INTO THE LIGHT:

This is Volume II of Into the Light: A Search for Excellence in the Arizona Public Behavioral Health System. The way to read this is as a "sourcebook" for implementing best practices in behavioral health systems, with further discussion of specific best practice elements, criteria for model components, performance measures, and specific examples of best practices in Arizona and elsewhere. These are representative examples only, and are not meant to be exhaustive.

Mental Health Dissemination Network of Arizona

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

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I. INTRODUCTION

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. St. Luke's Charitable Health Trust initiated the study in an effort to create a more enlightened public climate that would be receptive to appropriate treatment that ensures dignity and self-respect.

The elements of the study have included:

1. Development of a template of behavioral health "best practices" relevant to Arizona's current system;[1]

2. Completion of a strengths-based assessment of the current system as compared to the best practices template; and

3. Formulation of recommended initiatives and strategies to improve the public behavioral health system in Arizona.

Two separate but over-lapping volumes have been prepared as the final products of this study. Volume I provides background information on the participants in the study and on the methodologies employed to complete the study. In that volume the findings and recommendations related to the Arizona public behavioral health system are presented in the context of brief discussions of best practice models and examples of best practice models within Arizona and in other jurisdictions. Volume I includes an overview of the current Arizona public behavioral health system, plus a discussion of issues and problems to be addressed in that system. The identification of current issues, plus the comparison of best practice models to current Arizona behavioral health models, led to the detailed strategic recommendations for changes and improvements in that system contained in Volume I.

As a companion to Volume I, this second volume provides greater detail and additional objective criteria related to best practice models. Volume II does not contain additional discussion of issues to be addressed in the Arizona public behavioral health system. Rather, Volume II is intended to serve as a sourcebook for all parities engaged in the change and improvement process in Arizona. As a sourcebook, Volume II is intended to guide implementation efforts, and provide examples that can be adapted to Arizona's special needs and conditions.

Volume II should also serve as a basis for continued movement towards best practices throughout the Arizona public behavioral health system as well as in other jurisdictions. The models and criteria for best practice included in this volume should be treated as starting points, not end points. In fact, a significant indicator of a system's adoption of best practices is that the system is constantly driven towards higher quality, better performance, improved consumer and family outcomes, and

increased cost effectiveness. No matter how positive a practice model and approach may be today, if it becomes rigid or static it will also soon become obsolete. This is why both Volumes of this final report prioritize strategies that foster learning, growth, and change rather than strategies that rely on implementation of current service or administrative technologies.

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[1] "Best practices" are a set of realistic actions that are unique to a field such as a state behavioral health system. They are activities that, if followed, will ensure seamless, competent, and effective delivery of services and also positive internal management for care providers.

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III. Public Behavioral Health Best Practice Models for Children and Their Families

For many years, efforts have been made at the federal, state, and private level to develop and implement best practice approaches to behavioral health services for children and their families. 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 arranging and delivering integrated, comprehensive services for children with serious emotional disturbance and their families has improved substantially. Unfortunately, in almost all jurisdictions, even after many years of demonstration funding and effort, the children's' puzzle remains to be solved.

The children's puzzle remains unsolved for two primary reasons. First, services to children and their families require engagement and coordination of multiple disparate systems with differing requirements, missions, and imperatives. Second, too often children in need of behavioral health services are embedded in environments characterized by poverty, discrimination, abuse, and family instability. Both of the above issues are extremely difficult to overcome while attempting to access, integrate, and coordinate social, educational, criminal justice, and behavioral health services for children and their families.

Volume I of this final report describes the following elements of a best practice template for behavioral health services for children and their families:

- 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;
- Systematic and coordinated approaches to access, comprehensive assessment, service planning, and outcome measurement for services;
- Consistent implementation of Child/Adolescent Service System Program (CASSP) principles and approaches on a statewide basis; and
- In the context of CASSP principles, evidence-based clinical treatment and community service and support models are implemented and consistently improved.

Table I, provides criteria and performance measures for each of the above elements.

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TABLE I: MODEL ELEMENTS, CRITERIA, AND EXPECTED RESULTS FOR CHILDREN AND THEIR FAMILIES

Best Practice Model Elements	Criteria for the Best Practice Model Component	Expected Results for Children and their Families
There is a 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.	• A unified strategic plan encompassing all applicable child-serving agencies and funding sources has been developed and implemented. Attainment of objective milestones and performance targets in the strategic plan is routinely monitored and reported.	• All participants and constituents of the system, including children and their families, will have a clear understanding of how the disparate child-serving elements are integrated into a unified system of care, and how well the current system measures up to the vision of an integrated system. • Parents, teachers, and service providers will spend much less time attempting to access and coordinate disparate services.
	• All parties to the unified plan cede control and share resources in meaningful ways.	• Interactions among all parties in the child behavioral health system will focus solely on how to best meet the needs and choices of children and their families, not on turf or funding issues.
	• Locally-based single-site management of all resources has been established, and has the authority to access all applicable service modalities and to commit funds for these services.	• Each defined geographic region of the state will have a single entity with unified and singular clinical, administrative, and financial authority to manage and deliver integrated services to children and their families. • As a proportion of total system costs, administrative costs of child and family behavioral health services will be substantially reduced.
Best Practice Model Elements	**Criteria for the Best Practice Model Component**	**Expected Results for Children and their Families**
Methods and supports for empowering children and their families and front- line staff have been effectively implemented. *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*	• Families and their children participate in all levels of service planning, implementation, management, quality improvement and evaluation as well as in treatment planning and provider choice.	• The local integrated child behavioral health system will become accountable to the primary users of services, and will be less beholden to oversight and funding agencies. • As children and families become more engaged, knowledgeable, and empowered, their capacity for coping and problem resolution within the family will also be strengthened.
	• Families are supported in securing their own chosen methods of in-home, school and community-based services and supports.	• Child and family satisfaction with services of their own choice will lead to improved treatment outcomes.
	• Family peer supports are available to educate families and their children	• Effective peer support and advocacy will result in increased use of natural

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;	about service options and treatment planning, and to assist families and children to advocate for their needs and choices in the system.	as opposed to formal services and supports, will improve outcomes for children and their families, and will reduce the system-wide costs of serving high need children and their families.
	• Front-line staff receive sufficient training and support to feel competent and skillful in accomplishing their missions. Front-line staff also feels supported and protected by system management to be creative and to take risks.	• Staff will become more effective and efficient in meeting child/family needs and choices, staff turnover will be reduced, use of high cost residential services is reduced, and children and families will be more satisfied with their interactions with the system.
Best Practice Model Elements	**Criteria for the Best Practice Model Component**	**Expected Results for Children and their Families**
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.*	• Children and their families receive one unified comprehensive, strengths-based assessment and treatment plan governing all aspects of service access and delivery wherever they present in the child-serving system.	• Elapsed times for entering the service system and for moving among service components in the system will be reduced. • The single uniform strengths-based assessment and treatment plan will accurately reflect the total range of child and family strengths, needs, and choices. • Children and their families will become significantly more satisfied with the unified intake, assessment, and treatment planning process.
	• Children and their families have one single point of contact in the service system which (who) has full responsibility and accountability for maintaining contact with the assigned child and family and for coordinating and assuring continuity of care and service access.	• Continuity of system contact will result in reduced over-all lengths of stay in high intensity and/or out of home services, improved treatment outcomes, and reduced life-cycle costs of child behavioral health services.
	• Service access and treatment planning criteria facilitate movement among all components of the child/family service system without delays or the need for additional paperwork.	• Elapsed times for moving among service components will be reduced, and over-all system administrative costs will be reduced.
	• The child-serving system makes 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.	• Admission and length of stay rates to child inpatient and residential facilities will be reduced; child/adolescent arrests and incarcerations will be reduced; and out of home placements will be reduced.
	• All service modalities and locations within the child/family service system will be responsible for attaining the same outcome, performance, and satisfaction measures, and will use the same outcome and performance data	• The overall performance of the child/family behavioral health system will be measured and evaluated in a consistent manner, and the contribution of each component of the system to overall performance will be

	recording and reporting mechanisms. These include: timely access to urgent, emergent, and routine services; reduced admissions and days spent in hospitals and other congregate settings; increased time at home and in school settings; and increased self-report of choice, participation, and satisfaction.	objectively documented. • Outcome, satisfaction, and performance measures will address issues of greatest importance to children and their families. • Quality management plans and annual evaluations will document how child/family outcome, satisfaction, and performance data will be used to increase the quality and effectiveness of the system.

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EXAMPLES OF PUBLIC BEHAVIORAL HEALTH CHILD AND FAMILY SERVICES BEST PRACTICE MODELS AND APPROACHES FROM ARIZONA AND OTHER JURISDICTIONS

Storytelling

Storytelling is a school-based primary prevention program designed to provide culturally meaningful storytelling as part of the school curriculum to reduce youth violence and idleness, and increase self-esteem and productivity for youth from 12 to 14 years of age. The program is administered by Compass Health Care, Inc. and is located at the middle school at the Tohona O'odham Indian Reservation in Arizona. Each year this program serves 100 youth in the Indian Oasis Baboquivari School District and has a total annual budget of $150,000.

