225	440,582	107.6	+132,389
AK	400,516	516,611	29.0	35,699	92,235	158.4	+59,559
WY	307,216	380,192	23.8	57,693	144,843	151.1	-14,174
SD	444,064	469,081	5.6	108,131	186,629	72.6	-53,481
ND	386,873	392,293	1.4	94,478	166,611	76.3	-66,713
ID	779,007	940,187	20.7	145,916	374,410	156.6	-67,314
UT	1,324,249	1,559,168	17.7	190,222	494,003	159.7	-68,862
MT	551,184	599,757	8.8	120,949	274,424	126.9	-104,902
WA	3,718,130	4,477,116	20.4	662,148	1,580,554	138.7	-159,420
NV	1,267,529	13,44,107	6.0	218,929	486,854	122.4	-191,347
AZ	3,095,846	3,468,872	12.0	667,839	1,368,129	104.9	-327,264
OR	2,136,696	2,387,747	11.7	438,177	1,054,368	140.6	-365,140
CO	2,784,393	2,971,381	6.7	416,073	1,043,918	150.9	-440,857

Table 12. Western Regional Comparison of Idaho's Behavioral Health Occupations in 2006

	Total Employment[a]	Employment Per 100,000	Rank Among 13 Western Regional States[b]
Clinical, Counseling, and School Psychologists*	590	40.2	2
Psychologists, All Other	N/A	N/A	N/A
Substance Abuse and Behavioral Disorder Counselors	N/A	N/A	N/A
Educational, Vocational, and School Counselors	1,050	71.6	9
Marriage and Family Therapists	40	2.7	7
Mental Health Counselors	360	24.5	11
Child, Family, and School Social Workers	N/A	N/A	N/A
Medical and Public Health Social Workers	440	30.0	9
Mental Health and Substance Abuse Social Workers	470	32.0	10
Psychiatrists*	N/A	N/A	N/A
Psychiatric Technicians	510	34.8	2
Psychiatric Aides	100	6.8	7

Note. Data were not available for all states.
[a]Estimates do not include self-employed workers.
[b]Alaska, Arizona, California, Colorado, Idaho, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

Table 13. Behavioral Health Professionals for Idaho, 2004-2008[15]

Occupation	Employment		Annual openings due to:		
	Est. 2004	Proj. 2008	Growth	Replacements	Total
Child, Family, and School Social Workers	430	459	15	7	22
Clinical, Counseling, and School Psychologists	759	781	11	16	27
Counselors, Social Workers, and Community/Social S.	7,939	8,419	240	140	380
Educational, Vocational, and School Counselors	1,103	1,130	14	23	37
Family and General Practitioners	474	501	14	6	20
Licensed Practical and Licensed Vocational Nurses	3,236	3,362	63	66	129
Marriage and Family Therapists	57	60	2	1	3
Medical and Public Health Social Workers	464	493	15	7	22
Mental Health and Substance Abuse Social Workers	420	456	18	7	25
Mental Health Counselors	282	301	10	6	16
Physician Assistants	390	428	19	6	25
Psychiatric Technicians	652	678	13	8	21
Psychiatrists	95	100	3	1	4
Social Workers, All Other	110	116	3	2	5
Substance Abuse and Behavioral Disorder Counselors	183	193	5	4	9
Therapists, All Other	83	84	1	2	3

Table 14. Professional Licensed Behavioral Health Professions for Idaho, 2008[a]

Occupation	Current Licenses	# Per 100,000[b]	As of:
Licensed Clinical Professional Counselor	570	38	4-21-2008
Licensed Marriage & Family Therapist	212	14	4-21-2008
Licensed Professional Counselor	618	41	4-21-2008
Total Licensed Counselors	**1400**	**93**	**4-21-2008**
Licensed Clinical Social Worker	778	52	4-21-2008
Licensed Master Social Worker	685	46	4-21-2008
Master Social Work - Independent Practice	7	>1	4-21-2008
Licensed Social Worker	1451	97	4-21-2008
Licensed Social Worker - Independent	18	1	4-21-2008
Total Licensed Social Workers	**2939**	**196**	**4-21-2008**
Psychiatric Mental Health Registered Nurses			
Licensed Psychiatrists	97	6	4-21-2008
Licensed Psychologists	356	24	4-21-2008
TOTAL LICENSED BEHAVIORAL HEALTH PROFESSIONALS		(*.06669)	

[a] Excludes Non-Current and Renewable Licenses;

[b] Based on the US Census 2007 Estimate of Idaho's population of 1,499,402

have a given mental health problem vs. those being served). Thus, these trends strongly suggest the need to boost the state's workforce to meet growing demand.

Short-term workforce solutions include increased funding for nationally competitive salaries and additional positions. Long-term solutions consist of increased culturally appropriate rural training programs, rural internships with university collaboration, development of local training centers specific to the needs of each area utilizing a 'grow-your-own' approach, and student loan forgiveness in exchange for rural work.

Creating a renewed and sustainable workforce will require a set of building blocks that must be methodically engineered to serve Idaho's unique needs. This is not a set of challenges for which there is a pre-packaged manual. However, there are key elements that must be the drivers for whatever Idaho ultimately decides will be its workforce solutions including 1) building systems that support practitioner development and career ladders, 2) offering evidence-based training programs, 3) providing applied training opportunities that translate into real world job opportunities, and 4) offering current treatment practice information and resources delivered via multiple methods including web-based solutions. While there are numerous recommendations that potentially could improve Idaho's workforce shortages, three specific recommendations are noted in this report to target a few of the many mental health workforce issues in Idaho.

With a large proportion of Idaho's mental health workforce approaching retirement age during the next few years, it is imperative that Idaho educate and recruit a sufficient mental health workforce to meet the state's mental health demands. To determine the educational needs of Idaho's mental health workforce, it is essential that representatives from the state, higher education, and mental health workers come together to discuss solutions to the state's shortage of mental health workers.

Recommendation 7.1: Create a Workforce Collaborative to manage and coordinate a statewide behavioral health workforce study which will inform the development of a statewide strategic workforce plan.

Essential to the success of a statewide effort of this type is the infrastructure to identify and prioritize workforce problems, coordinate or implement interventions, and monitor outcomes. Perhaps most important, an infrastructure is necessary to link and leverage existing resources that are available within the state to strengthen its workforce.

The functions of such an infrastructure would include, but not be limited to the following:

- **Leveraging** existing resources by:
  - Identifying and disseminating information about existing workforce development resources (clearinghouse function).
  - Coordinating workforce development efforts among various public and private agencies to achieve efficiencies and reduce duplication of effort.
- **Linking** Idaho's mental health and higher education systems in a coordinated effort to develop a pipeline of culturally diverse and appropriately trained mental health providers. This includes:
  - Educating educators about current trends in service delivery as a strategy for fostering relevant curricula in the educational system
  - Working with the mental health, higher education, licensing systems, and payers to improve career ladders in mental health within Iowa.
- **Assessing** routinely the mental health workforce development needs within Idaho, including:
  - The magnitude, characteristics, and causes, of recruitment and retention problems, including the impact of compensation and benefits
  - The accessibility, relevance, and effectiveness of training and education resources/program.
- **Planning** in the form of a biannual strategic plan on mental health workforce development and report on the status of this workforce will be conducted by the Collaborative.
- **Implementing** interventions to strengthen the workforce.
- **Promoting** employment of consumers, youth, and family members in the mental health workforce.
- **Disseminating** best practices in workforce development to employers of the mental health workforce.
- **Advising** Idaho's executive, legislative, and judicial branches on workforce issues and policy.
- **Applying** for other potential sources of funds to support workforce development.

Recommendation 7.2: Design and implement applied mental health and substance abuse educational programs that translate into a job in the workforce system.

Another factor that supports the development of the behavioral health workforce is obtaining training that translates from the educational environment to the actual job marketplace. The shortages of mental health workers in Idaho are seen most acutely in rural areas of the state. Mental health professionals across all levels tend to reside and work in metropolitan areas, leaving rural areas in large need of mental health services. One solution to this problem is to make greater use of paraprofessionals to provide mental health services to rural populations. For example, the University of Alaska has recently implemented a certificate program for training paraprofessionals, whereby students meet for 1-3 weeks of intensive course work each semester to work toward an Associate of Applied Sciences Human Services degree. The idea is that this degree has real-world applicability in the state behavioral health system so that the degree leads to a job or range of jobs within the behavioral health system. The certificate program could be implemented in online courses through one of Idaho's universities or community colleges. Distance learning options may be ideal for rural individuals interested in becoming mental health service providers without having to travel large distances to attend courses or access supervision.

Another suggestion would be to establish a specialized mental health/substance abuse applied curriculum to serve individuals in rural settings. The Western Consortium on Rural Social Work Education (WCRSWE) is a relatively new effort which is working on developing a rural-specific social work certificate. This program is intended to provide specialized training to social workers who traditionally graduate from advanced generalist programs. The Consortium is a partnership between six universities in the West who plan to develop a curriculum relevant to those seeking to practice in rural environments and is delivered via distance.

Recommendation 7.3: Increase availability of applied training opportunities in behavioral health professional settings.

One of the factors that increases the recruitment and retention of workers in a given employment setting, is providing educational opportunities that allow individuals to gain field-based experience. Increasing the number of practica and internship opportunities in the work environments with the greatest need is one way to ensure individuals receive applied training. However, training opportunities across behavioral health disciplines often maintain different requirements for successful completion of training experiences. Thus, it may be useful to begin with a select group of disciplines on which to focus (e.g., psychology, social work) and expand from there. The Workforce Collaborative noted in recommendation 7.1 could be charged with identifying the location and content of training opportunities across the state and across several behavioral health disciplines in order to determine which are in the greatest demand. Training opportunities would need to be embedded within existing educational programs that would result in academic credit or some other determined benefit within in the employer setting.

Recommendation 7.4: Provide incentives for the recruitment and retention of behavioral health professionals trained to deliver evidence-based treatment interventions.

It is recommended that Idaho develop a workforce that is capable of bringing the best scientific knowledge about effective intervention and services to persons with behavioral health issues. This is generally referred to as the movement toward evidence-based practices (EBPs). It is likely that the rural nature of much of Idaho poses special challenges for implementing many of the more widely recognized, manualized evidence-based interventions. Therefore, Idaho will also need to create structures to evaluate modifications of standardized practices, but also to assess the effectiveness of current practice – what is often referred to as "practice-based evidence."

Providing incentives for the recruitment and retention of behavioral health providers with specialized knowledge and demonstrated competence in evidence-based treatment interventions is one way to address both the availability of and the quality of the behavioral heath workforce pool. Toward this end, Idaho could establish a pool of dollars to offer financial incentives (e.g., stipends, loan forgiveness, supplements) to professionals in the high-need categories who are willing and competent to treat persons with behavioral health issues. Idaho should select EBPs that have been demonstrated to have a positive impact and focus training toward competencies in those practices.

Stakeholders' Perceptions

Mental health and substance abuse system stakeholders' input was critical to this project, and was obtained in two primary methods: 1) in-person interviews; and, 2) publication of a web-based survey. The in-person interviews were conducted over a period from February to June 2008. WICHE interviewed dozens of system and community stakeholders during this period. These interviews ranged from individual, one on one to large, focus-group style meetings. WICHE utilized contact information obtained from staff at the legislature to determine who to interview. Persons interviewed in-persons included:

- legislators,
- legislative staff,
- governor's office staff,
- Department of Health and Welfare (DHW) leadership,
- leadership and staff from the Division of Behavioral Health's 'central office',
- leadership and staff from a number of regions (specifically, Regions 2, 3, 4 and 7),
- leadership and staff from other DHW agencies, including Medicaid, Family and Child Services,
- consumers/clients and family members,
- advocates,
- county staff,
- adult and juvenile corrections,
- private mental health and substance abuse providers, and,
- regional mental health board members.

Survey Findings and Analysis

Five-hundred fifty-five individuals responded to questions in the survey between March 13, 2008 and May 9, 2008. These individuals represented a range of positions in Idaho's Mental Health and Substance Abuse systems: Community Mental Health Centers, Substance Abuse Treatment Facilities, Corrections (Juvenile and Adult), the Court System, the Division of Behavioral Health Services, the Department of Health and Welfare, State Psychiatric Hospitals, Counties, Substance Abuse and Mental Health Council members, and other stakeholders in Idaho's systems. Respondents worked solely with mental health or substance abuse issues, or worked with a combination of mental health and substance abuse issues.

The survey questions focused on stakeholders' attitudes toward the mental health and substance abuse systems in Idaho. Respondents were able to add in their own comments throughout the survey. In order to facilitate the reader's understanding of the survey responses, responses and relevant comments are summarized below. Tables showing average responses to each question in the survey are provided in Appendix A, and a list consisting of the main comments is available from WICHE upon request.

