Brad Little
Governor

Sara Omundson
Jared Larsen
Co-Chairs

IBHC Meeting Minutes

August 16, 2024
9 a.m. – 11 a.m.

Location: Idaho Supreme Court, Lincoln Room (basement level)

Meeting Recording: https://www.youtube.com/live/hzU_uFfVnHY

Members in Attendance: Sara Omundson, Jared Larsen, Brent Mendenhall, Judge Gene Petty, Rep. Chenele Dixon, Sen. Doug Ricks, Kate Dolan, IDJC delegate – Jason Stone, SDE delegate – Greg Wilson

Members Absent: Ashley Dowell, Josh Tewalt, Dave Jeppesen, Rep. Brooke Green, Rep. Ali Rabe

Advisory Board Members Present: Jennifer Dickison, Dr. Nicole Fox, David Garrett, Kim Hokanson, Todd Hurt, Beth Markley, Dr. Stacia Munn, Dr. Mathew Niece, Debbie Thomas, Dr. Nikki Zogg

Presenters and Guests: Patia Tobias, Dr. Chris Cline, Dr. Ken Minkoff, Judge Steve Leifman, Rick Schwermer, Malia Cramer

Staff: Adrian Castaneda (Spark), Ross Edmunds (DHW), Cheryl Foster (IBHC), Shannon McGuire (Spark), Ryan Porter (AOC), Scott Rasmussen (DHW), Beth Rumpel (DHW),

Welcome
Co-Chair Sara Omundson welcomed members and said they did not currently have a quorum. They would delay approving the minutes until late arriving members were able to join,

Review of IBHC Vision and Guiding Principles
Co-Chair Sara Omundson reviewed the IBHC vision and guiding principles. She said they will have the opportunity to update the guiding principles in September.

Civil Commitments – Proposed Statutory Revisions
The Civil Commitments item was delayed until a quorum is met.

Expert-Informed Insights and Application on IBHC Workgroup Action Items
Co-Chair Omundson introduced Patti Tobias, former Administrative Director of the Courts for

Idaho, and the rest of the panelists: Dr. Chris Cline, Dr. Ken Minkoff, Judge Steve Leifman, and Mr. Rick Schwermer.

Dr. Cline began by saying they determined to add value by to the strategic planning process by providing a national perspective and six major structural components for cross-system design. Dr. Minkoff said that their high level examples of statewide strategic priorities would cover 80-90% of the recommendations and allow state leadership to engage all local systems and communities in partnership.

Their first strategic priority is to implement the **CCBHC model statewide** with the prospective payment system that allows paying for costs such as infrastructure. If this model is enacted, it will contribute to implementation of many of the other recommendations. It would require a multi-year strategic approach in partnership with Magellan and Medicaid.

The second strategic priority is to establish a state of the art **crisis system in every community**. The standards already exist to support crisis centers and mobile crisis. CCBHCs contribute to the crisis capacity.

The third strategic priority is to build the system around the complex needs of the people we serve. Built into the ASAM criteria, universal **co-occurring capability** can be built into every program to deliver integrated care to people with both mental health and substance use needs. This is now the expectation, not the exception – especially in the justice system.

Judge Leifman spoke about next three strategic priorities relating to the justice system. The fourth strategic priority is to **reform competency to stand trial system**. He noted that the system was put in place 60 years ago when there were between 5,000 – 6,000 people in U.S. jails and prisons. Today there are around 2 million arrests involving 1.5 million people with serious mental illnesses, which is overwhelming the system. He also said about 16 states are under Federal lawsuit right now because of the backlogs in getting people assessed and delays in treatment. Additionally, he asserted competency restoration process does not lead to good outcomes.

The Conference of Chief Justices and the Council of State Governments Justice Center have put together some reports on streamlining the system to limit it to basically individuals that are charged with very serious offenses leading to prison. The rest would be diverted into treatment, so they don't come back. Currently significant amounts of money are spent to restore competency to a small number of people, when there are larger numbers of people who need acute mental health treatment at the time of their arrest. Also, for 80% of the people who are restored, the crimes are eventually dropped, or they receive credit for time serviced or probation, while receiving no access to care.

The next strategic priority is **diversion** beyond mental health courts, which handle too few cases. A true diversion system needs a systemic change on how we address individuals who are at risk or have already come in contact with the justice system. There needs to be a pre-arrest system either through co-responder models or police models. There should also be a post-arrest system that identifies low-level offenses.

There should also be efforts to move more upstream and identify individuals who have gone through trauma and provide them services. The Advisory Board includes these as recommendations.

