maricopa county
Human Rights Committee
for the mentally ill

February 5, 2017

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

Dear Mr. Betlach,

Pursuant to A.R.S. § 41-3804(G), I transmit the 2016 Annual Report of the Maricopa County Human Rights Committee. We look forward to your response to permit us to incorporate your insights into our 2017 work plan and activities. In addition to this report, we welcome you to peruse our agendas and minutes and prior years' annual reports, which can be found at: www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/humanrightscommittees.html. These documents provide a diary of our activities during the past year.

We remain extremely positive about our relationship with Mercy Maricopa Integrated Care and we look forward to improved collaboration with AHCCCS.

Sincerely,

Scott Gormley
Chair, 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, AHCCCS Assistant Director

MARICOPA COUNTY HUMAN RIGHTS COMMITTEE

2016 ANNUAL REPORT

Membership
As of December 31, 2016, the MCHRC membership is as follows:

Holly Gieszl, Esq. (Law)
Joy Green (Family Member)
Scott Gormley (Family Member)
Debra Lou Jorgensen, (Behavioral Health)
Dr. Jack Potts, (Medical/ Psychiatry)
Charles Sullivan, (Housing)
Marilyn Viarengo (Consumer)
Ryan Welch, Ph.D. (Education)

ACKNOWLEDGEMENT OF CRAG CARTER, ED.D.

Our 2017 Annual Report begins with an acknowledgement of our former Chair, Dr. Craig Carter, a well-known professional in the field of special education who devoted years of his life to volunteer public service to improve the lives and protect the rights of Arizonans receiving publicly funded behavioral health services. Dr. Carter served as a decade's long member and Chair until his resignation in late 2016 to attend to important family matters. Dr. Carter consistently demonstrated an unusually keen ability to advocate on behalf of individuals living with mental illness while always respecting the practical realities facing Arizona's behavioral health service providers and government agencies. Dr. Carter understood and championed the value of meaningful collaboration among all stakeholders. He was as much "at home" on a site visit to a residential treatment facility as giving testifying at the legislature or reviewing a complex report from the RBHA or presiding over a Committee meeting. Dr. Carter left the MCHRC on sound footing. He will be missed, and his years of service are deeply valued. *"When the effective leader is finished with his work, the people say it happened naturally."* — Lao Tzu

MCHRC ACTIVITIES IN 2016

For the past four years, the MCHRC focused on improving its internal efficiency and effectiveness in meeting its statutory charge to provide oversight of publicly funded behavioral health services. Beginning in 2013 the MCHRC narrowed its primary focus to individuals with Serious Mental Illness ("SMI") who also receive Special Assistance ("SA"). Beginning in 2016, the MCHRC also focused on the challenges for individuals with SMI who interact with the criminal justice system and/or are incarcerated in jail or prison.

Site Visits to SA Members' Residences. Dr. Jack Potts continued to lead the Committee's site visits to randomly selected facilities where SA recipients reside. The Committee completed 11 site visits across the Phoenix metro area. Every facility visited received follow-up communication and feedback, both positive and negative. In one site visit to a group home, the Committee learned of an SMI individual who had been arrested and charged with a felony after he damaged the home. Regrettably, there were no efforts at crisis intervention before the incident leading to the member's arrest. This kind of incident reflects important opportunities and challenges across the continuum of law enforcement, housing providers, and case management on behalf of the Special Assistance population.

Although 11 visits is a very small sample, some commonalities warrant mentioning. Managers at each facility visited were receptive, cordial, and communicative. Residents generally were open and easily engaged in conversation about their residence. All of the residents interviewed expressed general satisfaction with where they lived. Residents commonly complained about lack of transportation, lack of activities other than television, case managers not making monthly visits, and lack of access to prescribed medications. Most of the facilities were clean and orderly. Furnishings and landscaping is generally minimal but adequate.

Because site visits are a unique aspect of the Committee's work, beginning in 2017, all Committee members make at least one site visit annually as a condition of membership. We also have begun to refine our protocol to better document conditions and to better analyze and report to MMIC especially regarding potential rights violations. The Committee remains committed to developing a mechanism to report apparent licensure violations through appropriate channels within the Arizona Department of Health Services ("ADHS").

