

ISSH Review Committee

Focus Group Responses

July 2009



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In response to the 2009 Legislative Intent regarding the transition of ISSH, focus groups met in July 2009 to discuss ISSH and what needs to be done to assist the developmentally disabled and medically fragile in the State of Idaho. The focus groups consisted of Providers, Legal and First Responders, Parents and Guardians, Advocates, ISSH and Developmental Disabilities Staff and Consumers. Various questions were asked of each focus group. Their responses, along with the questions, are documented within this report.



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PROVIDERS

1. A number of residents at ISSH are a danger to themselves or others, have a mental health disorder and a developmental disability, and may be opportunistic in acting out their maladaptive or predatory behaviors. How can we safely provide care and supervision of these residents in community settings? Please be specific regarding medical, pharmacological, residential, and treatment services needed as well as supervision. Indicate how these services might be paid for.

Intermediate Care Facility (ICF) survey guidelines are a barrier for serving some individuals.	1
Certified Family Home (CFH) - Res/Hab affiliation agencies no longer support CFH 24/7. Who is responsible for clients in an emergency? Adult Protection for emergency- crisis capacity?	2
There is ultimate stress to the client.	3
CFH no longer will have training without an affiliation agency. Need to assure training specific to those who are dangerous and to the medically fragile clients.	4
Some providers have behavioral support plans for psychiatric clients with dual diagnosis. The mental illness creates significant issues: <ul style="list-style-type: none"> - High staff turnover occurs with private providers (need better payment). - Behavioral support plans need to have an applied behavioral analyst on staff if possible. - Have a psychiatrist and an NP who will respond in a crisis. - Members of the management team must be on-call for crisis. - Must keep clients and staff safe – need an emergency crisis bed around the state with trained staff. - Hospitals won't take them and police won't take them. - Need 30-60 days for psychiatric evaluation and stabilization. THIS IS THE MAJOR ISSUE! - ISSH may fear long-term admission if they take them. - Parents and guardians of other clients are fearful and want that client out. - If ISSH had taken them for 30-60 days, it could have returned the client to the provider. 	5
Some clients may need just a few days of stabilization.	6
If a client goes to jail, that client cannot continue medication and may lose his/her medical card. Have quick eligibility upon release and need to administer current medication. <ul style="list-style-type: none"> - No one at the jail can help them with medication. - Can a nurse help them with distribution of medication? 	7
Some providers are just not trained or set up for clients with behavioral problems. Service coordinators try to tell us and we don't always listen to their concerns.	8
Need more support for agencies that accept clients and need better reimbursement.	9
Use of CSOT (Community Support Outreach Team) is helpful but they have to respond quickly. It has to be timely.	10
CSOT uses guidelines from ISSH; the supported living environment has different needs for support and ISSH protocols don't work there necessarily. Was the response the right fit for the environment?	11
In mental health, telepsychiatry can be billed under mental health, but it cannot be billed under developmental disabilities. They have to have a face to face visit.	12
In supportive living, after the ISSH discharge has been out one year, Medicaid authorizes <u>fewer</u> services. The client appears better due to the quality of service, level of care, and level of supervision and then this authorized service level gets reduced and the client deteriorates.	13
A special rate is helpful for ISSH discharges.	14
Need special rates in the supported living environment relative to how many others are in the home to staff around. Make the rate case-by-case whether living alone or with more than one client (this applies to both Res/Hab and CFH).	15
Currently use SIBR to get to the "correct" rate and the rate is not stable over time.	16
Budgeted time can be restrictive based on SIBR and be an inadequate reimbursement for the service.	17
Some Res/Hab providers like the new methodology determined by Medicaid for reimbursement. If funded at 100% it will work for supported living providers.	18
2:1 ratio drives the rate and on-call needs increase the costs to providers. Center-based facilities can access many staff quickly, unlike other home-like community placements.	19
Under Res/Hab you can get 2:1 ratio for a short duration (23 hrs per month). It's the immediacy that's challenging. This does not apply to CFH.	20

PROVIDERS

2. A number of guardians of ISSH residents do not want their family members to move out of ISSH. If ISSH were to close, what do you think the biggest concerns would be for parents and guardians of the residents living there? How can those concerns best be addressed?

Guardians have said ISSH will be there forever.	1
Guardians aren't looking for alternatives very seriously because they don't believe ISSH will close.	2
Change is hard.	3
Most vocal guardians live close to ISSH and it's convenient to them.	4
Guardians have refused to visit other types of providers.	5
Have guardians meet CFH providers.	6
If guardians like ICF at ISSH, why not a community ICF?	7
Parents really can transition to a placement close to their home; do they know that?	8
Talk to consumers and guardians' family members who have had a client transition that was successful. Target some clients who were at ISSH a long time.	9
There is a very diligent process for admission and transition and parents may not understand that.	10
Parents may believe there are <u>fewer</u> services for the medically fragile- we need to deal with this. Medicaid makes decisions based on budget concerns. Medicaid prefers service under the A&D waiver rather than a DD waiver for the medically fragile and profoundly impaired client. In-home medical service needs will eat up the budget allowing little for therapy services.	11
Medicaid is reinterpreting active treatment definition.	12
Res/Hab clients from ISSH may receive authorization for an intensive/high support daily rate which allows for 24 hours of care the next year. If the SIBR score doesn't show it or we can't show the need, we cannot get 24-hour services and the client's behavior deteriorates as the level of care deteriorates.	13
ICF is different. It is more stable regarding care levels and reimbursement so the care is consistent.	14
Supported living must address programs and safety. The authorization for services doesn't follow the need to maintain support and services to assure the continuity and quality of life. Providers always have to demonstrate measurable needs very precisely, which cannot be done.	15
The authorization process is problematic; we take away what's working and put them into a service that doesn't work.	16
A&D waiver doesn't adequately support some clients like a DD waiver.	17
Special rates are reduced once a client is doing well in ICF.	18

PROVIDERS

3. For those clients who are very assaultive and aggressive, what strategies should be used to provide for their safety and the safety of those around them. What barriers are there in the current system that impede the implementation of those strategies in the community? And what can be done to alleviate them?

Many need more flexibility and higher maximum time allowed in Res/Hab for a 2:1 ratio or whatever staffing level is needed.	1
The rent costs in supported living <u>prevent</u> clients from living alone when they should be living alone.	2
There are higher functioning clients with 65-75 IQ of which criminality has no consequences and the clients know this. They're not arrested and not sentenced so there is a barrier to safety with this group of clients.	3
The settings are so different between the community and the ICF/ISSH settings. It is a new environment. Too much staff and directive intrusion in more restrictive settings causes aggressive behavior.	4
Community providers try to avoid restraint because of liability.	5
No next level for some clients who are aggressive and they know there aren't any consequences.	6
Need a new funding mechanism. Why can't ICFs have less than four clients? Need more latitude in funding.	7
Need a continued role for ISSH. Some clients just aren't safe in the community for a period of time.	8
Have a better partnership between the criminal system and mental health. They may need a specialized "jail" for consequences. Some placements for criminal behavior "rewards" clients. It is a crisis for assaultive behaviors and some high functioning clients need consequences. However, typical jail/prison may not address medication and treatment needs.	9
Have a Mental Health Court for some who are dually diagnosed.	10
Develop a special placement.	11
The 65-75 IQ clients does not belong with the lower IQ group.	12
How do we handle those with Aspergers Syndrome?	13

PROVIDERS

4. Should people with developmental disabilities be adjudicated through the criminals system if they commit a crime? Why or why not?

