

HEALTH PLAN
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BEHAVIORAL

HEALTH

PLAN

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I. Introduction

The organization of behavioral health has been a primary concern of Donald B. Mathis, Director, Arizona Department of Health Services. He abolished the Division of Behavioral Health Services and established an interim organizational structure. In January, 1984, he appointed a task force to develop a behavioral health plan that would encompass both the delivery system and the Departmental structure. The need for reorganization was affirmed in a letter to Mr. Mathis from Governor Bruce Babbitt. The Governor's letter requested a comprehensive work plan which reviewed funding levels and procedures concerning the areas of Chronic Mental Illness, Alcohol Abuse, Mental Health, Substance Abuse, elderly, and child and adolescent services. The Governor reaffirmed his support to behavioral health programs by requesting an additional 4.5 million dollars in state funding for Fiscal Year 1984-85.

This plan is not intended to provide far-reaching solutions to rectify each and every issue that is currently facing the behavioral health system. The intent is to give specific examples of the types of problems that have plagued the behavioral health system and to outline a work plan with realistic timelines for completion. The plan will not attempt to address each problem as a separate issue, but rather present a list of problems as the rationale for developing an overall plan.

Every effort was made to solicit input from as many sources as possible during the planning process. To this end, a letter of introduction and brief explanation was mailed to several hundred interested persons and organizations. The letter invited the recipient to participate in the planning process, either by submitting written material, or by making a personal contact with a member of the task force. The task force also initiated several contacts in order to receive the broadest range of input.

The response to the task force request for input and information was extensive. The task force received comments from major providers of behavioral health services, city and county governments, other state departments, advocacy groups, Health Department staff, planning groups, private health care providers, and other interested persons. The input took the form of prepared documents and studies, existing plans, statistical reports, verbal presentations, and letters. The members of the task force would like to extend their sincere appreciation to all of the persons and organizations who expended their time and energy in providing valuable input into the plan.

The plan is organized into seven sections. The first five sections are intended to provide a philosophical base from which the Department views behavioral health, an historical overview, an explanation of the current behavioral health system and an overview of the need for behavioral health services in

Arizona. Section Six lists problem statements that are intended to highlight many of the major areas of concern. The problem statements are being presented as examples of why system changes or modifications are needed and are not intended to be all-inclusive.

The final section of this document presents a plan for changes and modifications to the Arizona Behavioral Health System. It describes the system of clinical Services, the structure of community programs and state institutions that must follow in order to deliver the clinical services, the organization of the Department of Health Services that will most effectively monitor and provide leadership to behavioral health, and lastly, legislative issues that impact the delivery of services. Patient care was the primary and overriding concern in the development of this plan. All modifications and changes are intended to provide a smooth and efficient mechanism for the delivery of quality services.

It was the conclusion of the Department, that several areas of concern will require an in-depth review which involves the combined effort of many people. In these situations, the plan will outline a mechanism for a more in-depth review and provide realistic timelines for completion. This approach appears to be more valuable than attempting to give quick, easy answers to complex problems without adequate planning.

A factor impacting this plan was the absence of adequate data. Data use and analysis has been deficient in the behavioral health system for many years. The state has not taken the leadership to ensure that data reporting is uniform and consistent and has not aggregated the data into report formats for easy use in planning or evaluating. Therefore, the task force relied more heavily on data from provider agency studies and national statistics and prevalence indicators.

The paramount limitation of any planning effort in Arizona is the severe shortage of funds available for behavioral health programs. National statistics indicate that Arizona ranks near the bottom in per capita funding for behavioral health programs, yet ranks above most other states in the indicators of problems. While the funding for behavioral health programs has remained low, indicators such as suicide, alcohol consumption, divorce and crime rates have risen in alarming proportions. Under this situation the best of plans and the most efficient programs can still only address a fraction of the need.

This plan was developed with the strict thought that services and programs would not be interrupted as changes are being made. The primary concern was always the client. It is the Department's intent that the changes outlined in this plan will improve the quality of services, the delivery of services, the accessibility of services, and the accountability for services.

II. Philosophy

The following principles represent the philosophy of the Arizona Department of Health Services concerning the behavioral health delivery system.

Behavioral Health Services are most effective when delivered in a Continuum of Care. Individuals should progress from a point where considerable structure and intensive programs are needed to where little or no structure and less intensive programs are required. A full continuum of care is necessary to meet the varying needs of behavioral health clients.

Services should be delivered in the least restrictive environment. Prior to entry into a behavioral health program, the client should be carefully evaluated to determine the least restrictive environment where he/she can be treated without compromising the client's safety or that of others.

Services should be specialized and individualized. Services should be specialized to insure that the needs of differing groups are met. Services should be individualized to insure that the unique strengths and needs of the person are taken into account in developing treatment methodologies.

Services should be available within a specific geographic area. Services should be available where they are needed. Individuals should not be required to move out of their home community or to travel inordinately long distances to receive services.

Services should be appropriate, responsive and sensitive to the concerns and needs of the client served, regardless of age, gender, sexual orientation, handicap, and racial and ethnic background.

Treatment programs should be designed and implemented to maximize the client's greatest potential.

Behavioral Health Services are more effective when delivered in an environment that provides the client with cultural identification.

The family should be involved in treatment and treatment planning whenever possible. Behavioral health programs should be designed and implemented in a manner that would allow the family to participate in treatment and avoid separation whenever possible.

Programs and services should be developed, implemented, and delivered at the local level to meet the needs of a community. There should be enough flexibility

within community programs and the Department in order to respond to changing needs.

A dual system of care should not exist for those clients who can pay for services and those who cannot. One quality system should exist which allows clients to pay according to their ability on a sliding scale from zero to full pay. Services cannot be denied because of inability to pay.

The cost of behavioral health services is a shared responsibility of the State, the local community and the client.

Behavioral health services should be delivered in a cost-effective manner while meeting established standards for approval, licensure, and performance.

The Department is the Single State Authority, as mandated by law, and therefore is responsible to take the lead in ensuring a statewide system of behavioral health services through integration and coordination of its activities with those of other state departments, local governments, community behavioral health programs, and public and private service providers.

III. Historical Overview

The development of mental health, alcohol abuse and drug abuse programs resulted from a combination of efforts on the part of federal, state and local governments and concerned citizens. The Arizona State Hospital was established in territorial days by legislative mandate to house the insane. Interested citizens throughout the state began movements to develop local, community-based mental health outpatient services and the Arizona Department of Health established a Division of Mental Health. Approximately ten years later, Congress passed the National Community Mental Health Centers Act and Arizona began to increase its community mental health services through the use of Federal grants. During this time, the Arizona State Hospital established a component (Southern Arizona Mental Health Center or SAMHC) to assist the five southern counties in screening patients for admission to the Hospital. At about this same time, interest began developing in alcohol abuse problems and the Division of Mental Health established a section on Alcohol and Drug Abuse. The legislature appropriated funds and authorized the Department to establish programs. Up until this point, drug abuse and alcohol abuse programming existed minimally as a grassroots effort of local citizenry. Several years after the State initiative, Congress passed alcohol and drug abuse legislation making funds available for specific programming. The Arizona Legislature then established, within the Department, a Division of Addictive Behavior Services. Both the Division of Mental Health and the Division of Addictive Behavior Services had responsibility for statewide planning and contracting for services.

The Federal initiative for mental health services predated that for addictive services by about ten years and was much more specific in terms of services to be provided, populations to target and geographic areas of responsibility. The intent of the federal mental health initiative was to deinstitutionalize the severely mentally ill population maintained in state hospitals and prevent chronic mental illness, through early intervention and community treatment. Catchment areas were established in the state for mental health based on a population density and federal funds were tied to the provision of a comprehensive range of services for that area. Although the severely mentally ill were targeted, federal regulations required all populations in the catchment areas to be served.

Federal drug abuse and alcohol abuse funding tended to be geared towards services specifically for more chronic populations through specialized programming. Service areas were not designated and programs were established that served larger geographic areas or were county-wide in scope. Federal funding through these drug abuse, alcohol abuse and mental health initiatives was made available directly to local programs on a decreasing percentage and time-limited basis. For instance, as the Federal percentage of participation in a program decreased over the years, it was anticipated that the State and local communities would increase their percentage of participation

until Federal dollars were no longer required. At the same time the Federal government was providing direct support to programs, it was making funds available to the State through the Department for alcohol abuse and drug abuse programming.

In 1974, the Legislature passed a bill which reorganized the Department of Health and a Division of Behavioral Health Services was created which encompassed the Arizona State Hospital, Southern Arizona Mental Health Center, the Bureau of Community Programs, (formerly the Divisions of Mental Health and Addictive Behavior) and the planning functions stipulated through Federal legislation.

After this point in time, deinstitutionalization of ASH patients became a focus of the Department and the numbers hospitalized decreased significantly. Hospital staff positions devoted to serving ASH patients after discharge were abolished and those resources were channeled to community programs. Apart from this, ASH funding has remained stable. Although community service funding has increased over the years, it has not done so commensurate with the increased responsibility for maintaining discharged patients in the community. In order to access aftercare services offered by the hospital, discharged patients tended to settle in the boarding and supervisory care homes in that same area. This relocation of ex-ASH patients in the Phoenix area produced the disproportionate distribution of chronic mentally ill persons across Arizona.

