BEFORE THE INTERIM LEGISLATIVE COMMITTEE
ON MENTAL HEALTH AND SUBSTANCE ABUSE
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Testimony of Kathleen P. Allyn, Administrator, Division of Behavioral Health:

I appreciate the opportunity to appear before you again to present the Department's plan for the state's behavioral health services.

In the 3 months that I have been Administrator of the Division of Behavioral Health, I have had an opportunity to review current services, studies on behavioral health systems, and the recommendations of State councils and agencies.

There is no dispute that Idaho's behavioral health services are inadequate to meet the present needs of its citizens. Numerous groups have identified problems with the mental health and substance abuse delivery structure. What is lacking is a clear and organized strategy that prioritizes needs, includes cost estimates for proposed program changes, and identifies the steps needed to develop a public behavioral health system.

I have three sets of proposals that I am presenting today:

1. Immediate actions that have already been initiated to improve current services, primarily community-based services;
2. Proposals to be taken to the Legislature to further the process of building a behavioral health system during SFY 2008; and,
3. Longer term proposals to implement a behavioral health system

To put these proposals in context, I want first to talk about the elements of a "good" public behavioral health system. In talking about this, I am drawing from the literature in the field, the collective wisdom of the Behavioral Health staff and their years of professional practice, and the ongoing work of the numerous state councils and committees with their broad and diverse representation.

I. SYSTEM CHARACTERISTICS

According to various authorities, including the President's New Freedom Commission on Mental Health and others, the **characteristics** of a good public sector behavioral health care system include:

1. Client focus and engagement;
2. Commitment to recovery and resiliency;
3. Clarity of system design;
4. Clinical and service excellence;
5. Sufficiency of resources;
6. Attention to human resources;
7. Equity of access;
8. Integration of care;
9. Community-based solutions;

10. Accountability for public funds.

Idaho should work to assure these 10 characteristics of a "good" system are present throughout the behavioral health system. We should use these characteristics to judge what changes are needed to make a more effective system of services for Idahoans. They are the basis for the recommendations about priorities and system changes that I will be presenting.

II. SERVICE ARRAY

The other thing I want to discuss briefly, again as context for our recommendations, is the array of services that a good behavioral health system needs.

A good behavioral health system includes an array of mental health and substance abuse services in each of the following categories:

- Prevention and education services aimed at educating the community and selected populations, such as pregnant women, parents, or primary care physicians, about risk and protective factors related to mental health and substance abuse.

- Early intervention and diversion services to identify at risk individuals and their families and reduce risk factors, increase resiliency or recovery factors and divert individuals from inappropriate settings such as jails or hospitals.

- Comprehensive assessment and case management -- a comprehensive evaluation of all presenting disorders, development of a single plan of care implemented across systems and funding sources, and coordination of services.

- Intensive community-based treatment services such as outpatient and residential services, and specialized therapies such as functional family therapy designed to address the short-term but intense needs of high risk individuals.

- Broad-based community recovery and maintenance supports – such as:

    - Client and family support services;
    - Supportive housing/living arrangements;
    - A range of psychosocial rehabilitation, supported employment, and family-based wrap around services.

- Crisis intervention services that include mobile crisis, ACT teams, and respite services.

Not all potential services under each category can, or should, be made available in every community. Some services may not be economically feasible. An inpatient psychiatric hospital, for example, requires a large capital investment, ongoing financial support and professional resources that currently may not be available in every region. However, in order to have a "good" behavioral health system, each Region should work to develop services in each of the categories.

Finally, a good behavioral health system must include specific services and system designs for different age groups and cultures. There is a need for the system to be able to treat dually diagnosed individuals. The system must also be able to deal with the special challenges presented by the juvenile justice and adult correction populations.

III. DEPARTMENT ACTIONS ALREADY UNDERWAY

Most of the recommendations I am discussing today add to or strengthen community-based services in each of the categories I mentioned. A few are directed at strengthening the underlying infrastructure of the system. The proposals also move toward greater integration of substance abuse and mental health services.

First – the Department already has or shortly will initiate the following actions:

1. **Partner with District Health Departments in Mental Illness and Substance Abuse Primary Prevention**. We have contacted the Directors of the District Health Departments about implementing prevention and education programs on mental health and substance abuse issues in partnership with the Department. The District Directors have expressed an interest in becoming involved in mental health and substance abuse primary prevention and education. This partnership will greatly strengthen prevention efforts around the state.

