maricopa county
Human Rights Committee
for the mentally ill

Craig Carter
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Tom Betlach, Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, AZ 85035

Dear Mr. Betlach,

This annual report highlights our activities and achievements in 2015 as required under ARS 41-3804(G).

Our Mission

The Human Rights Committees (HRCs) were created by the Arizona Legislature to assist the Arizona Department of Health Services (ADHS) and the Regional Behavioral Health Authorities (RBHA) in promoting the rights of persons who receive publicly funded behavioral health services.

Membership

As of December 31, 2015, the MCHRC consisted of ten members as follows:

Jessica Blaha (Consumer)
Craig Carter, Ed.D. (Education)
Holly Gieszl, J.D. (Law)
Joy Green (Family member)
Scott Gormley (Family member)
Jack Potts, MD (Medicine)
Karen Smith, (Mental Health)
Charles Sullivan, (Housing)
Marilyn Viarengo (Consumer)
Ryan Welch, Ph.D. (Education)

Here is a snapshot of our accomplishments, challenges, and recommendations:

Mercy Maricopa Integrated Care- Transition to the New RBHA
This past year saw the completion of the transition to MMIC. We are encouraged that our interactions to date with MMIC staff members have been supportive. Their support was clearly demonstrated when top level management leaders attended our April meeting and the subsequent focus meeting with Susan Junck, MMIC- HRC liaison, and selected committee members. In particular, we appreciate the assignment of Susan Junck to attend MHRC meetings and prepare the Committee's minutes.

Revised Statues
Senator Nancy Barto's leadership and legislative sponsorship resulted in the passage of SB1400 that accomplished the following goals:

- Increased the potential membership pool as seen by the addition of one new committee member representing Housing.

- Strengthened the legislative intent for independent, community-based oversight; although, the MCHRC is proposing further changes.

- Improved the efficiency of operation and effectiveness by removing barriers that hindered our ability to communicate and coordinate work activities with other human rights committees.

- Strengthened the communication between the Committee, Legislature, RBHAs, and state agencies.

Statewide Meeting of Arizona Human Rights Committees
On June 6, 2015, the three established Human Rights Committees representing the Arizona State Hospital, Pima County, and Maricopa County convened their first statewide meeting. This successful day-long workshop brought together committee members and participants from the Arizona Department of Health Services, Cenpactico and Mercy Maricopa Integrated Care executive leadership staff, David's Hope, Criminal Justice Mental Health Collaboration, Arizona Psychiatrist Society, and guest speakers Senator Nancy Barto and Dr. John Toma with Biltmore Evaluation and Treatment Services.

We were warmly welcomed by Senator Nancy Barto and her affirming remarks about the importance of our work. The Human Rights Committees presented Senator Nancy Barto with a plaque as a champion for improving the lives of individuals living with mental illness. Presentation topics included:

- Seriously Mentally Ill and Jails: Facts and Myths
- SB 1400 – Making It Work for Us

- New Incident/Accident Portal Process
- Site Review Protocols and Arizona State Hospital Related Issues
- Pima HRC Law Suit/Clarification on Peer Review
- Jails and the HRCs – How Can we Influence Change?

Site Visits

We continued our focus on the identified special assistance clients. The Committee conducted eight site visits; typically, these visits went well, and many of the sites were commended for their cleanliness and staff's willingness to share information with committee members. Although the Department and MMIC are working to ensure the special assistance list is current with correct addresses, these reports continue to contain an unacceptable error rate (typically about 30%). If there is to be adequate monitoring and services for this most vulnerable population, data integrity must become a priority focus for the Department and MMIC to correct.

Community Forum

On December 2, 2015, the Committee held its first community forum. Twenty-one individuals shared their stories of frustration in, and hope of, securing needed services for a family member or themselves before an audience that included Senator Nancy Barto, representatives from AHCCCS, MMIC, ADHS/DBHS, Arizona Council of Human Service Providers and Arizona Center for Law in the Public Interest.