<p>The general group consensus is that higher functioning clients should be adjudicated through the criminal courts for committing a crime, but this needs specialized consequences and placement.</p> <ul style="list-style-type: none"> - Need a partnership with local law enforcement about how best to respond to certain individuals. - Develop training in Post Academy regarding DD clients. - How should law enforcement do the arrest? May need special procedures for the arrest. - Need to get law enforcement to engage so they will make an arrest or write a police report to support the need for supervision. - We violate the client's rights because they don't go to court through proper channels and the client, who allegedly committed a dangerous act but is never proven to have done anything, gets committed to DHW. A client gets accused of sex offending behavior, but it is never proven!! 	1
It is hard to retain staff where there are aggressive clients when law enforcement is not responsive.	2
Rural areas may have a better law enforcement response.	3

PROVIDERS

4a. How is the Community Support Outreach Team (CSOT) doing? How can it be improved?

In more recent experiences- they are quick/timely and offer good consultation.	1
It is good that it is free.	2
They can be very helpful.	3
Keep some elements of ISSH, especially CSOT.	4
Need timeliness in true crisis.	5
Can't get qualified professionals with that level of expertise in the community. Have to go through lots of steps to get the service providers. Cannot afford this level of expertise given the intermittent need.	6
Pharmacy assistance is very valuable. Many clients take many medications. Pharmacists consult with the client's medical providers.	7
CSOT is sometimes limited because of liability. Won't do staff training, support, crisis intervention or on-site client intervention.	8
Need more training on functional CSOT assessment. They are able to write plans with a positive behavioral support and identifying replacement skills.	9
CSOT needs good boundaries regarding their role in partnering with providers around how best to assist.	10
It is like having outsider's eyes to look at challenging clients.	11
Providers appreciate expansion to rural areas.	12
Establish a community-based crisis team from many disciplines. Also need crisis beds in each region.	13

PROVIDERS

5. Please describe the elements of a crisis system that would need to be instituted to facilitate discharge of clients from ISSH and to prevent the need for admission to ISSH. How would those services be paid for?

Crisis beds in each region.	1
Crisis teams in each region.	2
Placement for stabilization on a short-term basis.	3
Psychiatric placement for those too dangerous for the community. A team for assessment, with strategies for intervention and medication.	4
Proactive prevention to avoid crisis. If not, then there needs to be a crisis option.	5
More crisis resources are needed to divert from ISSH. Have a six month return policy back to ISSH. There needs to be a comprehensive crisis bed and specialized staff and not back to ISSH necessarily.	6
There could be a combination of public and private partnerships.	7
It will ultimately be publicly funded.	8
It could be private only.	9
Have a funding mechanism to assist the private provider with crisis capacity.	10
The private sector can serve ISSH clients for less.	11
The funding mechanism won't support ISSH clients.	12
Private providers have clients like those at ISSH.	13
Property damage limits some options for housing.	14
Liability issues. Other clients' families don't want the dangerous person in the environment.	15
We have to have proactive supports.	16
Res/Hab supported living providers can't own the property.	17
Some management entities don't want the liability of dangerous clients.	18
The cost of serving the client is the primary barrier.	19
The provider needs time to get ready for a client to be admitted- paperwork, living arrangements and the funding needs to be stable.	20
Need a comprehensive plan and be able to pay for or provide a comprehensive plan. Some things aren't billable to TSC and aren't reimbursable (e.g., drive time).	21

PROVIDERS

6. Can all consumers who have a developmental disability live in a community setting? Why or why not?

Yes, with proper funding.	1
All clients should have the opportunity to live in a community setting with adequate crisis capacity and person-centered planning.	2
Saying it can be done and doing it isn't always possible, philosophically. It makes sense. Practically, It may not be.	3
We still need ISSH.	4
The option should be available to live in the community and keep trying to if not successful at first.	5
"Bad" behaviors learned at the institutions are transferred with the clients to the community setting. Some clients may need "out of the box" support and the funding to do it.	6
Payments from Medicaid and General Funds to ISSH as a source of funds, \$22 million and \$2.6 million respectively.	7
Medicaid as a primary source of payment.	8
The Idaho Center for Disabilities Evaluation (ICDE).	9
Lower CHIP income levels to create funds from Medicaid.	10
Tax long-term care beds to create funds.	11
Change regulations to ask ICF providers to create crisis beds (non-ICF bed).	12
Maintain a flat rate for TSC instead of fee for services.	13
Criminal justice- we spend funds there after the fact without prevention.	14
Community tax for crisis beds.	15
Cost sharing with clients.	16
Medicaid requires that vendors accept "payment in full."	17
Reduce costs associated with the Medicaid process with providers (e.g., mailings). Conduct all business electronically.	18
Vocational Rehab- the limits of vocational services and transportation prevent clients from earning money so there are no incentives for the clients to work. This impacts social security, etc.	19

PROVIDERS

7. How would you respond to a proposal that gave you no right of refusal for a specific client who had a history of dangerousness?

The right of refusal is dependent on the funding.	1
Meet with others to address other clients who are aggressive.	2
Move to another location.	3
Could only happen with a responsive system for crisis with adequate funding	4
Have the ability to place a dangerous client for stabilization.	5
Would not work for ICFs with a group living situation- too dangerous for the other clients.	6
Funding should meet the person's needs as they change.	7
ISSH cannot close unless the community funding changes.	8
Use ISSH dollars to serve community clients.	9

PROVIDERS

8. What is the state's role for the developmentally disabled system and client population?

Assure safety and well-being.	1
Assuring quality and access in the service system.	2
What is DHW's legal obligation under Medicaid to accept funding on behalf of people with disabilities?	3
Are we keeping clients safe by reducing funding? We'll go back to the "dark ages" in the way clients are treated (e.g., loss of medical transportation). We spend more to control costs resulting in overall cost increases.	4
Need caps to control costs rather than reducing the service levels for those clients.	5
Do we want people who are needy to be on a waiting list for service?	6
Aspergers Syndrome will add costs in the future.	7

LEGAL AND FIRST RESPONDERS

1. What do you see as the role of the State in care and treatment of people with developmental disabilities in the Idaho?

Have an oversight entity to address the needs of people with disabilities.	1
Crisis response support services to caregivers.	2
Train providers to manage a crisis (e.g., assault). Some providers now have assaultive client protocols that say, "call the police."	3
It is on the state, law enforcement or medical emergency/systems contingency program. The government will be responsible and is the safety net option.	4
Placement- hospitals aren't set up to handle assaultive crisis and really can't handle them. They are not resourced for the type of client who is not there for a medical reason. There's just nowhere to place them.	5
These situations take a lot of time and there is no one to call except between 8-5.	6
Care providers will drop DD clients off at the ER.	7
In providing oversight, the Department must provide a continuum of care. The rules are too restrictive. Providers just bring them to ER. The clients don't necessarily meet the acute criteria. There are not enough psychiatrists or therapists in Idaho.	8
They don't get better in a psychiatric unit.	9
A DD person spent 90 days in a psychiatric unit. This person had lost Medicaid while in jail so no payments were made to the hospital.	10
We need an emergency facility.	11
Jails are not the right place. Those there are not trained /equipped for them.	12
The state needs to provide a place with an adequate and well-trained staff.	13
Providers want them in jail as a "time-out" and then the provider won't take them back.	14
The provider of the client wants the DD person who is not competent to be charged with assault.	15
The 8-5 hour of work at DHW does not meet the needs for crisis response during off hours.	16
There are too many liability issues for jails.	17
Educating first responders on how to make complaints about problem providers.	18
Where do we send DD people with a criminal charge? We send them to where they are likely to commit the same offense and there is often nowhere for them to go.	19
Providers need access 24/7 to a crisis responder. Need the appropriate response available with a qualified provider.	20
ER is an expensive crisis response. ER can only medicate them and it's a short-term intervention.	21
Find out why they are acting out.	22
Need providers/caregivers to do early intervention with escalating behaviors. The client needs a crisis plan.	23
Have a database of client profiles for clients who are frequently in crisis. It should have contacts, a plan to respond and de-escalation strategies. Due to HIPAA issues, it would need client permission to share with first responders.	24

LEGAL AND FIRST RESPONDERS

2. As an officer on the scene or as health care personnel in a hospital, what do you need to provide adequate care and response for a person with a developmental disability who is aggressive, assaultive or a community nuisance and may jeopardize public safety, who may also have a mental illness?

