Idaho Mental Health Coalition

Introduction & Members

Introduction to the Idaho Mental Health Coalition

The Idaho Mental Health Coalition first came together in 2004, under the direction of the Idaho Department of Correction with an endorsement from the Governor's Office and a grant from the National Institute of Corrections.

The coalition is formed of many diverse stakeholders that include lawmakers, Governor's Office representatives, state agencies, county agencies, advocacy and community groups and representatives from the Criminal Justice Arena.

Idaho was the first state in the nation to create a broad-based coalition consisting of public agencies and private citizens.

One of the Coalition's first actions was to identify mental health resources statewide. The result of that work is the Idaho Mental Health Resource Guide, the first statewide comprehensive directory of its kind.

Our Mission

Create a continuum of care between communities and the criminal justice system to manage mental health treatment for offenders and positively impact community safety.

Our Vision

We will create a continuum of care for mental health offenders so effective that it reduces the need for incarceration, increases the probability of restorative living for those impacted and enhances community safety.

Members of the Idaho Mental Health Coalition

Idaho Department of Correction
Ada County 4th Judicial District
Ada County Adult Misdemeanor Probation
Ada County Sheriff's Office
Boise State University
Canyon County Juvenile Detention Center
The Commission for Pardons & Parole
Comprehensive Advocacy
Correctional Medical Services
Division of Financial Management
Division of Vocational Rehabilitation
Family Court Services
Friends & Families of Idaho Inmates
Healthy Families-Nampa Project
Idaho 7th Judicial District
Idaho Academy of Family Physicians
Idaho Association of Counties
Members of the Idaho Legislature
Idaho Department of Health & Welfare
Idaho Department of Juvenile Corrections
Idaho Hospital Association
Idaho POST Academy
Idaho Sheriff's Association
Idaho State University
Idaho Supreme Court
Legislative Services Office
National Alliance for the Mentally Ill
Office of the Attorney General
Office of Consumer Affairs
Office of the Governor
Other Community Members

Idaho Mental Health Coalition

Creating a continuum of care between communities and the criminal justice system to manage mental health treatment for offenders and positively impact community safety.

The Numbers

- More than **54 million** Americans will suffer from a mental health disorder during the course of a year, fewer than **eight million** will seek treatment.
- **2,187** inmates, **30%** of the inmate population, are designated as having some type of **mental health issue**
- **251** are designated as **mentally ill** with **special needs**.

The Cost

- Mental Health has an indirect cost estimated at **$79 Billion** each year in the United States.
- The **cost** of treating **mental health offenders** represents about **one tenth** of the Department of Correction health care contract cost.
- Based on first quarter costs, the IDOC anticipates **spending $1.5 million dollars** on mental health care this year, strictly in **medical contract costs**.

The Coalition

- The **Coalition** is made up of more than **75 individuals** representing **various interests** and **agencies**.
- Coalition efforts **focus on bridging gaps** for offenders with mental health issues.

Key Efforts

- The ***Mental Health Resource Guide*** is now available at **corrections.state.id.us**.
- First ever **Mental Health Conference** is being held June 9th-10th, 2006 in Boise, Idaho.
- 2006 Legislation: House Bill 430 became **law** in 2006. HB430 permits the **sharing of medical records** between agencies to help manage needs more quickly.

For more information on the Mental Health Coalition or the Idaho Department of Correction, Please visit: corrections.state.id.us

05/24/06

Idaho Mental Health Coalition

on the web corrections.state.id.us.us/mentalhealth/mentalhealth.hml

Idaho is pioneering an effort to bridge gaps in mental health care for offenders.

The Gem State is the first in the nation to create a broad based Mental Health Coalition consisting of public agencies and private citizens.

The Problem

Prisons became de facto mental health hospitals due to public policy shifts since 1955. Most state mental hospitals closed and community care became the standard. Deinstitutionalization worked for some, but many ended up in the criminal justice system.

The Data

United

- **16%** of adults incarcerated in jails and prisons have a mental illness
- Over **150,000 juveniles involved in the justice system** have at least one mental health issue
- Mental health has an indirect cost estimated at **$79 billion** each year in the United States

Idaho

- **26%** of inmates housed in Idaho's adult prisons have a mental illness
- **44%** of all **Idaho juvenile** offenders managed by juvenile corrections have a mental health issue
- **Mental health costs** the Idaho Department of Correction more than **$1.5 million** each year

Coalition Work

The Idaho Mental Health Coalition is about removing barriers and bridging gaps between community and criminal justice partners. It has already made progress in these areas.