The sixth priority is to **modernize civil commitment laws.** Most states' laws are based on 13th and 14th common law, but do not reflect modern science. They have worked with top experts in the country and developed a model commitment law. The law balances getting people the treatment they need with diversion options.

Dr. Omundson asked Judge Leifman to explain the success of his model program in Miami-Dade County. They began in the year 2000 by implementing pre- and post-arrest diversion programs. He noted that data on trauma had not yet come out at that time, so if he were implementing the program again, he would incorporate his school board and school superintendents into their first summit. Their major effort was to implement crisis intervention team policing for de-escalation and pre-arrest diversion to treatment.

They keep a lot of data on their pre-arrest program. Over a ten year period, they had 105,268 mental health calls resulting in only 198 arrests. The total number of arrests dropped from 118,000 to 53,000. Their jail audit dropped from about 7,400 to 4,400 and they closed a jail.

For post-arrest diversion, recidivism dropped from 75% to 20%. They expanded the program to non-violent felony cases, where recidivism dropped from 75% to 6%. The county reinvested the funds to treat individuals in need of acute care not available not in the current system of care and is building a mental health diversion facility that they hope will eliminate homelessness in Dade County.

They also learned that almost one-third of their jail audit is made up of the same 1,000 individuals who have been booked five or more times over five years. They hope to address these individuals who are repeatedly cycling through the program.

Cheryl Foster asked Judge Leifman to expand on his recommendation to include the school superintendent in his initial summit. He said that the data on trauma shows that in jails 92% of all women and 75% of men with SMI have significant trauma history. Trauma is physiological not emotional; it can be treated specifically. He would have worked with the schools to screen for ACEs (Adverse Childhood Experiences) to identify kids who are currently traumatized to provide treatment and interventions. He said they could have saved two generations from ever entering the system.

Dr. Minkoff added that there are data driven models of trauma-informed school culture initiatives that have demonstrated to significantly reduce or end the "school to prison pipeline." Missouri has taken it on a statewide level with an interdepartmental trauma council to support every school system to develop a trauma informed school culture. It has a big upstream impact and is cost effective. It's important to use data to measure its effectiveness to continue and maintain funding.

Mr. Schwermer recommended universal screening for everyone booked in jail. There are free screening tools in the public domain to conduct a five question trauma screening. Ross Edmunds

asked who performs the universal screening in the jails. Mr. Schwemer said there are good/better/best options. In Utah, they provide resources to the jails do the PCL5 for everyone who is booked. It isn't necessary for a clinician to perform a screening, although more training yields more consistent results. Dr. Minkoff noted that Texas requires jails do the basic screenings and the statewide network of CCBHCs is mandated to provide the assessments. Judge Leifman noted that the corrections personnel did not provide consistent screening results, so they have medical staff conduct the screenings. They also have a code on the arrest affidavit to identify a possible mental health defendant. Mr. Edmunds said they need screening tool that is not too inclusive but can identify people to receive resources.

Mr. Todd Hurt asked questions around pretrial release and mental health treatment. What agency takes the lead – who takes the cases and who funds it ongoing? Is it mandatory or voluntary? Judge Leifman said that their diversion program is voluntary. However, individuals can be transferred to crisis stabilization if they meet crisis criteria. The 72-hour hold under civil law doesn't apply for a criminal hold, and the cases are reset for two weeks to allow the person stabilize. The 72-hour hold is only for judicial review, but two weeks is long enough for a person to get better. If they voluntarily join the program, they are not rebooked in jail. When they go to the courtroom, peers are there to meet the person and provide resources. It reduces recidivism.

Dr. Minkoff told Mr. Hurt that funding opportunities have increased, such as Medicaid expansion, plus opportunities to connect to Medicaid in jail. They can also include incentives for jail diversion outcome targets for the managed care organizations, as well as leverage commercial coverage.

Director Omundson asked Judge Petty if he would provide an update on the diversion program being implemented in the 3rd Judicial District. Based on recommendations from the IBHC, the Idaho Legislature provided funding to the Department of Correction for diversion grants. Judge Petty said the process to divert people with behavioral health needs prior to entry into the criminal justice system has been led by their prosecutor, the public defender and Dr. Nikki Zogg from Southwest District Health. Southwest District Health hired a coordinator and a peer to administer the program. They are just getting started getting people diverted into treatment. If the individual completes the program, their case will not be filed in the criminal justice system.

Review and Discussion of Draft Strategic Plan Recommendations
***Suggestions and Proposals for Changes**

Shannon McGuire from Spark shared the norming slides describing the scope of the IBHC and its planning process.

