

THE GOVERNOR'S TASK FORCE ON THE SERIOUSLY MENTALLY ILL

FINAL REPORT

January 25, 1990

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PREFACE

Arizona has always been proud of its quality of life. This intangible element has lured thousands to our state and has induced those who were born here to stay. At least one class of citizen, however, does not share in the benefits offered by the Arizona lifestyle. Arizona has long either neglected or openly discriminated against its seriously mentally ill population. These Arizonans have been left behind in our pursuit of the good life under the sun.

In 1989 the Supreme Court of Arizona in *Arnold v. Sarn*, quoting Sen. Hubert Humphrey, said:

[t]he moral test of government is how it treats those who are in the dawn of life, the children; those who are in the twilight of life, the aged; and those who are in the shadows of life, the sick, the needy and the handicapped.

The court continued to say that "Arizona has imprisoned its CMI in the shadows of public apathy" and ordered that the CMI are entitled to adequate care under a comprehensive and unified system.

It is now time for our state to redress this grievance against a whole class of Arizonans. The Governor, on May 9, 1989, issued an Executive Order creating the Governor's Task Force on the Seriously Mentally Ill (SMI). What follows is the Task Force's recommendation, adopted unanimously on January 25, 1990, for a plan it believes carries out the Supreme Court's ruling, a plan designed to attack the public apathy which has for too long plagued the SMI.

*S. L. Schorr, Chairman
Governor's Task Force - SMI*

I.

Introduction

In 1981 a class action was filed on behalf of five indigent, chronically mentally ill individuals against the Arizona Department of Health Services (ADHS), the Arizona State Hospital (ASH), and the Maricopa County Board of Supervisors. The charge: Indigent chronically mentally ill individuals were being denied care in contravention of Arizona law which provided for a full continuum of care for the "chronically mentally ill" population of Arizona.¹ In 1989 the Supreme Court of Arizona in *Arnold v. Sarn*, upheld the lower court's decision. Finding that the rights of the class were, indeed, being violated, the high court decreed that all chronically mentally ill people are entitled to adequate care under a comprehensive and unified system.

In May 1989, Governor Mofford announced the formation of a Task Force, charging it with the responsibility to recommend a plan which would comport with the intent and requirements of the Supreme Court decision. Meetings commenced in late August of 1989 and have continued nearly every other week to the present. This final report of the Task Force has been prepared with the assistance of the Department of Psychiatry of the University of Arizona College of Medicine.²

Members of the Task Force represent a wide variety of interests and disciplines, including advocates for the mentally ill, consumers and their families, the Professor and Head of the Department of Psychiatry of the University of Arizona, government representatives, a member of the judiciary, legislators, a provider of services to the seriously mentally ill, representatives of the mental health system, and members of the business community. Interest and participation have been keen throughout the meetings.

The Task Force plan for a comprehensive system of care is based upon the following fundamental principles:

- All SMI are entitled to be served by a comprehensive system of care that provides them with a broad range of services;
- The system must be easily accessible and non-discriminatory;
- The "dollar must follow the consumer" at all levels;
- The SMI, their families, guardians, advocates, and clinicians should have significant control and reasonable options in selecting appropriate care;
- The system must be held to a rigorous standard of objective monitoring and evaluation and must be flexible and able to adapt to new data and ideas as they evolve;
- The system must be centralized, with statutory responsibility vested under a single authority -- the ADHS; and

¹As is explained below, the Task Force recommends that the term "seriously mentally ill" be used in place of and synonymously with the term "chronically mentally ill."

²Special thanks go to Ms. Jill Goetz from the College of Medicine and to Ms. Terry Rider for their assistance in preparing this report.

- To guarantee accountability as well as responsibility, a new SMI division within ADHS should be created to be solely responsible for administering the new system.

II.

The SMI Population

The chronically mentally ill are described in the Arizona Revised Statutes as follows:

* * *

3. The 'chronically mentally ill' are persons, who as a result of a mental disorder as defined in § 36-501, paragraph 21, exhibit emotional or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation.

A.R.S. § 36-550.

* * *

Mental Disorder is defined as follows:

21. 'Mental disorder' means a substantial disorder of the person's emotional processes, thought, cognition, or memory. Mental disorder is distinguished from:

(a) Conditions which are primarily those of drug abuse, alcoholism or mental retardation, unless, in addition to one or more of these conditions, the person has a mental disorder.

(b) The declining mental abilities that directly accompany impending death.

(c) Character and personality disorders characterized by lifelong and deeply ingrained anti-social behavior patterns, including sexual behaviors which are abnormal and prohibited by statute unless the behavior results from a mental disorder.

