INTO THE LIGHT:

December, 1999

Dear Friends:

There is not one state in our nation that serves all of the needs of its citizens with serious mental and emotional disorders. There is not one state that has sufficient financial and human resources to meet the growing demand for services, nor is there one state whose systems of care stand as examples of best practices in every dimension, and in every respect.

No matter where we live, there's work to be done.

St. Luke's Charitable Health Trust commissioned this study of Arizona's public behavioral health system to serve as a template for our program initiative in mental health over the next five to 10 years. We didn't want to fund one more study trashing the system, nor did we want to fund a white wash that would be politely received and end up sitting on a shelf somewhere. We wanted to tell the truth, but a truth that can emerge from the strengths already present in Arizona's public and private systems of care. We want to encourage positive change in these systems, not tear them down.

We've already learned some valuable lessons: First, no matter what you say or do, someone is going to take exception to it. Second, what we mean by "best practice" in mental health is a moving target. It's better to create a climate that fosters innovation, partnership and change, and not get hung up on definitions and structural issues. Third, contrary to what one occasionally hears on the legislative floor or in the media, Arizona's behavioral health system has numerous exemplary practices and a core group of dedicated, committed and thoroughly professional staff. Add the necessary financial resources and leadership, and we will continue to move into the light of care, support and recovery for persons with mental illnesses and disorders.

This study is based on a review of emerging standards and best practices in mental health drawn from a growing professional literature and experiences from across the country. It is drawn from interviews and focus groups with Arizonans both within and without the public behavioral health system, and as such reflects a diversity of views. For those who want to learn more about emerging practices in mental health, we will publish a summary Best Practices Addendum to this report, which will be available on the Mental Health Dissemination Network of Arizona's web site at www.azmentalhealth.org in early 2000. You will also find there literally hundreds of links to best practices in mental health throughout the country.

Mental health will be among the top critical public health issues worldwide in the early 21st century. We know too much and have come too far to stay any longer in the shadow of false stigma and defeatist expectations. Join us. Together we will move into the light.

Sincerely,

Roger A. Hughes, Ph.D.
Executive Director
St. Luke's Charitable Health Trust
Phoenix, Arizona

Mental Health Dissemination Network of Arizona

A Program Initiative of St. Luke's Charitable Health Trust

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EXECUTIVE SUMMARY

Introduction

There are few public policies and government programs that are less understood by the general public than state behavioral health care. In many jurisdictions it is the only part of the health care delivery system where state or local government is both the primary funder of care and a direct provider of care. Millions of dollars are spent on the treatment, support, and supervision of a narrow segment of our population. Very often this is a segment that has been shunned or ignored by traditional health care delivery systems, and where government has become the provider of last resort.

Millions of dollars are spent on the treatment, support, and supervision of a narrow segment of our population.

Most would agree that people with serious mental illness are among the most vulnerable in our society. Yet, attempts to adequately fund or provide services to these individuals are often viewed as low government priorities. In Arizona, like so many other states, the question of what to do for people with serious mental illness is debated not in state legislatures or county councils, but in courtrooms where lawsuits have resulted from years of inaction or restrictive care.

A state's policy toward the care and treatment of people with mental illness should not be treated as a low public health priority. Rather, as some states and local jurisdictions have found, the care and treatment of people with mental illness can include progressive policies and actions that foster effective rehabilitation and recovery, and the efficient use of tax dollars. But how do you get these systems and public attitudes to change?

In attempt to find the answer, St. Luke's Charitable Health Trust began a strengths-based analysis of Arizona's public behavioral health system. This analysis identified the elements of "best practice" found in public mental health care delivery systems across the United States and applied these best practice models to Arizona's public mental health care delivery system. The results of this analysis form the basis of this report.

Strengths of the Arizona Public Behavioral Health System

The findings and recommendations included in this report ultimately focus on issues and gaps that should be addressed if Arizona is to move toward the best practices goal for adults and children with behavioral health issues. Nonetheless, conducting a strengths-based assessment has been the appropriate focus, as many strengths and positive service delivery models have been identified. The intent was to find and document a foundation on which the improvements in the system could be built. That intent has been satisfied.

The 10 most promising aspects of the Arizona public behavioral health system identified in this study are:

1. **Structure for Managed Care -** Arizona has developed a managed care structure, based on the carve-out model. Although the carve-out model engenders issues with regard to primary health care integration, it is currently preferable in jurisdictions in which Medicaid is a primary funder of the public behavioral health system. The current structure supports the use of managed care principles and technologies, including utilization management, information management, outcome measurement and quality assurance.

2. **Risk-Based Financing -** Risk-based financing is used in Arizona to create incentives and push the system toward appropriate utilization and cost control. Risk based financing, with appropriate risk sharing arrangements such as those in use in Arizona, provide the most positive incentives to manage care effectively and efficiently. It also provides flexibility to local managers on the design and implementation of public mental health services.

3. **Local Systems of Care -** The behavioral health carve-out has been implemented in a manner that emphasizes local systems of care, and in which financial, clinical, and administrative authority is consolidated in the agencies managing the local systems of care. The five RBHAs in Arizona have different organizational and service delivery models, and have flexibility to arrange service delivery tailored to local needs.

4. **Strong Clinical Leadership -** There is evidence of strong and forward-thinking clinical leadership at the top of Arizona's public mental health system. Many of the clinical protocols and guidelines emanating from the Arizona Division of Behavioral Health Services are examples of evidence-based best practice, and provide a good foundation for implementing such best practices in the field.

5. **Examples of Innovation and Best Practice -** Pockets of cutting-edge best practices have been identified in Arizona, and these could be replicated more widely throughout the state as part of the strategy to improve the system.

6. **Strong Data Collection -** There is relatively good and consistent data collected throughout Arizona's public mental health system, and the management information systems are on a path to becoming even better. Consistent, timely, and accurate data that can be used for accountability, planning, quality improvement, and system management is essential to a high quality managed system of care.

7. **A Focus on Those with Serious and Persistent Mental Illness -** The system of care for adults in Arizona is appropriately focused on individuals with serious mental illness. This is partly a result of the state's efforts to comply with the Arnold vs. Sarn stipulation and order. It also reflects a firm and long-standing commitment on the part of state and local behavioral health system leadership to individuals with serious mental Illness.

8. **Strong Cultural Competency -** Arizona is a culturally and linguistically diverse state. Its successes in tailoring service components and delivery approaches to culturally and linguistically diverse individuals, when implemented more consistently statewide, will be a model for the rest of the country.

9. **Models of Rural Service Delivery -** There is a strong commitment to providing good public behavioral health services in rural areas of Arizona. Rural strategies such as telemedicine and paraprofessional behavioral coaching are good models for serving diverse populations in large rural areas.

10. **A Record of Research and Demonstration -** Arizona has a history of conducting demonstration projects aimed at improving behavioral health services. Several demonstration grants, such as the consensus panel activity related to co-occurring mental illness and substance abuse, show promise in terms of developing and replicating best practices in Arizona.

Areas For Improvement

As with many state public behavioral health systems, there remain a number of important

organizational problems and issues that must be addressed if the Arizona system is to continue to move towards best practices. These include:

~ The Arizona system needs to be more consumer and family driven. There are few formal efforts to organize and empower families and consumers or include them in governance, planning, policy development, quality management, or performance evaluation.

~ There needs to be a clear and cohesive vision of what Arizona's mental health system should be at all levels of the system. There is no multi-year budget or strategic business plan that brings all the elements of the system together. There does not appear to be a commonly understood definition of the horizon towards which all components of the service system should be moving.

~ Access to public mental health services should be improved. There are dual systems of care for both adults and children, one for Medicaid enrollees and adults with serious mental illness, and another less generous system for all others, including non-Medicaid but indigent children in need of services. Also, as noted in the main report, there are substantial inconsistencies in per capita resources and penetration rates throughout the state. These inconsistencies are indicators of unequal access to consistently delivered services for all citizens of Arizona.

~ There ought to be formal mechanisms to connect policy and knowledge to local practice/service delivery. Good clinical practices and guidelines are not yet consistently implemented at the service delivery level because there is no over-all training plan and strategy and few performance incentives for adopting best practices.

~ There ought to be effective linkages between primary care and behavioral health care. RBHAs and stakeholders reported difficulty referring clients and adequately sharing information among health care professionals. There are no structures or processes required by the state in contracts with either HMOs or RBHAs that foster and enforce meaningful or effective integration and collaboration between the primary health care and behavioral health systems.

~ There ought to be better linkage and integration between the behavioral health system and other important sources of resources and services for priority consumers. Despite numerous intergovernmental agreements at the state level, coordination of resources and access to services with school systems, adult and juvenile justice systems and affordable housing and vocational service systems remain inconsistent. Partially as a result of poor linkages, the supply of integrated services, particularly affordable housing and modern supported employment services, is relatively low.

Best Practices

The following is a summary of common elements in those states that have moved most successfully towards best practice:

- There is a strong and consistent leadership that articulates a vision and forges consensus and momentum for implementing that vision.

Arizona has a history of

- The vision articulated by leadership incorporates the concepts of recovery, consumer self-determination and choice, self-sufficiency, community and family-based services, and empowerment of consumers, families, and staff to be creative, flexible and accountable for local service delivery.

- Information about mental illness and emotional disability is made widely available to the general community; stigma and prejudice are publicly confronted when they become evident, and the vision and mission of the public behavioral health system are espoused constantly in all available forums.

- Consumers and families are engaged and involved in all aspects of the public behavioral health system, from governance and policy development through planning and program development to quality management and system evaluation. Consumers and families in those states have become the most effective advocates for the vision and mission of the public behavioral health system. They have also provided the motivation and momentum for the change process.

- Local systems of care have been developed, and these local systems have the requisite clinical and financial authority and accountability to carry out the statewide vision and mission in ways that are reflective of local conditions and needs. These local systems can be non-profit, for profit, quasi-governmental, county-based or multi-county programs.

- Information gleaned from a variety of data sources is used to drive system planning, budgeting, quality management and performance evaluation. In "best practices" states decisions are made at all levels based on consistent analysis and interpretations of accurate and timely data. Included in the information analyzed is literature describing evidence-based best practices from other jurisdictions as well as information generated from within the state's own systems.

- An organizational culture that fosters and supports constant learning, change, challenging of sacred principles, and trying out new ideas has been created throughout the public behavioral health system.

conducting demonstration projects aimed at improving behavioral health services.

In the above list of characteristics there is no mention of service types, financing levels or approaches, clinical technologies, or requirements for organizational models. Rather, the list incorporates attributes that move these systems toward excellence and responsiveness as a context for the details of service provision. Specific best practices related to service models and treatment models will continue to evolve and change. Public behavioral health systems that embody the above characteristics will be in the best position to implement specific changes. In fact, it is systems that meet the above characteristics that most often will generate new and improved ways of meeting consumer and family needs and choices in the most cost effective and accountable manner.

Recommendations

It is virtually impossible, and a poor use of the state's limited financial and human resources, to attempt to "fix everything" or create "wholesale" change in Arizona's mental health system. Rather than take a wholesale approach to change, we encourage the state to be more strategic in how to use the valuable and scarce resources it has to leverage change where it will dramatically improve care and provide leadership for ongoing policy and program advancements. Our analysis of the Arizona system has identified the following key strategic initiatives:

The Integration of Primary and Behavioral Healthcare. AHCCCS and BHS should jointly develop program specifications for the structural and functional integration of primary and behavioral healthcare. RHBAs, HMOs and other health care providers and insurers should be encouraged to develop creative approaches to integration through pilot projects.

Changes in the Regulation and Delivery of Benefits for People with Mental Illness or Emotional Disorders. Arizona should implement a flexible and individualized service benefit package through de-regulation at the state level and performance measurement based on consumer outcomes rather than process assessment. To accomplish this, the state should form a task force comprised of consumers, families, behavioral health professionals, and state and RBHA managers. The task force should be charged with the responsibility to review all regulations and funding requirements, assess the purposes of such regulations and requirements in terms of specific benefits to consumers, and then recommend outcome and performance measures that would assure the same positive benefits are being attained in the absence of regulations.

Raise TANF Eligibility. The eligibility rate for TANF should be raised to 100 percent of the state's federal poverty level to provide health coverage to this population now under served by the state's behavioral health care system.

Increase Enrollment under CHIP (KidsCare) Program. The state should continue to improve the current outreach and engagement strategy to enroll families in this important program. In doing so, the state will close another gap in coverage for behavioral health services. This will reduce the number of people who are to be served with the limited amount of funds set aside for those not under the AHCCCS or SMI program. Further, recent budget action notwithstanding, reductions to state appropriations for indigent care for children and families should not be reduced based on assumed savings from the KidsCare program.

Resolve Arnold v. Sarn. It is time for a concerted course of action by all parties to resolve the outstanding issues in this case. To accomplish this, we recommend that the state establish a court order unit in the state agency with sole responsibility for overseeing its implementation, including: (a) reexamining aspects of the court order to which modifications may be necessary; (b) implementing the core benefit package described above for public behavioral health that applies to all who have been found in need of services; and (c) instilling a commitment for quality management in the public behavioral health system.

Create a Culture for Change - Arizona needs a new culture within its mental health system. This new culture must support a learning environment conducive to change. To foster this climate and culture change, we recommend the creation of the Arizona Behavioral Health Institute. The institute cannot change the culture overnight alone, but it can provide a focal point for discussion, action and leadership that can begin the process of culture change.

St. Luke's Charitable Health Trust

St. Luke's Charitable Health Trust has begun to provide leadership in efforts to improve mental health services in Arizona. These efforts include underwriting this study as well as the formation and operation of the Mental Health Dissemination Network of Arizona (MHDNA). The Trust and MHDNA should continue to have an important role in fostering the strategies for change contained in this report. These strategies might include:

a. Funding of certain demonstration projects.

b. Sponsoring independent evaluations leading to improved evidence-based practices.

c. Providing leadership as a catalyst for change.

d. Sponsoring public education and information dissemination activities.

Summary

The purpose of preparing this report has not been to point the finger or affix blame for the system's shortcomings, or even to praise or applaud those areas of the system that are working well. Rather, the purpose has been to raise public awareness of the fact that some of Arizona's most vulnerable citizens, those children and adults with mental illness and their families, depend on others to ensure that there is excellence in Arizona's public behavioral health care system.

The report has attempted to quantify and qualify excellence through examples of best practices in Arizona and from across the country. In the end, excellence in public behavioral health care may have more to do with intangibles such as a culture of innovation and change, leadership, and continuous quality improvement. The authors of this report believe that Arizona's public behavioral health care system would benefit from additional resources, the development of new programs and services, and the expansion of eligibility.

Finally, it is important to emphasize that excellence will be truly achieved when there is a pervasive community spirit and culture that continually demands improvement in Arizona's public behavioral health system.

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There needs to be a clear and cohesive vision of what Arizona's mental health system should be at all levels of the system.

I. INTRODUCTION

Arizona's public behavioral health system has many participants, constituents, and interested observers. All of these see the public behavioral health system from different perspectives, and have varying opinions about what works well in the system and which elements of the system need improvement. State officials are justifiably proud of the public behavioral health system on "the cutting edge of mental health service delivery reform."[1] On the other end of the spectrum, advocates have pursued legal action in attempts to improve public behavioral health for adults with serious mental illness and children with serious emotional disorders.

Which perspective is correct? What is the true state of the Arizona public behavioral health system?

Which perspective is correct? What is the true state of the Arizona public behavioral health system?

St. Luke's Charitable Health Trust has sponsored a strengths-based assessment of the public behavioral health system in Arizona to better understand Arizona's public mental health care system and to recommend changes that would further improve services for people with mental illness. The study is one of the first steps of a Trust-initiated five to 10 year effort to improve the system of care in Arizona for persons suffering from mental illness or significant behavioral problems. It was initiated to create a more enlightened public climate that would be receptive to appropriate treatment that ensures dignity and self-respect.

The elements of this study include:

- Developing a template of behavioral health "best practices" relevant to Arizona's current system;
- Conducting a strengths-based assessment of the current system as compared to the best practices template;
- Recommending initiatives and strategies to facilitate dissemination of current best practices information and enhance and improve the public behavioral health system in Arizona.

The Trust has emphasized a strengths-based assessment for two reasons. First, the Trust wished to avoid the production of a highly critical "expert" report that engenders defensiveness rather than concrete and positive system changes. Second, the Trust recognizes that positive improvements must be built on the existing foundation of care, and thus existing strengths should be identified and enhanced as a first step in fostering system-wide improvements.

Participants in the Study

St. Luke's Charitable Health Trust is a Phoenix-based independent grantmaking organization formed in 1995 as the result of the sale of the St. Luke's Health System. Focused principally on the health needs of underserved and disenfranchised populations, it operates a community-based grants program, a medical assistance program through a network of community health providers, and program initiatives in the areas of access to care and mental health.

The centerpiece of St. Luke's mental health initiative is the creation of the Mental Health Dissemination Network of Arizona (MHDNA). MHDNA is a coalition of public and private organizations and individuals formed with a mission to become an independent source of analysis, dissemination and advocacy for the application of sound research to mental health issues in Arizona. Initially, MHDNA may recommend projects and strategies for funding to the Trust. Over time these will be combined with other funding sources and public/private partnerships to bring more energy, resources and creativity to bear on pressing mental health issues. Concurrent with the completion of

this study, MHDNA has implemented a web site designed to be a source of information about evidence-based best practice of importance both to Arizona and to other public behavioral health entities throughout the United States.