The program uses story telling to provide youth with a culturally appropriate curriculum in health, social studies and language arts and has been shown to reduce the number of disciplinary incidents in one year by 54 percent. The program has received an award from the Center for Substance Abuse and Treatment (CSAT) as an exemplary prevention program.

Contact Information:

Storytelling
Tohono O'odham Indian Reservation
Sells, AZ
Phone: 520-383-4966

Behavior Coaching

Behavior Coaching is a program that serves youths with serious emotional disability and/or related behavioral problems. Behavior coaches work with one youth at a time and function as an extension of the clinical services provided. A behavior coach works every day with youth in school and/or at home, at recreation, etc. This type of intervention has been shown to produce fewer class disruptions, facilitate the learning process and assist teacher, students, and other family members to work and relate with the youth. Behavior coaches are reported to improve the quality of life and increase the safety and stability of the youth and their families.

Contact Information:

Mohave Mental Health Center
Lake Havasu City
Phone: 520-855-3432

Interagency Case Management Project - ICMP

The Interagency Case Management Project in Lake Havasu City, Arizona serves to coordinate care and manage multi-service access for children with serious emotional disturbance and/or behavioral problems. The multi-agency team (MAT) is comprised of representatives from Child Protective Services, Developmental Disability Services, Juvenile Corrections, Probation and Parole, and local school systems. The team meets on a regular basis and has access to mental health flexible funds for most consumers. The MAT also utilizes behavioral coaches when available. This process provides improved coordination of care, utilizes creative problem solving, receives high level of parent satisfaction and at least anecdotally produces positive outcomes for children and systems. According to an Interim Impact Study Report in January 1999, children in the ICMP project experienced a statistically significant decrease in the restrictiveness of their out-of-home placements during the time period reviewed.[2]

Contact Information:

Arizona Department of Health Services

Behavioral Health Services
Phone: 602-381-8999

Luz / Southside Partnership

Luz is a substance abuse prevention program for Spanish-speaking youth located in the Southside of Tucson, Arizona. The program provides community education, neighborhood association development and training, prevention of alcohol and substance abuse and community empowerment.

The Partnership has been recognized for the many benefits that it has brought to the community, including improved community morale and an acceptance of community based mental health and substance abuse services. This occurred because the program was respectful of the local culture and the community's needs. Many youth and families have turned toward the Partnership for informal referral and support and the office now serves as a drop-in center for the community.

Contact Information:
Southside Partnership
Luz Social Services
4453 South 6th Ave. Suite 2
Tucson, AZ 85714
Phone: 520-294-7620

The Model Court Project

Pima County Juvenile Court is one of nine Model Court Projects nationwide to ensure an accelerated judicial process for cases that involve children who are the victims of abuse, neglect and abandonment. This program hopes to bring swift closure and hopefully a happy ending by implementing the following: one judge for one family, fast preliminary hearing, accelerated court calendar, centralized data collection, and specific recruiting and dependency training for all contract attorneys.

Contact Information:
The Model Court Project
2225 East Ajo Way
Tucson, AZ 85713-6295
Phone: 520-740-4780
FAX: 520-628-7104

State of Delaware - Integrated Assessment

Under the umbrella agency of the Department of Children, Youth and their Families, an integrated assessment, gate keeping and authorization unit has been established within the Division of Child Mental Health as part of the state's Medicaid Section 1115 waiver project. The centralized assessment, available to referrals from child welfare, juvenile justice, and mental health systems incorporate 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.

Contact Information:
State of Delaware
Intake and Assessment
DCMHS/DSCYF
Phone: 302-633-2579

State of Iowa - Clinical Assessment and Consultation Teams - CACT

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 program assesses children referred by the four systems for appropriate triage into various levels of community-based services. The team also provides continuing stay review and monitoring of service outcomes. The project was incorporated into the state's Medicaid plan as well as the Casey Foundation De-categorization Project in which all non-Medicaid funds at the county level were bundled and used by multiple children's systems. As a result of CACT's determination of children's medical/behavioral need for rehabilitative treatment services, Iowa received almost $25 million in federal Medicaid funding in FY '97 to serve approximately 4,000 children per month.

Contact Information:

State of Iowa
Department of Human Services
Phone: 515-281-8483

Systems of Care - Federal Department of Health and Human Services

Through the Comprehensive Community Mental Health Services for Children and Their Families Program, DHHS has put out a seven volume series called ***Systems of Care - Promising Practices in Children's Mental Health***. This publication of monographs is based on the experiences of 22 of the current 41 program grantees in their work to create a system of care that provides effective, coordinated care to children with a serious emotional disturbance and their families.

The series includes: *New Roles for Families in Systems of Care, Promising Practices in Family-Provider Collaboration, The Role of Education in a System of Care: Effectively Serving Children with Emotional or Behavioral Disorders, Promising Practices in Wraparound, Promising Practices: Training Strategies for Serving Children with Serious Emotional Disturbance and Their Families in a System of Care, Building Collaboration in Systems of care, and A Compilation of Lessons Learned from the 22 Grantees of the 1997 Comprehensive Community Mental Health Services for Children and Their Families Program.*

Contact Information:

The Substance Abuse and Mental Health Services
Administration's (SAMHSA)
Center for Mental Health Services (CMHS)
Phone: 301-443-2792

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[2]The Maricopa County ICMP demonstration site was also reviewed. A comprehensive evaluation of that pilot project is being conducted. Thus, it has been decided to await the results of that evaluation before adding that site as an example of best practice.

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IV. Public Behavioral Health Best Practice Models for Adults

Public behavioral health services for adults with serious and persistent mental illness have changed significantly over the past three generations. An individual experiencing the onset of schizophrenia or bi-polar disorder in 1950 could typically expect a lifetime of custodial care in institutional settings. All involved: the patient, her/his family, and her/his treating clinician(s) would have no hope for recovery and no expectation for independent community living. Fifteen years or so after first onset of the disorder, primitive psychotropic medications would become available and the individual could be stabilized, albeit intellectually and emotionally blunted, and subjected to the unpleasant and ultimately disabling side effects of the medications.

Another individual experiencing first onset of serious mental illness in 1970 would have different experiences and expectations. Most likely the individual would cycle repeatedly through psychiatric hospitalizations (on average about 20 days every two years.)[3] Between hospitalizations, the individual would face the choice of institutional- type care in congregate residential facilities or living independently (usually with family) and receiving intermittent clinic-based services. There was still no expectation on anyone's part that she/he would live or work independently, or would enjoy friendships and social activities. Medications would have no greater positive benefits, although the techniques for mitigating side effects would be improved. This individual would rarely experience lengthy or lifetime institutional care. Instead, she/he would be confined to a netherworld in which the care and supports supplied by the institution were removed, while no replacement or alternative care and supports were available in most communities.

In early 1990, an individual experiencing first onset of a serious mental illness could have a vastly different experience. 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, new atypical anti-psychotic medications were becoming widely available and new community services technology such as assertive community treatment, psychosocial rehabilitation, and supported housing and employment were being proven to be successful. Individuals and their families could see and feel the effects of new brain science and new services approaches; for the first time they could routinely hope for independent living and employment in communities of their choice. Throughout the '80s and early '90s the organized advocacy of families (i.e., National Alliance for Mental Illness [NAMI]) and somewhat later consumers, fostered service improvements and increased public accountability for the quality, responsiveness, and effectiveness of services. They also brought about national awareness of the needs of individuals with serious mental illness.

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 consequence, as well documented in the media, is increased incarcerations, increased homelessness, and increased stress on families and communities.

The preferred public behavioral health system for adults 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.

In Volume I the following key elements of the preferred public behavioral health system for adults have been described:

- Recovery values and principles
- Consumer self-determination and choice
- Continuity of connection with the system
- The Community Support Program (CSP) approach - services and supports for rehabilitation and Recovery
- Psychosocial rehabilitation approaches
- Peer supports/consumer operated services
- Early intervention
- Crisis services
- Mobile outreach/ACT/ACM teams
- Medical and clinical treatment/medication management

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[3] Fisher, W. and Altaffer, F. Unpublished study of Massachusetts and national hospitalization data. 1993