A.R.S. § 36-501.

In keeping with the modern trend, the Task Force recommends that the term "seriously mentally ill" be used in place of and synonymously with the term "chronically mentally ill." The Task Force believes that the current statutory definition should be maintained and that ADHS must broaden its checklist to determine SMI eligibility to bring it into compliance with the statutory definition. In addition, commitment laws should be modified to address the question of competency of the SMI to participate in medical and

health care treatment decisions and the process of adjudication as a CMI (SMI) be considered as an additional approach to define those persons eligible for treatment and to assure such treatment within the structure of the proposed system.

Subpopulations

There are subpopulations within the SMI population which have specific needs and require special attention. The proposed system must be sensitive to cultural and special needs of all subpopulations and be accessible to all those who are in need of care. Examples of such special groups are: minorities, the homeless, the SMI living in rural communities, Native Americans, and those in jails and prisons.

The Homeless SMI

Studies demonstrate that 20% to 40% of Arizona's homeless are seriously mentally ill. Their illness does not result from their homelessness; rather, their homelessness ensues from their illness.

The Task Force recommends that, in coordination with public and private organizations now working in the field, specific programs for the homeless SMI be established in all areas of the state to bring them into the state system. These special outreach programs shall identify the SMI and provide them with services -- including food, clothing and shelter -- in the soup kitchens, parks, and shelters where this proliferating and most vulnerable segment of the SMI now live.

The Incarcerated SMI

The Task Force recommends:

- That the fundamental goal of mental health treatment in jails and prisons should be to provide the same level of mental health services that are available in the community and to promote coordination between community care and the justice system;
- That all state agencies endorse the report of the American Psychiatric Association entitled "Psychiatric Services in Jails and Prisons" (March 1989), and that all correctional facilities, including county jails and facilities, that house the SMI comply with the standards of the National Commission on Correctional Health Care. A liaison should be established among the criminal justice system and mental health professionals to ensure that there is coordination among the various aspects of the system to assure proper placement and treatment; and
- That statutes be enacted which will give the criminal justice system authority, when appropriate, to divert the SMI into the mental health system for treatment and monitoring.

Establishing the Number of SMI

The Task Force charge is to define a system of comprehensive services responsive to the needs of the SMI and their families. As would be expected, the Task Force felt that getting an accurate estimate of the number of SMI in Arizona was a

prerequisite to defining such a system and establishing its cost. This proved to be no easy task: although there have been many studies and estimates, no one can say with assurance how many SMI live in Arizona.

As of 1989, Peat Marwick, in its state-commissioned report "Preliminary Plan for Complying with *Arnold v. Sarn*," estimated the number of SMI in Arizona at approximately 15,000. Maricopa County has said there are 7,500 within its county and, by extrapolation, 12,500 statewide. The Arizona Center for Law in the Public Interest estimates the number at about 18,000. Other professional studies estimate the number at anywhere from 25,000 to 45,000.

The fact is that the number of people in Arizona suffering with serious mental illness is unknown and will probably not be determinable until a viable system, accessible to all SMI, is up and running. However, in order to plan, we will assume a reasonable compromise estimate of at least 15,000 SMI currently within the state, increasing to 25,000 by the year 1995.

III.

Proposed System

Our primary goal is to create a comprehensive and cost-effective system of care. To achieve this, the current system -- which the Supreme Court characterized as a "non-system," inadequate, fragmented, and suffering from neglect -- must be modified substantially. We recommend that: county SMI responsibility and corresponding expenditures should be transferred to the state; current county expenditures be contributed to defray state costs; ADHS be designated as the single statutorily responsible agency for a statewide system; and a new SMI division within ADHS be established to carry out these responsibilities to assure suitable attention and authority to carry out this commitment to the SMI.

The ADHS-SMI Division will enter into agreements with SMI Regional Authorities throughout the state. These Regional Authorities will, in turn, enter into agreements with SMI Central Primary Care Organizations, which will become the focal points of the new system. These organizations will, within their regions, be responsible for crisis and case management, intake, advocacy, clinical services, and a wide range of other supportive services.

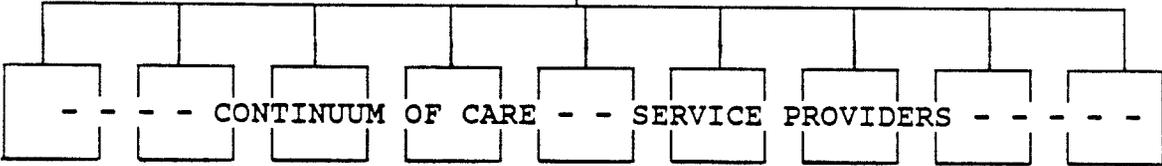
To meet specific needs, there may be circumstances where the Regional Authorities' duties may be combined with those of either the Central Primary Care Organization or the ADHS-SMI Division.

