

Public Behavioral Health Care in Arizona

Preparing for the Storm

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Introduction

The storm, in fact, is already upon us. Severe and widespread budget cuts in behavioral health and substance abuse services for lower-income Arizonans who don't qualify for AHCCCS have already taken effect across the state. These are not minor reductions: since FY2008 the overall budget for non-Medicaid behavioral health services has been cut by 47%. These reductions totaled some \$60 million and have resulted in thousands of Arizonans and their families facing either no publicly funded behavioral health treatment or severely restricted access to such services.

Even before these cuts were implemented, it was clear that the publicly-supported behavioral health system in our state was not adequately serving many Arizonans who needed mental health or substance use disorder treatment. And despite the slowdown in the state's population growth since 2007, it is likely that a population increase in combination with the severe economic recession have pushed the numbers of needy Arizonans even higher. The table provides some examples of severe reductions over the past four years.

The recession also prompted at least a temporary halt in the three-decade-old *Arnold v. Sarn* lawsuit, which seeks to obtain quality behavioral health services to Maricopa County residents diagnosed as seriously mentally ill, as state statutes require. The lawsuit, which sought changes costing hundreds of millions of dollars, was suspended earlier

Examples of Behavioral Health Budget Cuts, SFY 2008 – SFY 2011	FY2008 GF/OF Approp*	FY2011 GF/OF Approp
Arnold v Sarn	\$27,500,000	\$0
SMI Non-XIX	\$61,116,700	\$0
Mental Health Non-XIX	\$2,447,300	\$0
Substance Abuse Non-XIX	\$14,635,400	\$0
Children's Behavioral Services	\$9,351,800	\$0
ASH Placement	\$5,574,100	\$0
Medicare Part D Copay	\$802,600	\$0
Seriously Emotionally Handicapped Children	\$500,000	\$0
Youth Meth Prevention	\$500,000	\$0
* State-only General Fund & Other Fund appropriations		
Source: Joint Legislative Budget Committee		

this year with the agreement of parties on both sides. Both sides also pledged to continue negotiations. Few would deny that these and other changes sweeping through the system threaten to halt and reverse gains that Arizona has made towards a recovery-based system; more ominously, few would also deny that such changes will not come without costs to families and individuals denied critical care, or costs to other sectors of state including the criminal- justice and child-welfare systems. This paper represents an effort by Arizona State University's Centers for Applied Behavioral Health Policy and the Morrison Institute for Public Policy to promote and enrich Arizona's public dialogue about these problems and potential solutions.

Community-Based Behavioral Health Care: The Context

Fifty years ago, most people with serious mental disorders in Arizona and other states were treated in hospitals, such as the Arizona State Hospital in Phoenix, and considered too disabled to be anywhere else. Then, breakthroughs in treatment combined with an enhanced concern for patients' rights bolstered the belief that those who are mentally ill should be treated in the "least restrictive setting." Nationally, thousands of patients were moved from hospitals back to their communities; those who could not afford private care—the vast majority—were supposed to be treated by networks of publicly supported clinics, group homes, supervisory care homes and other facilities. In Arizona and elsewhere, some well-planned, coordinated networks of community care did arise. But "systems" of community services also sprouted up in unplanned, fragmented ways amid a lightly regulated array of agencies, clinics, therapists, group homes, and other actors. Many former hospital patients ended up homeless; others landed in jail.

Arizona developed the Arizona Health Care Cost Containment System (AHCCCS) in the early 1980s. Mental health and substance abuse treatment services were not included with other AHCCCS health services; instead, these behavioral health care services were added later and "carved out" as the responsibility of a state separate agency, the Arizona Department of Health Services' Division of Behavioral Health Services (ADHS/DBHS). In this arrangement, AHCCCS subcontracts with ADHS/DBHS, which in turn subcontracts with non-governmental Regional Behavioral Health Authorities (RBHAs), which in turn subcontract with a variety of local non-profit agencies and for-profit corporations to deliver an integrated and coordinated system of behavioral health care.

This "carve out," which many other states also employ, was meant to control costs and ensure that individuals with mental health disorders received the special attention they needed. The consensus of experts is that carve outs have saved money. In 1981, however, the *Arnold v. Sarn* lawsuit was filed, claiming that the state and Maricopa County were failing to fund a comprehensive behavioral health system for residents who are seriously mentally ill, as required by state law. The lawsuit, now 30 years old, has yet to be completely resolved.