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TABLE II: MODEL ELEMENTS, CRITERIA, AND EXPECTED RESULTS FOR ADULTS

Best Practice Model Component	Criteria for the Best Practice Model Component	Expected Results for Consumers and their Families
All services are based on the concepts, principles, and practices of recovery *Recovery includes building internal strengths, building social support networks, and overcoming stigma through activism and self-advocacy.*[4]	• The system fosters and supports independent thinking and action on the part of consumers. • All components of the service system treat consumers as equal partners in service planning and choice. • Consumers are offered opportunities and supports to make mistakes. • The system treats consumers with the belief and trust that they can shape their own futures. • All participants in the system listen to consumers and believe what they say. • Consumers' strengths and capabilities are recognized and supported by the system. • All elements of the system work with consumers to find the resources and services they want. • Key caregivers in the system are consistently and conveniently available to consumers when they need and choose communication and support.	• Consumers will have greater opportunities to achieve their individual goals. • Consumers will experience a reduction in the discrepancy between their expectations and their actual achievements. • The community and living environment for all citizens will change through reduced stigmatization of mental illness, improved public attitudes about people with disabilities living and working in the community, and through the development of new community resources. • There will be increased opportunities for consumers to work, play, and participate in the community. • Consumers will be come empowered and active as citizens and will develop political skills and strength. • There will be improvements of quality of life, such as vocational and educational opportunities, independent living, friendships, and contributions to others in the community.[5]
	• Consumers are taught the skills and knowledge to provide for self-care and to make informed choices and decisions about their services.[6]	• Consumers will develop and benefit from greater hope, trust in themselves and their thoughts, enjoyment of the environment, and increased self-esteem. • Consumers will develop faith in their own futures, and will improve confidence and skills in working and relating to others.[7] • Consumers experiencing rehabilitation and recovery will utilize fewer hospital days, reduced interactions with crisis services, and less high cost residential and day services.
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Expected Results for Consumers and their Families**
Self determination and choice *An essential ingredient of consumer recovery and empowerment is*	• The public behavioral health system will assure ample opportunities for consumer self- determination and choice through; (a) providing whatever supports are necessary to facilitate consumer self-determination and choice; and (b) assuring that there are	• Consumers and their families will benefit from an increased variety and flexibility of services and supports that can be tailored to their individual needs and choices. • Exercising informed choice of services and supports is a key ingredient in

self- determination and choice.	a range of options from which consumers can make reasonable choices.	recovery, and will result in improved outcomes and satisfaction for consumers and their families.
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Expected Results for Consumers and their Families**
Continuity of contact with the system *Consumers 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.*	• The public behavioral health system will assure that each consumer has an individual, team, or organization with specific responsibility for developing and maintaining a positive, mutual, and continuous relationship. • The system will take steps to reduce staff turnover to increase the consistency and tenure of relationships among system staff and consumers.	• Consumers will develop comfortable, safe, and growth-producing relationships with one or more caregivers, that will result in enhanced rehabilitation and recovery and will reduce hospitalization and other high cost services.
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Expected Results for Consumers and their Families**
The system meets CSP principles and service models *The CSP model emphasizes consumer centered strengths- based services, empowerment, cultural and linguistic competence, service flexibility, incorporation of natural supports, accountability to consumers, and coordination and continuity.*	• The system provides active and aggressive outreach, and works to provide or arrange transportation when necessary to facilitate access. • The system provides assistance and supports in meeting basic needs for food, clothing, shelter, personal safety, and medical and dental services. • The system provides a full array of mental health treatment, including inpatient and partial hospitalization, medications and medication management, individual and group counseling, and residential evaluation. • 24 hour seven day-per-week crisis response and stabilization is available in all areas of the state. • The system assures development and delivery of a wide range of psychosocial and vocational services, including consumer operated and peer support services. • The system works to provide access to affordable supported housing. • The system provides education about mental illness to the community and advocates for the rights and dignity of consumers.[8]	• Effective outreach and engagement, plus facilitated access to services, will reduce homelessness and incarceration rates for individuals with serious mental illness. • Community independence, self-sufficiency, and individual recovery will be enhanced and supported through access to primary health care and adequate food, clothing and shelter. • Rehabilitation and recovery will be facilitated through choice of and access to a full range of clinical treatment and psychosocial rehabilitation options. • Use of high cost services will be minimized, and individuals will be able to return to pre- crisis level of functioning quickly. • The elapsed time between hospitalizations and/or crisis presentations will be increased for most individuals. • The community will become more understanding of mental illness, and more supportive of people with serious mental illness living in the community. Both of these facts will stimulate and enhance the recovery process.
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Expected Results for Consumers and their Families**
Psychosocial rehabilitation service models	• See above: The system assures development of and access to a full range of psychosocial rehabilitation	• Consumers will learn skills, gather knowledge, and experience success in ways that support the recovery

Psychosocial rehabilitation services are designed to assist consumers to develop skills and strengths in all the aspects of their lives other than clinical treatment, and thus address skills and strengths related to living, learning, working, loving, socializing, and otherwise participating in community life.	services, including psychosocial clubhouses, consumer-operated drop-in centers, supported employment, supported education, and peer counseling services.	process. The result for the long term is reduced dependence on high intensity, high cost services, reduced life-cycle costs to the public behavioral health system, increased independence, self-sufficiency, and community tenure for consumers. The benefit for consumers and their families is independence, self-determination, and the pride and satisfaction gained by becoming productive members of society.
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Expected Results for Consumers and their Families**
Early Intervention *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.*	• The system assures quick response and early intervention for consumers and their families. This takes place soon after the onset of the illness, and includes outreach to consumers and family members, education about the illness, and linkage to consumer and family peer support organizations. This early intervention also includes highly skilled and strengths-based assessment and diagnosis, and may include psychological and neurological testing. Protocols for medication management include trials with atypical antipsychotic medications as the first choice for psychotic symptom amelioration.	• Successful early intervention strategies will reduce the long term disabling effects of the onset of serious mental illness. This means more rapid return to pre-onset functioning levels, reduced dependence on high cost services, and earlier initiation of the recovery process. When the system starts with individuals and their families from a position of hope and a belief in recovery, then the recovery process is usually briefer and less difficult.
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Expected Results for Consumers and their Families**
Comprehensive Crisis Services *Crisis services provide a number of important functions for consumers and*	• Regional behavioral health systems include a 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	• Individuals presenting in psychiatric crisis will receive a timely and clinically appropriate response that assesses the crisis, resolves presenting issues, refers to crisis stabilization resources, and refers to the least intensive services possible.

the behavioral health system. These include crisis response and stabilization, diversion form hospital or other high cost services, and returning of individuals to pre-crisis functioning as quickly as possible. They also often function as the front door intake system for after hours and on weekends. *Comprehensive crisis services also function for the community, providing the first line of response to individuals in crisis no matter what the cause of the crisis may be. They also assure that emergency room, ambulance, law officer, and jail resources are not inappropriately utilized for behavioral health crises.*	consultation with a psychiatrist. • The regional crisis response systems have the clinical capacity and legal authority to approve or deny admission, voluntary or involuntary, to any public (operated or paid) psychiatric inpatient facility. • The crisis response systems assure timely access to appropriate clinical specialties, such as board-certified or board eligible child psychiatrists. • Each crisis response system has mobile capacity, in which teams of mental health professionals and peer counselors are available to respond in a timely manner[9] to psychiatric crises wherever they present, including hospital emergency rooms, individual homes, and local jails. The mobile units also have the capacity to transport or arrange for transport of individuals in crisis to an appropriate evaluation and stabilization facility. • The crisis response systems have access to 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. • The crisis response systems arrange for appropriate linkages with other healthcare resources, to arrange for medical clearance, toxic screens, lab work related to rapid medication titration, and medical and non-medical detoxification. • Each crisis response system has direct access to cultural and linguistic clinicians and translation services to facilitate assessment and crisis stabilization.	• This response system will result in use of psychiatric hospital admissions only when clinically necessary, and thus will establish a rational and objective link between the clinical needs of the service population and the bed capacity of the psychiatric hospital system. • The crisis response system will also reduce and ameliorate the disabling effects of the crises, thereby enabling individuals with serious mental illness to return to pre-crisis levels of functioning more quickly and with less intensive resource utilization. • The crisis response system will result in facilitated access to the public behavioral health system, by referring individual presenting after normal business hours to the appropriate component of the behavioral health system for follow-up.
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Expected Results for Consumers and their Families**
Assertive Community Treatment - Intensive Case Management[10] *Assertive Community Treatment (ACT) and intensive case management (ICM) are the models most commonly used to provide intensive mobile services to consumers who are: (a) at very high risk of hospitalization or otherwise losing*	• The system assures access to ACT or ICM for individuals needing and choosing such services and at risk of frequent hospitalization, homelessness, and/or incarceration. • Assignment to an ACT or ICM team is based in clinical level of care criteria, but criteria for remaining with an assigned team are flexible to assure that an individual does not have to change teams as her/his level of functioning changes. • Team services are provided primarily in the home, place of employment, or other non- facility-based settings.	• At risk and/or difficult to engage consumers will use fewer hospital admissions, fewer hospital days, and fewer presentations in crisis. • At risk consumers will maintain independent housing and independent employment for longer periods of time. • Consumer satisfaction and positive outcomes will be improved through assured continuity of contact with the system and through assertive outreach on the part of ACT and ICM teams.