Across all stakeholder groups, respondents were somewhat negative regarding the restructuring/integration of the mental health and substance abuse programs within the Department of Health and Welfare. The majority of individuals who provided a response disagreed with the statement that the restructuring/integration of mental health and substance abuse services increased the accessibility and the availability of mental health and substance abuse services (50% disagreed regarding accessibility; 52% disagreed regarding availability). When asked whether the restructuring/integration has improved communication among different groups within Idaho's behavioral health system (e.g., consumers, providers, legislators), or has been supported by the different groups, the responses were fairly neutral (mean ratings across all respondents ranged from 2.74 to 3.01, on a scale where 1=strong disagree, and 5 = strongly agree). Individuals who provided a response were somewhat more negative, regarding the improvements to data monitoring/oversight (mean rating = 2.74), and data collection/evaluation (mean rating = 2.82) due to the restructuring/integration of mental health and substance abuse services.

Respondents were fairly negative when asked about the current administrative structure of the Department of Health and Welfare. They did not feel the Department's current administrative structure supports efficient mental health service delivery in the community (mean rating = 2.59), or in psychiatric hospital/inpatient settings (mean rating = 2.66). In addition, they did not feel the current administrative structure reduces or streamlines statutory/regulatory processes in the mental health system (mean rating = 2.38, or provides sufficient support to Behavioral Health Services (mean rating = 2.36). These ratings were reflected in the comments, which indicated there is currently too much paperwork. Respondents felt that providers often spent as much or more time with paperwork than treating clients, and that "red tape" gets in the way of providing services to clients. This additional "red tape" applied

not only to providers, but also to clients: Respondents were concerned that rules such as terminating treatment due to missed appointments made it more difficult for clients to access mental health and substance abuse services.

Respondents in each stakeholder group also commented on the Department's apparent lack of concern for community input regarding the structure and delivery of behavioral health services in Idaho. There was a good deal of concern that the administrators were too removed from service delivery, and did not understand the difficulties faced by providers in service delivery, and consumers in service use. In addition, respondents noted that administrators seemed unwilling to communicate with community stakeholders, by excluding them from discussions, ignoring their input, or failing to return phone calls. Comments such as, "Mental health service providers have been ignored by the Department of Health and Welfare" and "Community providers and consumers have little input" were fairly common. These comments are reflected in the quantitative responses to the survey. When asked whether community stakeholders had sufficient input or voice into past restructuring and/or current initiatives in the Department, mean ratings ranged from 2.09 to 2.40.

Most respondents indicated a substantial source of frustration with the current system was a lack of funding for mental health and substance abuse services. When asked whether the current funding was sufficient to provide quality community mental health, substance abuse, and inpatient services to adults and children, mean ratings ranged from 1.72 to 1.83, indicating a substantial amount of dissatisfaction with levels of current funding. Responses did not think the current funding was being used to maximum efficiency (mean rating = 2.19), however much of this dissatisfaction appeared to come from a perceived lack of knowledge and understanding of the priorities of the mental health and substance abuse communities by the legislature. Responses regarding the Division of Behavioral Health Services (mean rating = 3.08), the Department of Health and Welfare (mean rating = 2.81), and the counties' (mean rating = 2.62) knowledge and understanding of the priorities of the mental health and substance abuse communities were neutral, but were fairly negative for the Legislature (mean rating = 2.05).

Comments indicated respondents felt funding was lacking both with regard to the available resources for current services (providers, hospitals), as well as with regard to the ability to gain additional resources (e.g., by offering competitive salaries and benefits for recruiting additional providers). Respondents felt money was being wasted on costly but ineffective services. For example, one respondent noted that instant drug tests cost approximately $30/test, when cheaper and more reliable lab tests are not used. Many respondents noted that drug courts make it impossible for law-abiding, low-income people with substance use problems to get treatment because criminals have first priority in accessing services. Respondents also felt that the current regulatory and statutory environment is severely limiting access to services, particularly for the working poor, who do not qualify for Medicaid, are not criminals, and do not have private insurance. When asked directly whether Idaho's current regulatory and statutory environment resulted in the delivery of quality mental health and substance abuse services, responses were quite negative (mean rating for regulatory environment = 1.96; mean rating for statutory environment = 2.08).

When asked to rank the primary barriers to receiving mental health and substance abuse services, respondents indicated that the cost of mental health and substance abuse care (mean rank = 3.7 on a scale with 1=highest barrier, and 10 = lowest barrier), and a lack of insurance (mean rank = 4.3), were the primary barriers to care. Lack of knowledge of available resources was the next highest ranked barrier (mean rank = 5.1), followed by lack of appropriate providers, transportation, distance to care, and stigma.

One barrier mentioned frequently in the comments was a lack of quality service providers, rather than a lack of service providers. In particular, a number of respondents across stakeholder groups indicated that some PSR service providers were more interested in attracting and retaining clients through methods such as birthday gifts, parties, lunches, and rides than in treating clients. Respondents noted a lack of accountability for quality service provision, and many respondents suggested there needs to be a measure of quality service provision, and that some sort of training or certification process should exist to ensure quality services are provided to all clients.

The issue of eligibility was raised again as a primary barrier to accessing services. The system was noted as being very restrictive based on diagnostic severity or financial means, and many respondents indicated that these restrictions left out a number of people with

mental health and substance abuse service needs. One respondent summarized these responses by stating, "The current system is designed to prioritize those patients who create the most problems, rather than those patients with the greatest need," and went on to state that the system is "reactive rather than proactive."

When asked to rank the steps necessary for the transformation of Idaho's behavioral health system, most respondents indicated that providing additional funding to the mental health and substance abuse systems was the highest priority for overcoming the barriers to care (mean rank = 2.71 on a scale with 1 = highest barrier, and 10 = lowest barrier). However, respondents were specific in stating that additional funding should be used to provide quality care to those who cannot afford it but do not qualify for services under Medicaid. Increasing the number of providers was again not the priority, but, rather, increasing the number of quality providers. In the words of one respondent, "Increasing the number of providers does not increase the quality of services."

Respondents noted that administrative changes were unnecessary; adding more rules and regulations would help neither providers nor consumers. One respondent stated "Frontline staff view the Department of Health and Welfare as an obstacle to be tolerated." Instead, respondents suggested that the Department of Health and Welfare work to implement existing regulations, rather than implementing new regulations. A number of respondents stated that the Department does not respond to complaints about providers, and indicated that many agencies are only providing services for a profit. One respondent summarized these thoughts by stating, "We do not need an overhaul of the department, we just need to reduce unnecessary and burdensome regulatory barriers, and add a measure of accountability." These thoughts on steps necessary toward transforming Idaho's behavioral health system were echoed in the quantitative responses. Administrative changes, such as changes to the State, Department, and Division administrative/organizational structure; statutory changes to the Department's or Division's responsibilities; data system improvements; and changes to counties' responsibilities for funding of services were among the steps ranked the lowest for transforming the current system.

Endnotes

[1] Senate Concurrent Resolution 2007-108, Idaho Legislature.
[2] Sugarman, B. (2000). A Learning-based approach to leading change. [Electronic version.] Cambridge, MA: Society for Organizational Learning. Retrieved January 3, 2005 from http://www.solonline.org/repository/download/SugarmanReport.pdf?item_id=357321
[3] Kotter, J. (1996). Leading Change. Harvard Business School Press.
[4] Ibid.
[5] Gladwell, M. (2000). The tipping point: How little things can make a big difference. Boston: Little, Brown and Company.
[6] Brooks, T. (1995). Accountability: It All Depends on What You Mean. Akkad Press.
[7] National Academy Press, National Institute of Medicine (2001). Crossing the quality chasm, executive summary. [electronic version] Washington, DC: National Academies Press. Retrieved January 6, 2005 from http://www.nap.edu/execsumm/0309072808.html
[8] Alaska FY 2008 Community Mental Health Services Block Grant Plan.
[9] AK 2008 CMHS Block Grant Plan.
[10] This section is excerpted from: Substance Abuse and Mental Health Services Administration: Heath Care Spending: National Expenditures for Mental Health and Substance Abuse Treatment, 1997.
[11] Chart data source: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse (Washington, D.C.: 2000).
[12] Chapter 37, Idaho Code.
[13] http://www.census.gov/acs/www/index.html
[14] http://www.higheredinfo.org/
[15] http://stats.bls.gov/oes/current/oes_nd.htm

Appendix A: Idaho Behavioral Health System Redesign Survey Results

(Survey results are provided below grouped in four sets by the category each respondent chose to indicate their area of primary interest or work:

1. Mental health only
2. Substance abuse only
3. Both mental health and substance abuse
4. All respondents

Mental Health Only

The restructuring/integration of the mental health and substance abuse programs within the Department of Health and Welfare has (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Increased access to mental health services	5% (4)	10% (8)	18% (14)	**28% (22)**	18% (14)	22% (17)	79
b. Increased the availability of mental health services	4% (3)	10% (8)	11% (9)	**33% (26)**	22% (17)	20% (16)	79
c. Improved communication in the mental health system with **consumers and families**	3% (2)	19% (15)	15% (12)	**28% (22)**	13% (10)	23% (18)	79
d. Improved communication in the mental health system with **providers**	1% (1)	13% (10)	25% (20)	**27% (21)**	11% (9)	23% (18)	79
e. Improved communication in the mental health system with **other state agencies**	1% (1)	10% (8)	19% (15)	**27% (21)**	10% (8)	33% (26)	79
f. Improved communication in the mental health system with **the legislature**	3% (2)	11% (9)	16% (13)	**19% (15)**	13% (10)	38% (30)	79
g. Improved communication in the mental health system with **counties**	1% (1)	13% (10)	**22% (17)**	20% (16)	9% (7)	35% (28)	79
						answered question	**79**

Substance Abuse Only

The restructuring/integration of the mental health and substance abuse programs within the Department of Health and Welfare has (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Increased acess to substance abuse services	16% (5)	**22% (7)**	13% (4)	13% (4)	13% (4)	25% (8)	32
b. Increased the availability of substance abuse services	13% (4)	16% (5)	16% (5)	**22% (7)**	9% (3)	25% (8)	32
c. Improved communication in the substance abuse system with **consumers and families**	9% (3)	16% (5)	**22% (7)**	13% (4)	6% (2)	34% (11)	32
d. Improved communication in the substance abuse system with **providers**	13% (4)	**22% (7)**	19% (6)	9% (3)	6% (2)	31% (10)	32
e. Improved communication in the substance abuse system with **other state agencies**	16% (5)	**19% (6)**	**19% (6)**	6% (2)	6% (2)	34% (11)	32
f. Improved communication in the substance abuse system with the **legislature**	13% (4)	**22% (7)**	16% (5)	13% (4)	3% (1)	34% (11)	32
g. Improved communication in the substance abuse system with **counties**	6% (2)	19% (6)	**25% (8)**	13% (4)	9% (3)	28% (9)	32
						answered question	**32**

Mental Health & Substance Abuse

The restructuring/integration of the mental health and substance abuse programs within the Department of Health and Welfare has (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Increased access to mental health and substance abuse services	5% (18)	22% (88)	14% (56)	**24% (94)**	17% (67)	18% (71)	394
b. Increased the availability of mental health and substance abuse services	5% (19)	22% (85)	15% (61)	**24% (94)**	18% (70)	16% (65)	394
c. Improved communication in the mental health and substance abuse systems with **consumers and families**	5% (18)	17% (68)	20% (80)	**21% (83)**	10% (41)	26% (104)	394
d. Improved communication in the mental health and substance abuse systems with **providers**	4% (17)	**25% (98)**	17% (68)	20% (78)	12% (46)	22% (87)	394
e. Improved communication in the mental health and substance abuse systems with **other state agencies**	6% (25)	**24% (93)**	19% (74)	15% (59)	11% (42)	26% (101)	394
f. Improved communication in the mental health and substance abuse systems with the **legislature**	7% (28)	17% (68)	**19% (73)**	11% (45)	10% (41)	35% (139)	394
g. Improved communication in the mental health and substance abuse systems with **counties**	4% (17)	**20% (77)**	19% (76)	16% (64)	11% (45)	29% (115)	394
						answered question	**394**

