

A Review of the Public Behavioral Health System in Rural Arizona

ON THE EDGE OF OPPORTUNITY



Funding for this report was possible in part from the Arizona State Office of Rural Health Grant #H95RH00102 from the Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the US Government.

TABLE OF CONTENTS

Section 1: Introduction	1
Section 2: Management and Delivery of Public Behavioral Health Services in Rural Arizona	5
I. The Arizona Department of Health Services Division of Behavioral Health Services	5
II. Regional Behavioral Health Authorities	11
Section 3: Prevention and Treatment	17
I. Behavioral Health Prevention Services	17
II. Behavioral Health Treatment Services	21
Section 4: Integration of Behavioral and Physical Health	23
Section 5: Recommendations	29
Recommendation A: Developing Better Methods for Increasing Rural Behavioral Health Care Enrollment Penetration Rates	29
Recommendation B: Creating a Culturally Relevant Approach to the Integration of Behavioral and Physical Health	29
Recommendation C: Addressing Rural Behavioral Health Workforce Issues	30
Recommendation D: Improving the Transfer of RBHA Management of GSAs	30
Recommendation E: Addressing the Continuing State Budget Reductions in Arizona	31
Recommendation F: Coordinating Prevention Efforts Statewide	31
Recommendation G: Increasing Evaluation of Rural Health Prevention Programs	32
Recommendation H: Increasing Behavioral Health Residential Treatment Facilities in Rural Arizona	32
Recommendation I: Providing Leadership and Developing Policies for Improved Rural Behavioral Health Care in Arizona	33
Bibliography	35
Appendix A	37
Appendix B	38

SECTION 1: INTRODUCTION

Approximately 62 million people, or 20-23 percent of the United States' overall population, live in rural areas, distributed over 75 percent of the country's land mass (National Rural Health Association, 2006). Of those, estimates indicate that 16-20 percent or "at least 15 million rural residents struggle with significant substance dependence, mental illness, and medical-psychiatric comorbid conditions" (Roberts, Battaglia & Epstein, 1999). A more recent estimate is that 25 percent of the total U.S. population, aged 18 and older, suffers from a diagnosable mental disorder (Kessler, Chiu, Demler, & Walters, 2005). Excluding Arizona's two major urban counties (Maricopa and Pima), the rural population of Arizona was estimated in 2009 by the U.S. Census to be 1,552,446 people. Thus, using a moderate 20 percent estimate we can extrapolate that there are approximately 310,490 rural residents in Arizona that are in need of behavioral health care.

The term "Behavioral Health" was first used in the 1980s to describe the combination of mental health and substance abuse. In this report we use the term "behavioral health" instead of "mental health" for three reasons: 1) Behavioral health includes not only ways of promoting well-being by preventing or intervening in mental illness such as depression or anxiety, but it also includes preventing or intervening in substance abuse and other addictions; 2) Arizona has adopted this more inclusive term within its public health care system; and 3) Both mental health and substance abuse issues need to be addressed through specific policies designed for rural populations.

President Bush's 2002 New Freedom Commission on Mental Health was convened to investigate the problems and possible solutions in the U.S. mental and behavioral health system. The Commission reported that the vast majority of Americans living in underserved, rural, and remote areas experience disparities in mental health services compared with their urban counterparts. The Commission concluded that "...rural issues are often misunderstood, minimized, and not considered in forming national mental health policy. Too often, policies and practices developed for metropolitan areas are erroneously assumed to apply to rural areas" (President's New Freedom Commission on Mental Health, 2003).



“the smaller
the community
the fewer the
resources”

A significant body of research over the past thirty years demonstrates that the problems of rural America are unique and distinct from those of more urban and metropolitan areas. Rural areas are characterized by low population density, a larger elderly population, poorer general health status, a limited and fragile economic base, high rates of unemployment, cultural diversity, high levels of poverty, and transportation issues that limit travel and access to cities. While recent studies indicate that the prevalence and incidence of behavioral health problems are similar in rural and urban areas, a notable exception is the significantly higher rate of suicide and suicide attempts in rural America, especially amongst the elderly. In the primarily rural counties in Arizona, excluding Maricopa and Pima, there were 74 suicides in 2009 among people over 65. The Arizona rural per capita suicide rate for those over age 65 was 28 per 100,000 and the urban rate was 22 per 100,000, as compared with the national rate of 15 suicides per 100,000.

Arizona’s publically funded behavioral health clients die an average of almost 32 years sooner than the general population. That is greater than the national average of 25 years of potential life lost by individuals with serious mental illness (Colton & Manderscheid, 2006). In addition, rural residents experience many more obstacles to obtaining behavioral health services, which results in distinct behavioral health related disparities. Not only do rural areas frequently have shortages of behavioral health professionals and specialized behavioral health services, but the turnover rate for service providers is high, and providers that remain often express feelings of isolation from other health professionals. These conditions are exacerbated in isolated rural and frontier areas and areas with concentrations of poverty and migrant and seasonal farm workers (Sawyer, Gale & Lambert, 2006). “The mental health needs of rural America are immense, and it is increasingly recognized that the implementation of adequate services in non-metropolitan areas is a critical national health imperative” (Roberts, Battaglia & Epstein, 1999).

The themes of rural behavioral health have remained constant over the past 20 years. Mounting needs, a lack of available behavioral health providers, and restricted/limited resources strain existing services and limit access to rural residents in need (Sawyer, Gale & Lambert, 2006). Leadership is critically needed to develop comprehensive policies that: 1) adequately account for rural realities regarding access to behavioral health care, 2) do not result in smaller, under-resourced versions of urban programs, and 3) do not perpetuate the tendency to seek single policy solutions to the panoply of issues that surround the provision of quality behavioral health for America’s rural residents (NRHA, 2008).

In a 2006 National Association for Rural Mental Health report on *Rural and Frontier Mental and Behavioral Health Care: Barriers, Effective Policy Strategies, and Best Practices*, the authors called



“we have a long way to go to improve our system”

attention to the leadership role that federally designated State Offices of Rural Health need to play in advocating for and recommending policies to increase both the volume and scope of access to behavioral health care for rural residents.

State Offices of Rural Health can become a driving force behind developing networks and collaborations of relevant organizations to improve services and increase patient access. State Offices of Rural Health are essential partners, bridging primary care and mental health systems together, targeting program delivery to specific databased state and local needs, and encouraging collaborative partnerships. They are important in identifying and establishing linkages with underserved populations and connecting local peer-type programs with State and Federal systems for such underserved groups. They can be helpful in partnering the administration and delivery of rural services, especially in pilot and model programs where delivery skills are high but administrative and general management skills may be lacking. Finally, they can be an essential player in information and model sharing at both the state and regional levels (Sawyer, Gale & Lambert, 2006, p.11).

In an attempt to take on this leadership role on behalf of Arizona’s rural residents in need of behavioral health services, the Arizona

Rural Health Office (federally designated as the Arizona State Office of Rural Health) has developed a project to review the current status of rural behavioral health care in Arizona. This report represents the first phase of that project. It provides a snapshot in time of a dynamic system of behavioral health care available to rural residents, including approximately half of the Native Americans living in Arizona, who are eligible for Medicaid under the Arizona Health Care Cost Containment System (AHCCCS) and for state funding under Arizona Department of Health Services/ Division of Behavioral Health Services (ADHS/DBHS). It does not cover behavioral health care for other rural populations such as those with private health care insurance, inmates of rural prisons, Native Americans covered by the Indian Health Service, or Rural Veterans covered by the Veterans Administration. These populations will be addressed in future phases of this project.

It is always difficult to separate urban and rural data when most data is reported only at the county level, but many counties are composed of both rural and urban areas. In Arizona, for example, there are largely rural counties like Coconino County that have a non-rural community like Flagstaff, and there are largely urban counties like Pima and Maricopa that also have some rural areas. For this review, we have used data from the 13 counties, other than Pima and Maricopa, as proxy data to represent rural Arizona.

The methodology used for this review combined extensive interviews with state and local key informants, a focus group with behavioral health providers from Arizona Community Health Centers, significant review of existing public documents available online and listed in the bibliography at the end of this report, and review of the manuscript and additional contributions by key informants and others during the editing process.

Thank you to all who participated in this study (see Appendix A). Each provided important

views on ways in which the rural Arizona public behavioral health care system is working well and where there are challenges and opportunities for improvement. Human subject protection was approved for this study by The University of Arizona Institutional Review Board. All participant quotes in this report are anonymous, and are printed in *Italics*.

We hope that this report will be the first of several that can be used by policymakers, program planners, administrators, project managers, public health professionals, public officials, researchers, educators, behavioral health providers, and rural Arizona residents to ultimately expand and enhance behavioral health care for rural Arizonans.

To ask questions about this report, provide feedback, or join in the effort to improve Rural Behavioral Health Care in Arizona, please contact:

Lynda Bergsma, PhD
Director, State Office of Rural Health Program
Arizona Rural Health Office
The University of Arizona
Mel & Enid Zuckerman College of Public Health
520-626-2401
lbergsma@u.arizona.edu

References

- Colton, C.W. & Manderscheid, R.W., (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease*, 3. Retrieved December 28, 2010, from http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm.
- Kessler, R.C., Chiu, W.T., Demler, O. & Walters, E.E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 62(6), 617-27.
- National Rural Health Association. (2008). *Workforce Series: Rural Behavioral Health*. Retrieved December 27, 2010, from <http://www.ruralhealthweb.org/go/left/policy->

and-advocacy/policy-documents-and-statements/official-policy-positions.

