STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Disability Services Administration
PO Box 45050, Olympia, WA 98504-5050

November 29, 2012

Dear Interested Parties:

SUBJECT: Adult Behavioral Health System – Making the Case for Change

The Aging and Disability Services Administration (ADSA), Division of Behavioral Health and Recovery (DBHR), is pleased to announce the **Adult Behavioral Health System – Making the Case for Change** document has been finalized. This issue paper was initiated at the direction of Governor Christine Gregoire and DSHS Secretary Robin Arnold-Williams and offers an approach designed to move adult behavioral health to an outcome-based system that uses evidence-based and research-based practices.

We want to thank the large number of individuals, providers and community groups who submitted thoughtful feedback on the draft. We were able to incorporate quite a few of the comments and ideas received. Much of the feedback that was not incorporated into the document can be used for the implementation phase of this initiative.

Throughout the process of this proposed system change, we plan to use the Substance Abuse and Mental Health Services Administration (SAMHSA) working definition of recovery:

> *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*

Thank you again to all who submitted comments and ideas. As Washington State transitions to a new gubernatorial administration, we will keep you posted on any next steps in this process. The revised document can be accessed at DBHR's homepage: http://www.dshs.wa.gov/dbhr/.

Sincerely,

Jane Beyer
Interim Assistant Secretary

Chris Imhoff, LICSW
Director

cc: Governor Christine Gregoire
Robin Arnold-Williams, Secretary

Adult Behavioral Health System

— Making the Case for Change —

NOVEMBER 29, 2012

Implementation of the Affordable Care Act presents an opportunity to improve Washington's public treatment system for Mental Health and Substance Use Disorders. Any expansion of Medicaid will provide coverage for thousands of new people, creating a pressing need to focus the behavioral health system on early identification and intervention, the use of evidence-based practices, respect for the philosophy of recovery, and cultural competency at all levels.

The State Legislature provided leadership and direction for children's mental health treatment with the passage of SSHB 1088 in 2007 and ESSHB 2536 in 2011. These bills articulate a clear policy direction for children's mental health treatment including increased use of Evidence Based Practices, prevention and early intervention, integrated care plans and accountability for positive outcomes. *This paper seeks to begin a process that will move the adult mental health and substance use treatment systems in the same direction.*

The process for change must include all partners in the behavioral health care system. In addition to state agencies, the Initiative must include consumers and families, Regional Support Networks (RSNs) and counties, criminal justice programs, community providers, state and community hospitals, provider associations and consumer organizations.

An improved adult behavioral health system will support recovery, provide positive changes for local communities and be accountable and transparent in all of its operations. This document outlines the scope and impact of Mental Health and Substance Use Disorders, proposes solutions that work, and provides a map to get there. Following the lead of the Substance Abuse and Mental Health Services Administration (SAMHSA), the plan will reflect the knowledge that:

- Behavioral health is essential for health.
- Prevention works.
- Treatment is effective.
- People recover from mental illness and substance use disorders.

SAMHSA's Working definition of recovery from mental disorders and/or substance use disorders:

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Through its Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

Health. Overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem— and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.

Home. A stable and safe place to live.

Purpose. Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.

Community. Relationships and social networks that provide support, friendship, love, and hope.

1 Making the Case

1a Why is behavioral health important?

Behavioral health disorders can affect anyone, most receive no treatment

Mental illness and substance use disorders are common. National estimates are that one in four have met diagnostic criteria for a behavioral health problem in the past year (Miller, 2012; SAMHSA, 2011), and over 50 percent meet criteria at some point in their lifetime (Miller, 2012). It is a crisis that only 38 percent of those with Mental Health disorders and 18 percent of those with Substance Use disorders receive treatment.

Behavioral health disorders significantly impact adults receiving DSHS services

In the figure below, the estimated numbers of individuals who need Substance Use and/or Mental Health treatment are identified based on administrative data. Mental health needs are identified based on:

1. Health care claim or encounter diagnoses,
2. Receipt of mental health medications, or
3. Receipt of mental health services paid for through DBHR funding (both Medicaid and State funds).

Alcohol/drug service needs are identified based on:

1. Health care claim or encounter diagnosis of a substance use disorder,
2. Receipt of alcohol/drug treatment or detox services, or
3. Occurrence of substance related arrests (e.g., possession of illegal drugs or driving while intoxicated).

This method will result in an undercounting of those who need services, since it will miss any who have not been in contact with any health professional.