When direct Federal grants to community programs were depleted, the Department recognized Arizona's responsibility and began replacing those funds at 50% levels with State appropriated dollars. As more Federal grants terminated, the Department was unable to continue its policy of replacement because of insufficient resources. Therefore, those programs first receiving Federal money also received more State dollars in replacement. Since the major metropolitan areas developed earliest, they have more State resources compared to other areas. In addition, the Department did not implement program reductions which were intended to occur because of both Federal and State dollar cuts in the past few years. This action precipitates the current fiscal crisis.

The Federal Government continued its movement of responsibility to the State by consolidating all program funding into one block grant to Arizona. Programs formerly receiving direct support from the Federal Institutes now receive that money from the Department. Direct federal funding formerly used by programs to match State appropriated dollars was no longer available as match. Therefore, many programs were unable to meet the stringent match guidelines.

There are numerous legislative mandates that establish and define the behavioral health system and have helped to shape its development. The authority for the Arizona Department of Health Services to function as the State Alcohol, Drug Abuse and Mental Health Authority, is set forth in Arizona Revised Statutes

36-104, Paragraph 1-(C)-(i) and (ii). Authority is also identified in A.R.S. 36-2004, wherein it is stipulated that the Arizona Department of Health Services is designated as the Single State Agency (SSA) to develop and administer the State Plans for Alcohol and Drug Abuse. The statutory authority to implement the State mental health plan is found in A.R.S. § 36-104.8.

Single State Authority functions relating to the Department's ability to administer funds for the provision of behavioral health services are as follows:

A.R.S. § 36-189.B. authorizes the Department to use available funds to contract for the establishment and maintenance of local mental health facilities and services to be provided by either private or public agencies. This also establishes the 25% local matching funds mandate.

A.R.S. § 36-550 authorizes the Department to provide state funds to develop and implement community residential treatment systems for the Chronically Mentally Ill in the least restrictive alternative available and in accordance with the client's needs. This also establishes a 50% local matching requirement for County provided programs.

A.R.S. § 15-765 assigns responsibility for payment of noneducational, nonmedical costs of 24-hour residential placement of seriously emotionally handicapped children to the Department. Children are to be placed in this program by mutual agreement between the school district and the Department of Economic Security or Department of Health Services.

A.R.S. § 36-141 authorizes the Director to contract with public or private non-profit agencies to develop, maintain and provide alcohol and drug abuse prevention, education, consultation and treatment services.

A.R.S. § 36-3002 establishes the Domestic Violence Shelter Fund to provide temporary residential services, crisis and support counseling, plus information and referral services to victims of domestic violence.

The above statutes also prescribe the Department's role in establishing standards and methods to be utilized in administering these individual fund sources. Some of the above are quite specific in identifying criteria to be utilized in funding programs and identifying clients. Others simply place this responsibility upon the Department.

Further delineation of the role of the SSA as it relates to the Department's responsibilities for regulation of behavioral health treatment are addressed in the following statutes:

A.R.S. §§ 36-202 thru 215 establishes the Arizona State Hospital, describes the powers and duties of the Director, the

qualifications and duties of the Superintendent and programs that may be implemented.

A.R.S. §§ 36-501 thru 36-550 is the Mental Health Services Act which legislates the screening, evaluation and treatment of mentally disordered individuals in Arizona. It allows for involuntary commitment of individuals on the grounds of danger to self, danger to others or grave disability due to mental illness. It further mandates the Department to set forth rules and regulations to implement and carry out the intent of the law.

A.R.S. §§ 36-2001 thru 36-2004 requires the Director to establish services for addictive behavior and plan for, evaluate and promote coordination and cooperation in a drug abuse and alcohol abuse system. It establishes the Director's authority to request studies, accept grants, matching funds and direct payments, make contracts, match federal grants, make rules and regulations and provide a variety of treatment settings for drug and alcohol abuse control and prevention. It also establishes a variety of other powers and duties and establishes the Department as the lead agency in alcohol and drug abuse state planning.

A.R.S. § 36-2022 states the Department shall develop and foster plans and programs for prevention and treatment and provide technical assistance and consultation.

A.R.S. § 36-2023 requires the Department to make and enforce rules and regulations which establish standards for approved treatment facilities. It sets minimum standards and mandates the Department to coordinate with the Department of Corrections, Department of Transportation and other entities in establishing programs. It also mandates a method for keeping and sharing relevant statistical information.

A.R.S. § 36-2026.01 allows for involuntary commitment of chronic alcoholics to residential treatment and outlines the process for adjudication.

A.R.S. § 36-2028 mandates the Department to adopt rules and regulations governing client financial ability to pay and to prepare and adopt patient fee schedules.

A.R.S. §§ 36-2051 and 2052 designate the Department as the state authority under the Federal Drug Abuse Office and Treatment Act of 1972, and require the adoption of methadone maintenance treatment program rules.

Although the above statutes describe the major mandates of the Department, numerous other statutes have been identified that relate to specific duties and responsibilities of the SSA. The following is a listing of other statutes relating to the provision of behavioral health services:

A.R.S. §§ 41-2401 thru 2403

A.R.S. § 41-1308
A.R.S. § 4-203.02
A.R.S. §§ 36-1031 thru 1036
A.R.S. § 13-3408
A.R.S. § 36-142
A.R.S. § 36-2021
A.R.S. § 36-2024
A.R.S. § 36-2025
A.R.S. § 36-2026
A.R.S. § 36-2027
A.R.S. § 36-2030
A.R.S. § 36-2031

IV. Current System

Since its development in 1974, the Division of Behavioral Health Services has undergone many structural reorganizations. In December, 1983, the Division was abolished by the Director of the Department. Prior to December, 1983, the Division of Behavioral Health Services functioned as the organizational unit of the Department concerned with the prevention and treatment of alcohol abuse, drug abuse, mental disorders and emotional problems. The Division was responsible for assessing needs and developing and coordinating behavioral health services. The Division was further organized into four Bureaus: the Arizona State Hospital (ASH), the Southern Arizona Mental Health Center (SAMHC), the Bureau of Planning and Evaluation, and the Bureau of Community Services.

The Arizona State Hospital, located in Phoenix, functions to provide inpatient care and treatment to persons in Arizona suffering from mental and emotional disorders. It is the only state operated psychiatric inpatient facility in Arizona.

The Southern Arizona Mental Health Center, located in Tucson, is a community mental health program which serves some of the residents of Pima County.

The Bureau of Planning and Evaluation was established to provide the supportive services of planning and evaluation to the other three bureaus of the Division. The responsibility of maintaining both the Community Programs Data System (CPDS) and the Arizona State Hospital Data System rested with this Bureau.

The responsibility of the Bureau of Community Services is to support and monitor a statewide system of behavioral health services. This Bureau provides state appropriated and federal funds to local private, non-profit and public agencies through contracts for services. Staff of the Bureau monitor the contracts and provide technical assistance and training to assure that services are of sufficient quantity and quality.

As Arizona State Hospital and the Southern Arizona Mental Health Center are the only two bureaus providing direct services within the State, all other state supported community behavioral health services are provided through the contracts administered by the Bureau of Community Services. Most of these contracts are for general mental health, alcohol abuse and drug abuse treatment programs. In addition, three specialty programs are funded. These programs are: residential services for severely emotionally disturbed children, residential continuum programs for the chronically mentally ill and domestic violence Shelter programs.

Contract facilities are located in every mental health catchment area. Most mental health services are provided by one agency that serves the catchment area, although some mental health services are provided across catchment areas. In some

parts of the state the catchment area based agencies provide all categories of service: alcohol abuse, drug abuse and mental health. In addition, umbrella agencies providing specialty services operate across catchment areas. The specialty programs for emotionally disturbed children are provided statewide, whereas the specialty programs for the chronic mentally ill are combined with the catchment area programs or, in some cases, provided across catchment areas. The domestic violence shelters usually serve clients from any area of the state.

The Bureau of Community Services currently has 36 prime contracts for treatment services. Thirty-two of them are with private, non-profit corporations and four are with public agencies. Of the public agencies, three are Indian Tribes and one is a County Agency. Additional detail is reflected in Exhibit 1 which lists contractors, categories of service, and service areas. Exhibits 2 through 12 reflect contract dollars for FY 84, clients seen and services delivered in FY 83 by community agencies, ASH and SAMHC.

V. Indicators of Need

This section will list the major indicators of the need for behavioral health services in Arizona. It is intended to provide an understanding of the extent of problems that behavioral health providers are facing and the need for an integrated system of care.

- Arizonans drink 3.41 gallons of ethanol (distilled spirits, wine, beer) per person each year compared to a national average consumption of 2.82 gallons. This ranks Arizona 9th among the 50 states.
 - Arizonans drink 30.2 gallons of beer per person every year. Arizona ranks 7th among the 50 states. These figures reflect total population, including children, so the actual consumption rates would be even higher.
 - Arizona ranks 5th among the 50 states in percentage of deaths due to cirrhosis of the liver. The national average is .69 percent while Arizona is almost twice that at 1.13 percent.
 - Arizona ranks 4th in highway fatalities with a yearly rate of 41 deaths per 100,000 population. This compares to a national average of 24.3 per 100,000. Studies show that between 35 and 64 percent of drivers in fatal accidents had been drinking prior to the accident. Studies also show that between 45 and 60 percent of all fatal crashes involving younger drivers are alcohol-related.
 - The estimated economic cost of alcoholism in Arizona is approximately \$1 billion. Included in this estimate are costs attributed to lost production, health care, motor vehicle accidents, violent crime, fire loss, social welfare, criminal justice, fire protection, alcohol programs and highway safety. Even this estimate is low since it is based on national calculations and Arizona problems exceed most national statistics.
 - Over 25% of all arrests in Arizona (adults and juveniles) are for Driving While Intoxicated. This ranks Arizona 81% higher than the national average for DWI arrests.
 - Arizona's divorce rate is 7.5 per 1,000 population per year. This ranks Arizona 7th of the 50 States.
 - There are approximately 2.84 reported family cases of child abuse per 1,000 population. Among the thirty-two states reporting, Arizona ranks 11th in incidence.
- The FBI reports that forty percent of women murdered were killed by their sexual partners, while ten percent of men murdered were killed by their partners.

