Behavioral Health Care in Arizona 2015: 
Recommendations for an Integrated Future

access affordable appointments available behavioral children clients consumers crisis discharge employment enough families funding health hospital housing intervention lack management medication needs peer prevent prevention programs providers recovery service staff support transportation trauma treatment youth

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ARIZONA STATE UNIVERSITY
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Points of view represented in this report are those of the authors, and do not necessarily represent the official position or policies of either the Arizona Health Care Cost Containment System or the Arizona Department of Health Services/Division of Behavioral Health Services.

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Executive Summary

This report summarizes the results of an anonymous, statewide survey of behavioral health providers, affiliated agencies, service recipients, family members and advocates regarding their perceptions of the publicly funded behavioral health care system in the state of Arizona. This survey was designed and administered by the Arizona State University Center for Applied Behavioral Health Policy from June–July 2015. It was distributed to more than 8,000 individuals in Arizona to identify major policy and behavioral health care issues in that system. The online survey yielded responses from 146 individuals. The majority of respondents indicated being behavioral health service providers working for a Regional Behavioral Health Authority (RBHA) or RBHA-contracted agency.

The results of the survey were used to frame a town hall discussion that the CABHP convened as part of their annual Summer Institute. The panelists of the 2015 Arizona Behavioral Health Town Hall included Tom Betlach, Director of the Arizona Health Care Cost Containment System (AHCCCS); Margery Ault, Assistant Director of Compliance and Consumer Rights at the Arizona Department of Health Services (ADHS) Division of Behavioral Health Services (DBHS); and Shawn Nau, the Chief Operating Officer of the Northern Arizona Regional Behavioral Health Authority (NARBHA).

At the time that this survey was conducted, it had recently been announced that the AHCCCS would be absorbing the functions of the DBHS. These include, but are not limited to: contract oversight of the RBHAs, administrative responsibilities as the state’s designated Single State Authority (SSA) for receipt and management of the Mental Health Block Grant and the Substance Abuse Prevention and Treatment block grants from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), and ensuring ongoing conformance to the final terms and conditions of the Arnold v. Sarn lawsuit.

This report presents survey respondents’ perceptions of behavioral health services, issues related to the integration of ADHS/DBHS and AHCCCS, and recommendations for integrating primary health care and behavioral health care for children and adolescents with behavioral health needs, and adults with general mental health, substance abuse and serious mental illness designations.

What Behavioral Health Services are of Greatest Concern in 2015?

When asked to choose the behavioral health service issues that most concern them in their communities, respondents identified problems in all 11 service areas provided on the survey. The most frequently reported service issues included housing, prevention, crisis and transportation. Respondents identified a dearth of housing and prevention services, and asked for increased funding and support to provide and implement these services in all communities across the state. They also indicated that crisis and transportation services are lacking in certain regions, and exhibit striking problems in quality and customer service. Respondents identified hospitalization/hospital discharge, employment, medication/medication management, and court-ordered evaluation/treatment (COE/COT) as areas that require specific implementation and delivery improvements by providers. Finally, peer staff and consumer-operated services/programs (COSPs) were highlighted as service issues that need further support and recognition as integral to recovery.

Which Specialty Populations Represent the Greatest Service Availability and Quality Concerns in 2015?

Respondents were asked to rate, in terms of the availability and quality, behavioral health services offered to five specialty populations impacted by behavioral health disorders: dual-eligible Medicare-Medicaid clients, dual-enrolled RBHA and Division of Developmental Disabilities (DDD) clients, Comprehensive
Medical and Dental Program (CMDP) clients, individuals re-entering communities from jails and prisons, and children and adolescents. Children and adolescents with behavioral health needs were the highest rated specialty population, while dual-enrolled RBHA and DDD clients were the lowest rated specialty population. The range of concerns that respondents highlighted regarding service delivery to children and adolescents is wide, and almost every service issue identified in the current RBHA system directly affects children.

**Recommendations for Enhancing Behavioral Health Services in 2016**

Respondents were asked to provide recommendations AHCCCS should consider to improve the availability and quality of behavioral health care. Recommendations were classified into six policy and programmatic areas.

First, respondents recommended that AHCCCS develop statewide standards to better implement policy decisions, maintain RBHA accountability and partner with institutions and systems outside of behavioral health to meet the needs of consumers across the state.

Second, respondents suggested that AHCCCS align the requirements for acute and behavioral health care. Specifically, AHCCCS should clearly define integrated health care, require behavioral health care providers in primary care settings to be licensed, require reimbursement for behavioral health services in primary care settings, and recognize the costs of providing integrated health care to specialty populations.

Third, respondents suggested the expansion of prevention, support, peer-run, crisis and general mental health services to meet the needs of communities served.

Fourth, respondents recommended that providers be held accountable for outcomes, such that contracting and reimbursement for services be based on the quality of consumer outcomes. They recommended that the administrative burden be decreased for providers, including streamlining and simplifying administrative processes to allow providers to spend more time with consumers. Many responses recommended ways to increase funding of integrated health care services, including: raising the number of private insurance providers, reforming payment, adding services to the fee schedule, revising billing codes, and supporting needed technology and infrastructure. Respondents also called for hiring better-qualified staff, providing advanced training for non-clinical positions and incentivizing recruitment and retention of highly qualified staff. They requested that the application process be simplified and shortened to allow consumers easy and quick access to behavioral health care.

Fifth, respondents requested the development of service arrays that meet the needs of children and adolescents.

Lastly, respondents recommended that AHCCCS take actions to decrease caseloads; increase consumer autonomy and choice; include family in decision-making and treatment; implement community needs assessments, quality reviews and evidence-based practices; and treat consumers with respect and value their input.
The Context of the Arizona Behavioral Health Town Hall for 2015

Every July, the Arizona State University’s (ASU) Center for Applied Behavioral Health Policy hosts the Summer Institute, a four-day educational conference addressing significant contemporary issues in behavioral health practice and policy. For 16 years, the Summer Institute has provided messaging platforms for new and emergent state and federal policies through its Town Hall forum, a tradition the 2015 Summer Institute, *Innovations and Essentials for Advancing Health*, continued on Thursday, July 14, 2015. The 2015 Town Hall panel comprised three prominent Arizona leaders associated with the regulatory bodies of behavioral health care in the state: Tom Betlach, Director of the AHCCCS, Margery Ault, Assistant Director of Compliance and Consumer Rights at the ADHS, DBHS, and Shawn Nau, the Chief Operating Officer of the Northern Arizona Regional Behavioral Health Authority (NARBHA).

A 12-item, anonymous, online survey was distributed to more than 8,000 behavioral health providers, service recipients, family members, and other public/private entities that interact with the RBHAs, using a snowball sampling approach (for a full discussion of the survey methodology and analysis, see Appendix A). The survey was administered over a two week period approximately two weeks prior to the 2015 Town Hall (for a copy of the survey, see Appendix B). A total of 146 usable survey responses were captured electronically.

The quantitative results were analyzed and summarized with respect to the entire state, by RBHA and by respondent affiliation to a RBHA. The qualitative results were summarized utilizing a coding procedure that grouped similar comments by keyword. These groupings were then labeled to match the 11 issues listed in the survey (for more detailed information on this coding procedure and inter-reliability of coding, see Appendix A). The qualitative coding supported the quantitative results in that the frequency of comments matched almost exactly what the quantitative results produced.
Results

Who Was Surveyed?

