

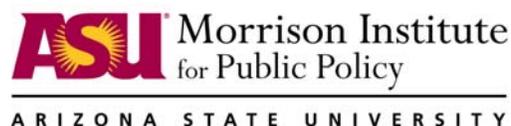
Arizona's Public Behavioral Health Care System

Critical Issues in Critical Times

A Joint Publication of Arizona State University's

Center for Applied Behavioral Health Policy

Morrison Institute for Public Policy



October 2009

EXECUTIVE SUMMARY

Arizona's public behavioral health care system, which serves some 150,000 mentally ill and vulnerable state residents, is wrestling with a number of urgent challenges. In addition to budget cuts resulting from the current economic crisis, and the demands of a 28-year-old class-action lawsuit, the system has been repeatedly criticized in several areas, including for inadequate staff, data, housing support and crisis services. On July 22, a panel of professionals who play key roles in the system discussed these and other issues before some 300 behavioral health providers, supervisors, and policy makers at the annual Summer Institute hosted by Arizona State University's Center for Applied Behavioral Health Policy. This paper provides an abbreviated report of that discussion, which was partially designed and moderated by ASU's Morrison Institute for Public Policy.

Arizona has a three-layered behavioral health system. It is supervised by the Division of Behavioral Health Services in the state Department of Health Services; this agency contracts with four non-governmental Regional Behavioral Health Authorities (RBHAs) around the state; these in turn subcontract with local agencies, clinics, and firms that treat patients. Panel members noted a number of the system's positive achievements, including a low rate of hospitalization, a high level of service integration, and a strong commitment to helping patients recover and return to productive lives. However, they also discussed the troubling shortage of funds to treat persons with mental illness and substance use disorders not covered by Medicaid, as well as shortcomings in Arizona's provision of housing and crisis services. Panelists also cited the need for the state to enhance its focus on treatment quality and outcomes by developing a more robust and comprehensive data system. They also agreed that the long-running *Arnold v. Sarn* lawsuit must be resolved before large-scale system improvements will be likely.

Some panelists argued that the fundamental impediment to system improvement is a core misalignment between legislative intent (as specified in state statute), executive decision making (as expressed in successive state administrations' response to the *Arnold* settlement) and the level of state funding, particularly for non-Medicaid/AHCCCS-eligible individuals and families. Despite their policy differences, however, they were united in the desire to see positive system change and to preserve funding levels for mentally troubled Arizonans in order to avert a human and fiscal crisis of major proportions.

A CHALLENGED SYSTEM

Few Arizonans would disagree that the state's public behavioral health care system is struggling in the face of severe challenges. Notable among these is the current national economic crisis, which has forced reductions in budgets and services across many or most Arizona agencies. In addition, the behavioral health system must cope with a high demand for services while devoting time and resources to a 28-year-old class-action lawsuit concerning the care of seriously mentally ill individuals in Maricopa County. There is no shortage of proposals—some new, others years old—for resolving some of the system's acknowledged problems. This paper takes no position on these proposals. Rather, it represents an effort by the Center for Applied Behavioral Health Policy and Morrison Institute for Public Policy to promote and enrich Arizona's public dialogue about these problems and potential solutions.

Fifty years ago, many people with serious mental disorders, if treated at all, were treated in hospitals, such as the Arizona State Hospital in Phoenix, and considered too disabled to be anywhere else. Then breakthroughs in treatment combined with an enhanced concern for patients' rights bolstered the belief that those who are mentally ill should be treated in the "least restrictive setting." Nationally, thousands of patients were moved from hospitals back to their communities; those who could not afford private care—the vast majority—

were supposed to be treated by networks of publicly supported clinics, group homes, and other facilities. In Arizona and elsewhere, some well-planned, coordinated networks of community care did arise. But "systems" of community services also sprouted up in unplanned, fragmented ways amid a lightly regulated array of agencies, clinics, therapists, group homes, and other actors. Many former hospital patients ended up homeless; others landed in jail.