For over three years, our site visits reveal one consistent and troubling fact: Approximately 25% of SA enrollees listed (by Magellan and, now, MMIC) as residing at a given address, in fact, are not at that address and, typically, have not been there for months. It remains unclear whether the RBHAs continued to pay the residences where their SA members were not residing. MMIC needs an improved mechanism for "real time" information of the physical whereabouts of its most vulnerable enrollees and to reconcile payments with a member's physical residence.

IAD Reports. Scott Gormley continued to lead the Committee's analysis of IAD reports with an emphasis on serious injuries or deaths. MMIC provided prompt and detailed follow-up on questions and comments from the Committee.

Quality of Care Reports. After initially declining to provide the MCHRC with Quality of Care (QOC) reports for our committee, AHCCCS has agreed that the Committee will have online access to redacted MMIC QOC reports in March of 2017. The Committee appreciates AHCCCS resolving this issue and looks forward to developing an appropriate approach to access and analyze QOC reports.

Individuals with SMI and the Criminal Justice System. Throughout the year, the Committee discussed and analyzed its oversight responsibilities of MMIC's coordination of care, outreach, engagement and re-engagement of individuals with SMI who are involved in the criminal justice system and/or in custody of the Maricopa County Sheriff's Office (MCSO). The Committee devoted a Study Session in June of 2016 to this issue. To date, the Committee's analysis has focused on three areas:

(i) Potential rights violations of MMIC enrollees post-arrest due to:
   a. Interruption of the Individual Service Plan (ISP), including changes and/or discontinuation of medications and therapy by Maricopa County Correctional Health Services (CHS) *without* coordination of care with the enrollee's physician.
   b. MMIC follows members post-detention, and case managers are supposed to visit jailed members monthly. However, MMIC has no actual input into clinical treatment.
   c. MCSO uses disciplinary measures against individuals with SMI for aberrant conduct without prior consultation with a physician at CHS. Such measures range from food deprivation (feeding only the "Loaf" or taking the inmate's purchased "store" food items) to housing in disciplinary segregation with resulting restrictions on

recreational time out of the cell and reduced human interaction. In short, these detainees are disciplined *because of* their mental illness, an unacceptable and ineffective approach to jail management of individuals with SMI.

d. SMI individuals may be unable to participate in "pill rounds" with resulting diminution of the effectiveness of the treatment regimen;
e. Violence by and against mentally ill individuals in MCSO custody due to MCSO's failure to protect detainees and lack of "safe" housing options for mentally ill individuals;

(ii) <u>The arrest and subsequent detention of individuals with SMI for conduct issues at UPC, in the MMIC housing network, and at hospital emergency departments is a deeply concerning occurrence</u>.

a. A person at a hospital or crisis center, and who is in crisis or psychotic, may act erratically. That person needs medical help, stabilization, and treatment. Law enforcement involvement should be a last resort and limited to situations with extreme, imminent danger.
b. When law enforcement must be involved, misdemeanor and felony diversion programs should be used to direct SMI individuals away from the judicial system and into a therapeutic system. Charging SMI individuals for assault on a clinic, hospital, or law enforcement officer is ineffective for both deterrence or prevention of a "crime" and *treatment* of their mental illness.

(iii) <u>Lack of data to meaningfully analyze "what happens" to individuals with SMI after arrest and detention in the MCSO.</u>

a. The Committee requested copies of the monthly statistical reports that are produced by the MCSO on detainees designated as SMI, but the reports were not provided on a regular basis. MMIC reported to the Committee on its case management activities in the jail and its reporting capabilities. MMIC can provide for example, date of booking, assigned case management clinic, the last date the incarcerated recipient was visited by community mental health staff, and court ordered treatment (COT).
b. MMIC does not have access to data in offense, housing unit, or time, if any, in solitary confinement because these pieces of information were not included in the last data link agreement between the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and Correctional Health Services (Maricopa County). In addition, verification of adherence to the ITP, e.g., verification of prescribed medications

and administration, while a member is in jail is not accessible at the RBHA level. The Case Manager does remain responsible for coordination with Correctional Health Services and, therefore, should have access to this information on a case-by-case basis. MMIC reported that it is engaged in discussions to obtain information on incarcerated members through AzHEC (the Network) or a daily feed from Correctional Health Service (CHS) to MMIC. The Committee looks forward to exploring these data sources as a priority 2017.

c. MMIC and AHCCCS were unable to assist the Committee in development of a jail visit protocol or coordination of jail visits. Given the Committee's other priorities, jail site visits were placed "on hold" for reconsideration by the Committee in 2017. The Committee intends to cultivate a positive relationship with the new MCSO Sheriff that would result in our ability to begin site visits to the MCSO jails in 2017.