Information
Coalition partners recommended a statute to allow the sharing of medical information. This statute became law in 2006.

Resources
A statewide mental health resource guide is now available on the website.

Education
The coalition is hosting a conference for June 9 and 10th titled "Idaho's Mental Health Transformation: It's a Community Issue."

The goal is to make Idaho communities more safe.

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TRANSFORMING OUR COMMUNITIES
REGIONAL DISCUSSION RESULTS
JUNE 10, 2006

The following pages are a verbatim transcription of the flip chart notes maintained by regional breakout groups at the Transformation Conference whose task was to

1. Identify those challenges that need to be addressed to move from a crisis intervention to a recovery model
2. Articulate a draft vision statement (by region) that reflects what transformation would like once achieved
3. Via a prioritization process, identify those three challenges that most need to be addressed to achieve this vision, and
4. Brainstorm concepts and methods for addressing those challenges.

This material is intended for use and review by the Transformation Work Group – a group of agencies and stakeholders tasked to collaboratively develop a draft Comprehensive Statewide Mental Health Action Plan, as well as any others who will find the information helpful.

Participants were available to generate at least one group to discuss that region's challenges and generate a draft vision. In Region 4 there were enough participants to generate 4 (four) different groups, and from Region 5 (five) there were enough participants to generate 2 (two) different groups.

Group results are found on the following pages as indicated:

REGION	PAGE
Region 1	2
Region 2	4
Region 3	7
Region 4 (1 of 2)	9
Region 4 (2 of 2)	11
Region 4 (3 of 2)	13
Region 4 (4 of 2)	15
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Region 5 (1 of 2)	18
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Region 7	21

REGION 1

DRAFT VISION

- System of care based o the philosophy and principles of recovery and prevention from the top down for both children and adults with collaborative funding streams.
    - This involves:
        - Team decision making through consensus
        - Best practice / best science
        - Involving all participants
    - This needs:
        - All the necessary resources from professionals through community networks, from housing to medications
        - This would result in all consumers knowing where to go to access what they need when they need it
- Mental health care must become an essential part of a National Heath Care System

TOP 3 PRIORITIES

1. Need commitment to prevention and recovery for children and adults / top down
    a. policies developed, written, including recovery
    b. Governor commitment
    c. Collaborative funding streams
    d. Resources put to it – funding practices that support recover, prevention identify
    e. Funding the individual resources needs to make recovery possible

2. In depth education
    a. Start in schools with anti stigma
    b. Use peer support specialists – all ages, all circumstances
    c. Anti-stigma throughout community
    d. Each agency education others about what they do
    e. Sharing recovery resources so that anyone can access easily
    f. All agencies make a commitment to incorporating the message of hope and recover
    g. Education is working together / where education occurs
    h. Any operations meetings

3. Communities' investment
    a. Involve communities partners in operational meetings
    b. Media / education / stories
    c. Ministerial / faith-based
    d. Speakers' bureau, resource location, local website?

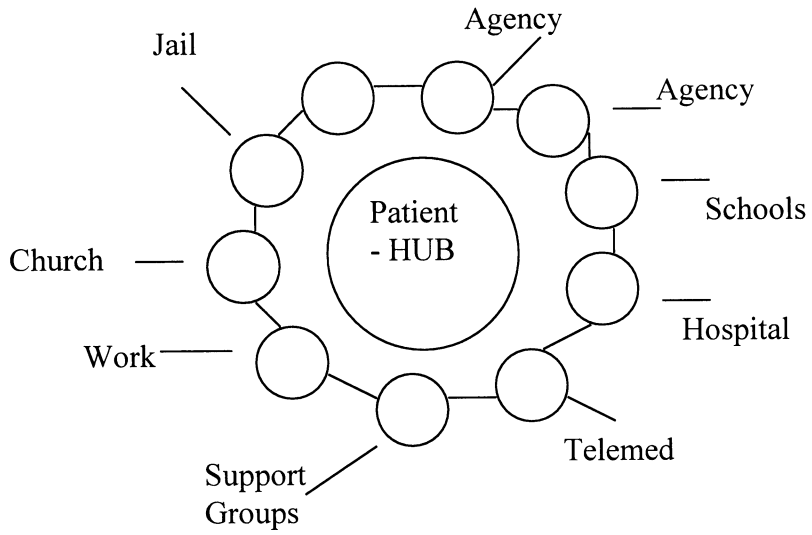
CHALLENGES (from crisis to recovery)