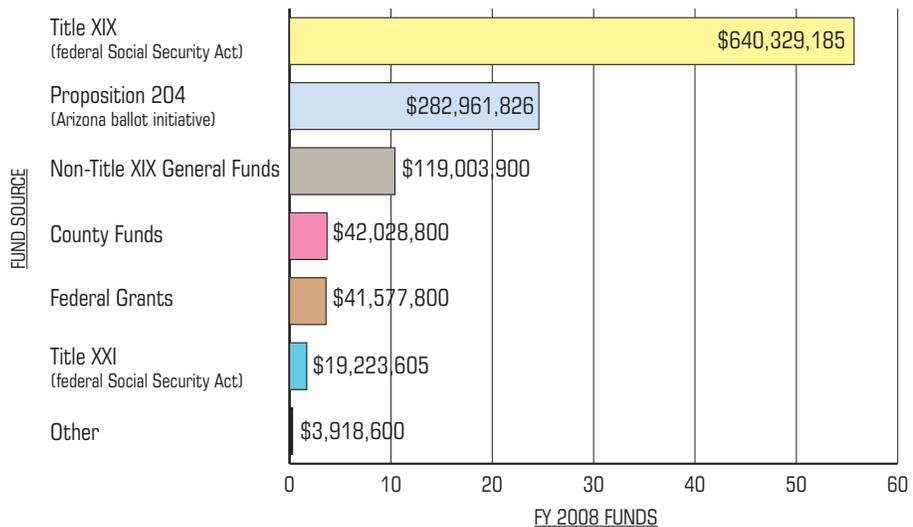
...we should be really proud of the fact that we have almost none of our consumers and our children in institutions—we have very, very low populations in secured or long-term institutions.

Anne Ronan

Arizona developed the Arizona Health Care Cost Containment System (AHCCCS) in the early 1980s as the state's Medicaid

program. Mental health services were not included with other AHCCCS health services; instead, these behavioral health care services were "carved out" and made the responsibility of a separate agency, the Arizona Department of Health Services' Division of Behavioral Health Services (ADHS/DBHS). Treatment of substance use disorders was later also placed in DBHS. In this arrangement, AHCCS subcontracts with ADHS/DBHS, which in turns subcontracts with non-governmental Regional

FUNDING FOR BHS COMES FROM A MIX OF FEDERAL, STATE, AND COUNTY SOURCES



Source: Arizona Division of Behavioral Health Services.

Behavioral Health Authorities (RBHAs), which in turn subcontract with a variety of local non-profit agencies and for-profit corporations to deliver an integrated and coordinated system of behavioral health care. This “carve out,” which many other states also employ, was designed to control costs and ensure that individuals with behavioral health disorders received the special attention they needed. The consensus of experts is that carve outs have saved money. In 1981, the *Arnold v. Sarn* lawsuit was filed, claiming that the state and Maricopa County were failing to fund a

Is recovery possible? I hear people say to me all the time, ‘Oh, but you’re not like my client, my daughter, my son, my whoever; you’re not like them.’ Well guess what? You are seeing me on a good day. I’m looking around the room at people that I know who are miracles. I see miracles every day, and if we’re discounting anybody by saying: ‘Oh, you’re not like them,’ you’re discounting people who can recover.

Ann Rider

comprehensive behavioral health system for residents who are seriously mentally ill, as required by state law. The lawsuit has yet to be completely resolved.

Today, Arizona’s public behavioral health care system annually treats more than 150,000 individuals, most of whom are among

the approximately 40% of Arizonans who are uninsured or have low incomes. The majority of these residents suffer from anxiety disorders, substance use disorders, phobias, and other problems that are challenging but may not be disabling. However, approximately 38,000 Arizona adults in the public system are classified as seriously mentally ill (SMI), typically suffering from severely debilitating diseases such as schizophrenia, bipolar disorder, and major depression. Another 30,000 children and adolescents in the system are classified as seriously emotionally disturbed, a diagnosis that is similar to SMI but with some added disease categories.

Mental disorders are more common than many people realize:

- ▲ Approximately as many Arizonans suffer from depression as from diabetes.
- ▲ Mental disorders are the leading cause of disability in the U.S. for residents ages 15-44.
- ▲ Up to one-half of all doctor’s visits in the U.S. are due to conditions caused or exacerbated by mental or emotional problems.
- ▲ A recent statewide survey found 12% of Arizonans reporting that they needed mental health services in the past year.
- ▲ Untreated mental disorders can lead to increased crime and homelessness, greater public costs for emergency services, lost productivity from ill individuals and their caregivers, self-medication with drugs and alcohol, and suicide, the 8th-leading cause of death in Arizona.

THE SUMMER INSTITUTE

Beginning in 1999, ASU’s Center for Applied Behavioral Health Policy has hosted an annual statewide conference on program and policy initiatives concerning behavioral health services in Arizona. This weeklong *Summer Institute* typically attracts more than 300 participants, many of whom are direct line providers, clinical supervisors, program managers, leaders and policy makers in the state system.