2. **Partner with the Courts in Co-occurring Disorder Training**. We are working with the Courts to develop co-occurring mental health and substance abuse training for Department staff and others working with drug and mental health courts. This is a first step in developing an integrated evidence-based model for dealing with co-occurring mental health and substance abuse disorders. I will discuss the model in more detail later.

3. **Increase the Number of Children/Adolescents Receiving Wrap Around Services.** We have developed a plan being presented for approval next week to the Idaho Children's Mental Health Council (ICCMH). This plan will significantly increase the number of children and adolescents with Serious Emotional Disturbances (or SED) served by wrap around services. This will be accomplished by contracting to have parents with children who are SED and others trained to facilitate the wrap around process. The current wrap around specialists, who are masters level clinicians, will continue to work in the children's mental health program. They will provide supervision of the paraprofessional wraparound facilitators, clinical assessments, and case management of the treatment plans developed through the wrap around process.

   This change is initially expected to increase the capacity of the program to serve 210 additional children by August 2007. However, the ability to sustain this effort is dependent on the approval of a Decision Unit to maintain the current level of funding in fiscal year 2008. I will discuss this Decision Unit in a few minutes.

4. **Improve the Mental Health Data System.** It will come as no surprise that part of the infrastructure needed to support these improvements is better access to data. At present, for the adult mental health program to run reports, we must access 14

different data bases. Needless to say, this is not an efficient process. The Division was awarded a federal Data Infrastructure Grant that can be used to analyze data needs and develop a plan for meeting those needs. The plan will include recommendations on the best way to integrate the adult data with the children's and substance abuse data. We began that study as of September 1 and hope to have it completed before the end of the year.

IV. DEPARTMENT ACTIONS FOR NEXT YEAR REQUIRING A DECISION UNIT

I want to turn next to initiatives that the Department is proposing as Decision Units to be brought before the Legislature in 2007. While the Department has proposed these DUs, we do not know at this time that they will be included in the new Governor's budget.

1. **Transition from Access to Recovery to State Priorities.** Let me first address the transition to state priorities and away from the federal Access To Recovery Grant. The ATR Grant is scheduled to end in August 2007 and has funded a significant portion of the substance abuse services in the state over the last two years. While there may be a potential to carry some federal funds beyond the end of the grant, that is very uncertain. Rather than risk severe service reductions, the Department is asking for an additional $6.5 million in general funds, additional receipts spending authority of $1.5 million, and anticipating a $460,000 increase in federal Block Grant funds. As you can see on the screen at the top right, this will make the total proposed budget for state substance abuse services in SFY 2008 come to about $20.4 million of which $6.5 million are new state general fund dollars.

   This money will provide critical substance abuse services previously funded by the approximately $7.6 million per year in federal funds received through the ATR Grant. The Department proposes to refocus the priorities – mixing new general funds with existing general funds, an increased Block Grant and additional receipts authority – to address the state needs shown on the screen:

   a. **Fund Prevention/Education at Current Level.** In the area of substance abuse prevention and education, the funding effort from fiscal year 2007 to fiscal year 2008 will remain essentially the same at approximately $2.9 million. The Department will continue to move community-based prevention services providers to evidence-based and emerging best practices. The Department will also involve the District Health Departments in the prevention and education effort.

   b. **Establish a New Adolescent Early Intervention Service.** The Department proposes to use part of the additional general fund monies to initiate two new community-based early intervention services for fiscal year 2008. One new service will be directed at adolescents who have completed school substance abuse programs but are still seen as at substantial risk of abusing substances. The program will cost just over $650,000 and serve about 1,000 youth.

   c. **Establish a New Early Intervention Program for Children of Addicts.** The other new community-based early intervention program is directed at children of addicts. This program will work with children whose parents are in treatment for drug addiction to prevent the children from becoming addicts. This program will

cost about $900,000 and serve about 2,500 youth. The total cost of the two new programs is $1.67 million.

d. **Localize Substance Abuse Services.** In the category of assessment and case management, the Department proposes to replace the current 800 number with 30 staff to be located in the Regions. The program will cost about $1.94 million – about $160,000 more than was spent last year on the 800 number, assessment, and case management. These staff will provide local, community-based assessments for services and act as case managers for complex cases. The staff will be supervised by the current Regional Mental Health Program Manager. In addition to working with the general public, these staff will work with local probation and parole to access treatment for clients being released from jail or prison. They will work with local mental health clinicians to access treatment for clients with co-occurring disorders, and with physicians to access care for pregnant and parenting women. In adding these employees, the substance abuse system will be more community-based and accessible to clients.