1. Link to communications (jail to treatment provider)
2. Financial coverage for recovery / treatment *(3 points)*
3. Transformation efforts start with children's needs rather than adults
4. Lack of resources and coordination *(3 points)*
5. need list of available mental health resources
6. Need to identify who is first contact
7. Need commitment to principles of recovery from top down for both children and adults *(24 points)*
8. Need a consistent evaluation (and process?) source in community
9. Coordination among legal profession, judiciary, corrections and treatment
10. Stigma – barrier to accessing treatment
11. Eliminating polarization between agencies (need to work cross settings)
12. Turf issues between agencies, community organizations, and special interests
13. Need resources (treatment/intervention) in schools
14. Recovery systems for co-occurring disorders
15. No regional control over budgets in state agencies
16. Medicaid eligibility issues (loss of Medicaid and loss of treatment/Medicaid for example when in jail) – Medicaid should follow person
17. Need collaborative funding streams – elimination of conflict between funding resources *(1 point)*
18. Need affordable housing
19. Need transportation
20. Need Mental Health / Drug Court for misdemeanor offenders
21. Communities need to be invested in solutions to problems – how to help communities accept their responsibilities *(8 points)*
22. Need for more in-depth education of community partners *(9 points)*
23. More involvement with legislature (local to state) *(5 points)*

REGION 2

DRAFT VISION

Comprehensive rural model implementing a HUB approach that promotes acceptance, accountability and access to services focused on early identification and intervention and recovery



Draft Vision Inputs

- Comprehensive rural model for service delivery
- Any door to receive services
- ER/ physician/ DHW
- Mental Health same as physical health
- Access to services
- "Medical Home" – school / clients / hospital
- Arrow points in
- Telemedicine
- Acceptance by community of recovery
- Interdisciplinary Training
- In the school
- Screening
- Pt. accountability
- Navigation
- Practical education
- Early learning / acceptance Dieticians
- Perceptions
    - Recovery – manipulation – balance
    - Preconceived – DHW is supposed to help.

- Stigma – problem person put THEM over there
- Hopeless – no cure –everyone belongs in State Hospital
- Behavior implies problem in person or choice
- Decision-makers – mental health issues are vote killers – other challenges fall into this

TOP 3 PRIORITIES

1. Funding
    a. Insurance parity – unified fund source
    b. Single stream – peer support
    c. Use vision statement – early intervention
    d. Grant money – non duplication of services, community of recovery, volunteers
    e. Existing
    f. Natural
    g. Collaboration to improve care, service organizations

2. Perceptions
    a. Early intervention / education paradigm shift / recovery model
    b. School system – expand to adults at risk
    c. Superstore – models (people successes)
    d. Collaboration – who's problem
    e. Service clubs, parent to parent, personal investment/involvement
    f. PTA, Church, Community meetings

3. Fragmentation
    a. Doesn't matter where they come in
    b. First appointment essential
    c. Interdisciplinary training
    d. Part of job – roadmap – generalist
    e. Identifying services in communities that are available – telemedicine

CHALLENGES

- Perceptions *(20 points)*
- Community Communications (stakeholder)
- Collaboration *(5 points)*
- Educational Outreach
- Transit treatment Plan – follow-through *(1 point)*
- Funding streams – legislation *(27 points)*
- Staff / facilities/ professionals
- Target population – rigidity --too narrow
- Transportation

- Sharing information
- System flexibility *(5 points)*
- Client participation *(9 points)*
- Access to Rx
- Understanding recovery
- Integration with health system *(1 point)*
- Rural Issues – where services to meet the need – what's OK?
- Telemedicine
- Transitional Respite beds
- Housing
- Forensic unit
- Gender differences
- Sex offenders
- Evidence based vs "new"
- More connect with outside correction – transitional fair
- Insurance
- Stigma
- Local control and accountability
- Understanding what each agency does
- Boxes of fragmentations difficult for recovery *(19 points)*
- Duplication of services
- Acceptance of bad decision
- Early identification
- Accessing services – SI
- Resource identification – one stop!
- Co – occurring disorders – MI/CD
- Continuity of Care *(14 points)*

REGION 3

DRAFT VISION

- To remove stigma and make mental health part of the continuum of health care system
- An integrated community-based health system . . . in which there is
    - Specialized training for all
    - Continuity
    - Equal access
    - Parents' resource / parents have voice
    - Entities communicate access and resources for education