Have a database containing client information.	1
Have information to connect with the client on a more personal level.	2
A home recovery team.	3
The most resource intensive clients are those who don't meet the hold criteria but are in a crisis and a problem.	4
Clients don't often meet the criteria for a mental hold or jailing for a criminal offense.	5
Need team plans on how to address crisis clients. Need training, protocols and methods to enhance communication.	6
An Ada County crisis intervention team.	7
How can law enforcement and first responders get the information they need? There is the HIPAA issue which requires legislative change.	8
Certain individuals need an ISSH level of care. We don't have enough inpatient psychiatric beds as it is. Are we really serving people well? With an inadequate cure they end up in prison.	9
They may be acting out due to loneliness.	10
They have a lack of structure in their community environment.	11
If ISSH closes, there needs to be smaller ISSH's.	12
ISSH needs 24 hour capacity for placement of DD clients.	13
What are the hidden costs to counties when we don't have appropriate services? There is the potential for shifting costs (e.g., jails, transportation, prosecutors, and hospitals) which drain resources for meeting other public safety needs.	14
There's just no place for some who are very dangerous.	15
The financial picture does not support losing ISSH.	16

LEGAL AND FIRST RESPONDERS

3. In a crisis situation, where should a dangerous person with a developmental disability be placed? Describe what that place offers that makes it a suitable placement.

ISSH since they are trained to work with people with DD.	1
Regulations need to allow staff to do what needs to be done. For example: <ul style="list-style-type: none"> - Restraint Rules - Medical Restraint - Emergent Response Protocols that are realistic 	2
Some settings regulate too much and other settings don't regulate enough.	3
Funding- investigate options.	4
Dealing with the loss of Medicaid/SSI while they're in jail is a problem. Need a better way to deal with this. There is no payment source for placement options.	5
Have a Board of Guardians to make decisions. Have guardianship for those frequently in crisis and have power of attorney to share information.	6
Judge Castleton- he has expertise relative to guardianship.	7
Have the Department Director as Guardian, i.e., commitment.	8
Look at what other states are doing.	9

LEGAL AND FIRST RESPONDERS

4. Please describe the elements of a crisis response system for people with developmental disabilities who may also have a mental illness.

- | | |
|--|---|
| Incorporate all that we've already heard. | 1 |
| Have access to experts. We don't have the psychiatrists and medical doctors who are skilled with this population. There is a need for a very specialized pharmacology. What ISSH has needs to be available to the community providers. | 2 |

LEGAL AND FIRST RESPONDERS

5. What strategies can we undertake that will assist you in your response to a person with a developmental disability who is in a crisis?

- | | |
|---|---|
| Each jurisdiction needs its own training regarding its protocols, etc. | 1 |
| Standardize the de-escalation training. | 2 |
| Need training regarding the identification of disabilities for law enforcement. Need the state to do this for rural areas. Who would do it? Also need to know what to do. | 3 |
| How do you respond to someone with a knife? Their diagnosis doesn't matter. | 4 |
| Help law enforcement tailor their response in low risk situations by identifying the diagnosis of the person and then how to respond. | 5 |

LEGAL AND FIRST RESPONDERS

6. To what extent should people with developmental disabilities who commit crimes have legal consequences such as incarceration, probation, parole? What are the perceived risks?

- | | |
|---|---|
| If they're competent to stand trial and it is a serious offense, they should go to prison. | 1 |
| Shorten the evaluation process to determine competency (18-211 and 18-212). | 2 |
| If the person is not competent, where do they belong when they are a public safety risk? | 3 |
| Jail for a weekend as a consequence for a person not competent to stand trial is very effective. They understand the consequences even if they are not competent to stand trial. | 4 |
| Protocol teams or staffing to make a good decision for each individual client. | 5 |
| Mental Health Courts; labs for drug and alcohol testing is low. Evidence-based recidivism for Ada Mental Health Court. Would this be effective for a DD client if he/she is competent to stand trial or plead guilty? | 6 |
| For those who are repeatedly in crisis, are they in the right placement? | 7 |
| Law enforcement must often treat DD people like everyone else. | 8 |
| Whatever we do, we also need to make it safe for the DD client. | 9 |

LEGAL AND FIRST RESPONDERS

7. What specifically should the Department's role (including ISSH) be with regard to people with developmental disabilities who are a danger to themselves or others?

Make sure they're not a danger.	1
Provide a safety plan.	2
Create a non-punitive safe environment.	3
By specializing and acting in a pro-active way to prevent crisis.	4
Psychiatric units for <u>ACUTE</u> needs. Once the acute crisis is over, the Department needs to assist in finding a placement.	5
Have a placement decision and seek placement options.	6
Assist in financing legal services to get a guardianship and <u>locate</u> a possible guardian.	7
"Foster Care" with another adult overseeing the needs of the DD person.	8

LEGAL AND FIRST RESPONDERS

8. Can, should the private sector take over responsibility for clients who are a danger to themselves or others? Why or why not?

There is no accountability if all the responsibility is in the private sector.	1
If they don't respond well, then what? The state has the licensing duty, it's all taxpayer money. It may be inefficient, which compounds the problems. The state gets the responsibility anyway.	2
We spend a lot of money with an ineffective system.	3
When patients are in the wrong placement, like an acute hospital bed, there's <u>no</u> progress. Then the psychiatric hospital can't provide help for those who need it. Idaho is not well funded, which is bad for the client, staff and a waste of money when there aren't proper services or placements. The State is shifting costs to counties at the jails, in courts, in hospitals and to law enforcement. It's all taxpayer money.	4

LEGAL AND FIRST RESPONDERS

9. What services are needed for adolescents who are dually diagnosed and cannot be cared for at home with their families?