community housing and supports; and (b) who are unwilling or unable to participate in or benefit from traditional clinic or facility-based services	• Teams are multidisciplinary and are trained in substance abuse, dual diagnosis, and employment skills as well as mental health interventions. • To the extent possible, teams include peer counselors and other consumers-as- providers.	
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Expected Results for Consumers and their Families**
Implementation of evidence-based clinical treatment best practices *Meeting clinical practice and utilization guidelines is important for a number of reasons. First, these guidelines 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.*	• Statewide evidence-based clinical protocols and treatment guidelines are promulgated for consistent application throughout the public behavioral health system. • The clinical protocols and guidelines govern all aspects of clinical treatment, and address both diagnosis-specific best practice interventions and specific treatment modalities. • Clinical practice guidelines reflect best practices in rehabilitation and recovery, and emphasize community services and supports, as well as focusing on clinical treatment. • All clinical and service program staff in the system are trained on a routine basis in both existing and new treatment protocols and guidelines. • Competency standards are applied on a regular basis to assure full competency at all levels for delivering evidence-based best practice protocols and guidelines. • Quality management and improvement functions at all levels of the system work to (a) assure proper implementation of best practice protocols and guidelines; and (b) to test and implement evidence-based improvements in clinical practice and service delivery. • Quality improvement of best practice guidelines and protocols will be enhanced though quantitative analyses of behavioral health utilization, costs, outcomes, and satisfaction, and by qualitative, on going clinical and peer review evaluations.	• Clinical and consumer-based outcomes will be consistently achieved and improved. • There will be a direct and documented link between individual consumer's diagnoses, level of functioning, and strengths-based assessment and the amount, duration, and scope of services provided. • Consumers will neither over-use nor under- use needed and chosen services. • The costs of treatments and services will be directly linked to the clinical needs of consumers and the outcomes produced for consumers. • The public behavioral health workforce will have the correct values, knowledge, and skills to deliver clinically appropriate and effective services. • Behavioral health consumers in Arizona will be assured of receiving the best evidence- based treatments and services, and that these will improve as new evidence is accumulated about best practices. • Arizona will contribute to the growing national body of evidence-based best practice as well as benefiting from the receipt of such information.

[4]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

[5]The above points were derived from Rapp, Charles A., Shera, Wes, and Kisthardt, Walter, *Research Strategies for Consumer Empowerment of People with Severe Mental Illness*. Social Work Volume 38(6) November 1993

[6]The above points were derived from 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 Page 6

[7]Ralph, Ruth, Ph.D., et. al. al. al. 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

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

[9]Usually one half hour in urban communities, and one hour in rural settings.

[10]ACT teams are customarily comprised of a part time psychiatrist, a psychiatric nurse practitioner, one of more masters level social workers, and various combinations of peer counselors, employment counselors, and substance abuse specialists. With ACT teams, the entire team is responsible for each consumer assigned to the team. ICM teams typically have access to a psychiatrist and a psychiatric nurse practitioner, but these individuals may participate in a number of other teams. ICM teams are usually comprised of masters and bachelor level social workers, sometimes joined by peer counselors or other specialists. Although the members function as a team, each team member will typically have his/her own assigned consumers.

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EXAMPLES OF BEST PRACTICE MODELS FOR ADULT PUBLIC BEHAVIORAL HEALTH SERVICES

Clubhouse Models - Our Place, Tucson

Our Place was established in 1988 to provide psychosocial, pre-vocational and vocational rehabilitation services for adults with serious mental illness residing in Pima County. The program utilizes the "Fountain House" clubhouse model where members are engaged in every aspect of the clubhouse operations. Through their work in the clubhouse, members build concentration, self-esteem, the ability to make decisions, and reduce isolation.

Our Place has a total annual budget of $311,000, and is funded directly by CPSA. The program serves approximately 165 members per month, and has a census of 60 people per day.

SAMHSA is currently funding a five-year research project to determine the effectiveness of community support services in helping adults with serious mental illness. The report hopes to assess how the clubhouse program affects members with respect to obtaining and keeping paid work, quality of life, emotional and physical well being, educational attainments, hospitalization rates, and satisfaction with services.

Contact Information:

Our Place
39 North Sixth Avenue
Tucson, AZ 85701
Phone: 520-884-5559

The International Center for Clubhouse Development
425 W. 47th Street
New York, NY 10036-2304
Phone: 212-582-0343
www.iccd.org

Ocotillo Program

The Ocotillo Program is a crisis group home providing short-term therapeutic services to 15 adults with serious mental illness. Services include counseling, behavior management, psychosocial rehabilitation, home health aids, nutrition counseling, mobility assistance, exercise or physical therapy, and hearing and speech aids. Staff offer services 24 hours per day, seven days per week. The program is reported to improve outcomes associated with crisis stabilization, rates of hospitalizations, medication management, and connections to aftercare and community services. Of the 447 clients who used Ocotillo, only 57 (13 percent) have been hospitalized during the period from 1997 to 1999. Of that, 56 percent had one admission, and 26 percent had two admissions.

Contact Information:

The Ocotillo Program
Tucson, AZ
Phone: 520-884-0707

Peer Mentor Program - Warm Line

The Peer Mentor Program serves adults with serious mental illness both as mentors and as those who utilize the services of the warm line. The Program offers people with serious mental illness an opportunity to become involved in community-based mutual self-help activities. The core of the program is the Warm Line, where trained consumers (mentors) answer telephone calls from persons with mental illness who are looking for conversation and support. The

program also provides peer support, socialization, hospital visitation, an Internet discussion group, and social events.

The program has a yearly budget of $150,000 and receives 300 to 470 calls per month using 12 to 20 mentors. The program is able to measure consumer satisfaction through follow-up calls and mentor/volunteer satisfaction through burnout and symptom rates.

Contact Information:

Peer Mentor Program
Warm Line
Tucson, AZ
Phone: 520-917-0841

ALFA - Arizona Level of Functional Assessment

The ALFA Service Level Checklist is a multi-domain, nine-scale instrument that is based on the Colorado Client Assessment Record (CCAR). ALFA is used by clinicians predict the level of care and case management needed by a client. ALFA can also be used as an outcome and monitoring instrument by comparing ALFA scores as treatment progresses.

The original CCAR was developed by Dr. Richard Ellis of the State of Colorado and is used by a number of states, including Colorado, Hawaii, Texas, and North Carolina.

Contact Information:

ALFA
Arizona Department of Health Services
Division of Behavioral Health Services
Phone: 602-381-8999

Access to Community Care and Effective Services and Supports (ACCESS)

The ACCESS Program is an innovative interdepartmental effort to test the impact of systems integration on outcomes for homeless people with mental illnesses. CMHS awarded 5-year cooperative agreements to nine states in FY 1993. (Connecticut, Illinois, Kansas, Missouri, North Carolina, Pennsylvania, Texas, Virginia, and Washington) The project will end in December 1999. Interim observations reveal that the projects are successful at getting people off the streets and helping them stay in housing, and that drug use *decreased* by 14.3 percent, commission of minor crimes *decreased* by 41.7 percent, and use of outpatient psychiatric services increased by 30 percent.

- The Connecticut ACCESS project, which reduces fragmentation by collocating services at a drop-in center, employs peer counselors who provide outreach and case management.
- In Pennsylvania, a consumer-operated Peer Engagement Team prepares consumers for less intensive and longer-term case management. The ACCESS project has also collected services at a drop-in center.
- The North Carolina ACCESS project, which is implementing an interagency management team and cross-staffing, has hired consumers as evaluation interviewers and outreach staff.

Contact Information:

ACCESS
Center for Mental Health Services
Homelessness Programs
Phone: 1-800-444-7415

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V. Public Behavioral Health Best Practice Models for Special Services

Volume I of this report outlines four categories of service program models that are recognized to be essential components of best practice public behavioral health service systems. These are:

- Services for persons with co-occurring mental illness and substance abuse disorders;
- Geriatric services;
- Supported Housing; and
- Employment.

Table III, summarizes criteria for and expected results of these program components.

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TABLE III: MODEL ELEMENTS, CRITERIA, AND EXPECTED RESULTS FOR SPECIAL SERVICES

Best Practice Model Component	Criteria for the Best Practice Model Component	Results to be Expected by Meeting Best Practice Criteria
Services for individuals with co-occurring mental illness and substance abuse *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***[11]*. Further, when mental illness and substance abuse diagnoses co-occur, they both must be treated as the primary diagnosis, not one or the other.*	• Dual diagnosis services are fully integrated and coordinated across outpatient, inpatient, and community support/residential service settings. • All integrated service components are welcoming, accessible, continuous, culturally competent, and linked to all other necessary service systems. • Integrated services recognize 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). • Integrated assertive community treatment and intensive case management teams have dual competencies in mental illness and substance abuse interventions, and are a primary modality for the delivery of services for individuals with co-occurring disorders. • All components of the public behavioral health system receive continuous co- and cross training in assessing and treating co-occurring disorders. • All components of the public behavioral health system have sufficient competencies in dual diagnosis services to assure effective responses wherever individuals with co-occurring disorders present. • There is coordinated, system-wide planning, development, and coordination of dual diagnosis services.	• Individuals with co-occurring mental illness and substance abuse disorders will be more likely to be engaged in services and to remain in treatment. • Consumers with co-occurring disorders will be more likely to maintain treatment compliance. • Consumers with co-occurring disorders will have greater success in maintaining community living and working arrangements, will use fewer hospital days, and will have fewer crisis program and emergency room encounters. • Local criminal justice systems and homeless service systems will have fewer encounters with individuals with co-occurring disorders, and will have greater success in referring such individuals to the public behavioral health system.

