Arizona Department of Health Services/Division of Behavioral Health Services—*Arnold v. Sarn* Status Report

December 19, 2008

INTRODUCTION

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) provides this Status Report (Report) on its activities in the *Arnold v. Sarn* lawsuit. Arnold v. Sarn is a class action lawsuit filed on behalf of persons with Serious Mental Illness (SMI) in Maricopa County in 1981. [1] Despite existing challenges, many improvements to Arizona's publicly funded behavioral health system have been made resulting in better outcomes for persons This Report summarizes those improvements and addresses the challenges facing the behavioral health community in 2009 and beyond. Throughout the Report, ADHS/DBHS has included true stories from persons and their clinical teams that illustrate how these improvements have made lives better. To protect each person's privacy, all personally identifiable health information was removed from each story.

WHO USES THE BEHAVIORAL HEALTH SYSTEM?

Who are the persons that use the publicly funded behavioral health systems in Maricopa County? They could be anyone. According to the President's New Freedom Commission on Mental Health (Commission), they could be, "…a child, a brother, a grandparent, or a co-worker… someone from any background…." In fact, there are 22,407 persons diagnosed with Serious Mental Illness (SMI) who utilize our publicly funded behavioral health system in Maricopa County—7,097 priority and 15,085 non-priority—and that number continues to increase every day.[2]

WHAT SERVICES DO PERSONS GET?

Prior to 2000, the service benefit for class members was relatively limited to the traditional "medical model" services such as counseling, medication and hospitalization. In 2000, ADHS/DBHS, in conjunction with Arizona's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), petitioned the federal government and received permission to expand the service array in the ADHS/DBHS Covered Service Guide. Services are now based upon the "recovery" concept and include a wide variety of home and community based services such as case management, peer support services, living skills training and employment/vocational training making Arizona one of the most comprehensive home and community based service delivery systems in the nation. In Fiscal Year 2008, Magellan of Arizona, the Regional Behavioral Health Authority (RBHA) for Maricopa County, spent 51% of its total service revenue on home and community based services.

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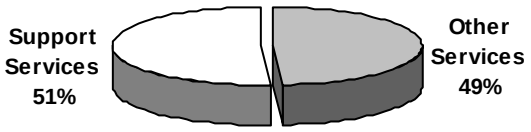
[1] Various phrases have been used to describe persons with Serious Mental Illness including "class members," "consumers," "behavioral health recipients" and "clients." For purposes of brevity and to reinforce our belief that a person with SMI is first and foremost a "person," we will use that term to describe them throughout this report

[2] Of the 22,407 persons, 7,097 are designated as priority and 15,805 as non-priority according the criteria in the Exit Stipulation.

FY 2008 Magellan
Service Revenue Expenditures



(Support services are comprised of: Support Services [41.01%], Rehabilitation Services [9.18%], Group Counseling [.9%], Medication Services [.2%], Family Counseling [.1%])

During the past decade, ADHS/DBHS has made tremendous progress in developing services that were previously non-existent. Examples of four of these services include Assertive Community Treatment (ACT) Teams, Peer Support, Housing and Employment.

ACT Teams

ACT Teams offer an array of services that are provided by community-based, mobile treatment teams to persons seven days a week, 24 hours a day. ACT Teams' success is dependent on implementing key principles:

- Individualized Treatment, support and rehabilitation services are available 24/7 to persons with the most acute needs.
- Rather than brokering services, the ACT Team directly delivers treatment, support and rehabilitation services to the person in the home and community.
- Although each Team member is considered a specialist, each of them share responsibility for every person assigned to the Team.
- The staff to person ratio is smaller (approximately 1 to 12), which allows for flexible, individualized and timely services that are delivered in the person's home and community.
- Using a shared case-load approach, the team, as a whole, rather than any one member, is responsible for engaging the person, treatment planning and service delivery.

Ten years ago, ACT Teams did not exist in Maricopa County. From their inception in 2001, when two teams were created as a pilot project, ADHS/DBHS has added more ACT Teams so that today there are 19 ACT Teams that served a total number of 1,414 persons in September 2008 alone. Four ACT Teams serve persons with specific conditions or needs. Currently, two ACT Teams serve persons with forensic needs: one Team serves persons discharged from supervisory care homes and the other Team serves persons discharged from the Arizona State Hospital.