- Nationally, forty percent of all police injuries and twenty percent of police deaths occurred while responding to family disputes.
- Nationally, police spend one-third of their time responding to domestic violence calls.
- Battery is now the single major cause of injury to women, surpassing rapes, muggings or traffic accidents.
- Of a total City of Phoenix police budget of \$47.8 million, an estimated \$16 million is spent responding to family dispute calls.
- In Phoenix, domestic violence calls average sixty-three per day. In one year's time, there will be one call for every twelve households.
- Fourteen percent of all Phoenix homicides for January through October, 1983, involved sexual partner relationships.
- Nationally, twenty-five percent of all suicide attempts by women are preceded by a history of battery.
- Arizona ranks sixth of all states for suicide rates with 17.6 per 100,000 population compared to the national average of 11.4.
- Suicide is now one of the leading causes of death among 15 to 19 year olds, second only to traffic accidents.
- The City of Phoenix has the highest adolescent suicide rate in the nation.
- 13.9% of Arizonans experience stress symptoms severe enough to prevent them from carrying out daily activities.
- 21% of the Phoenix homeless are chronic alcoholics and 21% are chronically mentally ill.
- There are an estimated 7,800 chronically mentally ill in Arizona.
- 8,198 persons were arrested in Arizona for drug violations in 1981. Of these, 7,118 were males, 1,080 were females and 1,650 were juveniles under the age of 18.
- Heroin admissions to the Phoenix treatment system for January-June 1983 increased 160% over July-December 1982. Admissions for other opiates and synthetics increased 130%.

- Phoenix drug abuse emergency room admissions for January-June 1983 increased 128% over July-December 1982.
- Hepatitis B cases have steadily increased since the last half of 1981.
- The estimated economic cost of drug abuse in Arizona is approximately \$325 million.

The above information was generated from the following reports:

Alcohol, Drugs and Mental Health in Arizona - Some Alarming Trends, Steve MacFarlane, M.A., Carl Brown, Ph.D., Steven B. Scott, Ph.D.

This report references the following sources:

National Center for Health Statistics, 1983
Newsweek, August 15, 1983
Survey, ADHS, 1982
Brown, Paredes, and Stark, 1982
Brown, MacFarlane, Paredes, and Stark, 1983
American Humane Association, 1983
Time, September 5, 1983
Police Magazine, 1978
Hyman, Zimmerman, Gurilo, and Helrich, 1980
DISCUS, 1982
United States Brewers Association, 1982
NIAAA, 1981a
National Center for Health Statistics, 1982
NIAAA, 1981b
Crime in Arizona, DPS, 1982
NIDA, 1982

Domestic Violence in Arizona, Alan Asher, M.C., Charlotte Harrison, MSW

Alcoholism, DWI, and State-Supported Treatment Programs in Arizona, BPE, DBHS, ADHS, 1981

Drug Use In Phoenix: Jan.-June, 1983, Deborah L. Rhoads, Ph.D.

Plan for Implementation of a Residential Treatment Continuum for the Chronically Mentally Ill, Braun & Associates, 1981

Vital Health Statistics, ADHS, 1982

VI. Problem and Issue Statements

This section will outline specific problems and issues that are currently affecting or perceived to be affecting the behavioral health system. The problems and issues are given as examples of why change or modification is needed.

- The Arizona State Hospital has never functioned as a component within a behavioral health system, but rather has functioned as an institution independent from the behavioral health services delivered by community providers.
- In the recent past, ASH and the state-supported community mental health agencies have never been administratively required to operate as a continuum of care; rather, they operate as two separate systems. This has led to conflicting goals of each system, competition between the systems, and a breakdown in continuity of care for clients to the extent that some clients have not received needed community services or have been denied admission to the hospital when appropriate.
- SAMHC was originally established as the southern Arizona screening unit of the Arizona State Hospital. It also provided aftercare services to discharged ASH patients whose residence was in one of Arizona's five southern counties. The role of SAMHC has since evolved based on the needs of Pima County but has not been determined based on the needs of the entire behavioral health system.
- Families of the chronic mentally ill are often excluded from the treatment planning process, although they often have major responsibility for follow-up. Programs involving families in treatment are few and far between and few family support groups are available to fill the gaps.
- The continuum of residential treatment for the chronic mentally ill mandated by A.R.S. § 36-550 is funded to serve only 10% of the estimated 7,800 chronic mentally ill persons in the state. In addition to the residential continuum, 58% of those in need are served in the general mental health system. Most of these persons require a more intensive array of services than is available. The remaining 32% of CMI persons are unserved due to the lack of specialty programs to meet their specific needs. Also, ASH has not properly served this population, particularly in reference to discharge planning and aftercare.
- A new population of chronic mentally ill homeless persons has been identified as needing services. Existing services are inadequate or inappropriate for this population.

- Services required to meet the needs of the chronic mentally ill are usually the most expensive services in the continuum. Treatment is needed for an indefinite duration and there are few sources of funding to support this treatment. This causes a reluctance on the part of community treatment agencies to accept responsibility for increasing services to this population.
- The role of the Arizona State Hospital children's unit has not been defined based on identified needs of referring agencies. The children's unit has not established the age of children to be admitted or a therapeutic approach that would best meet the needs of children referred by agencies such as the Department of Economic Security, the Department of Corrections and the Juvenile Courts.
- A continuum of children specific Behavioral Health services does not exist in the community programs. Services such as outpatient, evaluation/diagnosis and day treatment programs are currently not available in all areas of the state. There is a lack of coordination and linkages between Department funded programs, other State departments, and other providers of children's services.
- A number of elderly clients whose psychiatric problems are either stabilized or in remission are currently in the Arizona State Hospital awaiting placement. The cost of long-term, extended care placement of these elderly clients has been defined a county responsibility, but blocks to placement continue to exist.
- A continuum of elderly specific Mental Health services does not exist in the community programs. Services such as respite care, psychiatric evaluation, home based services and services provided in nursing homes are currently not available through community programs. Coordination with funded programs of the Area Agencies on Aging is lacking.
- There is an insufficient amount of funds to meet the growing demands for Mental Health services. Recent changes in the Mental Health statutes have increased the number of clients who are ordered by the courts to undergo Mental Health treatment. There has not been a corresponding increase of funds to support the demand.
- The full development of domestic violence programs into behavioral health programs that meet health and safety standards, regulations and program requirements is impaired by the funding ceiling of \$40,000 per shelter placed on the program through legislation.

- Many domestic violence programs receive funding for shelter and counseling services from both DES and DHS. Inconsistencies occur because DES prohibits the collection of client fees from Title XX clients and DHS mandates the collection of client fees.
- Domestic violence shelter clients have immediate medical needs that are not being met.
- Increased demand for and development of for-profit and not-for-profit methadone maintenance programs together with decreasing Federal control leads to a greater need for State standards and regulations.
- Drug abuse service needs change based on the quality and quantity of drugs available and the system is not flexible enough to expand and contract readily enough to meet those needs.
- There is an inadequate capability for residential drug abuse detox in the system.
- There is not enough drug abuse residential treatment available for women with dependent children.
- Involuntary commitment to alcohol abuse treatment is not available to populations other than the "revolving door" LARC client.
- There is not enough alcohol abuse residential treatment available for women with dependent children.
- Since the current treatment system is geared primarily toward the chronic alcoholic, alternative treatment methods for the early stage problem drinker are insufficient.
- There has not been a mechanism developed to follow clients after alcohol abuse treatment and assist them to maintain their gains in treatment and prevent their relapse to abusive drinking.
- DOC, DHS and other agencies provide education, screening, evaluation and treatment for the DWI offender; thus, overlapping roles and responsibilities occur in the continuum of care.
- Residential services available to implement involuntary commitment for alcoholics are insufficient.
- There is no uniform system of screening and evaluating clients for acceptance into community behavioral health programs.
- There is no uniform system of case management of behavioral health clients to insure movement along a

continuum of care as the client progresses.

- Not all behavioral health programs include the family as part of the treatment process.
- Appropriating treatment dollars in categories of drug abuse, alcohol abuse and mental health does not allow a flexible system of treating clients with multiple problems.
- Several governmental entities such as cities, counties, Department of Education, Department of Economic Security, Department of Corrections, and the Department of Health Services provide behavioral health services. There is a lack of coordination and integration of the different service systems. There is also conflict over service definitions which leads to additional confusion.
- Targeting of specific populations as a priority for services and funding has not been accomplished by the system. This is primarily due to a lack of coordinated planning based on a needs assessment for a specific section of the state.
- Data reporting systems and outcome evaluation methodologies have been inconsistent and do not accurately reflect the amount of services delivered or client improvement as a result of the treatment received.
- The Department has established payment rates which do not reflect the true costs of services.
- Specialized services for ethnic minorities are insufficient.
- Although mandated by Federal and State laws, the Department of Health Services has not fully assumed the role of the Single State Authority for behavioral health services.
- The internal organization of DHS has not lent itself to coordinated efforts among its various entities.