Best Practice Model Component	Criteria for the Best Practice Model Component	Results to be Expected by Meeting Best Practice Criteria
Geriatric Mental Health 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.*[12] *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*	• The public behavioral health system works to assure integration and coordination 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. • There is coordinated and active outreach to and engagement of elders, most successfully conducted by peers. • The system assures flexibility as opposed to specialization among service providers. The collaborating components of the system have an attitude of "these individuals belong to us"; not "we don't serve that type of person." • The system assures 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. • There are on-going cooperative efforts to provide cross training among a variety of practitioners about depression, substance abuse, co-occurring dementia, and other related conditions affecting elders. • The system cooperates with other service systems to engage natural community supports and people most likely to come in contact with elders, such as the faith community, shop keepers, transportation providers, postal services, etc.[14]	• Depression, substance abuse, and other behavioral health issues among elders will be quickly identified and successfully addressed. • Primary health care physicians will be better trained in identification of mental illness and/or substance abuse, and in pharmacological procedures and precautions for elders. • Linkages to services and coordination across behavioral health, primary health, and aging services will be facilitated. • The rate of institutionalization (primarily nursing home-based care) among elders with behavioral health needs will be reduced. • Social indicators of untreated behavioral issues among elders, such as isolation, poor nutrition, spousal abuse, etc. will be ameliorated and reduced.

85 years, and elders are predicted to comprise over 25 percent of the total population (double their current proportional representation in the general population.) [13]		
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Results to be Expected by Meeting Best Practice Criteria**
Housing *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*[15]*. 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 with virtually no other funds. 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.* *There is widespread agreement that when housing is permanent and flexible, individualized support services are available as needed, people with serious mental illnesses can achieve and maintain residential stability in the community. For*	• Access to affordable, safe, and decent independent housing by consumers is among the highest priorities of the public behavioral health system. Living in independent housing of one's choice is a key ingredient to the rehabilitation and recovery process. • The system provides an array of flexible community services and supports designed to assist consumers to select and maintain independent housing in communities of their choice. • At the state and regional levels the system has plans and strategies for increasing access of consumers to affordable housing and for increasing the supply of affordable housing for consumers. The strategies include accessing mainstream housing resources as well as specialized resources designed solely for individuals with disabilities. • At the state and regional levels the system has forged strong working relationships with organizations that fund, develop, and/or manage affordable independent housing. These organizations include housing finance agencies, public housing authorities, and non-profit organizations dedicated to the production and management of affordable housing. • The system provides regular training to consumer on the rights and responsibilities of tenancy and on approaches to accessing and selecting affordable housing. The system also regularly trains landlords, real estate brokers, public housing authorities, etc. in the housing rights and competencies of people with mental illness, and about the system of services and supports available in the community to assist individuals with mental illness to live successfully	• The number and proportion of consumers accessing independent affordable housing will increase on a year-to-year basis. • The length of time that consumers live in independent housing will increase substantially. • Consumer utilization of inpatient hospitalization and crisis services will be reduced. • Incarceration and homelessness for individuals with mental illness will be reduced. • Communities will become more knowledgeable about and accepting and supportive of people with mental illness. • The over-all supply of affordable housing available to very low- income individuals with disabilities will increase on a year-to-year basis.

persons with mental illness, supported housing offers a safe, viable, more affordable alternative that reaffirms independence and community living.	in independent housing.	
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Results to be Expected by Meeting Best Practice Criteria**
Employment *A 1972 study found that less than 30 percent of individuals with serious and persistent illness ever work.[16] 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.[17] Even using "place-then-train" supported employment approaches, about 50 percent of persons with serious mental illness obtain competitive employment. Only ½ of those who secure competitive employment remain employed in the same jobs six months later.[18]*	• The public behavioral health system assures consideration of individuals' interests, abilities, and goals in selecting jobs. This includes employment 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. • The system provides early intervention strategies designed to assist people to return to work as soon as possible after the onset of a psychiatric disability. • The system adopts supported employment strategies that focus on getting people into the workplace and then training on the job, rather than spending time in pre-employment training. • The system provides of a range of on-going services and supports to assist people to work and interact effectively in the workplace. • The system assures flexibility in work expectations during periods of acute exacerbation of the mental illness. • Supported employment strategies include a range of work experiences including short term job tryouts, on the job training, part time jobs, and other productive activities, including education and volunteer activities. • The public behavioral health system provides sufficient employment opportunities[19] for current and former consumers. • The system provides multi-disciplinary teams that blend vocational supports with other clinical and community supports.[20] • The system effectively coordinates behavioral health resources with vocational rehabilitation resources to provide continuity of employment training, placement, and follow-along services.	• Consumers with serious mental illness will increase their participation in competitive employment of their choice on a year-to-year basis. • Consumer income from competitive employment will increase substantially. • Employers will become more accepting of consumers as valued and competent employees, which will result in increased employment opportunities for individuals with serious mental illness. • Consumers maintaining competitive employment will use fewer hospital days and have fewer encounters with the crisis system.

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

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

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

[14]Ibid.

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

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

[17]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)

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

[19]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.

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

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EXAMPLES OF INTEGRATED SERVICES FOR INDIVIDUALS WITH CO-OCCURRING MENTAL ILLNESS AND SUBSTANCE ABUSE DISORDERS

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.

LADDER Program (Life Affirming Dual Diagnosis Education and Recovery)

The Ladder day treatment program serves the seriously mentally ill who also have a substance abuse problem. All clients are on psychotropic drugs, have an assigned case manager, and are SSI or SSD eligible. The program is highly structured and offers a variety of groups on illness management and recovery. Transportation to and from outside medical appointments is provided.

The program serves approximately 80 people annually, with an average of 22 clients at any point in time. The average length of stay at LADDER is three months. The program serves to train clients in every day life skills and is believed to be effective at keeping clients safe and out of the hospital.

Contact Information:

LADDER
Terros Inc.
Phoenix, AZ
Phone: 620-266-1100

Caulfield Center, near Boston, Massachusetts. This Center, started by Dr. Kenneth Minkoff,[21] 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.

Contact Information:

Caulfield Center
23 Warren Ave.
Woburn, MA 01801
Phone: 781-932-0649

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.[22]

EXAMPLES OF GERIATRIC SERVICES

Gate Openers - PGBHA

This program provides outreach to isolated elders to identify signs of isolation, poor nutrition, health problems, etc. Individuals who would normally come in contact with isolated elders, such as postal workers and delivery people, are trained to identify elder with needs and to notify the area mental health center which has trained case management staff who will reach out to elders and engage them in services. The service is coordinated with the local Area Agency on Aging (AAA), which facilitates access to socialization, nutrition, primary health care etc.

The program has reported the following benefits: Reduced isolation, reduced risk of hospitalization and/or negative health consequences, improved access to physical and behavioral health services, and improved coordination of geriatric health services with other elder services.

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.*

Contact Information:

Bazelon Center for Mental Health Law
Washington, DC
Phone: 202-467-5730

EXAMPLES OF HOUSING

Vera French Housing Development Corporation

In Davenport, Iowa, the Vera French Community Mental Health Center (VFCMHC) recognized a need for supported housing for persons with mental illness. Persons served in their system needed housing, but not a placement in a treatment setting or the county care home operated by the VFCMHC. With broad participation of stakeholders, including DHS, Scott County, HUD, community leaders, the Chamber of Commerce, the Real Estate Board, NAMI, Iowa, and local banking and finance representatives, they formed the Vera French Housing Development Corporation (VFHDC). This non-profit developed a housing plan and financing strategy aimed at leveraging federal, state, and local funding and technical assistance.

The VFHDC now is responsible for over 120 units, including single family homes duplexes, and a couple large apartment buildings for persons with mental illness and development disabilities. Because VFHDC was an outgrowth of the VFCMHC, there are natural linkages with the services of the VFCMHC, including case management and other supportive services. Over the past couple years, the program has involved other local ecumenical organizations, and organizations concerned with homelessness and poverty to secure grant funding for continued development projects in the community.

Contact Information:

Vera French
1441 W Central Park Ave
Davenport, IA
Phone: 319-383-1900

Baltimore Community Housing Associates

In 1992, Community Housing Associates (CHA), Inc., completed the purchase and rehabilitation of 15 residential properties in Baltimore, Maryland, to provide affordable housing for adults with mental illnesses. CHA blended private and public funding to develop the project, and made innovative use of case management services to provide supports to its residents. The CHA project is a useful model for mental health or community development agencies interested in developing housing for people with mental illnesses.

Contact Information:

Baltimore Community Housing Associates
201 E. Baltimore St., Suite 1340
Phone: 410-837-2647

Michigan Supported Housing Development

In Michigan, several demonstration programs are underway to develop and support housing for low-income and special needs populations. The program strives to develop permanent independent living residences in non-institutional settings that offer access to other community services. The Michigan Department of Community Health has joined with the Michigan State Housing Development Agency (MSHDA) and the New York City-based Corporation for Supportive Housing (CSH) to initiate demonstration programs in four Michigan sites to develop affordable supportive housing for individuals who are homeless or at risk of becoming homeless, including those with psychiatric disabilities. The program will explore ways that state health (including mental health) and housing agencies can work together, in cooperation with other public and private organizations, to provide housing and supportive services to individuals who have very low incomes and special needs.