ACT Teams have been of tremendous benefit to persons. Here is one of many examples of a person whose quality of life was vastly improved because of the efforts of his or her ACT Team.

> **"According to an assessment in November 2007 (the person) had poor social supports and unstable housing. She was experiencing increased agitation, auditory hallucinations, visual hallucinations,**

and delusions. She reported that when she was not doing well, she would feel confused, have difficulty concentrating, hear voices, and use illegal drugs. From November of 2006 when she was arrested for trespassing and possession of drug paraphernalia till November of 2007 when she was offered services from an ACT team, she had a history of arrests, CPS involvement, methamphetamine use, Court Ordered Treatment (COT) and amendments, and hospitalizations.

When initial assessment was done for the ACT team (the case manager) met with her. (The person) had recently been released from hospital. She was delusional, admitting to auditory and visual hallucinations and admitted to recent drug use. She was unable to engage in conversation. Her thoughts were incomplete and she was preoccupied with religious beings, the universe and believed spirits were talking to her. She was living in a van in the cold during winter time. She refused to leave the van. A relative was her payee and she was not seeing any of her money from Social Security.

The ACT team started doing daily outreach and engagement. She was placed on medication observation twice per day. The ACT team would go to her van every morning and evening to see her and give her the medications. Within a few months she stopped using the drugs. She continued to refuse housing assistance but did agree to change her payee, which allowed her to receive her money. After several months she agreed to move out of the van and into an apartment with family members. Shortly after getting into the apartment one of her family members was arrested, and she was left to find resources to provide for herself. She started taking medications daily independently and med observation was reduced to one time per day. She started looking for jobs and was always able to pay for the rent. She faithfully took medications, attended appointments (including weekly labs) and engaged with the clinical team. The ACT team continued to provide med observation and case management support and provided her with a food box from time to time and a monthly bus pass.

Currently, she takes all medications as prescribed independently and attends all appointments as scheduled and takes the initiative to keep track of her appointments, will call to verify appointment, and will call to request transportation if needed. She continues to maintain her apartment, care for herself. She has a job, which she found on her own and gets herself there daily and on time."

Peer Support

The development of a sustainable Peer Support network is one of the system's most remarkable achievements during the last ten years. Prior to then, peer support services did not exist. Today, there are 14 Community Service Agencies that offer peer support services—five are peer-operated agencies—in Maricopa County that provide services at 33 different sites. Services at these sites are provided by 486 peer support staff and 48 family support staff employed by Magellan or its subcontractors. Peer Support services are provided by persons or family members who are or have been recipients in the behavioral health system. Peer Support service includes offering assistance in navigating the service delivery system, understanding and coping with stressors, coaching, role modeling and mentoring.

The benefit of having a sustainable Peer Support network cannot be overstated both for the peer mentor and the person who receives peer support services. Persons who have been reluctant to engage with professional staff are more likely to make a connection with a peer—someone like them who have been through the same or similar experience. Exploring employment opportunities, assisting with learning new skills or simply being available to listen and offer encouragement and support are invaluable in helping achieve recovery.

Similarly, the peer support mentor benefits in his or her recovery by being employed, performing a valuable service, and helping others overcome the obstacles that they faced in their own past.

> **"Soon after his arrival at the Glendale clinic, our site peer mentor was inspired to create an innovative and unique weekly peer support group. Following the lead of several successful peer support pioneers, our peer mentor adopted the concept of "mutual empowerment" and set out to facilitate a weekly recovery-focused interactive support forum.**
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> **In the beginning, scheduling constraints dictated the group would meet on Friday. With this in mind, our peer mentor developed the acronym "FRIDAYS": a place where Friends Relating Improves Development And Your Success. FRIDAYS would become the name of the group and is echoed each week at the top of the meeting.**
>
> **Ten people attended the first meeting in October 2006, and since then, attendance has grown in excess of 20 people each week. There is often "standing room only" at his group. At a typical meeting, participants enjoy refreshments, review conduct guidelines and introduce themselves. Persons are encouraged to share recent successes and/or challenges to the extent they feel comfortable. After announcements there is an interactive weekly topic presentation.**
>
> **FRIDAYS has had an extraordinary impact on the Glendale site as a whole. Clinic staff has eagerly embraced its recovery-focused environment.**

Through this team effort, the clinic has taken on an aura of recovery as evidenced by overwhelming client referrals to FRIDAYS and growing group attendance. FRIDAYS can certainly be credited as playing an integral role in several individual success stories documented at our site. We are extremely pleased to have a site mentor with the ability to create and perpetuate this ongoing commitment to recovery."