Today, Arizona's public behavioral health care system annually treats more than 150,000 individuals, many of whom are among the approximately 40% of Arizonans who are uninsured or have low incomes. The majority of these residents suffer from anxiety disorders, substance use disorders, phobias, and other problems that are challenging but may not be disabling. However, approximately 38,000 Arizona adults in the public system are classified as seriously mentally ill (SMI), typically suffering from severely debilitating diseases such as schizophrenia, bipolar disorder, and major depression. Another 30,000 children and adolescents in the system are classified as seriously emotionally disturbed, a diagnosis that is similar to SMI but with some added diagnostic categories.

The Division of Behavioral Health supervises the delivery of health care through four RBHAs in six geographic regions. There are also three Tribal RBHAs and other tribal contractors.

The Summer Institute

Beginning in 1999, ASU's Center for Applied Behavioral Health Policy has hosted an annual statewide conference on program and policy initiatives concerning behavioral health services in Arizona. This weeklong *Summer Institute* typically attracts more than 300 participants, many of whom are direct line providers, clinical supervisors, program managers, leaders and policy makers in the state system.

The 2010 Institute for the second year included a town-hall-meeting format designed to stimulate dialogue among Institute participants and other state leaders. The July 22 meeting included some 300 participants and featured a panel of individuals recognized for their longstanding commitment to, and service in, the behavioral health care system.

The panelists were:

- **Charles Arnold**, attorney, Frazer, Ryan, Goldberg, & Arnold; original plaintiff in *Arnold v. Sarn*
- **Barbara Broderick**, chief, Maricopa County Adult Probation Department
- **Larry Green Jr.**, CEO, West Yavapai Guidance Clinic
- **Clarke Romans**, executive director, NAMI of Southern Arizona
- **Laura Nelson, M.D.**, deputy director, Arizona Department of Health Services, Division of Behavioral Health Services
- **Ann Ronan**, attorney, Center for Law in the Public Interest; counsel for plaintiffs in *Arnold v. Sarn*

Prior to the discussion, panelists were provided a series of open-ended questions. Members of the audience were given question and comment cards, which were collected for and selectively read by the meeting facilitator, Bill Hart of ASU's Morrison Institute for Public Policy. The panel discussion was recorded and transcribed for analysis by Dr. Shafer and Mr. Hart, using common methodology ascribed to the qualitative traditions of grounded-theory analysis. This report recounts the major themes raised by the panelists concerning issues introduced by panelists themselves and those brought up by audience members. It is hoped that this information will be useful to Arizona policy makers and concerned citizens as they seek to promote continued improvement in Arizona's public behavioral health care system.

Themes and Discussion Points

Advance questions presented to the panelists, together with questions and comments received from audience participants, prompted reactions from the panelists in four broad areas:

- Starting to Feel the Pain
- Critical Concerns
- Cost Saving or Cost Shifting?
- Expecting—and Witnessing—the Worst

Starting to Feel the Pain

Panelists and audience members agreed that they were meeting at an extraordinary time. That is, a time when much of what Arizona has built in terms of a functioning behavioral healthcare system was in jeopardy of stagnation or reversal; a time when government officials, advocates and providers will be heavily challenged to maintain quality services to the state's ill residents and their families. As of July 2010, Town Hall attendees agreed, the worst was clearly yet to come; major effects of state budget cuts on the system were just beginning to be felt. Many clients without Title XIX benefits were just shifting from name-brand to generic medications, while others had a transition period that enabled them to remain on newer medications for a short period of time. Others were still getting some counseling and other services. However, several panelists and attendees reported evidence of increasing anxiety among practitioners and clients statewide, including even some clients who were Medicaid eligible.

Panelists and attendees shared accounts of the fallout beginning to occur. One panelist, for example, said he'd already encountered cases of individuals who had been successful in managing the symptoms of their mental illness for years, but who were extremely anxious that they would not be unable to continue to do so in the face of reduced services. One Town Hall participant, a service recipient and a mother, expressed concern that her reduction in treatment could cause "ripple effects" both through her family and into the future. This, it was noted, points out the difficulty of achieving an accurate understanding of the true extent of the cuts' impact on Arizona. In the same vein, another panelist noted that, while funds for children's services had not been dramatically reduced, many of these children live with parents who are themselves receiving behavioral health services.

"Title XIX (patients)... are concerned that they will be the next ones with their benefits cut."

*– James Russo,
Visions of Hope*

Throughout the Town Hall session, panelists and participants expressed concern that many individuals will experience difficulties as they transition from the current system, which provides a number of benefits, to one offering many patients only generic medication, a periodic doctor visit and some nursing services. These panelists and participants also shared accounts of their experiences in attempting to provide effective and necessary treatment services with reduced funding availability.