Local nonprofit sponsors selected by community-level partnerships will develop about 300 units of housing. Funding for the initiative will come from state allocations of federal housing and development program moneys including H.O.M.E., Community Development Block Grants (CDBG), low-income tax credits, and donations from private sources such as foundations. CSH will assist nonprofit housing developers to build organizational capacity and will provide bridge financing. To date the program has generated $650,000, with the goal of reaching $1.4 million for capacity building and bridge financing.

Contact Information:
Michigan Supported Housing Development
Phone: 810-229-7712

EXAMPLES OF EMPLOYMENT

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 these targets. 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.

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[21]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.

[22]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.

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VI. Best Practice Models for Management of Public Behavioral Health Systems

This report contains considerable discussion of public behavioral health best practices and preferred systems for children and adults 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. The following are some important criteria for best practice management of the public behavioral health system.

- State, regional, and local components of the public behavioral health system are effectively and efficiently managed.
- There is system-wide implementation of consistent and comprehensive continuous quality improvement (CQI) practices grounded in consumer-based outcomes, satisfaction, and performance measures.
- There is assurance of cultural and linguistic competence throughout the system.
- There is consistent implementation of utilization management criteria and evidence- based clinical protocols and clinical pathways at every program/service site in the public behavioral health system.
- There is meaningful inclusion of consumers and family members at all levels and in all functions within the public behavioral health system.

These criteria, and some examples of the anticipated results of meeting the criteria, are detailed in Table IV.

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TABLE IV: MODEL ELEMENTS, CRITERIA, AND EXPECTED RESULTS FOR MANAGEMENT OF SYSTEMS

Best Practice Model Component	Criteria for the Best Practice Model Component	Results To Be Expected by Meeting the Best Practice Criteria
State and regional components of the public behavioral health system are appropriately and effectively managed	• The mission and vision of each component of the system is driven by and focused on consumers and families. • Each component of the system is an effective advocate for the mission of the organization and for the larger public behavioral health system. • Each component of the system is a learning organization - one that remains open to change, willing to learn, anxious to improve, and able to take risks. • There is an emphasis on integration, collaboration and coordination throughout the system. • There is a system-wide emphasis on outcomes and performance versus process and regulation. • There is a system-wide emphasis on the content as opposed to the structure of the system. This includes allowing and supporting creative and flexible use of resources. • Each component of the system is accountable to its constituents and the general public. • Each component of the system is efficient and effective in its use of public resources. • Organizational and procedural barriers to flexible and creative service design and delivery will be minimized. These include categorical funding limitations, competing organizational imperatives, discipline-based or disability-based service compartments, and excessive monitoring of compliance with process requirements. • The quality, performance, and cost-effectiveness of all components of the system are constantly and consistently evaluated, and the results of these evaluations are published and circulated widely on a regular basis. • The costs for administrative and compliance functions versus service delivery and quality functions will be minimized. Each component of the system will have effective information	• Every staff member in the public behavioral will be able to articulate what role and responsibility s/he has with regard to producing positive outcomes for consumers. Each staff member will also be able to articulate positive understanding of the strengths, capabilities, rights, and dignity of consumers of public behavioral health services. • Over time the public, the media, and policy makers and elected officials will come to understand mental illness and substance abuse, the rights and abilities of public behavioral health consumers to live and work in communities of their choice, and the need to substantial community resources to assure that this vision for consumers is attained. • Each component of the public behavioral health system will learn and adopt best practices from other jurisdictions, and also will contribute best practice knowledge and experience to other jurisdictions. • Consumers and their families will be able to access resources and services from non-behavioral health organizations as equitably as all other groups in the general population. Consumers of other systems will also enjoy facilitated access to behavioral health services when needed and chosen. Primary health care and behavioral health care will be integrated and coordinated at the level of delivery systems and at the level of each individual consumer. • Outcomes important for consumers and their families (i.e., independent housing, competitive employment, successful school and family functioning, increased perception of quality of life, etc.) will be measured and rewarded throughout the system, which in turn will drive the system towards ever-greater competence and success in assisting consumers and their families to attain these outcomes.

	technology for performance evaluation and decision support, and each component of the system will sufficient and highly qualified staff resources.	
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Results To Be Expected by Meeting the Best Practice Criteria**
Implementation of consistent and comprehensive continuous quality improvement (CQI) practices grounded in consumer-based outcomes, satisfaction, and performance measures in each major component of the system *CQI assures that, long after the current crop of experts is gone, the organizations and the system continues to learn, grow, change, and find new and better ways to carry out their mission in the public behavioral health sector.* *CQI becomes the organizational force to:* • *assure that evidence-based best practices are implemented as intended;* • *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;* • *identify and overcome organizational barriers to quality and effectiveness in*	• There is an equal commitment from both top leadership and line staff to constant improvements to the quality and effectiveness of the organization and its services. • Responsibility for CQI is assigned 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. • Consumers and families are consistently and substantively engaged in all aspects of the CQI process. • CQI activities and strategies are based on empirical data that include information on consumer outcomes and satisfaction. • There is 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.	• Every participant in the public behavioral health system will understand her/his role in contributing to the over-all quality and effectiveness of the organization. There also will be no doubt about the commitment of the public behavioral health system to quality and effectiveness. • Accountability for quality and effectiveness will not be diffused throughout public behavioral health organizations, and quality- related activities will not be discarded when other crises or priorities arise. • The CQI process will be converted from one that solely focuses on clinical practice issues to one that focuses on the over-all effectiveness of the organizations in meeting consumer needs and choices in a timely and responsive manner that is respectful of consumer and family rights and dignity. • Quantitative data on consumer level of functioning, service utilization patterns, outcomes, and satisfaction will inform the development and continued refinement of best practices throughout the public behavioral health system. • The CQI process itself will be regularly and consistently scrutinized to assure its true effectiveness in producing quality and effectiveness strategies of ultimate benefit to consumers and families.

working with primary and secondary customers of services; and • *assure constant learning and consequent re-shaping and re-vitalization of best practices within the organization.*		
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Results To Be Expected by Meeting the Best Practice Criteria**
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.*	• Culturally and linguistically competent practices are incorporated as part of all best practices. For example, clinical guidelines for treating oppositional-defiant behaviors in children address varying cultural approaches to intervening with such behaviors. • Consumers and families from diverse cultural and linguistic backgrounds are engaged to assist in developing cultural and linguistic competency strategies, and to train program staff on relevant cultural/linguistic factors affecting access to and utilization of public behavioral health services. • Policies and strategies for attaining cultural and linguistic competence will address the important roles of family, including extended family, in varying cultures. • Reference groups, including civic, religious, and cultural institutions outside the mental health community are included and employed in efforts to increase cultural and linguistic competence. • The system assures access to clinicians, program staff, and/or interpreters for all languages commonly spoken in Arizona	• Consumers and family members from all applicable cultural and linguistic backgrounds and traditions will enjoy easy access to culturally and linguistically appropriate and competent services throughout the public behavioral health system. • Consumers from culturally and linguistically diverse backgrounds will attain the same levels of positive outcomes and satisfaction as do all other consumers and families in the system. • The administrative and clinical/program service staff of all components of the public behavioral health system will reflect the cultural and linguistic diversity of the consumer population and the population of the wider community. • Program content and clinical practice that reflects and is respectful of cultural and linguistic diversity will be as cost effective and other program approaches and modalities.
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Results To Be Expected by Meeting the Best Practice Criteria**
Consistent implementation of utilization management criteria and evidence- based clinical protocols and clinical pathways	• Utilization management criteria based on evidence-based clinical protocols are implemented as a guide to service planning and service resource allocation decision- making. • These utilization management and service access guidelines are not	• Consumers and their families will attain the best possible outcomes and the highest possible satisfaction as a result of receiving the most clinically appropriate amount, duration, and scope of services. • The public behavioral health system

	established to create a barrier to service access and choice, but rather to assure that services are directly linked to clinical needs, and are predictably most appropriate in terms of producing positive outcomes. • Actual utilization of services is monitored to assure minimal over- or under-utilization of services. • Utilization management criteria are used to identify heavy users of service, to trigger service planning process or new service development to better address the needs of heavy service users. • Training on current and new utilization management criteria and protocols is provided on a routine basis, and staff competencies in utilization criteria and treatment planning is routinely monitored. • The quality improvement process assures that (a) utilization management criteria are properly implemented and applied, and (b) that application of the utilization management criteria have the desired result for consumers and their families.	will use its scarce resources most efficiently to produce the best outcomes with the least clinically appropriate amount of services. • Utilization management criteria will assist managers in the system to plan for the amount and types of services needed, and the competencies of staff in the system, based on the predictable needs of individuals presenting for services. • Consumers for whom the available mix of services is not producing positive outcomes and reasonable utilization patterns will be routinely identified and will have their needs reassessed for improved service planning.
Best Practice Model Component	**Criteria for the Best Practice Model Component**	**Results To Be Expected by Meeting the Best Practice Criteria**
Meaningful inclusion of consumers and family members at all levels and in all functions within the public behavioral health system	• Consumers and families are actively engaged in the overall governance and policy development functions of public and private behavioral health organizations in the system. • Consumers and families are directly involved in program planning and development, quality improvement, and program evaluation functions. • Consumers and families are hired and paid to train managers and practitioners throughout the system. • Consumers and family members are hired to be employees of the system - to function as real employees in real jobs, not limited to performing "consumer representative" functions.	• The public behavioral health system will become capable of being truly consumer and family driven. • Input from consumers and family members will provide the motivation and driving force for continuing improvements in the system. • All participants in the system will become better trained and better able to listen to the voice of consumers and family members. • The recovery process for many consumers will be enhanced through participation in the system, self-advocacy, and advocacy for others.