e. **Increase Funding for Direct Treatment Services.** The funding for direct treatment services is increased by about $461,000 to $9.2 million of which $800,000 are new general fund dollars. Treatment administrative costs, including personnel, operating and management costs are reduced by about $1 million to just under $2.5 million of which about $593,000 are new state general funds.

f. **Contract for Quality Improvement.** To strengthen the underlying infrastructure, the Department proposes to contract for program accreditation and continuous quality improvement. The cost of the contract is $135,000 in new general fund dollars.

g. **Maintain Recovery Support Services.** Finally, recovery support services in fiscal year 2008 will be funded at about the same level as fiscal year 2007 at $2 million of which about $1.4 million are new general fund dollars.

2. **Co-locate Clinicians with County Juvenile Justice Programs.** The Department is proposing a Decision Unit to add 2 clinicians to each Region to work with the county juvenile justice system. Although based in the Department Region, these clinicians will be available to travel to each county to work directly with county staff. They will assess county juveniles for mental health disorders and either place them in Department treatment services if they have a serious emotional disturbance or, if not SED, try to place them in community services. The clinicians will also be trained to do a substance abuse screen. If the screen is positive, they will refer clients to the community-based substance abuse program staff, I just discussed, for further assessment.

   The addition of these clinicians is expected to decrease the amount of time it takes for juvenile justice clients to access services. It will increase the capacity of the program to serve clients. The clinicians will be able to provide assessment to an additional 525 youths per year which is a 29% increase over the current capacity of 1803 per year. It will also increase the capacity of the CMH program to provide case

management to an additional 338 youth, which is a 23% increase over the current capacity of 1475.

The cost of the Decision Unit is $1.3 million of which $1.16 million are General Fund dollars.

3. **Expand Wrap Around Services for Children's Mental Health at Current Funding Levels.** The Department is proposing a Decision Unit to maintain funding of the Cooperative Agreement, the federal grant that currently funds wrap around services for children and adolescents with SED. The grant is beginning its 5th year and the federal match drops from a one for one match to one federal dollar for every two state dollars. The DU is for $130,000 in General Funds to maintain the current funding for CMH. As I mentioned previously, subject to approval of the ICCMH, we will immediately begin implementing a plan to triple the number of children and adolescents served by wrap around services using current funding. The proposed Decision Unit will allow us to continue that effort in fiscal year 2008.

4. **Increase the Capacity of the Community Mental Health Centers.** The Department is seeking a Decision Unit to increase by two per Region the number of state staff providing core adult mental health services. Since the Department refers most insured and Medicaid clients to private providers for treatment, these state clinicians will serve primarily the uninsured population. The addition of these clinicians is expected to increase the capacity of the adult mental health program to provide over 250 additional crisis screenings, court-ordered assessments or telephone screenings and to provide on-going treatment services to over 360 new clients. There will also be a small reduction in caseloads for all staff. The Decision Unit also adds an FTE to analyze performance and outcomes data. The cost of this Decision Unit is $1.24 million of which $1.08 million are General Fund dollars.

5. **Provide Integrated Mental Health and Substance Abuse Training.** The Department is requesting funds to develop a training program that integrates mental health and substance abuse services and provides the training at the local level. With the creation of the Division of Behavioral Health, the opportunity and need exist to keep all behavioral health clinical staff and community partners informed about evidence-based and best practices in mental health, substance abuse and co-occurring disorders. The decision unit also expands training in the Children's Mental Health program in connection with the federally-approved Program Improvement Plan (PIP) for Child Welfare services. The decision unit adds one clinician trainer in each of the seven Regions at a cost of $561,000 of which $533,000 are General Funds.

6. **Determine the Resources Necessary for JCAHO Accreditation of SHN.** The Department is submitting a Decision Unit for funding to assess what it will take in staffing, physical plant changes and, ultimately, cost for State Hospital North to be JCAHO accredited. The estimated cost of the study is $40,000 in General Funds.

7. **Conduct Quality Assurance of Medicaid Mental Health Clinic Services.** Finally, we are proposing a Decision Unit to initiate quality assurance reviews of mental health clinics that provide services to Medicaid clients, including partial care services.

Specifically we are asking for 15 state staff -- 13 will be in Regional offices conducting on-site Mental Health Clinic quality assurance audits, initial complaint investigations, and technical assistance and training on Mental Health Clinic rules; 1 FTE will supervise both the existing Psycho-Social Rehab Prior Authorization and Quality Assurance unit and the Mental Health Clinic Quality Assurance unit; and 1 FTE will provide administrative support to both units. The cost of this decision unit is $1.1 million of which $558,000 are General Fund dollars.