To complete the study, St. Luke's Charitable Health Trust engaged the Technical Assistance Collaborative, Inc. (TAC). TAC is a Boston-based non-profit actively involved in providing consultation and technical assistance to national, state and local health and behavioral health organizations to design and implement publicly funded systems of care, service delivery approaches, and supported housing. TAC has worked in more than 45 states and over 60 local jurisdictions to foster and facilitate improvements in behavioral health and related health and human services organizations.

To engage an entity with extensive experience in Arizona and to facilitate the database analysis component of the study, TAC formed a partnership for this project with William M. Mercer, Incorporated (Mercer), which has its behavioral health practice headquarters in Phoenix. Mercer has a history of high quality data collection and analysis in public behavioral health systems. Mercer has already conducted extensive analysis of the Arizona Health Care Cost Containment System (AHCCCS) data and related utilization and cost data from the Regional Behavioral Health Authorities (RBHAs). Mercer also assisted the state in preparing its request for proposals (RFP) for behavioral health services in Maricopa County.

Methodology

In concert with the St. Luke's Charitable Health Trust and the MHDNA Steering Committee, TAC and Mercer conducted a detailed assessment of the Arizona public behavioral health system. At the same time, data and information from other states and local jurisdictions were reviewed, as was the literature regarding evidence-based best practices in the field of behavioral health. Specifically, the team:

- Conducted a thorough document review, including reports generated by and/or about the Arizona system, and similar reports from other jurisdictions;
- Conducted an exhaustive literature review, compiling evidence-based best practice information relevant to Arizona's needs and local conditions;
- Analyzed three years of utilization and expenditure data from the Arizona behavioral health system and compared this data with similar information from other jurisdictions;
- Conducted over 25 focus groups with consumers, families, providers, staff and other stakeholders throughout Arizona;
- Conducted over 100 key informant interviews, ranging from elected and appointed state officials, physicians, judges, program managers, advocates, individual consumers and family members, and a variety of other informants knowledgeable about public behavioral health services in Arizona;
- Visited over 50 program sites, including all RBHAs, many directly operated or contracted program sites and several programs outside the behavioral health system, including school, jail and court programs.

Criteria for Selection of Best Practices

Best practices in public behavioral health are multi-dimensional. That is, best practices are defined by

several different domains, including vision and values, systemic implementation, and point-of-service excellence in clinical and program delivery. These domains, or conceptual approaches to best practices, are discussed in greater detail in Chapter III of this report. The practical criteria used to select specific best practices for inclusion in this report are:

- There have been qualified evaluations of the program model or clinical practice, and the positive effects of the approach(es) are described in peer-reviewed literature.

- The practice or approach has become a nationally accepted best practice and has been widely used as a standard and guideline for program implementation and service delivery for a substantial period of time.

- The team has knowledge and experience with the practice or approach from successful and beneficial implementation in other jurisdictions.

- The practice or approach is relevant to Arizona local conditions and definitions. It addresses gaps or needs in the current service system; and/or

- The implementation of the practice or approach is feasible within the current Arizona public behavioral health system.

Results of the Study

The extensive data analysis, literature review, information collection and field observations led to:

- A comprehensive, objective and multi-faceted picture of the Arizona public behavioral health system;

- A clear understanding of the environment, both statewide and nationally, in which the system operates;

- Development of preferred practice templates that can function both as a guideline and set of benchmarks for implementing improvements in Arizona's public behavioral health system;

- Documentation of where the current system deviates from the preferred practice template and identification of priorities to be addressed in improving the system;

- Recommendations for specific strategies for Arizona, its behavioral health partners, and for MHDNA to begin the process of improving the current system.

St. Luke's Charitable Health Trust has sponsored a strengths-based assessment of the public behavioral health system in Arizona to better understand Arizona's public mental health care system and to recommend changes that would further improve services for people with mental illness.

This information is summarized in the body of this report, and in more detail in the Best Practice Supplement that accompanies this report.

[1] Arizona Mental Health Services Plan for Children and Adults: Fiscal Year 1999 - 2001. Arizona Division of Behavioral Health Services, September 1, 1998.

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II. FINDINGS AND OBSERVATIONS: THE STATE OF ARIZONA'S PUBLIC BEHAVIORAL HEALTH SYSTEM

A. Introduction: What is the Arizona Public Behavioral Health System?

Arizona's public behavioral health system is comprised of several key components. These include:

1. A set of state agencies with various responsibilities and levels of funding for behavioral health services. These include:

   ~ Arizona Department of Health Services, the umbrella agency for many human services functions;

   ~ The Behavioral Health Services Division, with line management responsibility for inpatient and community behavioral health services for adults and children;

   ~ Arizona Health Care Cost Containment Services (AHCCCS), the single state agency for Medicaid in Arizona, and the manager of the state's Medicaid managed care program for primary health care;

   ~ Arizona Department of Economic Security;

   ~ Administrative Office of the Courts;

   ~ Arizona Department of Juvenile Corrections.

2. Arizona State Hospital has 308 licensed beds, 16 of which are reserved for adolescents. Arizona State Hospital accepts adult and adolescent commitments from the entire state, although utilization varies considerably from region to region.[2] Arizona State Hospital also serves as the host facility for adjudicated sex offenders.

3. Five Regional Behavioral Health Authorities (RBHAs) manage virtually all public funds allocated for community-based behavioral health services in Arizona and serve as the single point of authority for all citizens meeting clinical and financial eligibility criteria for public behavioral health services. RBHAs employ a variety of direct service staff models and contract providers to provide a range of community services. The RBHAs also provide or contract for local inpatient services, both in Psychiatric Health Facilities (PHFs) and private general or psychiatric hospitals.

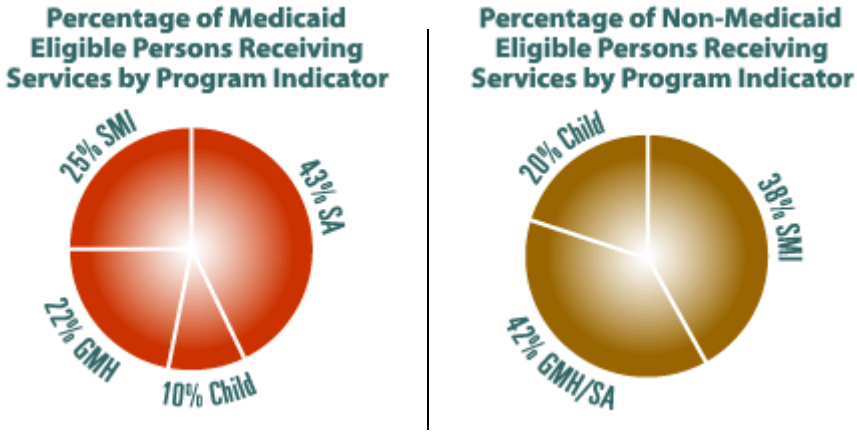
4. Numerous private organizations and individuals provide behavioral health services to individuals and families within Arizona. These include private general hospitals, private psychiatric hospitals, provider organizations (many of who contract with RBHAs to manage and deliver behavioral health services), and individual practitioners and professionals.

5. An array of non-behavioral health services and benefit organizations that have a direct bearing on individuals and families needing behavioral health services. These include primary health care providers and payers such as HMOs, insurance companies, and private physicians. It also includes housing authorities and vocational and educational service providers.

Last year approximately 42,300 Medicaid eligible enrolled individuals received services.

Public behavioral health funds for public behavioral health services derive from two basic sources, the state/federal Medicaid program and state general fund appropriations for non-Medicaid eligible individuals. The current annual expenditures for the public behavioral health system is $248,552,676

with 46 percent derived from Medicaid payments (including the state's share of Medicaid).



The majority of individuals receiving services through the RBHAs have diagnoses of serious mental illness, although a few indigent individuals with less severe mental illness are served as well. Last year approximately 42,300 Medicaid eligible enrolled individuals received services. As depicted in *Percentage of Medicaid Eligible Persons Receiving Services by Program Indicator* chart, approximately 25 percent of these persons were adults with serious mental illness and 10 percent were persons with primary substance abuse treatment needs.[3] Notably, 43 percent of all Medicaid enrolled individuals receiving services were children, while 25 percent were adults with serious mental illness. As depicted in *Percentage of Non-Medicaid Eligible Persons Receiving Services by Program Indicator* chart, for non-Medicaid eligible persons, approximately 38 percent of the average monthly users were adults with serious mental illness, and 42 percent were persons with substance abuse treatment needs.[4]

B. Perceptions and Realities-Establishing the Facts of the Arizona Public Behavioral Health System

As with all state behavioral health systems, the Arizona system is complex and comprised of a variety of formal and informal systems. In addition, although there is a considerable body of written policies, procedures, program and clinical guidelines, etc., much of the actual business of the system is carried out according to local traditions, beliefs, and perceptions. It is clear that some of these have powerful effects on the culture and therefore actions of the public behavioral health system in Arizona. Thus, before discussing specific strengths and needs of the system, it is important to try to objectify several of these perceptions.

Are these perceptions true reflections of the Arizona system, or are they traditions that have grown up without careful analysis of the facts?

Perception # 1: Arizona operates an advanced managed care model of public behavioral health.

Reality: Partially true

Because of Arizona's late start in participating in Medicaid, it is the only state in the United States to have begun its Medicaid behavioral health program as a capitated managed care system. RBHAs receive Medicaid funds in the form of per-member-per-month (PMPM) payments. State general fund appropriations and federal block grant funds are distributed to the RBHAs on a block grant (1/12th payment per month) basis. The Medicaid PMPM payments comprise approximately 45 percent of expenditures on a statewide basis, with 55 percent of the expenditures attributable to state general revenue funds.

The implementation of a full risk managed care system for public behavioral health has provided substantial benefits for Arizona. Many of the problems of traditional fee-for-service systems have only slightly been encountered in Arizona. These problems include incentives for over utilization, pressures to increase rates or unit prices, and incentives to over-enroll individuals without regard to the degree of service needed. However, risk-based managed care systems also have potential problems. These include incentives to under-serve and under-enroll high-risk individuals, enroll easier to serve individuals, and short-change service quality to achieve reduced service costs. Arizona uses risk-sharing arrangements to mitigate the potential negative effects of capitation.

Because Arizona implemented its Medicaid managed behavioral health service system without widespread and long term operations under a fee-for-service system, historical fee-for-service system utilization patterns and costs from which PMPM capitation rates could be accurately calculated were relatively unavailable. Further, there are no baseline measures of penetration rates[5] or utilization patterns that could be used to gauge whether the potential problems of under-enrollment and under-serving are actually occurring. Arizona's penetration rates for adults and children are very close to the one comparison state where comparable penetration data were available. Thus, overall access to Mental Health and Substance Abuse services for Medicaid eligible persons in Arizona appears consistent with another comparison state operating in a managed care environment.

Arizona's Medicaid 1115 waiver is quite comprehensive and could support numerous flexible strategies for modern managed systems of care. In addition, Arizona's structure and financing for behavioral health services have important characteristics of managed systems of care. The capitation payment model, paid as per member per month (PMPM) allotments to RBHAs, is a well established managed care model. However, as noted above, there were limited historical fee-for-service utilization patterns or costs on which to base the PMPM rates. Thus, it is difficult to evaluate whether the PMPM rates provide correct incentives to be efficient, while at the same time assuring access to high quality and cost effective services.

The combination of the 1115 waiver and the implementation of capitation payments to RBHAs has not consistently had the effect of stimulating flexible and individualized services in the same ways as have occurred in other jurisdictions.

The Medicaid taxonomy[6] permits delivery of a flexible array of services, but it does not appear that most RBHAs are taking advantage of that flexibility. In fact, the taxonomy does not include service definitions reflecting community support and rehabilitation models for adults, or wraparound, family focused services for children and their families. *Thus, although the system provides for flexibility, the taxonomy tends to drive service provision towards traditional models of care.* In addition, a historically inconsistent application of levels of care, service access and continuing stay criteria was reported throughout the system. Further, prospective and concurrent utilization review, quality management reviews of over and under-utilization, and similar practices that are common to managed systems of care were reported to be in development and not fully implemented. The Arizona Level of Functioning Assessment (ALFA), which promises to be an effective and reliable instrument and criteria for level of function assessment, has only recently been consistently administered and has not yet been fully utilized for quality improvement and best practice implementation.

The combination of the lack of historical and baseline data, the traditional service definitions in the taxonomy, and the as yet incomplete application of utilization management criteria and practices makes it difficult to assess whether all resources are spent effectively with respect to consumer need. Nor is there an empirical basis for calculating what funds, if any, could be re-deployed within the system for high priority recovery-oriented and family support type services.

Thus, Arizona operates the structure and financing elements of a managed system of care under its waiver and capitation payment process. However, these structural elements have not been implemented to full advantage. At the point of service delivery, at the point of management of service utilization, and at the point of making best use of data to manage the system of care, there remain many opportunities for improvements. *As will be reinforced throughout this report, now that the basic structure and financing mechanisms are in place, it is time to focus on the* ***content*** *of the public behavioral health system in Arizona.*

The conclusion of this analysis is that when all public dollars are counted, Arizona is right in the middle of the pack in terms of public per capita funding.

Perception # 2: The Arizona public behavioral health system is adequately funded.

Reality: Not true

Based on Fiscal Year 1997 data, Arizona's state mental health authority spent $66.48 per capita for behavioral health services for adults and children.[7] This per capita funding level ranks 17th among the 51 state and territory jurisdictions reporting for that time period. However, Arizona is somewhat unusual in that all public dollars, including Medicaid, are spent and reported through the state behavioral health authority. In most states, providers and/or local authorities bill Medicaid directly, and this revenue is added to state and block allocations at the local/ provider level.

For example, in Arizona only one percent of Medicaid behavioral health dollars are earned and spent outside the DBHS/RBHA system. In Iowa, 83 percent of Medicaid funds are earned and spent outside the purview of the state behavioral health authority. These Medicaid funds contribute to the overall value of public behavioral health system but are counted in a different way. For Arizona, when outside Medicaid funds are added, the national ranking goes from 17th to 21st among the 42 states reporting this information. For Iowa, when outside Medicaid funds are added, the ranking goes from 41st to 11th. The conclusion of this analysis is that when all public dollars are counted, Arizona is right in the middle of the pack in terms of public per capita funding.

On a comparative basis, Arizona shows low Medicaid PMPM expenditures for 24-hour (inpatient and residential treatment) Mental Health/Substance Abuse services for both children (under age 18) and adults (age 18+). For children, the PMPM rate of $4.71 is less than half of the next lowest comparison state at $10.76. Further, the Arizona rate is less than 25 percent of the highest comparison state. For adults, Arizona's 24-hour rate at $2.58 is even lower in comparison to the other "benchmark" states. The Arizona rate is less than one-third of the next lowest comparison state at $10.46 and is less than 10 percent of the highest comparison state. It should be noted that 24-hour care costs in state-operated facilities for adults aged 22 to 64 (i.e., Institute for Mental Disease-IMD-costs) are omitted from all of the states' data.

Arizona's cost per user per month for children of $398 is about one-third of the one comparison state with comparable data.[8] Thus, the level of expenditures on a per user basis appears low relative to the other comparison state. This finding is most likely due to Arizona's low use of 24-hour services.

Arizona's cost per user per month for adults of about $342 is almost two-thirds of the comparison state. Again, the differential is most likely due to Arizona's low use of 24-hour services. The differential for adults versus children within Arizona is driven primarily by the fact that Arizona's PMPM expenditure for adults for other than 24-hour care services is high relative to the comparison states. At the same time, the PMPM rate in Arizona for children for other than 24-hour services is about average relative to the comparison states.

The conclusion of this analysis is that when all public dollars are counted, Arizona is right in the middle of the pack in terms of public per capita funding.

It is fair to say two things about public behavioral health systems throughout the United States.

First, virtually all are under-funded and have insufficient resources to meet the priority service needs of their consumers. Thus, the fact that Arizona is ranked about in the middle of all states on the basis of per capita funding really means that Arizona is more under-funded than half the states and less under-funded than the other half of the states.

Second, although virtually all public behavioral health jurisdictions are under-funded, they also have resources tied up in services, facilities, staffing, or other components inefficiently and could be doing better with the money they already have. In Arizona, many concrete and measurable service improvements could be implemented without new money. A number of these are discussed in the Recommendations section of the report. Nonetheless, if all these improvements were implemented, Arizona would still have major gaps in services and would still have many needy individuals who would not be able to have their needs met in a timely fashion. Thus, no-cost service system improvements are not a substitute for the substantial additional funding needed to meet consumer and family needs in the Arizona public behavioral health system.

Perception # 3: The Arizona public behavioral health system serves far fewer individuals with behavioral health needs than live in Arizona (prevalence vs. penetration).

Reality: True

The following table details the estimated prevalence[9] of various mental health disabilities for Arizona.