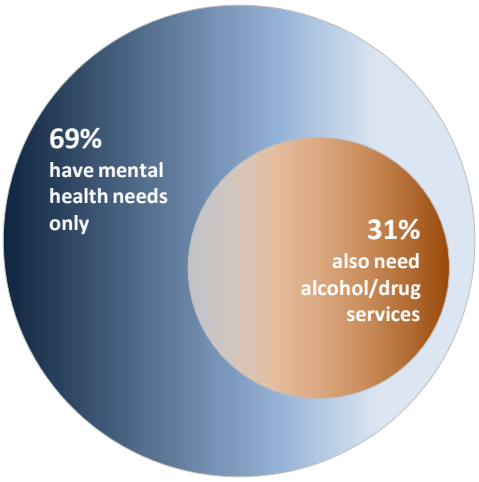
Percent of clients age 18-64 with current mental health or alcohol/drug service needs

SFY 2011

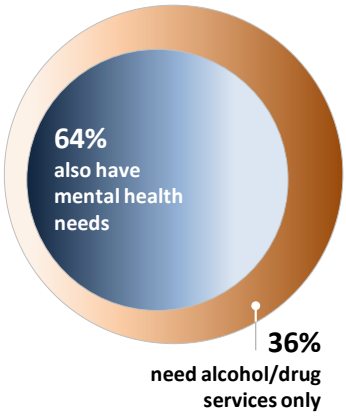
Among all DSHS clients ages 18-64 (n-505,959):

- *45 percent have current mental disorders*
- *22 percent need alcohol/drug treatment*
- *14 percent currently have both a mental illness and an alcohol/drug condition*

Of the 45 percent of DSHS clients age 18-64 with mental health needs (n = 227,000) . . .



Of the 22 percent of DSHS clients age 18-64 with alcohol or drug treatment needs (n = 110,000) . . .



SOURCE: Research and Data Analysis Division, DSHS, October 2012. Prevalence rates are presented for 505,959 DSHS clients age 18 to 64 as of June 2011 who were enrolled in state-funded medical coverage for at least one month in SFY 2011 or received DBHR mental health or substance abuse services in SFY 2011. For example, clients receiving only ESA child support or food assistance services are excluded from these tabulations due to the absence of health services data necessary to identify behavioral health needs.

Untreated behavioral health disorders are costly and life threatening

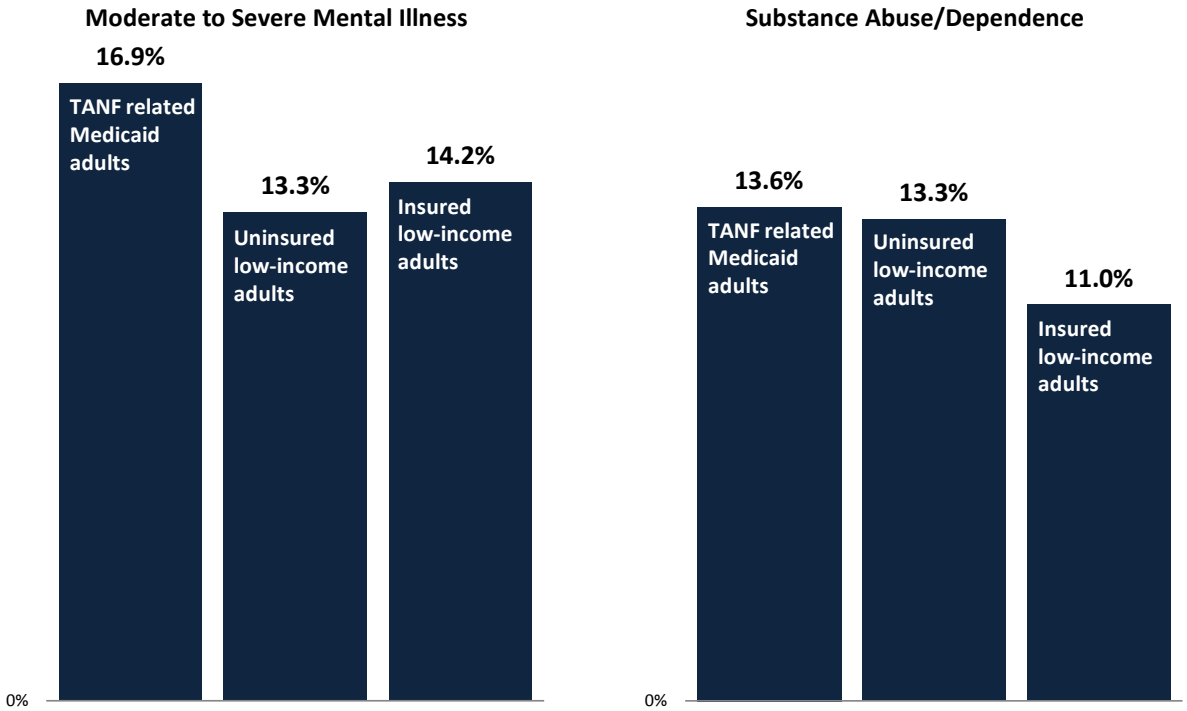
Behavioral health conditions are complex with a number of physical and psychological effects. They can cause lasting changes in the brain, and can involve all aspects of a person's functioning and life: brain and biology, psychological makeup, and social interactions and relationships with others.