President's New Freedom Commission on Mental Health (2003). *Achieving the promise: transforming mental health care in America*. Retrieved December 28, 2010, from <http://store.samhsa.gov/product/SMA03-3831>.

Roberts, L.W., Battaglia, J. & Epstein, R.S. (1999). Frontier ethics: Mental health needs and ethical dilemmas in rural communities. *Psychiatric Services*, 50, 497-503.

Sawyer, D., Gale, J. & Lambert, D. (2006). *Rural and frontier mental and behavioral health care: Barriers, effective policy strategies, and best practices*. Retrieved December 28, 2010, from <http://www.narmh.org/publications/publications.aspx>.

SECTION 2: MANAGEMENT AND DELIVERY OF PUBLIC BEHAVIORAL HEALTH SERVICES IN RURAL ARIZONA

I. The Arizona Department of Health Services Division of Behavioral Health Services

Overview

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) is responsible for the publicly funded behavioral health system in Arizona. ADHS/DBHS handles coordination, planning, administration, regulation, monitoring, and evaluation of mental health services and substance abuse prevention and treatment, along with overseeing the inpatient psychiatric Arizona State Hospital (ASH).

ADHS/DBHS does not provide services or directly contract with service providers except at ASH. Instead, the Division enters into contracts with management entities called Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs). These organizations – collectively referred to as T/RBHAs – operate as managed care organizations, sub-contracting with community providers who actually provide the services to eligible Arizonans. The T/RBHAs submit competitive bids to the state in order to win the contract to manage care in one or more of the state’s Geographic Service Areas (GSAs). The initial contracts are awarded for three-year periods, and can be extended for a fourth and fifth year before the GSA is once again up for general bid. A map of the GSAs and T/RBHAs is located on page 13. The state’s four rural-dominated GSAs are served by two organizations: Northern Arizona Regional Behavioral Health Authority (NARBHA) and Cenpatico Behavioral Health Service.

State residents can qualify for T/RBHA services through several different funding mechanisms. The largest group of people served is Arizonans eligible for the Arizona Health Care Cost Containment System (AHCCCS) – Arizona’s Medicaid Agency. AHCCCS is also known as Title XIX because that is the section that authorizes its funding in the Social Security Act. Arizonans with a serious mental illness are also eligible for some services paid for by the state.

Table 1. Common acronyms in this report

State acronym	Definition
AHCCCS	Arizona Health Care Cost Containment System, Arizona’s Medicaid agency
ADHS/DBHS	Arizona Department of Health Services/ Division of Behavioral Health Services
ASH	Arizona State Hospital
GSA	Geographic Service Area
RBHA	Regional Behavioral Health Authority
TRBHA	Tribal Regional Behavioral Health Authority
T/RBHA	Used when referring to both RBHAs and TRBHAs
Funding source acronym	Definition
TXIX	Funds from Medicaid which is administered by AHCCCS
Non-TXIX	Center for Mental Health Services and Substance Abuse Prevention and Treatment block grants and State appropriations are used for services to persons not eligible for Title XIX or Title XXI
TXXI	The State Children’s Health Insurance Program (SCHIP), the Arizona version of SCHIP is referred to as KidsCare
Client acronym	Definition
Child	Arizonan under age 18
CMDP	Comprehensive Medical and Dental Program serves children who are wards of the state
GMH	General mental health
SA	Substance abuse
SED	Serious Emotional Disturbance
SMI	Serious mental illness

This funding source is referred to as non-Title XIX and is paid for through the state general fund. Arizona children who qualify for KidsCare, the State Children’s Insurance Program (SCHIP), can also receive services through the T/RBHAs. In addition, Arizonans with substance abuse issues, who belong to highly prioritized groups, receive treatment through the T/RBHAs via a federal block grant.

Responsibilities

ADHS/DBHS is responsible for the coordination, planning, administration, regulation, monitoring, and evaluation of mental health services, substance abuse prevention and treatment, and oversight of the Arizona State Hospital. A large part of this work is done in partnership with the T/RBHAs. The Division solicits bids from prospective RBHAs for the six GSAs on a 3-5 year basis. These contracts are detailed to help ensure that the State’s vision is carried out by the contracting agencies. ADHS/DBHS requires the RBHAs to use clinical best practices and recovery-focused approaches, to emphasize individual empowerment, to use effective prevention programs, and to offer a comprehensive network of service providers. To monitor progress in achieving the state’s goals, the Division requires reports from the RBHAs on a monthly, quarterly and annual basis. ADHS/DBHS also provides technical assistance to the RBHAs.

The Division of Behavioral Health Services also has formal partnerships in place with other state agencies to facilitate the provision of comprehensive services to children and adults. Coordination occurs between ADHS/DBHS and the Department of Economic Security, Juvenile and Adult Corrections, the Administrative Office of the Courts, the Governor’s Office, the Division of Developmental Disabilities (DDD) and the Department of Education.

ADHS/DBHS oversees the state’s largest inpatient psychiatric facility, Arizona State Hospital (ASH). The hospital has a 338 patient

“ Rural adult services
have not kept up
... with Maricopa County ”



capacity and typically maintains a census in the 250s. Of those, usually more than half of the patients have been court ordered for pre or post trial treatment. The rest of the census is made up of civil adult patients who are involuntarily court ordered to ASH following 25 days of inpatient treatment in a psychiatric hospital. These patients tend to be the most chronically mentally ill residents of the state and who need longer lengths of treatment in an inpatient hospital setting. In the past, ASH also operated a 16-bed adolescent unit, which was closed in September 2009 due to under utilization.

Involving families and behavioral health recipients in the oversight process of behavioral health services has gained increased emphasis in recent years. ADHS/DBHS creates several opportunities for stakeholders, consumers, peers, and family members to participate in the development of the system of care. One such opportunity is the Arizona Behavioral Health Planning Council (ABHPC), which is comprised of consumers, family members, state employees, and providers who meet ten times a year in areas across the state. The council reviews the state’s plans, makes recommendations, advocates for Seriously Mentally Ill (SMI) adults and children with Serious Emotional Disturbance (SED), and evaluates the provision of mental health services across the state. Consumers and/or family members who are interested in applying to sit on the Council may contact Heather Ellis Heather.Ellis@azdhs.gov or (602)-364-4649. The state also

encourages the participation of consumer-run and family-run organizations in the behavioral health system. Finally the state also requires that each of the T/RBHAs create opportunities for consumers and families to have input in the system.

History

Since the 1950s, when the first medications to treat mental illness were introduced, states have been transitioning their citizens with mental illness from long-term inpatient psychiatric hospitals to community-based services. This process began in Arizona in the 1970s with the release of many patients from the Arizona State Hospital. An average ASH patient daily census of almost 2,000 rapidly decreased to just a few hundred. Released into Arizona's communities, these patients still needed significant services.

In 1980, the Legislature created ARS 36-550.01 that required the state to:

... provide for a statewide system of mental health residential treatment programs which provide to the seriously mentally ill a wide range of programs and services ... as alternatives to institutional care. [Available here.](#)

In 1981, the Maricopa County public fiduciary filed a class action lawsuit on the behalf of county residents with serious mental illness. The Arnold vs. Sarn lawsuit alleged that the state and county did not fund a comprehensive mental health system and thus were not fulfilling their statutory duty to the state's residents with severe mental illness. The judge ruled in favor of the plaintiffs, ordering the state to "provide a unified and cohesive system of community mental health care." When appealed to the Arizona Supreme Court, this ruling was upheld in 1986. That same year, the Legislature created the Arizona Department of Health Services' Division of Behavioral Health Services (ADHS/

DBHS Nine Guiding Principles

ADHS/DBHS envisions a public system of care that is comprehensive, person/family oriented, and focused on the principles of recovery. The Division is firmly committed to the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems:

1. Respect
2. Choice in services and program decisions
3. Focus on individual as a whole person
4. Facilitate individuals' transition to independence
5. Community integration
6. Partnership with individual, staff, and family in shared decision making
7. Self-defined success for those in recovery
8. Strength based services that are culturally appropriate
9. Hope

Source: ADHS/DBHS

DBHS) to administer the state's publicly funded behavioral health system. The court established an independent Office of the Monitor to oversee the terms of the Arnold v. Sarn settlement. The state has never exited the suit.¹ The state's work on meeting the terms has had a strong influence on the publicly funded behavioral health system. People with serious mental illness in the state of Arizona are entitled to services and, until recently, the state provided funds for many services for both AHCCCS and non-AHCCCS eligible (non-Title XIX) residents. In the Fiscal Year 2011 budget, the state funds for the non-Title XIX population with a serious mental illness were reduced to include just a generic medication benefit and outpatient treatment from behavioral health medical practitioners (physicians, nurse practitioners, physician assistants and nurses).

A second class-action lawsuit fundamentally changed the children's behavioral health system as much as Arnold vs. Sarn changed things for

1. Because of the state budget, in 2010 the plaintiffs and court agreed to put the settlement terms on hold until June 2012.

adults with serious mental illness. JK vs. Humble, originally filed as JK vs. Eden in Federal court in 1991, was brought by a father after the state's managed care system denied the recommended treatment for his son. The son ultimately ran away from home, attempted suicide and was admitted to a psychiatric facility. The class-action lawsuit was settled and led to the creation of the Arizona Vision, a new system-wide set of service goals:

In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural heritage. [Available here.](#)

This settlement also led to the creation of a timetable for the implementation of wraparound supports, which is a method of bringing multiple systems together with the child and family, and creating an individualized plan to address that child's and family's specific needs. These partnerships of children, families, and professionals are called Child and Family Teams (CFT). Along with CFTs, the settlement also provided more training for service providers, process evaluation, and changes in the structure of the managed care system. While many of these steps have gotten underway, current litigation is pending in regard to the implementation timeline.