All Survey Respondents

The restructuring/integration of the mental health and substance abuse programs within the Department of Health and Welfare has (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Increased access to mental health and substance abuse services	5% (27)	20% (103)	15% (74)	**24% (120)**	17% (85)	19% (96)	505
b. Increased the availability of mental health and substance abuse services	5% (26)	19% (98)	15% (75)	**25% (127)**	18% (90)	18% (89)	505
c. Improved communication in the mental health and substance abuse systems with **consumers and families**	5% (23)	17% (88)	20% (99)	**22% (109)**	10% (53)	26% (133)	505
d. Improved communication in the mental health and substance abuse systems with **providers**	4% (22)	**23% (115)**	19% (94)	20% (102)	11% (57)	23% (115)	505
e. Improved communication in the mental health and substance abuse systems with **other state agencies**	6% (31)	**21% (107)**	19% (95)	16% (82)	10% (52)	27% (138)	505
f. Improved communication in the mental health and substance abuse systems with the **legislature**	7% (34)	17% (84)	**18% (91)**	13% (64)	10% (52)	36% (180)	505
g. Improved communication in the mental health and substance abuse systems with **counties**	4% (20)	18% (93)	**20% (101)**	17% (84)	11% (55)	30% (152)	505
						answered question	**505**

Mental Health Only

The restructuring/integration of the mental health and substance abuse programs within the Department of Health and Welfare has (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
g. Improved monitoring and oversight processes for mental health services or programs	1% (1)	10% (8)	16% (13)	**30% (24)**	11% (9)	30% (24)	79
h. Improved data collection and evaluation for mental health services or programs	0% (0)	11% (9)	18% (14)	**19% (15)**	15% (12)	37% (29)	79
i. Been supported in the mental health system by **community providers**	1% (1)	16% (13)	**19% (15)**	**19% (15)**	10% (8)	34% (27)	79
j. Been supported in the mental health system by **consumers and family members**	1% (1)	22% (17)	**28% (22)**	14% (11)	8% (6)	28% (22)	79
k. Been supported in the mental health system by **legislators**	0% (0)	14% (11)	14% (11)	**16% (13)**	11% (9)	44% (35)	79
l. Been supported in the mental health system by **counties**	0% (0)	13% (10)	**25% (20)**	10% (8)	8% (6)	44% (35)	79
						answered question	**79**

Substance Abuse Only

The restructuring/integration of the mental health and substance abuse programs within the Department of Health and Welfare has (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
g. Improved monitoring and oversight processes for substance abuse services or programs	3% (1)	16% (5)	9% (3)	**28% (9)**	6% (2)	38% (12)	32
h. Improved data collection and evaluation for substance abuse services or programs	3% (1)	**19% (6)**	16% (5)	9% (3)	6% (2)	47% (15)	32
i. Been supported in the substance abuse system by **community providers**	3% (1)	**22% (7)**	13% (4)	13% (4)	3% (1)	47% (15)	32
j. Been supported in the substance abuse system by **consumers and family members**	6% (2)	9% (3)	**22% (7)**	9% (3)	6% (2)	47% (15)	32
k. Been supported in the substance abuse system by **legislators**	9% (3)	**22% (7)**	**22% (7)**	3% (1)	3% (1)	41% (13)	32
l. Been supported in the substance abuse system by **counties**	6% (2)	16% (5)	**22% (7)**	9% (3)	3% (1)	44% (14)	32
						answered question	**32**

Mental Health & Substance Abuse

The restructuring/integration of the mental health and substance abuse programs within the Department of Health and Welfare has (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Improved monitoring and oversight processes for mental health and substance abuse services or programs	4% (14)	**19% (74)**	18% (70)	**19% (73)**	10% (40)	31% (123)	394
b. Improved data collection and evaluation for mental health and substance abuse services or programs	4% (15)	**20% (79)**	18% (69)	15% (60)	10% (39)	34% (132)	394
c. Been supported in the mental health and substance abuse systems by **community providers**	3% (10)	**20% (78)**	17% (67)	15% (59)	9% (36)	37% (144)	394
d. Been supported in the mental health and substance abuse systems by **consumers and family members**	2% (8)	18% (71)	**21% (82)**	14% (56)	7% (27)	38% (150)	394
e. Been supported in the mental health and substance abuse systems by **legislators**	4% (15)	**19% (76)**	18% (69)	10% (41)	8% (32)	41% (161)	394
f. Been supported in the mental health and substance abuse systems by **counties**	3% (10)	19% (74)	**20% (80)**	14% (55)	8% (31)	37% (144)	394
g. Been supported in the mental health and substance abuse systems by **other state agencies**	4% (15)	**21% (84)**	18% (69)	13% (51)	8% (30)	37% (145)	394
						answered question	**394**

All Survey Respondents

The restructuring/integration of the mental health and substance abuse programs within the Department of Health and Welfare has (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Improved monitoring and oversight processes for mental health and substance abuse services or programs	3% (16)	17% (87)	17% (86)	**21% (106)**	10% (51)	31% (159)	505
b. Improved data collection and evaluation for mental	3% (16)	**19% (94)**	17% (88)	15% (78)	10% (53)	35% (176)	505
c. Been supported in the mental health and substance abuse systems by **community providers**	2% (12)	**19% (98)**	17% (86)	15% (78)	9% (45)	37% (186)	505
d. Been supported in the mental health and substance abuse systems by **consumers and family members**	2% (11)	18% (91)	**22% (111)**	14% (70)	7% (35)	37% (187)	505
e. Been supported in the mental health and substance abuse systems by **legislators**	4% (18)	**19% (94)**	17% (87)	11% (55)	8% (42)	41% (209)	505
f. Been supported in the mental health and substance abuse systems by **counties**	2% (12)	18% (89)	**21% (107)**	13% (66)	8% (38)	38% (193)	505
g. Been supported in the mental health and substance abuse systems by **other state agencies**	4% (15)	**21% (84)**	18% (69)	13% (51)	7% (30)	37% (145)	394
						answered question	**505**

Mental Health Only

The Department's current administrative structure (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Supports efficient mental health service delivery in the community	1% (1)	**30% (23)**	6% (5)	21% (16)	29% (22)	13% (10)	77
b. Supports efficient mental health service delivery in psychiatric hospital or inpatient settings	0% (0)	22% (17)	13% (10)	10% (8)	**23% (18)**	31% (24)	77
c. Reduces or streamlines statutory and regulatory processes in the mental health system	0% (0)	12% (9)	17% (13)	**27% (21)**	23% (18)	21% (16)	77
d. Provides sufficient support to the Division of Behavioral Health Services for completion of its duties	0% (0)	10% (8)	12% (9)	19% (15)	**29% (22)**	30% (23)	77
						answered question	

Substance Abuse Only

The Department's current administrative structure (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Supports efficient substance abuse service delivery in the community	0% (0)	**32% (10)**	6% (2)	19% (6)	16% (5)	26% (8)	31
b. Supports efficient substance abuse service delivery in psychiatric hospital or inpatient settings	0% (0)	16% (5)	6% (2)	**23% (7)**	10% (3)	45% (14)	31
c. Reduces or streamlines statutory and regulatory processes in the substance abuse system	0% (0)	13% (4)	10% (3)	**23% (7)**	16% (5)	39% (12)	31
d. Provides sufficient support to the Division of Behavioral Health Services for completion of its duties	0% (0)	**16% (5)**	3% (1)	**16% (5)**	13% (4)	52% (16)	31
						answered question	**31**

Mental Health & Substance Abuse

The Department's current administrative structure (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Supports efficient mental health and substance abuse service delivery in the community	3% (13)	24% (93)	13% (50)	**25% (97)**	20% (77)	15% (57)	387
b. Supports efficient mental health and substance abuse service delivery in psychiatric hospital or inpatient settings	2% (9)	**22% (85)**	14% (55)	17% (65)	15% (59)	29% (114)	387
c. Reduces or streamlines statutory and regulatory processes in the mental health and substance abuse systems	2% (6)	15% (58)	14% (55)	**22% (87)**	19% (72)	28% (109)	387
d. Provides sufficient support to the Division of Behavioral Health Services for completion of its duties	2% (9)	12% (45)	14% (56)	**18% (69)**	**18% (70)**	36% (138)	387
						answered question	

All Survey Respondents

The Department's current administrative structure (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Supports efficient mental health and substance abuse service delivery in the community	3% (14)	**25% (126)**	12% (57)	24% (119)	21% (104)	15% (75)	495
b. Supports efficient mental health and substance abuse service delivery in psychiatric hospital or inpatient settings	2% (9)	**22% (107)**	14% (67)	16% (80)	16% (80)	31% (152)	495
c. Reduces or streamlines statutory and regulatory processes in the mental health and substance abuse systems	1% (6)	14% (71)	14% (71)	**23% (115)**	19% (95)	28% (137)	495
d. Provides sufficient support to the Division of Behavioral Health Services for completion of its duties	2% (9)	12% (58)	13% (66)	18% (89)	**19% (96)**	36% (177)	495
						answered question	**495**

Mental Health Only

Community stakeholders in the mental health system (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Had sufficient input into the past restructuring/integration of the Department	0% (0)	4% (3)	12% (9)	**26% (20)**	14% (11)	44% (34)	77
b. Have sufficient input or voice into current initiatives and activities of the Division of Behavioral Health Services	0% (0)	6% (5)	12% (9)	**29% (22)**	14% (11)	39% (30)	77
						answered question	

Substance Abuse Only

Community stakeholders in the substance abuse system (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Have sufficient input or voice into current initiatives and activities of the Division of Behavioral Health Services	0% (0)	**23% (7)**	6% (2)	6% (2)	**23% (7)**	42% (13)	31
						answered question	**31**

Mental Health & Substance Abuse

Community stakeholders in the mental health and substance abuse systems (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Have sufficient input or voice into current initiatives and activities of the Division of Behavioral Health Services	2% (6)	14% (56)	15% (57)	**24% (93)**	17% (67)	28% (108)	387
						answered question	**387**

All Survey Respondents

Community stakeholders in the mental health and substance abuse systems (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Had sufficient input into the past restructuring/integration of the Department	0% (0)	6% (5)	12% (9)	**29% (22)**	14% (11)	39% (30)	77
b. Have sufficient input or voice into current initiatives and activities of the Division of Behavioral Health Services	1% (6)	13% (66)	14% (68)	**23% (115)**	17% (85)	31% (155)	495
						answered question	

Mental Health Only

The current funding in the mental health system is (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a.Sufficient to provide quality **child community mental health services**	0% (0)	4% (3)	9% (7)	30% (22)	**39% (29)**	18% (13)	74
b.Sufficient to provide quality **adult community mental health services**	0% (0)	7% (5)	8% (6)	23% (17)	**46% (34)**	16% (12)	74
c.Sufficient to provide quality **substance abuse services**	0% (0)	3% (2)	8% (6)	20% (15)	**41% (30)**	28% (21)	74
d.Sufficient to provide quality **inpatient services**	0% (0)	8% (6)	9% (7)	24% (18)	**34% (25)**	24% (18)	74
e.Being used to the maximum efficiency	3% (2)	8% (6)	9% (7)	**31% (23)**	28% (21)	20% (15)	74
f.Used to purchase evidence- or outcomes-based services	0% (0)	18% (13)	14% (10)	**20% (15)**	12% (9)	36% (27)	74
						answered question	**74**

Substance Abuse Only

The current funding in the substance abuse system is (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a.Sufficient to provide quality **child community mental health services**	4% (1)	0 (0%)	7% (2)	21% (6)	**32% (9)**	36% (10)	28
b.Sufficient to provide quality **adult community mental health services**	0 (0%)	11% (3)	14% (4)	21% (6)	**36% (10)**	18% (5)	28
c.Sufficient to provide quality **substance abuse services**	4% (1)	11% (3)	18% (5)	18% (5)	**43% (12)**	7% (2)	28
d.Sufficient to provide quality **inpatient services**	0 (0%)	4% (1)	14% (4)	25% (7)	**50% (14)**	7% (2)	28
e.Being used to the maximum efficiency	0 (0%)	7% (2)	11% (3)	32% (9)	**36% (10)**	14% (4)	28
f.Used to purchase evidence- or outcomes-based services	4% (1)	18% (5)	**25% (7)**	4% (1)	14% (4)	36% (10)	28
						answered question	

Mental Health & Substance Abuse

The current funding in the mental health and substance abuse systems is (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Sufficient to provide quality **child community mental health services**	1% (4)	6% (23)	5% (20)	29% (110)	**31% (117)**	28% (105)	379
b. Sufficient to provide quality **adult community mental health services**	1% (5)	6% (22)	6% (23)	34% (127)	**42% (159)**	11% (43)	379
c. Sufficient to provide quality **substance abuse services**	1% (4)	4% (16)	9% (33)	28% (107)	**46% (174)**	12% (45)	379
d. Sufficient to provide quality **inpatient services**	1% (3)	6% (22)	10% (38)	27% (101)	**42% (159)**	15% (56)	379
e. Being used to the maximum efficiency	3% (13)	10% (38)	12% (47)	**28% (106)**	27% (103)	19% (72)	379
f.Used to purchase evidence- or outcomes-based services	1% (3)	**16% (62)**	**16% (61)**	15% (57)	11% (42)	41% (154)	379
						answered question	**379**