A total of 146 respondents completed the online, anonymous, survey. Respondents were asked to choose the county in which they reside and/or provide services in. They were allowed to choose more than one. A total of 318 county selections were made, with 25 respondents choosing two or more counties. As this map indicates, survey responses were obtained from every county in the state, with responses from Maricopa County (64%) and Pima County (27%) approximating state population proportions present in these counties.

*Counties are not mutually exclusive (i.e., respondents were allowed to choose more than one county).

The 118 respondents (out of the total 146) who selected only one county were assigned to the RBHA operating at the time of the survey that had contractual responsibility for behavioral health care delivery in their county (for detailed information on this re-coding procedure, see Appendix A).

At the time of the survey, the following RBHAs were operating:

- Cenpatico of Arizona (Cenpatico) — Cochise, Gila, Graham, Greenlee, La Paz, Pinal, Santa Cruz and Yuma Counties
- Community Partnership of Southern Arizona (CPSA) — Pima County
- Mercy Maricopa Integrated Care (MMIC) — Maricopa County
- Northern Arizona Regional Behavioral Health Authority (NARBHA) — Apache, Coconino, Mohave, Navajo and Yavapai Counties
As Figure 1 reflects, the majority of respondents who selected only one county were within the catchment area of MMIC. The number of respondents from the catchment areas of Cenpatico, CPSA, and NARBHA were between 20 and 10 each.

Figure 2 shows the distribution of respondents by affiliation to a RBHA. Approximately half (52.1%) of 140 respondents identified themselves as direct service providers working at a behavioral health agency under contract with a RBHA or working for a RBHA. Nearly a third (31.4%) indicated that they work in a public/private entity that provides services to, or interacts with, individuals who are receiving services from a RBHA agency (e.g., law enforcement, medical care, housing) but are not a direct contractor of the RBHA. Slightly less than one-sixth (16.4%) indicated that they were a direct recipient of services provided by a RBHA, a family member or an advocate.

*N=140; Three respondents were excluded because they indicated being private providers of social and behavioral health services, not under contract with a RBHA. Due to these private providers not having direct contact with a RBHA, this group was not included in the analyses presented in this report.
As Figure 3 illustrates, service recipients/family members who completed the survey were located only in the catchment areas of MMIC and Cenpatico; no service recipients from the CPSA or NARBHA catchment area were detected. While RBHA-contracted service providers predominated in the MMIC, CPSA, and NARBHA catchment areas (50%, 72% and 63%, respectively), public/private entities predominated in the Cenpatico catchment area (73%).

**Figure 3: Respondents’ Affiliation by RBHA**

<table>
<thead>
<tr>
<th>Affiliation</th>
<th>MMIC</th>
<th>CPSA</th>
<th>NARBHA</th>
<th>CENPATICO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>27%</td>
<td>27.80%</td>
<td>36.40%</td>
<td>72.70%</td>
</tr>
<tr>
<td>Recipient</td>
<td>23%</td>
<td>0%</td>
<td>0%</td>
<td>18.20%</td>
</tr>
<tr>
<td>Public/Private Entity</td>
<td>50%</td>
<td>72.20%</td>
<td>63.00%</td>
<td>9.10%</td>
</tr>
</tbody>
</table>

*N=114; excluding respondents who indicated they worked in more than one county/RBHA, who did not indicate a RBHA affiliation on the survey, or who identified as a non-RBHA private provider.

### What Behavioral Health Services are of Greatest Concern in 2015?

Figure 4 shows the distribution of responses for each of the 11 behavioral health services identified on the survey. Of the survey respondents, 20 percent or more expressed concern over the availability or quality of every one of the behavioral health services. Housing (62.1%), prevention services (58.6%) and crisis services (51%) were identified as a service of concern by 50% of respondents or more. Transportation (46.2%), employment support services (40.7%), hospitalization (39.3%) and medication management (37.2%) rounded out the second grouping of service concerns for these respondents. Court-Ordered Treatment/Evaluation was identified by approximately a third of the respondents, while peer support services and COSPs were each identified as an area of concern by 27% and 23% of the respondents, respectively.

In general, the areas of service concern were shared by all respondents, although some variation occurred across respondent affiliation (i.e., service recipient/family member; public/private entity; provider) and RBHA. As shown in Figure 5, prevention, housing, crisis and transportation were the most frequently identified areas of concern among service recipients. Among public/private entities, prevention, housing, transportation and medication management were their greatest areas of concern. Among service providers, housing, prevention, crisis and transportation were their top four areas of concern.
Figure 6 below reveals variations in service areas of concern among RBHA catchment areas. Respondents in the CPSA catchment area cited crisis and transportation somewhat more than prevention, but appeared to follow the general pattern in all other issues. NARBHA respondents identified housing as their most salient issue and ranked transportation and COE/COT as more important than prevention. Cenpatico stands out as a RBHA that did not identify housing as a top issue, but still identified prevention and crisis services among the most important. Transportation was a top issue for all RBHAs except for Cenpatico, and crisis was a top issue for all RBHAs except for NARBHA. Employment was also not as salient an issue for NARBHA, compared to the other RBHAs. The MMIC catchment area, which also had the largest number of respondents, followed the general pattern indicated in Figure 4, with housing and prevention the most frequently cited service areas. These results may suggest some urban/rural differences or variations in need by community.
What Do People Have to Say about Behavioral Health Services in 2015?

In addition to selecting the behavioral health service areas of concern, respondents were asked to provide written comments that justified or elaborated upon their selections. Below is a summary of the comments for each of the 11 services included in the survey.

**Housing**

Fifty-seven of 128 respondents described their primary concern to be the availability and quality of housing services.

**Distribution of Respondents, by Affiliation, Who Identified Housing as a Priority**

<table>
<thead>
<tr>
<th></th>
<th>1st Priority (n=26)</th>
<th>2nd Priority (n=19)</th>
<th>3rd Priority (n=12)</th>
<th>Written Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>“Housing is the biggest concern. Stable housing is the foundation to build on recovery.”</td>
</tr>
<tr>
<td>(n=6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public/Private Entity</td>
<td>7</td>
<td>3</td>
<td>5</td>
<td>“Not enough housing supports to help healthcare succeed.”</td>
</tr>
<tr>
<td>(n=15)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider</td>
<td>17</td>
<td>13</td>
<td>6</td>
<td>“Lack of affordable and safe housing for our most vulnerable and disadvantaged members in our community.”</td>
</tr>
<tr>
<td>(n=36)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Nearly all respondents acknowledged a general lack of available housing, and a number of respondents implied that the housing that is available is of poor quality. Most respondents were primarily troubled by the limited availability of housing for persons with serious mental illness (SMI). “Participants often have long stays on the streets before housing becomes available,” said one participant.

A pervasive theme among responses related to availability was the understanding that housing is critical to recovery, and thus needs to be a priority for behavioral health providers. For example, two individuals noted that “housing is the biggest concern. Stable housing is the foundation to build on recovery,” and “recovery does not happen without safe affordable housing.” Several other respondents specifically mentioned the Housing First Model to describe their concern with availability, and many more referred to the relationship between success in treatment and housing: “…without a wide array of housing options, more individuals become homeless and less engaged in their treatment.”