These two lawsuits have had a profound effect on the delivery of state and federally funded services to the state's mentally ill populations, especially in rural areas. While the Arnold vs. Sarn settlement is only binding in Maricopa County, it led to the creation of a state-wide system of care for people with serious mental illness. Arizona's care for

The Arizona Vision

Behavioral health services for children are guided by the Arizona Vision developed from the JK Settlement along with the following 12 Principles:

1. Collaboration with the child/family
2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting
7. Timeliness
8. Services tailored to child/family
9. Stability
10. Respect for child/family's cultural heritage
11. Independence
12. Connection to natural supports

Source: ADHS/DBHS

its seriously mentally ill residents is far ahead of many states such as Georgia, which is still working to move its institutionalized population of more than 9,000 people out into the community to receive services. JK vs. Humble affected services for children across the entire state, regardless of geographic location. This means that children living in the most isolated frontier communities in the state are entitled to the same access to services as children in Phoenix or Tucson. While this may be truer in theory than in fact, one of the key informants for this review said:

"The next seven years after that settlement agreement (JK) we had the attorneys for the plaintiffs monitoring the system and continuously pushing the state to develop more and better services for children. So then, we had one (a lawsuit settlement) for a very long time in Maricopa County on adults but not the balance of the state. I think that some of the services for severely mentally ill adults are not nearly as well-developed in the rural areas compared with children's services."

Another influence on the behavioral health system was the decision to keep funds for behavioral health services separate from physical health services. Arizona was the last state to sign up for Medicaid and one of the first to implement a Medicaid managed care model with a behavioral health carve out. The term “carve out” refers to management of care by separate legal and administrative entities within a system. While AHCCCS directly contracts with providers for physical health services, the money for behavioral health services is directed to ADHS/DBHS, which then contracts with the T/RBHAs that then further subcontract with service providers.

Despite challenges, the Arizona system is exemplary in its emphasis on serving people in their communities rather than in large institutions. This shift is still ongoing in other states in the nation. An excellent timeline depicting the development chronology of the Arizona Public Behavioral Health System is [available here](#)

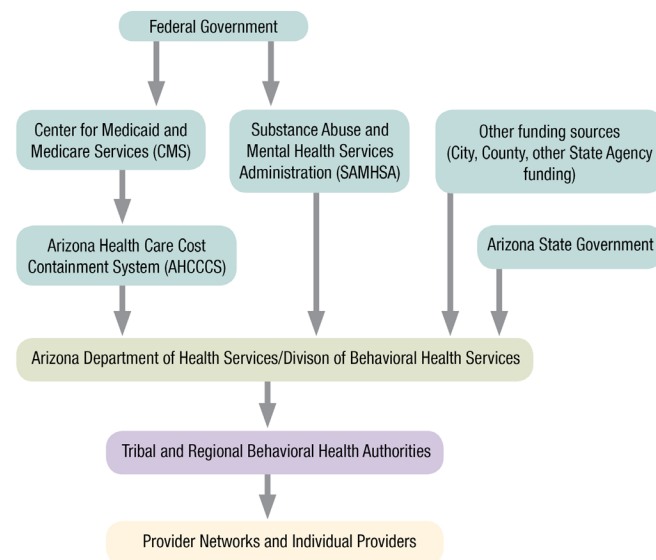
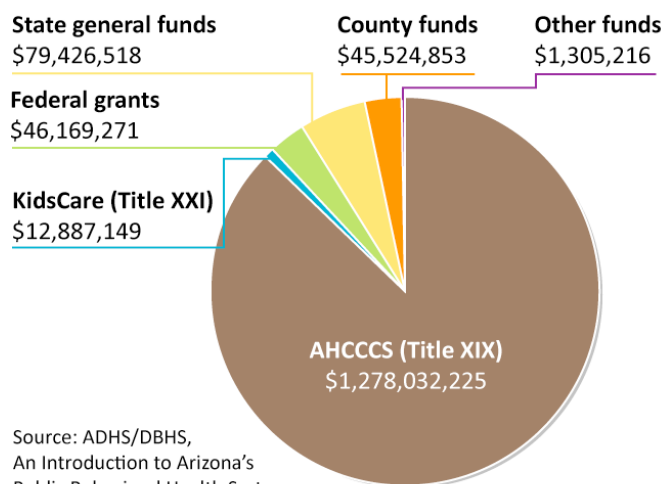
Funding

The monies to fund ADHS/DBHS administered services come from a variety of sources. In fiscal year 2010, \$1.3 billion was administered through the Division. The Arizona public behavioral health system is mainly funded by federal Medicaid dollars that are received by AHCCCS and funneled through ADHS/DBHS then out to the T/RBHAs. The flow of dollars is depicted in the chart below. These funds are provided under Title XIX (AHCCCS) and Title XXI (KidsCare) and matched with state dollars to cover services for 79 percent of Arizonans receiving care through the T/RBHAs.

Medicaid (Title XIX) dollars are the primary drivers of behavioral health care in the state. While state General Funds and federal block grants have also provide some funding, in the past two fiscal years the Legislature has reduced the amount of state funds appropriated to ADHS/DBHS. The overall ADHS non-Medicaid budget was about \$276 million on July 1, 2008. On July 1, 2010, the department non-Medicaid budget

Public behavioral health funding, FY 2010

While ADHS/DBHS receives funds from a variety of sources, AHCCCS is by far the largest part of behavioral health spending.



Source: ADHS/DBHS

was about \$143 million. KidsCare (Title XXI) has also been frozen, with no new children served since January of 2010. The funds for Arizonans with SMI who are not eligible for AHCCCS (Non-TXIX) have been reduced by more than 50 percent since fiscal year 2008. For fiscal year 2011, the state has budgeted \$40.2 million for a generic medication benefit, \$16.4 for the crisis system, and \$5.3 million for supportive housing for the non-Title XIX SMI population. Finally, the 15 Arizona counties also provide funds to the behavioral health system because they are responsible for

the costs when a resident requires an involuntary psychiatric evaluation either as an outpatient or in an inpatient psychiatric hospital.

ADHS/DBHS is also currently receiving funds from several federal grants:

- **Community Mental Health Services (CMHS) Block Grant:** The Substance Abuse and Mental Health Services Administration (SAMSHA) provides funding for adults with serious mental illness and children with serious emotional disturbance. The goal of the grant is to facilitate the provision of community-based services as an alternative to inpatient psychiatric care. Among its goals, the grant also seeks to ensure access for residents in rural areas. In fiscal year 2011, this grant provides about \$9.3 million, with the funding evenly distributed between adults with serious mental illness and children with serious emotional disturbance.
- **Substance Abuse Prevention & Treatment Block Grant:** SAMSHA funds this grant in order to provide substance abuse treatment services to priority populations and to fund state prevention efforts. At least 20 percent of the grant funds must be spent on prevention. In fiscal year 2011, the state received about \$37.4 million through the SAPT Block Grant.
- **Projects for Assistance in Transition from Homelessness (PATH):** SAMSHA funds this grant to provide outreach services, diagnosis, and mental health and substance abuse screening for homeless families and individuals with mental illnesses. Outreach teams are located in Maricopa, Pima, Yavapai, Cochise, and Coconino counties. In fiscal year 2010, the PATH grant was about \$1.5 million.

Federal funds include:

- State Mental Health Data Infrastructure Grant for Quality Improvement
- Synetics Drug & Alcohol Services

“We seem to be pretty far ahead of a lot of the other states”



- Information System (DASIS) Contract
- Youth Suicide Prevention and Early Intervention Grant

Strengths and Challenges

The Arizona behavioral health system is ahead of many states in its embrace of the concept of community treatment. Very few Arizona residents are served in institutions; instead the state has chosen to fund a system of community services that focuses on the concept of recovery that emphasizes the importance of hope, meaningful social contribution, and independent living. ADHS/DBHS is also strengthened by the combination of substance abuse services, mental health services, and prevention under the auspices of a single state organization (See Section 3 in this document. This helps foster the creation of a coordinated system of behavioral health care for Arizonans in need of services.

The largest challenge facing ADHS/DBHS is the ongoing state budget crisis. The Department has had its overall budget reduced and the state has had a hiring freeze in place since January 2008. As of June 2010, ADHS/DBHS had a 37 percent position vacancy rate resulting in their having to do more with less. The current high unemployment rate in the state has increased the number of Arizonans eligible for AHCCCS, and statewide Title-XIX RBHA enrollment increased by almost 25,000 people from September 2008 to September 2010. People not on the AHCCCS rolls and budget reductions have a disproportionate effect on the state’s rural areas, particularly rural hospitals. When behavioral health services are no longer available in the community, hospitals,

jails, and prisons become providers of last resort. According to a key informant:

We can expect that the rural hospitals are going to be slammed in terms of their emergency departments (because of behavioral health cuts) ... when all else fails you go to the hospital and they have to take care of you. But that's not something that a lot of rural hospitals have, a psychiatric facility or capacity.

ADHS and DBHS have also been struggling with high executive turn over during the past two decades. Since 1993, ADHS has had nine different directors and DBHS has been lead by seven different people. This revolving door of leadership at the highest levels can interfere with the top level planning needed to create a proactive rather than reactive system.

Another ongoing issue is incompatibility of data systems among the state's providers, T/RBHAs and ADHS/DBHS. This fundamental communication flaw contributes to barriers in timeliness, quality, and accuracy. Some work to address these issues is ongoing through a federal grant. An offshoot of this issue is a current lack of planning for a statewide electronic medical record system. These records were given special emphasis in the recently passed healthcare reform bill and it is important that mental health providers are not left behind.