ADHS/DBHS is committed to promoting recovery through peer support. In 2007, it created the Office of Individual and Family Affairs (OIFA) with the help of national experts, Larry Fricks and Peter Ashenden of the National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center (NTAC). Prior to establishing this important office, Mr. Fricks and Mr. Ashenden led a Consumer and Family Summit to solicit input from consumer and family leaders/advocates in order to make sure the OIFA was designed to meet their needs. The OIFA helps to build partnerships with persons, families, communities, organizations and key stakeholders to promote recovery, resiliency and wellness. The OIFA conducts many activities in collaboration with these partners. Examples of activities include increasing a person and family voice and participation at all levels; identifying and removing barriers to service delivery; outreach and education to promote leadership and advocacy skills, program development, resource identification and service coordination.

Housing

Providing persons with safe, affordable housing has proven to be the single most effective service in helping to achieve recovery. Ten years ago, housing options were limited and funding was minimal. Today, housing is being provided to over 6,000 persons and its impact on recovery is considerable.

"(The person) started receiving behavioral health services as a teenager. He has been homeless for many years and reports it wasn't until 2003 that he even heard about housing as a service. While he was put on the list at that time, he was also told it could take one to five years to actually obtain it. So he spent time moving from shelter to shelter, even sleeping on roofs. He would occasionally get a part time job and pay to stay in a halfway house or apartment, but would consistently lose the job and, therefore, the housing. At one point he broke his leg and had to rely on a family friend to pay for a halfway house until he was able to be more independent. As a result he found himself angry at the system and at the people who served him.

After the births of his child he knew he needed to find safe housing. Being homeless, he would spend time in his clinic early in the morning having coffee and watching television. On one morning a Magellan housing specialist was at clinic and heard his story. She told him she would try to

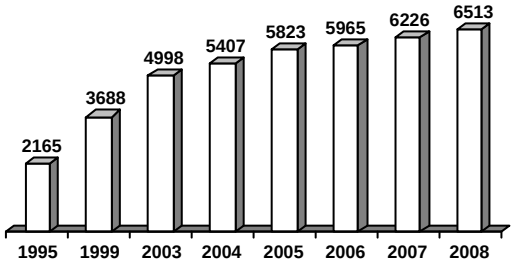
help and said she would be back to him soon. Within a week she found him and his family a safe and secure place to live. Not only that, but she also encouraged him to take his medications and request a counselor. He now reports that he has a good home, food for his family, is attending counseling and hopes to start training at the Maricopa Skills Center through Voc Rehab. He reports that meeting the Magellan housing specialist has changed his life, and he is appreciative of the hope and help she gave him."

One barrier to developing safe, affordable housing that was true then and remains true today is that Medicaid does not provide funds for housing. That means that ADHS/DBHS must seek funding from other federal programs, grants and the State Legislature.

In August 2000, after successfully advocating for a one time appropriation of approximately $50 million, ADHS/DBHS developed a permanent housing acquisition program, that for the first time in Arizona's history, specifically allowed the RBHA through non-profit organizations, to purchase homes and apartment complexes as permanent housing.

Available housing and those living in this housing has increased tremendously. Since 1999, ADHS/DBHS has increased the available housing by sixty-four percent (64%). The number of persons living in safe, affordable housing has increased from 2,165 in 1995 to more than 6,100 today, a more than one hundred eighty-two percent (182%) increase.

Class Members Living in Appropriate Housing



"The darkness came to my life many years ago when I fell ill and found myself homeless, wandering the streets of Phoenix. What I thought would be a very temporary situation became a 15 year journey in to the world of the forgotten. Life on the streets is very difficult for a new person. Trying to keep one's personal belongings, blankets and even clothing are commodities of value and thus street currency. Becoming a victim of thieves and robberies became a way of life. I had collected my entire life in two shopping carts which I would haul across the city. As a homeless person, I had no knowledge of community services and organizations like Magellan