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EXAMPLES OF ADMINISTRATIVE BEST PRACTICE MODELS AND APPROACHES

Mobile Service Offices - Excel Group

The Excel Group had dedicated two mobile recreation vehicles to act as mobile office space for clinical services. The vehicles traveled to rural/isolated parts of the service area on a regular schedule to deliver counseling and related behavioral health services to individuals unable to travel to centralized service locations.

The mobile service units were reported to be very successful and cost effective in getting services out to isolated individuals. Consumers and family members have reported that the mobile service units are welcoming, accessible, and effective in delivering services. The program is subject to the same outcome, satisfaction, and performance measurement and quality improvement activities as all other components of the Excel Group.

Contact Information:

Excel Group
Yuma, AZ
Mobile Service Offices
Phone: 520-341-9199 (children)
Phone: 520-341-0335 (adult)

Cultural Competency Strategies - Excel Group

The Excel Group has successfully attained a high degree of cultural competence through aggressive recruitment of bi-lingual and bi-cultural staff to accurately reflect its clients. All staff must complete a comprehensive training experience on social/cultural competency. In addition, the consumers served are proportional to their numbers in the general population (45 percent Hispanic, 2 percent American Indian, <1 percent Black, <1 percent Asian).

The Excel Group reports that it has been very successful in reaching out to and serving diverse communities because of its success in recruiting and training bi-lingual and bi- cultural staff.

Contact Information:

Excel Group
Phone: 520-329-8995

Tele-Medicine and Tele-Conferencing - NARBHA

NARBHA NET Tele-medicine and Tele-conferencing network sites providing psychiatric evaluations, medication monitoring, inpatient staffing meetings, individual therapy, and coverage for emergency and commitment evaluations. NARBHA has the most developed Tele-medicine network in Arizona, including sites in Lake Havasu City, Kingman, Prescott, Cottonwood, Flagstaff, Page, Springerville, Show Low, St. Johns, Holbrook, and Winslow.

The total operating budget for the Tele-conferencing program is approximately $370,000. The program provided high quality services to 266 consumers in fiscal year 1998. NARBHA staff feels that decreases in hospital lengths of stay and a reduction in overall medication costs are at least in part attributable to the introduction of the Tele- conferencing technology. According to consumer satisfaction surveys, consumers felt extremely comfortable and satisfied with this type of treatment.

Contact Information:

NARBHA NET
125 E. Elm Street, Suite E
Flagstaff, AZ 86001

Phone: 520-774-7128

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VII. Bringing it all Together: Characteristics of Excellent Public Behavioral Health Systems

This report contains detailed descriptions of best practices for public behavioral health systems. These best practices include child and family behavioral health, adult behavioral health, special services such as housing and employment, and best practice approaches for administration of the system. Examples of all these best practice approaches have been provided, but they do not present the whole story of best practices. In fact, many of the examples represent isolated best practice approaches, rather that characterizing a total system of care. Thus, an important question remains to be addressed: Are there places where the over-all public behavioral health system exemplifies best practices, and if so, what are the common characteristics of these jurisdictions?

There are a number of states that have over the past twenty years deliberatively made the conversion from traditional service models to best practice community support rehabilitation and recovery-oriented models of public behavioral health services. These states include **Vermont, New Hampshire, Ohio, Colorado, Rhode Island,** and **Wisconsin**. These states share a number of common characteristics, many of which have been highlighted as best practices throughout this report. The following Table contains a summary description of these characteristics, and provides some indicators than can signal that the characteristics are being attained.

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TABLE V: CHARACTERISTICS AND INDICATORS OF EXCELLENCE IN PUBLIC BEHAVIORAL HEALTH SYSTEMS

Characteristics for an Excellent System	Indicators that the Characteristics are Present
There has been strong and consistent leadership that has articulated a vision and has forged consensus and momentum for implementing that vision.	• Information about mental illness, emotional disability, and substance abuse is made widely available to the general community. • The vision and mission of the public behavioral health system is espoused constantly in all available forums. • The public behavioral health system has a positive image among policy-makers, elected officials, the media, and the general public. • State and local officials understand the operation of the system and are willing to support allocation of the resources necessary to meet the needs of citizens with behavioral health needs. • Stigmatizing actions affecting people with mental illness or substance abuse are routinely and publicly confronted • Public officials, the media, and the public trust system leadership to be honest, responsive, and to follow through on commitments.
Characteristics for an Excellent System	**Indicators that the Characteristics are Present**
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.	• Services for children and adults and their families are flexible and individualized, and are geared towards recovery and maximum community integration and participation. • The service system focuses on and measures performance with regard to consumer and family preferences and priorities such as independent housing and employment, home and school performance, and quality of life. • Over time the system converts from services delivered in facilities and congregate setting to services delivered in integrated community settings.
Characteristics for an Excellent System	**Indicators that the Characteristics are Present**
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 the named 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.	• Consumers and families are actively involved at every level of the system. • Consumers and families are effective and visible spokespeople and advocates for the public behavioral health system and its priority consumers. • Public officials and the media listen to consumers and families and take their advice about necessary improvements in the system. • The tendency for public dissonance among providers, professionals, and program managers is overcome by a primary focus on the part of these stakeholders on consumer and family priorities.
Characteristics for an Excellent System	**Indicators that the Characteristics are Present**
Local systems of care have been developed,	• All participants in the system, and the general public, can

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.	identify and understand the local systems of care, and know to who they should turn for information and advice or to lodge a complaint with regard to public behavioral health. • There is no diffusion or confusion of accountability for individuals with serious emotional disorders, serious mental illness, and serious substance abuse disorders. • Local service planners and managers have the flexibility and authority to tailor resources to the unique needs and choices of their priority consumers.
Characteristics for an Excellent System	**Indicators that the Characteristics are Present**
Information gleaned from a variety of data sources is used to drive system planning, budgeting, and quality management and performance evaluation. In the named states, decisions are made at all levels based on consistent analyses 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.	• All managers at all levels have access to consumer demographic, service utilization, cost, outcome, performance and satisfaction data to make informed decisions and to hold themselves accountable for achieving their system performance objectives. • Information collected and analyzed at one location in the system is routinely shared with other components of the system. • Comparative information collected and analyzed at the state level is routinely shared with the sources of such information in the field. • Consumers and families are included in the process of analyzing and interpreting information. • Information about best practices is routinely generated from the local systems of care, and is reviewed in the context of evidence-based best practices from other jurisdictions. • The system welcomes outside evaluation and research, and is eager to use and adopt the information gleaned from these studies.
Characteristics for an Excellent System	**Indicators that the Characteristics are Present**
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.	• Participants at all levels of the system express a willingness to learn and try new ways to deliver services. • All participants in the system feel free to challenge the status quo with no fear of retribution. • Communication within the system and between the system and other systems and the general public is open, honest, and non-defensive.

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VIII. Use of Data for Baseline Assessment and Measurement of Progress towards Attaining Best Practices in the Public Behavioral Health System

Much of this report has focused on operational criteria and expected results from the implementation of best practices in the public behavioral health system. For Arizona, it will be useful to establish a series of baseline measures that can be tracked over time in an attempt to quantify the effects of changes on the system and its priority consumers.

Increasingly, publicly funded behavioral health systems have turned to the collection and reporting of performance indicators in order to measure the effectiveness of systems of care or health plans. In recent years, a host of efforts have been undertaken by various organizations to standardize these performance indicators to allow comparisons between health plans and systems of care. A review of efforts undertaken by the National Committee on Quality Assurance (NCQA), the American Managed Behavioral Health Association (AMBHA), Health Plan Employer Data and Information Set (HEDIS), and the Mental Health Statistics Improvement Program (MHSIP) has resulted in a collection of performance and outcome indicators that are now being collected and reported in public and private systems of care throughout the nation. The collection and reporting of these indicators varies somewhat throughout the country, and performance reporting is still in the beginning stages. However, as with other aspects of public behavioral health, the knowledge and technology are improving rapidly, and improved approaches to measuring performance and outcomes are now becoming available.

The following is a brief description of performance indicators that could track changes over time as efforts to implement best practices are developed and implemented. These indicators include measures of access to and appropriateness of the care provided on a system level, allowing comparison of RBHAs throughout the state. The indicators have been included in this report because they are generally accepted national measurement standards that can be applied in Arizona, and they are supported by available and reliable data already collected throughout the Arizona Public behavioral health system.