TOP 3 PRIORITIES

1. Continuity of Care
    a. Centralized location and coordinated system – agency
    b. Identified community public health care system
    c. Inclusionary system – trying to figure out what they need vs. excluding them
    d. Accountability and consistency – participant, system, family of the participant / patient
    e. Education / buy in – early intervention, less expensive – cost and family and community

2. Consistency (community and follow-through)
    a. Health record / data base available to:
        i. Police department/ corrections
        ii. Health & Welfare
        iii. Schools
        iv. Parents
    b. All parties involved
        i. Plans
        ii. Responsibilities

3. Education
    a. Community
        i. Schools (teachers and students)
        ii. Parents
        iii. Law enforcement (and judges and prosecutors)
    b. Resources
        i. Directory (cards)
        ii. Interpreter
        iii. Hot lines
        iv. Counselors

4. Advertising
    a. Papers
    b. TV commercials
    c. Billboards

5. Doctors
    a. Mental Health issues
    b. Resources for referrals

CHALLENGES

- Consistency – communication, follow – through *(16 points, #2)*
- Continuity of care – schools resources *(25 points, #1)*
- Education – what level for physicians, law enforcement, patients *(10 points, #3)*
- Access to care (resource list), availability *(4 points, #4)*
- Education – law enforcement, judges *(3 points)*
- Money / funding (insurance) *(2 points)*
- Prevention – self esteem *(2 points)*
- Awareness
- Family support , resource list
- Language barrier
- H&W role, state hospital, prison connection
- Crisis beds (sheriff take to Twin Falls, costs associated, time associated) (1 point)

REGION 4.1 OF 4

DRAFT VISION

Every community fully provides access to health care services to include a continuum of integrated mental health services. These quality recovery-oriented services will be individualized to meet the needs and to utilize the strengths of the patient and community.

TOP 3 PRIORITIES

1. Communication, role definition and leadership within and across systems
   a. HW state authority / state agency who develops state-wide mental health programs (where mental health is solve focus)
   b. Advocacy at state level
   c. Accountability, credentialing, QI / data collection and analysis
   d. Staff issues – higher educational programs developing adequate workforce? Incentive program
   e. Joint trainings to facilitate communications, understanding o roles / responsibilities in other agencies

2. Resources
   a. Responsible use of current resources
   b. More efficient use of current resources
   c. Appropriate compensation to reduce costly turnover
   d. Incentives (scholarships, grants, etc., to draw more quality service providers)
   e. Legislative and other policy makers support
   f. Community supports
   g. Housing, jobs, skilled care

3. System Design
   a. Discharge / transition planning
   b. Move from a crisis management model to a prevention and recovery model
   c. Include mental health providers at family practice location
   d. Statewide mental health program which aids in coordination and collaboration
   e. Utilize technology to improve care coordination
   f. QI -- - needs assessment, identify and remove barriers

CHALLENGES

- Communication, role definition, leadership within and across systems*(36 points #1)*
- Contact person, referral process (standardized), accountability, educate/train staff in these areas
- Look for existing state systems that are achieving recovery and use as basis.
- Resources *(27 points #2)*

- Staff, money, physical plant, uninsured patients, transitionary care unit, communicate incentives to facilitate recovery model
- Training and education *(2 points)*
- Community, patients, support, legislators, improve diagnosis abilities
- System design *(21 points, #3)*
- Access issues, e.g. 2 forms of id
- Discharge planning at all levels especially corrections
- Continuity of care
- Coordination of efforts of providers/ agencies
- Need VISION – long term plan with long term funding with quarterly assessment for funding accountability
- Plan to decrease staffing turnover
- Accountability *(3 points)*
- Incentives to increase medical compliance

REGION 4.2 OF 4

DRAFT VISION

A transformed system would include:

- Political understanding and support of transformation objectives
- Adequate resources including qualified mental health professionals, funding facilities, support services
- Continuum of care accessible to all including quality assurance, early identification and intervention, comprehensive approach to dual diagnosis
- Educate public to view mental health as part of general health
- Focus on strengths of individuals and families
- Seamless coordination among public and private entities

TOP 3 PRIORITIES

1. Political consensus
    a. Educate elected officials at all levels
    b. Explanation of New Freedom Commission
    c. Educate public
    d. Direct contact – joint presentation / voice
    e. Grass roots – NAMA, Fed of families, Health Care Task Force – MHTCH
    f. Professional organizations
    g. Personal stories
    h. Reinforce "positive strokes" for policy changes moving in "right" direction

2. Continuum of care with adequate resources accessible to all
    a. Gap analysis
    b. Set priorities
    c. Develop plan / regional plants (TWG, etc.)
    d. Collaborative groups
    e. Identify WHO (public, private, faith based, consumers and family)

3. Implement with adequate funding (refer to #1) grants and private, faith based, other resources, reallocation, in kind, etc.