The Central Primary Care Organization will, in turn, contract with service providers to provide the entire continuum of care mandated by *Arnold v. Sarn*. The Central Primary Care Organization may be a public authority or any other nonprofit agency capable of performing the services required. We will elaborate on this proposed structure in the pages to follow.

ARIZONA STATE DHS
SMI - DIVISION

REGIONAL SMI AUTHORITY

CENTRAL PRIMARY CARE ORGANIZATION
(Includes Crisis and Case Management,
Intake, Advocacy, Clinical Services, etc.)



ADHS-SMI Division

The Task Force recommends that the ADHS be designated as the single statutorily responsible agency for a statewide system of care to the SMI population. To pinpoint responsibility and accountability, an SMI Division should be established within ADHS with responsibility to:

- Seek out and receive all federal, state, and local funds and allocate such funds, on a per-capita basis, with special consideration given to rural and other special areas to accommodate cost differences;
- Pursue and obtain Medicaid funding for services for the SMI;
- Establish and enforce standards for care, licensing, and certification of providers of services to the SMI;
- Coordinate intergovernmental activities within the state and between the state and the federal government;
- Maintain a comprehensive data bank to track the SMI and determine their individual needs, as well as the propriety of services provided;
- Establish formal public and academic relations with the state university system to facilitate research, professional training, and public education;
- Promote adequate housing by coordinating federal, state, and local housing programs for the SMI; assist in enforcing the Federal Fair Housing Act; obtain and administer housing subsidies where possible; certify housing services and monitor compliance; and coordinate local housing agencies, mental health service providers, and banking and real estate interests to encourage the establishment of all forms of appropriate housing for the SMI;
- Work with the Attorney General's Office to assure that all local government authorities in the state recognize the provisions of the Federal Fair Housing Act banning discrimination against the SMI and to take any action necessary to assure compliance with the law;
- Provide training and educational opportunities for case managers so that they can assist the SMI of Arizona in receiving all "entitlements" for which they may be eligible;
- Establish a State Advisory Board to the SMI Division, with membership to include consumers, advocates, and public officials; and
- Require independent and objective evaluations of the effectiveness and quality of the system, which will be integrated and conducted on an objective statewide basis by an independent organization. Input will be required from consumers, advocates, family members, and all those involved with the system. These evaluations, as well as ongoing internal ADHS evaluations, will be

submitted annually to the Governor, the President of the Senate, and the Speaker of the House.

Regional Authorities

SMI Regional Authorities should be established for as many regions as may be required to provide a geographically and culturally sensitive system. These authorities will:

- Act as regional administrative arms of the ADHS;
- Receive funds from ADHS;
- Monitor and audit the utilization of funds;
- Monitor quality assurance and peer review activities;
- Create liaisons with local law enforcement agencies, jails, and courts;
- Serve as a center for patient advocacy;
- Facilitate regional evaluation and planning;
- Coordinate and facilitate regional fund-raising activities for SMI services; and
- Enter into agreements with one or more Central Primary Care Organization within the region.

The geographical boundary of the region over which a Regional Authority will have jurisdiction shall consist of one county or more. The number of Regional Authorities will be based on the geographic distribution of SMI consumers in the state. Each authority may be a separate nonprofit organization and may be a county or other governmental body with a board of directors composed of consumers, family members, advocates, and public members. The management, monitoring, licensing, and administrative authorities shall be separate and distinct from the service delivery system.

Central Primary Care Organization

The Central Primary Care Organizations (CPCO's) will be focal points for the system within each region and entry points for consumers to the system. A CPCO will hire clinical case management teams to work with the SMI, determine their needs, provide or access appropriate services, and track their progress. Team members will include a psychiatrist, psychologist, social worker, nurse, psychiatric technician, and others. The CPCO will provide an alternative to what are now the traditional points of entry into the system -- hospital emergency rooms, walk-in clinics, and the criminal justice system.

Each team will guarantee that all SMI have access to supportive services, including, but not be limited to: case management, day treatment, outreach, medications, and crisis stabilization (see more complete list on the following pages). Case managers will also be able to arrange travel for the SMI to treatment centers and funding to help them cover survival expenses. All SMIs, whether they are coming through the jails, courts, homeless centers, or other institutions, will enter the system at this point.

It is estimated that nearly half of all of Arizona's SMI live at home. Therefore, the family participation is critical to the treatment plan. SMI individuals, their families, guardians, and/or advocates, and front-line clinicians will have significant control and reasonable options to create and/or purchase required services.