Among the public policy priorities outlined by Senator Barto were:

- Filling the gaps in the RBHA system.
- Increasing the currently insufficient number of 24-hour supervised facilities available for the most seriously ill.
- Increasing psychiatric bed availability.
- Improving contract oversight by AHCCCS focusing on progress towards outcomes not processes.
- Measuring whether clients are compliant with treatment plans, measuring homelessness, incarcerations, arrests, hospitalizations and suicides.
- Working with providers to remove legal barriers that are impeding the delivery of treatment therapies that work.
- Applying evidenced-based nontraditional therapies that work.
- Defining who defines "evidence-based."
- Increasing meaningful family involvement and access to information from doctors, if needed, for family members providing case management, care and housing.
- Interpreting HIPAA laws and statutory changes properly.
- Training hospital and treatment providers to respect and communicate with family members, pressing the point through a "Caregivers Bill of Rights. "
- Improving the Involuntary Treatment protocols.
- Improving care coordination between systems including dedicated case workers assigned to assist in transition from hospitals to communities.
- Increasing number and type of appropriate facilities to discharge members to.

- Fostering culture change at the Arizona State Hospital.
- Developing independent measures to hold Arizona State Hospital accountable for reporting and addressing serious injuries and preparing individuals for reintegration to the community.
- Implementing Prison transition plans overseen by dedicated navigator to assure proper treatment and community coordination.
- Building recidivism reduction goals into corrections contracts.

The Community Forum generated two lists (problems and what's working) which overlap substantially with the items listed by Senator Barto.

CHALLENGES/PROBLEMS:

1. **RBHA staffing:** Nurse Practitioners (NP), not psychiatrists provide most care; inadequate supervision of NPs and unlicensed therapists; staff miss impending self-harm; SMI eligibility decisions made by non-mental health professionals; lack of communication or inadequate communication with family of individuals enrolled as SMI, often attributed to HIPAA prohibitions; communication problems with ACT team; lack of understanding of biological basis of mental health challenges; COT teams need to do more to prevent self-isolation; families/friends often are the first to notice signs of clinical decline – providers need to listen; case manager salaries are too low with resulting high turnover, especially masters trained professionals.

2. **Homelessness:** Lack of transitional/group housing; members remain hospitalized because of lack of housing.

3. **Quality management:** Quality management does not address influence of staffing (item no. 1) and hold supervisors (and up) accountable; need to monitor services, cleanliness and safety in group homes.

4. **Access to Services:** Services to avoid arrest and criminal record during a crisis beyond the CITs; continuity of care, especially with services and medications when transition from one treatment setting or provider to another; no coverage for holistic, non-medical "alternative treatments;" need to recognize mental illness as "brain disease" not behavioral problem; adult system more difficult to navigate than children's system and lack of transition path from child to adult system.

5. **Lack of services for specific disorders.** Example: Reactive Attachment Disorder; need for trauma informed care.

WHAT'S WORKING:

1. UPC, peer support, and NAMI.
2. Integrated care so far, but child system is better than adult system.
3. A "great" case manager is key to achieve recovery.
4. Aspects of the public health system that work better than the private system and we can use those models to improve the private system. Private insurance should follow AHCCCS' requirement for a 14-day notice prior to discharge and mandatory discharge plan.
5. 504 plans in education.

The Committee will use the items identified by Senator Barto and participants at the community Forum to inform the Committee's efforts in 2016 and beyond.

Monthly Special Assistance Wait List for Advocate Assignment; Inaccurate Data about Physical Location of Special Assistance Clients

Within Maricopa County's SMI population approximately 1,124 MMIC clients are eligible for "Special Assistance" because they have concurrent medical conditions that hinder their ability to engage meaningfully in their treatment planning. By definition, Special Assistance clients are particularly vulnerable individuals. Accordingly, Special Assistance clients have a person --- legal guardian, family member, or responsible friend ---assigned as an "Advocate." If no one is available to serve as the Advocate, AHCCCS Division of Health Care Advocacy and Advancement, must assign an "Advocate" from its staff.