CHALLENGES

- Sufficient staff – psychiatrist
- Program Space
- Comprehensive identification guidelines of services
- Preventative / intervention vs. crisis
- Need for continuum of mental health services *(7 points #2.a.)*
- Teach coping skills
- Services continue into community

- Communication of between agencies
- More resources allocated to "front end" – early identification and treatment in community *(7 points #2.b.)*
- Adequate funding
- Strengths perspective
- How to address mental health issues related to meth use
- Proper diagnosis
- Understanding / education
- Best treatment practices
- Training & Education Cross training *(40 points #1)*
- Political consensus of moving towards recovery – reallocation towards treatment vs. protection
- Resistance to change of systems
- Stigma – mental illness *(3 points)*
- Implementation plan *(1 point)*
- Addressing minority issues
- School curriculum to address suicide prevention, substance abuse, mental health
- Rural resources *(1 point)*
- Understand consequences – taxpayers *(3 points)*
- Compensation for services
- Respite care

REGION 4.3 OF 4

DRAFT VISION

The new system will provide:

- Early detection, awareness, prevention unfettered access
- Good mental hospital (not just warehouse)
- Comprehensive, integrated
- Cooperative and collaborative
- Adequate funding
- Involve families at all points
- Still ensure public safety
- Provides prenatal and perinatal health care
- Speeds up science to proactive
- Acknowledges spiritual component
- Provides for geriatric populations

TOP 3 PRIORITIES

1. Access to services
    a. Technology applications (vides to be healthy)
    b. Utilization of NP, PA
    c. Public awareness of services
2. Communication of information / concerns to legislature / policy makers / community
    a. Marketing strategies
        i. 3 tiers: public awareness, gatekeepers (thought leaders), policy makers
3. Secure mental health facility

CHALLENGES

- Stakeholder commitment
- Access to services *(21 points)*
- Payment for services *(5 points)*
- Increase community care resources
- Lack of funding for QMHP (*5 points)*
- Lack of fluidity from institutions – communications *(3 points)*
- Change model from disease to recovery *(2 points)*
- Reduction of mental health stigma
- Physical plant
- Shifting culture (us—them)
- Whole picture / global view
- Medication costs *(1 point)*
- Medication availability *(3 points)*
- Record sharing *(1 point)*

- Adequate training non medical personnel (teachers, coaches, law enforcement, courts, etc.) *(7 points)*
- Need to integration of medical and mental health models
- Institutionalized funding streams *(3 points)*
- Increase multi-cultural competencies *(32 points)*
- Ongoing assessment
- Patient/client non compliance issues
- Money focused emergent / urgent care
- Secure mental health facility *(9 points)*
- Communication of information / concerns to legislators / policy makers / community? *(15 points)*
- Education of media *(1 point)*

DISCUSSION

- Find research from comparable states
- Determine cost savings (including law suites)
- Determine potential demographics, numbers profiles
- Look at potential funding sources
- Find location, deal with local resistance
- Find suitable workforce
- Release plans linked to community resources
- NGBR1 – reinstates that defense
- Uses public health model
- All modalities of treatment including non-traditional
- Provides case management
- Segregates child abusers culturally and gender and age inclusive
- Recovery-oriented
- Provides continuum of care
- Treated as per physical illnesses
- Evidence-based, outcome-oriented
- Trains primary health care providers
- Consumer and family driven
- Makes treatment affordable without regard to income
- Educate the public
- Balances best practices with local values and concerns
- Individualized plans of care
- Encouraged teamwork
- Uses technology (telehealth)

REGION 4.4 OF 4

DRAFT VISION

Individuals with mental illness promptly, uniformly and effectively receive appropriate services regardless of their location and need with the full understanding and support of the community. Services and resources are coordinated and defectively delivered by a team of providers who focus on prevention and recovery in a continuum of care.