Disorder	National Prevalence Rate	Arizona Estimate of Prevalence (based on 1990 census data)
Schizophrenia	0.6%	21,991
Bi-Polar Disorder	1.0%	36,652
Major Depression	3.0%	109,956
Personality Disorder	6.0%	219,913
Total Severely Mentally Ill	5.4%	197,922

Non-Severely Mentally Ill	20.0%	733,045

Based on these estimates approximately 197,922 persons will meet Arizona's diagnostic and functional criteria for SMI. Currently, Arizona serves approximately 23,000[10] adult SMI individuals per year, or 11.6 percent of the estimated demand population. It is not known at this time whether or where the remaining 174,922 individuals receive behavioral health care in Arizona. Some proportion is likely to be receiving care in the private behavioral health care sector. And, some proportion are likely to receive necessary medications from primary care physicians, and to receive supports in the community from family members. Unfortunately, some unconnected individuals may also become the responsibility of the criminal justice system and/or the homeless service system.

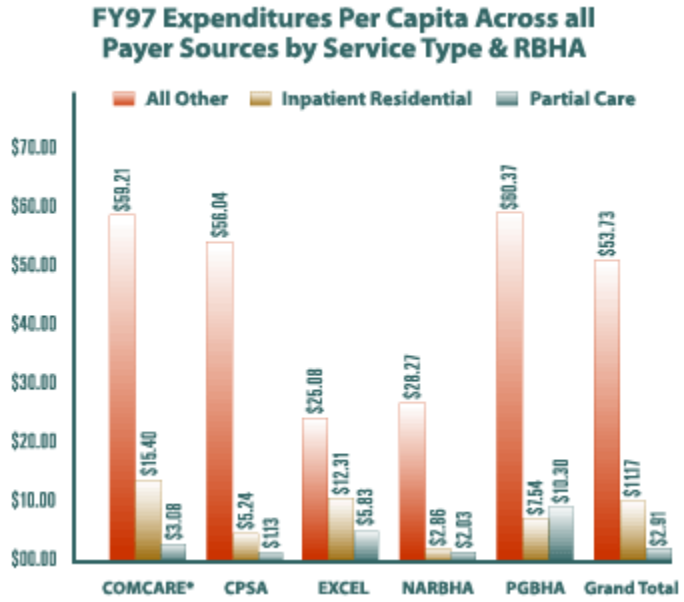
The large proportion of individuals estimated to suffer from mental illness in any year who are not connected to the public behavioral health system underscores the importance of forging effective linkages with the primary health care sector. Primary care physicians treating individuals with serious mental illness could benefit from both expertise and support from the public behavioral health system. The same is true for other agencies in the community, which find themselves in caregiver roles without the necessary knowledge or access to behavioral health services and supports. In combination with the analysis of the relative inadequacy of Arizona public behavioral health spending levels under perception # 2 above, the large proportion of unconnected individuals points to a substantial need for additional funding for the Arizona public behavioral health system.

Perception # 4: There is a disparity of resources among RBHA service areas within Arizona.

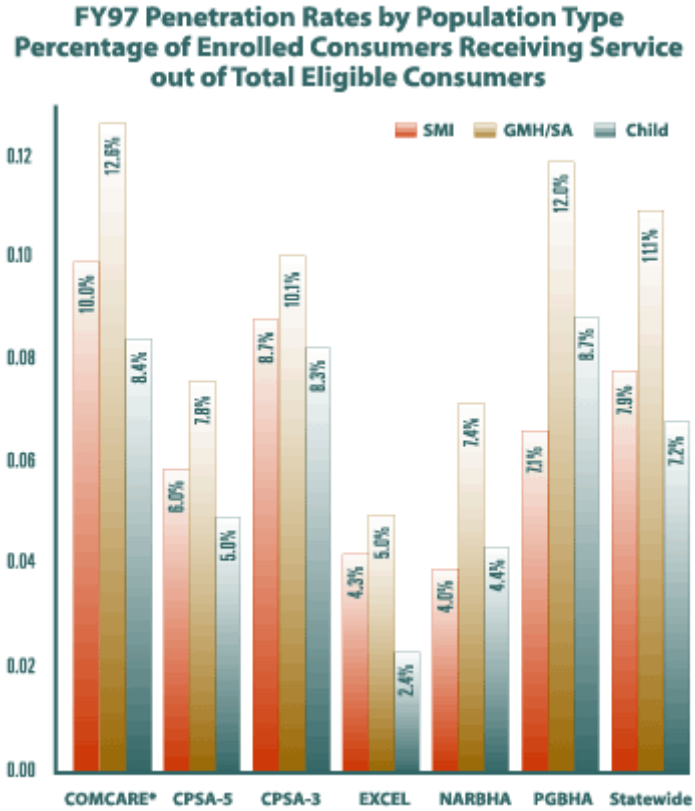
Reality: True

As depicted in *FY97 Expenditures Per Capita Across all Payer Sources by Service Type & RBHA* graph, there are marked differences among per capita expenditures throughout Arizona. Unexpectedly, PGBHA has the highest over-all per capita expenditures. Maricopa County is close behind. At the far other end of the per capita funding levels is Excel, in last place, preceded by NARBHA, in second to last place. These latter two are the most rural of the RBHA service areas. However, being rural areas does not necessarily mean that fewer per capita resources are needed. Actually, between fixed costs, poor economies of scale and travel distances, one would expect rural per capita expenditures to be slightly higher than those for urbanized areas. The low PMPM rates for certain rural areas may be based on historical low penetration rates and low utilization patterns, not on the underlying costs of delivery services.

What is the true state of the Arizona public behavioral health system? Is the Arizona public behavioral health system a cutting edge managed system of care or is it a system in need of repair? The answer, inevitably, is somewhere in the middle.



In the context of significant variances in per capita funding levels, there are also substantial variations in regional penetration rates. As demonstrated in *FY97 Penetration Rates by Population Type, Percentage of Enrolled Consumers Receiving Service out of Total Eligible Consumers* graph, there are substantial variations in penetration rates but these are not necessarily correlated with per capita funding levels. For example, in the Excel Group area the penetration rates are low, corresponding with low per capita funding levels. However, in the PGBHA area the penetration rates are low as well, even though the per capita funding levels are highest in the state. In the NARBHA region, per capita funding levels are low, but penetration rates are not as low as some other areas.



The variations in both per capita funding levels and penetration rates may be historical, idiosyncratic or explained by bona fide variations in consumer needs and service demands. Absent clear alternative explanations, they are indicators of important variations in service access among the behavioral health regions in Arizona.

Perception # 5: Arizona uses very little inpatient service as opposed to community-based care.

Reality: True

Arizona has a reputation for spending a high proportion of public behavioral health dollars on outpatient, community- based services as opposed to inpatient psychiatric hospital services. The proportion of outpatient versus inpatient service expenditures has been traditionally used as a global approximation of positive improvements in public behavioral health systems. When dollars flow from inpatient settings to community-based settings, the system is assumed to be making progress in the right direction.

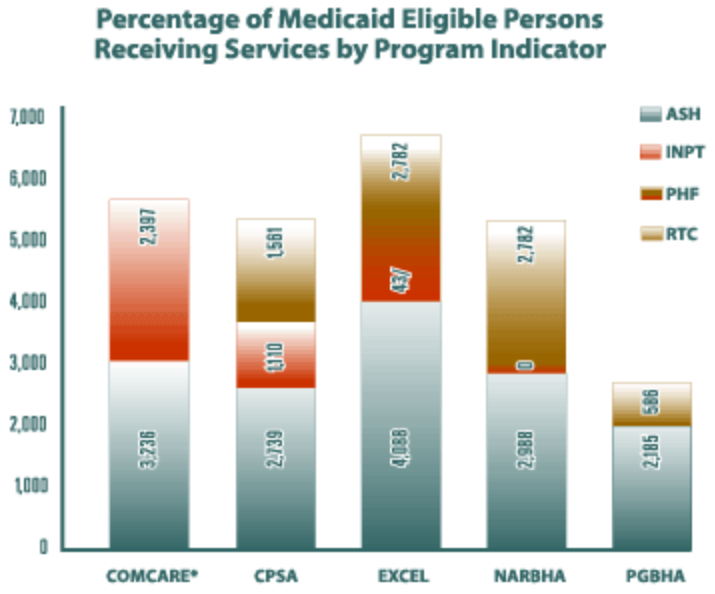
When looking at Arizona State Hospital expenditures, Arizona looks favorable compared to most other states. In fact, Arizona spends a lower percentage of total public behavioral health dollars on state hospital services than all other states (8.2 percent compared with the national average of 45.9 percent).[11] However, this figure does not include spending on PHFs, private general and psychiatric hospitals.

Arizona claims data for the past few years show that inpatient expenditures are consistently low for both Medicaid and non-Medicaid populations.

However, there are variances in utilization of inpatient days for people with severe mental illness throughout the state across all payer sources, as depicted in the *FY98 Acute Days Per 1,000 SMI Population by RBHA & Facility Type* graph. It is also apparent that there is widespread use of PHFs for acute care needs across the state. This leads to the conclusion that most adults needing inpatient services are receiving these services close to home, and that the state hospital is not being inappropriately used for routine acute inpatient care.

Therefore, it is safe to conclude that Arizona does not over-rely on or over use inpatient beds as opposed to community resources. In fact, while there are variances from RBHA to RBHA, Arizona appears to have among the lowest hospital bed day utilization patterns in the United States. This should be taken as a measure of positive practice in the Arizona public behavioral health system.

However, it should also stimulate further analysis, particularly when viewed in the light of the low proportion of adults predicted to need services compared to those who receive services. Is there enough capacity for public sector inpatient care? Where are people going for acute inpatient services if not to state-funded facilities? *Is there a correlation between low hospital use, low penetration rates, and the publicly identified problem of providing behavioral health services in jails and prisons?*



Perception # 6. Primary health care and behavioral health care are not well integrated in Arizona.

Reality: True

As Arizona has chosen to "carve-out" or separate the provision of mental health care for AHCCCS beneficiaries from their physical health care, there remains a fundamental question as to how these two distinct and important elements of an individual's emotional and physical well being can best be coordinated. At the time of the on-site portion of this study[12] this issue of integration of primary health care and public behavioral health care was on the top of many individuals' lists of issues to be addressed. This was primarily because of the logistical problems at that time of prescribing and managing access to psychotropic medications. Under the system in place at that time, primary care physicians were required to refer patients to the public behavioral health system for prescription of psychotropic medication by psychiatrists in that system. This often resulted in long delays while referred individuals went through the intake process and waited for an appointment with a psychiatrist in one of the RBHAs. That issue is reported to be in the first stages of resolution, with the implementation of a primary care prescriber model, which should benefit many consumers and families as well as facilitating the medical practice of primary care physicians.

This progress is positive, but it does not affect many other issues related to primary health and behavioral health integration in Arizona. During the on-site information collection activity, virtually all respondents, including consumers, family members, providers, RBHA management and private primary care physicians identified problems of access, coordination and communication between the primary health care system and the public behavioral health system. Specific problems from both sides included:

~ Long wait times to gain access to a primary care physician and/or a psychiatrist;

~ Lack of understanding among participants of the "rules" of each system: how decisions are made, who communicates with whom, who pays for what, who is eligible for what, etc.;

- ~ Poor communication between treating caregivers;
- ~ Lack of supply of primary care physicians and psychiatrists;
- ~ Lack of formal structures, functions and incentives to coordinate and integrate care.

In those states where the carve-out[13] model of managed behavioral health care is used, problems of integrating and integrating primary health care with behavioral health care are often encountered. Some states, such as Pennsylvania, have implemented formal regulatory and contractual requirements that establish formal mechanisms for primary health and behavioral health integration both in planning and operations, and in physician-to-physician communication at the point of service. In Arizona, several informal local efforts to integrate primary and behavioral health have been initiated, but these have not resulted in systematic improvements.

Although some improvements have recently been achieved, the primary health care system and the public behavioral health system are not well integrated in Arizona. This is the subject of one of the major recommendations of this report.

C. Strengths of the Arizona Public Behavioral Health System

The findings and recommendations included in this report ultimately focus on issues and gaps that should be addressed if Arizona is to move toward the best practices goal for adults and children with behavioral health issues. At the same time, conducting a strengths-based assessment has been the appropriate focus, as many strengths and positive service delivery models have been identified. The intent was to find and to document a foundation on which the improvements in the system could be built. That intent has been satisfied.

The 10 most promising aspects of the Arizona public behavioral health system identified in this study are:

1. **Structure for Managed Care -** Arizona has developed a managed care structure, based on the carve-out model. Although the carve-out model engenders issues with regard to primary health care integration, it is currently preferable in jurisdictions in which Medicaid is a primary funder of the public behavioral health system. While the system may evolve towards an integrated "carve-in" approach, it will accomplish that from a position in which the system of behavioral health services is well established and well managed. The current structure supports the use of managed care principles and technologies, including utilization management, information management, outcome measurement and quality assurance.

2. **Risk-Based Financing -** Risk-based financing is being used in Arizona to create incentives and push the system toward appropriate utilization and cost control. Risk based financing, with appropriate risk sharing arrangements such as those used in Arizona, provide the most positive incentives to manage care effectively and efficiently. Risk sharing reduces incentives for over or under utilization and provides flexibility to local managers on the design and implementation of public behavioral health services.

3. **Local Systems of Care -** The behavioral health carve-out has been implemented in a manner that emphasizes local systems of care, and in which financial, clinical, and administrative authority are consolidated in the agencies managing the local systems of care. The RBHAs exemplify the concept of local authorities, which have both the authority and the control of resources necessary to implement systems of care that best meet local conditions, needs, and resources. The five RBHAs in Arizona have different organizational and service delivery models,

and have flexibility to arrange service delivery tailored to local needs.

4. **Strong Clinical Leadership -** There is evidence of strong and forward-thinking clinical leadership at the top of Arizona's public mental health system. Many of the clinical protocols and guidelines emanating from the Arizona Division of Behavioral Health Services are examples of evidence-based best practice, and provide a good foundation for implementing such best practices in the field.

5. **Examples of Innovation and Best Practice -** Pockets of cutting-edge best practices have been identified in Arizona, and these could be replicated more widely throughout the state as part of the strategy to improve the system. Many of these are used as examples as specific best practice approaches are discussed in Section III of this report.

6. **Strong Data Collection -** There is relatively good and consistent data collected throughout Arizona's public mental health system, and the management information systems are on a path to becoming even better. Consistent, timely and accurate data that can be used for accountability, planning, quality improvement, and system management are essential to a high quality managed system of care. Arizona's data collection and reporting system will have the capability to support these functions, particularly if data analysis and data exchange between the state and the RBHAs are improved.

7. **A Focus on Those with Serious and Persistent Mental Illness -** The system of care for adults in Arizona is appropriately focused on individuals with serious mental illness. This is partly a result of the state's efforts to comply with the $Arnold\ v.\ Sarn$ stipulation and order. It also reflects a firm and long-standing commitment on the part of state and local behavioral health system leadership to individuals with serious mental Illness.

8. **Strong Cultural Competency -** Successful efforts to attain cultural competence have been implemented in many different ways throughout the system. Arizona is a culturally and linguistically diverse state. Its successes in tailoring service components and delivery approaches to culturally and linguistically diverse individuals, when implemented more consistently statewide, will be a model for the rest of the country.

9. **Models of Rural Service Delivery -** There is a strong commitment to providing good public behavioral health services in rural areas of Arizona. Rural strategies such as telemedicine and paraprofessional behavioral coaching are good models for serving diverse populations in large rural areas, and could be replicated throughout other rural areas of Arizona and in other rural jurisdictions.

10. **A Record of Research and Demonstration -** Arizona has as history of conducting demonstration projects aimed at improving behavioral health services. Several demonstration grants, such as the consensus panel activity related to co-occurring mental illness and substance abuse, show promise in terms of developing and replicating best practice in Arizona.

The Environment for Change in Arizona

In general, the citizens of Arizona believe strongly in self-reliance and self-sufficiency. The fundamental attitude is that people must "pick themselves up by their bootstraps" as opposed to receiving "handouts" from a public welfare or social service system. Arizona is also a fiscally conservative state. Based in part on these public attitudes and approaches, Arizona is a relative newcomer to the funding and management of Medicaid covered behavioral health services, having begun implementation in 1990.

The Arizona public policy context presents some benefits for both people with behavioral disabilities and for public administrators and taxpayers. For example, self-sufficiency and self-reliance are key elements of the recovery process. Further, the relative newness of the Arizona system in terms of Medicaid coverage for behavioral health services means there are fewer traditional programs and service delivery systems, and fewer special interests, to generate resistance to a positive change process. However, it also results in an environment that could stifle progress or increase the difficulty of implementation of positive new initiatives.

There are three factors that affect the ability of the system to meet the needs and choices of priority consumers. All of these are present to various degrees in other states, and most states struggle with these issues as they attempt to move towards best practice models of behavioral health services. They are discussed here because confronting these issues is critical to long term improvements in the Arizona public behavioral health system. Further, state behavioral health systems that have moved further along towards a best practice model of behavioral health services have proven that these issues and barriers can be overcome. These factors are:

1. In Arizona as in other states there is a widespread lack of public education and understanding about mental illness, emotional disturbance and substance abuse. This results in stigmatization of individuals with mental illness, emotional disturbance or substance abuse, which in turn makes the development and operation of integrated community services more difficult for both providers and consumers. In addition, public misunderstandings about behavioral health disabilities lead to a general unwillingness to add funds to the public behavioral health system.