Health which could help the mentally ill. My life was reduced to a daily routine of collecting cans for 10 hours per day to sell to meet my personal needs. I stayed free from the trap of drugs and alcohol that many I had come to know had fallen into by developing a work schedule. 10 hours of "work", 4 hours of sleep; then go to the public library to stimulate myself by reading out of town newspapers and periodicals. One day light begin to shine on my life in the form of an outreach to the homeless. As you might imagine, after 15 years of trauma, I was not a very trusting person but through the persistence and grace of staff at Southwest Behavioral Health Outreach and Magellan, they helped me obtain VA Benefits and other services which begin a process of recovery which I am still walking out. In 2008 I was admitted to Desert Vista for a number of months in which I was stabilized psychologically and physically. Thank God and Magellan for that hospitalization as this event uncovered a potential life threatening blood sugar level of over 500. I had an undiagnosed diabetes condition. Today, I am stable, living in my own subsidized apartment (with cable), and once again enjoy the benefit of a wonderful clinical support staff at the Magellan clinic. I will be starting peer support training shortly to be granted that privilege of helping others."

In addition to purchasing housing, ADHS/DBHS offers a wide variety of housing assistance including supportive services to maintain independent living; rent subsidies and flex funds to pay rent, utilities; and initial move-in costs for relocation. One of the many examples of successful housing initiatives is the Projects for Assistance in Transition from Homelessness (PATH) funding by a grant from the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). PATH provides an array of outreach services to homeless persons including housing referrals to both transitional and permanent placements. In 2008 alone, PATH successfully placed over 100 chronically homeless persons into safe, affordable housing.

ADHS/DBHS and the Arizona Department of Housing are also working with the Technical Assistance Collaborative (TAC) to find ways to leverage existing housing dollars in order to purchase more housing units and to provide more rental subsidies. The concept for this project is based on the state of Tennessee's model, which involves leveraging available housing funds in partnership with community stakeholders to buy more housing units. ADHS/DBHS' goal is for TAC to make recommendations to develop a program that will allow ADHS/DBHS to offer more choices for persons to live independently. A final report with TAC's recommendations will be completed in early 2009.

Employment

Like housing, obtaining meaningful employment is critical to achieving recovery. Having an employment goal promotes hope, working promotes empowerment and self-responsibility, and having a career allows a person to integrate into the greater community in a meaningful role; a role other than "patient" or "client" or "mentally ill."

Research has shown that persons who have employment goals or who obtain employment benefit in many ways; for example, reducing the stigma of mental illness, relief from poverty, fewer hospitalizations and encounters with the crisis system, and most importantly, improvement in the overall quality of life

Through the development of expanding the services in its Covered Services Guide beginning in 2000, ADHS/DBHS is now able to offer psycho-educational services to assist persons to choose, acquire, and maintain a job or other meaningful community activity. While the ideal goal may be for persons to achieve full-time employment in a competitive, integrated work environment, there may be many persons for whom this goal is not appropriate. For these persons, ADHS/DBHS offers individualized support services in a variety of settings; for example, a part time job, unpaid work experience, or meaningful volunteer work. Some persons are not ready to identify an educational or employment goal. In the past, these persons were told to come back when they were ready, which in most cases, meant they never returned. Today, these persons are provided with services to help explore their strengths related to a variety of goals, which leads to identifying an appropriate goal related to employment; for example, a socialization goal, which is often the first step to moving towards competitive employment.

> **"After I got off of probation I self medicated with crack cocaine. I just couldn't stand this hell anymore. This time I attempted suicide by taking a whole bottle of Methadone.**
>
> **But death wasn't to be. I woke up in the back of an ambulance with a paramedic pushing Narcan into my IV. After spending twenty eight days in a psych hospital in Phoenix I was finally diagnosed as Bipolar and found that my SMI diagnosis qualified me for treatment through the Regional Behavioral Health Authority. Finally I got medication, counseling, doctor visits and case management. I've had a couple of case managers who were great. They helped me to find what I needed to do to find the path of recovery. They held the hope when I couldn't.**
>
> **At one point I was on nine different medications, I'm down to two. With the help of my spirituality, my loving wife and my clinical team I got to work. And after I got to where I believed in myself, I took off. I went through the WRAP program and then went through Peer Support training. One month after I graduated I went to work for a non profit organization, then went to work for the RBHA as a Peer Mentor, and I am still there. I was also**

introduced to NAMI, which has provided further opportunities to participate. I am also trained in In Our Own Voice and Peer to Peer. I have also been through an Advocacy Institute, the Leadership Academy and work as an advocate.