TOP 3 PRIORITIES

1. One stop shopping – case manager follows
    a. Stakeholders plan provides regional consensus
    b. Research cost / determine needs

2. Money follows people – people follow need

3. Educate: public schools, colleges, CEUs/ PC respect
    a. Implement grants

CHALLENGES

1. Money available – funding *(16 points #2)*
2. Housing available
3. Available employment
4. Consensus of stakeholder
5. Common goals / separate paths
6. Proper mental health client in DOC facility / aftercare
7. Human element / change willingness
8. Systems rigidity *(3 points)*
9. Communication of system *(2 points)*
10. Understanding culture / hope / philosophy of recovery *(6 points #3)*
11. Money to prevent and early treatment (*32 points #2)*
12. Professional staff shortage – rural
13. Duplication of services
14. Inconsistent criteria
15. Multiple / absence with delegation
16. Court resources – turf issues *(1 point)*
17. Lack of public knowledge, lack of client knowledge
18. Training (ancillary staff) – IDOPC, first responders
19. Mental health in prison – to recovery
20. Equal and universal access to mental health care *(41 points #1)*
21. Stakeholder inputs (clients)

REGION 5.1 OF 1

DRAFT VISION

- All people are educated about and understand mental health and its significance, including school programs, corrections, Medicaid, etc.,
- Mental health is seen as a health issue, the same as diabetes, heart disease, cancer, etc.
- Affordable access to more mental health providers and treatment centers
- Consistent, coordinated and standardized care
- A pro-active holistic approach is the norm
- Identify an ACTION plan and delivery

TOP 3 PRIORITIES

1. Difficult accessing affordable treatment and meds
    a. Establish a community campaign to educate community leaders, generate interest
    b. Work with coalition to develop legislation to increase funding and access to mental health care, identify coalition to sponsor
    c. Private/public partnership to bring mental health care providers into primary care settings (modeled after "vaccines for children" program)

2. Public awareness of programs and issues
    a. End state's moratorium on health and welfare advertising (PSAs) – PSAs about stigma/ prominent community members
        i. Make clinicians available – use EPA model – materials available as well

3. Continuum of care for parolees, etc. and warehousing of mentally ill by law enforcement
    a. Early assessment of mental health aftercare program
        i. Affordable housing
        ii. Medication
        iii. Job placement
        iv. Education

CHALLENGES

- Difficulty accessing affordable treatments and medications *(16 points #1)*
- Public awareness of programs and issues – stigma and stereotypes *(15 points #2)*
- State's moratorium on DHW advertising services (PSAs) *(10 points #3)*
- Continuum of care for parolees, etc. *(6 points)*
- Shortage of professionals
- Integrating mental health and primary care *(6 points)*
- Warehousing of mentally ill by law enforcement *(3 points)*
- Difficult screening in schools (and awareness, treatment

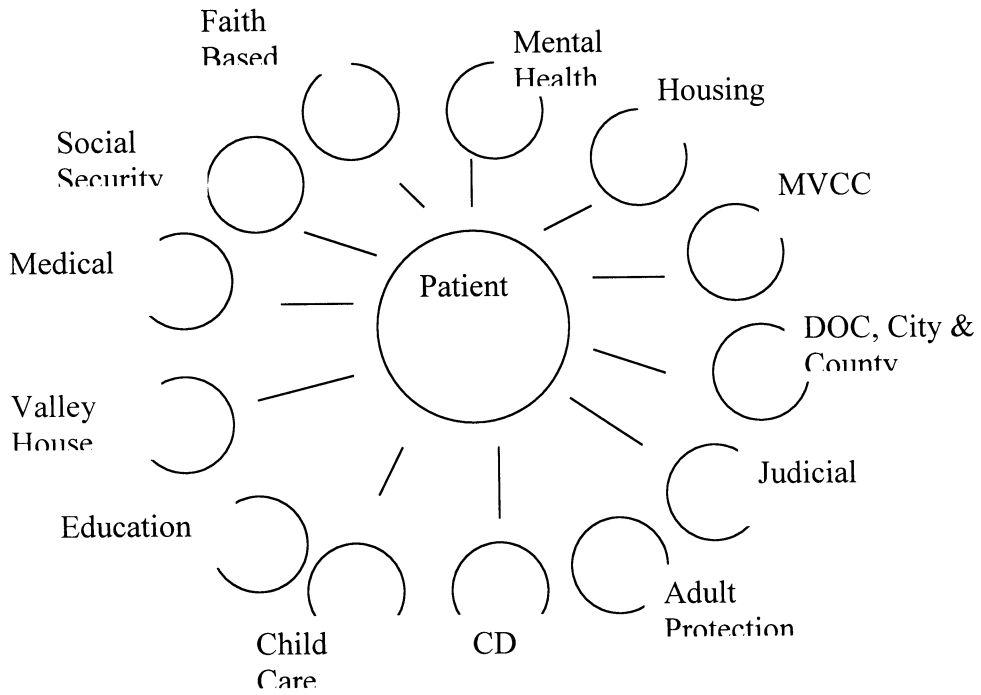
- Lack of after-school programs for high risk kids
- Lack of quality care, standard practices *(6 points)*
- Educate community leaders (combine with public awareness)
- Integrate public and private services
- Lack of training for care providers (traditional and non-traditional)
- Lack of integration of social supports (combine with warehousing of mentally ill)