- The mortality rate is double for those with mental illness: 2,543 per 100,000 compared to 1,025 per 100,000 (Miller, 2012).
- Those with serious mental illness die earlier than the general population (Miller, 2012).
- The rate of suicides in Washington has increased more than 11 percent over the last 10 years (DOH, 2011). Having a Mental Health and/or Substance Use Disorder increases the risk of suicide.
- To put these numbers in context, suicides are much more common than homicides, but receive less attention. Nationally, suicides outnumber homicides 3:2 (SAMHSA, 2012).

Behavioral health problems are common in Medicaid expansion groups

- The Urban Institute (2012) has estimated that Medicaid expansion will increase enrollment of adults in Medicaid in Washington State by approximately 250,000.
- The proportion of the adult expansion population who have Mental Health and Substance Use Disorders will be similar to (slightly lower than) the prevalence rates observed among non-disabled adults currently receiving Medicaid coverage. Prevalence rates are based on estimates from the National Survey on Drug Use and Health, adjusted to reflect the demographic composition of Washington State's low-income populations using a synthetic estimation process (RDA, 2012).
- The enhanced federal match available for the adult expansion population creates a financial incentive to invest in mental health and alcohol/drug treatment for expansion adults prior to persons becoming functionally impaired to the point of disability (Mancuso, Ford Shah, and Felver, 2011).

Estimating Behavioral Health Condition Prevalence



What are the impacts of behavioral health disorders on other systems?

People with behavioral health disorders have multiple needs

Individuals with behavioral health disorders are involved with multiple systems and require coordinated services between those systems.

System	Mental Health Need	Substance Abuse Need	Co-occurring MH and SA Need	Population Size
Long-term services and supports *Adults age 18 to 64*	85.0%	20.6%	19.6%	21,087
Long-term services and supports *Adults age 65+*	66.6%	3.1%	2.7%	28,196
Persons with developmental disabilities *Adults age 18 to 64*	57.6%	3.3%	2.8%	18,897
With major chronic physical health problems* *Adults age 18 to 64*	80.7%	34.8%	31.7%	49,704
Received Children's Administration services *Adults age 18 to 64*	55.5%	34.1%	23.1%	61,619
Received Economic Services Administration services *Adults age 18 to 64*	48.5%	23.7%	15.9%	418,276
Received Vocational Rehabilitation services *Adults age 18 to 64*	68.1%	25.1%	21.3%	13,320

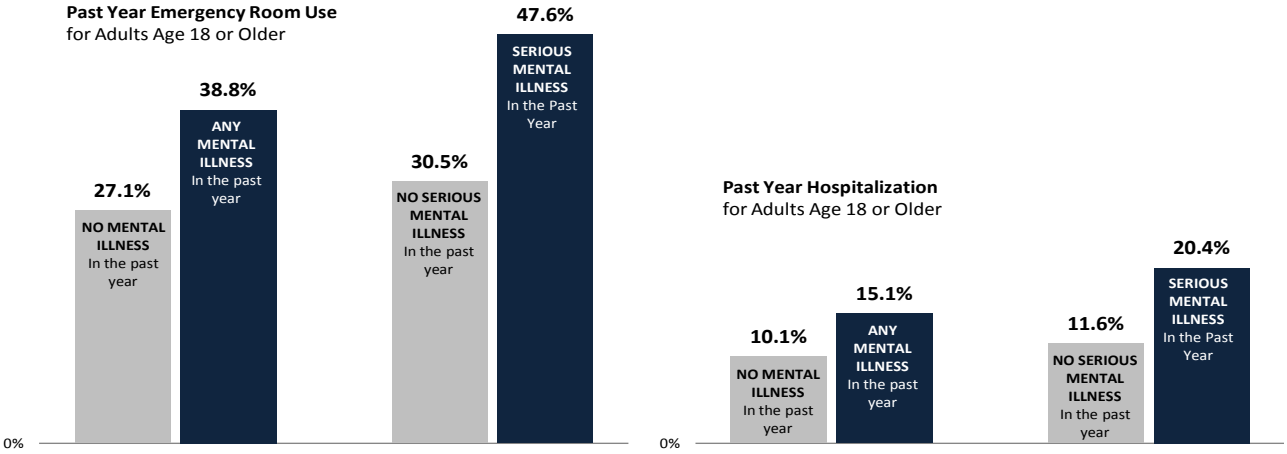
SOURCE: Research and Data Analysis Division, October 2012. Prevalence rates are presented for the population of 505,959 DSHS clients age 18 to 64 as of June 2011 who were enrolled in state-funded medical coverage for at least one month in SFY 2011 or who received DBHR mental health or substance abuse services in SFY 2011. For example, clients receiving only Economic Services Administration (ESA) child support or food assistance services are excluded from these tabulations due to the absence of health services data necessary to identify behavioral health needs. Mental health needs are identified based on (1) health care claim or encounter diagnoses, (2) receipt of mental health medications, or (3) receipt of mental health services paid for through DBHR funding. Alcohol/drug service needs are identified based on 1) health care claim or encounter diagnosis of a substance use disorder, (2) receipt of alcohol/drug treatment or detox services, or (3) occurrence of substance related arrests (e.g., possession of illegal drugs or driving while intoxicated).