All Survey Respondents

The current funding in the mental health and substance abuse systems is (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. Sufficient to provide quality **child community mental health services**	1% (5)	5% (26)	6% (29)	29% (138)	**32% (155)**	27% (128)	481
b. Sufficient to provide quality **adult community mental health services**	1% (5)	6% (30)	7% (33)	31% (150)	**42% (203)**	12% (60)	481
c. Sufficient to provide quality **substance abuse services**	1% (5)	4% (21)	9% (44)	26% (127)	**45% (216)**	14% (68)	481
d. Sufficient to provide quality **inpatient services**	1% (3)	6% (29)	10% (49)	26% (126)	**41% (198)**	16% (76)	481
e. Being used to the maximum efficiency	3% (15)	10% (46)	12% (57)	**29% (138)**	28% (134)	19% (91)	481
f.Used to purchase evidence- or outcomes-based services	1% (4)	**17% (80)**	16% (78)	15% (73)	11% (55)	40% (191)	481
						answered question	

Mental Health Only

Please answer the following questions (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. The **Division of Behavioral Health Services** knows and understands the priorities of the mental health community	3% (2)	**38% (28)**	12% (9)	16% (12)	7% (5)	24% (18)	74
b. The **Department of Health and Welfare** knows and understands the priorities of the mental health community	3% (2)	**31% (23)**	9% (7)	22% (16)	16% (12)	19% (14)	74
c. The **legislature** knows and understands the priorities of the mental health community	1% (1)	5% (4)	8% (6)	**38% (28)**	34% (25)	14% (10)	74
d. Idaho's current regulatory environment (e.g., Medicaid rules, contract rules, etc.) results in the delivery of quality services in the mental health system	0% (0)	8% (6)	9% (7)	24% (18)	**49% (36)**	9% (7)	74
e. Idaho's current statutory environment (i.e., state laws) results in the delivery of quality services in the							
						answered question	

Substance Abuse Only

Please answer the following questions (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. The **Division of Behavioral Health Services** knows and understands the priorities of the substance abuse community	7% (2)	**29% (8)**	7% (2)	21% (6)	14% (4)	21% (6)	28
b. The **Department of Health and Welfare** knows and understands the priorities of the substance abuse community	4% (1)	21% (6)	18% (5)	**29% (8)**	14% (4)	14% (4)	28
c. The **legislature** knows and understands the priorities of the substance abuse community	0 (0%)	21% (6)	11% (3)	25% (7)	**29% (8)**	14% (4)	28
d. Idaho's current regulatory environment (e.g., Medicaid rules, contract rules, etc.) results in the delivery of quality services in the substance abuse system	0 (0%)	4% (1)	7% (2)	29% (8)	**32% (9)**	29% (8)	28
e. Idaho's current statutory environment (i.e., state laws) results in the delivery of quality services in the							
						answered question	

Mental Health & Substance Abuse

Please answer the following questions (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. The **Division of Behavioral Health Services** knows and understands the priorities of the mental health and substance abuse communities	4% (15)	**30% (115)**	15% (58)	14% (54)	9% (36)	27% (101)	379
b. The **Department of Health and Welfare** knows and understands the priorities of the mental health and substance abuse communities	3% (12)	**27% (102)**	17% (63)	22% (84)	13% (48)	18% (70)	379
c. The **legislature** knows and understands the priorities of the mental health and substance abuse communities	1% (3)	12% (45)	12% (46)	24% (92)	**33% (124)**	18% (69)	379
d. The **counties** know and understand the priorities of the mental health and substance abuse communities	3% (13)	18% (67)	20% (76)	**21% (78)**	17% (64)	21% (81)	379
e. Idaho's current regulatory environment (e.g., Medicaid rules, contract rules, etc.) results in the delivery of quality services in the mental health and substance abuse systems	1% (3)	5% (20)	15% (56)	**41% (154)**	26% (99)	12% (47)	379
f. Idaho's current statutory environment (i.e., state laws) results in the delivery of quality services in the							
						answered question	

All Survey Respondents

Please answer the following questions (Check DK if you do not know):

Answer Options	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	DK	Response Count
a. The **Division of Behavioral Health Services** knows and understands the priorities of the mental health and substance abuse communities	4% (19)	**31% (151)**	14% (69)	15% (72)	9% (45)	26% (125)	481
b. The **Department of Health and Welfare** knows and understands the priorities of the mental health and substance abuse communities	3% (15)	**27% (131)**	16% (75)	22% (108)	13% (64)	18% (88)	481
c. The **legislature** knows and understands the priorities of the mental health and substance abuse communities	1% (4)	11% (55)	11% (55)	26% (127)	**33% (157)**	17% (83)	481
d. The **counties** know and understand the priorities of the mental health and substance abuse communities	3% (13)	18% (67)	20% (76)	**21% (78)**	17% (64)	21% (81)	379
e. Idaho's current regulatory environment (e.g., Medicaid rules, contract rules, etc.) results in the delivery of quality services in the mental health and substance abuse systems	1% (3)	6% (27)	14% (65)	**37% (180)**	30% (144)	13% (62)	481
f. Idaho's current statutory environment (i.e., state laws) results in the delivery of quality services in the							
						answered question	

Mental Health Only

Please rank the following in the order of priority for the primary barriers to receiving care in the mental health system, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Lack of knowledge of available resources	16% (11)	1% (1)	**24% (16)**	16% (11)	6% (4)	6% (4)	7% (5)
b. Lack of transportation	3% (2)	4% (3)	6% (4)	**15% (10)**	**15% (10)**	13% (9)	9% (6)
c. Lack of appropriate providers for **children**	**18% (12)**	13% (9)	10% (7)	4% (3)	7% (5)	4% (3)	13% (9)
d. Lack of appropriate providers for **adolescents**	6% (4)	**19% (13)**	13% (9)	6% (4)	9% (6)	9% (6)	9% (6)
e. Lack of appropriate providers for **adults**	3% (2)	1% (1)	13% (9)	10% (7)	**21% (14)**	9% (6)	12% (8)
f. Lack of appropriate providers for **older adults**	1% (1)	3% (2)	6% (4)	9% (6)	9% (6)	15% (10)	15% (10)
g. Distance to care	0% (0)	7% (5)	4% (3)	10% (7)	15% (10)	**16% (11)**	15% (10)
h. Stigma/perception of others	1% (1)	7% (5)	9% (6)	10% (7)	6% (4)	15% (10)	12% (8)
i. Cost	**27% (18)**	18% (12)	7% (5)	12% (8)	7% (5)	4% (3)	4% (3)
j. Lack of insurance	**24% (16)**	**24% (16)**	6% (4)	6% (4)	4% (3)	7% (5)	3% (2)
						answered question	**67**

Mental Health Only (continued)

Please rank the following in the order of priority for the primary barriers to receiving care in the mental health system, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Lack of knowledge of available resources	7% (5)	10% (7)	4% (3)	67
b. Lack of transportation	13% (9)	12% (8)	9% (6)	67
c. Lack of appropriate providers for **children**	13% (9)	4% (3)	10% (7)	67
d. Lack of appropriate providers for **adolescents**	15% (10)	13% (9)	0% (0)	67
e. Lack of appropriate providers for **adults**	7% (5)	13% (9)	9% (6)	67
f. Lack of appropriate providers for **older adults**	13% (9)	9% (6)	**19% (13)**	67
g. Distance to care	13% (9)	9% (6)	9% (6)	67
h. Stigma/perception of others	7% (5)	9% (6)	**22% (15)**	67
i. Cost	6% (4)	9% (6)	4% (3)	67
			answered question	

Substance Abuse Only

Please rank the following in the order of priority for the primary barriers to receiving care in the substance abuse system, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Lack of knowledge of available resources	4% (1)	9% (2)	4% (1)	**13% (3)**	9% (2)	4% (1)	**13% (3)**
b. Lack of transportation	4% (1)	9% (2)	**22% (5)**	9% (2)	4% (1)	0 (0%)	4% (1)
c. Lack of appropriate providers for **children**	9% (2)	13% (3)	4% (1)	4% (1)	4% (1)	4% (1)	13% (3)
d. Lack of appropriate providers for **adolescents**	4% (1)	22% (5)	4% (1)	9% (2)	4% (1)	**30% (7)**	4% (1)
e. Lack of appropriate providers for **adults**	9% (2)	4% (1)	9% (2)	13% (3)	**26% (6)**	13% (3)	9% (2)
f. Lack of appropriate providers for **older adults**	4% (1)	4% (1)	0 (0%)	4% (1)	22% (5)	**26% (6)**	9% (2)
g. Distance to care	0 (0%)	4% (1)	13% (3)	**26% (6)**	4% (1)	4% (1)	4% (1)
h. Stigma/perception of others	0 (0%)	0 (0%)	9% (2)	4% (1)	4% (1)	4% (1)	9% (2)
i. Cost	**39% (9)**	13% (3)	9% (2)	0 (0%)	0 (0%)	4% (1)	9% (2)
j. Lack of insurance	13% (3)	**22% (5)**	13% (3)	4% (1)	9% (2)	9% (2)	0 (0%)
						answered question	23

Substance Abuse Only (continued)

Please rank the following in the order of priority for the primary barriers to receiving care in the substance abuse system, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Lack of knowledge of available resources	4% (1)	**13% (3)**	0 (0%)	23
b. Lack of transportation	9% (2)	13% (3)	13% (3)	23
c. Lack of appropriate providers for **children**	**22% (5)**	0 (0%)	0 (0%)	23
d. Lack of appropriate providers for **adolescents**	4% (1)	4% (1)	0 (0%)	23
e. Lack of appropriate providers for **adults**	0 (0%)	13% (3)	4% (1)	23
f. Lack of appropriate providers for **older adults**	9% (2)	4% (1)	4% (1)	23
g. Distance to care	9% (2)	9% (2)	13% (3)	23
h. Stigma/perception of others	13% (3)	4% (1)	**39% (9)**	23
i. Cost	9% (2)	13% (3)	4% (1)	23
			answered question	

Mental Health & Substance Abuse

Please rank the following in the order of priority for the primary barriers to receiving care in the mental health and substance abuse systems, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row and ***AND*

Answer Options	Highest (1)	2	3	4	5	6	7
a. Lack of knowledge of available resources	**16% (56)**	6% (22)	14% (49)	9% (31)	10% (36)	9% (30)	9% (31)
b. Lack of transportation	3% (10)	7% (25)	9% (33)	11% (39)	12% (41)	12% (41)	9% (30)
c. Lack of appropriate providers for **children**	9% (31)	8% (28)	**12% (42)**	**12% (42)**	11% (38)	**12% (41)**	**12% (43)**
d. Lack of appropriate providers for **adolescents**	5% (18)	12% (42)	10% (34)	11% (40)	14% (48)	13% (45)	**15% (52)**
e. Lack of appropriate providers for **adults**	9% (30)	5% (17)	11% (40)	**13% (47)**	**13% (45)**	12% (42)	11% (37)
f. Lack of appropriate providers for **older adults**	1% (2)	3% (10)	3% (12)	13% (45)	14% (49)	**15% (53)**	**15% (52)**
g. Distance to care	3% (12)	3% (12)	11% (40)	9% (33)	11% (39)	8% (29)	**15% (51)**
h. Stigma/perception of others	4% (15)	6% (22)	9% (30)	7% (26)	5% (17)	9% (31)	6% (21)
i. Cost	**31% (109)**	24% (83)	8% (28)	6% (21)	6% (20)	5% (17)	3% (12)
j. Lack of insurance	19% (66)	**25% (88)**	12% (41)	7% (25)	5% (16)	6% (20)	6% (20)
						answered question	349

Mental Health & Substance Abuse (continued)

Please rank the following in the order of priority for the primary barriers to receiving care in the mental health and substance abuse systems, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row and ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Lack of knowledge of available resources	8% (33)	8% (35)	10% (45)	349
b. Lack of transportation	**14% (61)**	13% (56)	10% (44)	349
c. Lack of appropriate providers for **children**	10% (45)	6% (25)	9% (38)	349
d. Lack of appropriate providers for **adolescents**	13% (56)	8% (34)	1% (4)	349
e. Lack of appropriate providers for **adults**	11% (47)	8% (37)	7% (31)	349
f. Lack of appropriate providers for **older adults**	11% (50)	12% (53)	13% (58)	349
g. Distance to care	12% (54)	**15% (65)**	10% (42)	349
h. Stigma/perception of others	12% (53)	13% (59)	**27% (117)**	349
i. Cost				
			answered question	

All Survey Respondents

Please rank the following in the order of priority for the primary barriers to receiving care in the mental health and substance abuse systems, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row and ***AND*

Answer Options	Highest (1)	2	3	4	5	6	7
a. Lack of knowledge of available resources	**16% (71)**	6% (25)	**16% (69)**	10% (45)	10% (42)	8% (35)	9% (39)
b. Lack of transportation	3% (13)	7% (30)	10% (42)	12% (51)	12% (52)	11% (50)	9% (40)
c. Lack of appropriate providers for **children**	10% (45)	9% (40)	11% (50)	11% (49)	11% (47)	10% (45)	**13% (55)**
d. Lack of appropriate providers for **adolescents**	5% (23)	**14% (60)**	10% (44)	10% (46)	13% (55)	13% (58)	13% (59)
e. Lack of appropriate providers for **adults**	8% (34)	4% (19)	12% (51)	13% (57)	**15% (65)**	12% (51)	11% (47)
f. Lack of appropriate providers for **older adults**	1% (4)	3% (13)	4% (16)	12% (52)	14% (60)	**16% (69)**	15% (64)
g. Distance to care	3% (12)	4% (18)	10% (46)	10% (46)	11% (50)	9% (41)	**15% (65)**
h. Stigma/perception of others	4% (16)	6% (27)	9% (38)	8% (34)	5% (22)	10% (42)	7% (31)
i. Cost	**31% (136)**	22% (98)	8% (35)	7% (29)	6% (25)	5% (21)	4% (17)
j. Lack of insurance	19% (85)	**25% (109)**	11% (48)	7% (30)	5% (21)	6% (27)	5% (22)
						answered question	439

All Survey Respondents (continued)

Please rank the following in the order of priority for the primary barriers to receiving care in the mental health and substance abuse systems, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row and ***AND* in each column.