V. LONGER TERM DEPARTMENT ACTIONS

What I've talked about so far are actions that are being taken immediately or require Legislative approval for the next fiscal year. What I want to talk about next are actions that will be started in the next 12 months but will take more time to complete.

1. **Develop a Behavioral Health System Implementation Plan.**

   a. **Better Coordinate and Integrate Department Behavioral Health Services.** The Department needs to get its own house in order. We will develop a behavioral health system implementation plan to coordinate and integrate Department behavioral health services, including Medicaid-purchased services. The plan will be based on priorities identified by key statewide committees and Regional advisory groups, and include cost estimates for proposed program changes. It will incorporate evidence-based or emerging best practices and include expected outcomes from services as well as a management and improvement process. And it will identify the steps needed to implement the plan.

   b. **Integrate Mental Health and Substance Abuse Advisory Groups.** As part of that plan we will work with public advisory groups to identify gaps in community-based services and the Regional priorities to fill those gaps. Advisory groups are potentially a valuable resource but to date the Department has not used them effectively. At the same time, there are at least 12 groups that have been created by statute or actions of prior Governors and there may need to be a consolidation of some of these groups. We will work with these public groups to determine with them how best to fulfill their statutory or executive mandates and make what changes we can right away.

   c. **Address the Recommendations of the Estimé Report**. Something else that will be addressed are the recommendations of the Mental Health Facilities Plan, dated September 29, 2005. Known as the Estimé Report, this document made the following recommendations that will be addressed:

      i. **Improve Recruitment and Retention of Mental Health Professional Staff.** We have made some progress in the area of recruitment and retention of mental health professionals – base salaries for physicians, particularly psychiatrists, have been increased by 6.7%. As you know, we now have a second psychiatrist at State Hospital North – Dr. Karla Eisele. We have also raised the base salaries of nurses by 10.5% and social workers by 9.3%. In addition to these base pay increases, the Department also provided some bonuses and short term salary increases to these professional staff during

last fiscal year. We are grateful to the Legislature for supporting all of these increases. While this seems to be helping with retention, it is too soon to know for certain how effective these measures have been. Even so, Idaho remains a mental health professional shortage area and a plan to attract and retain more mental health professionals is being developed

ii. **Develop Community-Based Crisis Respite Facilities.** Another recommendation of the Estimé Report is to develop 8-bed 72-hour crisis respite facilities. The estimated cost of one of these facilities in 2005 was $1.2 million for construction costs and an additional $1.46 million in operating costs.

These community-based facilities can provide psychiatric evaluation, crisis stabilization and intervention, medication management and monitoring, and substance abuse detoxification. They can avoid the need for more expensive inpatient hospitalization.

As you know, during the last session, the Legislature appropriated $2 million to be awarded as grants to Regions to start up mental health or substance abuse services. The deadline for the first round of grant applications is October 1 so there may proposals for such facilities. If not, we will proceed with a proposal to develop them.

iii. **Resolve How to Care for People with Mental Illness that Makes Them Dangerous to Themselves or Others.** Idaho needs a way to care for people who, due to mental illness, pose a significant danger to themselves or others. Over the past 12 months there were about 40 adults who needed to be kept in a secure environment to prevent harm to themselves or others. About 30 of them have committed violent acts but cannot stand trial because they cannot assist in their defense. About 10 of them have not engaged in criminal behavior but need to be kept in a secure facility to prevent them from harming themselves or others.

Idaho desperately needs a secure psychiatric facility or facilities for these people. The state hospitals do not have the secure environment to care for them. The Department of Correction secure facility of 12 beds is nearly always full.

The question is easy to state, do we build one secure facility to house both convicted and non-convicted people or do we build more than one facility to separate those adjudged guilty from those who have not been convicted of a crime. The question is easy but the answer is more difficult -- one facility appears to be more cost effective; two or three facilities seem more appropriate from a philosophical point of view as well as for purposes of access. It is a difficult issue for which there is no clear answer. I, personally, am not ready to express an opinion on how to proceed without further research.

At the same time, for the safety of staff, clients and the public, we must take some action during the interval before additional secure space can be constructed. State staff are currently being asked to take care of very dangerous people in facilities that were not designed for that purpose. Not only does this put state staff in jeopardy, but it poses a risk of injury to the client and potentially endangers other clients and the public, in the event of an escape from a non-secure building.