*Those with major chronic physical health problems are identified using a chronic condition risk score criteria that would make one eligible for health home services. This risk score uses methodology developed by Research and Data Analysis.

Behavioral health problems affect physical health and increase health costs

- Use of emergency rooms and hospitals occurs at a higher rate for people with mental illness, particularly those with serious mental illness (SAMHSA, 2012b).
- In Washington, hospital costs in 2005 for alcohol-related injuries and diseases were $316 million (Wickizer, 2007). Nationally, the most recent data available indicated that in 2006, nearly $24.6 billion in healthcare costs was caused by excessive alcohol consumption (Bouchery et al, 2011).
- In SFY 2008, total medical savings for Chemical Dependency treatment expansion patients was $21.7 million (DBHR, 2010).
- Coordination with primary care providers is essential given that rates of hypertension, asthma, cardiovascular disease, diabetes, stroke, and pulmonary disease are substantially higher among individuals with psychiatric disabilities, based on 2009/2010 NSDUH survey data. 52 percent of people eligible for both Medicare and Medicaid have a psychiatric illness (Miller, 2012).
- Many psychiatric medications, particularly anti-psychotics, can cause weight gain, obesity, and type 2 diabetes (Miller, 2012).

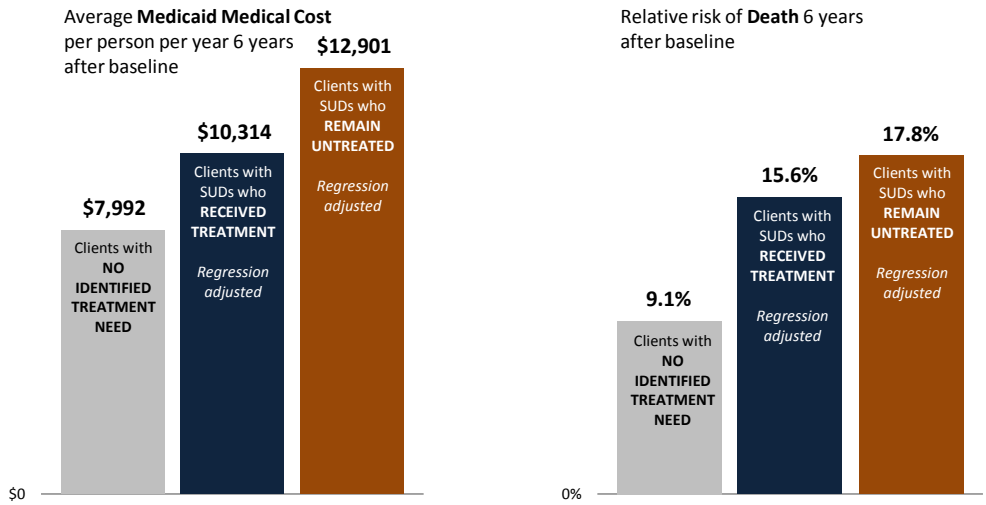
Emergency Room visits and hospitalizations are higher for those with mental illness



SOURCE: NSDUH REPORT, *Physical Health Conditions among Adults with Mental Illnesses (SAMHSA*, 2012).

Medical costs and death rates are higher for clients with untreated Substance Use Disorders

Alcohol/drug treatment reduces the risk of mortality, delays the onset of hypertension/cardiovascular disease, and slows the progression of cardiovascular disease for substance users over time.



SOURCE: *The Health Impact of Substance Abuse: Accelerating Disease Progression and Death* (Mancuso, Ford Shah, Huber, Felver, 2011).

Too many with behavioral health disorders are in the criminal justice system

- Of those persons incarcerated in Washington State prisons, 18 percent have been diagnosed with a Serious Mental Illness, 63 percent have diagnosed with a Substance Use Disorder, and one-third have both (Department of Corrections, 2012).
- Of all adults with a Mental Health Disorder served by DSHS or HCA in 2009, 13.4 percent were arrested at least once based on the most recent data available (Mental Health Transformation Grant Dashboard).
- The federal Bureau of Justice reports that jails have even higher rates of Mental Health Disorders (60%), and 23 percent have a least one symptom of a psychotic disorder (Bureau of Justice, 2006). This same report indicates that 76 percent of the jail population with a Mental Health Disorder also is dependent on alcohol or drugs.

Behavioral health problems and homelessness are intertwined

- Homelessness is traumatic, cyclical, and puts people at risk for Mental Health and Substance Use Disorders. Homelessness also interferes with one's ability to receive services, including services for behavioral health conditions, and jeopardizes the chances for successful recovery.
- Compared to DSHS clients overall, homeless children and adults were significantly more likely to have a Mental Health Disorder (50% increase for children/youth; 23% increase for adults) and three times as likely to have a Substance Use Disorder (Ford Shah, Black, and Felver, 2012a).
- Nearly half of the clients discharged from residential chemical dependency (CD) treatment facilities and 30 percent of those discharged from state mental health hospitals are homeless in the year following discharge. Less than one in five of those in need received housing assistance (Ford Shah, Black, and Felver, 2012b).