2. Arizona and many other states do not exhibit a clear consensus on behavioral health service system priorities. There are numerous examples of organizational turf and resource battles between and among state administrative agencies. There also are continuing political and resource differences between the urban and rural sections of the state, and continued dissonance among consumers, families, and other stakeholders about priorities for changing and improving the public behavioral health system. Examples of the consequences of this lack of priorities and implementation strategies include: (a) the failure of consumer organizations to sustain growth and develop legitimacy; (b) the development of plans to capitalize a replacement for Arizona State Hospital (ASH) without corollary planning for improvements to the community behavioral health system; and (c) several issues related to the integration of behavioral health and primary health care services remain unresolved.

3. Arizona has a number of characteristics that exacerbate the universal difficulties of developing and managing public behavioral health services. Arizona has vast, sparsely populated and geographically isolated rural areas in which the delivery of responsive community mental health services is difficult. This problem is compounded by the lack of any viable affordable transportation services in rural areas. Arizona is also an unusually diverse state, with large numbers and proportions of Spanish-speaking Mexican American residents and Native American residents. Finally, Arizona is a fast growing state, and many of the new residents are retirees, some of whom need or will need specialized behavioral health services.

Conclusion: What is the True State of the Arizona Public Behavioral Health System?

This report starts by posing a question: What is the true state of the Arizona public behavioral health system? Is the Arizona public behavioral health system a cutting edge managed system of care or is it a system in need of repair? The answer, inevitably, is somewhere in the middle. There are pockets of excellent programs in Arizona, and some statewide policy initiatives that are being implemented in a manner consistent with evidence-based best practice. There are also some significant gaps in the Arizona public behavioral health system-gaps that will take years of effort and substantial resources

to correct. As with many other states, there is a significant gap between stated policy and practice at the state level versus actual practice at the point of service delivery.

One problem encountered in this study is a general perception that little or no improvement can be made in the Arizona public behavioral health system unless new resources are appropriated. This report documents that, to the contrary, there are numerous opportunities in the Arizona public behavioral health system to make significant improvements without new resources. Yes, the over-all public behavioral health system in Arizona needs more money. But no, the absence of new resources should not be erected as a barrier to implementing positive changes that will have a substantial impact on the quality and effectiveness of services delivered to priority consumers.

This becomes the thrust of the recommendations of this report. Strategies can and should be implemented at the state, regional, and local levels that (a) take advantage of evidence-based best practice relevant to the current system in Arizona; and (b) make better use of existing resources to deliver efficient and effective services to people with the greatest needs. New resources should be added over time but should be used to enhance already proven preferred practice service delivery and service management models, not to just do more of the same.

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[2] See Percentage of Medicaid Eligible Persons Receiving Services by Program Indicator and Percent of Non-Medicaid Eligible Persons Receiving Service by Program Indicator charts.

[3] Based on available data, it was possible to approximate unduplicated number of persons served within payer sources but not across payer sources. Calculating the percentage of total enrolled Medicaid clients receiving services that were reported as seriously mentally ill and persons with substance abuse treatment needs determined this respectively. Data is based on information provided by the Division of Behavioral Health Services.

[4] Calculating the percentage of average monthly-enrolled non-Medicaid clients receiving services that were reported as seriously mentally ill and persons with substance abuse treatment needs determined this respectively. Data is based on information provided by the Division of Behavioral Health Services.

[5] Penetration rates refer to the proportion of total eligible or enrolled individuals actually accessing services from the system. Penetration rates are typically used as a measure of the degree to which the system is reaching out to and serving the number of individuals and families that are likely to need services at any one time. For example, in the Medicaid program it is generally expected that a minimum of 10 percent of all Medicaid enrollees will access behavioral health services in the course of a year.

[6] Taxonomy refers to the list of specific service types and service codes that are permissible to be delivered and paid for under the managed system of care. The taxonomy is important because it defines the parameters of what services will be offered to consumers, and also guides professional staff in their decision-making about which services are appropriate for individual consumers.

[7] Funding Sources and Expenditures of State Mental Health Agencies: Fiscal Year 1997. NASMHPD Research Institute. Data from the Arizona Division of Behavioral Health Services differed by a very small margin, resulting in a per capita expenditure amount of $67.81. This amount is referenced later when comparing RBHA expenditures per capita.

[8] Member months are the number of persons enrolled multiplied by the number of months eligible for services. User months indicate the number of months an enrolled member is receiving services.

[10] Number supplied by the Arizona Division of Behavioral Health Services.

[11] Funding Sources and Expenditures of State Mental Health Agencies: Fiscal Year 1997. NASMHPD Research Institute.

[12] Spring, 1999

[13] Carve-out refers to establishment of funding and service delivery structures for behavioral health services that are separate and distinct from the funding and delivery system for primary health care.

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III. PREFERRED SYSTEMS AND BEST PRACTICES FOR ARIZONA

A. Introduction: What are Best Practices?

As discussed in Chapter I of this report, there are several conceptual domains of best practice that are important to consumers and families in the public behavioral health system. The first domain reflects characteristics of any public sector human services, health care, or behavioral health care system in any jurisdiction. These include:

~ **Customer orientation -** respect for and responsiveness to the individual needs and choices of consumers and their families at all levels of the system. This also includes consumers and families in governance, planning, program development, quality management and system performance evaluation;

~ **Clinical excellence -** implementation of evidence-based clinical treatment practices consistently throughout the system, enforced through clinical leadership, training, standard clinical treatment protocols, and constant learning and improving through a strong and systemic quality management process;

~ **Continuity -** assurance that every individual and family will have a single point within the system with the accountability and responsibility to be there when needed, and to respond to individual and family needs as they change over time;

~ **Integration -** assurance of seamless and facilitated movement among the components of the public behavioral health system and full and coordinated access to and integration with other important services and supports, including primary health care, housing and vocational services; and

~ **Stewardship of public funds -** clearly identified single points of public accountability for the quality, effectiveness and efficiency of the public behavioral health system and consistent evaluations of the quality and performance of the system.

In an important way, psychosocial rehabilitation services are designed to assist consumers to develop skills and strengths in all the aspects of their lives other than clinical treatment.

The second domain reflects the practical elements of implementing specific program model and clinical treatment best practices within the preferred public behavioral health system. These are elements without which the first set of criteria cannot effectively be met, and include:

~ **Vision -** clearly articulated and understood mission, values and strategic direction for the public behavioral health system as a whole;

~ **Strategy -** feasible and proven approaches to structuring, organizing, financing and operating the public behavioral health system:

~ **Technology -** the actual practice and delivery of services to priority consumers and their families;

~ **Human Resources -** the supply of trained, competent, and culturally relevant staff necessary to deliver best practice service models; and

~ **Culture -** the expectations and beliefs by all participants in the system in the value and potential of all consumers and the value of a high quality, customer-oriented, efficient and effective public behavioral health.

The third domain reflects the combination of empirical research, professional judgement, feasibility of implementation and relevance to Arizona. As stated in Chapter I, these include:

- ~ There have been qualified evaluations of the program model or clinical practice and the positive effects of the approach(es) are described in peer-reviewed literature;

- ~ The practice or approach has become a nationally accepted best practice and has been widely used as a standard and guideline for program implementation and service delivery for a substantial period of time;

- ~ The team has knowledge and experience with the practice or approach from successful and beneficial implementation in other jurisdictions;

- ~ The practice or approach is relevant to Arizona local conditions and definitions. It addresses gaps or needs in the current service system; and/or

- ~ The implementation of the practice or approach is feasible within the current Arizona public behavioral health system.

The best-practice templates represent a combination of practices that fit one or more of these criteria. They share not only common features that can be found in any preferred system of care, but also the following unique characteristics:

- ~ They were developed as a result of an open attitude toward change, including the willingness to learn from mistakes and start over again;

- ~ They started small and were replicated elsewhere-the best practice can become evidence-based through repeated replications and revisions;

- ~ They represent practices that go beyond behavioral health care-many practices affect other systems of care as well.

B. The Preferred System of Best Practices for Children and their Families

The federal definition of children with serious emotional disturbance (SED) includes children from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM. That DSM diagnosis must have resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. Using this definition, it is estimated that between nine to 13 percent of children have diagnosable SED.[14]

For many years efforts have been made at the federal, state, and private level to develop and implement best practice approaches to behavioral health. These have included the Ventura County study in California. In addition, the Robert Wood Johnson Foundation, the Kellogg Foundation, and the Annie B. Casey Foundation have all sponsored major studies and demonstrations of integrated child serving models. Through these and many other studies, the technology of serving children and their families with serious emotional disturbance has improved substantially. For example, clinical interventions with psychotropic medications, including some of the newer atypical antipsychotic medications and selective serontonin re-uptake inhibitors (SSRIs such as Prozac and Paxil) are becoming documented.[15] Clinical treatment protocols for many SED conditions, such as oppositional defiant disorder and attention deficit hyperactivity disorder, are also well established.[16] Unfortunately,

in almost all jurisdictions, even after many years of demonstration funding and effort, the children's' puzzle remains to be solved.

This fact is true for two reasons. First, whether or not children are diagnosed as having SED or general behavioral disorders, the manifest problems and needs of children, families, schools and community life are inevitably intertwined. Children needing treatment and supports often live in environments where substance abuse is rampant, family stability is uncertain, physical and sexual abuse is common[17], schools are overcrowded and under funded, poverty and unemployment are widespread, and class, race, and cultural characteristics create unspoken but intransigent barriers to family well-being. For many, the successful treatment of children with SED rests on social and economic interventions far broader than the realm of behavioral health services.

Second, children and their families are impacted by a multitude of often un-coordinated community entities. These include the educational system, the juvenile justice system, the child protective service system and the primary health care system. They are further impacted by the uncoordinated entities from which their families may be seeking services and supports as a way to improve the lives of their children. These multiple entities all have scarce resources, conflicting missions, excessive demands for service, and high risks of failure for youth in their care. It is no surprise that the children's puzzle cannot be put together easily in the face of these organizational differences.

At the federal level, the Child and Adolescent Service System Program (CASSP) philosophy has long been recognized to define best practice and preferred systems of care for children and their families. The CASSP principles clearly state that services for children and families should be child-centered, family-focused, community-based, multi-system, culturally competent, and least restrictive.

At the direct service delivery level, specialized programs have been developed during the last decade to target high-risk children and families. These include the Family Preservation Program, based on the Homebuilder Model pioneered in Tacoma, Washington, to address children at imminent risk of out-of-home placement. Intensive Case Management, tried in several states (New York, Ohio, Oklahoma, Texas), has been used to work with children and families who have not responded to traditional approaches to service delivery. In addition, various assessment tools have been developed to measure the functioning of children and families, from CAFAS (Child and Adolescent Functional Assessment Scale[18]), to NCFAS (North Carolina Family Assessment Scale[19]), to Vermont's Child Behavior Checklist.[20]

To help children gain access to appropriate and effective services, protocols for levels of care for children with behavioral health care needs have also been developed. The American Academy of Child and Adolescent Psychiatry has a working draft for levels of care for children and adolescents and several levels-of-care protocols for children have been developed for Erie, Pennsylvania; Delaware; Iowa; Ohio; Oklahoma; and South Carolina.[21] There is recognition that these tools can help determine medical necessity for services and help support child- and family-centered services. Moreover, they are prerequisites to effective utilization management.

Consistent with the above discussion, the elements of a best-practice template for behavioral health services for children and their families include:

~ System-wide commitment to tearing down institutional barriers to allow state and local child-serving agencies to openly and fully coordinate access to and delivery of their discrete services;

~ Methods and supports for empowering children and their families and front-line staff. Children and their families do best when they participate fully in treatment planning and service choice. In many best practice models, families choose service models, select providers, and train and supervise them to work in their own homes and schools. In a similar fashion, front-line staff must feel free to be

flexible, creative, and individualized in assisting children and their families to access services. They must also feel supported and free to take risks without fear of retribution;

~ Systematic and coordinated approaches to access, comprehensive assessment, service planning, and outcome measurement for services. Children and their families should have one and only one integrated assessment and treatment plan, and should be able to access all needed and chosen services from wherever they present in the system. This unified access and treatment planning approach should also assure continuity of treatment and supports as well as facilitate access to a variety of services across agency lines;

~ CASSP principles should be implemented consistently on a statewide basis. These include:

- Providing needed services in the child's home community
- Least restrictive, most normalized environment
- Comprehensive array of services that address physical, emotional, social, and educational needs
- Child and family-centered approach to strengths-based service delivery
- Culturally appropriate services
- Interagency collaboration and cooperation
- Early identification and intervention
- Include specific child/family outcomes in the accountability system
- Allocation of resources to prevention and early intervention services

Examples of Best Practice Approaches
in Arizona and in other Jurisdictions

Against this template, some Arizona promising practices, such as the two Interagency Case Management Project (ICMP) demonstrations for children and families with multiple system involvement, and the Model Court as practiced in Pima County have achieved promising results. The Juvenile Drug Court in Maricopa County shows promise as a treatment modality, but its costs and longer term outcomes are still being evaluated. Examples of successful, culturally competent prevention and early intervention programs include the South Side Partnership/Luz Social Services (a substance abuse prevention program for Spanish-speaking youth located in Tucson) and "Storytelling" (a school based primary prevention program of Compass Health Care, Inc. located at the middle school at the Tohono O'odham Indian reservation).

Another promising model is behavioral coaching services for seriously emotionally disturbed youth, currently used in the NARBHA region. In this model, paraprofessional staff are trained to work one-on-one with youth in school and/or at home. The staff assists the assigned youth through important functions of daily living and learning, and teaches skills and coping mechanisms. At the same time, the staff train teachers, parents, and other caregivers on how to work with the particular mental and behavioral difficulties presented by the youth.

In the State of Delaware, under the umbrella agency Department of Children, Youth, and Their Families, an integrated assessment, gatekeeping and authorization unit has been established within

the Division of Child Mental Health, as part of the state's Medicaid 1115 waiver project. The centralized assessment, available to referrals from child welfare, juvenile justice, and mental health systems, incorporates EPSDT requirements with a standardized tool that is linked to a protocol for levels of care. Since the unit became operational in 1997, the state has reduced length of stay in residential treatment and psychiatric hospitalization. In 1998, the Division became the first publicly run Managed Services Organization to be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The new atypical anti-psychotic medications are now almost always the treatment of first choice rather than last choice. This is a major change from clinical practice of only a few years ago.

In Hamilton County, Ohio, a public/ private partnership has resulted in collaboration among three public systems (child welfare, drug and alcohol, and mental health) to jointly purchase information system, care management, and managed care technologies from the Magellan Public Solutions. A uniform assessment, together with a protocol for levels of care, has provided consistency of provider performance in three service systems.

In Iowa, through a statewide Children's Medicaid initiative, five systems (child welfare, juvenile justice, mental health, mental retardation, and substance abuse services) have collaborated to develop Clinical Assessment and Consultation Teams. This is located in social service regions, with the primary responsibilities for assessing children referred by the four systems for appropriate triage into four levels of community-based services (general family-based support, intensive family preservation services, foster care, and group care). The team also provides continued stay review and monitoring of service outcomes. The project was successfully incorporated in the state's Medicaid plan. The project also complemented a Casey Foundation-supported De-categorization Project at chosen pilot sites in which all non-Medicaid funds at the county level were bundled and used by multiple children's systems.

In addition to the specific examples noted above, a number of other jurisdictions throughout the United States have successfully implemented best practice child/family systems of care consistent with CASSP principles, including attainment of relative integration and coordination among all child-serving agencies. These include a consortium of area programs in the Blue Ridge section of western North Carolina, Erie County, PA, and certain multi-county regions of Iowa. All of these jurisdictions have accomplished this through:

~ A planned and thoughtful willingness on the part of all parties to cede control and share resources in meaningful ways;

~ Single-site management of all resources, with the authority to access all applicable service modalities and to commit funds for these services;

~ Integration of and adherence to CASSP principles throughout the system of care;

~ A unified comprehensive, strengths-based assessment and treatment plan governing all aspects of service access and delivery;

~ Leadership committed to managing and delivering services in new, creative, and flexible ways[22];

~ A commitment to include families and their children in all levels of service planning, implementation, management, and evaluation as well as in treatment planning and provider choice; and

~ A promise not to let children and their families go - the system will be there for them whenever and wherever they want, with whatever they need and choose.

Issues to be addressed in the Arizona Child and Family Public Behavioral Health System

As documented in other sections of this report, the child behavioral health system is significantly under-funded in Arizona. It also appears true that state level policies, procedures, eligibility and funding requirements, and service practices and priorities have not been effectively coordinated and integrated for the benefit of children and their families. The combination of scarce resources, funding, and fragmented services administration results in much of the effort of both families and case managers being spent trying to negotiate the various child serving agencies. Effort is also spent trying to piece together a needed array of services from a variety of service delivery and funding sources. Informal efforts such as the multi-agency teams (MAT) in Flagstaff, Apache Junction, and Yuma for example, and the more formal interagency case management projects (ICMP) in Phoenix and Lake Havasu, have found ways to coordinate access and cut through the complexities of these programs. However, these promising approaches rely on personal good will and ingenuity at the point of service level. They are not systematically supported by policy changes or administrative actions at the state level to integrate and coordinate services and to break down bureaucratic barriers to service access.