Dr. Laura Nelson of the Arizona Department of Health Services noted the severity of the challenges facing the system but added that the budget crisis has forced providers, advocates and others to “step up and unite us in a way that we’ve never been united before.” Nelson said she’d already seen evidence of the “resiliency” of system members, and urged them to continue to pull together. Other panelists and participants shared worries that the service cuts could endanger current efforts to transform Arizona’s public behavioral health system from an acute care model into a recovery-oriented system of care model. The cuts, some said, threatened to transform the system into a strict “medical model” for many clients, as some of the largest cuts in care were directed toward supportive services for non-Medicaid-eligible clients such as employment supports, transportation assistance and case management. These are all key service elements in a recovery-oriented system of care.

Critical Concerns

Panelists and audience members discussed specific topic areas that they said were raising especially worrisome issues, both present and future. Among them were the required use of generic medications for non-Title XIX SMI clients, the inability to track some clients who lose service benefits, the potential for an increasing public stigma to be associated with behavioral health problems and the difficulties facing rural providers.

Several audience members said they felt that the reduced pharmacy formulary presented significant risks. The head of one Arizona RBHA said community forums and focus groups made clear that some clients—and their family members—were frightened at the prospect of having to go off the newer medications which they had found, in concert with their psychiatrist, to be effective in managing their symptoms. Some of the older medications were not as effective as the newer ones, attendees said, while others among the older products included side effects that discouraged patients from continuing them. In addition, one audience member noted, some physicians complained that they lacked adequate training and knowledge in the use of these older, generic medications. Overall, the return to

generic psychotropic medications was cited as a key factor in the system’s overall reversal of momentum in combating the most severe behavioral disorders.

“Over the last couple of weeks, we have seen increased incidents of consumers being violent, destroying property, getting into fights. The police have been called. It’s very unusual for this to happen, but the frequency has increased and so has the severity. I’m very concerned about it.”

***– Mitch Klein,
CEO, CHEERS, Inc.***

Another question raised was what would happen to patients who fell from providers’ rolls due to reduced service eligibility. For one thing, providers said, the loss of funds for crucial non-medical services such as housing support and utility assistance meant more clients would risk homelessness and associative

problems. For another, monitoring or even simply locating clients whose services had been reduced or eliminated will pose challenges that providers fear will be beyond their abilities.

The perennial problem of stigma was also discussed, and cited as a factor that the service cuts could well aggravate. A number of audience members said stigma-related incidents were already increasing; some blamed that at least in part on an increase in “bad behaviors” by clients who were alarmed and confused by service cuts that were pending or already taking effect. As the impacts of cuts deepened, providers said, they expect more incidents to occur, perhaps involving physical injury or property destruction, that could impede recovery and promote negative stereotypes of people with behavioral problems. One provider said some clients are so concerned about retaining their services that they had decided to quit their jobs so they could resume eligibility—which is hardly considered a therapeutic move.

Cost Saving or Cost Shifting?

A recurrent theme raised by panelists and audience members concerned the anticipated downstream effects that cuts in services will cause. The major anticipated effect was of cost shifting, as reductions in mental health and substance abuse treatment capacity results in increased utilization of the criminal justice system to manage some undertreated individuals. Chief Maricopa County Adult Probation Officer Barbara Broderick, for example, noted that, in spite of making significant cuts to her own system as a result of the budget crisis, she felt it necessary to add two new probation officers. She did so in anticipation of significant growth in the more than 700 individuals with serious mental illness already on probation in Maricopa County, as social services become less available.

In addition, panelists and audience members said, declining resources may spur negative behavior by untreated or under-treated clients. Such conduct, principally public nuisance behavior such as urinating in public, public vagrancy, and panhandlings, will likely lead to increased interaction with law enforcement while reinforcing many of the negative stereotypes associated with mental illness and substance use disorders “We have, and you have, been very committed to serving the mentally ill in our community,” Broderick said. “We try not to use our jail. We try not to send people to prison, and with a lack of resources ... if people are getting more violent, the public will get more afraid and therefore we will wind up putting people that we could have had in our communities living decent lives, basically going further and further into the justice system.”

Declining resources will restrict access to the social services that have been shown to help divert individuals with behavioral health disorders from prosecution and incarceration. The availability of mental health and substance abuse treatment resources, reimbursable by AHCCCS, has contributed significantly to the expansion in the capacity of drug and mental health courts. It has also helped promote other approaches to the management of non-violent offenders with mental health and/or substance use disorders in the community. At the very least, restricting access to these behavioral health services will shift a greater share

of the costs of these services from one system (AHCCCS) to another system (e.g., the Arizona Supreme Court).

On a more positive note, panelists pointed out that, despite the budget cuts, DBHS wisely—and with strong encouragement from the community—established dedicated funding for crisis services. For many individuals, these services provide the necessary resource to manage mental health crises in the community. Crisis services, including hot lines, mobile crisis teams and psychiatric urgent care centers, often also serve as additional resources for law enforcement officials. The individuals operating these crisis systems report already witnessing both increases in the number of individuals seeking assistance and in the severity of the crises they are encountering. The program manager for a consumer-operated crisis hotline, for example, reported a significant increase in call volume in the month leading up to the Town Hall, a period when cuts were being decided and initiated.