Have respite for the parents.	1
Teach coping strategies for parents.	2
Planning for the care of the child when the parents die. This means having a long-range view of the child's needs as an adult.	3
Some kids need placement; they are too taxing for parents. Many psychiatric hospitals won't take adolescents or those with low IQs.	4
Need better planning/response regarding DD kids who commit a lewd act. What do we do with them? Rule 16- juvenile and child protection judges argue about the decision for those kids.	5
Judges are very frustrated with how to handle kids in multiple systems.	6
Have a facility for DD and SED kids and substance abuse.	7
There is a cost shifting of adolescent in crises to law enforcement and the counties. The State gets off the hook.	8

PARENTS AND GUARDIANS

1. What are the supports that your family member MUST have to ensure safe and adequate care?

Supervision- constant supervision. The family member might hurt someone or get hurt by others.	1
Have a well-trained staff.	2
Have reliable staff. Cannot have providers who are “no shows” for example.	3
We have had drunk providers.	4
Can’t hold on to providers who are consistent and maintain a bond with the family member.	5
Providers (i.e., direct care) don’t really know how to handle them.	6
Aggressive clients scare direct care staff and they leave. It’s too complicated so they are scared, especially if they’re right out of high school.	7
IBI is a very good service with highly qualified staff. Wish we had same level of providers for adults.	8
The service is more reliable with degreed staff.	9
The IBI training really helps the quality of the staff.	10
The direct care staff is not prepared.	11
The medically fragile need nurses who know the needs and history of specific clients and have immediate access to a doctor.	12
The need for very individualized medical care for those with multiple health issues like swallowing and feeding, seizures and a weak immunity so they are readily quarantined when necessary.	13
If the private service had worked out as well as ISSH, the client wouldn’t be at ISSH. There have been some bad experiences.	14
Psychiatric care for mental health disorders and the proper medication.	15
Idaho just does not have enough psychiatric care and fewer choices to select from.	16
Need specialized neurological care treatment from qualified neurologists. Families have to go out of the state to get this care.	17
We want a normalized experience for a family member with DDA, e.g., they may have good plan and assessment, but no experience and training at the direct care level. The turnover rate is high for direct care in the private sector.	18
The plan and payment is more important than the actual direct care services with the private providers. This is caused by the quality assurance process that relies on documentation and paperwork.	19
Degrees alone don’t help the quality of service. Providers need to listen to parents and direct care staff about the client’s needs. They need to listen to the consumer too.	20
Direct care listens to their boss. We are empowering direct care to pay the bills, not help the clients.	21
Self-directed planning and service has resulted in improvements in services. It is much more client and family driven- they have their own budget. It is challenging to get started, but it is much better. They can select and determine who is qualified.	22
The system is overwhelming to consumers and parents.	23
It is hard for parents to keep everyone safe when their child is up and awake at night.	24

PARENTS AND GUARDIANS

2. What are the supports that are desired for optimum quality of life for your family member?

A person with a disability needs to be respected. They're not someone's job.	1
Need a service that is individualized. They have a "herd" mentality to services.	2
The family member needs routine and minimal change- transitions are "evil" (e.g., a new car can cause problems for a client).	3
The family member needs to feel a sense of trust about those who take care of them.	4
The family member needs a sense of equality with those they interact with.	5
We don't use flexible strategies to manage a client with behavioral challenges. The service system/schools tend to use authority as the strategy to get good behavior.	6
It is too intrusive in its approach. The service system wants to control everything in that school or treatment environment that a client is engaged in.	7
The way some clients express themselves gets judged as "wrong" or "bad" and they can't undo it.	8
With the medically fragile, having a provider who notices how the client prefers to be loved and engaged.	9
A program to learn life skills, e.g. for the medically fragile- they need activity and engagement such as art, music, etc. They're normalizing activities instead of doing nothing. Self-directed planning really facilitates this for normalizing experiences in the community.	10
Clients are having their lives for therapy dictated by providers instead of "living." Do twelve year olds go swimming or learn grocery shopping?	11
The activity should be appropriate to the age of the individual that's normalizing and integrating it.	12

PARENTS AND GUARDIANS

3. If your family member currently lives in the community, why did you consider community placement?

To live close to the family to interact with them.	1
Will they be exposed to the "bad" behaviors of others that would make their behaviors more problematic? Parents really want a voice about where their family member lives.	2
To live with the people the client knows.	3

PARENTS AND GUARDIANS

4. If your family member currently lives at ISSH have you considered community placement? If you haven't, why not?

Moves are stressful, especially for some clients like the medically fragile. Some clients have an instant negative reaction to respite, such as depression, illness, etc.	1
Some clients need comfort and the predictability of their return to ISSH or in a rural community placement or back to the parents' home. Some clients can tolerate the transition so the families keep working at it in small steps.	2
Transition, change in routine, is very hard on parents because they have the burden of the consequences such as an injury, increased acting-out behavior or starting over with what they are working on (e.g., refusing medication and fluids resulting in seizures and then what if they died?)	3
Changing routine is a big deal for the client and the family.	4
Transitions and how to deal with them- there is constant preparation, repetition and discussion, medication, consistency of substitute response and warnings of changes.	5

PARENTS AND GUARDIANS

5. What information, knowledge, or assurance would you need in order to select a community placement?

Service that is equal to or better than ISSH. The knowledge is based on the observation of the staff, their training, the programs offered, the services offered, the guarantee they can be there and the location of service.	1
The background of the staff, survey results, and staff turnover.	2
What are the other clients there like and how will the family member do with them there?	3
For apartment placement- small setting, personal and a full-time trained staff.	4
For the medically fragile, parents may not feel competent to evaluate the quality of medical services. Is the only option a nursing home?	5

PARENTS AND GUARDIANS

6. Can all consumers who have a developmental disability live in a community setting? Why or why not?

Yes if they have the right supports.	1
Parents aren't assured of the safety with their family members who have disabilities.	2
Head injuries create a whole set of other challenges. The schools don't know how to handle aggression.	3
Schools don't serve children with aggressive behaviors well.	4
Don't know what works for head injuries and these can bring seizures.	5
Age tends to subdue behavior.	6

PARENTS AND GUARDIANS

7. If ISSH were to close, what are your biggest concerns? How could those concerns be addressed?

The medically fragile- would they die?	1
If no ISSH and they commit a crime, they will go to prison.	2
The medically fragile- would they maintain any quality of life?	3

PARENTS AND GUARDIANS

8. When you have experienced a crisis with your family member, what assistance did you receive? Was it adequate to prevent a more restrictive placement?

Called Mike Day who showed appropriate techniques and the acquired services (e.g., "Ready, Set, Go").	1
Often can't help.	2
Pass the buck to another provider. Don't know what to do and don't always have the information. Need respite on-site assistance. Parents sleep with a lot of vigilance so they aren't sleeping well.	3
Can't use typical community options, they get thrown out due to behaviors.	4
Summer is really hard with disabled children.	5
Caregiver, breadwinner, etc. not providing enough support.	6
Medical establishments and schools need more compassion and training.	7

ADVOCATES

1. A number of residents at ISSH are a danger to themselves or others, have a mental health disorder and a developmental disability, and may be opportunistic in acting out their maladaptive or predatory behaviors. How can we safely provide care and supervision of these residents in community settings? Please be specific regarding medical, pharmacological, residential and treatment services needed as well as supervision. Indicate how these services might be paid for.