Respondents also expressed concern about the poor quality of available housing. “Housing is limited and if you are lucky enough to get housing it is un-safe and dirty.” Another respondent provided a recommendation in lieu of a quality concern, suggesting, “Case managers are often unaware of the living conditions endured by consumers. Physical visits to housing sites and communication with group home staff would significantly lower the number of cases in which consumers experience deplorable and damaging living conditions over extended periods of time.” Additionally, one individual indicated dissatisfaction with the cost of housing for persons with SMI, stating: “I cannot believe the amount of taxpayer dollars going toward providing private apartments to people. Maybe they should only be allowed studios or shared apartments until they can get on their feet.”
Prevention Services

Fifty-three respondents identified prevention services as a primary concern in the provision of behavioral health care. These responses identified a need for prevention services to prevent incarceration, hospitalization, worsening mental health problems, trauma and chronic health conditions. Additionally, numerous responses described prevention services as cost-effective, saying that, when a problem is identified and responded to early or before crisis, “the better the outcome for the patient, society, and our expenses.”

Respondents seemed particularly concerned with the lack of prevention services directed toward children and adolescents, citing the need for preventive services to reduce the likelihood and impact of chronic issues later in life. For example, one respondent stated that “prevention is crucial and needs funding. [C]hildren, youth and families are negatively impacted.” Another respondent suggested that “comprehensive [prevention] services for children reduce the risk of chronic issues.”

Almost all respondents who indicated concern over prevention services acknowledged that such services were cost-effective: “prevention and early intervention services are proven effective and economically efficient. A significant number of families with young children would be served more effectively with less recidivism, greater long-term success and less cost.” “Prevention is a key component in reducing health care costs in the future and yet most of our schools do not have ongoing/sustainable prevention programs.” Additionally, several respondents identified the current system as a “reactive vs proactive system,” which “is shortsighted as the evidence points to its reduc[t]ion of future more expensive inte[r]ventions be it child abuse, alcohol and drug abuse, disease prevention.”

Transportation Services

Forty respondents designated transportation as the largest barrier to accessing care, citing the limited availability, poor reliability and high cost of current services. Additionally, many respondents expressed concern about the state’s Medicaid waiver proposal to eliminate reimbursement of non-emergency transportation. For example, “Transportation — the bill requiring waiver language to not cover non-emergency transportation. Children, famil[i]es and poverty level income individuals continue to rank tran[s]portation as one of their biggest barriers to getting to proper medical care, jobs an[d] or school.” Those who are troubled by the waiver proposal consistently describe the consequences of limiting transportation to emergency medical services, such as “impact[ing] show rates and ability for recipients to access care,” a “decrease in efforts to improve community re-integration,” and “caus[ing] more crisis for non-med[ical] ER needs.”

Respondents also expressed concern about the limited availability and high cost of current transportation services, both for service recipients and service providers. For example, providers explain that, while transportation services are critical, they are prohibitively expensive: “There is very limited budget or providers for transportation,” and “transportation services [are] needed but very expensive.” Another area of concern involves the reliability of current transportation services: “Transportation for the consumers with whom I work is characterized by inefficiency and denial of service failures. Daily tardiness (often arriving hours later than scheduled) leads to missed medical appointments, meetings, and supervised day treatment. Unexpectedly early arrival (again, hours early) creates a sense of anxiety and uncertainty in consumers. Contracted transportation providers are required to meet the basic needs of the consumers who rely on their services. This is a consistent, constant problem.” Other respondents seemed predominantly concerned with transportation services to special populations, such as youth under the custody of the Department of Child Safety (DCS), Comprehensive Medical and Dental Program (CMDP) clients and Native Americans.
Crisis Services

Thirty-one respondents commented on the lack of adequate and high-quality crisis services. Respondents mentioned insufficient mobile teams, delayed response times, “lack of highly trained persons to handle the work load,” and lack of comprehensive care to prevent future crises.

Multiple respondents who appeared to have experience as or with first responders mentioned the consequences of unavailable crisis services, such as “police…handling crisis calls more than [CRN],” “clients access[ing] ERs,” and “law enforcement involvement and hospitalization.” Respondents also highlighted issues such as overcrowded centers that fail “to recognize risk and also to connect people to ongoing services.” Furthermore, crisis centers were described as “frightening” the consumer, and as potentially inhibiting healthy recovery. A couple of respondents also addressed the need for expanded crisis services in rural communities.

Hospitalization/Hospital Discharge

Twenty-six respondents noted key problems regarding hospitalization/hospital discharge, including discharge plans that often failed to prevent re-hospitalization, and a lack of coordination and continuity of care between hospitals and outpatient providers. Respondents mentioned multiple problems with hospital discharge planning, including consumers who were discharged too soon, unable to access needed services after discharge, and/or staying at shelters after discharge. Additionally, respondents addressed issues regarding the misuse of hospitalization, noting such problems as the “over utilization of acute care hospitals for non-medical issues,” “[ER] boarding,” “patients left in ER too long [due to lack of] availability of hospital beds,” and “hospitalization used for treatment for many members due to lack of resources.”

Employment Support Services

Employment was mentioned as an important issue for 24 respondents, who indicated that employment is necessary for recovery and well-being, and that people need to engage in productive activities engage in meaningful livelihoods. Respondents mentioned specific populations in need of employment services, such as youth aging out of the behavioral health system, adult criminal offenders and jail/prison re-entry adults, and adults in recovery. They addressed the general lack of employment services, with one noting that “employment services have been lost in the integration discussion.” Another respondent commented that the “lack of effective programming and employment services impact the success of individuals who are capable of receiving the support to be productive members of society.”

Medication/Medication Management

Twenty respondents mentioned medication management as an issue that warrants attention, noting such aspects as frequent and unnecessary changes in consumers’ medications, overmedicating consumers, and psychiatrists spending insufficient time to make proper diagnoses and determine appropriate prescriptions. A few examples illustrate the point: “Frequent changes in psychiatrists result in frequent changes in client’s medication. Not sure if psychiatrist is receiving pay-backs by using certain medication[s], but these changes in medications (ones client is actually benefitting from) have impeded upon cli[ent]’s…stability, etc.” “So many of psych[iatric] patients are being overmedicated.” Consumers who have never seen a psychiatrist and who would benefit from medication treatment in conjunction with other interventions (e.g., therapy or peer support) face long wait times due to a lack of providers. Other problems mentioned include low health literacy among consumers and lack of support for effective medication management, which result in non-compliance, potential hospitalization or other instabilities. “Consumers need assistance with medication management. Non med-compliance is another reason why
consumers end up in hospitals.” Respondents also mentioned the need for improved medication and medication management services for homeless individuals, adults who have been released from prison, those who have been discharged from hospitals, and the uninsured. These populations speak to the need for improved continuity and coordination of care for consumers who come from special populations and have complex needs.

**Court Ordered Treatment/Court Ordered Evaluation (COT/COE)**

The 13 respondents who identified COE/COT as a top issue considered these services vital for specific populations, specifically criminal offenders and adults who are non-medication compliant. One respondent commented that COE/COT can be used as a way “to prevent the consumer from becoming more ill where they then most likely will end up in jail where they have no hope.” One respondent implied that the confusion, anger, misunderstanding and lack of motivation from consumers who receive COE/COTs could be decreased, and attendance increased, if transportation were provided, along with “a clear explanation of why the evalu[ation] is requested.” Several respondents also mentioned the poor quality of COE/COTs, highlighting issues such as “long waits for evaluation appointments and…treatment [that] is generic rather than client specific,” and stating that “many individuals are petitioned or court-ordered inappropriately.” Recommendations to improve the quality of COE/COT included: “better involvement/supervision of outpatient providers,” “more outpatient step-down services,” standardization of COE/COT, and changing the definition of danger-to-self/danger-to-others “to include psychosis unsupervised in the street.”