I guess as you can tell, I have found my passion. And to top it off, I have three years clean and sober and my family and I have a wonderful life together. So to wrap this up I guess I would have to say it may be a lot of work but, recovery is very possible and worth every ounce of work you put into it. DON'T GIVE UP!"

To better provide these services, ADHS/DBHS has steadily increased the number of employment providers in the network, begun co-locating employment providers at the direct care clinic sites to promote assertive engagement and outreach, strengthened its partnership with the Arizona Department of Economic Security/Rehabilitative Services Administration (RSA) and have established a Rehabilitation Specialist on each Supportive and ACT Team.

Staff is trained to practice psychosocial rehabilitation engagement skills to assist individuals in increasing personal closeness, developing readiness, choosing a goal, and attaining and maintaining that goal. Rehabilitation specialists participate in the development of Individualized Treatment Plans in order to help a person create goals on quality of life domains: learning, working, living, and socializing. Doctors are part of vocational discussions and RSA Vocational Rehabilitation Counselors are active members of the clinical team. Presently, rehabilitative services are considered the primary vehicle to recovery and the SAMHSA Evidence Based Practices in Supported Employment are upheld.

TRANSFORMING THE SYSTEM

Transitioning Clinics to Provider Network Organizations

During 2006, ADHS/DBHS had a choice. It could have retained the same RBHA contract and continue with business as usual or chart a new and different course to address the pervasive problems in the behavioral health service delivery system. It chose the latter, and today we are on the cusp of system transformation.

A major problem with the prior RBHA contract was the role the RBHA had as both the managed care entity responsible for oversight of service delivery and the service provider itself, operating 23 direct service delivery clinic sites. This inherent conflict of interest that permitted the RBHA to oversee itself did not work.

As a result, with the help of persons, community stakeholders and system partners ADHS/DBHS made extensive modifications to the RBHA contract and developed a new and better way of doing business. Instead of the RBHA being the oversight entity and the service provider, services are going to be provided by community based Provider Network Organizations (PNO),

whose sole responsibility is to deliver behavioral health services. This means that the RBHA can fully devote its efforts to the activities it does best— perform managed care operations— without the conflict of being both the and the oversight organization.

Of course, transferring existing clinics to PNOs could not happen overnight. During the time Magellan was recruiting, developing and supporting PNOs, it was also operating and delivering behavioral health services at 23 direct care clinic sites. By September 2009, all behavioral health services will be delivered by PNOs or their subcontractors. To date, Magellan has contracts with two PNOs: Southwest Network and Choices. As of November 15, 2008, five clinics have transitioned to Southwest Network. By February 2009, eight clinics will be transferred to the Choices network.

The advantages for class members receiving services from PNOs are many:

- Recovery oriented services will be the primary focus of each PNO.
- Persons will have a choice of providers.
- Competition among PNOs will encourage innovation and improve service delivery.
- Local, long standing community based organizations will have a greater "hands on" role in shaping the system toward recovery.
- The PNOs will be responsible to operate a smaller number of clinics, which will encourage innovation, flexible service delivery models and greater class member involvement.
- The PNOs can focus entirely on providing services to class members and not have to perform managed care activities and other administrative functions, which are the sole responsibility of the RBHA.

Commitment to Recovery: The Villages Model

What do persons want from the publicly funded behavioral health system? Of course, many have said they want adequate, timely and appropriate behavioral health services to meet their needs. But not just any services. Most persons want a behavioral health system that provides services to promote recovery.

"Recovery" has taken hold throughout the national behavioral health community during the past ten years and is best described in a consensus statement released by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services as:

> Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

Recovery is about whether a person's quality of life improves. Recovery embodies a set of principles including choice, self-direction, self empowerment, respect and hope among others. Recovery means the consumer is in charge of his or her treatment. In other words, it is the

person who helps chart the direction of the behavioral health system based on his or her treatment goals and service plan and not others making decisions for them.