Some pose a threat to themselves or their caregivers.	1
<ul style="list-style-type: none"> - Separate them from those who are a community threat - The community serves some clients like those at ISSH - Court adjudication for criminal offense – electronic surveillance (voluntary, waiver) 	
The importance of crisis capacity, e.g., CSOT for diversion, bed capacity for stabilization within the consumers’ area of the state with a public or private contract.	2
Nursing support to continue medical support/services.	3
Home visitation by a nurse to see the consumers in their residence.	4
Children don’t have options equal to supported living for adults. Need supported living for children to keep them in the community.	5
Daily living activities, e.g., employment (job support), center-based activities, volunteering for structure and stimulation.	6
The activities should include job coaching and children educational options. One-on-one aides in school/tutoring.	7
24-hour one-to-one supervision is now a Medicaid supported living option for \$400 a day.	8
The medically fragile at \$400 a day for one-to-one care. This would need to supplement the current rate for 24-hour one-to-one for the more aggressive clients.	9
Need direct care personnel who are trained to match the level of the clients’ behavior. This needs a special category.	10
Aggressiveness endangers staff and other clients living with them.	11
More support for caregivers like CFH who do 24-hour care. Caregivers need respite since they are often up and awake.	12
Support for families and training for families about how to deal with difficult behaviors.	13
The work needs to be done with the courts regarding what’s appropriate and what services are available.	14
Help train those in law enforcement to work with people with DD. This needs to be ongoing.	15
Need an emergency plan regardless of the placement. What is the plan for that client if a crisis develops? Each caregiver or provider needs to know who to call and what to do. What resources do you need as a response for a specific client?	16
DHW Mental Health needs some kind of mobile crisis for the dually diagnosed.	17
Provide information to prevent crisis or know how to respond and who to call in a crisis for those who need it. This needs to be 24-hour coverage.	18
Need psychiatric nursing and psychiatric technicians (having national certification) in case of the need for restraint. They need to have CEU’s so they are current about the law, etc.	19
Under Res/Hab, cannot get temp/quick interim staff to assist with a client in crisis. The client is then placed somewhere else and so loses his/her home resulting in no place to return.	20
Need a temporary stabilization placement with crisis beds (like Franklin House) throughout the state and longer placement needed for a crisis client. Need a way to preserve the place/home they came from since this helps them return to their home.	21
How do we reimburse to keep the crisis bed capacity available?	22
How can we engage providers to provide crisis care to a client? What would it take?	23
Sources of funds:	24
<ul style="list-style-type: none"> - Medicaid: Not flexible regarding service and the billing codes have to fit into a billing code placement setting specific to the codes. Need flexibility for billing payment. - 1915C Waiver as a way to finance (Medicaid won’t pay rent). - General Funds. - County indigent funds. - Prevent other expenses to the county for non-Medicaid clients and court expenses. 	

ADVOCATES

2. A number of guardians of ISSH residents do not want their family members to move out of ISSH, especially those who are medically fragile. If ISSH were to close, what do you think the biggest concerns would be for parents and guardians of the residents living there? How can those concerns best be addressed?

They have to be addressed with each parent and their family member individually.	1
This needs to be planned and takes time. What would it take for them to feel comfortable in a setting other than ISSH?	2
Move groups of ISSH clients together into the community.	3
Have a medical safety net.	4
There is the fear of getting less or less quality care.	5
The parents feel the provider who accepts their family member will be gone for some reason such as the provider is no longer in business, has an injury, etc.	6
Parents need the assurance that there's qualified staff, coverage for vacations and training for those new staff since there is staff turnover.	7
Staff turnover is an issue. Need special rates for special populations to prevent turnover.	8
Introduce parents to other families with similar needs. The system may not be adequate for the medically fragile population.	9
Address with parents, "What happens to your family member when you die?"	10
Parents need breaks if they are going to care for the medically fragile. There needs to be training for families and other natural supports.	11
The Person-Centered Planning Implementation Grant (Council Grant). What are the needs for support of the caregivers and those who provide natural supports?	12
Rural areas often do better with natural supports. They have to and may be less isolated, thus preventing admission to a facility like ISSH.	13
Need more infrastructure to help families maintain the medically fragile (education, support). <ul style="list-style-type: none"> - Parents need to be assured of protocols to respond to the needs of the medically fragile. It's very specifically defined by the medical staff and not left to the decision of the direct care staff. - Better training for families about medical conditions. - Mental health day treatment for children in lieu of the hospital. 	14

ADVOCATES

3. For those clients who are very assaultive and aggressive, what strategies should be used to provide for their safety and the safety of those around them? What barriers are there in the current system that impedes the implementation of those strategies? And what can be done to alleviate them?

Special rates to providers for special populations.	1
The criminal population needs a special response.	2
Need to protect other clients from aggressive clients.	3
The ability to place those who are assaultive in a single person residence to reduce triggers and potential victims.	4
Have training for staff to deal with assaultive behaviors. Need high ethical standard for staff. How do we prevent client abuse when it's one staff only in a "one client only" residence?	5
Protocols to help staff to know how to respond. Need a back-up identified in the protocol. Specialists need to develop the protocol and when to call for help.	6
Need to credential providers for assaultive clients so they have special training. Need this for the criminally adjudicated as well.	7
Help with the premium payment to get liability insurance for the criminally adjudicated or have a code change to assist in getting the liability insurance.	8
What will it cost to serve the criminally adjudicated?	9
We don't want to just save money, we want a better system. We've made tremendous strides.	10
Do providers want the ISSH client?	11
Are the criminally adjudicated eligible for the appropriate level of care?	12
Need a criminal justice system to take the responsibility for those who are competent to stand trial.	13

ADVOCATES

<p>4. Should people who have developmental disabilities be adjudicated through the criminal system if they commit a crime? To what extent should individuals with a developmental disability be placed on probation, incarcerated, etc.?</p>	<p>It depends on the crime and the person. The system makes determinations about those who are competent to stand trial. These standards are constitutional and should be applied. This requires legal, judicial and clinical information and perspective. Don't need to change the system.</p>	1
	<p>Have time limited consequences. The individual would need to understand what was occurring and the reason. There should also be a measurability of benefit.</p>	2
	<p>We don't have placement options in prisons to incarcerate a DD person. Judges believe they won't get the appropriate treatment.</p>	3
	<p>The only way the Department of Corrections (DOC) could handle them would be placement in isolation.</p>	4
	<p>Clients do need appropriate consequences.</p>	5
	<p>Do DOC contractors of service know and have the skills to treat DD people?</p>	6
	<p>Have house arrest and an electronic monitoring system.</p>	7
	<p>Have community service appropriate to the crime as defined by the parents and their direct care providers or Targeted Service Coordination (TSC).</p>	8
	<p>Probation-like action when appropriate.</p>	9
	<p>Have a Mental Health/Developmental Disability Behavioral Court as long as they understand the expectations and why they are in court.</p>	10

ADVOCATES

<p>5. Please describe the elements of a crisis system that would need to be instituted to facilitate the discharge of clients from ISSH and to prevent the need for admission to ISSH. How should those services be paid for?</p>	<p>Onsite crisis counseling for the individual and support/direct care staff with natural supports.</p>	1
	<p>Acuity-based reimbursement.</p>	2
	<p>Natural supports can de-escalate a crisis.</p>	3
	<p>Training to prepare staff for specific clients.</p>	4
	<p>Service <u>like</u> the regional mental health mobile crisis team- available 24-hours and in all parts of the state. It needs to be a little more robust than the mental health team.</p>	5
	<p>ISSH CSOT is a great service and is one piece of the system.</p>	6

ADVOCATES

<p>6. Can all consumers with a developmental disability and/or a mental health disorder live in a community setting? Why or why not?</p>	<p>Yes, with all the supports. It needs to be very individualized.</p>	1
	<p>Very difficult for families when children are placed at some distance from them. It is a very big financial burden for families to visit the Nampa site.</p>	2
	<p>Support for people who provide support. Need statewide availability.</p>	3
	<p>Respite care is critical and could develop into a network for a "respite care co-operative" no cost option through IFAD/IPUL. Need the infrastructure to make this possible. Can we get support to develop the infrastructure?</p>	4
	<p>An Idaho help website through the DD Council Grant.</p>	5
	<p>IPUL's Family to Family Health Education Grant for information sharing for parents.</p>	6

ADVOCATES

7. What options need to be created to prevent admission of adolescents to ISSH who are a danger to themselves or others or have other risky behaviors that threaten others?