Answer Options	8	9	Lowest (10)	Response Count
a. Lack of knowledge of available resources	8% (33)	8% (35)	10% (45)	439
b. Lack of transportation	**14% (61)**	13% (56)	10% (44)	439
c. Lack of appropriate providers for **children**	10% (45)	6% (25)	9% (38)	439
d. Lack of appropriate providers for **adolescents**	13% (56)	8% (34)	1% (4)	439
e. Lack of appropriate providers for **adults**	11% (47)	8% (37)	7% (31)	439
f. Lack of appropriate providers for **older adults**	11% (50)	12% (53)	13% (58)	439
g. Distance to care	12% (54)	**15% (65)**	10% (42)	439
h. Stigma/perception of others	12% (53)	13% (59)	**27% (117)**	439
			answered question	

Mental Health Only

Please rank the following in order of priority for strategies for the mental health system, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Increase the number or capacity of community treatment facilities	19% (13)	13% (9)	**21% (14)**	9% (6)	13% (9)	6% (4)	1% (1)
b. Increase the number or capacity of inpatient treatment facilities	4% (3)	**21% (14)**	10% (7)	19% (13)	7% (5)	15% (10)	6% (4)
c. Change insurance plans	3% (2)	**22% (15)**	13% (9)	10% (7)	6% (4)	7% (5)	4% (3)
d. Provide additional funding	**48% (32)**	10% (7)	10% (7)	12% (8)	4% (3)	4% (3)	1% (1)
e. Increase the number of providers for **children**	9% (6)	13% (9)	7% (5)	10% (7)	**22% (15)**	6% (4)	7% (5)
f. Increase the number of providers for **adolescents**	4% (3)	10% (7)	9% (6)	9% (6)	16% (11)	13% (9)	10% (7)
g. Increase the number of providers for **adults**	3% (2)	1% (1)	6% (4)	7% (5)	4% (3)	18% (12)	**28% (19)**
h. Increase the number of providers for **older adults**	0% (0)	0% (0)	3% (2)	7% (5)	1% (1)	10% (7)	**30% (20)**
i. Increase available transportation	1% (1)	1% (1)	10% (7)	7% (5)	16% (11)	10% (7)	6% (4)
j. Provide more information about available resources	7% (5)	6% (4)	9% (6)	7% (5)	7% (5)	9% (6)	4% (3)
						answered question	67

Mental Health Only (continued)

Please rank the following in order of priority for strategies for the mental health system, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Increase the number or capacity of community treatment facilities	6% (4)	3% (2)	7% (5)	67
b. Increase the number or capacity of inpatient treatment facilities	0% (0)	9% (6)	7% (5)	67
c. Change insurance plans	1% (1)	10% (7)	21% (14)	67
d. Provide additional funding	1% (1)	4% (3)	3% (2)	67
e. Increase the number of providers for **children**	6% (4)	9% (6)	9% (6)	67
f. Increase the number of providers for **adolescents**	**18% (12)**	9% (6)	0% (0)	67
g. Increase the number of providers for **adults**	16% (11)	10% (7)	4% (3)	67
h. Increase the number of providers for **older adults**	22% (15)	9% (6)	16% (11)	67
i. Increase available transportation	13% (9)	**22% (15)**	10% (7)	67
			answered question	

Substance Abuse Only

Please rank the following in order of priority for strategies for the substance abuse system, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Increase the number or capacity of community treatment facilities	**26% (6)**	**26% (6)**	4% (1)	13% (3)	9% (2)	4% (1)	4% (1)
b. Increase the number or capacity of inpatient treatment facilities	**30% (7)**	13% (3)	26% (6)	0% (0)	4% (1)	9% (2)	9% (2)
c. Change insurance plans	0% (0)	**22% (5)**	13% (3)	13% (3)	4% (1)	9% (2)	9% (2)
d. Provide additional funding	**30% (7)**	22% (5)	22% (5)	17% (4)	0% (0)	0% (0)	0% (0)
e. Increase the number of providers for **children**	9% (2)	0% (0)	4% (1)	22% (5)	**26% (6)**	9% (2)	9% (2)
f. Increase the number of providers for **adolescents**	0% (0)	9% (2)	13% (3)	9% (2)	9% (2)	**22% (5)**	13% (3)
g. Increase the number of providers for **adults**	0% (0)	4% (1)	4% (1)	13% (3)	17% (4)	**22% (5)**	9% (2)
h. Increase the number of providers for **older adults**	0% (0)	0% (0)	0% (0)	4% (1)	13% (3)	13% (3)	**30% (7)**
i. Increase available transportation	0% (0)	4% (1)	9% (2)	4% (1)	4% (1)	9% (2)	13% (3)
j. Provide more information about available resources	4% (1)	0% (0)	4% (1)	4% (1)	13% (3)	4% (1)	4% (1)
						answered question	23

Substance Abuse Only (continued)

Please rank the following in order of priority for strategies for the substance abuse system, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Increase the number or capacity of community treatment facilities	9% (2)	0% (0)	4% (1)	23
b. Increase the number or capacity of inpatient treatment facilities	0% (0)	4% (1)	4% (1)	23
c. Change insurance plans	4% (1)	9% (2)	17% (4)	23
d. Provide additional funding	4% (1)	0% (0)	4% (1)	23
e. Increase the number of providers for **children**	9% (2)	9% (2)	4% (1)	23
f. Increase the number of providers for **adolescents**	9% (2)	17% (4)	0% (0)	23
g. Increase the number of providers for **adults**	13% (3)	4% (1)	13% (3)	23
h. Increase the number of providers for **older adults**	22% (5)	9% (2)	9% (2)	23
i. Increase available transportation	17% (4)	**26% (6)**	13% (3)	23
			answered question	

Mental Health & Substance Abuse

Please rank the following in order of priority for strategies for the mental health and substance abuse systems, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Increase the number or capacity of community treatment facilities	15% (52)	**21% (73)**	20% (70)	13% (47)	7% (23)	5% (19)	5% (19)
b. Increase the number or capacity of inpatient treatment facilities	12% (43)	**18% (62)**	16% (56)	15% (52)	7% (26)	6% (20)	5% (16)
c. Change insurance plans	8% (28)	**17% (60)**	10% (36)	10% (35)	6% (22)	7% (26)	6% (22)
d. Provide additional funding	**46% (161)**	15% (53)	15% (52)	7% (24)	5% (19)	2% (6)	3% (11)
e. Increase the number of providers for **children**	3% (11)	7% (23)	9% (30)	10% (35)	**16% (57)**	15% (54)	15% (52)
f. Increase the number of providers for **adolescents**	3% (10)	5% (19)	9% (31)	11% (39)	16% (56)	**22% (77)**	14% (49)
g. Increase the number of providers for **adults**	1% (5)	5% (18)	5% (17)	15% (53)	16% (55)	16% (57)	**20% (70)**
h. Increase the number of providers for **older adults**	1% (2)	0% (0)	3% (12)	6% (20)	11% (38)	11% (39)	20% (71)
i. Increase available transportation	3% (11)	7% (23)	7% (25)	6% (21)	7% (26)	7% (24)	5% (19)
j. Provide more information about available resources	7% (26)	5% (18)	6% (20)	7% (23)	8% (27)	8% (27)	6% (20)
						answered question	349

Mental Health & Substance Abuse (continued)

Please rank the following in order of priority for strategies for the mental health and substance abuse systems, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Increase the number or capacity of community treatment facilities	5% (16)	5% (16)	4% (14)	349
b. Increase the number or capacity of inpatient treatment facilities	8% (28)	7% (24)	6% (22)	349
c. Change insurance plans	9% (32)	8% (28)	**17% (60)**	349
d. Provide additional funding	3% (10)	3% (9)	1% (4)	349
e. Increase the number of providers for **children**	12% (41)	8% (29)	5% (17)	349
f. Increase the number of providers for **adolescents**	12% (41)	7% (23)	1% (4)	349
g. Increase the number of providers for **adults**	9% (32)	7% (25)	5% (17)	349
h. Increase the number of providers for **older adults**	**23% (79)**	15% (53)	10% (35)	349
i. Increase available transportation	12% (43)	**24% (83)**	21% (74)	349
			answered question	

All Survey Respondents

Please rank the following in order of priority for strategies for the mental health and substance abuse systems, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Increase the number or capacity of community treatment facilities	16% (71)	**20% (88)**	19% (85)	13% (56)	8% (34)	5% (24)	5% (21)
b. Increase the number or capacity of inpatient treatment facilities	12% (53)	**18% (79)**	16% (69)	15% (65)	7% (32)	7% (32)	5% (22)
c. Change insurance plans	7% (30)	**18% (80)**	11% (48)	10% (45)	6% (27)	8% (33)	6% (27)
d. Provide additional funding	**46% (200)**	15% (65)	16% (64)	8% (36)	5% (22)	2% (9)	3% (12)
e. Increase the number of providers for **children**	4% (19)	7% (32)	8% (36)	11% (47)	**18% (78)**	14% (60)	13% (59)
f. Increase the number of providers for **adolescents**	3% (13)	6% (28)	9% (40)	11% (47)	16% (69)	**21% (91)**	13% (59)
g. Increase the number of providers for **adults**	2% (7)	5% (20)	5% (22)	14% (61)	14% (62)	17% (74)	**21% (91)**
h. Increase the number of providers for **older adults**	0% (2)	0% (0)	3% (14)	6% (26)	10% (42)	11% (49)	22% (98)
i. Increase available transportation	3% (12)	6% (25)	8% (34)	6% (27)	9% (38)	8% (33)	6% (26)
j. Provide more information about available resources	7% (32)	5% (22)	6% (27)	7% (29)	8% (35)	8% (34)	5% (24)
						answered question	439

All Survey Respondents (continued)

Please rank the following in order of priority for strategies for the mental health and substance abuse systems, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Increase the number or capacity of community treatment facilities	5% (22)	4% (18)	5% (20)	439
b. Increase the number or capacity of inpatient treatment facilities	6% (28)	7% (31)	6% (28)	439
c. Change insurance plans	8% (34)	8% (37)	**18% (78)**	439
d. Provide additional funding	3% (12)	3% (12)	2% (7)	439
e. Increase the number of providers for **children**	11% (47)	8% (37)	5% (24)	439
f. Increase the number of providers for **adolescents**	13% (55)	8% (33)	1% (4)	439
g. Increase the number of providers for **adults**	10% (46)	8% (33)	5% (23)	439
h. Increase the number of providers for **older adults**	**23% (99)**	14% (61)	11% (48)	439
i. Increase available transportation	13% (56)	**24% (104)**	19% (84)	439
			answered question	