Another important issue is the very low threshold for eligibility for Aid to Families with Dependent Children (AFDC) (33 percent of the federal poverty level). This has the effect of excluding a large group of indigent, uninsured families and children from Medicaid Arizona Health Care Cost Containment System (AHCCCS) funded services. In concert with slow enrollments in Arizona's KidsCare program, this low threshold creates excessive demand and unmet need for state-funded services for non-Medicaid children and their families.

Finally, funding-related service system capacity limitations remain a consistent issue. There are long wait times to initiate services and to receive a psychiatric evaluation, and there are too few case managers to meet current demand. Child/adolescent residential treatment does not exist in most rural areas, and crisis stabilization resources for youth are particularly limited. Flexible wraparound and family-focused services for youth are also very limited. Several of the recommendations in Section IV of this report offer solutions to these issues.

C. The Preferred System of Best Practices for Adults with Serious Mental Illness

The technology of behavioral health services for adults has improved significantly in the past 30 years. For general mental health services (i.e., depression, anxiety, post-traumatic stress, etc.) the combination of new medications and brief cognitive-supportive therapies have proven to be almost universally effective. For individuals with serious mental illness (i.e., schizophrenia, bi-polar disease, chronic depression) the new technology includes atypical anti-psychotics and proven community treatment approaches such as assertive community treatment, supported housing and employment, and recovery- oriented psychosocial rehabilitation services.

Some individuals suffering serious mental illness today have benefited greatly from these scientific and service technology advances in public behavioral health care systems. Unfortunately, for a variety of reasons public behavioral health systems throughout the United States have been slow to implement these proven technologies. The result is that the vast majority of low income individuals with serious mental illness, including those in Arizona, continue to receive services and supports more reminiscent of the 1960s than reflective of the 1990s. The consequences, as well documented in the media, are increased incarcerations, increased homelessness, and increased stress on families and communities.

The preferred public behavioral health system is comprised of a number of interlocking and

interdependent elements. These start with basic treatment philosophy and values, and extend to specific face-to-face clinical and community support services. As with the preferred child and family public behavioral health system, the integration and continuity of these components are as important to consumers and families as is the presence of each discrete element. The following are the key elements of the preferred public behavioral health system:

Treatment and Support Service Philosophy, Vision, and Values

Recovery values and principles - Recovery includes building internal strengths, building social support networks, and overcoming stigma through activism and self-advocacy. For the recovery vision to be achieved, all participants in the system must come to believe in the value, individuality, and recovery potential of each individual, and must incorporate recovery principles and values in policy-making, system planning, resource allocation and performance evaluation within the system.[23]

Consumer self-determination and choice - An essential ingredient of consumer recovery and empowerment is self-determination and choice. This is delivered by the system through: (a) assuring ample opportunities for consumer self-determination and choice; (b) providing whatever supports are necessary to facilitate consumer self-determination and choice; and (c) assuring that there are a range of options from which consumers can make reasonable choices.

Continuity of connection with the system - Most consumers say becoming empowered and exercising choice is the best and most therapeutic way to interact with professionals. Consumers also emphasize that a lasting relationship with trusted caregivers and continued receipt of needed and chosen services are key elements of each person's personal path to recovery.

Examples

Arizona is in the beginning stages of developing a recovery vision and principles for adult community mental health services. The community service models being developed under the Arnold v. Sarn Stipulation and Order incorporate recovery values and consumer choice and empowerment strategies, but these are for the most part still in the planning stages. As will be described below, there is at least one consumer-operated program, located in Maricopa County. Outside Phoenix, several of the RBHAs are talking about recovery and rehabilitation, and are exploring service models from other jurisdictions, such as Colorado. But again, much of this service philosophy and approaches has not been translated to the level of consumer services and program models.

States that have fully implemented the federal community support program (CSP) model (see below) tend to be the furthest along in terms of truly integrating recovery and empowerment values and principles into the local public behavioral health delivery systems. These include Rhode Island, Ohio, Vermont, Colorado and Wisconsin.

The Community Support Program (CSP) Approach - Services and Supports for Rehabilitation and Recovery

For many years the widely accepted preferred model of community-based services has been the federal community support program (CSP)[24] The CSP model emphasizes consumer centered strengths-based services, empowerment, racial and cultural appropriateness, service flexibility, incorporation of natural supports, accountability to consumers, and coordination and continuity. CSP standards for minimum service capacity include: (Note: some of these are discussed in more detail

below.)

- ~ Outreach, including transportation to facilitate access;
- ~ Assistance in meeting basic needs for food, clothing, shelter, personal safety, and medical and dental services;
- ~ Mental health treatment, including inpatient and partial hospitalization, medications and medication management, individual and group counseling, and residential evaluation;
- ~ 24 hour crisis assistance;
- ~ Psychosocial and vocational services;
- ~ Rehabilitative and supportive housing;
- ~ Education about mental illness to the community;
- ~ Protection of consumer rights; and
- ~ Case management and community support.

Clearly, CSP principles and service components are consistent with and supportive of the recovery, empowerment, self-determination, and choice visions outlined above. For most state and local jurisdictions, the CSP guidelines have functioned as the preferred system template for adult behavioral health services in the community.

Psychosocial rehabilitation approaches - Recovery is what people with disabilities do… rehabilitation [is] what helpers do to facilitate recovery…."[25] Psychosocial rehabilitation, also known as psychiatric rehabilitation, includes a set of services and supports designed to assist individuals regain maximum independent functioning in living environments and communities of their choice. The service modalities, usually defined within psychosocial rehabilitation, include community supports such as peer supports, psychosocial clubhouse services, supported employment and supported housing. The philosophy that binds these services together "involves (a) respect for the consumer and encouragement of his/her active participation in the rehabilitation process; and (b) positive assumptions about each individual's potential for recovery of function and enhancement of quality of life."[26]

Arizona has developed many of these excellent clinical guidelines, protocols, and now needs to concentrate on assuring consistent implementation in the field.

In an important way, psychosocial rehabilitation services are designed to assist consumers to develop skills and strengths in all the aspects of their lives other than clinical treatment. Psychosocial rehabilitation services are concerned with what people do for the 160 hours per week or so in which they are not participating in counseling, medication management, or visits with case managers. Thus, psychosocial rehabilitation addresses skills and strengths related to living, learning, working, loving, socializing and otherwise participating in community life.[26]

Peer supports/consumer operated services - Consumer operated peer support and self-help activities can take a number of forms. Many consumers form clubhouses or drop-in centers, and/or operate warm lines, peer outreach, and related services. Consumers as peer supports have also been successfully integrated into crisis outreach teams and assertive community treatment teams. Consumers have become engaged in training, satisfaction and quality reviews, ombudsmen services, and a variety of related self-advocacy activities. And, consumers have branched out into entrepreneurial activities, both within and without the behavioral health fields.

From the literature and from self report, two themes are clear: (a) consumers find peer operated self-help type services helpful and satisfying in their path towards recovery; and (b) consumers help themselves substantially by becoming caregivers for others (not necessarily just other behavioral health consumers.) Thus consumer operated peer support and self-help are integral to any community behavioral health system of care, and contribute significantly to the vision of recovery and rehabilitation.

Early intervention - Most individuals exhaust all private insurance and other private and family resources before arriving at the front door of the public system. This is unfortunate, since the public behavioral health system is usually substantially more adept at treating serious mental illness than is the private sector. It is even more unfortunate because proper interventions early in the course of serious mental illness usually have very beneficial results

Early intervention is better for consumers and their families because it reduces the long-term negative effects of the illness and initiates the recovery process at a time when the disabling effects of the illness are minimal and personal and family resources are not yet exhausted. Early intervention also has beneficial consequences for the public behavioral health system, in that it has the potential to reduce the life-cycle costs of services and supports for a substantial number of individuals with serious mental illness.

Examples

Arizona has begun making progress towards adopting and implementing recovery and rehabilitation-oriented service values and approaches. For example, consumer operated services such as peer mentoring and warm line services have been implemented in both Tucson and Phoenix. In addition, there are examples of good psychosocial clubhouse models (i.e., CPSA region) and good supported employment programs (i.e., NARBHA region.) These examples can and should be replicated throughout Arizona.

There are many signals that in parts of Arizona the CSP principles and program components are being viewed as defining the direction in which the adult behavioral health system should be progressing. For this to be accomplished will require years of effort directed to system change, service development, effective engagement of consumers and families at all levels, and in-depth training leading to fundamental culture changes in the system. Thus, it should not be expected that the fruits of this transition to CSP principles would be evident at this juncture. What is important is to plan the steps necessary to get there, and then to consistently monitor progress to assure that the system is moving at the right speed in the correct direction.

As noted above, state jurisdictions such as Ohio, Rhode Island and Vermont that have fully implemented the CSP model of services have in place a wide variety of recovery and rehabilitation services that meet the best practice standards discussed above. Specific examples of best practice include Fountain House model psychosocial clubhouses in numerous jurisdictions[27], and peer operated services in New York City, Philadelphia, PA, Austin, TX, and Denver, CO.

Acute and On-Going Treatment Interventions

Crisis services - The essential elements of a comprehensive community-based crisis response system include:

- Twenty-four hour, seven day per week, 365 day per year central telephone response system staffed by qualified mental health professionals and having immediate capacity for face-to-face assessment plus on-call consultation with a

psychiatrist;

~ Clinical capacity and legal authority to approve or deny admission, voluntary or involuntary, to any public (operated or paid) psychiatric inpatient facility;

~ Assured and speedy access to appropriate clinical specialties, such as board-certified or board eligible child psychiatrists;

~ Mobile capacity, in which teams of mental health professionals and peer counselors are available to respond within one hour to psychiatric crises wherever they present, including hospital emergency rooms, individual homes, and local jails. The mobile unit must also have the capacity to transport or arrange for transport of individuals in crisis to an appropriate evaluation and stabilization facility;

~ A variety of short term (23 hour to 14 day) adult and child holding and intensive residential treatment resources for crisis stabilization and hospital diversion;

~ Facilitated linkage with other healthcare resources, to arrange for medical clearance, toxic screens, lab work related to rapid medication titration, and medical and non-medical detoxification; and

~ Direct access to cultural and linguistic clinicians and translation services to facilitate assessment and crisis stabilization.

Mobile outreach/ACT/ACM teams - Assertive Community Treatment (ACT) is the model most commonly used to provide intensive mobile services to consumers who are: (a) at very high risk of hospitalization or otherwise losing community housing and supports; and (b) who are unwilling or unable to participate in or benefit from traditional clinic or facility-based services. ACT is defined as "a self contained clinical team that:

~ Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified consumers with severe and persistent mental illness;

~ Minimally refers consumers to outside service providers;

~ Provides services on a long-term basis with continuity of services over time;

~ Delivers 75 percent or more of the services outside program offices;

~ Emphasizes outreach, relationship building, and individualization of services."[28]

ACT teams are typically comprised of a team leader, a psychiatrist (usually part time), licensed mental health professionals (usually including at least one psychiatric nurse), mental health workers, and peer specialists.[29]

Medical and clinical treatment/ medication management - There are a number of fundamental principles or standards for high quality and effective clinical treatment services in the public behavioral health arena. For example:[30]

~ Inpatient and partial hospital treatment should be as brief as possible, should focus on acute stabilization and symptom amelioration, and should clinically prepare individuals for smooth and speedy transition into rehabilitation and recovery ser vices. In well-managed systems of care, the average length of stay for acute hospital

admissions averages 7 to 10 days.

~ Participation in partial hospital or other intensive day services averages 14 to 21 days.

~ Longer-term, less intensive day services are no longer considered to be appropriate in well managed behavioral health systems, and many systems are now systematically converting traditional day service programs into psychosocial rehabilitation, clubhouse, and supported employment services.

~ Individual or group psychodynamic therapies are being replaced by short-term intensive cognitive ego-supportive treatment modalities. With the exception of medication reviews and medication management groups, it would be unusual for an individual with serious mental illness to be receiving office-based counseling services exceeding 7 to 10 encounters.

~ The new atypical anti-psychotic medications are now almost always the treatment of first choice rather than last choice. This is a major change from clinical practice of only a few years ago.[31]

~ Discharge policies and practices from intensive clinical treatment services should assure connection with the appropriate array of community support services. Re-admissions within 90 days should not exceed 10 percent of discharges from hospitals.

Meeting these types of clinical practice and utilization guidelines are important advances for a number of reasons. First, they result in better clinical and personal outcomes for most consumers. Second, they facilitate the recovery and rehabilitation process, and minimize the potential for long term dependence on clinical service modalities. Third, appropriate and therefore minimal utilization of expensive inpatient and other intensive clinical services permits the maximum amount of public resources to be focused on more cost-effective community support and recovery-oriented programs.

Another important development in the clinical treatment arena is the development of evidence-based and widely accepted treatment guidelines and clinical pathways for most major mental illnesses. The schizophrenia expert consensus guidelines, cited above, are one example of this type of improvement in the behavioral health system. Preferred clinical interventions, which include combinations of medication, clinical treatment, and on-going community support, are no longer a mystery for most mental illness. Thus, there is no longer a basis for wide and unexplained variation in treatment approaches. Even more important, all components of the behavioral health treatment system can be expected to deliver essentially the same level of consumer outcomes with similar ranges of number of encounters and costs for each episode of care. Finally, these treatment guidelines provide a firm basis for further evidence-based improvements to clinical practice and treatment outcomes for consumers.

Consistent with the new clinical guidelines, a considerable amount of evidence-based work has been done specifying and objectifying the clinical standards and workforce competencies needed to efficiently and effectively operate behavioral health services that meet standards for managed systems of care. For example, the federal Center for Mental Health Services (CMHS) recently assembled panels to define competencies related to adult mental health services, child mental health services, dual diagnosis services, mental health services for elders, and culturally appropriate services for African-Americans, Asian-Americans, Hispanic-Americans, and Native Americans.[32] All of the competency guidelines were developed after exhaustive literature reviews and discussions with stakeholders.

The clinical guidelines and competencies support planning for service development, service

operations, clinical protocols, and staffing models. They also support development of training and human resource development plans and strategies to assure that the public behavioral health workforce has the correct values, knowledge, and skills to deliver clinically appropriate and effective services.

Examples

Arizona has developed some excellent examples of clinical treatment guidelines. These include the service planning guidelines, such as guidelines for treating attention deficit hyperactivity disorder and oppositional defiant disorder for youth, and borderline personality disorders and depressive mood disorders for adults. The recently issued clinical treatment protocols for schizophrenia also reflect up to date evidence-based best practice. Further, the Arizona level of functioning assessment (ALFA) is a good instrument for uniform and consistent level of functioning assessment within Arizona.

Arizona has developed many of these excellent clinical guidelines, protocols, and now needs to concentrate on assuring consistent implementation in the field. Under the bast of circumstances it takes time and effort for evidence-based best practices to the places it is needed most - the point of service between the clinician or other caregiver and the individual consumer. Successful implementation requires continuous and broad-based training, strong and committed local clinical leadership, focused clinical supervision, frequent peer review, and quality management continuous quality improvement of these promising clinical practices. For example, the efficacy of certain clinical interventions for individuals with varying disabilities and diagnoses will be able to be tested reliably in Arizona, now that the ALFA instrument is applied and reported consistently, and clinical diagnoses have been added to the database to which ALFA information is reported.

40 to 80 percent of individuals seen in mental health treatment settings have substance abuse problems, and over 50 percent of individuals admitted to state psychiatric hospitals have a history of substance abuse.

Arizona has the basis for evidence-based best practice in its clinical treatment operations and approaches. Once recovery and rehabilitation- oriented services and supports in the community are more fully developed, the clinical protocols and guidelines need to address effective linkages among and between these service modalities. It is neither appropriate nor cost effective for these service and support modalities to operate either in parallel or sequentially. They must be fully integrated at all points of the system, and the clinical guidelines, utilization management criteria, and quality management process should all foster and encourage that integration.

In New Hampshire each area mental health center is expected to be competent in and compliant with clinical best practice, but also has performance expectations related to employment and independent living. This model assures a holistic approach tailored to each individual's needs and choices, and also assures improved outcomes for each component of the system of care. In Dane County, Wisconsin, which is the birthplace of assertive community treatment and community rehabilitation services, there is an equal emphasis on best practice clinical treatment interventions as there is on community recovery and rehabilitation.

The guidelines for length of stay and clinical approach to certain acute or intermittent services listed above reflect industry standards in both public and private managed systems of care. Informally, it appears that clinical practices in parts of Arizona meet these basic standards. However, these types of thresholds for treatment activity are not codified clearly in current clinical treatment guidelines, nor are they used as specific measures of performance throughout the system. Many states that have implemented managed systems of care now use these types of measures, not so much as pure indicators of clinical excellence, but rather as indicators of how well all components of the system are working to facilitate access to clinically appropriate services when and as needed. Iowa and Massachusetts are two examples of states with statewide carve-out models for Medicaid managed care that have adopted these types of standards and measures.