Don't implement the Katie Beckett Cost Sharing.	1
Families don't know about Early Periodic Screening, Diagnosis and Treatment (EPSDT).	2
Need respite care.	3
In-home support staff during sleeping hours for parents through PCS (Personal Care Service) for example.	4
PCS 24-hour coverage.	5
PCS or IBI or Dev Tx hours are hard to get for exhausted parents.	6
Parents don't get good information out of EPSDT Service Coordination (ESC), the quality is variable. Parents surpass the knowledge of information known by the ESC.	7
Single parents have challenges.	8
Training and support for parents and siblings to deal with DD children.	9
Parents need a long-term view of their children.	10
The families withdraw. They don't trust, don't know what to ask or where to go.	11
Be more attentive to transitions for children.	12
Educate those who serve families, like medical doctors.	13
Have information such as brochures in doctors' offices.	14
The health care system doesn't want to deal with DD people.	15
Work with schools.	16
Develop and make available a parent manual for transitioning to adulthood.	17
Missing identification of kids with SED. We lose opportunities for intervention early. They then become DJC/DOC inmates.	18

ADVOCATES

8. Which system should serve the dually diagnosed (Behavioral Health or DD or both)? Why?

It depends on the individual.	1
What about the children? They are served where they are first referred.	2
The team approach for assessment and diagnosis is not identified well in the cost.	3
Need a separate system for dual diagnosis.	4
Parents sometimes won't allow assessment to get a diagnosis.	5
Wrap-around specialists for kids with SED brings in a team when they are at the most out-of-home placement service.	6
Help parents at the entry of their children in school to identify SED and behavior issues early.	7

ADVOCATES

9. What is the best use of the ISSH campus?

Temporary inpatient psychiatric care in the Treasure Valley.	1
Sell it.	2
Use the staff knowledge to make it a training and education center.	3
Try to figure a way to use the staff knowledge.	4
Work in the private sector.	5
National research and training center.	6
ISSH's history needs to be preserved.	7

ISSH AND DD STAFF

1. What do you see as the role of the Department in the system of treatment and care for people with disabilities? Why?

Partner for training and resources with the private sector.	1
Fill in the gaps, encourage and provide services not offered in the private sector.	2
Be the guardian of last resort. The family should be involved. Fill the gaps and link with law enforcement, families, prosecutors, providers, et.al.	3
Be the provider of last resort. Be a safety net for those who fall through the cracks and are not served privately.	4
Assist with rehabilitation, technical assistance and transition.	5
Provide support, training and knowledge to the family members.	6
Have vocational services as part of the last resort service array.	7
Assist families maneuvering through the court system with their DD family members. Neither the courts nor the police know this population.	8
Assist and guide prosecutors and courts about the process.	9
There is confusion about the mentally ill and DD population.	10
Provide services for refugees who are DD.	11
Provide training and technical assistance to courts and prosecutors.	12
Encourage the collaboration between police and prosecutors.	13
Have oversight of the private sector regarding quality assurance and the protection of the participant's rights.	14
Find medical services for appropriate medication.	15
DD participants are challenged with medical procedures and processes.	16
The dually diagnosed in crisis can't get a placement in the psychiatric hospitals. They sit in a jail or are out on the street.	17
Service groups in rural areas. There is little crisis support.	18
Discharge clients to Region 3- close to ISSH.	19
ISSH can continue its volunteer and other services to clients.	20
ISSH clients have jobs. They then get discharged from ISSH with no job.	21
Maintaining rights and the medical educational code status regarding medical conditions. Providing oversight to assure that clients receive annual medical services.	22
Complex medical/mental health issues need a continuity of service and highly skilled care.	23
The State provides expertise not found in the community providers. The private sector doctors may give very specialized psychiatric care and then release the client back to the less experienced community provider.	24
ISSH has access to a team of experts who put together the whole picture.	25
The State should manage and be the guarantor of an array of services for the DD population of the State. The State must provide oversight, evidence-based medicine, licensure, certification, provider agreements, budget and financial control.	26

ISSH AND DD STAFF

2. What training and skills do you have specific to your work with ISSH and the Department that are not available in the private sector?

The community system is not set-up to get together for teaming. The staff at ISSH work together, while in the private sector it is one person working at a time.	1
Because of the discharge process, one cannot pay the private provider to know the ISSH client while those at ISSH are getting paid.	2
Targeted Service Coordination (TSC) provides more advocacy and is encouraged by reimbursement.	3
There is high turnover in the private sector with young, untrained and inexperienced staff. Improved reimbursement could improve this.	4
Applied behavior analysis, CSOT.	5
ISSH is the best in the State for those with a dual diagnosis.	6
More understanding of sex offenders.	7
Teaming.	8
The staff training at ISSH is more frequent and better.	9
There are community psychiatric beds specially set aside for the dually diagnosed (for those with IQs under 70). These individuals need to have one-on-one with staff since the dually diagnosed disrupt groups.	10
There is training and education by the State to the private sector providers.	11
ISSH has access to information from the professional staff on the job.	12
There is more staff continuity who are trained to specific clients.	13
The community providers need to know how to restrain and how to prevent the need for restraint.	14
There is limited staff in the community placement for restraint.	15
It may not be realistic to have multiple sites. An example would be the psychiatric hospital. There is not enough of a population to support the costs. There is the need for a crisis placement site.	
ICF regulations don't allow quick medication changes like a hospital can.	17
Hospitals can't transition DD clients well. This is big problem for hospitals. The plans for discharge have to be approved by Medicaid.	18
Have to do upstream planning and identification of clients who are likely to lose placement because of escalating behaviors.	19
Clients at ISSH are often there a long time and get to know staff members who can work with them and change their behavior. We must pay the higher wages at ISSH to keep the staff.	20
There is very intense and specific training to improve behavior in an institutional setting which doesn't always translate to community placement.	21
Some ISSH clients placed in the community return to ISSH. This could be prevented if the provider spent more time with the client prior to the transition.	22
The ISSH staff members are very strong advocates for difficult clients and, due to their skills and expertise, the ISSH staff are comfortable with them.	23
The private provider solution for those with behavior problems is to call the police. The provider staff is encouraged not to touch the clients due to liability.	24

ISSH AND DD STAFF

3. What are the barriers to transitioning the medically fragile to a community setting? How can those be addressed?

The numbers and varieties of private providers are not ready to take on ISSH clients.	1
There is fear if the provider accepts a client and they are then stuck with that client.	2
We can't get them to the hospital.	3
Special rates are needed to accept a client.	4
Send the ISSH staff to a client's new placement.	5
The medical staff must be specialized.	6
In RN case management there are multiple specialists who are involved. There is interaction for changes in medication.	7
Identify doctors who would be willing to learn about and be with the medically fragile.	8
The inclination is that there will be discharges to Regions 3 and 4 due to logistics for services, staff contact, etc.	9
The medically fragile need quality of life- touch, interaction and activities.	10
Parental fears are a barrier to discharge. There needs to be a clearly defined safety net.	11
A big barrier is getting a doctor.	12
Having a contract for a medical doctor.	13
Medicaid clients are not attractive to medical doctors.	14
Maintaining the same specialist providers.	15
There is medical complexity that needs activity and a quick response. At ISSH, the RNs know the clients.	
There are a combination of conditions that create medical treatment challenges such as seizures, mental illness and diabetes.	17
Make sure they get the needed nursing services for the very fragile. This needs enough support and follow-through	18

ISSH AND DD STAFF

4. Please describe the elements of an effective crisis system for people with developmental disabilities who are a danger to themselves or others in order to prevent admission to the ISSH facility. How should those services be paid for?