This risk to staff, clients, and the public is not acceptable and must be addressed as soon as possible. We are examining this issue and plan to bring a proposal to the next Legislative session.

iv. **Develop Public-Private Partnerships to Develop and Operate New Facilities.** The Estimé Report recommends the development of new facilities for detoxification and transitional housing. Both of these are important services in a behavioral health continuum of care. Once we know the results of the grant program, we'll assess the status of these services.

We expect the Behavioral Health System Implementation Plan to be completed in time to submit budget and legislation proposals to the 2008 Legislature. Implementation of the plan will begin as soon as the plan is complete.

2. **Implement a Integrated System of Care Model for Co-occurring Disorders.** I mentioned earlier that we are starting a program to train field staff about co-occurring disorders as an initial step in implementing an integrated model for co-occurring psychiatric and substance abuse disorders. An estimated 50% of individuals with severe mental illness also will develop a substance use disorder during their lives. Co-occurring diagnoses are the expectation, not the exception to the rule. Further, when mental illness and substance abuse diagnoses co-occur, they both must be treated as the primary diagnosis, not one or the other.

   The model we propose to implement (developed by Dr. Kenneth Minkoff) has proven the efficacy of integrated treatment. The program can be implemented incrementally to result in an integrated system of care that combines substance abuse and mental health treatment on an individualized basis. Within a year, we will be able to report to the Legislature on the status of the program and the plan and time to complete implementation of this model.

3. **Review Medicaid Funding of Mental Health and Substance Abuse Services**. According to the report developed by the Legislative Services Office, Idaho currently spends about $61 million in state general fund monies (not including the Medicaid state match) on mental health and substance abuse services. Although some of that money may be serving as match for other federal programs, a portion of that general fund money potentially could be used to leverage additional federal money through Medicaid.

   We know, for example, that Idaho Medicaid's coverage of substance abuse services is indirect and limited only to acute care hospitalization and to counseling where there

is a primary mental illness diagnosis. Community-based mental health services funded by Medicaid are limited in scope rather than comprehensive.

As the Department rolls out Medicaid reform, there is an opportunity to review Medicaid coverage of mental health and substance abuse treatment. However, any proposed expansion of Medicaid coverage needs to demonstrate that the expenditure is replacing services currently covered by General Funds or that no additional General Funds are being spent to fund an expansion of services. Of course, the services proposed to be covered must meet efficacy (i.e. evidence-based and emerging best practices) as well as quality criteria.

4. **Adopt Uniform Assessment Tools.** We will work with other public agencies to adopt uniform assessment tools for both mental health and substance abuse assessments. In the area of substance abuse assessment, the Department will be contracting to identify the best substance abuse assessment tool to assist in the effort of adopting standard assessments.

5. **Broaden the Definition of Serious Emotional Disturbance Used for Children and Adolescents**. Related to the Decision Units discussed earlier, a recurring concern raised by the Department's partners and families is the definition of Serious Emotional Disturbance or SED used by the Department. The exclusion of conduct disorders as a serious emotional disturbance is a particular point of contention.

   The Division is currently reviewing its definition of SED to determine the impact of broadening the definition to include conduct disorders within defined parameters. An initial review indicates that the definition could be broadened to include the majority of juvenile justice clients who were denied eligibility for Department services. It would require that the Children's Mental Health Decision Units are approved. Division staff will be working on this proposal with the Children's Mental Health/Juvenile Justice workgroup to gain consensus on the definition of SED.

6. **Negotiate Reduced Rates for Community Hospitalization.** In the area of mental health treatment, as you are aware, the Department presently contracts with community hospitals for inpatient care until the patient is able to get into one of the state hospitals. The rates being paid for community hospitalization vary from $550 to $1,000 per day. In some Regions, we may be paying the best price we can get but in other areas, there may be an opportunity to contract with a single provider for this service. Over the next year we will be negotiating contracts for community hospitalization where we think we can get a better rate.

7. **Conduct a Community and Family Psychoeducation Pilot**. A recently developed program designed to prevent the onset of psychosis early in life is being conducted by researchers at the Maine Medical Center. Known as the Portland Identification and Early Referral Project or PIER, this program is based on the knowledge that psychotic episodes physically damage the brain and that preventing the onset of the psychotic phase of the disease is critical for preventing life-long problems.