Mental Health Only

Please rank the following in order of priority, with one (1) being the highest priority, as to the steps necessary for 'transformation' of Idaho's behavioral health system: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Changes to the State's organizational structure for Behavioral Health	**12% (8)**	8% (5)	9% (6)	5% (3)	3% (2)	5% (3)	6% (4)
b. Changes to the Department's or Division's administrative structure	2% (1)	9% (6)	9% (6)	11% (7)	3% (2)	6% (4)	9% (6)
c. Additional state Behavioral Health staff	12% (8)	**18% (12)**	11% (7)	9% (6)	9% (6)	6% (4)	8% (5)
d. Changes to the state's Medicaid Plan	**17% (11)**	9% (6)	14% (9)	8% (5)	11% (7)	11% (7)	5% (3)
e. Statutory changes to the Department's or Division's responsibilities	2% (1)	3% (2)	5% (3)	12% (8)	15% (10)	8% (5)	6% (4)
f. Increasing the use of performance- or outcomes-based contracts	0% (0)	5% (3)	2% (1)	14% (9)	**15% (10)**	9% (6)	11% (7)
g. Additional funding for mental health services	**38% (25)**	17% (11)	11% (7)	8% (5)	5% (3)	6% (4)	3% (2)
h. Creation and adoption of a plan to coordinate programs and initiatives among state agencies	2% (1)	5% (3)	11% (7)	9% (6)	11% (7)	12% (8)	14% (9)
i. Data system improvements	5% (3)	6% (4)	**12% (8)**	3% (2)	5% (3)	9% (6)	9% (6)
j. Changes to the types of services provided	5% (3)	9% (6)	5% (3)	12% (8)	5% (3)	**14% (9)**	9% (6)
k. Creation and adoption of a statewide plan for continued/future integration of the mental health and substance abuse systems	6% (4)	8% (5)	8% (5)	6% (4)	11% (7)	8% (5)	**17% (11)**
							answered question

Mental Health Only (continued)

Please rank the following in order of priority, with one (1) being the highest priority, as to the steps necessary for 'transformation' of Idaho's behavioral health system: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	10	11	Lowest (12)	Response Count
a. Changes to the State's organizational structure for Behavioral Health	8% (5)	11% (7)	**12% (8)**	**12% (8)**	9% (6)	65
b. Changes to the Department's or Division's administrative structure	5% (3)	9% (6)	15% (10)	**18% (12)**	3% (2)	65
c. Additional state Behavioral Health staff	3% (2)	9% (6)	3% (2)	5% (3)	6% (4)	65
d. Changes to the state's Medicaid Plan	3% (2)	6% (4)	9% (6)	2% (1)	6% (4)	65
e. Statutory changes to the Department's or Division's responsibilities	6% (4)	**18% (12)**	11% (7)	11% (7)	3% (2)	65
f. Increasing the use of performance- or outcomes-based contracts	11% (7)	5% (3)	11% (7)	5% (3)	14% (9)	65
g. Additional funding for mental health services	6% (4)	3% (2)	2% (1)	2% (1)	0% (0)	65
h. Creation and adoption of a plan to coordinate programs and initiatives among state agencies	**17% (11)**	11% (7)	3% (2)	2% (1)	5% (3)	65
i. Data system improvements	**12% (8)**	6% (4)	**12% (8)**	**12% (8)**	8% (5)	65
j. Changes to the types of services provided	9% (6)	11% (7)	8% (5)	6% (4)	8% (5)	65
k. Creation and adoption of a statewide plan for continued/future integration of the mental health and						
					answered question	

Substance Abuse Only

Please rank the following in order of priority, with one (1) being the highest priority, as to the steps necessary for 'transformation' of Idaho's behavioral health system: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Changes to the State's organizational structure for Behavioral Health	**18% (4)**	0% (0)	14% (3)	0% (0)	9% (2)	5% (1)	5% (1)
b. Changes to the Department's or Division's administrative structure	5% (1)	14% (3)	0% (0)	9% (2)	5% (1)	9% (2)	5% (1)
c. Additional state Behavioral Health staff	9% (2)	**14% (3)**	5% (1)	**14% (3)**	**14% (3)**	5% (1)	5% (1)
d. Changes to the state's Medicaid Plan	0% (0)	5% (1)	0% (0)	9% (2)	14% (3)	9% (2)	**18% (4)**
e. Statutory changes to the Department's or Division's responsibilities	0% (0)	5% (1)	9% (2)	9% (2)	14% (3)	9% (2)	**18% (4)**
f. Increasing the use of performance- or outcomes-based contracts	5% (1)	**14% (3)**	**14% (3)**	9% (2)	5% (1)	**14% (3)**	9% (2)
g. Additional funding for substance abuse services	**50% (11)**	18% (4)	5% (1)	5% (1)	0% (0)	5% (1)	14% (3)
h. Creation and adoption of a plan to coordinate programs and initiatives among state agencies	5% (1)	9% (2)	**18% (4)**	5% (1)	14% (3)	**18% (4)**	5% (1)
i. Data system improvements	0% (0)	5% (1)	9% (2)	9% (2)	5% (1)	**18% (4)**	9% (2)
j. Changes to the types of services provided	5% (1)	5% (1)	9% (2)	**18% (4)**	9% (2)	5% (1)	9% (2)
k. Creation and adoption of a statewide plan for continued/future integration of the mental health and							
							answered question

Substance Abuse Only (continued)

Please rank the following in order of priority, with one (1) being the highest priority, as to the steps necessary for 'transformation' of Idaho's behavioral health system: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	10	11	Lowest (12)	Response Count
a. Changes to the State's organizational structure for Behavioral Health	14% (3)	14% (3)	0% (0)	9% (2)	14% (3)	22
b. Changes to the Department's or Division's administrative structure	5% (1)	9% (2)	**18% (4)**	9% (2)	14% (3)	22
c. Additional state Behavioral Health staff	5% (1)	5% (1)	**14% (3)**	9% (2)	5% (1)	22
d. Changes to the state's Medicaid Plan	**18% (4)**	9% (2)	5% (1)	9% (2)	5% (1)	22
e. Statutory changes to the Department's or Division's responsibilities	9% (2)	9% (2)	9% (2)	5% (1)	5% (1)	22
f. Increasing the use of performance- or outcomes-based contracts	9% (2)	5% (1)	5% (1)	5% (1)	9% (2)	22
g. Additional funding for substance abuse services	0% (0)	5% (1)	0% (0)	0% (0)	0% (0)	22
h. Creation and adoption of a plan to coordinate programs and initiatives among state agencies	14% (3)	0% (0)	9% (2)	5% (1)	0% (0)	22
i. Data system improvements	5% (1)	9% (2)	14% (3)	9% (2)	9% (2)	22
j. Changes to the types of services provided	9% (2)	**18% (4)**	5% (1)	9% (2)	0% (0)	22
k. Creation and adoption of a statewide plan for continued/future integration of the mental health and						
					answered question	

Mental Health & Substance Abuse

Please rank the following in order of priority, with one (1) being the highest priority, as to the steps necessary for 'transformation' of Idaho's behavioral health system: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Changes to the State's organizational structure for Behavioral Health	9% (30)	6% (19)	5% (18)	7% (24)	6% (21)	6% (21)	6% (21)
b. Changes to the Department's or Division's administrative structure	4% (14)	7% (24)	6% (20)	4% (14)	7% (24)	7% (25)	10% (33)
c. Additional state Behavioral Health staff	**14% (46)**	11% (36)	12% (41)	8% (28)	10% (32)	7% (25)	7% (22)
d. Changes to the state's Medicaid Plan	6% (21)	8% (26)	11% (36)	**13% (45)**	8% (27)	11% (38)	8% (27)
e. Statutory changes to the Department's or Division's responsibilities	3% (10)	2% (8)	4% (15)	6% (21)	10% (34)	9% (29)	12% (39)
f. Increasing the use of performance- or outcomes-based contracts	4% (14)	7% (24)	**10% (34)**	7% (25)	9% (29)	**10% (32)**	9% (30)
g. Additional funding for mental health services	**34% (114)**	19% (65)	10% (35)	9% (30)	4% (15)	5% (18)	5% (17)
h. Creation and adoption of a plan to coordinate programs and initiatives among state agencies	6% (20)	**14% (47)**	9% (31)	9% (29)	13% (42)	9% (31)	9% (29)
i. Data system improvements	2% (8)	4% (12)	7% (24)	7% (24)	5% (17)	7% (24)	7% (23)
j. Changes to the types of services provided	2% (7)	5% (18)	9% (29)	**13% (45)**	12% (39)	11% (37)	10% (32)
k. Creation and adoption of a statewide plan for continued/future integration of the mental health and							
answered question							

Mental Health & Substance Abuse (continued)

Please rank the following in order of priority, with one (1) being the highest priority, as to the steps necessary for 'transformation' of Idaho's behavioral health system: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	10	11	Lowest (12)	Response Count
a. Changes to the State's organizational structure for Behavioral Health	11% (36)	9% (31)	9% (29)	**13% (42)**	**13% (43)**	335
b. Changes to the Department's or Division's administrative structure	8% (26)	11% (36)	12% (41)	**14% (48)**	9% (30)	335
c. Additional state Behavioral Health staff	6% (20)	6% (19)	6% (19)	6% (19)	8% (28)	335
d. Changes to the state's Medicaid Plan	9% (29)	7% (23)	6% (20)	7% (24)	6% (19)	335
e. Statutory changes to the Department's or Division's responsibilities	11% (36)	14% (47)	**17% (58)**	7% (25)	4% (13)	335
f. Increasing the use of performance- or outcomes-based contracts	8% (28)	11% (36)	8% (28)	7% (24)	9% (31)	335
g. Additional funding for mental health services	4% (13)	4% (12)	3% (11)	1% (2)	1% (3)	335
h. Creation and adoption of a plan to coordinate programs and initiatives among state agencies	12% (39)	7% (23)	6% (21)	5% (18)	1% (5)	335
i. Data system improvements	8% (28)	13% (42)	10% (33)	13% (43)	**17% (57)**	335
j. Changes to the types of services provided	12% (39)	7% (25)	9% (30)	6% (20)	4% (14)	335
k. Creation and adoption of a statewide plan for continued/future integration of the mental health and						
answered question						

All Survey Respondents

Please rank the following in order of priority, with one (1) being the highest priority, as to the steps necessary for 'transformation' of Idaho's behavioral health system: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Changes to the State's organizational structure for Behavioral Health	10% (42)	6% (24)	6% (27)	6% (27)	6% (25)	6% (25)	6% (26)
b. Changes to the Department's or Division's administrative structure	4% (16)	8% (33)	6% (26)	5% (23)	6% (27)	7% (31)	9% (40)
c. Additional state Behavioral Health staff	**13% (56)**	12% (51)	12% (49)	9% (37)	10% (41)	7% (30)	7% (28)
d. Changes to the state's Medicaid Plan	8% (32)	8% (33)	11% (45)	**12% (52)**	9% (37)	11% (47)	8% (34)
e. Statutory changes to the Department's or Division's responsibilities	3% (11)	3% (11)	5% (20)	7% (31)	11% (47)	9% (36)	11% (47)
f. Increasing the use of performance- or outcomes-based contracts	4% (15)	7% (30)	9% (38)	9% (36)	9% (40)	10% (41)	9% (39)
g. Additional funding for mental health services	**36% (150)**	19% (80)	10% (43)	9% (36)	4% (18)	5% (23)	5% (22)
h. Creation and adoption of a plan to coordinate programs and initiatives among state agencies	5% (22)	12% (52)	10% (42)	9% (36)	12% (52)	10% (43)	9% (39)
i. Data system improvements	3% (11)	4% (17)	8% (34)	7% (28)	5% (21)	8% (34)	7% (31)
j. Changes to the types of services provided	3% (11)	6% (25)	8% (34)	**14% (57)**	10% (44)	11% (47)	9% (40)
k. Creation and adoption of a statewide plan for continued/future integration of the mental health and							
answered question							

All Survey Respondents (continued)

Please rank the following in order of priority, with one (1) being the highest priority, as to the steps necessary for 'transformation' of Idaho's behavioral health system: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	10	11	Lowest (12)	Response Count
a. Changes to the State's organizational structure for Behavioral Health	10% (44)	10% (41)	9% (37)	**12% (52)**	**12% (52)**	422
b. Changes to the Department's or Division's administrative structure	7% (30)	10% (44)	13% (55)	**15% (62)**	8% (35)	422
c. Additional state Behavioral Health staff	5% (23)	6% (26)	6% (24)	6% (24)	8% (33)	422
d. Changes to the state's Medicaid Plan	8% (35)	7% (29)	6% (27)	6% (27)	6% (24)	422
e. Statutory changes to the Department's or Division's responsibilities	10% (42)	14% (61)	**16% (67)**	8% (33)	4% (16)	422
f. Increasing the use of performance- or outcomes-based contracts	9% (37)	9% (40)	9% (36)	7% (28)	**10% (42)**	422
g. Additional funding for mental health services	4% (17)	4% (15)	3% (12)	1% (3)	1% (3)	422
h. Creation and adoption of a plan to coordinate programs and initiatives among state agencies	**13% (53)**	7% (30)	6% (25)	5% (20)	2% (8)	422
i. Data system improvements	9% (37)	11% (48)	10% (44)	13% (53)	**15% (64)**	422
j. Changes to the types of services provided	11% (47)	9% (36)	9% (36)	6% (26)	5% (19)	422
k. Creation and adoption of a statewide plan for						
answered question						