Proof that Recovery works is found at the Mental Health America (MHA) Village program (Village), located in Long Beach, California, and developed in 1990. The Village provides an integrated service approach bringing together all the services and support persons need to live, learn, work, and be involved in the community. Recently, ADHS/DBHS invited key leaders from the Village to design a similar model in Maricopa County with the goal of changing existing culture to Recovery. The Maricopa County Village model vision incorporates the following key concepts:

- All services and interactions are designed to assist persons in moving through the four stages of recovery: hope, empowerment, self-responsibility, and a meaningful role in life.
- There is no distinction between "professional" and "patient"—all are equal partners.
- Choice is emphasized.
- Improvement of quality of life defines success.
- Staff must devote time to community development and anti-stigma activities.
- Improving quality of life and having choice are more important than symptom reduction.

ADHS/DBHS has begun work to replicate the Village Model in Maricopa County. Some of the initial activities include:

- Work groups that include persons, clinic staff and ADHS/DBHS and Magellan administrators are identifying and resolving barriers to effectively plan for the future.
- Training and coaching sessions are being held to teach staff effective engagement techniques, skill sets for the provision of vocational and rehabilitative services, and an enhancement in customer service skills.
- The physical appearance in the lobby of each clinic is being analyzed and changed to promote a welcoming environment and to remove physical barriers between individuals and staff.

"I am writing this because I don't have the ability to say what I feel. Since I have been coming to class, I have felt an acceptance that I have not known in nearly 25 years. When I come to class I feel that I can relax and be myself and not feel as if I'm being looked at as if I were different from everyone else! At class, because of all of you, I have felt like a normal person for the first time since I got sick. The good and decent things that all of you have brought into my life cannot be measured in mere words or deeds, and all I can say is thank you from the bottom of my heart! All of you have a special place in my heart and always will."

HOW IS THE SYSTEM PERFORMING?

As of today's date, the results from the Court Monitor's 2008 Annual Independent Case Review (ICR) have not been officially released. In past audits, ADHS/DBHS has received scores below the compliance targets, specifically in Appendix C.3 ("Within ninety days of a determination of eligibility, priority clients whose clinical needs require extended ISPs have extended ISPs, with a functional assessment and long term view.")[3] and C.7 ("The needs of priority clients are met, consistent with their ISP."). In the 2006 ICR, ADHS/DBHS received a score of 35% on C.3 and 29% on C.7. In 2007, the scores were 13% for C.3 and 13% for C.7.

ADHS/DBHS is not satisfied with these scores and recognizes that improved performance must be its primary goal. While there is much room for improvement, it is important to note that whether one's performance is considered deficient, adequate or superior depends on what is being examined and how performance is measured. For example, a closer, more comprehensive analysis of the data supports the conclusion that persons are highly satisfied with case managers and clinical teams; they experience above average outcomes in living and employment; and individual service planning occurs in the majority of cases.

Customer Satisfaction

The ICR instrument contains a series of questions that ask a person how he or she perceives services offered by case managers and the clinical team. Below are the tables and scores from data provided in the 2007 ICR in each of the categories.

Perception of a Person's Clinical Team I

Question	Always	Usually	Total
Does your clinical team give you reassurance and support?	60%	15.6%	75.6%
Do the members of your clinical team spend enough time with you?	48.9%	31.1%	80%
Does the clinical staff that treats you work well together as a team?	61.4%	25%	86.4%
Do members of your clinical team listen carefully to you?	71.1%	22.2%	93.3%
Does the clinical team explain things in a way you understand?	75.6%	20%	95.6%
Does the clinical team treat you with respect and dignity?	82.2%	11.1%	93.3%
Are you involved as much as you wanted in decisions about your treatment?	55.5%	25.6%	81.4%
	Average Satisfaction Score		**87%**

[3] ISP is an Individual Service Plan

Perception of a Person's Clinical Team II

Question	Quite a bit	A great deal	Total
Would you recommend your clinical team to someone else who needs behavioral health or substance abuse treatment?	61.4%	27.3%	88.7%
Have the members of your clinical team given you information about how to reduce the chances of relapse?	29.6%	25%	54.6%
Has your case manager or clinical team members told you about available self-help or support groups?	40.9%	27.3%	68.2%
Has your clinical team told you whom to contact in case of a problem or emergency?	48.8%	27.9%	76.7%
Did clinical team members tell you about the benefits and risks of medications (s) you are taking?	48.4%	11.6%	60%
Did clinical team members give you information about your rights as a consumer?	45.5%	34.1%	79.6%
How much are you helped by the help you are receiving?	38.1%	40.5%	78.6%
	Average Satisfaction Score		**72%**