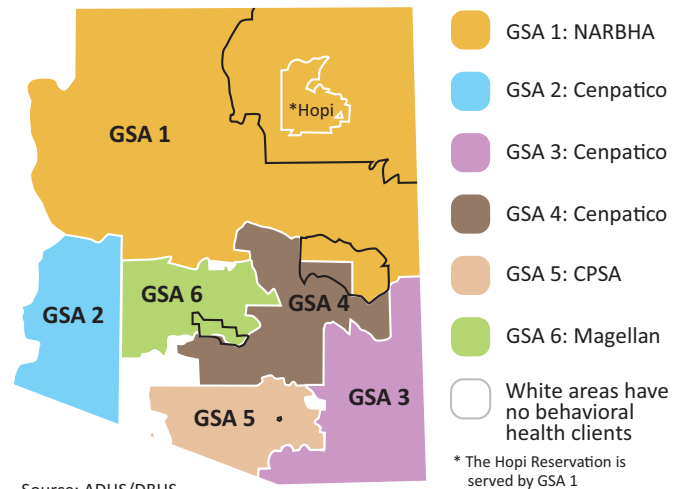
II. Regional Behavioral Health Authorities

Overview

RBHAs are administrative and quality oversight entities – like health maintenance organizations – that are awarded contracts through a competitive bidding process. RBHAs do not provide direct services. Medicaid funds are allocated by the Arizona Department of Health Services Division of Behavioral Health Services (ADHS/DBHS) to a RBHA based on a capitation rate utilizing

Arizona Geographic Service Areas

In addition to the 6 GSAs, four Tribal RBHAs serve the areas outlined in black. The TRBHAs are: Navajo Nation, White Mountain Apache Tribe, Gila River Indian Community, and the Pascua Yaqui Tribe



the number of AHCCCS eligible residents in the Geographic Service Area (GSA). For the purposes of this review, we will consider GSAs 1, 2, 3, and 4 rural, although this does not count the substantial rural areas of Pima and Maricopa Counties. A review of the 2010 capitation rates reveals that they are generally lower for the rural GSAs, though not in all categories of funding. The FY2010 capitation rates are [available here](#). Other funds are allocated based on historical utilization, grants and performance incentives.

The ADHS/DBHS distributes funds through the following process:

- Competitive bids for each of six GSAs are let every three years to five years
- Once a contract is awarded, up to two one-year extensions are possible
- RBHAs may continue rebidding after completing each three to five year contract
- RBHAs establish and contract with provider networks to deliver actual behavioral health services.

History

Geographic Service Areas and Regional Behavioral Health Authorities were authorized through state

Table 2. Four RBHAs serve the state’s six Geographic Service Areas

GSA	RHBA	2009 Enrolled Members	2009 Amount ADHS paid for services
GSA 1 Apache, Coconino, Mohave, Navajo, Yavapai	Northern Arizona Regional Behavioral Health Authority, (nonprofit)	17,398	\$140,758,119
GSA 2 La Paz, Yuma	Cenpatico, (for profit)	6,286	\$112,922,455* *combined amount paid for GSA 2 and GSA 4, separate figures were not available
GSA 3 Cochise, Graham, Greenlee, Santa Cruz	CPSA (in 2010 this RBHA was awarded to Cenpatico) (nonprofit)	5,180	\$41,415,828
GSA 4 Gila, Pinal	Cenpatico, (for profit)	10,685	\$112,922,455* *combined amount paid for GSA 2 and GSA 4, separate figures were not available
GSA5 Pima County	Community Partnership of Southern Arizona (nonprofit)	29,627	\$234,768,120
GSA 6 Maricopa County	Magellan Health Services, (for profit)	83,856	\$673,571,488

Sources: 1: System of Care Network Development and Management Plan 2: Division of Behavioral Health Services, Bureau of Financial Operations: Contractor Annual Audited Financial Reports

legislation in 1992. The two previously described lawsuits, which greatly influenced Arizona’s response to mental illness, also influenced the creation of Arizona’s RBHA system. Early efforts resulted in bankruptcy for several RBHAs in Maricopa County and the state had to operate the services while reorganization occurred. The Northern Arizona Regional Behavioral Health Authority (NARBHA) and Community Partnership of Southern Arizona (CPSA) have been in the RBHA system since its inception.

Funding

In 2010, the contracts for GSAs 1-5 were up for bid. In March 2010, ADHS/DBHS awarded contracts for these GSAs to three RBHAs to develop and administer complete systems of behavioral health care. NARBHA, Cenpatico, and CPSA maintained their contracts for GSAs 1, 2, 4, and 5. The award for GSA 3 to Cenpatico was initially contested by CPSA, which had previously managed GSA 3. CPSA dropped their protest in September 2010 and in December 2010, Cenpatico took over management of GSA 3. CPSA continues

to manage GSA 5. Tab 2 above summarizes information about the four current RBHAs.

The ADHS/DBHS also contracts with TRBHAs to manage tribal behavioral health service funds for Native Americans:

- The White Mountain Apache TRBHA had 500 members in 2009.
- Gila River TRBHA had 1,200 members in 2009.
- Pascua Yaqui TRBHA had 1,058 members in 2009.
- ADHS/DBHS holds intergovernmental agreements (IGAs) with the Navajo Nation for the provision of case management services to enrolled Navajo Nation members and requires the Navajo Nation to perform limited administrative functions.
- ADHS/DBHS contracts with the Colorado River Indian Tribe for the delivery of non-AHCCCS behavioral health prevention services to registered Colorado River Indian Tribal members.

RBHAs also receive most of the Federal Substance Abuse Prevention and Treatment (SAPT) block grant funds distributed by the ADHS/DBHS, Office of Prevention Services (for more detail, see Section 3). Grant funds are allocated on a per capita basis to the RBHAs and the Gila River Indian Community TRBHA for substance abuse and mental health illness prevention services. Block grant funds support a variety of covered substance abuse services in both specialized addiction treatment and more generalized behavioral health settings. SAPT dollars cover specific populations not eligible for AHCCCS. Special target groups mandated by the SAPT Block grant include:

- Pregnant women with a substance abuse disorder
- Persons who use drugs by injection
- Women with dependent children, including women attempting to regain custody of their children, with a substance abuse disorder
- Any non-Title XIX eligible person with a substance use disorder

Direct Activities

Each of the RBHAs varies in how they establish a system for behavioral health care delivery. RBHAs use different terminology to describe network provider agencies such as “responsible agency” or “provider network organization.” All intake agencies are contracted to supply a full array of covered behavioral health services although the systems of care they use differ from one to another.

People who are already on AHCCCS or those eligible for AHCCCS can receive behavioral health services under the Medicaid funding stream. Funded RBHA services include intake, assessment, and service delivery. Covered services for adults and children fall under eight domains:

- Treatment services (e.g., assessment, evaluation, screening, counseling services)

- Rehabilitation services (e.g., psychosocial rehabilitation living skills training)
- Medical services (e.g., physician and nursing services, medications, laboratory, radiology and medical imaging)
- Support services (e.g., housing, transportation and case management)
- Crisis intervention services
- Inpatient services (e.g., hospital)
- Residential services
- Behavioral health day programs

In its 2009 report entitled “System of Care Network Development and Management Plan” [available here](#), the Division of Behavioral Health Services states, “ADHS/DBHS requires that each GSA has established contracted providers who offer a broad range of behavioral health services identified in the ADHS/DBHS Covered Behavioral Health Services Guide, which includes descriptions for services offered in the evening, early morning and on weekends to ensure that individuals and families have choice and convenient access to needed services.” Convenient access is considered within 25 miles of a behavioral health recipient’s residence. During the FY09 network development review period, services were prioritized for the following special populations:

- Homeless individuals and families
- Members living in border communities
- Members with Developmental Disabilities
- Members experiencing sexual abuse trauma
- Infant and Early Childhood Mental Health
- Individuals involved with the criminal justice system
- Treatment for individuals who act out sexually
- Dialectical Behavioral Therapy (DBT)
- Substance Use/Abuse

Most RBHA contracts for prevention services cover the entire population in defined communities. Rural exceptions include Coconino, Yavapai, Apache and Navajo

counties. Here most of the specific population services are for children, although Yavapai also has specific population services for older adults. RBHAs actively participate with the Arizona Substance Abuse Partnership in the Governor's Office for Children, Youth, and Families (for more detail, see Section 3) and contract with consumer-run and advocacy groups to further prevention goals.

The ADHS/DBHS also partners with the Department of Economic Security (DES) through a program called "Arizona Families F.I.R.S.T. (Families in Recovery Succeeding Together)." RBHAs provide substance abuse services for families identified by DES through TANF (Temporary Assistance for Needy Families) and Child Protective Services.

The ADHS/DBHS prepares a comprehensive annual network development plan, which is submitted to AHCCCS, and [available here](#). The plan accomplishes the following goals:

- Attests that the statewide behavioral services network offers appropriate and adequate services
- Ensures providers meet service and accessibility needs
- Describes plans to address identified gaps in RBHA services
- Provides a plan for the next fiscal year

Each RBHA must also develop a performance plan that addresses ADHS/DBHS standards of performance. These include an approved medication formulary, practice protocols, and services. In addition, RBHAs must meet quality standards established by the contracts.

Strengths and Challenges

While there are many improvements that could be made to Arizona's RBHA system, especially with the increased need for services and deficits in funds, Arizona's behavioral health system includes many positive qualities

that do not exist in other states. ADHS/DBHS establishes standards of performance and monitors RHBA performance to ensure that the quality and quantity of services is consistent and comprehensive for both urban and rural communities. As noted earlier, DBHS has developed a guiding philosophy for care and identified populations for prioritized services that also drive the management of services by RBHAs.