Mental Health Only

Please rank the following systems in the order of their willingness to collaborate with others on mental health issues, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Courts/criminal justice	8% (5)	9% (6)	**12% (8)**	9% (6)	9% (6)	**12% (8)**	3% (2)
b. Adult corrections	5% (3)	5% (3)	5% (3)	6% (4)	9% (6)	3% (2)	11% (7)
c. Juvenile corrections	2% (1)	6% (4)	9% (6)	9% (6)	11% (7)	11% (7)	14% (9)
d. Child welfare	11% (7)	12% (8)	8% (5)	14% (9)	9% (6)	9% (6)	**18% (12)**
e. Public health	0% (0)	6% (4)	3% (2)	8% (5)	20% (13)	18% (12)	5% (3)
f. Mental health	**46% (30)**	11% (7)	11% (7)	17% (11)	6% (4)	5% (3)	3% (2)
g. Education	2% (1)	11% (7)	11% (7)	11% (7)	9% (6)	11% (7)	11% (7)
h. Community providers	9% (6)	**26% (17)**	12% (8)	9% (6)	9% (6)	9% (6)	9% (6)
i. Consumer/family members or advocacy organizations	**17% (11)**	11% (7)	15% (10)	15% (10)	8% (5)	8% (5)	9% (6)
j. Substance abuse	2% (1)	3% (2)	14% (9)	2% (1)	9% (6)	14% (9)	**17% (11)**
						answered question	65

Mental Health Only (continued)

Please rank the following systems in the order of their willingness to collaborate with others on mental health issues, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Courts/criminal justice	**12% (8)**	**12% (8)**	**12% (8)**	65
b. Adult corrections	11% (7)	22% (14)	**25% (16)**	65
c. Juvenile corrections	**17% (11)**	9% (6)	12% (8)	65
d. Child welfare	9% (6)	2% (1)	8% (5)	65
e. Public health	**22% (14)**	14% (9)	5% (3)	65
f. Mental health	2% (1)	0% (0)	0% (0)	65
			answered question	

Substance Abuse Only

Please rank the following systems in the order of their willingness to collaborate with others in substance abuse services or programs, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Courts/criminal justice	**24% (5)**	**24% (5)**	14% (3)	0% (0)	0% (0)	**24% (5)**	5% (1)
b. Adult corrections	**43% (9)**	24% (5)	10% (2)	0% (0)	5% (1)	0% (0)	10% (2)
c. Juvenile corrections	0% (0)	14% (3)	**29% (6)**	14% (3)	10% (2)	0% (0)	5% (1)
d. Child welfare	0% (0)	0% (0)	10% (2)	14% (3)	5% (1)	14% (3)	10% (2)
e. Public health	0% (0)	0% (0)	5% (1)	5% (1)	10% (2)	**19% (4)**	10% (2)
f. Mental health	0% (0)	10% (2)	5% (1)	5% (1)	**24% (5)**	14% (3)	10% (2)
g. Education	0% (0)	5% (1)	5% (1)	5% (1)	19% (4)	5% (1)	**38% (8)**
h. Community providers	5% (1)	10% (2)	5% (1)	**38% (8)**	0% (0)	10% (2)	14% (3)
i. Consumer/family members or advocacy organizations	10% (2)	5% (1)	14% (3)	5% (1)	14% (3)	10% (2)	0% (0)
j. Substance abuse	**19% (4)**	10% (2)	5% (1)	14% (3)	14% (3)	5% (1)	0% (0)
						answered question	21

Substance Abuse Only (continued)

Please rank the following systems in the order of their willingness to collaborate with others in substance abuse services or programs, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Courts/criminal justice	0% (0)	10% (2)	0% (0)	21
b. Adult corrections	5% (1)	5% (1)	0% (0)	21
c. Juvenile corrections	14% (3)	5% (1)	10% (2)	21
d. Child welfare	14% (3)	10% (2)	**24% (5)**	21
e. Public health	14% (3)	**19% (4)**	**19% (4)**	21
f. Mental health	19% (4)	14% (3)	0% (0)	21
			answered question	

Mental Health & Substance Abuse

Please rank the following systems in the order of their willingness to collaborate with others on mental health and substance abuse issues, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Courts/criminal justice	**24% (79)**	16% (54)	11% (37)	7% (23)	8% (25)	6% (21)	7% (24)
b. Adult corrections	9% (31)	**15% (50)**	14% (47)	9% (29)	9% (29)	7% (24)	5% (17)
c. Juvenile corrections	2% (8)	9% (31)	**17% (57)**	14% (47)	9% (31)	9% (31)	10% (33)
d. Child welfare	3% (11)	5% (15)	8% (25)	**14% (47)**	**14% (48)**	11% (38)	**14% (46)**
e. Public health	2% (6)	5% (17)	4% (14)	8% (26)	11% (36)	**16% (52)**	13% (42)
f. Mental health	**24% (80)**	10% (33)	10% (34)	12% (41)	8% (26)	11% (38)	7% (24)
g. Education	3% (9)	4% (14)	6% (19)	8% (25)	10% (34)	8% (27)	14% (48)
h. Community providers	9% (30)	**12% (40)**	11% (38)	11% (36)	10% (34)	11% (37)	11% (38)
i. Consumer/family members or advocacy organizations	**17% (57)**	13% (44)	8% (26)	9% (29)	8% (27)	10% (33)	7% (22)
j. Substance abuse	6% (21)	10% (34)	11% (35)	9% (29)	**13% (42)**	9% (31)	11% (38)
						answered question	332

Mental Health & Substance Abuse (continued)

Please rank the following systems in the order of their willingness to collaborate with others on mental health and substance abuse issues, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Courts/criminal justice	5% (15)	8% (28)	8% (26)	332
b. Adult corrections	8% (26)	11% (35)	13% (44)	332
c. Juvenile corrections	15% (50)	9% (30)	4% (14)	332
d. Child welfare	13% (42)	9% (29)	9% (31)	332
e. Public health	14% (45)	**16% (53)**	12% (41)	332
f. Mental health	6% (21)	5% (15)	6% (20)	332
			answered question	

All Survey Respondents

Please rank the following systems in the order of their willingness to collaborate with others on mental health and substance abuse issues, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Courts/criminal justice	**21% (89)**	16% (65)	11% (48)	7% (29)	7% (31)	8% (34)	6% (27)
b. Adult corrections	10% (43)	**14% (58)**	12% (52)	8% (33)	9% (36)	6% (26)	6% (26)
c. Juvenile corrections	2% (9)	9% (38)	**17% (69)**	13% (56)	10% (40)	9% (38)	10% (43)
d. Child welfare	4% (18)	6% (23)	8% (32)	14% (59)	13% (55)	11% (47)	**14% (60)**
e. Public health	1% (6)	5% (21)	4% (17)	8% (32)	12% (51)	**16% (68)**	11% (47)
f. Mental health	**26% (110)**	10% (42)	10% (42)	13% (53)	8% (35)	11% (44)	7% (28)
g. Education	2% (10)	5% (22)	6% (27)	8% (33)	11% (44)	8% (35)	15% (63)
h. Community providers	9% (37)	**14% (59)**	11% (47)	12% (50)	10% (40)	11% (45)	11% (47)
i. Consumer/family members or advocacy organizations	**17% (70)**	12% (52)	9% (39)	10% (40)	8% (35)	10% (40)	7% (28)
j. Substance abuse	6% (26)	9% (38)	11% (45)	8% (33)	12% (51)	10% (41)	12% (49)
						answered question	418

All Survey Respondents (continued)

Please rank the following systems in the order of their willingness to collaborate with others on mental health and substance abuse issues, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Courts/criminal justice	6% (23)	9% (38)	8% (34)	418
b. Adult corrections	8% (34)	12% (50)	**14% (60)**	418
c. Juvenile corrections	15% (64)	9% (37)	6% (24)	418
d. Child welfare	12% (51)	8% (32)	10% (41)	418
e. Public health	15% (62)	**16% (66)**	11% (48)	418
f. Mental health	6% (26)	4% (18)	5% (20)	418
			answered question	

Mental Health Only

Please rank the following systems in the order of their level of innovation in mental health services or programs, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Courts/criminal justice	12% (8)	12% (8)	8% (5)	14% (9)	14% (9)	5% (3)	3% (2)
b. Adult corrections	5% (3)	9% (6)	8% (5)	5% (3)	8% (5)	9% (6)	8% (5)
c. Juvenile corrections	3% (2)	5% (3)	**20% (13)**	12% (8)	8% (5)	12% (8)	6% (4)
d. Child welfare	5% (3)	12% (8)	6% (4)	11% (7)	11% (7)	5% (3)	**22% (14)**
e. Public health	2% (1)	3% (2)	5% (3)	5% (3)	**19% (12)**	**19% (12)**	11% (7)
f. Mental health	**33% (21)**	17% (11)	20% (13)	5% (3)	3% (2)	8% (5)	3% (2)
g. Education	5% (3)	11% (7)	5% (3)	9% (6)	14% (9)	9% (6)	**19% (12)**
h. Community providers	14% (9)	**16% (10)**	14% (9)	9% (6)	9% (6)	6% (4)	14% (9)
i. Consumer/family members or advocacy organizations	**19% (12)**	8% (5)	11% (7)	14% (9)	6% (4)	14% (9)	3% (2)
j. Substance abuse	3% (2)	6% (4)	3% (2)	16% (10)	8% (5)	12% (8)	11% (7)
						answered question	64

Mental Health Only (continued)

Please rank the following systems in the order of their level of innovation in mental health services or programs, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Courts/criminal justice	3% (2)	12% (8)	**16% (10)**	64
b. Adult corrections	12% (8)	16% (10)	**20% (13)**	64
c. Juvenile corrections	**20% (13)**	8% (5)	5% (3)	64
d. Child welfare	9% (6)	11% (7)	8% (5)	64
e. Public health	14% (9)	14% (9)	9% (6)	64
f. Mental health	8% (5)	2% (1)	2% (1)	64
			answered question	

Substance Abuse Only

Please rank the following systems in the order of their level of innovation in substance abuse services or programs, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Courts/criminal justice	**33% (7)**	24% (5)	10% (2)	10% (2)	14% (3)	0% (0)	0% (0)
b. Adult corrections	**43% (9)**	24% (5)	10% (2)	0% (0)	10% (2)	5% (1)	0% (0)
c. Juvenile corrections	0% (0)	19% (4)	**29% (6)**	5% (1)	5% (1)	5% (1)	14% (3)
d. Child welfare	0% (0)	0% (0)	5% (1)	**19% (4)**	5% (1)	**19% (4)**	10% (2)
e. Public health	0% (0)	5% (1)	5% (1)	0% (0)	14% (3)	10% (2)	**19% (4)**
f. Mental health	0% (0)	5% (1)	5% (1)	**24% (5)**	5% (1)	19% (4)	14% (3)
g. Education	0% (0)	0% (0)	5% (1)	5% (1)	19% (4)	14% (3)	**24% (5)**
h. Community providers	10% (2)	**14% (3)**	10% (2)	**14% (3)**	**14% (3)**	**14% (3)**	5% (1)
i. Consumer/family members or advocacy organizations	0% (0)	5% (1)	10% (2)	10% (2)	10% (2)	5% (1)	0% (0)
j. Substance abuse	14% (3)	5% (1)	14% (3)	14% (3)	5% (1)	10% (2)	14% (3)
						answered question	21

Substance Abuse Only (continued)

Please rank the following systems in the order of their level of innovation in substance abuse services or programs, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Courts/criminal justice	0% (0)	5% (1)	5% (1)	21
b. Adult corrections	10% (2)	0% (0)	0% (0)	21
c. Juvenile corrections	0% (0)	10% (2)	14% (3)	21
d. Child welfare	14% (3)	10% (2)	**19% (4)**	21
e. Public health	14% (3)	**19% (4)**	14% (3)	21
f. Mental health	**24% (5)**			
			answered question	