   The treatments used in the program are all standard, empirically validated approaches. The critical feature of this effort is the clinical outreach by a team to

general practitioners, school guidance counselors, and the population at large to educate and inform them about the early signs of psychosis.

At-risk youth are identified and provided family intervention and education along with medication therapy. They are being tracked over time to determine whether this prevention/early intervention strategy will result in less dysfunction later. Early experience is showing that this approach clearly and dramatically reduces later problems.

The Division has been in touch with Dr. William McFarlane, one of the project managers, about the possibility of piloting this program in Idaho and we are in the early stages of assessing what will be required to conduct a limited pilot.

8. **Work With Other Agencies To Clearly Establish Agency Responsibilities.** Numerous comments have been made to this committee about what agency has the responsibility for providing mental health and substance abuse services. Frankly, in my review of the interactions between the Division of Behavioral Health and the Counties, Juvenile Corrections, Adult Correction, the schools, and the courts, it is not always clear, either in law or policy, where responsibility for providing or paying for services lies.

   The Division will begin discussions with each of these entitles to identify and resolve disputed areas of responsibility. In some cases, this may be an easy task; in other cases, it will take some time to work through.

   The plan is to jointly develop a flow chart showing an individual's process through a given system and identify each point at which a mental health or substance abuse assessment or service may be needed. The next step will be to identify areas of disagreement about whose responsibility it is to provide the service and whose responsibility it is to pay for it and reach consensus on what makes sense from a system standpoint. To the extent that additional resources are needed to carry out the responsibilities identified, a plan will be developed to seek additional resources. Ultimately, the agencies will develop and enter into memoranda of understanding or joint protocols setting forth each agencies role and responsibilities.

VI. SUMMARY

To review the impact of the proposals I've discussed today on the behavioral health continuum of care:

The Department will be increasing prevention and education programs through:

- Partnering with District Health Departments in mental illness and substance abuse primary prevention;
- Cross-training Division staff and others in mental health and substance abuse;
- Conducting a community and family psychoeducation pilot to recognize the early signs of psychosis.

The Department will be increasing early intervention and diversion services by:

- Providing a new service for adolescents who are identified as not being "reached" by standard programs.
- Providing another new service directed at children whose parents are drug addicts.

In the areas of assessment and case management, the Department will be:

- Working with other state agencies to standardize assessments for both mental health and substance abuse issues.
- Partnering with the courts to train staff about assessing and treating co-occurring disorders of substance abuse and mental health
- Co-locating additional state clinicians with county juvenile justice staff to provide assessments and referrals to mental health and substance abuse services.
- Adding state staff in the Regions to localize assessment and case management for substance abuse treatment and recovery.

In the area of treatment, the Department will be:

- Negotiating more favorable contracts for community hospitalization;
- Looking at the resources necessary to achieve Joint Commission accreditation of State Hospital North.

Across the categories of assessment, case management, treatment, recovery maintenance, and crisis intervention, the Department proposes to:

- Increase the capacity of the community mental health clinics by adding two clinicians per Region;
- Restructure the current wrap around process to more than triple the number of children served.

To strengthen the continuum from early intervention and diversion to crisis intervention, the Department proposes to:

- Broaden the definition of "serious emotional disturbance" used for children and adolescents;
- Implement an integrated system of care model for co-occurring disorders;
- Review Medicaid funding of mental health and substance abuse services.

To strengthen the entire continuum, the Department will:

- Develop a Behavioral Health System implementation plan.

To shore up the infrastructure underlying the Behavioral Health system, the Department proposes to:

- Improve the mental health data system;
- Contract for quality improvement of substance abuse services;

- Provide quality assurance of mental health clinic services, including partial care, provided to Medicaid clients;
- Work with other agencies to clearly establish agency responsibilities;

VII. FIRST STEPS TO A FULLY INTEGRATED SYSTEM.

What we are proposing are first steps in the development of a fully integrated and comprehensive state system for behavioral health in Idaho.

In order to be a "good" and effective behavioral health system, there must be a system of care, not just a collection of services. Building that system will require strong and consistent leadership, a single, clear vision, and consensus and momentum for implementing that vision. It will require an informed and supportive public, and active engagement in the system by clients, families and advocates. It will require a system-wide culture that fosters and supports constant learning, change, challenging of sacred principles, and trying out new ideas throughout the system.

This is a tall order to accomplish, but the time has come for the State of Idaho to take on this challenge. The result will be an enhancement of behavioral health services throughout the state, with better outcomes for clients, while making the most effective use of tax dollars.

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