Director Omundson expanded on the difference between action items and recommendations. The council adopts and prioritizes the recommendations, but not the action items as those may change over time. Then each of the prioritized recommendations is assigned a sponsor.

Ms. McGuire first shared Zia Partners' six strategic priorities as a starting place for a discussion in order to streamline the recommendations. She asked the Council members which priorities the Operations Team and Advisory Board should focus on.

Dr. Minkoff wanted to know of Idaho's familiarity with CCBHCs. Director Omundson said that they were very familiar and asked Ross Edmunds to provide an update on their status in Idaho. Mr. Edmunds said that Idaho has five CCBHs and described how they build the required network of providers. He talked further about the planning grants and installing the Prospective Payment System rate, which eliminates the payment for illness model and incentivizes keeping patients healthy. Judge Petty asked if the Council needs to prioritize CCBHCs to assist in developing the statewide network. Co-Chair Omundson asked if there needs to be data to identify the challenges. Mr. Edmunds said that the FQHC model is already in place and the CCBHCs are building on top of that.

Co-Chair Omundson asked Mr. Edmunds if some of the action items could be folded into a CCBHC recommendation. Ms. Foster noted that the action items identified gaps within the system and did not necessarily visualize changes to a new system. Co-Chair Omundson said that she hoped that many of the action items, including workforce could be addressed by implementing CCBHCs.

Judge Petty requested that Strategic Priority #2 be included, as there are a number of crisis system recommendations included.

Ms. McGuire mentioned that there was discussion around Strategic Priority #3 on Universal Co-Occurring Capability and asked Ms. Foster to elaborate. Ms. Foster asked the panelists for clarification on how they address that priority, along with the Comprehensive Health Integration strategy. Dr. Minkoff noted that they had not highlighted the Comprehensive Health Integration for the Council like they did for the Advisory Board, but they are systemic levels of integration. The integration of services for co-occurring mental health and substance use disorders is important for crisis and criminal justice diversion services. These are included within CCBHCs. The integration of behavioral health into physical health is a much broader, including bi-directional integration which integrates health support into our behavioral health services for people with very serious mental health needs. They have developed a new framework with the National Council for states to implement. With Idaho's FQHCs taking the lead on CCBHCs, this is a wonderful opportunity to deliver an integrated system of care.

Judge Petty recommended including Strategic Priority #4 Competency to stand trial for as an action item to Treatment #8. He would like a report with a comprehensive review of the system as it currently exists, including data available, and an analysis of what would be appropriate reform, to get a full understanding of the entire system. Mr. Edmunds said that he has data on the numbers, such as length of stay. Over the past six years, they've had a 700-800% increase in competency restoration cases; State Hospital North competency restoration cases went from 20% to 75-80% of admissions. Minor misdemeanors are put in the hospital for up to six months to restore competency, but it would be better to get them treatment so they can stabilize their mental health. Judge Petty noted that misdemeanor offenders not needing competency restoration spend much less time in jail, so our current system is taxing the jail as well as the state hospital.

Judge Petty ask for the report to be brought to the council first for further guidance on what to do from there for further discussion and adoption of further action items. The report should also

address differences between misdemeanor and felony cases, and how those might be addressed quicker without spending so much time at state hospital. Mr. Edmunds said that we do not have to start from scratch as it has been well researched in other states.

Co-Chair Omundson asked Mr. Edmunds about Strategic Priority #3 - Specific universal co-occurring capability. He said that not everyone looks at co-occurring specifically as mental health and addiction, or even physical health and mental illness. Other types of co-occurring are psychiatric conditions plus development disabilities or dementia. Dr. Minkoff added that co-occurring usually starts as mental health and substance use disorder, but then expands to include others and becomes "complexity capability" or multi-occurring. It's important to specify the issue and start with a foundation, then the others become easier to deal with.

Mr. Edmunds noted that for Strategic Priority #6 –Civil commitments reform, there has been a recent change with the hospitals' and physicians' interest into changing the system. The current requirement is two designated exams, as well as an inpatient and outpatient commitment process. Historically hospitals and the medical association have not been supportive of changing the initial evaluation process, but their recent interest provides an opportunity to do a real investigation into potentially changing our civil commitment system. Co-Chair Larsen asked Mr. Edmunds what the analysis would be like, after the improvements made over the past several years. Dr. Minkoff said that they have a new model civil commitment law that would be a good place to start rather than the previous incremental improvements. Mr. Edmunds said that the challenge in Idaho is the multiple stakeholders involved. They must first bring all stakeholders together to begin looking at how Idaho would like to respond. Co-Chair Omundson said it was critical to bring together all of the stakeholders, as there have been struggles legislatively for previous changes. She suggested having a summit to bring stakeholders in the room to discuss the art of the possible rather than starting with a defined outcome and see what might be supported as far as change.