Arizona has examples of good crisis response and stabilization services, such as the Octotillo

Program, a fifteen-bed crisis residential program in the CPSA region. This could be a model selected for replication as part of comprehensive 24-hour, seven day per week crisis services as they are implemented consistently throughout the state. Examples of best practice crisis services from other jurisdictions include Rescue Crisis in Toledo, Ohio, which has short term stabilization capacity, mobile crisis stabilization teams, and authority to approve or deny psychiatric admissions to both private and public psychiatric facilities.

D. Services for Special Populations

Services for persons with co-occurring mental illness and substance abuse disorders

30 percent of people with mental illness have co-occurring substance abuse. 37 percent of alcohol abusers have mental illness, and 53 percent of drug abusers have mental illness. 40 to 80 percent of individuals seen in mental health treatment settings have substance abuse problems, and over 50 percent of individuals admitted to state psychiatric hospitals have a history of substance abuse. Among homeless adults, 50 percent are active substance abusers, and 30 percent have co-occurring mental illness and substance abuse. Co-occurring disorders are major contributing factors in loss of housing, treatment non-compliance, emergency room use, and re-hospitalization. From these facts it can be seen that *dual diagnosis is the expectation, not the exception*.[33] Further, when mental illness and substance abuse diagnoses co-occur, they both must be treated as the primary diagnosis, not one or the other.

Thus, the public behavioral health system must be prepared and competent to serve individuals with co-occurring disorders in all components of the system, from inpatient to outpatient to community support and rehabilitation services. Services for individuals with co-occurring disorders are not a separate service component requiring distinct staff and new funding resources. Rather, the systems and competencies must be fully embedded in the entire system of care for individuals with serious mental illness.[34]

The technology and competencies necessary to serve individuals with co-occurring disorders have been proven for a considerable period of time over many empirical studies. The essential components are:

- Integrated services coordinating treatment across outpatient, inpatient, and community support/residential service settings;

- Assurance that all integrated service components are welcoming, accessible, continuous, culturally competent, and linked to all other necessary service systems;

- Recognition that recovery is not a linear process, but rather one that must flexibly respond to individual consumer needs for engagement, self-acceptance, active treatment, relapse prevention, and maintenance - abstinence is step-wise, not absolute);

- Use of integrated community support or assertive community treatment teams with dual competencies;

- Continuous system wide co- and cross training; and

- Coordinated, system-wide planning, development, and coordination.

Examples

Arizona has a federal Substance Abuse and Mental Health Services Administration (SAMHSA) Integrated Treatment Consensus Panel grant to support statewide consensus building and technical assistance related to the implementation of best practice integrated dual diagnosis services. Under this grant, the state has received consultation from some of the foremost experts in the field of co-occurring disorders. The anticipated outcome of this process is the development of state policies, practice guidelines, and training curricula to foster implementation of integrated services and competencies throughout the Arizona public behavioral health system. Arizona also has examples of integrated dual diagnosis service programs, most notably the New Arizona Dually Diagnosed Residential Program and the Life Affirming Dual Diagnosis Education and Recovery (LADDER) Program, both located in Maricopa County.

An example of best practice dual diagnosis service models from other jurisdictions is the Caulfield Center, near Boston, Massachusetts. This Center, started by Dr. Kenneth Minkoff,[35] has developed and proven the major tenets of integrated treatment (i.e., definition as lifelong disorders, effective use of rehabilitation models, the need to address stigma, etc.) The program combines substance abuse and mental health treatment on an individualized basis, and is adjusted to both the individual's specific diagnoses and her/his phase of recovery.

In New Hampshire, integrated treatment of individuals presenting with co-occurring disorders is commonplace, and is the expected mode of treatment for the public mental health system for adults.[36] Other examples include several of the McKinney homeless housing demonstration grant sites (i.e., Austin, Texas), the Center for Mental Health Services ACCESS sites (eight states), and the Robert Wood Johnson Program on Mental Illness demonstration sites, particularly those in Columbus (Franklin County) and Cincinnati (Hamilton County), Ohio.

Geriatric services - 15 to 25 percent of elders in the United States suffer from significant symptoms of mental illness. Persons over 65 years of age represent approximately 12 percent of the total population of the United States, yet they account for over 20 percent of the suicides nationwide. Despite these statistics, fewer than four percent of individuals treated in mental health centers nationwide are over 65. And, less than 1.5 percent of the direct costs for treating mental illness in this country are spent on behalf of elders living in the community.[37]

As a proportion of total population, those over 65 are the fastest growing group. This is caused by two factors. First, the substantial burst of population growth in the late 40s and early 50s (the baby boomer generation) results in proportionately higher numbers of individuals who will turn 65 within the next 10 to 15 years. Second, average life expectancies have increased markedly, going from 68.2 years in 1950 to 74.9 years in 1985. By the year 2025, average life expectancies are expected to exceed 85 years, and elders are predicted to comprise over 25 percent of the total population (double their current proportional representation in the general population.)[38]

These trends are particularly important for Arizona, which already has over 15 percent of the population comprised of individuals over 65. Continuing in-migration patterns of retirees, most of whom are over 55 years of age when they arrive in Arizona, will push Arizona far ahead of the national trends in the aging population. Further, many of these new residents have arrived without natural support systems such as nearby family members and long term neighborhood relationships. Many respondents interviewed for this study identified social isolation, substance abuse, spousal abuse, and co-occurring health and mental health problems among elders as among their greatest concerns with regard to the public behavioral health system in the future.

The characteristics of best practice community-based behavioral health include:

~ Integration and coordination with among resources important to elders, particularly primary health care, mental health and substance abuse treatment, and elder services such as homemakers, meals-on-wheels, and visiting nurse services;

~ Active outreach to and engagement among elders, most successfully conducted by peers;

~ Flexibility as opposed to specialization among service providers. The collaborating components of the system must have an attitude of "these individuals belong to us", not "we don't serve that type of person.";

~ Provision of a full array of clinically competent services designed to reduce institutionalization and to support on-going community living and integration. These include mobile services provided in homes and community centers, in-home services with integrated health and behavioral health competencies, and facilitated access to community social and recreational opportunities;

~ Cross training among a variety of practitioners about depression, substance abuse, co-occurring dementia, and other related conditions affecting elders. Primary care physicians are often the primary caregiver and prescriber of psychotropic medications, usually without specialized training, information, and/or consultation;

~ Engagement of natural community supports and those most likely to come in contact with elders, such as the faith community, shop keepers, transportation providers, postal services, etc.; and

~ Advocacy for the rights of elders in the community.[39]

Examples

One coordinated outreach geriatric service program has been implemented in the PGBHA region. This program, called the "Gate Openers" project, is jointly funded by the RBHA and the regional Area Agency on Aging (AAA). Through the coordinated project, local people likely to come in contact with elders (such as postal workers) are trained to identify signs of social isolation, depression, substance abuse, and/or deteriorating health status. If these warning signs are identified, the individual notifies the AAA and the local mental health center, which in turn arrange for outreach and engagement visits to the home. If applicable, treatment services are then arranged through the mental health center and other local caregivers.

The Bazelon Center has identified a number of programs that meet the above criteria for competent and integrated elder behavioral health programming. These include the Elderly Services Program in Spokane, WA, the Older Adult Services Program in Detroit, MI, The Philadelphia Mental Health Corporation in Philadelphia, PA, and Gulf Coast Jewish Family and Mental Health Services in Florida. Other exemplary integrated elder service programs can be found in the Medicaid On Lok replication waiver demonstration programs, which build on the On Lok Elder Services program in San Francisco.

E. Non-Behavioral Health Best Practices Critical to the Preferred Public Behavioral Health System

There is widespread agreement that when housing is permanent

Housing

and flexible, and individualized support services are available as needed, people with serious mental illnesses can achieve and maintain residential stability in the community

People with serious mental illnesses have difficulty locating and maintaining safe, affordable housing for a number of reasons. In addition to the occasionally debilitating symptoms of the illness itself, they often lack adequate income and social supports, and many have co-occurring disorders, including alcohol or other drug problems and acute or chronic physical health problems. They also face the stigma associated with their illnesses and the fears of potential landlords or neighbors. When the competition for low-income housing increases, individuals with mental illnesses may become homeless.

A recent study by the Consortium for Citizens with Disabilities found that in the Phoenix-Mesa Area, a mental health consumer would need to use 84.4 percent of their $494 monthly SSI check to rent an efficiency apartment leaving them with only $77 a month for all other household expenses including food.[40] To rent a one-bedroom apartment in the Phoenix Area, a SSI beneficiary would need to spend 102.2 percent of their monthly income on rent, leaving virtually no funds for other necessary expenses. This scenario is no better in Flagstaff or Tucson, where the percentages are 92.7 percent and 91.9 percent respectively for a one-bedroom apartment.

Many states and counties have addressed this housing issue by developing strategies to build affordable housing capacity or to increase the amount and types of subsidies available to support the housing needs of this population. Local communities have also developed proactive community education programs to combat the stigma of mental illness as a way to deal with the NIMBY - not in my back yard - problem.

There is widespread agreement that when housing is permanent and flexible, and individualized support services are available as needed, people with serious mental illnesses can achieve and maintain residential stability in the community. For persons with mental illness, supported housing offers a safe, viable, more affordable alternative that reaffirms independence and community living. Supported housing is based on the commitment to 1) assert the rights and choices of consumers of mental health services to access affordable, decent, and permanent housing and 2) to develop a flexible and responsive system of community supports that may be accessed by consumers to assist them to maintain independence and quality of life in the community.

A number of factors have contributed to the movement toward supported housing for persons with mental illness:

- de-institutionalization and the shift toward community-based residential alternatives;
- shortcomings of residential or other quasi-institutional settings in moving people with psychiatric disabilities toward independence;
- increasing pressures to manage inpatient utilization and costs;
- the increase in homelessness among individuals with mental illness; and
- the growing strength and recognition of the consumer empowerment movement, family advocacy organizations (AMI), and homeless advocates.

These contributing factors provide the rationale for a movement towards supported housing, but there often still exists a gap in the service array for persons with mental illness. In order to fill these gaps in the service array, progressive systems of care should attempt to provide independent living alternatives. This requires a set of core service capacities that sharply contrast with traditional mental health services and service delivery. Thus, a movement to development of supportive housing often involves a significant reorganization of existing services. Some key components of the service array

should include home-based services, natural community supports, housing-related activities (e.g., owner outreach and housing search), and developing a flexible and readily available safety net, such as respite and mobile crisis services, assistance with access to financial subsidies for housing costs, daily living expenses and health care. This requires leadership at the local and state level to encourage and support this change, to re-prioritize programs and services and to build consensus around these new priorities. These changes may come at a cost to current services and programs either through re-deployment of staff and program dollars, or, in some cases, complete program elimination.

Examples of best practice in supported housing include the Vera French Housing Development Corporation in Davenport, IA; Baltimore Community Housing Associates in Baltimore, MD; and the Supported Housing Development Initiative sponsored by the Michigan Housing Development Authority.

Employment

A 1972 study found that less than 30 percent of individuals with serious and persistent illness ever work.[41] More recently, a 1998 study found that less than 12 percent of persons with schizophrenia or bi-polar disorder obtained jobs in the competitive sector, even after finding training in job-finding skills.[42] Even using "place-then-train" supported employment approaches, about 50 percent of persons with serious mental illness obtain competitive employment. Only one-half of those who secure competitive employment remain employed in the same jobs six months later.[43]

The above reports paint a dreary picture of employment prospects for people with serious mental illness. This picture is in stark contrast to the wishes of consumers themselves, who almost always list satisfying employment among their top two to three life goals. It is also in stark contrast to the vision of recovery and rehabilitation that has been presented as best practice in this report.

Despite the strong desire to work on the part of consumers, plus the known benefits of employment to most individual's personal recovery process, there remain many barriers to achieving competitive employment for people with mental illness. First, gainful employment often results in a loss of benefits, particularly Medicaid coverage, which is essential for most individuals to maintain access to medications and needed community supports.[44] Second, stigma and lack of understanding often create barriers to people with mental illness attempting to enter the competitive workplace. Third, the current structure and process of publicly funded vocational rehabilitation services often do not match the individual processes and timeframes necessary to successfully move into employment for some people with mental illness. Very often, individuals lose on the job supports after the federal vocational rehabilitation service package has been used up, and the behavioral health system does not provide sufficient follow-along services.

The technology of successful supported employment programs is well documented. It includes:[46]

- Assuring consideration of individual's interests, abilities, and goals in selecting jobs;
- Early intervention efforts designed to assist people to return to work as soon as possible after the onset of a psychiatric disability;
- Strategies that focus on getting people into the workplace and then training on the job, rather than spending time in pre-employment training;
- Strategies that match individuals' education and skill levels with employment opportunities. People with mental illness do not have to work only in minimum wage, service sector jobs;

~ Provision of a range of on-going services and supports to assist people to work and interact effectively in the workplace;

~ Flexibility in work expectations during periods of acute exacerbation of the mental illness;

~ Provision of a range of work experiences including short term job tryouts, on the job training, and part time jobs;

~ Provision of a range of other satisfying and productive activities, including education and volunteer activities;

~ Assuring that all components of the public behavioral health system provide sufficient employment opportunities[46] for current and former consumers; and

~ Establishment of multi-disciplinary teams to blend vocational supports with other clinical and community supports.

These attributes of successful supported employment programs do not have to be contained in separate and discrete employment service program components. A variety of approaches have been used, including the ACT team model, expanded clubhouse programs, and consumer operated models. In fact, recent experience has shown that all program elements should be focused on supporting individuals in moving towards their choice of productive activity, and then providing sufficient supports to maintain the productive activity.

Arizona and many other states make good use of federal Vocational Rehabilitation Act funds by (1) developing state-level and local agreements with the vocational rehabilitation agency(ies); and (b) by contributing matching funds to draw down the federal dollars. These agreements can be very effective, but in Arizona local implementation has been sporadic. Local success depends on two interlocking strategies. First, it is necessary to engage the local vocational rehabilitation (VR) staff as equal partners in employment service planning and development.[47] Second, the local behavioral health system must develop mechanisms and processes to dovetail behavioral health funds with locally administered VR funds. This is particularly important for follow along services after the VR resources have been used to their fullest extent.

Several RBHAs in Arizona reported good rapport with the local VR offices. This also appeared true at the state level. These existing relationships provide a good model for expanding coordinated VR and behavioral health services throughout the state. As the behavioral health system in Arizona moves more towards recovery and rehabilitation services, and emphasizes consumer operated and peer support services, the service and support capacity for effective coordinated employment services will be in place. Once this service and support capacity is in place, the more targeted VR funding can be used to its best advantage.

States such as Wisconsin and New Hampshire have emphasized employment for several years, and have had some positive successes. In New Hampshire, increasing the number of individuals with serious mental illness in competitive employment has been a priority for many years. The state sets performance targets and measures each community mental health center against them. This had the effect of having all local service components working towards the same goal - to see that consumers found and kept competitive employment or other productive activity of their choice. In Wisconsin, state behavioral health dollars have been used to match federal VR funds to create VR capacity in rural areas. The behavioral health system then uses ACT teams to provide all the pre and post employment services and supports that are not provided through VR funding. In several jurisdictions in Michigan, VR staffing and equipment grants have been used to enhance the capacity of psychosocial clubhouses to provide meaningful training and employment experiences that are

relevant to the local employment marketplace.

G. Organizational Excellence

This report contains considerable discussion of public behavioral health best practices and preferred systems for adults and children in Arizona. However, best practices cannot be implemented, and certainly cannot thrive, without considerable organizational support. At all levels of the system the organizational and administrative infrastructure must not only support best practices - it must become the source of energy and direction for continuous improvement of best practices.

What are the elements of and criteria for organizational excellence and best practice? The following are some important examples:

~ Customer orientation, including governance by consumers, family members, and other stakeholders;

~ Clear leadership with authority that equals accountability;

~ Consumer-driven mission;

~ Effective advocacy for the mission of the organization and for the larger public behavioral health system;

~ A learning organization - one that remains open to change, willing to learn, anxious to improve, able to take risks;

~ Emphasis on integration, collaboration and coordination

~ Emphasis on outcomes and performance versus process and regulation

~ Creative and flexible use of resources

~ Public accountability; and

~ Efficient and effective use of public resources

- Minimal costs for administration and compliance versus delivery and quality
- Information for management and decision-support
- Consumer-based outcome and performance measurement
- Quality improvement/quality management
- Adequate and competent human resources
- Cultural competence
- Appropriate incentives for performance

At all levels of the system the organizational and administrative infrastructure must not only support best practices - it must become the source of energy and direction for continuous improvement of best practices.

All organizational entities within the public behavioral health system, from state agencies to RBHAs to

provider agencies to consumer-operated services, should hold themselves accountable for attaining the level of organizational excellence described by these criteria. In addition, there are certain key management capacities and functions that are critical to the change process in Arizona. That is, the functions provide ongoing motivation and sense of direction for the process of continuously improving the quality, efficiency, and effectiveness of public behavioral health services in Arizona. These functions and capacities are:

Meaningful inclusion of consumers and family members at all levels and in all functions within the public behavioral health system - This includes:

~ engagement of consumers and families in the overall governance and policy development functions of public and private behavioral health organizations in the system;

~ involvement of consumers and families in program planning and development, quality improvement, and program evaluation functions;

~ hiring consumers and families to train managers and practitioners throughout the system; and

~ hiring consumers and family members to be employees of the system - to function as real employees in real jobs, and not limited to performing "consumer representative" functions.