A. AHCCCS --- Wait List for Advocate. At last report, 124 Special Assistance clients are "wait listed" for an Advocate to be assigned. *Nine of these individuals have been on the wait list since 2014.* The Office of Human Rights (OHR) and MMIC reported that they are working to increase staff to serve as advocates. OHR reported that it had requested an increase in the number of staff advocates. ADHS reported efforts to develop a "peer academy" to train Peer Advocates for Special Assistance population.

B. MMIC --- Inaccurate Monitoring Special Assistance Clients Whereabouts. The Committee receives from MMIC monthly client reports of "active" special assistance clients, (assigned advocate) and "wait" list (no assigned advocate). The Committee uses these reports to randomly generate a list of individuals who Committee members then visit during a site visit. Inaccuracy of the "active list" is a persistent, systemic problem: every Special Assistance list that the Committee has received has at least one inaccurate address for the Special Assistance client and most lists have 25% to 33% error rate. MMIC reports that it does know where the Special Assistance Clients reside, but they are unable to generate an accurate list of addresses at any

point in time. (Parenthetically, Magellan had a comparable error rate with its lists of the address for Special Assistance clients.)

The Committee strongly recommends that

i. assignment of an advocate to Special Assistance clients become a priority for AHCCCS;
ii. development of an information system to maintain *always current* information about the living address of Special Assistance clients become a priority for MMIC.

The Committee further recommends that AHCCCS and MMIC, respectively, work collaboratively with the Committee by providing monthly status reports on progress made to reduce the number of "waitlisted" Special Assistance clients (AHCCCS) and to generate an accurate list of the residences of Special Assistance clients (MMIC).

Status of 2014 Annual Report Recommendations
The following is a status update of the Committee's 2014 Annual Report recommendations.

That ADHS, as part of the licensure approval for providers, be required to submit a statement of assurance and employee attestation statements about client rights. We believe this provision is currently lacking in the licensure process.

- Status: The Department requested additional clarification and noted that licensure rules would likely require a rule change that is currently under a rules moratorium at the direction of Governor Ducey.

- We disagree that such a requirement is necessarily subject to the formality of rule-making. This topic will be addressed at a future Committee meeting.

That ADHS/DBHS ensures that our input is solicited in future service capacity assessments.

- Status: The Committee received assurance that Committee input will be solicited moving forward.

Improve the accuracy and timely posting of Committee minutes and related documents on the Department's website.

- Status: We have seen a marked improvement in the accuracy and posting of minutes.

That MMIC and ADHS (AHCCCS) implement reporting procedures for SMI eligibility determinations and service planning for the jail, as an inpatient facility, providing treatment to our members.

Status: From January to December 2015, the prevalence number of SMI individuals in Maricopa County's jail system ranged from a monthly low of 445 to a monthly high of 588 persons during calendar year 2015. Protecting the human rights of the mentally ill and the provision of quality care across all community settings to include the SMI population in our jail and prison system is now a priority focus of the Committee. To that end, the Committee is creating a protocol to visit jailed SMI members.

AHCCCS, in their limited monitoring/oversight duties is tracking and sharing SMI eligibility determinations and discharge service planning data with the Committee. However, this is an area that needs to be strengthened because independent oversight for the incarcerated SMI population (jails and prisons) is presently missing.

- Maricopa County Jails

  - Correctional Health Services is not licensed or contracted through the Department and is not considered an "inpatient facility" as the term is defined in administrative rule R9-21-101. Excluding Arizona's County jails from independent oversight for the jailed SMI population creates a serious omission in the State's check-and-balance system. We recommend this topic be clarified in statute and regulations.

  - The oversight role and authority of MMIC as to its enrollees who are arrested and remain in jail is unclear and should be clarified in statute and regulations.