Ms. McGuire mentioned that Strategic Priority #5 remained unaddressed. Judge Petty offered that strategic priority #5 be with Engagement #5. There is interest in setting up diversion, but the concern is "divert to what." There is currently nothing there except the current criminal justice system, so we need to look at what systems can be implemented.

Co-Chair Omundson proposed to the Council that Strategic Priority #1 – Statewide CCBHCs be added as a recommendation with action items mapped to this recommendation, similarly Strategic Priority #2 to be a new recommendation with action items mapped to the recommendation. Strategic Priority # 4 - Competency to stand trial is currently Treatment #8, with the added action item to review the system before reforming it. Strategic Priority #5 on Diversion is already Engagement #5. Strategic Priority - #6 Modernizing civil commitment system – new recommendation with an action item to hold a summit.

Co-Chair Omundson deferred to Mr. Edmunds on Strategic Priority #3 on Co-Occurring Capability, while Ms. McGuire asked for Dr. Fox's input. Dr. Fox agreed with Mr. Edmunds previous recommendation that the definition be made very clear, but not limit the possibility of expansion in the future. Dr. Fox added that she wanted to provide input on Strategic Priority #6,

speaking for the Idaho Psychiatric Association. They would like to partner on that work but would need a dedicated Project Manager to guide the process, starting with a literature and data review to from the different states for what is politically palatable and align with best practices. She agreed that working with what we have may not allow us to modernize.

Mr. Edmunds responded to Co-Chair Omundson that he would like to take some time to look at Strategic Priority #3, as it is an evolving issue in Idaho. It is all under Magellan contract now, so there is opportunity to look at it under that.

Shannon recommended to the council that the recommendations get sent back to the Operations Team to re-crosswalk prior to putting out for public comment.

Director Omundson said the report will be posted publicly and reminded the members of the three in-person and one virtual public comment events. Information on the events is published on the IBHC website. All Council members are welcome to attend.

Public Comment Events Reminder

Bonneville County:	August 22nd, 6:00 - 7:30 pm
Virtual:	August 23rd, 10:00 - 11:30 am
Kootenai County:	August 26th, 6:00 - 7:30 pm
Canyon County:	August 27th, 6:00 - 7:30 pm

Anti-Fentanyl Campaign Presentation

Co-Chair Omundson asked Co-Chair Larsen if he would like to speak about the Governor's Office's work on this project. Co-Chair Larsen said that the Governor's Office in 2022, led by Communications Director Emily Callahan, used emergency funds to bring awareness to the fast-moving fentanyl crisis. They are pleased with the successful outcomes

Malia Cramer from Drake Cooper said that the original campaign in 2023 was "Fentanyl. All it takes is everything." This year, they kept the campaign the same but refreshed the copy and imagery. They deployed outdoor boards, TV and Facebook videos, digital banner ads, and a lot of social media.

The five month media plan was for $300,000, but they received additional funds from the Office of Drug Policy. The additional budget allowed for additional outdoor boards in high traffic corridors, and they kept their TV spot until the Super Bowl. They had 400,000 impressions across Idaho with those placements with three distinct audiences: youth, parents and caregivers, and all Idahoans.

They had websites in English and Spanish with over 65,000 visitors and 15% engaged users. They used a fake captcha interstitial "Click on all the images with counterfeit pills" that increased the website engagement rate.

The campaign resulted in an increase in awareness that drug use is a problem in Idaho, and specifically fentanyl. There is not much room for growth with for the parent segment with 91%

describing teen and young adult drug use in Idaho as a problem and 96% concerned about fentanyl use among teenagers and young adults.

Ms. Cramer said that Idahoans are talking about fentanyl. They had 90 million impressions during the lifetime of the campaign, which is 50% more than they had in 2023.

Co-Chair Larsen lauded Marianne King from the Office of Drug Policy for her role in the project and her office's leadership in primary prevention. He also said that he would continue to advocate for primary prevention.

Co-Chair Larsen also asked Ms. Cramer what they would do for a third round for the fentanyl campaign. She said that they would do a media spend with existing assets but refresh after a year to 18 months. She said they would see increased results and familiarity with the campaign if it continued.

Adjourn

Co-Chair Omundson told the Council members that on September 13, they will adopt and prioritize recommendations and find groups to sponsor the recommendations. It is critical to be in a room together, as they will debate with other council members as they vote on their priorities with stickers. Please make the effort to come in person.

Co-Chair Omundson adjourned the meeting at 11:15 a.m.