Consistent implementation of utilization management criteria and evidence-based clinical protocols and clinical pathways - This means taking many of the good, evidence-based clinical guidelines and practices developed at the state level, and translating them into actual practice in the field. It also means translating those guidelines into uniform utilization management criteria for service access and continuing stay, and then monitoring actual utilization against the criteria. It means expanding the use of clinical protocols and clinical pathways to assure that consumers presenting with certain conditions receive the best and most cost efficient treatment and supports. Finally, it means conducting regular training throughout the system to assure that all service managers and practitioners understand the utilization management criteria and clinical protocols (including ALFA), and apply them consistently.

Assurance of cultural and linguistic competence throughout the system - Given the cultural and linguistic diversity of Arizona, it is not surprising that positive efforts have been made to attain cultural and linguistic competence and relevance in the public behavioral health system. The next essential step is to incorporate culturally competent practices as part of all best practices, with unique features for addressing some of the prominent cultural issues, such as:

~ Role of family, including extended family;

~ Use of reference groups, including civic, religious and cultural institutions outside the mental health community;

~ Proficiency in the language of, and in communication with, consumers; and

~ Respect for different cultural practices of consumers in designing service interventions.

Implementation of consistent and comprehensive continuous quality improvement practices grounded in consumer-based outcomes, satisfaction and performance measures in each major component of the system - The cornerstone of the whole change and improvement process

is continuous quality improvement (CQI). CQI becomes the organizational force to:

1. assure that evidence-based best practices are implemented as intended;

2. assure that the implementation of such best practices has the desired effect in terms of beneficial outcomes for consumers and families in a cost effective manner;

3. identify and overcome organizational barriers to quality and effectiveness in working with primary and secondary customers of services; and

4. assure constant learning and consequent re-shaping and re-vitalization of best practices within the organization.

CQI assures that, long after the current crop of experts is gone, the organizations and the system continue to learn, grow, change, and find new and better ways to carry out their mission in the public behavioral health sector. The essential components of an effective continuous quality improvement system include:

~ Equal commitment from both top leadership and line staff to constant improvements to the quality and effectiveness of the organization and its services;

~ Assignment of responsibility for CQI to a single point of accountability within the organization with the resources and the authority to make sure the process is implemented and that there is follow-through on CQI activities;

~ Consistent and substantive engagement of consumers and families in all aspects of the CQI process;

~ Basing CQI activities and strategies on empirical data that include information on consumer outcomes and satisfaction; and

~ Completion of an annual evaluation of the CQI process to document: (a) specific improvements implemented; (b) benefits derived by consumers and families from the improvements; and (c) identification of priority CQI activities for the coming year.

Examples

Arizona exhibits a number of promising administrative practices, some at the state level, and some at the regional level.

For example, the widely dispersed and rural NARBHA region is now connected through an efficient and effective telecommunications network. Several RBHAs now use performance contracts with performance incentives built in. PGBHA has implemented a good model of utilization management and service access guidelines that is both flexible and individualized and also reflective of both clinical levels of functioning and the costs of various combinations of service packages. The Excel Group successfully experimented with the use of mobile clinical outreach offices to provide convenient services in rural locations, and is now seeking permanent sources of funding to continue their operations. The Excel Group has also developed good models for attaining cultural competence, both through extensive staff recruitment and training, and through the modes of service delivery in certain areas. Finally, the coordinated efforts of many of the RBHAs to attain JCAHO accreditation as managed behavioral healthcare organizations could result in better and more consistent application of clinical standards and quality management practices throughout the state,

At the state level, the Arizona level of functioning assessment (ALFA) and a number of clinical protocols and guidelines have been identified as evidence of promising practices. The state has also been aggressive in seeking federal grants to enhance system development, and is in the process of developing improved dual diagnosis services and substance abuse service outcome measurement under two examples of these grants. The state is also in the process of implementing a new quality assurance process, to be supported by an improved management information system.

Issues

As with many state public behavioral health systems, there remain a number of important organizational problems and issues that must be addressed if the system is to continue to move towards best practices. These include:

~ The Arizona system needs to be more consumer and family driven. There are few formal efforts to organize and empower families and consumers or include them in governance, planning, policy development, quality management or performance evaluation.

~ There needs to be a clear and cohesive vision of what Arizona's mental health system should be at all levels of the system. There is no multi-year budget or strategic business plan that brings all the elements of the system together. There does not appear to be a commonly understood definition of the horizon towards which all components of the service system should be moving.

~ Access to public mental health services needs to be improved. There are dual systems of care for both adults and children, one for Medicaid enrollees and adults with serious mental illness, and another less generous system for all others, including non-Medicaid but indigent children in need of services. Also, as noted earlier in this report, there are substantial inconsistencies in per capita resources and penetration rates throughout the state. These inconsistencies are indicators of unequal access to consistently delivered services for all citizens of Arizona.

~ There needs to be formal mechanisms to connect policy and knowledge to local practice/service delivery. Good clinical practices and guidelines are not yet consistently implemented at the service delivery level because there is no over-all training plan and strategy and few performance incentives for adopting best practices.

~ There needs to be effective linkages between primary care and behavioral health care. RBHAs and stakeholders reported difficulty referring clients and adequately sharing information among health care professionals. There are no structures or processes required by the state in contracts with either HMOs or RBHAs that foster and enforce meaningful or effective integration and collaboration between the primary health care and behavioral health systems.

~ There needs to be better linkage and integration between the behavioral health system and other important sources of resources and services for priority consumers. Despite numerous intergovernmental agreements at the state level, coordination of resources and access to services with school systems, adult and juvenile justice systems, and affordable housing and vocational service systems remain inconsistent. Partially as a result of poor linkages, the supply of integrated services, particularly affordable housing and modern supported employment services, is relatively low.

[14] Friedman, Robert M., et al. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996, pp.71-89.

[15] For example, see DeVane CL, Sallee, FR. Serotonin Selective Reuptake Inhibitors in Child and Adolescent Psychopharmacology: A Review of the Current Literature. Journal of Clinical Psychiatry 57:55-66. 1996 and Constantino, JN, Liberman M, and Kincaid M. Effects of Serotonin Reuptake Inhibitors on Aggressive Behavior in Psychiatrically Hospitalized Adolescents: Results of an Open Trial. Journal of Child and Adolescent Psychopharmacology 7:31-44, 1997

[16] Arizona has published evidence-based clinical guidelines for these and other SED conditions.

[17] Across all social and economic strata.

[18] Hodges, K. Manual for the Child and Adolescent Functional Assessment Scale. Unpublished manuscript, Department of Psychology, Eastern Michigan University, 2140 Old Earhart Road, Ann Arbor, Michigan 48105,1990.

[19] Kirk, R., Reed, K, and Lin, A., North Carolina Family Functional Scale, Center for Human Services Lab, University of North Carolina at Chapel Hill, North Carolina, 1997.

[20] Achenbach, T.M. Child Behavior Checklist for Ages 4-18, University of Vermont, 1 S Prospect St., Burlington, VT 05401, 1991.

[21] For additional information, contact Dr. Alice Lin of Technical Assistance Collaborative, Inc., One Center Plaza, Suite 310, Boston, MA 02108.

[22] For example, one agency in North Carolina put its own child serving mental health clinic out of business because it could purchase better and more flexible services in the marketplace.

[23] For example, see Fisher, Daniel M., MD. Empowerment and Rehabilitation: Boston University Center for Psychiatric Rehabilitation; Coping and Recovery: Ralph, Ruth, Ph.D., et. al.; Recovery Issues in a Consumer Developed Evaluation of the Mental Health System Proceedings - Fifth Annual Conference on Mental Health Services Research and Evaluation, Arlington, VA February, 1996

[24] For example, see Sproul, B. A., Models of Community Support Services: Approaches to Helping Persons with Long Term Mental Illness NIMH August, 1986

[25] Anthony, William A. Recovery from Mental Illness: the guiding Vision of the Mental Health Service System in the 90s Psychosocial Rehabilitation Journal 16(4) April 1993

[26] Kuehnel TG, Liberman RP, and Backer TE. Psychiatric Rehabilitation: Competencies for Mental Health Workers Center for Improving Mental Health Systems, Northridge, CA 1997. p. 85

[27] The International Center for Clubhouse Development in New York City is the clearinghouse for information on psychosocial clubhouses.

[28] Allness, Deborah and Knoedler, William, Recommended [P]ACT Standards for New Teams Revised 3/31/99. p. 1

[29] Allness, Ibid. p. 7

[30] These standards have been synthesized from managed behavioral health contracts, public sector managed behavioral health care utilization management guidelines and clinical protocols, and

All organizational entities within the public behavioral health system, from state agencies to RBHAs to provider agencies to consumer-operated services, should hold themselves accountable for attaining the level of organizational excellence described by these criteria.

discussions with leaders in public managed behavioral health care in Arizona and other jurisdictions.

[31] McEvoy, Ibid. p. 12

[32] These guidelines can be obtained from the University of Pennsylvania School of Medicine, Center for Mental Health Policy and Services Research 3600 Market Street, Philadelphia, PA 20742.

[33] These data were synthesized from the environmental catchment area (ECA) studies, and published articles by Osher, Drake, Test, and Minkoff

[34] Minkoff, Kenneth. Presentation to the National Community Behavioral Health Directors, St. Louis, July, 1999

[35] Dr. Minkoff is a national expert on dual diagnosis services, and is the primary consultant to Arizona under the SAMHSA Integrated Treatment Consensus Panel Grant.

[36] New Hampshire is the home state of Robert Drake, MD, who, along with Dr. Minkoff has been a leading pioneer in dual diagnosis services delivery and research.

[37] These facts were extracted from a literature review conducted by the American Psychiatric Association, 1998

[38] Bazelon Center. At Home: Strategies for Serving Older People with Mental Disabilities in the Community. Washington, DC, 1995

[39] Ibid.

[40] Priced Out: The Housing Crisis for People with Disabilities. Consortium for Citizens with Disabilities Housing Task Force. Technical Assistance Collaborative, Inc. March 1999.

[41] Anthony WA, Buell GJ, Sharrett S, et. al. The Efficacy of Psychiatric Rehabilitation Psychological Bulletin 78:447-456, 1972

[42] Liberman RP and Mintz J. Psychopathology and the Ability to Work Unpublished, June 1998 (Quoted in Wallace CJ, Tauber R, and Wolde J. Teaching Fundamental Workplace Skills to Persons with Serious Mental Illness Psychiatric Services 50(9):1147-1153)

[43] Drake RE and Becker DR. The Individual Place and Support Model of Supported Employment Psychiatric Services 47:473-475 1996

[44] Note: if the Work Incentives Act is enacted by Congress, this barrier could be mitigated in the future.

[45] The following were extracted from a National Technical Assistance Center for Mental Health Planning publication on supported employment published in 1999.

[46] Some public behavioral health systems have made the mistake of employing consumers only as "consumer advocates" or representatives. While these roles are necessary and productive, consumers should also be employed as case managers, administrative staff, and any other functions that meet their skills, education level, and choices.

[47] Occasionally these local VR staff need to be reminded by their state administrators of their responsibilities to serve individuals with serious mental illness.

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IV. STATE PUBLIC BEHAVIORAL HEALTH PROGRAMS THAT EXEMPLIFY BEST PRACTICES

In the previous sections of this report a series of specific best practices have been identified related to child and family services, adult services, and administrative practices. Specific state and local examples have been provided as well, representing best practice models from both Arizona and other jurisdictions. The question that remains is this: Are there states where all the pieces come together? Are there states in which best practices have been implemented throughout all parts and all locations of the administrative and service delivery components that comprise the public behavioral health system in that state?

Are there states in which best practices have been implemented throughout all parts and all locations of the administrative and service delivery components that comprise the public behavioral health system in that state?

The answer is: not entirely. Nonetheless...

The answer is: not entirely. Nonetheless, there are several states that exemplify system-wide progress towards a vision of best practice - that have implemented all the necessary capacities and competencies to move the system in the right direction. In these states, although not all best practice standards are met in all local jurisdictions, examples of best practice are the rule rather than the exception. *The states that come closest to meeting the vision of best practice in public behavioral health care are Colorado, New Hampshire, Ohio, Rhode Island, Wisconsin, and Vermont.*

From among all the various best practice models and examples outlined in this report, what are the essential characteristics that have assisted these states to move towards best practice? The following is a summary of common elements in those states that have moved most successfully towards best practice:

1. There has been strong and consistent leadership that has articulated a vision and has forged consensus and momentum for implementing that vision.

2. The vision articulated by leadership incorporates the concepts of recovery, consumer self-determination and choice, self-sufficiency, community and family-based services; and empowerment of consumers, families and staff to be creative, flexible and also accountable for local service delivery.

3. Information about mental illness and emotional disability is made widely available to the general community; stigma and prejudice are publicly confronted when they become evident; and the vision and mission of the public behavioral health system are espoused constantly in all available forums.

4. Consumers and families are engaged and involved in all aspects of the public behavioral health system, from governance and policy development through planning and program development to quality management and system evaluation. Consumers and families in those states have become the most effective advocates for the vision and mission of the public behavioral health system. They have also provided the motivation and momentum for the change process.

5. Local systems of care have been developed, and these local systems have the requisite clinical and financial authority and accountability to carry out the statewide vision and mission in ways that are reflective of local conditions and needs. These local systems can be non-profit, for profit, quasi- governmental, county-based or multi-county programs.

6. Information gleaned from a variety of data sources is used to drive system planning, budgeting, and quality management and performance evaluation. In the above states,

decisions are made at all levels based on consistent analysis and interpretations of accurate and timely data. Included in the information analyzed is literature describing evidence-based best practices from other jurisdictions as well as information generated from within the state's own systems.

7. An organizational culture that fosters and supports constant learning, change, challenging of sacred principles, and trying out new ideas has been created throughout the public behavioral health system.

In the above list of characteristics there is no mention of service types, financing levels or approaches, clinical technologies, or requirements for organizational models. Rather, the list incorporates attributes that move these systems towards excellence and responsiveness as a context for the details of service provision. Specific best practices related to service models and treatment models will continue to evolve and change. Public behavioral health systems that embody the above characteristics will be in the best position to implement specific changes. In fact, it is systems that have the above attributes that most often will generate new and improved ways of meeting consumer and family needs and choices in the most cost effective and accountable manner.

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V. RECOMMENDATIONS: STRATEGIES FOR CHANGE

This report has identified specific strengths and deficiencies in how the State of Arizona funds and provides care to children and adults with mental illness. In many ways, identifying these attributes of the state's mental health system is the easy work. The more difficult challenge is how to use this information to create change that provides immediate and lasting benefits to people with mental illness, their families, and the citizens of Arizona. Now that Arizona has implemented the structure of a managed public behavioral health system, the content of that system can be further addressed. Many of the immediate steps require no new resources, but they do require a commitment at all levels and among all constituents of the system to reexamine core values and benefits, create a culture for change, and continue to seek excellence. This should be accomplished in a spirit of openness, collaboration, willingness to challenge and be challenged, and willingness to take risks. The strategies for change contained in this section of the report attempt to do just that.

In many ways, identifying these attributes of the state's mental health system is the easy work.

It is virtually impossible, and a poor use of the state's limited financial and human resources, to attempt to "fix everything" or create "wholesale" change in Arizona's mental health system. Rather than take a wholesale approach to change, we would encourage the state to be more strategic in how to use the valuable and scarce resources it has to leverage change where it will dramatically improve care and provide leadership for ongoing policy and program advancements. Our analysis of the Arizona system has identified several of these key strategic areas: *The Integration of Primary and Behavioral Healthcare; Creating a Defined Benefits Package for People with Mental Illness; Resolving the Arnold v. Sarn Court Case; and Creating a Culture for Change.*

A. The Integration of Primary and Behavioral Healthcare

Since 1990, Arizona has implemented a behavioral health care carve-out program through its RBHAs on the heels of the state's implementation of a Medicaid waiver program AHCCCS. The development of a behavioral health care carve-out in Arizona, as in several other states, means that there is a fundamental separation of physical healthcare from behavioral healthcare despite growing evidence of co- morbid conditions among people with serious mental illness. In Arizona, some integration efforts have been initiated, but to date they have not been linked to state-level policy and funding practices, and thus have had only limited impact.

While complete integration of physical and behavioral healthcare may not be the answer for Arizona, it is apparent that some effort is needed to provide both structural and functional integration of primary and behavioral healthcare. Recent discussions among ADHS, AHCCCS, RBHAs and the Medical Association have highlighted the complexity of forging integration between primary and behavioral health care. To effectively deal with the complete health status of individuals with mental illness in Arizona, this issue must be examined and strategies developed which bring new direction to this issue.

How should integration between primary care and behavioral health care be achieved?