Perception of a Person's Case Manager

Question	Always	Very Often	Often	Total
I am satisfied with my case manager.	59.5%	21.4%	9.5%	90.5%
My case manager has negative biases towards me.	-	-	2.4%	2.4%[4]
I am treated as good as other consumers are by my case manager.	57.1%	23.8%	7.1%	88%
I am getting what I want from my case management services.	46.5%	23.3%	4.7%	74.5%
I believe the amount of time that my case manager spends with me is fair.	38.6%	27.3%	18.2%	84.1%
		Average Satisfaction Score		**87%**

Further inquiry and analysis is needed to explain the difference between the low scores in whether priority class members had their clinical needs met (consistent with their ISP), while in the same review the overwhelming majority reported a high degree of satisfaction with the treatment provided by case managers and clinical teams.

Living and Working

National data collected by SAMHSA for the National Outcome Measures (NOMS) study, which is acknowledged as the industry standard in measuring behavioral health outcomes, shows

[4] Factored as 97.6% in calculating the average satisfaction score.

persons in Arizona receiving services to help with living (adults living in a private residence) and working (adults competitively employed) fare much better than the national averages.

NOMS Data

	Arizona	States	% Difference
Living	85.4%	78.0%	+7.4%
Working	38%	22.0%	+16%

The ICR in Appendix C.7 has similar domains of living, working and meaningful day. In order to receive a "yes" on C.7, a person must score "yes" in each of these three domains on the day of ICR audit. Stated differently, anything less than a "yes" to all three domains counts as a "fail" on C.7 leading to the conclusion the person does not have his or her "needs met."

A closer analysis of the 2007 ICR data is consistent with the NOMS data and supports the belief that more persons are receiving services to meet their needs in living or working. When the scores in the living and working domains are separated from the final C.7 "needs met" score, it is clear that a substantial number of persons are receiving the services that they need. Moreover, if factors that account for deficiencies in a person's Individual Service Plan (ISP) are removed from the domain, scores, even greater numbers of persons are receiving the services they need.

2007 Independent Case Review Findings—Living, Working

	With ISP	Without ISP	Total % Receiving Services
Living	36%	20%	56%
Working	21%	16%	36%

Individual Service Plans

Similar findings are found when breaking down the data in Appendix C.3. In order to receive a "yes" on C.3, a reviewer must to answer "yes" to eleven individual questions. If ten are "yes" and one is "no," the reviewer must score C.3 as a "fail." In looking more closely at ADHS/DBHS' performance on each of the eleven questions, questions 1, 5, 6 and 7 are contributing to the low C.3 score. The following chart is the breakdown of the scores from the 2007 ICR,

2007 Independent Case Review Findings—ISP

Question	Yes
1. Based on the Comp-Assessment and other documentation are all areas of need addressed in the ISP?	25%
2. Is there evidence of professional input in the development and formulation of the ISP?	83%
3. Are there specific steps/methods documented in the ISP that describe how goal will be achieved?	58%
4. Are there individualized service goals or objectives in the ISP?	68%
5. Functional Assessment: Social/Community Integration.	34%
6. Functional Assessment: Working/Learning.	37%
7. Functional Assessment: Living Situation.	42%
9. Long Term view/Vision: Social/Community Integration.	79%
10. Long Term View/Vision: Learning/Working/Meaningful day.	73%
11. Long Term View/Vision: Living Situation.	86%
12. Does the person have a current (ISP)	80%
C.3 Priority Clients have ISPs with a functional assessment and a long term vision	13%

In fact, if the four questions related to the functional and comprehensive assessment are removed from the analysis, the remaining scores for each question are much higher than the final C.3 reported score with the lowest at 58% to the highest at 86%.

During the last six months, after collecting and analyzing the data, ADHS/DBHS and Magellan have been working to address improvement related to the four questions that have the greatest impact on the overall score. One barrier that contributed to the problem was that the functional assessment was not incorporated into the ISP itself and was handled through a separate process. To remove the barrier, Magellan created a design team to automate ISP development into its ClaimTrak system by including the functional assessment into the ISP. The process has been operational since June and preliminary data shows a 30% increase in performance in completing functional assessments.

THE FUTURE

Managing Growth

Since 2000, when the total number of class members was 11,561, we have seen an increase of 10,846 to a total of 22,407 which represents a 94% increase in class members. In contrast, the overall population in Maricopa County has increased from 3,097,778 to 3,880,181 for a 25% increase during the same time period. Simply put, class member growth is rising almost four times faster than the overall population growth in Maricopa County.