Have a predictable source of stabilization for a client.	1
It doesn't need to be a long-term residential provider, just short-term.	2
Easier admission for stability.	3
Have an ultimate final safety net. The hot potato syndrome has created a provider/first responder aversion to assisting with crisis.	4
This needs to be predictable and quick.	5
It may have to be a state-run last resort option.	6
The hospital psychiatric unit is not taking anyone with an IQ below 70.	7
Unwilling providers. Contract to get what we need.	8
Although the clients get Medicaid, they are not eligible for all Medicaid services (i.e., waiver).	9
Assure access to crisis stabilization.	10
Key contacts for admission.	11
Have a single point of entry.	12
Take all services to the clients' existing placement. How do we do medication management?	13
Make the entry point accessible to law enforcement, mobile crisis, ER, etc.	14
A specialized team is needed for crisis. Not everyone can be served in their own placement.	15
Available 24-7 for the far reaches of Idaho and for all ages.	
A mobile team to respond immediately on-site.	17
Have a super nanny model (behavior analyst).	18
With mobile crisis team the option would not be to call the police. The police may then be more helpful in other crises.	19
Need to know the system- providers, funding services, etc.	20

ISSH AND DD STAFF

5. Should people with a developmental disability be adjudicated through the criminal system if they commit a crime? To what extent should individuals with a developmental disability be placed on probation, incarcerated, etc?

The courts are not consistent.	1
There is competency to stand trial, but judges may not pay attention to it.	2
Judges won't incarcerate unless there's a severe crime.	3
Can't get them in jail.	4
Have a DD court system like a Mental Health Court or a Dual Diagnosis Court. The current Mental Health Court may not be the best option. It needs to be for DD/MI.	5
18-211 and 18-212 cannot be changed.	6
Yes they should be adjudicated if they commit a crime and are competent.	7
Prosecutors are overwhelmed and they don't have time to deal with the lesser crimes by those with DD. What will benefit the community as a whole?	8
Jails don't want to house DD people.	9
Be consistent in the policy regarding crimes.	10
The Mental Health Courts have a participant criteria to fit the model; therefore, they need a DD specialty court with a different benchmark that has more reliance on a case manager.	11
The consequences for the DD population are behavior modification and <u>NOT</u> the cognitive-based approach.	12
Work with prosecutors for a DD short-term jail.	13
Probation officers are effective with DD clients.	14
The Washington example of a supervision waiver for criminal behavior.	15
Reduced supervision supports for the offender and they re-offend.	16
Need data about the numbers to determine "how much" court time for judges.	17
There is a resistance to deal with it now but we can get prosecutors and magistrates to give it up to a specialty court.	18
A segment of the system to serve the DD population <u>NEEDS</u> knowledge and a provider who could deal with them based on the specialized needs of the individual adults or children.	19
Build bridges to law enforcement and the courts.	20
Have a court order for supervision. As soon as you withdraw supervision, they re-offend.	21
Prosecutors should either prosecute criminally or commit.	22

ISSH AND DD STAFF

6. What employment opportunities are there for staff in the community? As ISSH transitions to a lower census, how do we address employee morale at ISSH?

EAP for employees.	1
Tell me what's going to happen. Give me a timeline. But will staff jump ship too soon?	2
Communicate and be honest.	3
Create a mobile crisis team with staff from ISSH.	4
Use direct care staff for mobile crisis, expanded training, technical assistance and stabilization.	5
The staff personnel get attached to clients.	6
The staff personnel are grieving the loss of the clients they cared for.	7
We have a DD population that is not going away. There will be jobs for the staff following clients who go into community placements.	8
Need a plan before you just close ISSH or abandon the clients there.	9
What does the future hold for health care in general?	10
Empower more families to be CFH and PCS providers. Keep family members in the home.	11
Direct care staff should be paid better and regarded as professional staff.	12
The training of career-track staff is non-reimbursable time. There is a vicious cycle of training and turnover issues.	13
Standardized credentialing and training for direct care is not equal to the on-the-job training with specific clinicians to specific clients.	14
Need more partnership with universities around training and placement experiences.	15
The community can't put together a team due to the reimbursement and schedule.	16
Have providers come together as teams. They don't team well and they haven't really come up with a plan as a team before each provider has already decided what to do on its own.	17
Have the ISSH staff as technical support and have adequate reimbursement.	18
Teaching behavior modification.	19

ISSH AND DD STAFF

7. What methods, strategies and policies must be in place to assure support accountability of providers and DHW who accept dangerous or medically fragile clients?

Specialized support and training of staff for the type of clients.	1
Knowledge of restraints.	2
ISSH can assist with training related to restraint.	3
Standardization of training and credentialing for equal skills and abilities.	4
Support needed to assure accountability. Mobile crisis can ask for access to consultation and a safe place for the provider and client.	5
Hands-on on-site support to the provider.	6
24-hour phone availability and a web page to know the services.	7
How can we help law enforcement and intervene?	8
Maintain continuity of the policy regarding how we respond and who is responsible.	9
Sporadic, on-site inspections of provider facilities. Have written policies regarding calls to police with an explanation and a description of policies of how to respond to various scenarios.	10
Stronger statutes and roles for adult protection.	11
Clearer Medicaid rules about standards.	12
How do we deal with uncertified family homes?	13
Greater risks with clients and greater liability. Need improved reimbursement incentive for very intensive high risk clients.	14
Use contractors to serve the dangerous because DHW has a duty to place them. Select and contract each provider client-by-client. Have consistent funding to engage the providers with stabilized funds.	15
Good communication for transition; there needs to be a good connection between medical and behavioral issues. The medical causes the behavior issues. It is important to carefully review the chart of the client's needs. Need a team that can give and follow recommendations.	16

ISSH AND DD STAFF

8. What is the highest and best use of the ISSH campus?

It is nice to know ISSH is there.	1
Another golf course.	2
Mental health beds.	3
A forensic inpatient psychiatric treatment center.	4
Other related services for the DD population- outpatient services.	5
A training center for vocational services. Make the ISSH resources available to other community clients.	6
Res/Hab to clients who have higher needs.	7
Partner with hospitals for specialty services, e.g., EEGs.	8
Emergency bed outreach, etc.	9
Maintain the campus.	10
Relicense as criminal placement for DD. A forensic unit for those with DD. Specialized, short-term units for juvenile DD sex offenders.	11

ISSH AND DD STAFF

9. What would private providers need to serve the clients at ISSH?

Reimbursement for training.	1
A higher rate of staff coverage, e.g., 2:1 per client.	2
Crisis intervention.	3
Strong team approach.	4
Specialized medical services for the medically fragile.	5
CNA's.	6
Good community support, tolerance and volunteers to be the social support for clients.	7
Collateral supports through the expansion of benefits for the enhancement of community integration.	8
A paradigm shift in thinking for providers (the Res/Hab and ACT team, for example).	9
DD and MH need to be in one structure again. There is an adversarial relationship between DD and MH. DD is in Medicaid too so we have three decisions-makers with the burden on one (DD). There are three administrators who can trump each other.	10
There is a specialty of various client groups, e.g., the dually diagnosed and the medically fragile.	11

CONSUMERS

1. Why are you living at ISSH or why did you live at ISSH?

Angry – problems with children – 15 yrs.	1
Family could not take care of me – 7 years.	2
Wasn't making good choices – angry	3
Have lived in institution starting at 13 yrs old – SHS there for medication adjustment.	4
Registered sex offender – in own apartment now.	5
Anger and assaults.	6