Case management teams will have the responsibility for deciding what services are to be purchased for their clients. Case management teams may either provide directly or purchase services from any provider. Private or governmental agencies and hospitals independent of the system's administrative structure will be eligible.

The CPCO will either deliver or purchase from service providers a full range of services for the SMI, including:

- 24-hour emergency services;
- hotline services;
- short-term crisis beds;
- mobile acute crisis teams;
- intake and referral;
- diagnosis and evaluation;
- crisis intervention;
- walk-in services;
- psychiatric hospitalization;
- crisis foster care and respite care;
- day support services;
- long-term outpatient psychiatric care;
- sheltered workshops;
- prevocational and vocational rehabilitation;
- job training and placement;
- domestic skills and training;
- adult foster care;
- volunteer services;
- alcohol and drug abuse services;
- dependent, semi-independent, independent, open community, and congregate care residential services;
- outreach to the homeless; and
- outreach to nursing homes.

Service Providers

The CPCO will enter into agreements with service providers to furnish the continuum of care and services required to serve the SMI. These services may be provided by any organization or group, including governmental organizations. We further recommend that regional branches of the ASH be established which will all be an integral part of this continuum of care.

IV.

Funding

The Task Force has concluded that the exclusion of mental illness coverage from the Arizona Health Care Cost Containment System (AHCCCS) is discriminatory and that the State of Arizona should immediately commence negotiations with the federal government to qualify the SMI for coverage under Title XIX of the Social Security Act. This program should be coordinated by the newly created ADHS-SMI Division.

The Regional Authorities, under the SMI Division direction, will establish and coordinate local methods of purchasing services. These different methods will include fees for service and prepaid and capitated financing based on patient needs and program evolution. Any ADHS prepaid or capitated funds designated for the provision or purchase of services for the SMI but not expended by a Regional Authority or its service provider

contractors at the end of a contract year may be rolled over into the next contract year but should continue to be restricted to the purchase or provision of services to the SMI. Such funds should not revert to ADHS. Each individual clinical case management team will retain the authority for referral and purchase of services based on individual patient needs. All purchase of service agreements will be flexible enough to quickly increase or decrease funding based on actual need and utilization pursuant to established standards of care. Counties shall contribute to the cost of the system and be capped commensurate at their current expenditures. The ADHS should administer the program in a way that will ensure that funding priority is given to the most critical survival needs of the SMI.

As previously pointed out, because we cannot accurately determine the number of SMI in Arizona, establishing the cost of a comprehensive service system for them is very difficult: one cannot allocate dollars per client when the number is unknown. There are as many views of what the cost of a system would be as there are commentators. The state-commissioned Peat Marwick study estimates the total cost to be \$335.9 million. The estimated statewide cost based upon an extrapolation of the Maricopa County numbers is \$133 million per year. The Arizona Center for Law in the Public Interest predicts about \$292 million per year. All of these numbers include the aggregate state and federal monies necessary to establish an effective system. Estimates of Medicaid reimbursement of state expense range from 30 percent to over 60 percent -- further reflecting the wide range of opinions held on this complex issue.

As with the population statistics, the reality is that we really will not know what the true costs of the system will be until the system has been created and is in operation. The lack of good data presents a Catch-22. However, there is a credible solution to predicting the cost of a viable SMI system. We call it the "*Let's be Average*" formulation. In calculating the cost of the SMI system, the formulation depends not on the number of SMI but rather on the average per-capita expense for the general population of the various states' SMI programs.

We believe that the best way for Arizona to budget its system is to seek to become an average funding state. It is to be noted that some of the states with only average SMI budgets have the best SMI systems of care. While the Task Force does not suggest that average is acceptable, it recognizes the reality of fiscal constraints and that attaining a level of funding equal to the national average is a viable and reasonable goal.

We know that Arizona is now spending about \$17.00 per Arizonan for adult mental health care -- the lowest per-capita cost of any of the 50 states. We also know that the U.S. average per-capita cost was about \$46 in 1989. To achieve the reforms required and become an average funding state over the next five years, the state should budget about \$32 per Arizonan in 1990-91, \$37 in 1991-92, \$43 in 1992-93, \$49 in 1993-94, and \$54 in 1994-95.

The "*Let's be Average*" formulation assumes that the budget for the new system will be phased in over a five-year period. Thus, it will not be necessary to reach the full budget until the fifth year. The following schedules demonstrate the effect of this formulation.