**Peer Support Services**

The 12 respondents who provided comments about peer support services noted the lack of support toward peer staff and COSPs, noting the minimal value placed on these services despite their integral role in recovery. Respondents pointed out two critical themes in peer recovery support: 1) Peer staff need additional workforce and professional development, and 2) with effectively trained peer support, staff must be reimbursed appropriately. One respondent mentioned the lack of training and education among peer staff, a comment in keeping with other respondents’ recommendations that more training and support be provided to peer staff to support career advancement. “Peer recovery staff tend to be untrained and uneducated to perform their job effectively.” “Peer Recovery Staff [need] ongoing training and support.” Other respondents mentioned that peer staff are “a proven method in recovery aid” and “very important for recovery and should be fortified.” Another respondent suggested that “more information on peer recovery to both providers, families and clients” be provided.

**Consumer Operated Services/Programs**

Seven respondents identified COSPs as a top issue, noting the lack of support that COSPs receive from the mainstream behavioral health system. One respondent commented, “Consumer Operated Services — there is a lack of choice and diversity in both counties, especially in Pima County. The providers in Pima County do not seem to value these services as they do other services.” Another respondent stated, “As [behavioral health] moves to AHCCCS and the more traditional medical model seems to drive thinking in this arena, there has been little use, understanding or interest historically from Medical providers to engage peers in health promotion, recovery and education. It has demonstrated success!” One respondent was concerned with COSPs not becoming licensed, and another urged for “providing technical assistance to strengthen consumer operated programs and fidelity to SAMHSA best practice.” Highlighting the effectiveness of peer-run services and programs, respondents stated that “peer support, recovery and consumer operated programs have the most benefit” due to the “focus on role models with lived experience and recovery.”
Cross-Issue Considerations

An additional 76 comments were received that were not service-specific and identified concerns regarding the behavioral health system as a whole. These issues included the lack of available services, inaccessibility of providers in specific service realms and geographic areas, poor quality of behavioral health services and providers, fragmentation of the behavioral health system, and the need for services targeted at various, specific populations. The respondents’ concerns undergird general perceptions of the quality, availability, accessibility, and responsiveness of RBHA-provided services as described more fully in the next section.

Which Specialty Populations Represent the Greatest Service Availability and Quality Concerns in 2015?

In addition to asking what types of behavioral health services most concerned individuals their communities, the instrument asked respondents to evaluate the availability and quality of behavioral health services to specific specialty populations impacted by behavioral health disorders. For this question, five specialty populations were identified: dual-eligible Medicare-Medicaid clients, dual-enrolled RBHA and DDD clients, CMDP clients, individuals re-entering the community from jails and prisons, and children and adolescents. As illustrated by the accompanying chart, “children and adolescents with behavioral health needs” was the most frequently cited specialty population, while dual-enrolled RBHA and DDD clients were cited the least frequently.

The respondents highlighted a wide range of concerns regarding service delivery to children and adolescents. These included a lack of adequate prevention services directed toward children and adolescents, and a lack of funding “to provide mental health services to…children who are undocumented.” Regarding psychiatric services specifically, one respondent suggested that the “integration of [medication-only behavioral health] serviced youth back into [p]ediatricians/family practice with behavioral supports and coaching where necessary,” and another addressed the lack of hospital beds. One respondent addressed the need for employment services for youth aging out of the behavioral health system.

Respondents also requested that services be family-oriented when considering the health and well-being of children and youth. They cited the need for transportation if children and families are to receive proper health care, employment and education. Other comments that focused on including family in the service provision to children included, “having the whole immediate family involved in the child's recovery” and “children and adolescents along with their families need access to more family oriented services,
including family preservation services.” In short, almost every service issue identified in the current RBHA delivery system appears to directly affect children.

Although CMDP clients are children and adolescents, comments regarding this population were analyzed separately from the general children/adolescents population due to the unique issues that youth under the custody of DCS experience. Respondents raised multiple concerns about service delivery and quality for foster children, including the lack of both a transportation and “a comprehensive array of services especially focused on trauma [and] reunification.” Regarding youth in group homes specifically, respondents brought up the following problems: “group home youth do not have consistent, convenient, comprehensive behavioral health services,” and “10 youth in one home can have up to 10 different providers in all areas of the county.” One respondent expressed difficulty and frustration in working with DCS:

“DCS is a monumental wreck. Some behavioral health providers don't work hard to decrease barriers. Departmental collaboration to decrease barriers is woeful ... getting DCS caseworkers to just return calls/emails to update, for consents, etc. ... can be almost impossible.”

Justice-involved consumers (i.e., adults re-entering the community after release from prison/jail) were identified as another group in need of improved services. Respondents recommended expanded and enhanced employment, medication/medication management, and COE/COT services for the prison population, adult criminal offenders and adults who have been released from prison/jail. One respondent said that the “prison population are the most under served and most in need of mental health intervention.” For adults re-entering the community from prison/jails, respondents asked for “transition services to reduce recidivism.”

What is the Availability, Accessibility and Quality of Behavioral Health Services in 2015?

Respondents were asked to rate current behavioral health services in their community on four different dimensions: 1) accessibility of behavioral health services, 2) quality of behavioral health services, 3) availability of behavioral health services, and 4) responsive and adaptable to community needs. With the exception of providers working at a RBHA-contracted agency or working for a RBHA, respondents generally rated current services as poor. It appears that respondents did not believe behavioral health services are accessible, available, of sufficient quality, or responsive and adaptable to community needs. Respondents attributed these perceived lacks to fragmentation in the behavioral health system and, in particular, to the need to improve services for specific populations who are not well served under the current system.
Respondents’ Median Ratings on the Accessibility, Quality, Availability, and Responsiveness of Behavioral Health Services

<table>
<thead>
<tr>
<th>4-point scale:</th>
<th>Overall (n=139)</th>
<th>Recipient (n=18)</th>
<th>Public/Private Entity (n=44)</th>
<th>Provider (n=72)</th>
<th>Cenpatico (n=11)</th>
<th>CPSA (n=19)</th>
<th>MMIC (n=70)</th>
<th>NARBHA (n=13)</th>
</tr>
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<tbody>
<tr>
<td>Accessibility of behavioral health services</td>
<td>2</td>
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<td>3</td>
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<td>Quality of behavioral health services</td>
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<td>Responsive and adaptable to community needs</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
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<td>2.5</td>
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As these data reflect, service recipients/family members and affiliated entities evaluated all four dimensions of behavioral health services to be poor. In contrast, behavioral health service providers working at a RBHA-contracted agency or working for a RBHA evaluated their services to be good in all four dimensions. Additionally, these data suggest some variations by RBHA: CPSA received ratings of 3 (“good”) for accessibility and quality; NARBHA received ratings of 3 for accessibility and responsiveness; MMIC received one rating of 3 for service quality; and Cenpatico received only ratings of 2 (“poor”).

Respondents were also asked to compare current behavioral health services to those available one year ago. No matter their RBHA or affiliation, they rated past behavioral health services as the same as present services in terms of accessibility, quality, availability, or responsiveness/adaptability to community needs. Generally, these results indicate that respondents perceived behavioral health services as poor, both today and in the past.