Mental Health & Substance Abuse

Please rank the following systems in the order of their level of innovation in mental health and substance abuse services or programs, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Courts/criminal justice	**37% (121)**	14% (46)	12% (40)	6% (20)	5% (16)	4% (13)	4% (14)
b. Adult corrections	5% (18)	**18% (60)**	14% (46)	11% (35)	5% (17)	7% (24)	8% (25)
c. Juvenile corrections	5% (17)	9% (29)	**18% (58)**	10% (33)	12% (38)	10% (32)	10% (34)
d. Child welfare	2% (5)	4% (14)	4% (14)	11% (36)	12% (41)	12% (40)	**18% (59)**
e. Public health	1% (2)	3% (10)	5% (16)	6% (20)	10% (32)	15% (51)	**16% (52)**
f. Mental health	**22% (73)**	13% (43)	8% (28)	14% (46)	10% (34)	9% (31)	8% (27)
g. Education	3% (9)	4% (14)	6% (21)	8% (26)	12% (39)	10% (32)	12% (39)
h. Community providers	8% (25)	12% (41)	10% (33)	**13% (44)**	11% (36)	12% (41)	8% (27)
i. Consumer/family members or advocacy organizations	10% (33)	12% (38)	10% (32)	9% (29)	12% (40)	8% (27)	10% (32)
j. Substance abuse	8% (27)	11% (35)	**13% (42)**	12% (41)	11% (37)	12% (39)	6% (21)
						answered question	330

Mental Health & Substance Abuse (continued)

Please rank the following systems in the order of their level of innovation in mental health and substance abuse services or programs, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Courts/criminal justice	6% (20)	3% (11)	9% (29)	330
b. Adult corrections	8% (28)	12% (40)	11% (37)	330
c. Juvenile corrections	11% (37)	12% (39)	4% (13)	330
d. Child welfare	15% (48)	11% (37)	11% (36)	330
e. Public health	13% (43)	**16% (53)**	15% (51)	330
			answered question	

All Survey Respondents

Please rank the following systems in the order of their level of innovation in mental health and substance abuse services or programs, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	Highest (1)	2	3	4	5	6	7
a. Courts/criminal justice	**33% (136)**	14% (59)	11% (47)	7% (31)	7% (28)	4% (16)	4% (16)
b. Adult corrections	7% (30)	**17% (71)**	13% (53)	9% (38)	6% (24)	7% (31)	7% (30)
c. Juvenile corrections	5% (19)	9% (36)	**19% (77)**	10% (42)	11% (44)	10% (41)	10% (41)
d. Child welfare	2% (8)	5% (22)	5% (19)	11% (47)	12% (49)	11% (47)	**18% (75)**
e. Public health	1% (3)	3% (13)	5% (20)	6% (23)	11% (47)	**16% (65)**	15% (63)
f. Mental health	**23% (94)**	13% (55)	10% (42)	13% (54)	9% (37)	10% (40)	8% (32)
g. Education	3% (12)	5% (21)	6% (25)	8% (33)	13% (52)	10% (41)	13% (56)
h. Community providers	9% (36)	**13% (54)**	11% (44)	**13% (53)**	11% (45)	12% (48)	9% (37)
i. Consumer/family members or advocacy organizations	11% (45)	11% (44)	10% (41)	10% (40)	11% (46)	9% (37)	8% (34)
j. Substance abuse	8% (32)	10% (40)	11% (47)	**13% (54)**	10% (43)	12% (49)	7% (31)
						answered question	415

All Survey Respondents (continued)

Please rank the following systems in the order of their level of innovation in mental health and substance abuse services or programs, with one (1) being the highest priority: *Please Note: There can be only one check mark in each row ***AND* in each column.**

Answer Options	8	9	Lowest (10)	Response Count
a. Courts/criminal justice	5% (22)	5% (20)	10% (40)	415
b. Adult corrections	9% (38)	12% (50)	12% (50)	415
c. Juvenile corrections	12% (50)	11% (46)	5% (19)	415
d. Child welfare	14% (57)	11% (46)	11% (45)	415
e. Public health	13% (55)	**16% (66)**	14% (60)	415
			answered question	

Appendix B. Mental Health Professional Shortage Areas

Mental Health Professional Shortage Areas (MHPSA)[1]

Ada	Butte	Gem	Minidoka
Adams	Camas	Gooding	Nez Perce
Bannock	Canyon	Idaho	Oneida
Bear Lake	Caribou	Jefferson	Owyhee
Benewah	Cassia	Jerome	Payette
Bingham	Clark	Kootenai	Power
Blaine	Clearwater	Latah	Shoshone
Boise	Custer	Lemhi	Teton
Bonner	Elmore	Lewis	Twin Falls
Bonneville	Franklin	Lincoln	Valley
Boundary	Fremont	Madison	Washington

Mental Health Region I	Benewah, Bonner, Boundary, Kootenai, Shoshone
Mental Health Region II	Clearwater, Idaho, Latah, Lewis, Nez Perce
Catchment Area #3	Adams, Canyon, Gem, Owyhee, Payette, Washington
Mental Health Region IV	Ada, Boise, Elmore, Valley
Mental Health Region V	Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, Twin Falls
Mental Health Region VI	Adams, Bear, Bingham, Caribou, Franklin, Oneida, Power
Mental Health Region VII	Bonneville, Butte, Clark, Custer, Fremont, Jefferson, Lemhi, Madison, Teton

Council Community Rural Health	Adams County
Pocatellos Health West	Bannock County
Coeur D'Alene Tribe	Benewah County
Boundary Regional Community Health Center	Boundary County
Terry Reilly Community Health Center	Canyon County
Idaho Migrant Council	Canyon County
Glenns Ferry Health Center	Elmore County
Dirne Community Health Clinic	Kootenai County
Valley Family Health Care	Payette County
Family Health Services	Twin Falls County
State Hospital South	*Bingham County*

1 http://hpsafind.hrsa.gov/HPSASearch.aspx

Appendix C. National Adult and Child/Family Consumer Survey Data

Adult and Child/Family Consumer Survey Data
(2006 CMHS Uniform Reporting System Data – Output Tables)

	Idaho Rate	West Rate	US Rate
Adult Consumer Survey Measures			
Positive about Access	85%	85%	85%
Positive about Quality and Appropriateness	83%	86%	87%
Positive about Outcomes	68%	69%	71%
Positive on Participation in Treatment Planning	73%	86%	82%
Positive General Satisfaction with Services	91%	88%	88%
Child/Family Consumer Survey Measures			
Positive about Access	78%	85%	83%
Positive about Outcomes	56%	64%	73%
Positive on Participation in Treatment Planning	81%	88%	87%
Positive General Satisfaction with Services	70%	85%	81%
Positive Cultural Sensitivity with Providers	87%	95%	91%

NR = Not Reported

In 2006, 51 states and territories submitted adult and child/family consumer survey data to the Center for Mental Health Services (CMHS) as part of the CMHS Uniform Reporting System. The measures identified above are based on specified groupings of survey items that are combined for national reporting of the identified measures.

Idaho's data for the Adult Survey is very similar to that of the Western and US rates, except for the measure for Participation in Treatment Planning, which is 73% of Idaho compared with 86% for the Western States and 82% for the US. This data suggests an opportunity for the adult regional behavioral health staff to more actively engage consumers in the development of their treatment plans and goals.

Idaho's Child/Family Consumer Survey results are lower than those of the Western States and US for all five (5) measures. This indicates a clear difference in the perception of services for children when compared with adults in Idaho, a difference which is not noticeable cross the Western States or US.

Appendix D. Project Fact Sheet

3035 Center Green Drive
Boulder, CO 80301
303.541.0311
Fax 303.541.0291
http://www.wiche.edu/mentalhealth

Idaho Mental Health and Substance Abuse System Redesign/'Transformation'
***"Supporting Behavioral Health System Improvement for Idaho"* (SCR 108)**
Fact Sheet

The Legislature of the State of Idaho passed Senate CR Number 108 in 2007, implementing a review of Idaho's current mental health and substance abuse treatment delivery system, and the development of recommendations to improve the system. The legislative Health Care Task Force is the oversight body for the study, and is responsible to reporting back to the legislature on this project.

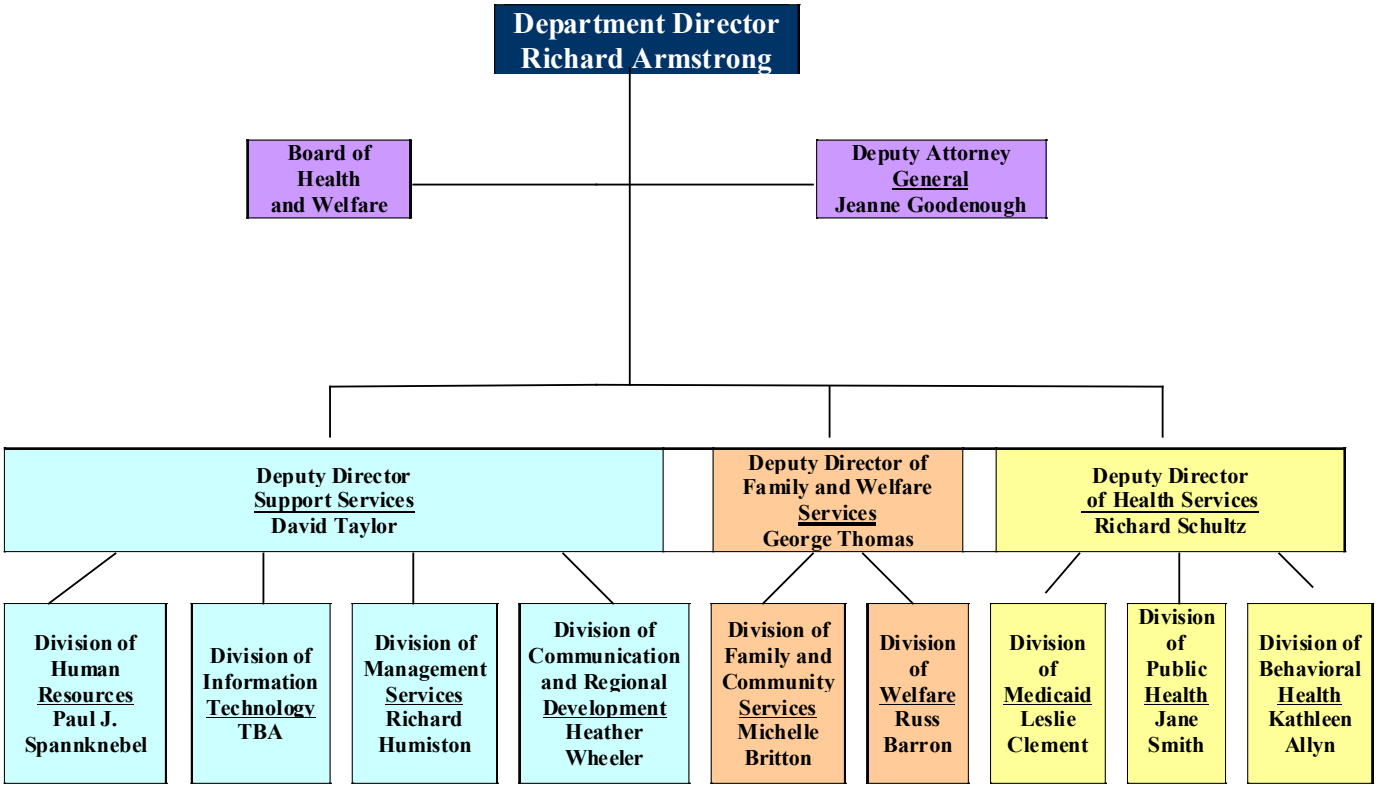
The legislature's intent to provide a comprehensive review of the public behavioral health system is indicative of an evolving understanding among public policy makers that the current mental health and substance abuse systems are falling short in their ability to effectively meet the needs of adults, children and their families. This effort offers Idaho the opportunity to promote the transformation of its behavioral health system to enhance its ability to meet the needs of Idaho residents with behavioral health care needs.
The Western Interstate Commission for Higher Education's (WICHE) Mental Health Program will complete this project. Founded in 1953, WICHE is a collaborative Interstate Compact with 15 western states, and a regional governmental entity. The WICHE Mental Health Program is one of the oldest WICHE programs, having been established in 1955. Idaho was a founding member of the WICHE Interstate Compact.
The WICHE Mental Health Program will utilize a multi-component process of technical assistance to the legislative Health Care Task Force. This process will include meetings in Idaho with key stakeholders, and dissemination of a web based survey to all identified stakeholders. Throughout this process, we will provide comparisons with other similar western states in the individual target issue areas. Using a coordinated approach with the legislative Task Force and others, we will review, assess and recommend appropriate changes in the following issue areas:

1. Management structure;
2. Existing efforts of system integration and transformation;
3. Delivery systems, including access to services and system capacity, for adults and children;
4. State hospital and forensic mental health bed needs and capacity;
5. Data systems and information sharing; and,
6. Financing.

WICHE will draft and present a final report, which will include any recommendations for change. Please feel free to contact WICHE with any questions that you may have. We thank you in advance for your assistance with this project, and we look forward to hearing from, and meeting with, you.

Appendix E. Department of Health and Welfare Organizational Chart

Idaho Department of Health and Welfare Organizational Chart—February, 2008



Appendix F. Gains Sequential Intercepts Model