REQUIRED EXPENDITURES TO ACHIEVE NATIONAL
AVERAGE PER CAPITA RATE OF SPENDING BY ADHS

<u>YEAR</u>	<u>ESTIMATED POPULATION³</u>	<u>X</u>	<u>PROPOSED PER CAPITA RATE TO ACHIEVE NATIONAL AVERAGE IN FY 94-95⁴</u>	<u>=</u>	<u>TOTAL \$</u>
FY 90-91	3,675,000	X	31.69	=	116,460,750
FY 91-92	3,822,000	X	37.29	=	142,522,380
FY 92-93	3,974,880	X	42.89	=	170,482,603
FY 93-94	4,133,875	X	48.49	=	200,451,599
FY 94-95	4,299,230	X	54.09	=	232,545,351

<u>YEAR</u>	<u>PRIOR YEAR \$ ADJUSTED FOR INFLATION⁵</u>	<u>±</u>	<u>REQUIRED NEW \$</u>	<u>=</u>	<u>TOTAL REQUIRED \$</u>
FY 90-91	63,935,157		52,525,593		116,460,750
FY 91-92	121,119,180		21,403,200		142,522,380
FY 92-93	148,223,275		22,259,328		170,482,603
FY 93-94	177,301,907		23,149,692		200,451,599
FY 94-95	208,469,663		24,075,688		232,545,351

POTENTIAL MEDICAID REIMBURSEMENT LEVELS BY RECOVERY PERCENTAGE

<u>TOTAL \$ REQUIRED</u>	<u>30%</u>	<u>40%</u>	<u>50%</u>	<u>60%</u>
116,460,750	34,938,225	46,584,300	58,230,375	69,876,450
142,522,380	42,756,714	57,008,952	71,261,190	85,513,428
170,482,603	51,144,781	68,193,041	85,241,302	102,289,562
200,451,599	60,135,480	80,180,640	100,225,799	120,270,959
232,545,351	69,763,605	93,018,140	116,272,675	139,527,210

³Adjusted annually for growth.

⁴Using ADHS budget figures of:

Community Services	31,334,400
Administration	1,563,713
AZ State Hospital	28,578,000

The current estimated expenditure per capita is \$16.75. Current national average is accepted as \$46.23. This figure is adjusted annually for inflation, with the expectation that the average will be \$54.08 in FY 94-95.

⁵Each prior year figure includes an inflationary adjustment for maintenance of effort.

State legislation should also examine requiring insurance companies to provide equivalent coverage for physical and mental illness. It is clear to the Task Force that the impact of the insurance industry's failure to address the needs of the SMI creates a burden on the public system. Both private and federal insurance, including Medicaid, must be integrated into the system of care.

V.

Implementation

The Task Force recommends that funding for the new system be appropriated on the basis of a five-year plan, commencing in fiscal year 1990-91, and then be phased in over the next four years. During the first year, we recommend that the following actions occur:

- Enact legislation so that ADHS becomes the central authority for a statewide system and consolidate all funding sources;
- Create SMI Division within ADHS;
- Appropriate funding increases to conform with the plan;
- Expand ADHS checklist to include all of Arizona's SMI as defined by law;
- Establish and select Regional Authorities;
- Establish and select CPCOs;
- Establish standards of care and define compliance criteria;
- Create data bank;
- Immediately apply for federal Medicaid assistance and integrate both private insurance and Medicaid payments into the system;
- Ascertain the needs of all SMI within the state and then prioritize the delivery of services to those most in need;
- Create ADHS housing office;
- Initiate plan for ASH regionalization; and
- Designate the Task Force as an oversight body to monitor that the system is implemented.

VI.

Conclusion

The Supreme Court of Arizona in *Arnold v. Sarn* mandated an overhaul of the current system of care for the SMI. This landmark decision affirmed the fundamental principle that the SMI people of our state have legal rights to adequate and accessible treatment for their illness. Acknowledging that Arizona's SMI population has been denied that right, the state must enact a plan to put this decision into practice.

The Task Force is recommending just such a plan -- one that will bring dramatic reforms. Putting it into effect will be a daunting challenge, but one that should result in a system of care for the state's SMI that is unified, cost effective, and fair. By doing so, we demonstrate that Arizona intends to meet the moral test of government and free the SMI from the shadows of public apathy.

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Governor's Task Force on the Seriously Mentally Ill
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Chairman

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Executive Committee

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Claire King, President of Survivors on Our Own, Phoenix

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Senator Robert B. Usdane, President, Arizona State Senate, Phoenix

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*Limitation of Endorsement: Because of an ethical limitation, Judge McDougall cannot endorse the Final Report in regard to any express or implied certification that the matters contained therein comply with the requirements or mandates of *Arnold v. Sarn*.