In addition to rating these four service parameters, 76 respondents also provided written comments that addressed one or more of these dimensions. Topics covered included a lack of certain types of treatments that respondents felt were critical, a lack of services in specific geographic areas and for specific populations, and poor quality of services, including a lack of qualified staff. Respondents also highlighted the fragmentation of the behavioral health system as a context for these problems.

**Accessibility and Availability**

Many respondents addressed the lack of providers in specific service realms and geographic areas. They called for more providers and services in: Medicaid, respite, infant-toddler mental health, trauma-informed care, detox, developmental disabilities, peer bridge programs, case management, autism-spectrum disorders, counseling, and assertive community treatment teams.

“Our primary mental health provider lacks trained counselors; most work under the license of one or two MSW licensed therapists. While many of the counselors mean well, they are neither qualified nor able to meet the needs of many clients. Too, it takes weeks to schedule an appointment, so availability of services is poor.”
Other respondents asked for increased services in rural settings, including Flagstaff, Northern Arizona, Casa Grande and the rest of Pinal County. Example statements included: “Outside of Casa Grande services are very limited,” and “Court ordered evaluation and treatment does not exist in Yavapai County.” Respondents also noted that underfunding, high turn-over, and large caseloads have led to poor availability of services and provision of services by underqualified staff. A few respondents acknowledged improvement in the provision of behavioral health care over the past two decades.

**Quality**

Other respondents addressed the quality of services in the behavioral health system. Respondents discussed issues such as long wait times for services to begin or for appointments to be scheduled, as well as unsanitary, unsafe facilities. They also noted the lack of consumer-driven customer service and practices, stating that consumers “are not given the right to [a] second opinion[,] they want you to see the [doctor] they work w[ith] for your second opinion,” and that providers lie “to clients about right[t]s or deny their request to file grievance.” One respondent highlighted the contradiction that both consumers and providers experience within the behavioral health system: “being [Title] 19 and not getting services however being a case manager expected to provide and or create services.”

Respondents stated that “people need to feel valued,” and “family is a huge part of someone[’s] health and needs to be acknowledged and applied.” Regarding case management, one respondent stated, “Some really good case managers and PNO Team Members but some have inadequate skills and/or negative approach to people they serve. More training needed in the person-centered approach and in understanding trauma-informed care. M[a]ny service recipients want counseling and/or other treatment programs/services that are specific to their needs and too often case management response is ‘That doesn't exist’ or ‘There’s a wait list’ etc. Not addressing a person’s core needs ultimately is more expensive than finding a way to meet these needs.”

Some respondents linked the poor quality of service provision to the availability and quality of direct service staff. “There is such a shortage of qualified staff at all levels.” Some mentioned the lack of competent and licensed providers, such as psychiatrists and therapists. Respondents mentioned “high turnover resulting in diminished services,” and said that non-licensed staff provide services that fall outside of their professional or educational expertise.

**Responsive and Adaptable to Community Needs**

Respondents offered some key insights regarding the need for the last dimension, services that are “responsive and adaptable to community needs.” Here the community was not necessarily identified geographically but rather functionally. Respondents expressed concern with the availability and quality of services to target populations as well as with the service providers ensuring that services meet the unique needs of specific communities. The specific populations mentioned by respondents included the following individuals who are: not covered by Title XIX; justice-involved; transgender; uninsured and under-insured; aging adults (particularly those not covered by Medicare or Medicaid); Native Americans; children and adolescents in the child welfare system; ethnic minorities (including refugees and the
undocumented); veterans; homeless. Respondents also discussed individuals who have experienced domestic violence and other traumas, as well as individuals with co-occurring disorders.

Respondents’ comments suggest that the needs of special populations, which extend beyond persons with SMIs to encompass the general mental health population, go undertreated and unidentified. One respondent commented that “focus is always heavily weighted toward the SMI population and there has been decades of legal oversight regarding services to those with SMI.” Anxiety is growing that, for populations who are already underserved, services will not be provided under an integrated system.
Recommendations for Enhancing Behavioral Health Services in 2016

Respondents were asked to provide three recommendations or specific actions AHCCCS should consider as they continue to make enhancements in the availability and quality of behavioral health services in Arizona. A total of 108 respondents supplied 296 recommendations that were classified into six policy and programmatic areas:

1. Develop State-Wide Standards and Create Effective Partnerships
2. Align the Requirements for Acute and Behavioral Health
3. Expand Services to Meet the Needs of Communities
4. Promote RBHA Accountability with State-Wide Standards
5. Develop Service Arrays that Meet the Needs of Children and Adolescents
6. Improve Quality and Customer Service Delivery

Similar to the qualitative procedure utilized to classify open-ended responses for identified issues into major themes, respondents recommendations were also coded using a key-word based coding procedure that developed frequency counts for each recommendation area and grouped by theme (for a full discussion of this methodology including inter-coder reliability procedures, see Appendix A). The recommendations were synthesized and are summarized below.

Develop State-Wide Standards and Create Effective Partnerships

Thirty-two responses addressed systemic issues, which fell under four main domains: policy/statewide standards, geography/RBHA catchment areas, target populations, and partnerships. Concerning state-wide standards, the central recommendation suggested AHCCCS needs to develop consistent standards state-wide to better implement policy decisions and maintain RBHA accountability. For instance, one respondent recommended more “thoughtful implementation of policy changes.” The RBHA catchment areas (how many RBHAs there should be, the coverage associated with each RBHA, and the provider network structure) was another domain. Perhaps more interesting were the number of comments concerning target populations, such as refugees, foster children, children with autism, and populations that require additional services beyond behavioral health care. This speaks to the need for AHCCCS to create partnerships in the system with those who know their target populations best and can provide services in addition to those provided by behavioral health, including but not limited to criminal justice, counties, and DCS. Responses included: “Don’t give all the mo[n]ey for [behavioral/mental health] services to RBHA (let Counties manage some),” “require [RBHA]’s to work with criminal justice to reduce recidivism,” “recognize and contract directly with [I]ndian health service providers,” and “consider ending the use of RBHA in Maricopa and th[ro]ughout the state.” Finally, as integrated care evolves, the RBHAs must re-evaluate partnerships with private providers and establish standards of care that meet the needs of consumers state-wide.

“Work toward increased consistency statewide from all RBHA’s with regard to what’s expected of providers. For those agencies that provide services statewide it’s very difficult [to] meet all the varied requirements from all RBHA’s.”
Align the Requirements for Acute and Behavioral Health

Fifteen recommendations addressed the lack of alignment of behavioral health (BH) and acute care service delivery. Specifically, the recommendations suggested: 1) clearly defining integrated health care, 2) requiring BH providers to be licensed, 3) requiring reimbursement for behavioral health services and recognizing the cost of specific populations under integrated health care. Respondents recommended that integrated health care be implemented “truly” and “fully” and that integrated health care providers be monitored for success and quality. For instance, one respondent said, “Integrated care needs to be more than shared information and co-location.” Another respondent suggested to “support the expansion of integrated behavioral health and medical services … as opposed to only the ‘pilot project’ agencies.” Several respondents requested that behavioral health providers be licensed within primary care settings. Additionally, respondents recommended that requirements for integration be modified and improved to ensure that providers, both in primary and behavioral health care, can effectively and efficiently provide integrated health care. For example, one respondent suggested that behavioral health providers not be required to provide physical health care services. Other responses suggested that primary care physicians be required to coordinate with behavioral health providers, and to change the requirements so that behavioral health services can be reimbursed within primary care/medical settings. Finally, respondents recommended that the cost of providing integrated health care to specific populations — such as children, individuals with comorbid behavioral health and primary care conditions, adults with SMI, and the uninsured — be reflected in reimbursement (or capitation) rates.