The 2009 Institute included, for the first time, a town-hall-meeting format designed to stimulate dialogue among Institute participants and other state leaders. The July 22 meeting included some 300 participants and featured a panel of individuals recognized for their longstanding commitment to, and service in the behavioral health care system. The panelists—who, it should be noted, have frequently been on opposite sides in policy debates—were:

Charles Arnold—disability rights lawyer, Phoenix; original plaintiff in *Arnold v. Sarn* and currently counsel for the Court Monitor

Neal Cash—CEO, Community Partnership of Southern Arizona, Tucson

Laura Nelson, M.D.—acting deputy director, Division of Behavioral Health Services, Arizona Department of Health Services

Ann Rider—executive director, Recovery Empowerment Network, Phoenix

Anne Ronan—disability rights lawyer, Phoenix; counsel for plaintiffs in *Arnold v. Sarn*

Michael Shafer, Ph.D.—professor, Arizona State University

Ted Williams—CEO, Arizona Behavioral Health Corporation, Phoenix

Prior to the event, panelists were given a series of open-ended questions; members of the audience also submitted questions during the discussion, which was moderated by Bill Hart of ASU's Morrison Institute for Public Policy. The panel was recorded and transcribed for analysis using common methodology ascribed to the qualitative traditions of grounded-theory analysis. This report recounts the major themes raised by the panelists concerning issues introduced by panelists themselves and those brought up by audience members.

...if in fact folks that have a behavioral health problem are not in a place where they can be secure or treated or be compliant with their meds and have case managers check on them and provide service and be involved in the community, it's likely they are going to wind up in jail. It's likely they are going to wind up in a more acute medical setting, it's expensive, and it obviously is really lousy care.

Ted Williams

THEMES AND DISCUSSION POINTS

Advance questions presented to the panelists, together with questions and comments received from audience participants, prompted reactions from the panelists in four broad areas:

- I. An Inventory of our Strengths
- II. Areas of Vulnerability
- III. Critical Investment Targets
- IV. The Life of *Arnold*

I. An Inventory of Our Strengths

A Commitment to Community-Based Care

The panelists generally agreed that the values underlying Arizona's public system, as codified in the Arizona Revised Statutes (ARS), clearly support a commitment to serving Arizonans and their families with behavioral health needs in the community rather than behind institutional walls. This is also reflected in the fact that Arizona has among the lowest rates of hospitalization and institutionalization of any state. Concerns may properly be raised concerning the adequacy of access to secure settings, including hospitals, for children and adults in psychiatric crisis. But the panelists acknowledged that the state remains distinguished by its devotion to a community-based system of care, and the articulation of this commitment in state statute.

Integration of Services

Panelists also noted that Arizona's behavioral health care system is unique in the country in being organized in an integrated manner, from the Division of Behavioral Health Services down to the regional and local level. Many states across the country continue to maintain separate administrative structures ("silos of care") for adults with mental illness, adults with substance use disorders, and children experiencing behavioral health issues. In contrast, Arizona's system provides "one-stop shopping" for individuals and families experiencing behavioral health needs across the lifespan. The strength of this integration is the result of the success with which various funding streams—including federal, state, and local grants—are woven together, or "braided," to provide a

seamless stream of programming support. This minimizes the fragmentation of services that bedevil many other communities. This braiding allows Arizona families to access the psychiatric, psychosocial, and other services needed to address the full range of behavioral health needs from a coordinated system of care.

A Commitment to Recovery

Another strength discussed by the panelists was Arizona's embrace of the key concept of recovery. The recognition that individuals and families afflicted with mental illness or substance use disorders can recover and establish a meaningful and productive life has emerged in only the past 10 to 15 years. One important result of Arizona's early commitment to this concept is the official integration of peer-support workers in the system. Arizonans formerly identified as clients or patients are being transformed into paid care providers, working alongside psychiatrists, nurses, and other health care providers, with formal recognition of their professional role and function. Within our behavioral health workforce, more than 600 peer-support specialists provide outreach and support to individuals and families, while serving as a living testimony to the promise of recovery from mental illness and addiction.

We have a severe shortage of inpatient beds, and of the beds we do have, ... many of the hospitals we do have, will not admit somebody who has an amended court order, or anything like that... There is some real work we need to do to build and establish what we need in our local communities....