VII. The Plan

The following outlines the plan to enhance, modify and reorganize the existing Behavioral Health System in order to address the problems listed in the previous section. The planning portion of this document will describe the system of clinical services and programs considered necessary, address the delivery mechanisms necessary to implement the service delivery system and identify legislative restraints and limitations on the provision of behavioral health services. Timelines for implementing major changes to the service delivery system will also be included.

A. The Organization of Clinical Services

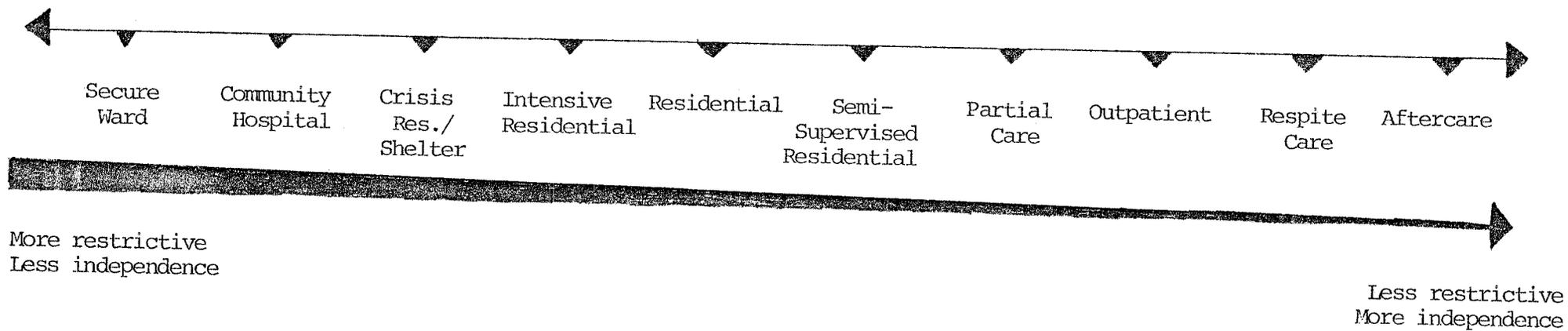
Behavioral health must be organized into a system of clinical services that addresses the client's needs and facilitates movement from highly supervised and expensive settings to less supervised and less expensive settings and vice versa, as the client progresses and/or changes. This system is a continuum of care. The clinical services must be delivered with the recognition that each client is unique and has specific problems and needs for services. Services must be arranged in steps that help the client reach his/her highest potential and allow for the most gain in independence as he/she improves. Some clients will progress through the continuum with discharge as the final step. Some of these clients may relapse and the continuum must be flexible enough to intervene prior to and during this at risk period in order to maintain the gains made while in treatment. Other clients will reach their maximum potential and will need to be maintained at some level within the continuum.

Programs within the continuum must have different levels of intensity to accommodate the varying client needs. For instance, partial care programs may range from an intensive, goal-oriented treatment program to a minimally structured, socialization program. The functional level of the client is the determining factor in the program composition.

The continuum includes a full range of behavioral health services, as well as, social support, medical and educational services. These services are integral to the continuum of care, but are delivered by and are the responsibility of entities other than the Department. Although the Department is not responsible for providing these services, it is responsible for assuring this continuum exists and is available to clients.

Services within the continuum should maintain the expertise necessary to treat alcohol abuse, drug abuse and mental and emotional problems. Specialized programs for these areas may be necessary. The continuum must also allow for specialization in the treatment of women, children, elderly, ethnic minorities and the chronic mentally ill. The Arizona State Hospital will continue to provide specialized services within the continuum.

BEHAVIORAL HEALTH CONTINUUM OF CARE



Clients can enter or exit at any point along the continuum. Intervention can occur at any point. Clients do not necessarily need to receive every service, but may skip as their needs dictate. Depending upon their functional level, clients may need to be maintained at different points within the continuum.

Adjunct services should also be considered when viewing the continuum. They include screening and intake, case management, prevention, consultation and education and all services provided outside the ADHS contract system. These may include, but are not limited to, entitlements, vocational, educational, rehabilitation and social services, advocacy, medical and legal assistance, housing, referral, transportation and private sector services.

The services described below reflect a continuum of the most restrictive to the least restrictive environment, based upon the client's need for security and protection and level of functioning.

Most Restrictive
Secure Ward

A fully secure unit provides constant supervision and control. This level of care is needed for the violent client who is a danger to himself and/or others or who is gravely disabled as a result of mental illness or substance abuse. The immediate treatment goal is the stabilization of the client's behavior and a reduction of the threat of harm to himself or others. This stabilization usually is brought about by drug and milieu therapy and/or drug therapy and medical intervention.

The treatment process includes the availability of medical and psychiatric evaluation and treatment. This level of service will be provided in a residential setting for alcohol abuse and in a hospital setting for mental health. The Arizona State Hospital is the most widely used facility for this level of mental health treatment.

The legal status of clients admitted to this level of treatment will often be involuntary commitment. Involuntary commitment is possible under Mental Health and Alcohol statutes. Holding any client involuntarily in this level of care is only possible under court order.

Although most clients will require this level of security for a very short period of time, some clients will need this intensive treatment for longer periods. However, there are statutory limitations on the amount of time clients can be treated on an involuntary basis.

Community Hospitalization/Open Unit

This level of care provides the continuous supervision of clients, but not a total monitoring of behavior. The use of an open unit allows the client to assume more responsibility for his own behavior and life choices than a secure unit, while still providing supervision and protection to the client. The open unit would care for clients on a long term (more than 28 days) or a short term (less than 28 days) basis. The long term care unit is usually the treatment requirement of a client with chronic mental illness. Clients with acute episodes of mental illness or those detoxifying from substance abuse usually can reconstitute and organize their resources in less than 28 days. The short term open unit treating the acute episode would focus treatment on the immediate re-entry to the social environment that was the situation prior to the time of crisis. Treatment for persons with mental illness usually includes stabilization on medications. Treatment offered for substance abusers usually requires medical detoxification. Screening and evaluation is performed and treatment plans are developed that include

modalities to be utilized for further treatment after discharge.

The long term care treatment would include an education and training module in personal living skills development. These skills would include personal care, socialization skills, basic education and pre-employment (habilitation) skills.

The usual setting for the open unit is the community hospital. Where long term treatment is anticipated, however, the state hospital has the resources for providing the full service requirements of this level of care and is the more cost effective method. Acute care on an open unit should be provided in the community rather than at ASH unless other conditions pertain, because it is more cost effective.

Crisis Residential/Shelter

A crisis residential program provides close supervision and intensive care to an individual in an acute crisis, but not needing a hospital setting. Medical attention can be provided through nursing care, physician's monitoring and psychiatric intervention. The service period is usually less than a week, but could be longer. The treatment goal is to allow temporary relief from an aggravating or exacerbating situation and allow the client to re-integrate. The treatment process includes insight therapy, support therapy and rest.

This service varies in intensity and treatment approach according to the population using the shelter. For all populations, screening and evaluation of the client's environment and personal situation is essential. Substance abuse clients usually begin the detox process in this level of treatment. The local alcoholism treatment centers are well known for providing this service. For victims of domestic violence, shelter may be the only service needed, although medical attention and assistance in obtaining necessary support services are standard. Stabilization of symptoms of chronic mental illness, usually through medication therapy, occurs with the goal of avoiding hospitalization.

Intensive Residential

Intensive residential services are programs that provide a relief from a threatening situation before an acute crisis precipitates. This program allows a resident to withdraw and constructively rebuild his emotional and physical strength to handle the demands of his daily life.

The length of stay is usually more than three days and less than a month. The treatment process is primarily reality oriented, with initial separation from family and home situations. The treatment plan is usually based upon immediate problem solving and beginning to utilize coping techniques.

Residential

Residential care is a program directed toward the training and rehabilitation of severely impaired individuals who need assistance in learning basic living skills. These programs would anticipate residency of no less than six months and might extend to an individual's lifetime. The daily activities are highly structured and supervised.

The severely impaired, including elderly chronic mentally ill, may need to be maintained at this level of treatment for an indefinite period. Although quite restrictive, maintenance at this level reflects success in allowing the client to avoid the more restrictive settings of nursing homes and hospitals.

Due to the long term nature of this level of treatment, support systems for families of the clients in this component are essential. Families should be encouraged to be actively involved in the ongoing treatment of their relative, as well as given support to deal with the client's illness themselves.

Semi-Supervised Transitional Residential

Transitional residential care is a setting that develops independent living skills through a gradual introduction to ordinary community relationships. This program may be monitored by house parents who assist the residents in developing group dependence, self reliance and personal responsibility for behavior and its consequences. In some cases, program staff are not stationed in the residence but rather visit on a periodic basis. The program is usually associated with a day treatment program (partial care) and/or rehabilitation services. Residents are encouraged to look forward to independent living and self support.

Partial Care/Day Treatment

Partial care is a structured setting that is not residential in nature. Clients gather at this setting to receive a variety of educational and vocationally oriented services, including pre-vocational training, work activities, work adjustment, job training, sheltered employment, etc. The group activity supports individuals in their adjustments to independent living or residential living. If the program is coordinated with an inpatient facility, the partial care component is sometimes used as a transitional step to residential or independent living for its patients. The activities may also include the formation of self-help and educational groups. The treatment goal is to maintain growth and prepare individuals for independent living. The intensity of partial care programs may vary from activity oriented drop-in centers to intensive training programs in a sheltered workshop setting.