Expand Services to Meet the Needs of Communities Served

Of 296 recommendations, 24% (71) recommended the expansion of services that are responsive to the needs of the community served. Respondents recommended expansion of prevention, quality support services, peer-run, crisis, and general mental health services for targeted populations across the state. For instance, respondents encouraged the implementation of prevention services in schools. Housing and transportation were highlighted as necessary support services for veterans, justice-involved individuals, youth and homeless individuals. Respondents asked that the quality of crisis response services in Maricopa County be improved, and that quality substance abuse treatment be provided for low-income individuals. They requested that the general mental health population be afforded access to behavioral health care, including peer support and family-run services. Arizonans’ mental health will improve greatly by matching the array of quality services to the unique needs of the community or the specific population being served.

Prevention. Prevention was cited numerous times as a necessary and complimentary component to intervention services. Respondents recommended increasing prevention services, such as screening, and providing more funding for prevention and to “cover more wellness and prevention services in integrated medical plans.” One respondent stated that it is “important to focus on the branches (the pressing needs/challenges/problems) as well as the roots (the core needs and potential of each person). Proactive/Pro-Wellness/Pro-Independence services are just as important as reactive/problem-focused services. We need to empower people to thrive, not just survive. Doing so will create lasting positive outcomes for people and save [money] in the long run.” Respondents were also concerned with providing
“community education about substance abuse” and general mental health to “reduce stigma and promote understanding,” and to serve as a prevention mechanism. One recommendation was to “increase substance abuse/dependency education and prevention services from preschool through graduate school for all discipline[e]s.” Related to this issue of community education were recommendations that asked for increased outreach to engage individuals who would benefit from behavioral health services. For example, one respondent said to “focus on efforts of engagement as the beginning of effective treatment,” and another commented that services should “reach out before dropping clients.”

Quality Support Services. Twenty-four respondents recommended the expansion of support services that are responsive to the needs of the community served. They recommended expansion of transportation, life skills, employment, and housing services in terms of geographical availability and targeted populations. For instance, one respondent recommended to “increase accessibility to transportation services, not only to medical appointments but to increase engagement in communities ... as these activities are essential to recovery.” Another respondent stated that “people only seek, and benefit from, treatment when basic needs are met and transportation is available. Protect support services and the safety net.” Housing and transportation are still widely needed for certain populations, including veterans, justice-involved, and homeless individuals. One respondent said to “enhance services to persons leaving jail/prisons.” Another indicated that “veterans need more individualized therapy and housing, homeless people need more housing, homeless youth need housing. The Housing First Model of care has been proven to be successful with fostering other successes for individuals. Let’s get them housing and help to learn job skills, have job placement assistance, coping skills addressed in classes.”

Peer-Run Services. Increasing the quantity and quality of peer-run services and organizations was addressed by eight respondents. They recommended to “support the continued development of peer and family run organizations and services and encourage their use in the traditional physical health community,” and to “encourage peer support services throughout the industry at all levels.” Respondents addressed the value of peer support in promoting “recovery services” and “self-education regarding managing symptoms,” but also asked for oversight of these services. Respondents recommended to “clarify the role of family [and] peer run agencies” and to “increase ... quality peer support personnel (educated).” One respondent recommended to “develop more non-professional services that have meaning and value and are not just for the purpose of generating revenue.”

Crisis Services. Nine respondents provided various recommendations concerning the improvement of the quality and general provision of crisis services. Generalized concern for the current state of crisis services in Arizona was indicated by responses such as, “improve quality of crisis response services in Maricopa County” and “beef up crisis services with recovery supports.” Respondents were also specifically concerned with the way crisis services were delivered, recommending that the “brutality and fear [be] taken out of the process of providing crisis services [and] more funding and better training for staff in some of our community's crisis centers.” Respondents also suggested that crisis services be delivered solely in person and not “through the telephone,” and that short-term support services, such as housing and transportation, be provided for those in crises. Many respondents provided recommendations for improving service delivery at the intersection of crisis, psychiatric hospitalization, and hospital discharge. For instance, respondents asked for “increase[d] bed availability for psychiatric stabilization.” Recommendations to prevent crises and hospital re-admissions included improving discharge plans and coordination of care “through provider education, performance measures, [and] sanctions.”

General Mental Health Services. Seventeen respondents recommended that general behavioral health services be available and accessible throughout the state. “The [a]vailability of behavioral health services is perhaps the most important recommendation. It must be a focal point and priority to our State and the families that represent our State.” “The [a]ccessibility of behavioral health services, provides everyone with a fair and consistent opportunity to be afforded quality behavioral health services.” Along
these lines, several respondents highlighted the need to expand case management specifically “for general mental health,” “for everyone enrolled in the [RBHA],” “to assist in receiving benefits,” and “for substance abuse.” Several respondents were also concerned with the needs of consumers with dual substance abuse and mental health diagnoses, recommending to increase “psychiatric/psychological pharmaceutical assistance for the dual diagnosed,” “more quality substance abuse treatment for low income and dually diagnosed,” and expanding trauma-informed care.

Promote RBHA Accountability with State-Wide Standards

Twenty respondents recommended monitoring of the RBHAs, with analysis of these responses revealing two major themes: outcomes-focused reporting and improving quality of services. Respondents indicated that providers be accountable for outcomes and that contracting and reimbursement for services be based on the quality of consumer outcomes. Respondents suggested to “focus in outcome pay for performance” and “look at a wide range of outcomes for reimbursement, rather than fee for service.” Related to this issue of monitoring RBHAs, respondents were also concerned with holding them accountable. For instance, one respondent suggested to “confront RBHA for services that are in name only (disengenuine).” Respondents appeared to be more broadly concerned with quality of services, recommending that quality standards be implemented and monitored continuously. A few concrete suggestions were made, such as “do regular in depth case reviews and don’t rely on the systems data” and “raise the bar, increase quality by increasing competition for the [M]edicaid dollar.”

In conjunction with holding RBHAs accountable, respondents spoke to the need for holding RBHAs to statewide standards and expectations that would support providers and ultimately lead to positive consumer outcomes. These include reducing administrative burden for providers, providing adequate financing for expansion and integration, providing incentives to recruit and retain qualified staff, and requiring improved outreach and access to services.

Reduce Administrative Burden. Fourteen responses specifically requested to decrease the providers’ administrative burdens. Respondents asked for decreased paperwork, less “red tape,” and to “streamline and simplify administrative processes” in order for providers to spend “more time with people.” Responses indicated that “unnecessary administrative burdens” were related to decreased accessibility and quality of services. For instance, one respondent noted that the documentation requirements when a consumer changes medical group/home is so burdensome that “[it] has greatly reduced group referrals,” and another stated that “less regulation[s] can help to focus on quality of care, more client slots available, better outcomes.”