- Arizona Department of Corrections (ADOC)

  - Reports by court monitors under the Parsons case will be released in 2016. Anecdotal reports to and observations of Committee members dealing with the incarcerated SMI population within ADOC suggest that ADOC is not in compliance with the requirements as to inmates who are designated SMI upon arrival. The Committee was informed that ADOC requested ADHS to reclassify some inmates presently deemed to be SMI without providing a basis for the change. To date, these requests have been refused by the Department. The apparent purpose of the request was to reduce the numbers of inmates who must be provided SMI services under Parsons.

It is our recommendation that the Department coordinates and schedule a meetings with representatives from the Committee, the Department, and Maricopa Correctional Health Services.

That the Committee, MMIC, and ADHS create a member informational notice / brochure for enrollees and family members of enrollees to be provided at the time of or shortly after arrest, and again at the time of any sentence to jail or prison.
That ADHS collaborate with the Committee, MCSO, and ADOC to provide information for Families of the Incarcerated by including a section addressing mental health services.

- Status: No action. As an independent entity, Correctional Health Services is responsible for the development of such a document The Department, in their response to the Committee, suggested drafting a letter with this proposal and also indicated their willingness to collaborate with CHS if requested. We disagree with this approach.

- The Department and MMIC did not dismiss the need for member informational notice/brochures, just the explanation that they lacked the jurisdiction. We believe the Department and MMIC have the authority to create and disseminate such a document as part of the site visits conducted by the Department's Office of Human Rights staff and case managers.

That consideration is given to creating a pre-release agreement between the MCSO, ADHS (AHCCCS), and the RBHAs and between the ADOC, ADHS (AHCCCS) and the RBHAs.

- Status: No action yet, although MMIC offered to work with CHS to produce a collaborative protocol.

- Unfortunately, good intentions do not produce results in the absence of a viable action plan; although, we are encouraged that the Maricopa County Board of Supervisors supports the Stepping Up Initiative. This will be a topic of discussion at a future Committee meeting.

Alternative Services-Unmet Service Needs (R9-21-311)
This topic was addressed in our 2014 Annual Report and is presented again as an unresolved problem. The Committee previously requested a list of unmet service needs and was informed that the report is no longer a required "deliverable" to ADHS (AHCCCS). It is our understanding the original impetus for this rule was to satisfy Arnold v. Sarn requirements and has been replaced with Network sufficiency reporting requirements resulting from the dismissal of the case in January 2014.

This is a good administrative rule. It permits the clinical team to write ISPs based on client's needs and provides a reporting mechanism if services are unavailable. The identification of an unmet need is created from clinical staff closest to the client and processed through the chain of command. These unmet service needs may or may not be identified as a systemic issue resulting from a broad base service capacity assessment. The unmet service needs report is an important data point and is consistent with the January 2014 Court Stipulation, which, in part states at paragraph 35:

The assessment may also utilize customer satisfaction surveys; complaint data; geo-access mapping; hospital emergency room utilization; criminal justice records; homeless prevalence; employment data; suicide rates; public forums; and **other data as appropriate that may indicate unmet need, utilization or availability of covered services.**

Recommendation:

- We recommend that AHCCCS reinstate the reporting requirements under R9-21-311-E as a required scope of work. To that end, we recommend that MMIC revise its provider manual (next revision cycle) to reflect the requirement as a provider "deliverable" and add a section that addresses Alternative Services (R9-21-311)

We look forward to our continued work together.

Regards,

Craig Carter Ed.D.,
Chairperson, Maricopa County Human Rights Committee

cc: Andy Biggs, Speaker of the Senate
David Gowan, Speaker of the House
Senator Nancy Barto, Chairperson of the Health & Human Services Committee
Representative Heather Carter, Chairperson of the Health Committee
Paul Galdys, Assistant Director of Healthcare Advocacy and Advancement