Outpatient

Outpatient care is a periodic scheduled clinical interaction between a client and therapist for the purpose of resolving emotional problems, maintaining psycho-social skills, or reviewing compliance and benefits from prescribed medication. The setting is usually an agency office, but may be at the client's home or work place. Intervention models include individual, group, or family therapies.

Respite Care

Respite Care is a level of treatment which provides support to the client in order to maintain treatment benefits and prevent relapse to lower functioning levels. The service may be delivered in a residential setting or a person's home. Services are supportive in nature rather than treatment oriented and are intended to relieve a stressful situation.

Aftercare

Aftercare service is a planned contact with persons formally discharged from active treatment for the purpose of reviewing performance, preventing the recurrence of illness and maintaining treatment benefits. This contact may be by phone, office visit, or visit to the home. This service is important in maintaining an achieved state of health and/or for monitoring any signs of relapse.

The following services are a required extension of the continuum of care although they are not considered treatment and the recipients are not usually identified as clients. These adjunct services extend the continuum and serve to enhance the treatment system or prevent client dysfunction altogether.

Consultation and Education

Case consultation provides assistance to someone in providing services to a specific individual, client or family unit. Agency consultation is assistance offered to an agency in planning and developing programs or in solving program system problems. Community consultation is assistance offered to a community group in developing an understanding of community needs and organizational responsiveness to those needs. Community education is a one-way process of imparting knowledge to and changing attitudes of the general public or special target groups.

Prevention

Prevention services provide skills and knowledge which can be used to avoid and/or protect people from substances, conditions, or situations which may cause them to be unable to manage their personal, family, work or community responsibilities.

Services Provided by Other Agencies

These services include all those that are provided outside the Department contracted system but which are necessary to complete the continuum. They include entitlements, vocational, educational, rehabilitation and social services, advocacy, medical and legal assistance, housing, referral, transportation and the private sector of service delivery.

Central Intake and Screening

Clients may enter the continuum of care at different levels according to their needs. There could be a process of central intake and screening to evaluate the client's needs and determine which program is the most appropriate setting to meet those needs.

One entity, per service area, could be designated to be responsible for the intake and screening of all the clients that need treatment. The Central Intake unit could evaluate the client's treatment needs, security needs and program needs. Upon completion of the assessment, the Intake unit, through the assigned case manager, would take the appropriate action to place the client in the level of care on the continuum that is most appropriate.

Case Management

A single point of responsibility may be beneficial in the continuum of care to assure that the needs of persons receiving behavioral health services are responded to in an efficient and dignified manner. This focal point usually is designated as the case manager. The concept of case management is vital to ensure continuity within the continuum and among the several agencies that might be working with one client.

A case manager could be assigned to each client upon screening and intake. The case manager has the overall responsibility for assuring that the client is receiving appropriate care and for making the necessary arrangements for services outside the contracted system. Service tasks include but are not limited to: assessment, referral, professional consultation, supervision, monitoring, report writing, and coordination.

The case manager is responsible for managing the program resources on behalf of the client and for moving the client through the services of the continuum that are appropriate. The case manager would be responsible for developing and initiating a plan of care for the individual. When a client is admitted into a behavioral health program, the case manager could: 1. provide for an assessment of service needs; 2. assist in the development of the treatment plan; 3. identify and secure services as needed by the client; 4. make arrangements for financial assistance and other services offered by other than

behavioral health providers; 5. monitor the service delivery system and the client progress; and, 6. move the client to other programs along the continuum as the client progresses.

Program and Staffing Standards

A uniform set of standards that addresses the quality of services and the staffing of programs would be the basis for monitoring the continuum. Each service component of the continuum would have specific standards for programs with the number and qualifications of staff required to deliver that service.

B. The Organization of the Service Delivery System

Many of the problems that have adversely affected the delivery of behavioral health services can be traced to a lack of direction established by a viable planning process. Although the Department has been responsible for the development of the State Health Plan, the process by which the plan was developed was suspected of being overly controlled by agencies delivering services and the plan itself was insufficient to set direction. The need for a more effective planning mechanism has been identified by the Director as essential, not only for behavioral health, but for other Departmental entities. The Department will, therefore, establish an Office of Planning which reports to the Director, to coordinate the development of the State Health Plan.

Once developed, the State Health Plan will be the driving force for both internal operation of the Department and the implementation of systems in the community. Notwithstanding the fact the plan will be the driving force, it is also recognized that the process of planning is vitally important. The following will outline how the planning process will be implemented to assure that the behavioral health needs of communities are addressed and the direction is established to guide Department staff in implementing the Plan. Exhibit 13 is a diagram which reflects the process, and the proposed structure within the Department to develop the State Plan.

The planning process proposed reflects a dual approach to the development of the plan utilizing both local community input and Departmental input. The Office of Planning will be responsible to coordinate the process and prepare the State Health Plan for presentation to the Director.

The community planning effort will be accomplished through utilization of the State Health Coordinating Council (SHCC) which has been tasked with the development of a health plan. The SHCC will utilize standing committees which will be responsible for the development of certain portions of the plan. A Standing Committee on Behavioral Health will be reconstituted to assure adequate development of the behavioral health portion of the plan. The Behavioral Health Standing Committee will be comprised of representatives from local area Health System Agency (HSA) planning bodies and community citizens. The local HSA planning bodies will be comprised of community representatives. Guidelines require these local planning bodies have consumer and advocate representation; city, county, and tribal governmental entity representation; and reflect the ethnic, cultural, age, and sexual makeup of the community. In no instance will any local planning body or the Standing Committee on Behavioral Health be composed of a majority of service providers. The Office of Planning will be responsible to assure the local planning bodies and the standing committees meet the requirements for local representation. The Office of Planning will also be responsible for developing guidelines for the content of the plan that assure how the behavioral health

continuum needs will be addressed by the local communities. It will be the local planning bodies' responsibility to determine whether the full continuum should be available in its service delivery area or to demonstrate how all needs will be met without the total continuum.

In addition to staffing the SHCC and the standing committees, the Office of Planning will coordinate the intra-Department planning effort as well. It is essential that the Office of Planning have some staff with behavioral health experience as well as technical planning expertise. The intra-Department planning process will utilize staff expertise from each Division within the Department. In addition, other offices of the Department and entities such as the Arizona State Hospital will be tapped for input. The Office of Planning will assure that the expertise within the Department is shared with the SHCC community process. The planning process will therefore be ongoing, with the intra-Department planning and the community planning taking place concurrently. The Office of Planning will assure that these two processes are coordinated and that the product of each process is compiled to create the official State Health Plan. The process through which the plan is developed assures both community and Departmental managerial support of the final plan. The Plan, once completed and approved by the Director, sets the direction for the operation of the Department as well as the implementation of the behavioral health system in the State.

The Department will develop working agreements, either by contract or by other means, with geographic entities. These local entities will be funded and responsible for the selection of local service providers and for service/program implementation. The local entities will be given the flexibility to make service/program decisions within parameters established by the Department. It is the intent of the Department to shift the primary responsibility and control of behavioral health services and programs from the state to the local level.

As was noted in the history, the evolution of the service delivery system in Arizona has resulted in a mixture of catchment area services and cross area services. In order for the planned service delivery system to evolve, the first step is to officially designate service delivery boundaries.

The geographic boundaries could be counties; groups of counties; cities and counties; Indian reservations; COG's; United Way areas; D.E.S. Program Districts; H.S.A. Planning Districts; and so forth. The local officials which represent these groups should be involved in the decision-making process which determines the ultimate geographic boundaries. Service areas could be designated based upon the following factors: population distribution and density, geographic barriers, cultural and ethnic distribution, needs and resources of areas, differences between rural and urban areas, patterns of utilization of services, governmental entities, and political realities.

The Department will select one entity in each

geographic area to administer behavioral health programs on the local level. The entity will receive the total amount of behavioral health funds for the area and will be responsible for administering all behavioral health programs in that area. The selection of the administrative entity could be through the Request for Proposal process, a designation process by local entities or designation by the Department's Director.

The local administrative entity will be responsible for implementing behavioral health programs through contracts with direct service providers and programs that will best meet the needs of the area. The behavioral health program which is developed by the administrative entity must be consistent with the Arizona Revised Statutes regarding Behavioral Health, the approved State Health Plan, established Rules and Regulations, as well as standards and policies promulgated by the Department.

To avoid a possible conflict of interest, the administrative entity shall not be a direct service provider except:

1. For Case Management activities which may be activated.
2. For central and/or initial screening activities which may be activated.
3. In areas where documented proof demonstrates that there are no other providers available to deliver services.

The Department will also need to develop a funding formula that is equitable and considers the needs of each area. Basing funding on population distribution alone, does not address the fact that some areas have higher rates of problems and require more funds. A funding formula could establish a per capita funding base for each area, but other factors would need to be considered in determining the total amount of funds allocated to an area. These other factors might include:

- ° The number of chronically mentally ill residing in the area
- ° Unemployment statistics
- ° Incidence of DWI arrests
- ° Juvenile and adult crime data
- ° Suicide data
- ° Incidence of drug overdoses
- ° Alcohol-related illness and death
- ° Incidence of teenage pregnancy
- ° Cultural and ethnic factors

- Homeless data
- Distribution of GA and AFDC populations
- Incidence of Child Abuse and Domestic Violence
- Divorce Statistics

The Department will also need to consider initial startup costs of the administrative entities when determining the funding allocation formula. Local input will be sought in establishing the funding formula.