CONSUMERS

2. When you are/were here, do you think you received quality care?

So I could be safe in the community and around children. My guardian wants me here.	1
Let's me learn what I need to learn, like anger management. Teaches me to ignore people in the community when they say things to me – learned things that help me live on my own.	2
Learn not to yell and scream and to be a good person and not to quit. She is ready to move on.	3
ISSH is one of the better facilities for offender issues, anger issues, medication. Helped me through my past into the future. Best facility that allowed me to be successful in the community. ISSH is more productive and efficient in getting me through issues. If ISSH falls there will not be a place for someone to go with behavior issues. Other facilities will not accept clients with behavior issues. Has been out for years. Had two strong guardians that helped make decisions so he didn't come back to ISSH when his Res/Hab became a problem. He no longer has services. He was made to live with one of his guardians and it ruined their relationship.	4
Care depends on having good staff. Some staff wants her to get past being angry. Food isn't flavored very well. Some people do not want to live in an institution. Living here is not a positive thing because the community looks down at you.	5

CONSUMERS

3. When you lived here, do you feel safe here?

Doesn't feel safe here sometimes. Cause staff is not always good blockers. Trust and consistency important. False calls to police make it so they will not come out when it's real.	1
Felt safe until they started moving staff around. Feel less safe when there are too many changes. Reducing staff on a unit makes him feel less safe. Some of the VOC options they used to do, they no longer do. Had two good VOC people and like what went on back then. Hears a lot of negative things about the new program. Let the clients advocate for the things that they want.	2
Thinks highly of Fred George. Trust and consistency are really important for safety. Some clients may need to be put in a lock up facility because of too many problems. There are problems like false fire alarm pulls. When we call the police they do not come out for us. They issue tickets and then we have to go to court.	3
Does not feel safe at Aspen; Birch, Pine and Redwood feels safe. Feels like he needs to do something. They will not stop playing music too loud and he is working really hard not to deck someone. Staff doesn't stop those aggravating issues. Sometimes when serious issues happen and I've called the police, they don't come out.	4
She feels safe here. Other people may think they are not safe because they think something will happen from a client acting out. When other clients act out, she may not feel safe but can move out of way. Feels highly of workers, staff and Qs. Will be discharged in a few weeks. Thinks highly of the police force and when they come out for simple things. It pulls them out of the community and the staff can handle the situations. They can't respond to everything.	5

CONSUMERS

4. Do you feel you learned and your skills improved?

Taught how to be stable in the work place and to work hard.	1
Learned to cook and to put things together. How to build things. Learned to build a phone booth.	2
Learned that I am a good person. Learned to love myself and that I can work and be successful. Learned to ask for help. Learned that somebody loves me.	3
Here to give opinions and how I am successful. I've come back and visited and tells what his life is like in the real world. When I was here before, the program was not set up for learning to pay bills and before I got in trouble I had the skills to manage my money. There were things I needed to learn to be ready to live outside of ISSH. When I was here my attitude was that I did not want to change. After being committed again for 3 years I had a very good counselor and it helped a lot. Came out of the jail system – I am not happy with what I did. Jail did not help me. Here you actually become a productive citizen. An offender program that you could access if you're at ISSH or not at ISSH would be helpful. I will not go backwards and come back to ISSH. I can still call ISSH staff and talk to them.	4

CONSUMERS

5. Do you think you need to live at ISSH a while?

Yes – takes a long time to be discharged once you know where you are going to be discharged to.	1
No – Doesn't need to live here anymore. Learned what I needed to learn.	2
Yes – needed to live here awhile – made bad choices – has taught me to say no. The government doesn't give the funding to other facilities. Paperwork takes a long time.	3
Yes I needed a place to go – family was not an option to live with. Would have rather come here than another ICF/MR because I would get the type of help I needed. Other ICFs/MR were not using funding to bring in staff for things like anger management programs or cooking classes and don't offer what's needed. He was not able to be accepted in some places because of his past history. Hurts him that his guardian has become alienated because of past issues.	4
Yes – takes a long time to be discharged once you know where you are going to be discharged to.	5

CONSUMERS

6. Are there things you like about living on your own?

More freedom to do what I like. I like to go for walks.	1
Friends that I could meet somewhere. Could make more friends. Better life because I had my freedom. People don't tell you to shut up.	2
More freedom. Could go over to visit my dad in Pocatello. I would like to be transferred to SHS so could see my dad. I used to work at SHS.	3
ISSH was helping me with a lot of stuff. But couldn't get a driver's license, insurance or a car. Now I have my license and a car. I kept getting my offender issue thrown at me. I needed more transition time – I only had three days to move out of my apartment. I decided that I needed to jump out and just do what I needed to do. I need to be strong and survive. I am functional and am by myself. I was in the State system since I was young. Some ICFs don't allow people with disabilities to advocate for themselves. Was discharged from ISSH and put in a Res/Hab. Had roommate because of funding issues. Was forced to have roommate and did not want one. The roommate left and I was told I would need to come back to ISSH. I moved out on my own instead because I couldn't move in with a guardian. There was no other option for me. I had a very successful job and am still very successful. Facilities do not prepare people for what people in the community will think. Some of the offenders have a difficult time in the community. As an offender I have to worry what the neighbors think and sometimes I am forced to move.	4

CONSUMERS

7. With the right supports do you feel they can be successful without ISSH?

I feel I could have been successful with the right supports. The courts tell people that they have to come to a facility. I was already locked up in jail and a lot of State people have helped me. A lot of people would need more care to be productive.

1

CONSUMERS

8. For the medically fragile individual will there be the kind of care available?

Is everything going to be in place before ISSH is closed so we don't put people's lives at risk?

1

We are looking at all the options and then making a recommendation. I've been in an institution, and several other facilities and Res/Hab programs. I think that the question is - are all the programs going to be available? The community programs that I have had have been good. People can be integrated into the community. It is important to gather the information.

2

CONSUMERS

9. Do some people need to live here for a while?

Yes – they need to learn how to control their behavior and anger. A lot of people get angry here.

1

I chose to move here because they kicked me out of the house and the judge made me come here. People understand you better here are ISSH. The supervisor is a wonderful man. Some members of my family do not like me because I am a sex offender. The staff acknowledges that I do good things here. The staff members have big hearts.

2

With the right supports people wouldn't need to live here. The right supports would allow them to be productive. Having a transition place was helpful and would need to be done very carefully. Don't want to bounce from one place to another without a transition.

3

Those who come out of jail need a place to get their life going in the right direction to get back into the community and need a transition to regroup.

4

CONSUMERS

10. What about the people that have lived here their entire life?

It would make the adjustment to a new facility difficult when they have been here a long time. As an advocate of people with disabilities, need to look at all the people that have lived here long term. To those long term people this is home. Don't fix something that is not broke.

1

I want to be a part of my dad's life. I have been here so long now that ISSH is home. I am worried people may find out who I am and hurt me. Not all providers are equipped to provide for the medically fragile. They might end up in a nursing home and that won't help them. They may take care of them but won't help them. Sometimes they don't get good care in the nursing homes.

2

We have to think about not only ourselves but also the people on E, S, and R. The community may not have places available for everyone. Need a win/win situation. We need extra staff to work with the fragile.

3

We need to make sure that the new home knows all the things they need to know about a client like allergies etc. Clients here get changed when they get wet.

4