Having a behavioral health problem increases risk of unemployment

- Of all adults with Mental Health and Substance Use Disorders served by DSHS and HCA, only 21.7 percent had employment (WorkFirst, 2010). The rates of unemployment for those with Mental Health and Substance Use Disorders are much higher in Washington than is the case nationally (NOMS, 2011).
- It is important to note that unemployment itself increases the risk for Mental Health and Substance Use Disorders (SAMHSA, 2012). A focus on employment would be a strong behavioral health prevention/intervention strategy.
- Behavioral Health problems lead to significantly worse outcomes for clients on the Temporary Assistance for Needy Families (TANF) program: those with Mental Health and Substance Use Disorders tend to stay on TANF longer, and to cycle back into the TANF system more frequently (WorkFirst, 2010).

Stigma regarding behavioral health disorders interferes with care

- People with behavioral health disorders experience many types of stigma, both in the attitudes and beliefs in the general public and in self-stigma (negative beliefs about themselves). The behavioral impact of stigma may take four forms: withholding help, avoidance, coercive treatment, and segregated care (Corrigan & Watson, 2002). Stigma can affect many aspects of people's lives. For instance:
  - There are significant barriers to accessing primary care for people with serious mental illness, further contributing to health disparities (Morden et al., 2009).
  - Stigma can interfere with seeking treatment, cause relapse, and hinder recovery (Parle, 2012).
- NASMHPD recommends CDC designation of people with serious mental illness as a Health Disparities Population (Miller, 2012).
- An effective behavioral health system must address stigma.

Having a behavioral health disorder impacts families and the next generation

- There are significant impacts on the Child Welfare system as well. Recent findings indicate that within the DSHS system, 9 percent of adults with mental illness and 12 percent of those with a Substance Use Disorder are currently involved with the child welfare system (DBHR, 2011).
- Women with Substance Use Disorders who receive Medicaid are 20 times more likely to have their infants removed from their care by CPS (DBHR, 2012).
- Over 40 percent of pregnant and parenting youth in Foster Care in State Fiscal Year 2008 to 2011 have a Mental Health Disorder and 25 percent have a Substance Use Disorder (Lucenko, Black et al., 2012).

1c What is the science behind the causes of behavioral health disorders?

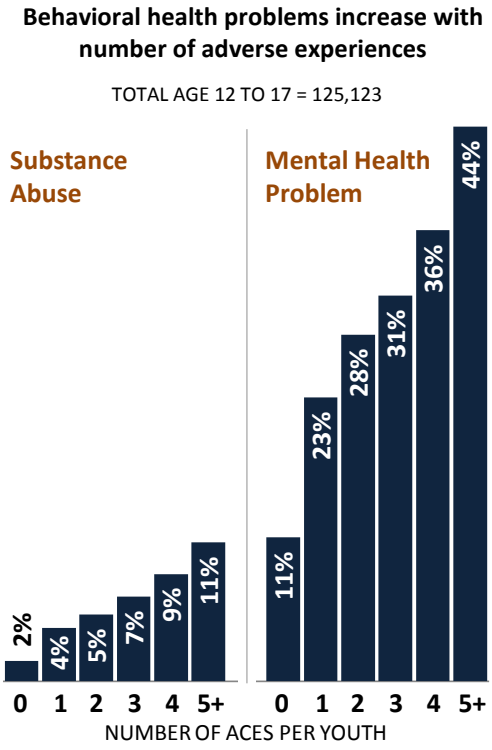
Behavioral health disorders have a biological basis

Mental Health and Substance Use Disorders are a product of biological, environmental and social factors. These disorders are most often associated with a genetic predisposition, and/or experiencing trauma as a child or adult. Over 90 percent of clients with Mental Health and Substance Use Disorders have been exposed to violence, abuse, neglect and other trauma, with most having repeated exposure (SAMHSA).

Substance Use Disorders change the structure of the brain and how it works. These brain changes can be long lasting, but treatment can heal many of these changes. Addiction is similar to other diseases, such as heart disease: both disrupt normal, healthy functioning, have serious harmful consequences, are preventable, treatable, and if left untreated, can last a lifetime (NIDA, 2012). Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death (ASAM, 2012). Scientists estimate that genetic factors account for between 40 and 60 percent of a person's vulnerability to addiction (NIDA, 2012).

Mental illnesses, in general, are caused by a variety of genetic and environmental factors. Mental illness is more common in people whose biological (blood) relatives also have a mental illness. Certain genes may increase the risk of developing a mental illness, and life situations may trigger mental illness. Biochemical changes in the brain are thought to affect mood and other aspects of mental health. Naturally occurring brain chemicals called neurotransmitters play a role in some mental illnesses. In some cases, hormonal imbalances affect mental health. Inherited traits, life experiences and biological factors can all affect brain chemistry linked to mental illness (NIMH, 2012a).