The single state authority (SSA) function for behavioral health is required by Federal and State statute and provides the leadership, advocacy, planning, regulation and monitoring that are necessary to manage a continuum of care. Specific functions that are mandated by State statutes are as follows:

- Develop and administer a state plan.
- Implement training and education programs.
- Conduct research.
- Provide information to the public.
- Evaluate the effectiveness of state and local services.
- Develop and enforce rules and regulations which establish standards for treatment facilities.
- Approve and license treatment facilities.
- Evaluate and make recommendations on improving the coordination and cooperation between all the State and local agencies involved in behavioral health services.
- Collect and make available statistical information.
- Prepare and adopt patient fee schedules.
- Require contract agencies to submit a record of all Federal, state, county, city and private funds supporting behavioral health services.
- Formulate policies, plans and programs to carry out the intentions of law.

The entity within the Department responsible for implementing the community behavioral health component of the state health plan will be the Office of Community Behavioral Health. This Office reports directly to the Deputy Director. As some of the support functions necessary to supervise the

behavioral health continuum are spread throughout the Department, the Office must coordinate these functions to assure appropriate communication takes place. Coordination must occur in areas of planning and budget development, contracts management, training and education, auditing, information dissemination, regulation and licensing and data systems. This takes place within the setting of the Department's management team. The Office is then directly responsible for resource development, State and Federal liaison, coordinating and contracting with local administrative entities, developing uniform guidelines for RFP and contracting processes, developing uniform service definitions and program standards, evaluating data and preparing reports, studies and information for public dissemination.

The Office is responsible for reviewing Federal Initiatives to determine the appropriateness for State response or to make local entities aware of fund generating opportunities. Another critically important function is the development of relationships with other states and the Federal Government. The sharing of program expertise and experience with other states is of tremendous value in creating new programs and avoiding problems. A relationship with the Federal funding source is necessary to successfully carry out the intent of the block grant program.

The Office of Community Behavioral Health will contract with designated local entities to administer the delivery system. Standards for the performance of these administrative bodies must be established and uniform guidelines for the Requests for Proposal and contracting processes must be developed.

The services outlined in the continuum of care will be studied and further defined and made uniform for use in all local contracts. Definitions should be expanded to make services available to family members in all settings within the continuum. Services should also be provided outside of the clinic setting in the home, nursing homes, elderly centers and supervisory care facilities. Services provided in this manner support and enable agencies outside the Department contract system to care for the client with behavioral health treatment needs. A uniform set of standards that addresses the quality of services and the staffing of programs should be developed as guidelines for local entities to use in their monitoring and contracting processes.

A central registry should be developed at the State level to assign unique identification numbers to all clients entering the behavioral health system. Instead of assigning a number to an alcohol client as opposed to a drug or mental health client, a behavioral health number will be given. Since many clients have multiple problems, this will allow every client to receive alcohol abuse, drug abuse and mental health services as they require them. This allows for the ability to track clients through the continuum of care; thereby revealing a pattern of service provision. Through this view of client progression, the

case management system can be monitored and the continuum can be evaluated for cost effectiveness, efficiency and gaps that may be present. Through the use of a registry, an unduplicated count of clients in the system can be obtained and readmission and drop-out rates, length-of-stay, movement through the continuum, other adjunct services and patterns of client movement between service areas can be studied. A system of individual goal attainment could be easily instituted by following a client's movement within the continuum. The highest potential for some clients is to reach a maintenance level within the continuum. Therefore, discharge would not be the only measurement of success.

A data system must be established that assists in monitoring and evaluating the continuum of care. This system must collect client demographics, service movement information, client functional levels and cost information. The data must be compiled into reports that can be used by local communities and by Department staff as the basis for program and system planning.

The Arizona State Hospital must be organized in a manner that will provide direct linkage with the geographic service areas. The service areas must have access to the hospital in terms of admissions, treatment coordination and discharge back to the area. The State Hospital is a vital service in the continuum of care and therefore must become readily accessible to the service areas.

To achieve this direct linkage, the State Hospital could designate staff that work directly with the geographic area. The staff would be assigned the responsibility to coordinate all admissions and discharges for the specific area.

The State Hospital could also be reorganized into units and patient grouping that corresponds with the geographic areas. The geographic areas would then have an identifiable section and staff of the hospital that would provide the direct linkage.

The geographic service areas could develop a case management function that would track, monitor and have contact with their patient while they were hospitalized at the State Hospital. The case manager could coordinate the admission, be involved in treatment planning and coordinate the discharge back to the geographic area. This process would establish a person that was responsible for the client and avoid the patient being released without the necessary arrangements.

It will become a Department policy that all patients released from the State Hospital will have a realistic, comprehensive discharge plan and a contact point or person in the patient's geographic area. To operationalize this policy, the Department will train all Hospital staff so that they become intimately familiar with the continuum of services existing in the geographic areas.

The Department will also review the role and function of the Southern Arizona Mental Health Center (SAMHC). It is the intent of the Department to explore all options available so that SAMHC will best fit into the behavioral health system. Some of these options may include:

- Placing SAMHC administratively under the Arizona State Hospital to function as the screening unit for Southern Arizona.
- Placing SAMHC administratively under the University of Arizona.
- Spinning SAMHC off into a private, not-for-profit agency.
- Placing SAMHC administratively under the office of Community Behavioral Health.

VII.C. Legislative Issues

This section is intended to highlight areas where legislation change or modification would enable programs to perform more efficiently, remove barriers to treatment or expand programs to serve a broader range of clients.

The law that enacted the domestic violence program (ARS 36-3002) places a \$40,000 maximum amount for each contract. This amount has proven to be very low considering the complex problems encountered in treating victims of domestic violence. Agencies providing shelter services must be held accountable for fiscal and programmatic management of the shelters. Staffing requirements are high, as 24-hour availability is mandatory. In addition, highly trained mental health professionals are needed to deliver the mandatory crisis counseling services. The cap on funding limits the capability of programs to provide needed services and maintain necessary standards of service provision. The \$40,000 limitation should therefore be eliminated.

An additional issue in the delivery of domestic violence programs is the difficulty of involving the abuser in treatment. If the family unit is to be restored, the abuser, not only the abused, must be treated. Currently, the abuser can only be treated on a voluntary basis, which accounts for the low rate of participation in treatment. If the abuser could be identified as the primary client, removed from the home and placed in a facility for treatment, the remaining family would stay together at a cost savings. An expansion of the legislation to require mandatory treatment to the abuser, as a diversion from the criminal justice system, is therefore recommended.

Currently, state funds are appropriated on a categorical basis for alcohol abuse treatment, drug abuse treatment, and mental health treatment. By appropriating funds that must be used for categorical programs, an artificial barrier to treatment is created which requires service providers to consider funding when treating and diagnosing clients. If state funds were combined and appropriated for behavioral health services, treatment of clients with multiple problems would be facilitated.

The legislation authorizing involuntary commitment of chronic alcoholics for treatment (A.R.S. § 36-2026.01) prescribes who may be committed, the length of time for the commitment, and is contingent upon approved facilities being available. This legislation defines a chronic alcoholic as one who is incapacitated by alcohol and who has been admitted to a Local Alcoholism Reception Center (LARC) on ten or more occasions during the preceding twelve months. This definition limits the commitment to the public inebriate population and does not allow for commitment of the chronic alcoholic who may have avoided admission to a LARC. This definition should be expanded. The legislation also limits commitment to twenty-eight days. This

limitation is currently considered too short and should be expanded, possibly to be consistent with the mental health commitment timelines. The treatment system does not have the necessary facilities available to provide the required services under the commitment law, including the capacity to provide the controls and security necessary to prevent a client from leaving. It is therefore necessary that this legislation receive an appropriation to be utilized to fund the development of such facilities.

The legislation that provides for the development and implementation of a residential treatment continuum (A.R.S. § 36-550) for the chronically mentally ill requires a fifty percent match of state funds from local or other fund sources. Legislative appropriations for other fund sources allow the matching requirement to be reduced to a 25/75 ratio. The chronic mentally ill population has only a minimal ability to participate in the cost of these services. In addition, agencies providing these services have few sources of funds to match the state and federal funds appropriated. It is therefore recommended that this legislation be amended.

D. IMPLEMENTATION TIME FRAMES

1. Hire Director of Planning 4/1/84
2. Establish and staff the Office of Community Behavioral Health 4/1/84
3. Begin establishing the geographic boundaries 4/15/84
4. Hire and/or assign Planning staff 5/1/84
5. Begin planning process with HSAs, SHCC, Department communities, advocacy groups, etc. 5/1/84
6. Department develops guidelines for planning process. 5/1/84
7. Designate the geographic boundaries. 9/1/84
8. Determine the formula to be used for dollar distribution. 9/1/84
9. Develop service definitions and program standards by: 9/1/84
10. Finalize formula for dollar distribution. 10/1/84
11. Develop funding parameters, options for administrative costs for each geographic area. 10/1/84
12. Develop guidelines for RFP and contract process by: 10/1/84
13. Select administrative entities
 - A. By RFP 1/1/85
 - B. By Department designation 11/1/84
14. Contract with administrative entity 2/1/85
 - A. Administrative entity begins its RFP process 3/1/85
 - B. Contracts with providers 7/1/85

Exhibit 1.