Provide Adequate Financing for Expansion/Integration. Many responses (n=45) made recommendations to improve funding and financing of integrated services. These responses ranged from generic fears to very specific suggestions regarding funding services, increasing the number of private insurance providers, payment reform, adding services to the fee schedule, revising billing codes and supporting needed technology and infrastructure. Many respondents recommended expanding Title XIX coverage. Some suggested to “increase rates,” “not cut funding” and “protect Medicaid expansion.” One respondent suggested that Arizona increase funding for non-Title XIX services. For example, respondents suggested directing resources to “law enforcement, jail and courts system.” Another recommended “limit[ing] executive salaries and administrative budget percentage for RBHA and providers.” Respondents recommended increasing private insurance carriers and other non-RBHA
provider options. One respondent mentioned that “providers taking private insurance…is lacking. If I qualified for AHCCCS, I would have access to an abundance of services. This is a disparity for people who pay for their insurance and can’t receive the same service as those who don’t.” Other responses recommended a “fee for service to providers that are [not] connected to a RHBA” and to “open up Medicaid provider options.” Respondents also called for “payment models that are more flexible [and] outcomes focused” and that ensure the financial sustainability of providers. Regarding services and billing codes, respondents called for expanding the fee schedule in specific service areas, such as dental, eyesight, primary care, and prevention. Respondents recommended developing specific billing codes for certain services, such as “community health worker” and “phone support services.” Respondents also expressed concern over the high cost of certain types of providers, such as “Doctors/NPs,” and urged to “review rates for covered services” and “address the provider fee schedule for both physical and behavioral health services.” Finally, respondents recommended that an investment in the behavioral health system’s infrastructure be made, including upgrading its use of technology. Respondents mentioned that “health IT and innovation requires capital” and to “encourage and support technological advances in service delivery.”

Provide Incentives to Recruit and Retain Qualified Staff. Twenty respondents recommended improving the quality and continuity of direct service staff. These recommendations can be classified into two main categories: staff qualifications/licensure and retention. Respondents recommended the hiring of better qualified staff, for example more Master’s-level trained clinicians. In addition, they suggested that advanced training be provided for non-clinical positions such as peer support specialists. Respondents urged to “stop allowing unqualified clinicians to perform Master's level work,” “pay for professional licensed staff to provide outpatient behavioral health services with increased skill level,” and “invest in training peer recovery staff.” One respondent specifically recommended “licensure requirements for all administrative and clinical Behavioral Health positions.” Respondents suggested incentivizing recruitment and retention of highly qualified staff through loan repayment programs and offering higher salaries. In addition, many respondents suggested improving staff knowledge and awareness around trauma when serving special populations, such as justice-involved individuals, children, adolescents, Native Americans and transgender individuals. They also recommended increasing cultural competency.

Require Improved Outreach and Access to Services. Another 21 recommendations addressed enrollment and access to available services. Clearly, respondents are concerned with ensuring that consumers can easily and quickly apply, and begin receiving, behavioral health services. Respondents highlighted multiple barriers to enrolling in services within the current process, including long and complicated application forms, long wait times for decisions, and lack of information and resources to inform people of the services available. One respondent suggested behavioral health services be advertised to the general population, and “not only for SMI consumers.” Concerning barriers in accessing care, one respondent encouraged providers to “reach those that need help — do not make someone who is trying to find help go through what my daughter did before she was helped.” Another pervasive concern among respondents was related to gaining access to specific services, such as substance abuse treatment, as well as the delivery method of services. One respondent requested “allow[ing] services other than CM to be provided over the phone” and another suggested the allocation of “more resources towards immediate (same day/next day) appointments” to improve timely access to services. Concerning geography, one respondent suggested AHCCCS “move[s] away from the outpatient model and look[s] at more community-based centers that are more accessible for individuals; increase health care models on school campuses.” Overall, respondents agreed in the views that services were not always easily accessible and that providing more options regarding accessing services, as well as reducing the administrative burden of enrolling for such services, would greatly improve quality of care.
Develop Service Arrays that Meet the Needs of Children and Adolescents

Eight respondents recommended some form of expansion or improvement of services for children and adolescents, either through the future provision of, increased access to, or increased coverage of services. In particular, respondents were interested in the inclusion of support for the family of the child through “more options for child care for children with disruptive behavioral health issues” and expanding housing options for families of children in the mental health system, such as women with children. Respondents generally requested increased services for children or adolescents and for these services to be covered for patients transitioning to adult services, “serve GMH/SA aged young adults so that medication compliance, wellness journey continues past age 18.”

Improve Quality and Customer Service Delivery

Forty-three responses were related to improving quality of services or customer service and delivery. To improve the quality of services provided, a large number of respondents recommended increased time with providers and improving care coordination. Respondents suggested fewer caseloads per provider to increase time spent in consultation with consumers, and ensuring treatment is delivered as required, such as “have treatment really be treatment 16 hours means staff 16 hour [etc].” A number of respondents also recommended increased patient autonomy and choice in the provision of care, citing “consumers have reported that they are stuck with a team and they like their BH Provider but not their PCP or they do not work well with their CM. Consumers should have more choice and empowerment.”

Additionally, numerous respondents recommended the inclusion of family in the treatment of the patient or decision-making process. For example, respondents suggested, “Indivi[d]uals and the[i]r familie[s] should be acknowledged by the doctor in the coordination of care,” and to “meet consumers in their environment; more emphasis on including the family (whatever that means to the consumer) in the recovery process.” Several respondents suggested implementing community needs assessments and quality reviews of communities to understand if additional resources are required. Various respondents suggested providing evidence-based services and multi-systemic services. In terms of treatment, respondents suggested focusing on more sustainable, long-term solutions when developing the Individual Service Plan.

Concerning customer service, respondents offered general recommendations such as “train[ing] the eligibility staff in customer ser[v]ice”, “treat[ing] individuals with respect,” and at least four separate individuals recommended staff “actually listen to the individuals seeking care.” Other recommendations included employing consumer navigators to improve the coordination of care and communication with consumers. A number of respondents also advised the reduction of clinician and case manager turnover to improve stability and quality of care and customer service.

“Enhance the rapid response so that it is not just about the child, but inclusive of [the] child’s family and current caregivers”

“Services need to be responsive to individual needs. In the long run ‘We don’t cover that’ is more expensive than saying ‘Let’s find a way to cover this legitimate need.’ When people’s individual needs are not addressed proactively, they are more likely to get sick and need more expensive services like hospitalization.”
Appendix A: Methods and Data

Sampling Procedure

The 12-item, anonymous, online survey was distributed via email to more than 8,000 individuals affiliated with Arizona’s behavioral health care system. These individuals, which included behavioral health providers, advocates, service recipients, family members and other public/private entities that interact with 12 RBHAs, were previous participants of one or more professional development workshops or continuing education trainings offered by the Center for Applied Behavioral Health Policy. They also indicated working or residing in the state of Arizona. A snowball sampling approach was utilized that allowed respondents to forward the survey to others who would be interested in completing it.

Data Analysis

Several methodological procedures were executed to prepare the raw survey data for analysis. These procedures included re-coding the closed-ended responses on the survey (quantitative data) to create new variables or to account for errors on the survey. Additionally, the open-ended responses (qualitative data) were compiled, read, and coded by multiple people, multiple times to accurately distill the major themes from respondents’ comments. Data reduction techniques were also utilized to collapse comments to capture all information provided from the data. The following sections describe in detail the specific procedures used to prepare the quantitative and qualitative data for analysis.