There are at least three levels of integration:

1. **On the individual consumer level -** it is important to recognize the mind-body connection, with timely identification of psychosomatic symptoms and treatment, and addressing co-morbidity of health and behavioral health issues. Preventive care and wellness services should be coordinated to reduce the incidence of mental illnesses, along with ongoing collaboration on

treating those with chronic and serious mental illnesses to provide the most effective and efficient care.

2. **On the discipline level -** interaction is fostered between PCPs and psychiatrists, various disciplines within physical medicine, and behavioral health disciplines. There needs to be mutual understanding and appreciation of what both generalists and specialists have to offer, and special protocols for referrals and follow-through.

3. **On the systems level -** collaboration between physical health and behavioral health is ensured, and among provider networks there are inter- and intra-network coordination and collaboration. Boundary management between plans is also part of the system level integration.

Given these levels of integration, design options for an integrated service could aim at one of two types of integration:

~ *Structural integration:* In this design option, structurally all primary and behavioral health services are accountable to the same entity; or

~ *Functional integration:* In this model, structures may be separate, but functional integration is clearly articulated with accountability built in for both primary care and behavioral health care.

To this end, we recommend that:

~ AHCCCS and BHS should jointly develop program specifications for the structural and functional integration of primary and behavioral healthcare. These specifications should detail how integration can be supported at the policy level (state agencies), program level (RBHAs and HMOs), and the client level (primary care physician and therapist/case manager). These program specifications should also provide the criteria by which successful integration can be measured and monitored.

~ With these program specifications in place, both agencies should develop and implement several pilot projects that can test the efficacy of these structural and functional integration healthcare models within Arizona. RHBAs, HMOs and other health care providers and insurers should be encouraged to develop ideas and initiatives through these pilot projects. A prudent approach is to sponsor two pilots, one urban and one rural, for an integrated plan that structurally and functionally integrates primary care and behavioral health care. Allow all interested parties to apply, including both public and private organizations.

~ Allow sufficient time for these models to be tested and for the results to be processed through an independent evaluation process.

~ Use the information from these pilots to suggest further structural and functional integrative strategies that can be formalized throughout the system of care.

Models of integrated primary care with behavioral health care can be found in limited private managed care plans. For example, the Northern California Kaiser-Permanente Plan has attempted to achieve primary care/behavioral health care integration through a combination of structural and functional integration, such as:[48]

~ Case finding integration-early identification of problems that require either medical or psychiatric interventions;

~ Specialized program-place specialists in the primary care setting, such as addiction treatment in OB/GYN clinics for pregnant women;

~ On-site integration-place personnel from primary care and behavioral health care in one physical location;

~ Behavioral health education- provide practice guidelines to PCPs through organized classes, as well as ongoing communication channels; and

~ Data system-share knowledge between providers through a Clinical Information Presentation System.

Another example of integrated primary care and behavioral health care can be found in group practice models such as Allina Health System in Minnesota.[49] In this not-for-profit regional model, the group practice consists of 550 PCP providers working in Allina-owned clinics in 40 communities, with one million subscribers. Methods of integration include:

~ Site-based integration-add behavioral health professionals to the primary care setting when a "critical mass" is reached;

~ Multi-specialty group practice-restructure the primary care practice into multi-specialty practice, including behavioral health; and

~ Ongoing communication-focus on integration of practices at the delivery level.

B. Changes in the Regulation and Delivery of Benefits for People with Mental Illness or Emotional Disturbance

The Arizona mental health system is complex. There are various categories of eligibility and different service benefits, depending on eligibility and various funding streams used to support these benefits. In many respects, what one gets from the state's mental health system is a product of what one is financially eligible for rather than what may be needed. This has created in Arizona a confusing system that provides unequal access to care.

In the past, efforts to re-shape Arizona's mental health system have focused on the structural aspects of the system- eligibility, financing, regional authorities, and levels of care. While these are important aspects of the system of care, there has been a little attention on content-what do people get? When do they get it? And, does it work?

As has been stressed throughout this report, the basic structure and financing to manage public behavioral health care in Arizona is in place. This recommendation focuses on strengthening the content of Arizona's mental health system by examining the methods and modalities through which flexible, individualized, and recovery- and family- oriented services are made available to people with mental illness.

To strengthen the content of the state's mental health system we recommend the following:

Implement a Truly Flexible and Individualized Service Benefit Package through De-Regulation at the State Level and Performance Measurement Based on Consumer Outcomes Rather than Process Assessment.

As noted throughout this report, Arizona's behavioral health system is overly complex, rigid, and un-coordinated at the level of state policy and financing. *The state, the RBHAs, service practitioners and providers, and consumers and families would all benefit from de-regulation of the entire system.* This means that the state would get out of the business of defining how services are to be delivered, but would focus instead on the outcomes of services delivered. The recent RFP and subsequent contract for the new RBHA in Maricopa County contain examples of steps in the right direction. However, considerable effort remains to change the culture of over- regulation and process orientation in the system, and then to act on that change in culture through massive reductions in regulatory requirements and financial restrictions.

The more difficult challenge is how to use this information to create change that provides immediate and lasting benefits to people with mental illness, their families, and the citizens of Arizona.

A task force comprised of consumers, families, behavioral health professionals, and state and RBHA managers should be convened to accomplish this task. The task force should be charged with the responsibility to review all regulations and funding requirements, assess the purposes of such regulations and requirements in terms of specific benefits to consumers, and then recommend outcome and performance measures that would assure the same positive benefits are being attained in the absence of regulations. To be effective, the state must empower this task force to make recommendations for significant changes. The state must also make a commitment to do everything in its power to implement the recommendations of the task force.

In the context of reviewing de-regulation options and approaches, the task force should also review current access standards and outcome measures that either support or detract from the flexible, individualized, equitable and clinically appropriate utilization of services across the state. The task force should make recommendations to the field for the adoption of aggressive care management strategies that can improve equitable access to care and appropriate utilization.

In addition to the above recommendations regarding the content of the behavioral health system, there are several structural changes needed in the Arizona mental health system to reduce the rising pressure that is being placed on the limited amount of funds available to provide behavioral health services to those not eligible for AHCCCS or SMI services. This is an area of great concern that can be partially resolved through the following recommendations:

Raise TANF Eligibility

The current eligibility threshold for AHCCCS coverage for Transitional Assistance for Needy Families (TANF) is 33 percent of the state's poverty rate. This is an extremely low rate-one of the lowest in the country. It creates a gap in eligibility for health coverage under the AHCCCS program. This has been a long-standing issue in Arizona that has generated significant public policy interest. In 1996 this issue was brought to the voters in the form of the Proposition 203 referendum to raise the eligibility rate to 100 percent of the state's federal poverty level. Proposition 203 was approved by the voters but was never implemented.

We recommend that the eligibility rate for TANF be raised to 100 percent of the state's federal poverty level to provide health coverage to this population now under served by the state's behavioral health care system.

Increase Enrollment under CHIP Program

The Child Health Insurance Program (CHIP)-Arizona KidsCare-is being implemented in Arizona through the state's AHCCCS Program. This program provides health insurance to children who are not eligible for coverage under the traditional AHCCCS benefit categories. The KidsCare Program includes good coverage for behavioral health services.

We recommend that the state continue to improve the current outreach and engagement strategy to enroll families in this important program. In doing so, the state will close another gap in coverage for behavioral health services. This will reduce the number of people who are to be served with the limited amount of funds set aside for those not under the AHCCCS or SMI program. Further, recent budget action notwithstanding, reductions to state appropriations for indigent care for children and families should not be reduced based on assumed savings from the KidsCare program.

C. Resolve Arnold v. Sarn

The State of Arizona has been under a court order, *Arnold v. Sarn*, since 1991. This case has stipulated the development of a comprehensive community mental health system in Maricopa County to prevent unnecessary and inappropriate hospitalization of those diagnosed as having serious mental illness, and to meet other requirements as set forth in the court order. Eight years after the signing of the order, there has been much progress, but the state is no closer to satisfying the requirements, even though considerable resources have been expended, and more are to be requested in future years.

The Arnold v. Sarn case has consumed time, energy and leadership, leaving little of each to deal with the many overarching policy, program and fiscal needs of the state's mental health system. It is fair to describe the current sentiment surrounding Arnold v. Sarn as one of mutual frustration on all sides, with insufficient progress to show to date for satisfying the court order. There is also a lack of understanding of whether services delivered are indeed worth the expenditure.

It is time for a concerted course of action by all parties to resolve the outstanding issues in this case. We recommend the following actions:

1. Establish a court order unit in the state agency with sole responsibility for overseeing its implementation, including:

   ~ Identification of issues for resolution; troubleshooting and expediting;

   ~ Developing proactive initiatives to modify standards and procedures, to gain back policy control of the programs and services;

   ~ Monitoring of progress of compliance; and

   ~ Reporting to key stakeholders on the progress.

2. Reexamine aspects of the court order in which modifications are necessary:

   The field has changed since 1991 when the order was issued. Certain clinical and program requirements should be revisited for modification. More immediately required is reexamination of the clinical case management team recommended by the court monitor's office.

3. Implement the core benefit package described above for public behavioral health that applies to all who have been found in need of services:

   This step will address the current inequities in the system and the negative impacts of the court order. There should be a basic core benefits package for all seriously mentally ill adults, whether or not they are Medicaid eligible. Similarly,

there should be a core benefit for children with serious emotional disturbances and a sound early intervention strategy for children at risk.

4. Instill a commitment for quality management in the public behavioral health system:

   Ultimately the best assurance for not only fulfilling court order requirements but also avoiding future litigation is to "do the right thing" for all consumers served by the public system. A system that is dedicated to improving quality will be a proactive system, in which judicial interventions will become unnecessary.

D. Creating a Culture for Change

What is most problematic in Arizona is a pervasive spirit that only limited success or change is possible within the state's public mental health system. Throughout our review we were struck by how many good people with good intentions felt powerless to change the state's system of care. While many good programs and services are being provided, there are few opportunities to share success or .learn from others. In many ways it is a system where every provider and every RHBA is on its own to succeed or fail, and the failures of past providers and RBHAs remain as vivid reminders of what could happen to those that strive to move the system forward.

In mental health systems such as this, it is often easier for participants to look for someone to blame, rather than for someone to provide leadership. Where leaders do exist they may have a hard time gaining followers, or be viewed as troublemakers by those in positions of power. What often develops in these systems is a culture of blame, rather than a culture of change.

Arizona is in need of a new culture within its mental health system. This new culture must support a learning environment conducive to change. The new culture must seek and foster innovation in programs and create an atmosphere that encourages and promotes recovery for consumers of mental health services. Creating this culture cannot be left to government or local officials. Rather, it is the responsibility of all of those with an investment in Arizona's behavioral health system to create the climate for and the culture for change.

To foster this climate and culture change, we recommend the creation of the Arizona Behavioral Health Institute. The institute cannot change the culture by itself, but it can provide a focal point for discussion, action and leadership that can begin the process of culture change. The mission of this institute would be simple: to improve behavioral health and behavioral health care in Arizona. The institute would pursue this mission by providing programs, services and leadership in a variety of new initiatives targeted at the state, regional and local level.

The state, the RBHAs, service practitioners and providers, and consumers and families would all benefit from de-regulation of the entire system.

The institute would be governed by a broad coalition made up of the key constituencies within Arizona's mental health community. It could be housed in a university or similar institution or be freestanding. Its revenues would come in many forms, including program fees, grants and operating support from the state and federal government.

While the Institute could pursue a variety of activities, core activities of the Institute should include the following:

1. **Leadership Forum -** A regular forum for key behavioral health leaders to meet, discuss and plan for innovative changes in the state's system of care. These meetings would not be forums to discuss current business, but rather opportunities to think collectively about pioneering changes in direction. The Leadership Forum could also be used as a structure for developing new leaders, including consumer leaders from within the mental health system.

2. **Training -** The Institute would develop and offer training programs to support the human resources development needs of the public mental health system. These training programs would include competency-based training to meet credentialing requirements, as well as training in support of new models of service delivery or concepts of rehabilitation and recovery.

3. **Information Dissemination -** The Institute would provide a vehicle for disseminating information about promising programs and initiatives within Arizona's mental health system. Information could be targeted to specific audiences (consumers, family members, and clinicians) or be organized around specific topical areas such as housing, clinical advancements, or emerging best practices.

4. **Technical Assistance -** The Institute would develop the capacity to provide a variety of technical assistance to aid the state, RBHAs and providers with critical issues in the delivery of care. The technical assistance could be in the form of conferences, newsletters, manuals, or on-site problem solving.

5. **Evaluation -** The Institute would develop the capacity to provide independent evaluations of programs and services. This evaluation capacity could be used to evaluate pilot programs or to undertake special studies on specific aspects of the public mental health system.

6. **Quality Management Council**

The Institute would form a quality management council to regularly analyze and distribute quality indicator information about Arizona's public mental health system. The Quality Management Council would also use this information to suggest key policy and program changes to seek improvement in the quality of care.

E. Strategies for Change: The Role of the St. Luke's Charitable Health Trust

St. Luke's Charitable Health Trust has begun to provide leadership in efforts to improve mental health services in Arizona. These efforts include underwriting this study as well as the formation and operation of the Mental Health Dissemination Network of Arizona. These are important and valued contributions, but the Trust can also have an important role in fostering the strategies for change contained in this report."

Funding

The Trust should not be viewed as a funder of direct care. This is clearly a government responsibility. However, the Trust can use its limited funds as venture capital for new initiatives, such as to provide planning grants or seed money for pilot projects (primary care integration) and initiatives. Funding should be directed to those areas where new knowledge, models and ideas can be generated and shared with the larger mental health community. Funds can also be used as leverage to obtain other larger funding from government or other foundations interested in participating in these new models. The Trust can also help to sponsor the formation of the Institute referenced above.

Evaluation

It is appropriate for St. Luke's Charitable Health Trust to sponsor an evaluation study of the results of the some of the strategic changes referenced above. These include the primary care integration

pilots, as well as changes that may result from the Benefit Task Force or changes in AHCCCS eligibility. At the very least, independent evaluations underwritten by the Trust will help state policy makers in deciding about the next steps.

Catalytic Leadership

The independence of the Trust puts it in an enviable position to remain independent of special interests and to provide leadership for resolving many of the issues facing the Arizona mental health system. The Trust should not assume a day-to-day leadership position, but rather view itself as a catalyst for change. It can be the organization that brings together interested parties in a neutral environment with a focus on change. This convener and facilitator role is vitally important to foster a climate of change within Arizona.

Public Education

As discussed in Section II of this report, in Arizona there is a pervasive lack of knowledge about, understanding of, and sympathy for individuals and families suffering from the effects of mental illness. This lack of understanding and support results in: (a) difficulty generating legislative support for sufficient funding for the system, and (b) hinders the implementation of appropriate services and supports that foster community integration. Thus, a key strategy for the Trust should be to generate positive and accurate public information about persons with mental illness: their strengths, capacities, and needs for on-going community supports. Concurrent with positive public information dissemination, the Trust could sponsor anti-stigma activities, such as letter-writing campaigns when negative stereotypes of mental illness are portrayed in the popular media.

V. Conclusion

We began this project in search of excellence in Arizona's public behavioral health system. The report has identified many strengths in this system-integrated care management for children, peer mentoring programs for adults, and crisis and outreach services. It has also identified serious weaknesses-the lack of integration with primary care, limited assertive community treatment programs for adults, and inadequate and poorly coordinated child and family service resources. It has also provided a framework for understanding this system in relation to what are acknowledged "best practices" in this field.

Our purpose in preparing this report has not been to point the finger or affix blame for the system's shortcomings, or even to praise or applaud those areas of the system that are working well. Rather, our purpose has been to raise public awareness that some of Arizona's most vulnerable citizens, those children and adults with mental illness and their families, depend on the rest of us to ensure that there is excellence in our public behavioral health care system.

But what constitutes excellence? Although we have attempted to quantify and qualify excellence through examples of best practices in Arizona and from across the country, excellence in public behavioral health care may have more to do with intangibles, such as a culture of innovation and change, leadership and continuous quality improvement. The authors of this report believe that while Arizona's public behavioral health care system could benefit from additional resources, the development of new programs and services, and the expansion of eligibility, excellence will be achieved when there is a pervasive community spirit and culture that continually demands

improvement in Arizona's public behavioral health system.

Achieving this kind of excellence will not be easy. It will take a commitment of all stakeholders, those inside and outside government, to abandon old program models, redirect resources, reengineer services, adopt new recovery concepts and embrace new strategies to improve the lives of people with mental illness.

It is time for everyone to join together to make Arizona a true national model for cost effective and quality care for persons with mental illnesses and disorders.

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[48] Dea, Robin, The Integration Experience in a Group Model HMO: Northern California Kaiser-Permanente. In Primary Care Meets Mental Health: Tools for the 21st Century, Habor, Joel D., Mitchell, Grant E. (eds.), Tiburon, California: Centralink Publications, 1997, pp. 75-86.

[49] Trangle, Michael, M.D., The Group Practice Model: Allina Health System. In Primary Care Meets Mental Health: Tools for the 21st Century, Habor, Joel D., Mitchell, Grant E. (eds.), Tiburon, California: Centralink Publications, 1997, pp. 115-120.

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