The 2011 state plan for the Community Mental Health Services Block Grant states that methods to deliver services to rural areas are often innovative and less traditional. One innovation is the use of telehealth and telepsychiatry to provide behavioral health services. In addition, RBHAs provide extensive training to therapists and other behavioral health providers in their system.

Challenges to delivering behavioral health services in Arizona exist for a number of reasons. Separating the funding and oversight of behavioral health services (delivered through ADHS/DBHS and the RHBA system) from medical services (delivered through AHCCCS Health Plans) makes it difficult to implement the current national trend of integrating mental and physical health care services. One key informant stated that:

It was always carved out, mental health over here, physical health over there... but I think that carve out has so many issues with it. It's created a lot of different barriers.

Arizona's decision to carve out mental health services distinct from physical health services, along with the decision to create a separate system of RBHAs, shapes the public behavioral health services delivered to Arizona residents. Some advocates argue that this separation of the responsibility for behavioral health services in ADHS/DBHS and the RBHAs from the

Table 3. Title XXI and XIX eligibility, enrollment, and penetration rates for Arizona and each GSA

Area	AHCCCS Eligibility	RBHA Enrollment	Penetration (%)*
Statewide			
Title XIX	1,216,590	129,693	10.7
Title XXI	27,364	1,935	7.1
GSAs			
GSA 1 Apache, Coconino, Mohave, Navajo, Yavapai	Title XIX: 123,601 Title XXI: 2,455	15,488 182	12.5 7.4
GSA 2 La Paz, Yuma	Title XIX: 54,795 Title XXI: 1,209	4,532 79	8.3 6.5
GSA 3 Cochise, Graham, Greenlee, Santa Cruz	Title XIX: 50,872 Title XXI: 975	4,691 53	9.2 5.4
GSA 4 Gila, Pinal	Title XIX: 58,835 Title XXI: 1,087	7,286 113	12.4 10.4
GSA 5 Pima	Title XIX: 179,514 Title XXI: 3,568	26,896 370	15 10.4
GSA 6 Maricopa	Title XIX: 663,257 Title XXI: 16,770	66,846 1,106	10.1 6.6

* Percentages rounded to the nearest tenth of a percent. Source: ADHS/DBHS Enrollment-Penetration Report, October 2010

responsibility for physical health services in AHCCCS and the AHCCCS Health Plans diverts administrative overhead funds from treatment services. Others argue that without guaranteed funding and oversight for mental health treatment, behavioral health recipients are not guaranteed that their behavioral health care needs would be met by the AHCCCS system, which focuses on physical health care.

Contracting with separate entities to manage regional systems creates disruption in the system when contractors change. Each transition to a new RBHA requires establishing new arrangements with direct service contractors as well as new record keeping and reporting systems. According to one key informant interviewed:

“There are lots of (transition) issues. A new provider (RBHA) has to come in and reestablish contracts with all of the individual providers under

them ... They have to bring in new management structures, new IT systems. It’s horrendous. It’s a lot of work.”

Not all who are eligible and need behavioral health services receive them, and the enrollment penetration rates vary across GSAs. Table 3 above is a chart of eligibility, enrollment and penetration rates for the state as a whole and each GSA. The penetration rate is calculated by dividing the number of people enrolled in a RBHA by the number of people eligible for AHCCCS. As can be seen, the enrollment penetration rates vary from a low of 8.3 percent in La Paz and Yuma counties to a high of 15 percent in Pima county for those eligible under Title XIX funds and from a low of 5.4 percent in Cochise, Graham, Greenlee, and Santa Cruz Counties, to a high of 10.4 percent in Gila and Pinal Counties for those eligible under Title XXI funds. It is important to remember that some discrepancies in these

penetration rates exist because of the high number of individuals eligible for AHCCCS on the reservations. RBHAs are responsible to make available covered behavioral health services to all Title XIX/XXI eligible American Indians, whether they live on or off reservation. Eligible American Indian members may choose to receive services through a RBHA, TRBHA or at an IHS or 638 tribal provider. Many choose to not receive services through a RBHA.

Of course not all people eligible for Title XIX and XXI funding require behavioral health services, but if we assume that the figures given in the Introduction Section of this report constitute a reasonable estimate – 20 percent of rural residents struggle with significant substance dependence, mental illness, and medical-psychiatric comorbid conditions – then the penetration rates in the rural GSAs (1,2,3, &4) are insufficient.

In addition to the rural disparity issues discussed in the Introduction Section, the following describes underlying issues for behavioral health services for rural populations:

Cultural and language challenges: Hispanic peoples have unique cultures that do not always pair well with mainstream behavioral health practice. Two key informants said that cultural differences can lead to differing symptoms and ideas of appropriate treatment:

There are cultural issues with using the mental health system ... I think that the Hispanic culture is a little bit more (reluctant) to accepting that care, which means that most of those symptoms manifest themselves in physical ways.

Stigma associated with mental health care: Concern about being seen when seeking mental health services is a greater issue in rural communities because maintaining anonymity is more difficult.

Need for transportation to services: Long distances, lack of public transportation, the poor condition of rural roads, rising fuel costs, and the frequency of old vehicles in need of repair due to the lower socioeconomic status of rural populations often make traveling several miles to see a health care provider prohibitive. While transportation is a covered service under AHCCCS, those funds are limited.

Behavioral health crisis response challenges: Timely crisis response is especially difficult for geographically isolated communities, such as the Havasupai at the bottom of the Grand Canyon.

Shortages of providers: While all rural communities have difficulties recruiting providers, Mexico border communities have even greater challenges because of concerns over undocumented immigrants and drug trafficking. A major challenge throughout Arizona is finding specialty clinicians to work with the birth-5 population, developmentally disabled individuals, and sex offenders. Although ongoing training is an important strength of the RBHA system, it also is necessary because of frequent provider and staff turnover.

High rates of substance abuse: In 2009, alcohol use prevention was identified by the ADHS/DBHS Office of Prevention as a major substance abuse priority because it was the most prevalent and costly substance to Arizona. Another priority is the recent increase in prescription drug abuse/misuse and resulting deaths. The RBHAs and the communities they serve also identify priority prevention needs, which may vary from those identified statewide by the Office of Prevention. For example, southern Arizona has targeted marijuana use, and Pinal County has targeted methamphetamine addiction. Arizona's prevention system for behavioral health, and the myriad of issues facing it, will be discussed further in the next section of this report.

SECTION 3: PREVENTION AND TREATMENT

I. Behavioral Health Prevention Services

Coordination and Planning

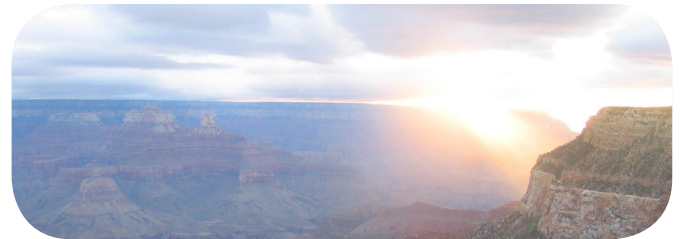
Established in June 2007, the Arizona Substance Abuse Partnership (ASAP) represents a strategic, data-driven, and collaborative approach to Arizona’s substance abuse prevention, treatment, intervention, and recovery efforts. Located in the Governor’s Office for Children, Youth, and Families (GOCYF), ASAP serves as the single statewide council on substance abuse issues. It brings together stakeholders at the federal, state, tribal, and local level to utilize data and practical expertise to develop effective methods to integrate and expand services across the state by maximizing available resources.

ASAP is run by an administrator and continues to be supported by the Governor’s Office after its initial federal grant ended in September of 2010. It is chaired by the Governor’s Deputy Policy Director, and a complete list of the ASAP members is available on the [ASAP website here](#). The entire group meets every other month and its Substance Abuse Epidemiology Work Group meets monthly.

The Deputy Director of ADHS/DBHS sits on the ASAP advisory committee. State prevention staff contribute to ASAP discussions and decisions through the Deputy Director of ADHS/DBHS, through sitting on various ASAP subcommittees, and by working directly with the GOCYF on numerous initiatives.

Other state government agencies represented on ASAP include the Department of Education, Department of Public Safety, Department of Liquor License and Control, the Department of Economic Security’s Family and Youth Services Administrator and AHCCCS. Community drug abuse coalitions are represented and tribal representatives also participate. ASAP has a strong law enforcement and corrections focus, with local, state, and federal law enforcement representation.

Of particular note is a collaborative effort between ASAP and the Arizona Criminal Justice Commission to develop the Community Data



“ Our biggest priority is alcohol ... because it’s the most prevalent and costly ”

Project. Currently sponsored by GOCYF, the primary goal of the project is to create a central repository for Arizona’s substance abuse and crime data in an effort to enhance the use of data in decision making, programmatic planning and monitoring, and reporting consistency. The user-friendly website, [available here](#), allows individuals to access selected types of data at the geographic level of interest (state/county/community coalition).

Direct Service Activities

Prevention services in Arizona are provided by several different sources. The ADHS/DBHS Office of Prevention receives federal funds in the form of the Substance Abuse Prevention and Treatment (SAPT) Block Grant, [available here](#), from the Center for Substance Abuse Prevention

and the Garrett Lee Smith suicide prevention grant from the Substance Abuse and Mental Health Services Administration. Therefore the majority of the Office of Prevention's focus is on substance abuse and suicide prevention.