Trauma and psychosocial risks increase behavioral health disorders



Adverse experiences in childhood are linked to future chronic behavioral health problems. The term adverse experiences includes potentially traumatic experiences, such as child abuse, sexual assault, intimate partner violence, combat, involvement with the criminal justice or child welfare systems, family conflict and natural disasters. Each adverse experience increases the chances of developing behavioral health problems later in life. Often people refer to Adverse Childhood Experiences (or ACEs) to encompass the range of potentially traumatic experiences one might experience as a child.

The impact of traumatic experiences is severe, cumulative, and intergenerational. For example, the odds of having a substance abuse or mental health problem during adolescence or young adulthood increase directly with the number of adverse experiences during childhood (ACEs).

The impact of an adverse experience is most severe for those who experienced child abuse or neglect and those who have parents with behavioral health problems.

SOURCE: *Lucenko, Sharkova et al.*, 2011.

2 Meaningful Outcomes

We must focus on meaningful outcomes

Previous work through the Mental Health Transformation Grant, the Children's Mental Health Redesign, and the Substance Abuse Treatment Expansion Initiative can guide us in establishing meaningful outcomes. There is a need for measures that matter, and to address disparities in outcomes, regardless of the evolving system. We need to articulate meaningful recovery-based outcomes, similar to those defined by SAMHSA (i.e., health, home, community, and purpose). Given the impacts of behavioral health disorders on multiple systems, it is imperative that the outcomes be broader than those under our immediate control.

- Improve health status and wellness.
- Increase meaningful activities, including employment and education.
- Reduce involvement with criminal justice systems, including jails and prisons.
- Reduce avoidable costs in hospitals, emergency rooms, crisis services, and jails/prisons.
- Increase stable housing in the community.
- Improve satisfaction with quality of life, including measures of recovery and resilience.
- Decrease population-level disparities.

3 What Works

We commit to Evidence-based, Research-based, and Promising Practices

We commit to ensuring the accountability, quality, and cost-effectiveness of the behavioral health programs and services. As part of this commitment, we need to focus on EBPs.

An earlier report by Washington State Institute for Public Policy (Aos, 2006) reviewed the "what works" literature regarding treatment for people with mental health and substance use disorders.

WSIPP estimated the monetary value of the benefits, including factors such as improved performance in the job market, reduced health care and other costs, and reduced crime-related costs.

Evidence-Based Practices (EBPs) refer to the full set of evidence-based, research-based, and promising practices. This adult behavioral health system initiative will follow the legislatively developed definitions for those terms (ESSHB 2536). WSIPP recommends modifying the current-law to include a focus on heterogeneity. This allows programs that are directed toward specific populations (e.g., elderly or Latinos) to be potentially categorized as evidence-based (Aos and Trupin., 2012).

The findings were particularly striking:

- **Evidence-based treatment works.** The average evidence-based treatment achieved a 15 to 22 percent reduction in the short-term incidence or severity of these disorders.
- **EBP treatment is a good investment.** EBP treatment of these disorders achieved a 56 percent rate of return on investment. From a narrower taxpayer's-only perspective, the cost-benefit ratio is 2 to 1. The risk of losing money with an evidence-based treatment policy is small.

Start with existing lists of EBPs: There are existing EBP lists, such as SAMHSA's National Registry for Evidence-Based Programs (NREPP), state entities such as WSIPP, and the Alcohol and Drug Abuse Institute (ADAI). The identified EBPs include medication and behavioral therapies for Mental Health and Substance Use Disorders. In an effort to accelerate the adoption of EBPs, we recommend starting with these lists.

Examine what is already working in Washington: In addition to evidence-based, research-based and promising practices, we will evaluate where existing services and programs demonstrate positive, meaningful outcomes. We will consider both state and national models that could be used as building blocks for ongoing systemic change. In addition to treatment, we will focus on supporting prevention and recovery, and be responsive to the unique needs and strengths of local communities.

Work to develop promising and research-based practices. The evidence regarding the co-occurrence of Behavioral Health and other conditions (e.g. chronic medical conditions, developmental disabilities, traumatic brain injury) requires the development of programs and practices that meet the needs of these complex populations. We will support the work of moving these practices into EBPs.

Maintain access to Behavioral Health treatment: We are committed to balancing the cost of implementing effective modalities while maintaining access to behavioral health treatment.

Prevention can significantly reduce behavioral health problems

There are proven strategies designed to prevent substance abuse and mental disorders and to promote positive mental health. Effective strategies include those that reduce risk factors (i.e., family problems, academic failure, community attitudes about substance use) and those that enhance protective factors (i.e., family and community involvement). These strategies are cost effective (Aos et al., 2004).

SAMHSA sponsors the National Registry of Evidence-based Programs and Practices (NREPP) which identifies specific evidence-based prevention strategies. For young adults and adults, direct services include suicide prevention efforts, parenting programs and early interventions, while environmental strategies such as the establishment and enforcement of laws/policies and training have saved thousands of lives.