Laura Nelson

II. Areas of System Vulnerability

As Arizona like other states struggles through the national economic crisis, policy makers including the governor, the legislature, and agency heads are confronting difficult and painful decisions: Which of the programs serving our more vulnerable community members do we keep, and which do we reduce or eliminate? The panelists agreed that there are no easy choices, but identified three critical areas of vulnerability.

The [Arnold v. Sarn] court hasn't mandated these obligations. The parties have agreed to it. That there hasn't been sufficient funding, sufficient to support the agreements of the parties, perhaps is where we ought to be focusing our attention

Charles Arnold

The 35% Issue—Adults Who Don't Qualify for AHCCCS

The total amount of funding dedicated to public behavioral health services has grown exponentially in the past 10 years. However, it's important to note that this growth is due almost exclusively to the development and expansion of Medicaid-based

funding. Arizona has a Medicaid Home and Community Based Waiver program for serving children/adolescents and adults, including adults with serious mental illness; we also have successfully implemented a Medicaid-based funding program for persons with substance use disorders. The federal

government provides most of the funding for these programs (the federal portion has varied around 70%), with the state required to provide the rest. Together, these have accounted for nearly all of the recent growth in behavioral services in Arizona.

The Regional Behavioral Health Authorities (RBHAs) and their community-based treatment providers are required to provide services to individuals identified as seriously mentally ill, regardless of their Medicaid/AHCCCS eligibility status. But approximately 35% of all adults with serious mental illness served in our communities do not qualify for AHCCCS/Medicaid, primarily because they are working poor and uninsured. Compounding the issue is the fact that, for many of these families, the current economic crisis is putting them at greater risk for behavioral health needs as unemployment and other stressors increase. Indeed, last month a number of Maricopa County providers reportedly warned they would stop

accepting non-Medicaid eligible patients—despite the requirements to do so in *Arnold v. Sarn*—because they said they can't afford to care for them. The panelists noted that, while the economic crisis has exacerbated the issue, the demands upon Arizona's

behavioral health care system, as mandated by state statute and state policy, are not matched by the resources available in the state budget. The Human Services Research Institute Report (“Leff Report”), issued in 1999, estimated the costs to the state of Arizona to be approximately \$317 million in order to meet state-negotiated performance criteria concerning services to persons with serious mental illness in Maricopa County. DHS has since estimated that the cost, adjusted for inflation and population growth, has risen to \$800 million. By all estimates, the amount of funding available for behavioral health services has increased significantly; but it remains below the level indicated by the Leff report, as adjusted. This, as noted, is due in part to the near-exclusive reliance upon Medicaid-based funding, and to limits on access for non-Medicaid eligible Arizonans. A third factor mentioned is the underfunding of other, non-Medicaid-reimbursable components of a comprehensive community-based system, notably including housing supports and crisis services.

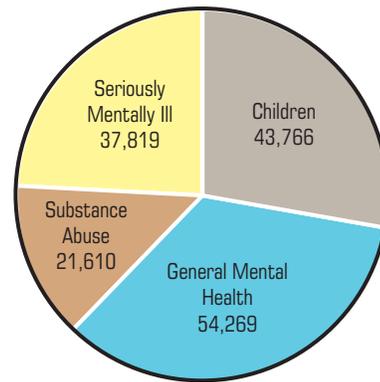
A Place to Call Home is Critical for Recovery

Housing services and supports include rent subsidies, semi-supervised apartments, group homes, residential treatment facilities, and in-home supported living services. These are examples of what’s available in most communities to persons with serious mental illness, substance use disorders, and other behavioral health issues. However, the costs of providing housing and food for individuals using these forms of housing support cannot be paid using Medicaid funding because they are not considered “medically necessary.” But the panelists agreed that, while housing support services may not be considered “medically necessary,” they clearly are “recovery necessary.” If recovery and long-term stability are to be achieved, several panelists said, the convergence of the conditions that we refer to as mental illness and substance use disorders with unemployment, underemployment, and low educational achievement create a constellation of issues that must be addressed in a coordinated and focused manner.