Quantitative Data

Creating the RBHA Variable

To determine the distribution of respondents residing or working within the catchment areas of the RBHAs, respondents were assigned to one of the four RBHAs operating at the time of the survey that had contractual responsibility for behavioral health care delivery, based on the county respondents selected. A new RBHA variable was created with the following numeric values representing the four RBHAs: 1=MMIC, 2=CPSA, 3=NARBHA, 4=Cenpatico. Only respondents who chose a single county were assigned to a RBHA (n=118). Respondents who chose only Maricopa County were assigned to MMIC, and those who chose only Pima County were assigned to CPSA. Respondents were assigned to NARBHA if they chose only one of the following counties: Apache, Coconino, Mohave, Navajo, or Yavapai. They were assigned to Cenpatico if they chose only one of the list including Cochise, Gila, Graham, Greenlee, La Paz, Pinal, Santa Cruz and Yuma counties. Respondents who chose two counties or more were not assigned to a RBHA (n=25).

Re-Coding Responses to Question 2

A total of 143 respondents answered survey Question 2, which asked respondents to choose the affiliation that best describes them (i.e., service provider, service recipient or family member, public/private entity, or other) (for a copy of the survey, see Appendix B). Preliminary analysis of this survey item demonstrated a high response rate (17.5%) for the “other” option, which allowed respondents to specify an affiliation not provided on the survey. Due to such a high “other” response rate, respondents’ written responses to this option were reviewed more closely to determine if they could be re-classified under the three categories provided on the survey. Seven respondents were re-classified as behavioral health service providers contracted with a RBHA or working for a RBHA. Five respondents were re-classified as service recipients, family members or advocates. Ten respondents were re-classified as working in a public/private entity. Finally, three respondents were identified as private providers of behavioral health care.
or social services not contracted with a RBHA, a category not included in the survey. To account for these three respondents’ answers, which represented a distinct group among survey respondents, the “other” option was re-coded into a fourth response category that included private providers of behavioral health services. However, due to a low sample size and the fact that these private providers do not have direct contact with a RBHA, this group was not included in the analysis presented in this report.

_Reversing Scale on Question 3_

Preliminary analysis of survey Question 3, which asked respondents to rank five service populations on the importance of improving services for them (see Appendix B), demonstrated that the response scale was counterintuitive and led to misinterpretation of the results. The response scale on the survey had 1=most important and 5=least important; however, when looking at the results, most people would naturally interpret a higher number to mean a more important ranking. Therefore, to improve accurate interpretation of Question 3 results and its visual presentation in graphical form, the response scale was reversed so that 1=least important and 5=most important. This meant that all responses were re-coded as follows: 1=5, 2=4, 3=3, 4=2, 5=1.

_Addressing Error on Question 4_

After the survey had been distributed online, the research team was informed of an error in Question 4 such that “Employment Services” was listed twice (Appendix B). To control for this error when analyzing the results, a new “Employment Services” variable was created that included selections from respondents who chose one or both of the employment options. Respondents who chose both employment options were counted only once for this service.

Qualitative Data

_Reliability Checking and Collapsing Responses_

Survey Question 5 asked respondents to choose the top three issues from Question 4 and to describe what it is about those issues that concerns them. Each response was coded utilizing a procedure that grouped similar comments together based on key words. The 11 issues listed in the survey provided 11 key words used to code the responses. For example, all the responses with the key word “transportation” were grouped together, all the responses with the key word “housing” were grouped together, and so on. Of the responses, 76 did not match any of the 11 issues/key words, and which were coded and grouped based on other prominent themes/key words (i.e., inaccessible/unavailable services, low quality of services, services to specific populations).

Survey Question 12 asked respondents to provide three recommendations or specific actions AHCCCS should consider as they continue to make enhancements in behavioral health services in Arizona. These responses were coded using the same procedure discussed previously that grouped similar comments together based on major themes/key words.

To increase intrarater and interrater reliability, and to insure that the coding procedure and the coders’ interpretations remained consistent, this process — including reading each response, identifying major themes/key words, coding and grouping responses — was repeated multiple times with three coders who coded both independently and together. Groupings were not finalized until all coders agreed on the interpretations of the responses for both survey questions.
Although Question 5 asked respondents to choose the top three issues, responses were grouped together based on key word regardless of whether the response was identified as the top first, second or third issue by the respondents. Similarly, the recommendations provided for Question 12 were grouped together based on key word, regardless of whether the response was listed as the first, second or third recommendation. Collapsing the responses in this way provided a more accurate representation of all comments and recommendations made by respondents for any one specific issue.
Appendix B: 2015 ASU-CABHP Town Hall Survey of Behavioral Health Care in Arizona

Q1 In what county do you reside or do you provide services? (Please select all that apply)
- Apache
- Cochise
- Coconino
- Gila
- Graham
- Greenlee
- La Paz
- Maricopa
- Mohave
- Navajo
- Pima
- Pinal
- Santa Cruz
- Yavapai
- Yuma

Q2 Which of the following best describes you?
- I work in a behavioral health service providing agency under contract with a Regional Behavioral Health Authority (RBHA) or I work for a RBHA
- I am a direct recipient of behavioral health services, a family member of a service recipient, or an advocate on behalf of service recipients and their families
- I work in a public or private entity that provides services to, or interacts with, individuals who are receiving services from a RBHA agency, such as law enforcement, criminal justice, homeless services, child welfare, hospitals, etc.
- Other, please specify: ____________________

Q3 For the following groups, please rank order the importance of improving services on a scale from 1 to 5, where 1 means that improving services for this group is most important and 5 means it is least important.
- Dual eligible Medicare-Medicaid clients
- Dual enrolled RBHA and Division of Developmental Disabilities (DDD) clients
- Comprehensive Medical and Dental Program (CMDP) enrolled clients
- Prison/Jail Re-entry clients
- Children and Adolescents
Q4 Which of the following behavioral health service issues are you most concerned about in your community? (Check all that apply)
- Transportation Services
- Consumer-Operated Services/Programs
- Peer Recovery Staff
- Housing Services
- Employment Services
- Prevention Services
- Medication/Medication Management
- Crisis Services
- Employment Services
- Court-Ordered Evaluation/Treatment
- Hospitalization/Hospital Discharge
- Other, please specify: ____________________

Q5 Of the issues you identified above, please choose the top three and briefly describe what it is about these issues that concerns you.
- Issue #1
- Issue #2
- Issue #3

Q6 Compared to one year ago, how would you rate behavioral health services in your community with regard to:

<table>
<thead>
<tr>
<th></th>
<th>Much worse (1)</th>
<th>Somewhat Worse (2)</th>
<th>About the Same (3)</th>
<th>Somewhat Better (4)</th>
<th>Much Better (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility of behavioral health services (1)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Quality of behavioral health services (2)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Availability of behavioral health services (3)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Responsive and adaptable to community needs (4)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Q7 Please feel free to comment on your responses to the previous question.
Q8 How would you rate current behavioral health services in your community with regard to:

<table>
<thead>
<tr>
<th></th>
<th>Very Poor (1)</th>
<th>Poor (2)</th>
<th>Good (3)</th>
<th>Very Good (4)</th>
</tr>
</thead>
<tbody>
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<td>○</td>
<td>○</td>
</tr>
<tr>
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<td>○</td>
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</tbody>
</table>

Q9 Please feel free to comment on your responses to the previous question.

Q10 Compared to today, what do you think behavioral health services will be one year from now in your community with regard to:

<table>
<thead>
<tr>
<th></th>
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<th>About the Same (3)</th>
<th>Somewhat Better (4)</th>
<th>Much Better (5)</th>
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<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

Q11 Please feel free to comment on your responses to the previous question.

Q12 What are three recommendations or specific actions AHCCCS should consider as they continue to make enhancements in the availability and quality of behavioral health services in the state of Arizona?
   Recommendation #1
   Recommendation #2
   Recommendation #3