The SAPT Block Grant stipulates that not less than 20 percent of the funds must be spent on primary prevention strategies. These federal dollars are mostly apportioned out to the RBHAs and community coalitions to provide these services. According to key informants, the ADHS/DBHS state general funds that were spent on prevention efforts have been largely cut in recent years.

...as far as prevention, there was roughly around \$4.5 million in state substance abuse prevention funding that was allocated in fiscal year 08/09. Approximately \$2.2 million of that was cut, and it's anticipated that probably the majority of it will be cut in 2011.

The ADHA/DBHS Office of Prevention provides tools, resources, and technical support to promote the resiliency and prevention of behavioral health/substance abuse disorders in Arizona. Its goal is to empower communities to make healthy choices and its staff works cooperatively with community groups to:

- Collaborate with Arizona's prevention workforce, including the T/RHBAs, government entities, local communities and other stakeholders on developing state wide prevention services
- Strategically reduce substance abuse and suicide rates
- Evaluate the effectiveness of prevention programs

The ADHS/DBHS Office of Prevention has developed a prevention framework that lays out expectations for how the RBHAs will conduct their substance abuse and suicide prevention

“It's really hard and expensive to get people down there (Havasupai) to do prevention”



activities. The RBHAs can choose to provide the services themselves or subcontract out with other providers, but in either case, the RBHAs must perform a needs assessment of their communities on an ongoing basis. These assessments must include regional data on substance abuse morbidity and mortality, along with suicide. The assessments also must take into consideration the cultural factors at play in the communities concerned. All the RBHAs and subcontracted prevention provider agencies must be involved with at least one regional or local coalition working on the prevention of behavioral health disorders. All the prevention programs must be evaluated, both on process and outcomes, at least once annually to ensure that goals are being met. The ADHS/DBHS Office of Prevention also stipulates that each community targeted to receive prevention services must be actively involved in the design, implementation, and evaluation of all the services delivered to that community. This is mainly accomplished through working with the community coalitions, which must have substance abuse prevention program participants or family members represented (with decision-making authority) on each coalition.

The ADHS/DBHS Office of Prevention substance abuse prevention goals are to:

- Integrate effective substance abuse prevention, education, early intervention, enforcement, treatment, and aftercare

strategies to achieve the most favorable outcomes for all Arizonans.

- Enhance the ability of public, private, and community-based organizations to engage diverse and underserved populations to participate in planning strategies and activities for reducing the consensus of substance abuse behaviors.
- Enhance the capacity of families and communities to reduce the causes and effects of substance abuse and associated behaviors.
- Establish and sustain a state-wide prevention and enforcement substance abuse infrastructure that incorporates: a common purpose/planning efforts, ongoing examination and development of policy, mechanisms for effective state and local partnerships, a data infrastructure, and evaluation systems to assess and improve outcomes.

Other State Behavioral Health Prevention Efforts

The state also provides preventive behavioral health services through several other agencies. The ADHS Bureau of Tobacco and Chronic Disease funds tobacco use prevention through contracts with county health departments and the Department of Education. The early childhood program, First Things First, provides help to parents for mental health and behavioral issues in children birth to 5 years old. The Arizona Early Intervention Program in the Department of Economic Security also provides help to families with children showing developmental delays. The ADHS Bureau of Women's and Children's Health (ADHS/BWCH) has several prevention programs including Health Start, which screens new mothers for post-partum depression and young children for early identification of developmental delays and makes appropriate referrals.

The ADHS/BWCH receives funds from the Centers for Disease Control (CDC) to provide

programs aimed at preventing sexual violence in Arizona. The mission of the Sexual Violence Prevention and Education Program is to promote prevention of sexual coercion and violence by increasing the public's knowledge about sexual coercion and violence and applying that knowledge through diverse prevention efforts.

The ADHS/BWCH also receives Federal funds through the Family Violence Prevention and Services Act for the prevention of domestic violence and the provision of domestic violence education. This funding also supports domestic violence coalitions in the provision of advocacy, planning, public awareness and education, administration, and direct service. Because victims of domestic violence in the rural areas of Arizona may not have ready access to services due to isolation and long distances between available domestic violence safe homes or shelters, these funds are used primarily to provide services to the rural areas of the state utilizing Rural Safe Home Networks and to support the Arizona Coalition Against Domestic Violence (AzCADV). Currently the Department funds six safe homes.

A Rural Domestic Violence Services Network operates domestic violence hot lines, and provides domestic violence victims and their children with temporary, emergency safe shelter, peer counseling, case management, and advocacy. AzCADV provides domestic violence training throughout Arizona to domestic violence service providers, law enforcement, legal systems, medical communities, social service providers, and others, as requested. AzCADV also provides Information and Referral Services to domestic violence victims and others who request the information throughout the state. Family Violence Prevention and Services funds are also used for legal advocacy services for victims, counseling services for children, and education and prevention targeting Indian communities.

Strengths and Challenges

Arizona's prevention efforts are strengthened by combining mental health and substance abuse and suicide prevention services within the ADHS Department of Behavioral Health Services, and the Division's requirement that the RBHAs undertake prevention efforts throughout the state. This coordination of efforts through a central agency ensures that important prevention efforts take place in rural areas as well as in the state's urban centers. Another strength brought about by ADHS/DBHS is the requirement that the RBHAs work with their respective communities to ensure that prevention programs are culturally appropriate and relevant for residents.

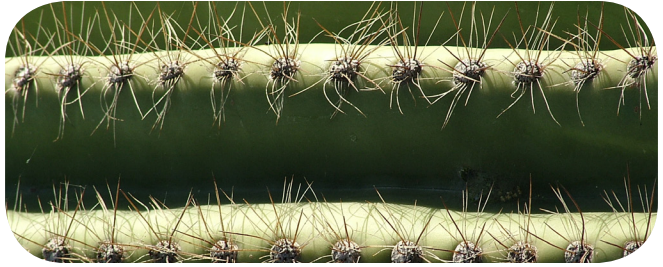
As with all aspects of Arizona's behavioral health system, the most pressing challenge is the economic downturn and corresponding cuts in state funding. While the SAPT and suicide prevention dollars flow from the federal government and remain safe, state funds have been cut, thus reducing prevention efforts. For example, cuts in state funding for suicide prevention in rural areas have made it more difficult for rural groups to apply for federal prevention funds that require state matching funds.

While it is a strength that the RBHAs work with coalitions in their communities, it remains unclear how all the coalitions are involved with the ADHS/DBHS Office of Prevention, ASAP, or other state prevention efforts and how there is integration of activities, or effort to avoid duplication of activities/programs and gaps in services. According to one person interviewed for this review:

There are roughly about 160 coalitions throughout this state – many of those in rural communities that are providing prevention services and education in the schools.

In Arizona, there are community coalitions for the prevention of almost every behavioral

“ There are a lot of challenges for people to cope with in rural Arizona ”



health issues, including substance abuse, suicide, obesity, sexual and domestic violence, and early childhood developmental delays. Just the plethora of community coalitions against substance abuse is hard to identify, let alone coordinate in an effective manner.

It depends on what kind of coalition is being referred to in order to determine how many exist. Some coalitions target only substance abuse, while others target such issues as obesity.

As of October 2010, 26 community coalitions are listed on the Arizona Community Data Project Website, referred to above as a collaborative project of ASAP and the Arizona Criminal Justice Commission. Yet the Arizona Substance Abuse Prevention Coalition Directory, published by the ASAP Community Advisory Board, lists 117 coalitions, 65 of which are located in rural areas of counties other than Pima and Maricopa. Finally, the ADHS/DBHS Office of Prevention lists 24 rural substance abuse prevention coalitions in their Substance Abuse Prevention and Treatment block grant application for 2011. This lack of consistency among many sources presents a worrisome challenge to the coordination of prevention efforts, especially in rural areas of Arizona.

Another challenging question revolves around the quality of the programs that these diverse coalitions are supporting and how carefully the program outcomes are being evaluated. The system generally focuses on small, problem-oriented, unintegrated programs that fail to address the real issues that exist in rural communities through an integrated model of dealing with the whole person, the family and the community. Behavioral health efforts in rural Arizona often do not employ such a model resulting in the fact that prevention programs are the first to be singled out as ineffective and doomed for cuts.

II. Behavioral Health Treatment Services

In Arizona, some prevention and treatment efforts are clearly delineated, such as the tobacco use prevention efforts in schools and the Arizona Smokers' Helpline statewide telephone and web-based counseling services (treatment) to help people quit using tobacco. As the information above on rural domestic violence services indicates, however, prevention and treatment services are often comingled, especially in rural areas where small numbers of both prevention and treatment services are available. The following information provides an overview of substance abuse treatment efforts.

In 2010 there were 70,179 individuals enrolled in Arizona's public behavioral health system for substance abuse treatment, an increase of 1.3 percent from 2009. Of these individuals 24,714 (35 percent) could be classified as rural residents since they were located in counties other than Maricopa and Pima County, three tribal RHBA areas, and the Navajo Nation.

Patterns in substance use differ greatly between children/adolescents and adults. Alcohol abuse is more prevalent among adults, although there has been a noticeable decline in alcohol prevalence between 2006 and 2010 among both adults and children/adolescents. Children and

adolescents receiving treatment overwhelmingly report marijuana as their primary drug. Its rate of use has been steadily increasing over the past five fiscal years, from 59 percent in 2006 to 75 percent in 2010. Alcohol abuse ranks second (18 percent) and stimulants remain a distant third (3 percent) as primary substances reported by children and adolescents.