CURRENT BUREAU OF COMMUNITY SERVICES
CONTRACTORS AND SERVICE AREAS

Contract Agency	Alcohol- ism	Drug Abuse	Mental Health	Residential Continuum	Special C.M.I. Chil- drens' Res.	Domestic Violence	Service Area
ARCA	x						Maricopa County
BHACA	x	x	x	x			Central West Pinal
B.H.S. of Yuma	x	x	x	x			Yuma and La Paz Counties
Cocopah Indian Tribe		x					Cocopah Reservation
Colorado R. Indian Tribe	x	x					Colorado River Reservation
CODAC		x					Pima County
CODAMA	x	x	x		x	x	Maricopa County
Intermountain	x	x	x	x		x	Gila East Pinal Catchment Area
NACGC	x	x	x	x			Northern Arizona Catchment Area
Navajo Tribe	x	x	x	x			Navajo Reservation
ADAAPT	x	x					Pima County
Salt River	x						Salt River-Pima Maricopa Indian Community
Camelback	x	x	x				Maricopa NE Catchment Area
CBS	x	x	x	x	x		Phoenix Central, Maricopa SW, NW C.A.
La Frontera			x	x			Pima E, Pima S Catchment Areas
Maricopa County	x		x	x			Maricopa County
North Center	x	x	x				Maricopa North Catchment Area
Phoenix South CMHC	x	x	x				Phoenix South Catchment Area
Tri-City Mental Health Ctr	x	x	x				Maricopa E, SE Catchment Areas
SEABHS	x	x	x	x		x	Southeast Arizona Catchment Area
Against Abuse						x	Statewide
Catholic Comm. Svce/Yuma						x	"
Catholic Soc. Svcs/Tucson						x	"
Salvation Army						x	"
Catholic Soc. Svcs/Yavapai						x	"
Flagstaff Battered Woman Ctr						x	"
Sojourner						x	"
Tucson Center/Women,Children						x	"
Tucson Metropolitan Ministries						x	"
Valle Del Sol						x	"
YWCA						x	"
Arizona Baptist					x		"
Arizona Childrens' Home					x		"
Brown Schools					x		"
Devereux Center					x		"
Introspect					x		"

Exhibit 2

BUREAU OF COMMUNITY SERVICES

FY 84 BEHAVIORAL HEALTH CONTRACT BUDGET

CONTRACTOR	ALCOHOL			DRUG ABUSE			MENTAL HEALTH		
	DHS SHARE	CONTRACTOR SHARE	TOTAL	DHS SHARE	CONTRACTOR SHARE	TOTAL	DHS SHARE	CONTRACTOR SHARE	TOTAL
Against Abuse									
Arizona Baptist									
Arizona Children's Home									
ARCA	\$ 748,653	\$ 187,163	\$ 935,816						
ADAAPT	1,429,171	601,933	2,031,104	\$1,543,499	\$ 703,721	\$2,247,220			
BHACA	334,663	129,950	464,613	155,512	60,405	215,917	\$1,026,619	\$ 446,695	\$ 1,473,314
BHS of Yuma	276,902	56,934	333,836	64,693	9,828	74,521	296,069	441,231	737,300
Brown Schools									
Camelback Hospitals	21,296	36,185	57,481	19,488	63,126	82,614	380,235	522,411	902,646
Cath.Comm.Svcs.-So.Az.									
Cath.Comm.Svcs.-Yuma									
Cath.Soc.Svcs.-Yavapai									
Cocopah Indian Tribe				17,295	17,294	34,589			
CODAC				418,779	63,603	482,382			
Colorado Riv.Ind.Tribe	30,789	30,767	61,556	37,491	37,491	74,982			
CBS	149,682	78,486	228,168	857,781	130,303	988,084	2,488,079	939,101	3,427,180
CODAMA	1,261,572	1,000,971	2,262,543	2,581,339	975,506	3,556,845	313,782	570,579	884,361
Desert Hills									
Devereux Center									
Flag.Women's Shelter									
IMBHA	325,185	66,850	392,035	170,858	31,182	202,040	762,280	200,452	962,732
LaFrontera Center							2,129,408	883,911	3,013,319
Maricopa Co. DHS	1,053,421	846,597	1,900,018				912,526	1,210,687	2,123,213
Navajo Tribe	164,517	733,259	897,776	46,120	46,120	92,240	171,372	301,152	472,524
North Comm.B.H.Ctr.	52,165	32,208	84,373	32,284	6,365	38,649	243,436	132,276	375,712
NACCC	1,058,644	402,085	1,460,729	385,588	58,573	444,161	2,138,049	926,232	3,064,281
Phoenix South CMHC	231,354	48,511	279,865	112,844	17,511	130,355	1,880,692	463,616	2,344,308
Salt River Ind.Tribe	53,578	147,682	201,260						
Salvation Army									
Sojourner									
SEABHS	480,665	133,994	614,659	102,663	22,002	124,665	1,186,367	357,458	1,543,825
Tri-City M.H.Ctr.	308,300	190,171	498,471	141,590	70,611	212,201	546,203	332,851	879,054
Tuc.Ctr.Women & Child.									
Tuc.Metro Ministries									
Valle del Sol									
YWCA - Tucson									
TOTAL	\$7,980,557	\$4,723,746	\$12,704,303	\$6,687,824	\$2,313,641	\$9,001,465	\$14,475,117	\$7,728,652	\$22,203,769

RESIDENTIAL CARE FOR CHILDREN (2049)

<u>DHS</u> <u>SHARE</u>	<u>CONTRACTOR</u> <u>SHARE</u>	<u>TOTAL</u>
\$ 26,916	-0-	\$ 26,916
55,872	-0-	55,872
42,960	-0-	42,960
112,512	-0-	112,512
52,416	-0-	52,416
45,780	-0-	45,780
308,616	-0-	308,616
<hr/>		<hr/>
\$645,072	-0-	\$645,072

DOMESTIC VIOLENCE SHELTERS

<u>DHS</u> <u>SHARE</u>	<u>CONTRACTOR</u> <u>SHARE</u>	<u>TOTAL</u>
\$ 21,670	-0-	\$ 21,670
30,000	-0-	30,000
30,000	-0-	30,000
30,000	-0-	30,000
60,000	-0-	60,000
27,888	-0-	27,888
30,000	-0-	30,000
30,000	-0-	30,000
30,000	-0-	30,000
30,000	-0-	30,000
30,000	-0-	30,000
30,000	-0-	30,000
30,000	-0-	30,000
30,000	-0-	30,000
26,300	-0-	26,300
<hr/>		<hr/>
\$435,858	-0-	\$435,858

TOTAL

<u>DHS</u> <u>SHARE</u>	<u>CONTRACTOR</u> <u>SHARE</u>	<u>TOTAL</u>
\$ 21,670	-0-	\$ 21,670
26,916	-0-	26,916
55,872	-0-	55,872
748,653	\$ 187,163	935,816
2,972,670	1,305,654	4,278,324
1,516,794	637,050	2,153,844
637,664	507,993	1,145,657
42,960	-0-	42,960
421,019	621,722	1,042,741
30,000	-0-	30,000
30,000	-0-	30,000
30,000	-0-	30,000
17,295	17,294	34,589
418,779	63,603	482,382
68,280	68,258	136,538
3,608,054	1,147,890	4,755,944
4,269,109	2,547,056	6,816,165
45,780	-0-	45,780
308,616	-0-	308,616
27,888	-0-	27,888
1,288,323	298,484	1,586,807
2,129,408	883,911	3,013,319
1,965,947	2,057,284	4,023,231
382,009	1,080,531	1,462,540
327,885	170,849	498,734
3,582,281	1,386,890	4,969,171
2,224,890	529,638	2,754,528
53,578	147,682	201,260
30,000	-0-	30,000
30,000	-0-	30,000
30,000	-0-	30,000
1,799,695	513,454	2,313,149
996,093	593,633	1,589,726
30,000	-0-	30,000
30,000	-0-	30,000
30,000	-0-	30,000
26,300	-0-	26,300
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\$30,224,428	\$14,766,039	\$44,990,467

Summary of Behavioral Health Services

FY 1982 - 1983

	Outpatient (Visits)	Partial Care (Day)	Residential (Days)	Inpatient (Days)	Non-Registered (Units)
Children's Residential Services Program			7,921		
Chronically Mentally Ill Residential Continuum		43,177	68,090		
Regular Mental Health Program	239,493	50,528	31,678	7,038	97,892
Southern Arizona Mental Health Center	32,997	6,419	5,962		4,655
Arizona State Hospital				122,640	
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Mental Health Combined	272,490	100,124	113,651	129,678	102,547
Regular Alcohol Abuse Treatment Program	97,319	5,886	181,323	62	59,023
Regular Drug Abuse Treatment Program	77,447	2,874	67,948	449	52,696
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Behavioral Health Combined	447,256	108,884	362,922	130,189	214,266

CLIENTS SEEN IN COMMUNITY AGENCIES BY COUNTY OF RESIDENCE, SEX, AND AGE
ARIZONA FY 1982-1983

ALCOHOL ABUSE

COUNTY OF RESIDENCE	TOTAL	M	F	<18	65+
Apache	716	516	200	45	19
Cochise	386	311	75	5	12
Coconino	1,688	1,384	304	34	47
Gila	406	313	93	---	18
Graham	99	77	22	1	4
Greenlee	36	33	3	---	---
Maricopa	8,434	6,151	2,283	261	257
Mohave	413	274	139	17	29
Navajo	893	626	267	60	19
Pima	2,705	2,091	614	92	78
Pinal	779	645	134	13	35
Santa Cruz	107	97	10	3	4
Yavapai	768	452	316	47	29
Yuma	992	870	122	5	93
Transient/ Unknown	1,438	1,247	191	15	59
TOTALS	19,860	15,087	4,773	598	703
Percents	100	76	24	3	4