Improved Collaboration Post-Transition to MMIC. The MCHRC spent substantial time in 2011 through 2015 trying to overcome administrative barriers to information sharing by Magellan. The transition to Mercy Maricopa Integrated Care ("MMIC") brought *much* improved collaboration and transparency. The Committee acknowledges with gratitude the diligent work of Norm Nigro, who retired from MMIC in 2016 following completion of the Magellan-to-MMIC transition.

The Committee also acknowledges its deep appreciation and respect for MMIC's representative, Troy Chester, who consistently demonstrates professionalism and commitment in his collaboration with the MCHRC. The Committee completed much of its work in 2016 in large measure because of Mr. Chester's collaboration. His assistance will be essential in 2017 and beyond.

MCHRC PRIORITIES FOR 2017

Maintaining and Growing Membership. The MCHRC remains committed to deepening its capacity and relevance through expanded membership of individuals currently living with SMI or who have had been designated as SMI and. We intend to increase our membership by having each current member recruit at least one potential new member and, also, by communicating, marketing and collaborating our activities to groups with an interest in behavioral health issues. We look forward to adding new members with backgrounds in law enforcement, corrections, the justice system, social work, and psychology.

The Committee further intends to add additional non-voting members and regularly drawing on subject matter experts to enhance the Committee's work. The Committee hopes that the Director and MMIC will suggest individuals for Committee membership as well.

Treatment vs Punishment. The Committee understands that law enforcement cannot 'punish' the severe mental illness out of a person and, continued homelessness, trauma (4th Street jail / UPC) lack of access to services and abandonment, increase the likelihood of an SMI person to become a "frequent Flier" of the 'system'. This results in draining taxpayer dollars and contributing to stretch precious resources. We know that an SMI person incarcerated will stay longer in jail and upon release, will have an increased risk of returning to jail again more than other persons without a mental illness.

The Committee recognizes and respects the efforts of law enforcement to train and participate in Crisis Intervention Training (CIT) classes for officers throughout the County. Their continued commitment to improving outcomes of SMI individuals and, to ensure all are safely returned to their loved-ones each evening set a very high standard for other counties and states to emulate. We recognize and respect the leaders:

Phoenix Police Department - Sabrina Taylor

Scottsdale Police Department -Natalie Summit

Mesa Police Department / East Valley Amanda Stamps

Glendale Police Department / West Valley Matt Apodaca

Outreach and Communication with Stakeholders and Communities. The Committee will improve its communication with key stakeholders and communities through a series of activities, including:

- Hosting one or more community forums in 2017 to elicit information about the experiences of individuals living with SMI (and their families and caregivers) across the care continuum.
- Improving distribution of the Committee's work product including minutes and more detailed reporting and dissemination of findings from site visits and analysis of IADs and quality of care reports.
- Enhancing the Committee's capabilities with better use of technology.
- Deepening the Committee's capabilities by participation of students from Arizona's institutions of higher learning.
- Strengthening the Committee's collaboration with Arizona's other HRCs for improved efficiency and knowledge sharing.
- Continued collaboration with the Arizona legislature on the rights of individuals receiving publicly funded behavioral health services.

Analysis of Quality of Care ("QOC") Reports. The Committee will develop an approach to analyzing QOC reports and reporting on Committee findings. However, this work necessarily awaits availability of the QOC reports, which AHCCCS has scheduled for March of 2017. If AHCCS or the RBHA add additional quality review data or activities, the Committee looks forward to participating in collaborative analysis.

Committee Documents. The Committee will generate quarterly reports throughout 2017 and will approve Operating Guidelines in early 2017 meeting.

CONCLUSION

The MCHRC exists to serve the State and individuals with SMI who received publicly funded behavioral health services. We are volunteers who devote time, treasure, and talent to assist AHCCCS and MMIC better serve those who receive publicly funded behavioral health services. We look forward to discussing our 2016 Annual Report and our 2017 Priorities in a mutually respectful and supportive manner.

We welcome suggestions as to how we may better meet our statutory obligations and assist AHCCCS.