This trend is expected to continue in the coming years. Based on current trends, class member growth is projected to increase by an additional 10,080 (44.9%) for a total of 32,487 members by 2015. This represents an additional 45% increase in just seven years.

With growth comes challenge. In order to meet the needs of ever increasing numbers of persons, the publicly funded behavioral health system will need additional funding to develop an increase in service capacity, recruit and train a workforce of professionals and peer mentors and enlist the help of persons, family members, providers, system stakeholders and anyone else who depends on publicly funded behavioral health services to achieve recovery.

Funding

In comparison to other states, Arizona fares well in receiving funds for behavioral health services. As of Fiscal Year 2005, Arizona ranked 7th in per capita spending for mental health services while maintaining one of the lowest per capita spending rates for inpatient state hospital services.[5]

Despite significant increases in funding, the system remains underfunded. In 1998, ADHS/DBHS retained Human Resource Institute Inc., consultant, Dr. Steven Leff to conduct an analysis of the funds needed to fully implement the court orders. Dr. Leff concluded that at that time approximately $316 million was needed to adequately fund the system. It took ADHS/DBHS over a decade to achieve this funding level and as of 2004, Dr. Leff's report, adjusted for population growth and inflation only, indicated that approximately $570 million was needed to fully implement the court orders.

2009 And Beyond

Even with the dual challenge of maintaining service levels in the face of increasing growth and lagging funding, ADHS/DBHS will continue its progress in moving the system forward to a recovery based model. By September 2009, all of the direct care clinics will be managed by the PNOs and the RBHA will be allowed to do what it was contracted to do: perform managed care behavioral health care functions. By then, we expect to see real progress in those clinics that employ the Villages model, and hope to import this recovery based approach to other settings where behavioral health services are delivered. Also by then, for the first time in almost two decades, persons will be offered a choice, not only with a specific PNO, but also with the service delivery provider that best suits their needs. Finally, through the efforts of ADHS/DBHS' Office of Individual and Family Affairs, we expect to see greater individual and family voice in making the decisions that affect persons and their families.

One of the key elements of recovery, whether it is embraced by an individual or a system, is hope. The following story illustrates what hope means and how powerful it can be when put into action.

[5] National Association of State Mental Health Program Directors Research Institute, Inc. http://www.nri-inc.org/reports_pubs/pub_list.cfm?getby=Revenues%20and%20Expenditures

"For me personally, I do not measure success as reaching a forward goal. I measure success by leaving a backward disaster. That, being my motivator, I suppose I have succeeded time and time again.

I have gone from hopelessness to bearableness, from suicidal to rational, competent thinking, from weariness to strength, from walking to riding, from no money at all to a monthly income, from rejection of myself to believing in myself.

With the patience and guidance of (clinical team members), I have gone from seeing myself as "not worth fixing" to "Yes, well worth fixing!"

I have gone from borderline recluse to finding friends, speaking to a group of people and volunteering my time - time that five years ago was not worth throwing away. I have unearthed talents that had been buried alive.

I have gone from feeling sorry for myself to feeling sorry for others, others, who by my success story, might listen to that one small grain of sand they may find on the beach of life that whispers, "keep on going, keep on trying, hold that head up high" and you will leave your disasters behind, one by one, by one."

ADHS/DBHS acknowledges that performance stills needs to improve. As we stay focused on making improvement, we also want to recognize the accomplishments that have been made over the last ten years. Much like a person struggling in his or her journey to achieve recovery, transformation is a long process and the system cannot succeed unless we collectively identify and build on our strengths. Deficits must be addressed, but strengths, empowerment and hope are the ingredients needed to conquer these deficits. To that end, ADHS/DBHS has articulated its vision for the future:

> "All Arizona residents touched by the public behavioral health system are easily able to access high quality prevention, support, rehabilitation and treatment services that have resiliency and recovery principles at their core, which assist them in achieving their unique goals for a desired quality of life in their homes and communities."

ADHS/DBHS is committed to partner with persons, families, and system stakeholders to come together collaboratively and to continue our work together toward realizing this vision for better outcomes and recovery. There is still work to be done, and together, we will continue to make progress toward recovery.