ADHS/DBHS contracts with the T/RBHAs to provide a full continuum of services for individuals with substance use disorders. The single largest source of substance abuse treatment funding comes from Medicaid (77 percent from Title XIX & Proposition 204) followed by the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant.

According to the December 31, 2010, Annual Report on Substance Abuse Treatment Programs from the ADHS/DBHS, the substance abuse treatment network consists of 73 providers, operating 477 individual sites throughout Arizona. This includes 12 free-standing detoxification centers, 53 short-term residential facilities, 294 non-intensive rehabilitative outpatient sites, and 21 opioid replacement therapy clinics. In addition, more than 20 agencies in Arizona offer peer-support services to assist those with a substance use disorder. In addition, the State established three Methamphetamine Centers of Excellence in 2006, which use an integrated best practice model for stimulant abuse, combining outpatient group therapy, medication, peer support, urine testing & contingency management.

Although data about the availability of adult and youth substance abuse treatment services in rural and urban areas are only available from 2008 and 2009, the data show that many of the services decreased from 2008 to 2009 (see Appendix B), and there is no reason to assume they have increased given the economic constraints of the past few years.

Strengths and Challenges

In 2006, the state established three Methamphetamine Centers of Excellence (COE) (two urban and one rural) in an effort to combat an increasing trend in methamphetamine use among the substance abusing population through an evidenced-based intensive outpatient treatment approach. ADHS/DBHS provides funding to support three centers, one each in Tucson and Phoenix and one in rural Sacaton/Gila River area. The Methamphetamine COE in Gila River adheres to the Matrix best practice model, providing culturally and gender responsive treatment to female methamphetamine abusers on the reservation. As of fiscal year 2010, this program has provided assistance to its members working towards their GED accreditation, offered multiple therapy sessions, participated in community outreach projects, and connected members with self-help groups. Because of this program's actions, 30 members have been reunified with their children, 14 members have moved into independent housing, 10 have

found employment, and two are in college working toward an Associates Degree. While a strength of the treatment system is that one of the three Methamphetamine Centers was established in a rural location, the disproportionate Methamphetamine use among rural populations means that there is a need for treatment services in additional rural areas of the state.

The number of substance abuse treatment services is decreasing while the number of people needing services is increasing statewide, but disproportionately in rural areas due to factors like high levels of unemployment. Though some treatment services for rural adults are insufficient, there is a severe lack of many services for rural youth. For example, according to the Arizona Community Data Project's Substance Abuse Treatment Capacity-Youth Resources Table (see Appendix B), the 13 youth substance abuse residential treatment facilities located in rural Arizona in 2008 decreased to three in 2009.

SECTION 4: INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTH

Overview

Over the past several decades, the development of coordinated care service delivery models — those that connect behavioral and physical health — has led to the promising approaches of integration and collaboration. There are several reasons why health policymakers, planners, administrators, analysts, providers, and consumers are interested in what is commonly referred to as “integration.” One compelling reason is the strong evidence of co-morbidity between serious physical health and behavioral health-related problems. As many as 70 percent of primary care visits stem from psychosocial issues (Gatchel & Oordt 2002). Mortality is also a devastating concern: Recent data from several states have found that people with serious mental illness served by public mental/behavioral health systems die, on average, at least 25 years earlier than the general population. In Arizona, a study estimated the years of potential life lost to be 31.8 (Colton & Manderscheid, 2006).

Two consumer-driven arguments for better integration of behavioral and physical health are greater convenience and efficiency. For many consumers, it is attractive to access care for both physical and behavioral health issues at one location, and, for rurally-located consumers, the co-location of services can help lessen the transportation, time, and stigma-related barriers to accessing care. Better collaboration between different types of health care providers also leads to greater efficiencies in patients being seen in a timely manner, obtaining adjustments to their treatment plans when necessary, and avoiding paperwork and billing frustrations.

There is a clear trend that Arizona will look closely at ways to adopt one or more models of integration in the near future. In part, this is a facet of the movement toward the “medical home” concept. In July 2010, ADHS Director Will Humble wrote in his blog that:

There’s broad consensus that integrating mental health services into primary care settings offers a promising and efficient way to ensure that people have access to needed mental health services. Additionally, mental health care delivered in an integrated setting can help to minimize stigma and discrimination,

The Biopsychosocial Model

The “granddaddy” of collaborative and integrated care is the biopsychosocial model... [which] acknowledges that biological, psychological, and social factors all play a significant role in human functioning in the context of disease. This model is endorsed by most medical professionals yet seldom practiced. However, it is the theory at the root of collaborative and integrated care and is universally embraced as a “best practice.”

Source: Milbank Memorial Fund, 2010

while increasing opportunities to improve overall health outcomes. Likewise, integrating physical healthcare services into behavioral health clinics has increased access to physical health care screening and treatment for individuals who are more likely to see their behavioral health provider than a primary care physician.

According to Humble (2010):

One of our primary objectives will be to better integrate behavioral health, physical health, and wellness at the “retail” level (i.e., at the point of care). By strengthening integration and

collaboration with community health centers and other providers of primary care, we expect to improve overall wellness as well as lower the use of emergency departments, decrease admissions and readmissions to hospitals, improve service delivery and improve adherence to treatment plans. This'll translate into lower healthcare costs while producing improved health outcomes.



“Most certainly there are
billing constraints”

Integration and collaboration can flow in two directions. One direction is the screening and treatment of mental health and substance abuse problems in primary care settings. Another direction is to improve the medical care of individuals with serious mental health and substance abuse problems within behavioral health settings.

Integration of Physical and Behavioral Health in Arizona Federally Qualified Health Centers

Primary care is usually the first point of patient contact. One key informant interview for this review estimated that at least 50 percent of all visits to Federally Qualified Health Centers (FQHCs), which provide primary care, are due to conditions that have mental or emotional problems as a root cause or contributing factor. In Arizona, FQHCs provide an accessible and convenient example for learning more about what is being done to advance integration and collaboration in a primary care setting. There are 18 FQHCs in Arizona, and collectively these centers offer one of the most diverse arrays of programs in the United States. Funded by the USDHHS, Health Resources and Services Administration (HRSA), FQHCs are mandated to provide accessible health services to improve the health status of individuals and families who need primary care services and may not have the financial resources or health insurance to pay for them. In many ways, FQHCs are at the forefront of the nation's trend toward the integration of primary and behavioral health care. For example,

in the cases where a behavioral health specialist is employed by a FQHC, he or she is usually not referred to as a counselor or a behavioral health professional, but rather as a “medical consultant” who is a fulltime member of the medical department.

We achieve very good outcomes at the community health center. Patients receive immediate access to (behavioral health) care because we meet with them in the exam room during their doctor appointment. It's very efficient. In the real world, we (behavioral health professionals) don't have time for twelve sessions, but maybe one.

The principal reimbursement for services provided at FQHCs comes from Medicaid, which in Arizona is administered through the AHCCCS program. Behavioral health services are mandated through Medicaid and paid through a Prospective Payment System (PPS). This system is a method of reimbursement in which Medicaid payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service.

On a practical level, mental health and substance abuse treatment options are at the discretion of the physician. In one FQHC, for example, a doctor may notice issues with a patient and bring in a behavioral health professional as a consultant. The physician and the behavioral health professional each bill \$170 for the visit. Because the behavioral health professional's salary is within a midlevel health care professional range, but reimbursement is the same as for the higher-paid physician, it is cost-effective for the FQHC to incorporate the behavioral health professional into the care received by the patient. Another way that FQHCs meet the HRSA mandate is to subcontract with the RBHA for their service area to have a behavioral health professional co-located within the health center. In this way, FQHCs can get appropriate patients into psychiatric care or longer-term therapy. Again, these options vary from center to center. If a patient's behavioral health needs cannot be served within the center, the center will refer the patient to outside services.

Behavioral health professionals act as a conduit for patients to communicate with their physicians about psychiatric issues and prescribed medications.

“Never has there been more interest in integrating behavioral health services and primary care”



But...there are lots of difficulties without seamless Electronic Health Records.

A significant challenge in Arizona to the provision of behavioral health services within a primary care setting like an FQHC is the division of the Medicaid funding stream between primary care and behavioral health care. Under the Mental Health Parity and Addiction Equity Act, which took effect in 2010, the mental health and substance abuse benefits that a health plan provides have to be just as generous as its coverage for medical and surgical treatments. HRSA released a mandate that state Medicaid agencies had to pay for certain behavioral health services (96150-96155 codes – behavioral assessment and intervention with medically ill patients). The state of Arizona responded, however, that only persons enrolled with a RBHA and served by a clinician who is contracted with a RBHA can be reimbursed through the RBHA system. The result of this interpretation is that patients at FQHCs in Arizona qualify for mental health services when they are delivered as part of a treatment plan for a medical (physical health) diagnosis. When an FQHC refers a patient for specialty behavioral health services elsewhere, continuity of care can be challenged. This is especially true when the individual being referred either does not qualify for, or has been dropped from, AHCCCS benefits.

In September 2010, the USDHHS announced nearly \$100 million in grants under the new Prevention and Public Health Fund. These funds include more than \$20 million to help local behavioral health agencies integrate primary care into the mental health care they already provide, and another \$5 million to establish a national resource center dedicated to the integration of physical and mental health care. Receiving this support, however, does not always mean that the path is clear to implementing integrated services, especially in rural areas. Challenges involved to getting these grants up and running include:

- Profound shortages of qualified and certified behavioral health providers and primary care physicians in rural areas
- The task of assessing the training needs and readiness of the behavioral health professional and para-professional workforce
- The lack of medical care case management
- The complexity of implementing training to expand the skills set of behavioral health providers and primary care providers

The FQHC focus on management of chronic disease, such as diabetes, childhood obesity, asthma, and heart disease, and also on cancer screenings, offers a way to address more behavioral health issues. Patients who have chronic disease are at higher risk for depression, anxiety, and other mental health disorders. A behavioral health professional can help patients with their medical and behavioral health decision-making, leading to greater positive outcomes.