Penetration Rates - Comparison of RBHA Penetration Rates of Enrolled Consumers by Program Indicator. This can be used to monitor the progress of RBHAs in delivering services to severely mentally ill adults, seriously emotionally disabled children, and general mental health/substance abuse populations as compared to the overall statewide average for the penetration rate of enrolled consumers receiving services by these same population groups. Over time, the RBHAs should focus on increasing the penetration rates of defined priority consumer populations. This can be measured through comparing average monthly users to the estimated number of persons potentially eligible for mental health and substance abuse services.

Inpatient Days per 1,000 or 100,000 Population. This can be used to assess the level of utilization of acute service types versus lesser intensity community-based services.

Inpatient Average Length of Stay. This indicator should be applied to psychiatric

health facilities (PHFs) and other facilities to determine whether lengths of stay are in acceptable ranges for the acute and intermediate levels of care. Long lengths of stay may indicate a need for development of residential services or supportive services in the community.

Person Served by Program Indicator. This measure can be used to determine which population group is consistently receiving the most services by RBHA. Although there is a possibility of variation in demand by RBHA, these measures in combination with penetration indicators could be used to assess whether adults, children and/or persons with substance abuse are receiving less or more treatment than the general mental health (GMH) population.

Expenditures - Comparison of RBHA Expenditures per Capita by Level of Service. This measure can be used to assess whether RBHA to RBHA expenditure for behavioral health care are achieving a minimum statewide standard. By breaking this down and reporting it by level of service, the data can provide illustration of whether one service disproportionately comprises the bulk of the expenditures. Case management service expenditures are now a significant component of expenditures. Over time it will be important to assess if these expenditure patterns change.

The use of acute services versus lesser intensive treatment can be monitored at an aggregate level by assessing the expenditures per capita by service type. This too should be monitored over time.

30-Day Acute Readmission Rates. This can be used to determine the availability of community resources and provides a rough indicator of appropriateness of care provided. If there is a high degree of recidivism, it may be an indicator that there is a lack of lesser intensive service alternative in the community.

The above indicators could be augmented over time. However, given currently available data, they will provide the most effective and reliable measures of system performance. The use of these indicators over time will provide useable tools to assess the progress of the publicly funded behavioral health care system.

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IX. Conclusion

As noted in the introduction to this document, the purpose of this volume is to provide greater detail and information about recommended best practice approaches for the public behavioral health system. Most of the best practice models described in this report would be applicable in any public behavioral health system. The challenge is to pick which among the best practices are the highest priorities for implementation, and then to tailor the selected best practice models to local conditions and resources. By providing greater detail about best practice models and examples, the intent has been to address two fundamental questions. The first is: How will we know when we have actually attained implementation of a given best practice? The second is: What can we expect will be the long-term effects of making the changes necessary to implement best practice models. Thus, this volume is intended to serve as a menu from which best practice approaches may be selected and adapted. It can also serve as a series of guideposts to support the implementation process and to assist system managers to anticipate the effects of the changes.

In Volume I, a number of recommendations for immediate action to improve the Arizona public behavioral health system have been made. These are based on immediate needs for system improvements identified through the strengths-based assessment of the Arizona public behavioral health system. They were also recommended because, once implemented, they would create both a track record of success and additional motivation for further changes and improvements. These are important elements of any change process: (a) starting with a limited but important agenda and gaining some immediate successes; and (b) leveraging early successes into an on-going and highly motivated change process.

Change is always difficult, even when all parties have the best intentions. It typically takes a huge amount of effort to make changes, and only a small amount of effort to stop or delay the change process. It is hoped that the information and examples in this volume can both stimulate positive change, and also assist the change agents to overcome inertia and resistance to change.

The best practices discussed in this volume represent the state-of-the-art, as it is known today. However, the state-of-the-art is developing and changing very rapidly. One of the most exciting aspects of public (and private) behavioral health today is the pace of new knowledge development. There continues to be an explosion of new clinical trials and studies that introduce new medications and related practices. There is also an explosion in good services research, leading to greater confidence with many of the best practice models contained in this report. The new services research is also challenging some commonly held opinions about the efficacy of certain program models and approaches.

Thus, this volume must be viewed as a work in progress. It has been noted throughout this report that a willingness to learn and to challenge traditional approaches is a best practice itself. Thus, it is hoped that all participants in the public behavioral health arena will challenge the contents of this volume, and will contribute to the knowledge and skill of the public behavioral health system in meeting the needs and choices of priority consumers.

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APPENDIX A
CRITERIA FOR PUBLIC BEHAVIORAL HEALTH BEST PRACTICE DOMAINS

System Best Practice Domain	Criteria for Measuring the Degree to which the Best Practice Domain is Met
Customer Orientation	• Services are welcoming, engaging, accessible, and culturally competent; • The service system responds to individual needs in an effective manner; • All customers are treated with dignity and respect; • Customer satisfaction and dis-satisfaction are routinely and effectively assessed, and the information collected is used for service planning and quality improvement activities; • Every staff person in every service location and at every level of service delivery and management knows who the customers are, and feels personally responsible for satisfying each customer. • Customers and their families are meaningfully involved in all aspects of service planning, development, delivery, and evaluation; • All services and supports are individualized and tailored to individual needs and choices; • Customers are perceived and understood to be whole people with ranges of strengths, resources and needs, and not simply as individuals with behavioral health problems; and • The system provides public information and advocacy to reduce stigma and to assure understanding, acceptance and support on the part of communities for individuals with disabilities.
System Best Practice Domain	**Criteria for Measuring the Degree to which the Best Practice Domain is Met**
Clinical Excellence	• Strong clinical leadership is empowered at all levels of service delivery and management throughout the behavioral health system; • The system supports all service components through the provision of adequate resources, training, technical assistance, and coordination of quality improvement efforts; • The system implements evidence-based best practice for all service modalities; • Clinical and program support staff receive regular and timely competency - based on the job training and supervision related to evidence-based best practice, and receive support for implementing best practice approaches throughout the service system; • All applicable components of the service system attain the highest level of credentialing and accreditation; • All components of the service system employ comprehensive consumer outcome-based quality management and quality improvement practices; and • Utilization management criteria and protocols assure appropriate service access and utilization, while protecting against under- or over-utilization of services. • The services and supports provided by the system foster and enhance independence, self- sufficiency, recovery, and integration in normal community activities;
System Best Practice Domain	**Criteria for Measuring the Degree to which the Best Practice Domain is Met**
Integration	• The system takes responsibility for assuring integration and coordination with the primary health care system • Each service component within the behavioral health system is effectively linked and integrated with all other components; • Clinicians and service providers at all levels are co- and cross trained and have sufficient skill and understanding to provide integrated treatment and/or responses to

	consumers presenting with multiple needs and/or disabilities; • The service system assures effective communication, coordination, integration, and facilitated access for consumers to housing, employment, recreation, education, and other necessary community resources and services; and • The service system fosters and supports integration of all consumers into normal community living.
System Best Practice Domain	**Criteria for Measuring the Degree to which the Best Practice Domain is Met**
Continuity	• The behavioral health system provides a person or team to function as the single point of responsibility, accountability, communication, and continuity for each consumer of long-term services; • Clinicians and service providers understand, respect, and respond to the need of most long term consumers to have a trusting and continuous relationship with individuals and program components; • Teams rather than individuals provide most community services and supports. This assures continuity of service for consumers, and reduces the discontinuity resulting from staff turnover. • Policy, program guidance, and performance measurement approaches must constantly change and improve. At the same time, continuity is maintained between old and new approaches to build on past strengths and successes, to facilitate the transition process, and to support longitudinal outcome, cost and performance analyses.
System Best Practice Domain	**Criteria for Measuring the Degree to which the Best Practice Domain is Met**
Stewardship of public funds	• There are identified single points of combined clinical and financial accountability, responsibility, and authority at appropriate locations throughout the behavioral health system; • All elements of the behavioral health system are routinely evaluated to assure their cost-effective contribution to consumer outcomes and satisfaction and to system-wide performance improvement; • At all levels of the system there is a strong commitment to learning and to change; • The results of these evaluations of cost-effectiveness and performance are routinely published and interpreted to consumers, family members, and other stakeholders; • Financial incentives that foster high performance and efficiency are implemented; • Data on individual consumer and program characteristics, utilization, cost, outcome, satisfaction, and performance is regularly available in a timely, consistent, and accurate manner; • The system is an effective advocate for its constituents, and effectively communicates to key policy- makers, funders, and the general public about its ability to serve people with serious mental illness or emotional disability, the costs of providing high quality and effective services to these individuals, and the public imperative to provide adequate care; • The system is as productive and efficient as possible, and minimizes the use of public resources for administration, indirect costs, and non-performing service components; • There is minimal duplication of regulatory and related licensure requirements, and deemed status is granted to program components accredited or credentialed by accepted nation accrediting/credentialing bodies; and • Financial systems and controls at all levels of the system assure fiduciary responsibility for public resources.

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