REGION 5.2 OF 2

DRAFT VISION

Magic Valley community's wellness partnerships provide coordination of care and access to services to meet the needs of the individual for comprehensive wellness, insuring the continuing success of healthy, caring communities

Region V – solution focus
Multi-disciplinary – community based advocacy group



Living in the solution: Region V
Surround system of every door open support

TOP 3 PRIORITIES

1. Communication
   a. Resource guide updates Region V mental health Board
   b. Protocol for response relationship
   c. Funding
   d. For protocol
   e. Contact point – case management
   f. Office –24 hour line (4357 help)

g. Advertise marketer to providers and individuals
h. Proactive – follow-up discharge plan

CHALLENGES

- Involve family
- Involve education
- Involve county, jails
- Involve county commissioners
- Qualified professionals – diagnosis
- Multi-cultural understanding
- Communication – interagency multidisciplinary team *(28 points #1)*
- Community – meth (*4 points)*
- Programs available
- Monday – assistance accesses, advocates
- Resources *(11 points #2)*
- Transportation
- Housing

REGION 6

DRAFT VISION

A seamless system in each Idaho community that allows the individual and families affected by mental illness to access the mental health help that they need – and to actively participate in their plan of care.

TOP 3 PRIOIRITIES

1. Funding
    a. Change the insurance laws
    b. For every dollar spent "downstream" spend two dollars "upstream" on early intervention / prevention
    c. Medicaid changes

2. Early Identification and Diagnosis
    a. Educate of the public through schools and churches of mental health
    b. Increased public involvement within the community
    c. Mental health awareness similar to the President's physical fit ness program

3. Expanding public services
    a. Increased ease of communication among service providers – development of e-records
    b. Better access to mental health services through ER
    c. Halfway houses – easing transition of offenders back into community
    d. Supportive housing following halfway housing that is appealing to renal management business (private sector)
    e. Develop community level taskforces to design coordinated metal health services in each community

CHALLENGES

- Funding – where to direct it *(15 points)*
- Communication *(1 point)*
- Mental Health awareness, education (3 points)
- Rural outreach *(3 points)*
- Expanding public service *(9 points)*
- Mental health triage in facilities
- More physicians
- Early identification *(11 points)*
- Continuity of care *(5 points)*
- Inability to voluntarily seek assistance
- Community Stigma *(7 points)*

REGION 7

DRAFT VISION

Accessible state funded healthcare clinic for all individuals in need of services. Clinics would provide mental health, physical health, substance abuse and educational services and follow-up. Oversight and support from regional Mental Health Boards. Integration of community stakeholders to provide continuum of care.

TOP 3 PRIORIRITES

1. Resources – money and services
    a. Reorganize current resource allocation
        i. Money follows client
        ii. Health clinics
        iii. Integrate with community stakeholders (physicians including)
        iv. Examine Mediate rates surrounding integration
    b. Streamline funding
    c. Open to new systems of care
    d. Telehealth

2. Fill in the gaps to provide services to all (not only Medicaid/ insurance)
    a. Prevent emergency room visits
    b. State Health clinics
    c. Create budgeting / money allocation (share resources
    d. Parity