Since housing supports are not reimbursable by Medicaid, providers of these services are required to

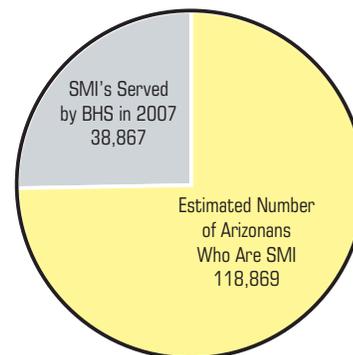
rely upon appropriations from the state General Fund, the Housing Trust Fund, the U.S. Department of Housing and Urban Development, or other non-

ENROLLMENT IN ARIZONA'S STATEWIDE BEHAVIORAL HEALTH SYSTEM March 2009

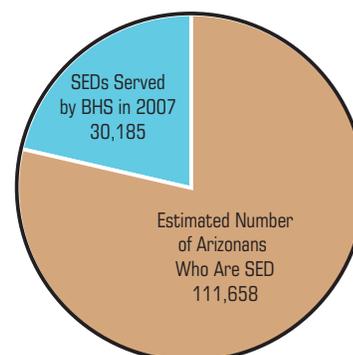


Source: Division of Behavioral Health Services (BHS), Arizona Department of Health Services.

Adults who are seriously mentally ill (SMI)



Children and Adolescents who are seriously emotionally disturbed (SED)



Source: State Plan for Mental Health Services, 2009. Arizona Behavioral Health Services, Arizona Department of Health Services.

Medicaid based fund sources. These, as has been noted, have shown negligible increases in the past decade. As Arizona's legislature and governor continue to deal with the economic crisis through budget cuts, panelists expressed concern that housing supports for persons and families with behavioral health disorders will be further reduced. This will inevitably displace them to the streets, to homeless shelters, and to jail. Such displacement is of course also likely to negatively impact the effectiveness of any outpatient mental health and/or substance abuse treatment services they might be receiving.

A Crisis in Crisis Response

The Maricopa County Crisis Response Network, which provides coordinated behavioral health crisis services, receives on average 15,000 calls a month from families and individuals in crisis, law enforcement officials, area hospitals and emergency rooms, and state Child

Protective Services personnel. On any given day, mobile crisis teams are dispatched throughout the county to assist law enforcement, assess and transfer patients from emergency rooms, and to assess the emotional needs of children being placed into foster care. Throughout the state, in fact, responding to the needs of those in behavioral health crisis is a major operation that cuts across health care, social service, and public safety boundaries. However, as panelists noted, a significant proportion of the individuals using crisis services are not enrolled in the public behavioral health system, and/or not eligible for AHCCCS/Medicaid funding. Again, state and other non-Medicaid-based sources must pay for these services. This means that, as access to state funds and other non-Medicaid-

based sources continues to decline, the availability of coordinated crisis services faces the very real risk of reduction or elimination. This would be a major setback for Arizona. Crisis services not only avert suicides and drug overdoses, they provide vital assistance to local hospitals unequipped to provide acute psychiatric care and to local law enforcement officials responding to all-too-common "nuisance," vagrancy, or other non-criminal situations. If budget-driven reductions in crisis services occur, it's clear that more Arizonans with behavioral health needs will be stranded in local emergency rooms, on the streets, and in jails.

III. Critical Investment Targets: Outcomes and Informatics

Panelists pointed out two critically needed investments in Arizona's public behavioral health care system: Investing in outcomes and investing in

informatics. These are of course related issues, both focused on defining and measuring the benefits individuals and families derive from behavioral health services. Unfortunately, Arizona is currently unable to assess the quality and effectiveness of these services in a meaningful and scientifically valid manner. This observation has been supported by recent reports from the state Auditor General, various consultants, and an independent review by the Health Services Advisory Group (HSAG). This severely impairs our ability to achieve an effective monitoring system that can produce accurate, timely, and actionable information about the quality of services and the relative efficiency of contracted service providers and networks. The absence of an effective system also reduces our ability to detect and

[Questions] that I think a reasonable person out in the community that knows nothing about what we do, can [ask] then say, you know what, the money seems well spent ...

- *Are people [with mental disorders] being hospitalized less frequently?*
- *If they are being hospitalized, are they being re-hospitalized less frequently?*
- *Are more people being employed in meaningful and competitive employment?*
- *Are there more people engaged in ...safe and affordable housing?*
- *Are people getting appropriate medical care for non-behavioral health issues, and how is that integrated?*
- *Are people going to jail less often and if they are, are they being diverted?*

Neal Cash

effectively manage individuals and families who are high-risk, high-cost, and involved in multiple service systems.

Critical to building an effective quality monitoring system are both clarity in the outcomes to monitor, and the ability to do so in an efficient manner. However, the monitoring and reporting requirements of Arizona's public system have been repeatedly characterized as too focused on compliance and process. Excessive reporting and paperwork requirements take clinicians away from critical time with consumers and are frequently identified as a major cause of professionals leaving the public system. Panelists identified the critical need to upgrade and modernize the informational platforms by which services are monitored. This effort would focus on electronic health record development and integration, coupled with client-level data mining and other informatically driven processes; creating inter-operability among community, regional, and state-level information systems and data bases; and ensuring the validity of the information through redundant data verification and validation procedures.