Suicide is the second leading cause of death for Washington youth/young adults (those between the ages of 10 and 24; DOH, 2012). Depression is an issue for many older adults but it is often undiagnosed, treated inappropriately, or not treated at all. If left untreated, depression can create diminished quality of life, and may ultimately lead to suicide (NIMH, 2012b). An estimated 2-20% of persons diagnosed with depression or bipolar disorder die by suicide, depending on the specific diagnosis and demographic factors (UW School of Social Work, 2012). Yet, research shows that the majority of suicide is preventable.

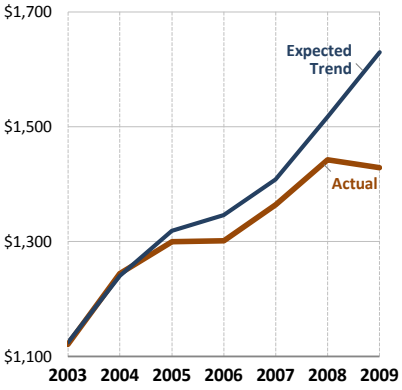
Substance Abuse Treatment Expansion "bent the curve" in healthcare costs

In 2005, the legislature provided funding to expand substance abuse treatment with approximately $32 million more funding for adults and $6.7 million funding for youth in the 2005-07 Biennium. The expansion was targeted for persons enrolled in Medicaid or General Assistance Unemployable (GA-U, now Medical Care Services) medical coverage, and was funded primarily by assumed savings in medical and long-term care costs, based on research documenting the potential health care cost savings associated with AOD treatment.

- Treatment Expansion funding for adults was increased to about $40 million in the 2007-09 Biennium.
- Treatment expansion reduced the growth in healthcare costs—this change in the rate of increased costs is described as "bending the curve". Costs in the following diagrams are measured and displayed using a "per member per month" (pmpm) calculation.

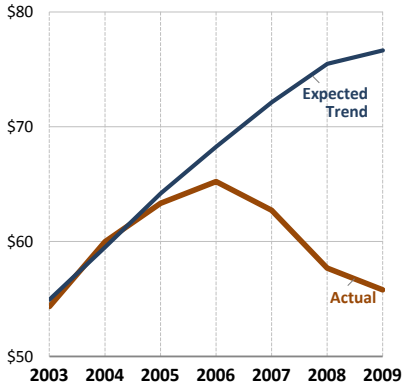
Medicaid Disabled Adults with identified AOD treatment need

Medical Expenditures pmpm, excludes dual Eligibles



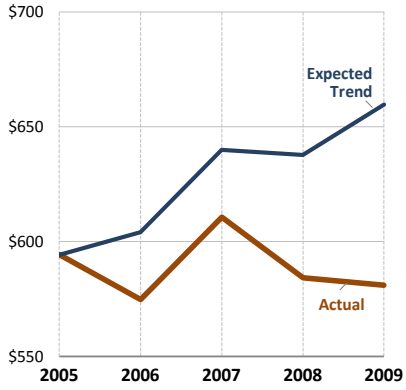
Medicaid Disabled Adults with identified AOD treatment need

Aging and Adult Services Nursing Home Expenditures pmpm, includes dual Eligibles



GA-U (Disability Lifeline) Clients with identified AOD treatment need

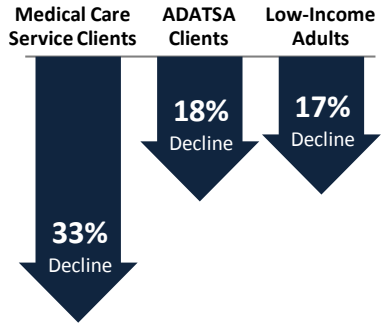
Medical Expenditures pmpm



SOURCE: Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment (Mancuso and Felver, 2010).

Chemical Dependency treatment reduces arrests and saves public funds

Decline in arrests in the year after treatment for substance use disorders



The risk of arrest is significantly lower for clients who receive treatment for substance use disorders.

- Medical Care Service Clients (MCS) who received substance use treatment saw a 33 percent decline in the number of arrests per client in the following year, when compared to MCS clients who needed but did not receive substance use treatment.
- Similarly, arrests were reduced 18 and 17 percent for substance use treatment provided to ADATSA and other low-income adults.

SOURCE: Chemical Dependency Treatment, Public Safety: Providing Chemical Dependency Treatment to Low-Income Adults Results in Significant Public Safety Benefits FMancuso and Felver, 2009.

Providing Chemical Dependency (CD) treatment to those who need it, reduces arrests and saves public funds (Aos et al., 2006). When considering both benefits to taxpayers and crime victims, estimates are that we see.

- **$2.83** savings ▸ for every CD treatment dollar spent on **Medical Care Services adults**.
- **$1.69** savings ▸ for every CD treatment dollar spent on **ADATSA clients**.
- **$2.58** savings ▸ for every CD treatment dollar spent on **other low-income clients**.