Another participant—on the staff of a rural-based clinic in the eastern part of the state—spoke of her personal experience with cost shifting as she and a colleague drove an individual from an isolated community along the Mogollon Rim to a psychiatric hospital in Phoenix. Transportation services had recently been eliminated in their community; the Sheriff’s Department was willing to transport the man, but their procedures required that he be handcuffed—which the participant feared would only re-traumatize the client. She and a colleague used their own car and paid for the gas to make the four-hour drive on their own time to ensure that their client received the care he needed in a humane manner.

“One of the things I’ve heard from folks that’s the most scary is: ‘This is just how it’s going to be. This is the system. Live with it.’ ...I think we’ve got to make sure we don’t let this become the reality beyond this economic crisis.”

– Ann Ronan

This example reflects a different kind of cost-shifting that many participants described. This is the personal toll being taken on counselors, case managers, and other care-givers working on the front lines of the system, attempting to do more with less while maintaining the health and safety of the individuals and families entrusted to their care. Such costs, however real, are difficult to quantify. The full impact of the tangible system-wide cost shifts, especially with regard to increased incarceration and the criminal justice system’s involvement, remains to be seen.

Expecting — and Witnessing — the Worst

Panelists and participants generally agreed that Arizona’s continuing economic recession and large anticipated future state budget deficits left little hope that budget cuts to the behavioral health system would be restored any time soon, or that future cuts will be averted. One panelist noted that if two November budget propositions failed, the state General Fund would have to fill an additional \$450 million gap right away. In fact, both of

these propositions (Propositions 301 and 302) were rejected by the voters, meaning that further human-services cuts could be ordered before the end of the current fiscal year. In addition, as the national healthcare reform legislation begins its phased-in implementation, maintenance-of effort requirements and lowered eligibility requirements will place additional strain on an already broken budget. This will likely mean further cuts in services to individuals failing to qualify for Medicaid.

Despite their efforts and their resolve to continue serving Arizonans with behavioral health needs, most panelists and participants agreed that the future for behavioral health services in Arizona was grim. Only so much in lost resources can be replaced by extra effort, longer hours and personal expenditures. “We’re preparing for bad outcomes...,” a panelist said. “There may be some [clients] that thrive. However, there are some that will not. There are some that will be lost souls as a result of not having the supportive services that they’ve had for years and years....”

Another participant noted that Arizonan’s behavioral healthcare system itself seemed in jeopardy: “What I want to...encourage you all to think about is, we talk about this [system’s] “recovery” model, and we need to be thinking about the recovery of our system.”

“We can't use the fiscal crisis as cover to deny services to those of us who are most vulnerable, and whose resulting cost will have a negative impact on our communities throughout the state. It's bad public policy.”

– Charles Arnold

No one at the Town Hall suggested that proposals and plans could easily defuse the crisis confronting Arizona’s public behavioral health system and the thousands of ill and vulnerable people it serves. Indeed, there was general agreement that the combination of the recession and government officials’ reactions to it have plunged Arizona into the equivalent of an enormous social experiment that challenges the core assumptions of current state statutes and the (now suspended) *Arnold v. Sarn* lawsuit. Those assumptions rest on the fundamental belief that providing community based services for persons with behavioral health disorders is not only *morally* right, but also *policy* right; that access to such

services saves lives, preserves families, promotes stable neighborhoods, supports employment and productivity, reduces long-term public outlays and reduces clients’ encounters with criminal justice authorities, emergency rooms and the streets. This experiment is now underway. The only certainty for Town Hall panelists and participants is that the results—especially in combination with simultaneous cuts to other social services—will have profound and longstanding implications for Arizona’s behavioral health care landscape.

The challenge for behavioral health professionals and advocates is to ensure that the stories resulting from this experiment are told; that the lives impacted, both the triumphant and the tragic are chronicled. The costs to society, to the multiple systems touched by undiagnosed and untreated behavioral health disorders, and to the afflicted individuals and their families, will be real. Based upon the experiences and the expectations of those attending this Town Hall meeting, these costs are likely to be high.

This publication was prepared by Michael S. Shafer and Bill Hart of the College of Public Programs at Arizona State University. Shafer is a professor in the School of Social Work. Hart is a policy analyst at Morrison Institute for Public Policy. No endorsement of the opinions in this document by the authors, the university, the college, or the agencies represented by Town Hall participants is to be inferred. In citing this report, please use the following reference:

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