We need to look to the Department of Health Services, we need to look to the Governor, look to the Legislature and say, "Tell us how much money there really is; tell us the services by law, by policy that you want provided, and we'll go provide those services."... We've danced around the issue for years ... unwilling to actually hold the politicians' feet to the fire...and to also educate them into the effect of what their decisions cause.

Ted Williams

IV. The Life of Arnold: Getting Past the Lawsuit

Any discussion of Arizona's public behavioral health care system must take into account the lingering *Arnold v. Sarn* class-action lawsuit, filed in 1981. In 1985, a county Superior Court judge ruled in favor of the plaintiffs that the government had in fact violated its legal duty. In 1989, the Arizona Supreme Court agreed, stating that "Arizona has failed to meet its moral and legal obligations to our state's chronically mentally ill population." In 1991, the state developed a plan to answer the suit's claims. In 1995, the parties to the suit agreed on "exit criteria" that would determine when the state had established an acceptable behavioral health care system. Those

criteria remain unmet. The two sides also agreed that a "monitor" employed by the court would perform annual audits of the system to gauge its progress. The latest audit, released in January 2009, found "a pattern of regression and significant declines in a number of areas," and called for an extensive overhaul of the system.

The panelists expressed a variety of perspectives on the effects, value of, and ultimate resolution to the nearly 30-year-old suit. Legally, the lawsuit has been settled. However, the state's continuing inability—characterized by some panelists as unwillingness—to meet requirements to which it previously agreed has prolonged the matter. As noted above, one of the strengths of Arizona's behavioral health care system is its statutory basis for a community system of care as codified in Arizona Revised Statutes (ARS). Panelists noted that while the statutory language is relatively narrow in its focus upon a community-based system, the structure of the actual system that has developed is much more robust. The state in fact has met the majority of the criteria to which it agreed in 1995. Significant growth has occurred, most notably in the areas of housing, vocational services, services for individuals with co-occurring disorders, and consumer- and family-operated systems.

According to the Court Monitor, however, the state still has not been successful in attaining negotiated criteria concerning the quality of services in three core domains: housing, employment or meaningful day activities, and socialization/community integration. Some have criticized the Court Monitor's assessment as being too focused on processes and record-keeping; but the lack of an effective quality monitoring system has, as previously noted, precluded the state from independently conducting its own assessment.

V. Final Thoughts: Life After Arnold

The panelists agreed that much valuable recent progress has been made in improving Arizona's public behavioral health system and that, despite their policy differences, they were united in the desire to see that progress extended—or at least preserved during these difficult economic times. There was also general agreement that the state must get the *Arnold* lawsuit behind it before large-scale system improvements will be possible. The fundamental impediment to this shared goal, some panelists argued, is a core misalignment between legislative intent (as specified in state statute), executive decision making (as expressed in successive state

administrations' response to the *Arnold* settlement) and the level of state funding, particularly for non-Medicaid/AHCCCS-eligible individuals and families. Modifications in one or more of these three domains (statutory language, negotiated settlement criteria, funding levels) must occur. Panelists differed on which approaches would be likely to yield the best results. But they generally agreed that a renewed commitment to *Arnold* negotiations from the highest levels of government, and a preservation of funding levels for the most ill and vulnerable among us, offer the best chance to break the logjam in Arizona's public behavioral health care system and avert a human and fiscal crisis of major proportions.

[Resolution of the lawsuit would be closer] if the system regularly collected data that everybody believed in and felt was reliable, and could report out on a regular basis how many people avoided hospitalization, how many court orders did we reduce, how many people did we keep out of jail, how many people worked, and that it was the behavioral health system that was doing it....

Anne Ronan

This publication was prepared by Michael S. Shafer and Bill Hart of the College of Public Programs at Arizona State University. Michael S. Shafer is a professor in the School of Social Work and Bill Hart is a policy analyst at Morrison Institute for Public Policy. No endorsement of the opinions in this document by the authors, the university, the college, or the agencies represented by Town Hall participants is to be inferred. In citing this report, please use the following reference:

Shafer, M.S. & Hart, B. (2009). *Arizona's Public Behavioral Health Care System: Critical Issues in Critical Times*. Tempe, AZ: Arizona State University

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