Treatment for Mental Health Disorders improves health and reduces costs

There are promising indicators that mental health treatment can both improve health status and impact total healthcare costs. Specific examples in Washington State include:

- The Mental Health Integration Program (MHIP), a large scale collaborative care program for low-income primary care patients with depression and other common mental health disorders, reduced depression, reduced medical admissions, and decreased arrests (Unutzer & Park, 2012a).
- A review of multiple randomized trials on the effectives of Assertive Community Treatment (ACT) concluded that ACT clients had reduced homelessness and improved psychiatric symptom severity (Coldwell and Bender, 2007).

- In other research, ACT decreased psychiatric hospitalizations, increased housing stability, improved treatment retention, increased consumer and family satisfaction, and modestly improved quality of life (Bond, et al. 2001). High fidelity ACT teams are cost effective when serving consumers with higher hospitalization rates (Latimer, 1999).
- The Improving Mood-Promoting Access to Collaborative Care (IMPACT) program is a measurement-based stepped care for late-life depression in primary care settings using care management to integrate mental health and primary care. IMPACT reduced depressive symptoms, decreased health-related functional impairment, improved quality of life, and reduced healthcare costs (Unutzer & Park, 2012b).

4 Implementation Strategies

Communication and Collaboration

Change will require work with Partners and Stakeholders, including the Legislature, State Partners, Local Government, Behavioral Health Advisory Committee, Consumers and Families, and Providers. This larger group will look at all elements of the Redesign initiative.

Governance

Given the scope of the system change, there would be a benefit to having a Steering Committee comprised of consumers, families, DSHS and external partners. The Steering Committee would be responsible for keeping the Initiative moving forward.

Assess the Current State of System

Assessment of the current behavioral health system to identify areas for improvement or change, including examining work already done by the Mental Health Transformation grant, the 2005 Legislative/Executive Mental Health Task Force, Chemical Dependency Treatment Expansion, and the Children's Mental Health Redesign:

- Inventory and assessment of current practices, including peer support services.
- Provider capacity.
- Capacity to support needs across the continuum of care, including state and community hospitals.
- Review of current data availability and data infrastructure needs.
- Assess any current pilots.
- Identify gaps.

Tribal Centric Mental Health

DSHS, the Healthcare Authority, and tribal representatives from the Office of Indian Policy, the American Indian Health Commission and the Northwest Portland Area Indian Health Board, have begun a process to redesign tribal mental health services. This will expand eventually to all behavioral health services. Services will be culturally appropriate and readily accessible. The design will include EBPs that are appropriate for the American Indian/Alaskan Native consumers. As these two efforts progress, the Tribal-Centric Redesign and the adult behavioral health system redesign will inform each another.

Evidence-based, Research-based, and Promising Practice Development

Similar to the Children's Mental Health redesign, we will work with system partners and experts to:

- **Work with a research-based entity to develop a list of EBPs for adults. The list must include information on the following domains:**
  - Quality of the Research Evidence.
  - Rating of the Readiness for Dissemination (availability of materials, training/support resources, quality/fidelity procedures).
  - Impact on Meaningful Outcomes (the EBP improves the outcomes identified in this document).
  - Ranking on Cost-Effectiveness (consideration of initial and ongoing costs relative to standard cost impact areas).
  - Information on the appropriateness for specific populations.
- **Work with WSIPP and universities to identify EBPs based on diagnoses, age, ethnicity, culture, tradition and other factors that recognize a diversity of populations.**
  - Create Workforce Development Plan to ensure providers are qualified and culturally competent.
- **Complete an inventory on the current implementation of EBPs throughout the state.**
- **Create a process to identify and evaluate research-based and promising practices and expand available EBPs.**
- **Encourage the development of peer-support services as a promising practice.**
- **Develop plan for implementation of additional EBPs in Washington and identify funding approaches.**

System Design and Finance

Review and assess system structures and finance mechanisms to identify the best ways to promote the outcomes and goals of the Redesign Initiative.

- **Explore practices that can be included in the state plan for Medicaid reimbursement**
- **Address transition and continuity for people in jail/prison.**
- **Consider the potential to streamline funding and reporting requirements.**
- **Assess technical resources and funding necessary for high fidelity EBPs and workforce development.**
  - Sufficient training/certification
  - Ongoing supervision
  - Workforce development
  - Establishing minimum standards
  - Maintaining fidelity
  - Program supports
- **Consider mechanisms to address stigma affecting individuals with behavioral health problems.**
- **Encourage working on the Behavioral Health system in the context of other systems.** Consider the opportunities for better outcomes, system efficiencies, and cost containment in the purchase of increasingly coordinated and managed medical, behavioral health and long-term services and supports.

Quality Management

The Redesign initiative will require a quality strategy that evaluates outcomes and informs decisions. The quality strategy must measure individual and system success in improving outcomes. The Quality Management plan will describe evaluation processes for the redesign outcomes and define the metrics to measure success.

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