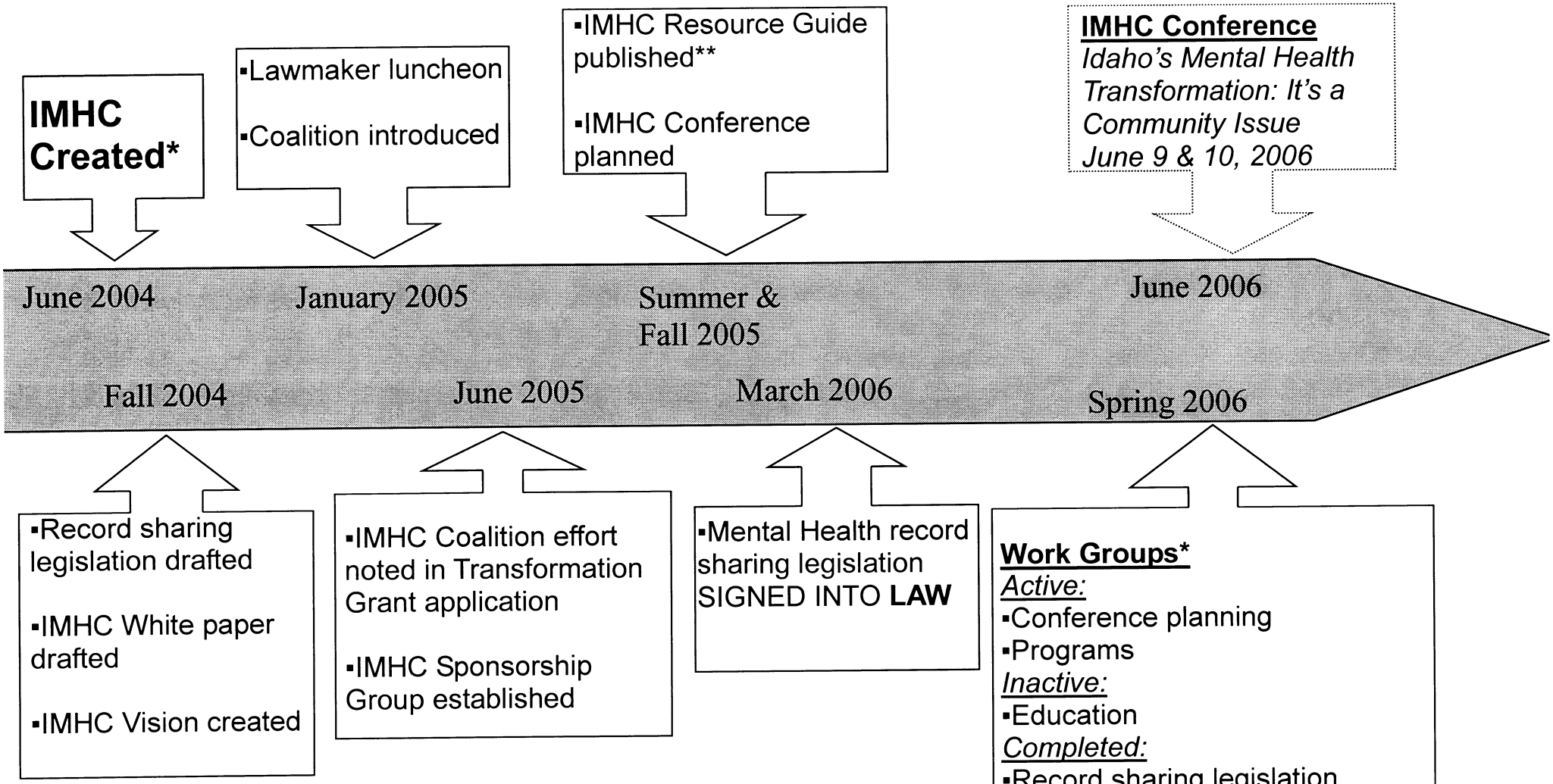
3. Collaborative, integrated partnerships throughout entire system
    a. PREVENTION and RECOVERY!
    b. Integration
        i. Mental Health and substance abuse
        ii. Mental Health and children / adults
        iii. Mental Health and vocational rehabilitation / employment
        iv. Mental health and primary care (medical)
        v. Mental Health and school districts
        vi. Mental Health and law enforcement (CIT)
        vii. Mental Health and Hospitals (social workers, w4/7 in emergency rooms
    c. Community outreach

CHALLENGES

- Integrate with primary care (nurses, physicians) with mental health at the beginning, telehealth, mental health providers in office *(2 points)*

- Insurance / Medicaid – fill in gap for who do not have insurance *(15 points #2)*
- Culture shift of service delivery (flexibility) population criteria
- Resources to make happen – revamp how resources are allocated –resources should follow the client! *(18 points #1)*
- Educate legislature
- Collaborative partnership throughout entire system – prevention and recovery *(13 points #3)*
- Early access to appropriate services
- Fragmented system between children / adult system
- Treat the whole family!
- School districts limited mental health clinician model
- Transportation
- Continuity of care statewide with still having regional control
- Access to medications (all)
- Access to physicians for medical care *(6 points)*

Idaho Mental Health Coalition Timeline



**In the inaugural meeting the coalition created work groups: To share information, resources, training and begin the education process mental health issues as they relate to offenders.*
***The Mental Health Resource Guide will be posted on Coalition member sites. The White paper and Coalition information is available at corrections.state.id.us or idahoissues.com, Summer 2005 edition.*