CLIENTS SEEN IN COMMUNITY AGENCIES BY COUNTY OF RESIDENCE, SEX, AND AGE
ARIZONA FY 1982-1983

DRUG ABUSE

COUNTY OF RESIDENCE	TOTAL	M	F	<18	65+
Apache	122	74	48	59	---
Cochise	66	37	29	11	1
Coconino	209	142	67	54	3
Gila	121	86	35	48	7
Graham	15	11	4	7	---
Greenlee	4	4	---	1	---
Maricopa	3,325	2,110	1,215	497	26
Mohave	117	69	48	14	1
Navajo	205	99	106	47	24
Pima	1,229	803	426	133	4
Pinal	193	134	59	36	3
Santa Cruz	27	25	2	13	---
Yavapai	229	119	110	30	3
Yuma	221	132	89	65	42
Transient/ Unknown	111	85	26	7	3
TOTALS	6,194	3,930	2,264	1,022	117
Percents	100	63	37	16	2

CLIENTS SEEN IN COMMUNITY AGENCIES BY COUNTY OF RESIDENCE, SEX, AND AGE
ARIZONA FY 1982-1983

MENTAL HEALTH

Contract Agencies

COUNTY OF RESIDENCE	TOTAL	M	F	<18	65+
Apache	473	170	303	121	20
Cochise	794	359	435	181	34
Coconino	950	391	559	141	49
Gila	655	252	403	170	74
Graham	206	78	128	60	5
Greenlee	87	33	54	25	4
Maricopa	12,863	5,366	7,497	1,778	664
Mohave	1,131	458	673	172	62
Navajo	1,195	452	743	199	158
Pima	3,542	1,555	1,987	939	164
Pinal	1,590	734	856	405	110
Santa Cruz	299	126	173	88	11
Yavapai	1,428	624	804	350	59
Yuma	894	342	552	330	17
TRANSIENT/ UNKNOWN	725	411	314	78	334
CONTRACTOR TOTALS	26,832	11,351	15,481	5,037	1,765
Southern Arizona Mental Health Center					
SAMHC TOTALS*	3,194	1,512	1,682	444	148
TOTALS	30,026	12,863	17,163	5,481	1,913
Percents	100	43	57	18	6

*SAMHC: 95 1/2% Pima county - 3 3/4% Transient/Unknown -
3/4% other counties

Exhibit 7

CLIENTS SEEN IN COMMUNITY AGENCIES BY COUNTY OF RESIDENCE AND RACE/ETHNICITY
ARIZONA FY 1982-1983

ALCOHOL ABUSE

COUNTY OF RESIDENCE	RACE/ETHNICITY				
	WHITE	BLACK	INDIAN	HISPANIC	OTHER/ UNKNOWN
Apache	125	4	550	35	2
Cochise	309	11	7	55	4
Coconino	352	22	1,240	70	4
Gila	209	2	148	44	3
Graham	56	3	17	22	1
Greenlee	16	---	2	17	1
Maricopa	5,547	402	1,137	1,282	66
Mohave	359	2	36	12	4
Navajo	239	3	607	36	8
Pima	1,879	118	180	509	19
Pinal	349	25	167	231	7
Santa Cruz	23	2	1	80	1
Yavapai	693	4	43	26	2
Yuma	633	56	112	147	44
Transient/ Unknown	804	53	446	86	49
TOTALS	115,93	707	4,693	2,652	215
Percents	58	4	24	13	1

CLIENTS SEEN IN COMMUNITY AGENCIES BY COUNTY OF RESIDENCE AND RACE/ETHNICITY
ARIZONA FY 1982-1983

DRUG ABUSE

COUNTY OF RESIDENCE	RACE/ETHNICITY				
	WHITE	BLACK	INDIAN	HISPANIC	OTHER/ UNKNOWN
Apache	70	2	36	12	2
Cochise	45	1	1	17	2
Coconino	128	10	45	23	3
Gila	61	1	49	9	1
Graham	6	---	7	2	---
Greenlee	1	---	---	3	---
Maricopa	2,398	186	65	644	32
Mohave	108	2	1	3	3
Navajo	119	2	69	13	2
Pima	749	73	85	305	17
Pinal	103	6	27	55	2
Santa Cruz	3	---	---	22	2
Yavapai	218	---	6	4	1
Yuma	72	4	55	90	---
Transient/ Unknown	79	3	6	7	16
TOTALS	4,160	290	452	1,209	83
Percents	67	5	7	20	1

CLIENTS SEEN IN COMMUNITY AGENCIES BY COUNTY OF RESIDENCE,
RACE/ETHNICITY, AND CHRONICALLY MENTALLY ILL
ARIZONA FY 1982-1983

MENTAL HEALTH

Contract Agencies

COUNTY OF RESIDENCE	RACE/ETHNICITY					CMI
	WHITE	BLACK	INDIAN	HISPANIC	OTHER/ UNKNOWN	
Apache	287	2	136	46	2	31
Cochise	590	17	9	156	22	15
Coconino	725	18	134	62	11	53
Gila	495	2	80	67	11	24
Graham	154	4	2	44	2	---
Greenlee	54	---	1	31	1	4
Maricopa	10,341	776	206	1,327	213	3,077
Mohave	1,060	8	10	26	27	56
Navajo	592	8	529	55	11	41
Pima	1,984	143	116	1,245	54	465
Pinal	1,050	43	59	427	11	81
Santa Cruz	55	1	1	232	10	2
Yavapai	1,358	2	19	45	4	94
Yuma	660	34	7	182	11	51
TRANSIENT/ UNKNOWN	436	23	13	76	177	124
CONTRACTOR TOTALS	19,841	1,081	1,322	4,021	567	4,118
Southern Arizona Mental Health Center						
SAMHC TOTALS*	2,767	140	21	200	66	551
TOTAL	22,608	1,221	1,343	4,221	633	4,669
Percents	75	4	4	14	2	16

*SAMHC: 95 1/2% Pima County - 3 3/4% Transient/Unknown - 3/4% Other Counties

ENTRIES, DISCHARGES, AND INPATIENT CENSUS FOR ARIZONA STATE HOSPITAL
 BY COUNTY
 ARIZONA FY 1982-1983

COUNTY*	ENTRIES		DISCHARGES	INPATIENT CENSUS	
	NUMBER	% READ- MISSIONS		AS OF 6-30-82	AS OF 6-30-83
Apache	4	0%	5	2	2
Cochise	12	50%	7	10	9
Coconino	16	31%	9	1	5
Gila	28	39%	19	14	13
Graham	8	50%	8	6	4
Greenlee	1	0%	0	0	0
Maricopa	317	62%	286	214	230
Mohave	9	33%	4	2	4
Navajo	16	25%	14	7	5
Pima	61	38%	49	47	46
Pinal	28	50%	20	17	14
Santa Cruz	3	100%	3	2	3
Yavapai	19	37%	15	7	4
Yuma	30	27%	14	7	8
OUT OF STATE	0	---	56	0	0
UNKNOWN	0	---	9	0	0
TOTAL	552	52%	518	336	347

* Entries and inpatient census: county from which patient is admitted
 Discharges: county to which patient is discharged

Median stay in hospital for discharges: 49 days

ARIZONA STATE HOSPITAL
07/01/82 THRU 06/30/83

DISCHARGES BY UNIT AND AFTERCARE REFERRAL

AFTERCARE REFERRAL	UNIT						TOTAL
	PSYCH/SOC REHAB	ADMISSION/ EVALUATION	CHILD/ ADOLESCENT	BEHAVIOR MGMT	GERO- PSYCH	LONG TERM CARE	
PHOENIX-SOUTH MH CENTER	4	21	0	2	0	0	27
MARICOPA CTY MH SERV	6	53	0	8	0	0	67
ARIZONA GUIDANCE	0	0	0	0	0	0	0
TRI-CITY MH CENTER	0	22	0	0	0	0	22
S.A.M.H.C.	1	10	0	0	0	0	11
N.A.C.G.C.	0	6	1	1	0	0	8
SEABHS	2	14	0	1	0	0	17
BHACA	1	6	0	2	0	0	9
OTHER MH AGENCIES	2	30	0	7	0	0	39
ALL OTHER	5	39	1	8	0	1	54
NONE	21	151	31	41	13	7	264
UNKNOWN	0	0	0	0	0	0	0
T O T A L	42	352	33	70	13	8	518

ARIZONA STATE HOSPITAL
07/01/82 THRU 06/30/83

DISCHARGES BY UNIT AND DISCHARGE PLACEMENT

DISCHARGE PLACEMENT	UNIT						TOTAL
	PSYCH/SOC REHAB	ADMISSION/ EVALUATION	CHILD/ ADOLESCENT	BEHAVIOR MGMT	GERO- PSYCH	LONG TERM CARE	
FAMILY	7	117	12	24	3	0	163
INDEPENDENT LIVING	3	82	0	10	0	0	95
BOARDING HOME	23	72	5	7	6	3	116
NURSING HOME	1	1	0	0	2	3	7
HALF-WAY HOUSE	0	1	0	0	0	0	1
MH INPATIENT FAC.	4	25	0	2	2	2	35
CRIMINAL COURT	0	0	1	17	0	0	18
JUVENILE COURT	0	2	5	0	0	0	7
OTHER	1	15	8	4	0	0	28
UNKNOWN	3	37	2	6	0	0	48
T O T A L	42	352	33	70	13	8	518

Exhibit 13