In 2010, the Milbank Memorial Fund commissioned a report entitled, *Evolving Models of Behavioral Health Integration in Primary Care*, which “summarizes the available evidence and states’ experiences around integration as a means for delivering quality, effective physical and mental health care” (Collins, Hewson, Munger, & Wade, 2010). Throughout the report, considerations related to different integration/coordination models are outlined and discussed. The following factors, paraphrased from the Milbank Memorial Fund report, are particularly important for increasing the integration of primary health and behavioral health care, and were corroborated in our interviews with key informants for this report.

1. Support (authority and resources) at the system level for integration
2. Organizational structure conducive to collaboration (practice size, staff accommodation, etc)
3. Facilitation of joint involvement in

“The way Arizona divides their money between physical and mental health goes against treating the whole person”



4. Recruitment, support, and supervision of staff willing and skilled to work in primary care and behavioral health
5. Communication systems such as regular meetings and the use of a common care plan
6. Guidelines that document crisis plans, referral protocols, and follow up arrangements
7. Feedback evidence about outcomes to service partners
8. Client involvement in care

Challenges to Integration

There are many compelling challenges to the integration of behavioral health services with primary care and to be successful, there must be careful planning that is inclusive of all stakeholders. Issues related to competition for resources, including both funding and workers, came out strongly in our key informant interviews. One key informant observed that these issues were at a tipping point due to the severity of the State’s economic woes.

There are turf wars. If you're the RBHA, you will say because of your funding stream that you are the entity that can make a difference by joining primary care. If you are the medical silo you're going to say "hell no I'm not sharing my money with the RBHA, we're going to figure this out on our own." Part of it is a turf war. Now, never in the history of the Arizona system has there been more interest in integrating behavioral health services and primary care. Part of that is due to serious economic duress. People are finally seeing that this might save us some money.

While all agree that it is important, establishing better continuity of care is also a major challenge to both behavioral health and physical health providers. While the structure of the funding for different services may be one of the root issues in achieving better continuity of care, it is too simplistic to blame it all on funding mechanisms. Other problems such as differences in licensure regulations, formularies, provider credentialing, mandated documentation regulations, and patient rights contribute to the difficulty.

The way that Arizona divides their money between physical health and mental health goes against treating the whole person. And it is really detrimental to health care in Arizona that we have two separate entities like that.

The key informants interviewed also frequently mentioned issues related to the comfort and culture of primary care and behavioral health care patients, as well as providers. For example, one key informant told us,

I think one thing that prohibits some of the very important work to be done with mental health or substance abuse problems within primary care is related to tradition. Our medical

providers who are traditionally trained...see those things as a Pandora's Box – questions that they don't necessarily want to ask because they're afraid of the answers.

I think there are cultural issues with using the mental health system, I really do. I think the mental health system is so ... stigmatized, and maybe that's across all cultures to some degrees. But I think that the Hispanic culture has a real view of that, (and) they're a little but more resistant to accepting that care.

The behavioral health system for American Indians in Arizona is complex and the array of services includes the State system, Indian Health System, and health care facilities that are owned and operated by tribes. There are valuable models for the integration of physical and mental health within the tribally focused system. One model of note is Gila River Health Care (GRHC), an independent, tribally-operated corporation which provides comprehensive health care services for the Gila River Indian Community, the Ak-Chin Indian Community, and other federally recognized tribes. In 2004, GRHC constructed a Behavioral Health Services Building for providing services as well as training for providers. GRHC's integrated, community-based model of health care delivery includes a high degree of electronic health record exchange between primary care, emergency, and behavioral health departments, as well as with any IHS facility in Arizona. This and other elements of GRHC's integrated model are credited with outcomes such as a TRBHA penetration rate of 32 percent prior to the new AHCCCS automatic enrollment process, and the TRBHA achievement of 55 consecutive months without a program enrollee suicide.

A significant challenge for Arizona lies in the State's budget cuts, which in 2010 dropped

approximately 2,000 children, and 8,000 adults off the AHCCCS rolls because of the loss of the program that insured the parents of children eligible for KidsCare (the State Children's Health Insurance Program) and the freeze on future KidsCare eligibility. Further reductions in eligibility are a possibility during the next legislative session. As these individuals attempt to access health care at the FQHCs, physicians will be strained to accommodate those with mental health and substance abuse disorders, as well as adapt to a client base where a greater percentage of individuals are going without their stabilizing psychiatric medications.

It is important to remember that primary care physicians have different levels of comfort and some may feel that psychiatric care is outside their scope of practice. As a result, patients with intensive psychiatric needs, or needing antipsychotic medications, may not be able to access care through a primary care physician. In contrast to the RBHA system, FQHCs and primary care providers are currently not funded to offer housing, advocacy, and case management. Meanwhile the RBHA system can identify but not treat common medical conditions. For example, RBHA psychiatrists are required to obtain labs that screen for diabetes, high cholesterol, and liver disease when starting medications, and then at least annually. Physical conditions discovered by the screening, however, are supposed to be handled by a referral to a primary care

physician, even though the behavioral health recipient may not have a PCP. One possible remedy to this issue of care coordination is that FQHCs may try to obtain an expansion grant from HRSA to job-share a psychiatrist and a physician with a RBHA provider. This type of collaboration would need to be carefully planned. Some models for this type of work are already being piloted in the northern area of the state.

References

- Colton, C.W. & Manderscheid, R.W., (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease*, 3. Retrieved December 28, 2010, from http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm.
- Gatchel, R.J., & Oordt, M.S. (2002). *Clinical Health Psychology and Primary Care*. Washington DC: American Psychological Association.
- HHS Press Office (2010, September 24). HHS awards nearly \$100 million in grants for public health and prevention priorities. Retrieved March 3, 2011, from <http://www.hhs.gov/news/press/2010pres/09/20100924a.html>
- Humble, W. (2010, July 20). Integrating physical & mental health. [Web log entry]. Retrieved March 3, 2011, from <http://directorsblog.health.azdhs.gov/?p=557>
- Humble, W. (2010, December 13). 2011 Department priorities spotlight - behavioral health. [Web log entry]. Retrieved March 3, 2011, from <http://directorsblog.health.azdhs.gov/?p=940>
- Milbank Memorial Fund. (2010). *Evolving models of behavioral health integration in primary care*. Retrieved March 3, 2011, from <http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf>.

SECTION 5: RECOMMENDATIONS

From the information and analysis in this review, it is possible to make some recommendations for improving the scope and delivery of behavioral health care to Arizona’s rural residents. Some of these recommendations require policy formation or change, some point out the need for additional study, and some advocate more education and training. Following are the recommendations in no particular order of importance.

Recommendation A: Developing Better Methods for Increasing Rural Behavioral Health Care Enrollment Penetration Rates

Current Status

Not all rural residents in Arizona who need behavioral health services and who are eligible to receive them through AHCCCS, actually receive them. Until October 1, 2010 the RHBA enrollment penetration rates for people receiving behavioral health services varied in rural counties from a low of around 5 percent to a high of around 12 percent. Yet studies estimate that approximately 20 percent of the rural population in the country requires behavioral health services. Even though, as of October 1, 2010, all persons enrolled in AHCCCS are now automatically enrolled in a T/RHBA, it cannot be assumed that all of these enrolled people are actually receiving behavioral health care services as needed.

Recommendations

1. Better methods must be developed to identify rural residents who are both eligible to receive public behavioral health care services and are in need of these services.
2. Arizona has a history of effectively utilizing Lay Community Health Workers or *Promotoras* for this type of work to increase the number of rural residents receiving primary care through AHCCCS. Therefore, it is recommended that the ADHS/DBHS require the T/RBHAs to employ and/or train more Lay Community Health Workers to identify rural residents eligible for, and in need of, behavioral health services. The

T/RBHAs already utilize community-based peers as Recovery Support Specialists, which is an evidence-based practice that could be used, with appropriate modifications, to increase their rural outreach efforts to those who qualify for AHCCCS and need behavioral health care services.

3. Other pilot projects to increase the delivery of behavioral health care services to those rural residents in need should be developed, evaluated, and shared amongst the T/RBHAs. One suggestion for such a pilot project would be to develop programs for addressing the stigma and lack of anonymity associated with accessing behavioral health services in small rural communities.

Recommendation B: Creating a Culturally Relevant Approach to the Integration of Behavioral and Physical Health

Current Status

The State of Arizona is poised to make improved integration and coordination in physical health and behavioral health a state healthcare priority. This turning point is in part driven, and made more complex, by the higher morbidity and mortality rates that are associated with mental illness, as well as the access-to-care challenges faced by rural, border, and tribal communities. Morbidity and mortality in mentally ill people are largely due to preventable medical conditions and modifiable risk factors. There are multiple motivations for, as well as challenges to, establishing a seamless continuum between primary care and behavioral health.

Recommendations

1. It is critical that rural stakeholders are included in the conversation and planning for systemic changes intended to integrate physical health and behavioral health care. Building relationships through inclusive dialog, workshops and conferences, and policy discussions will help ensure that the solutions are relevant and workable for Arizona's diverse rural communities.
2. Flexibility in the implementation of integration is key for rural communities. There are many points along a continuum of collaborative, team-based care that are workable and economically feasible.
3. Given the nationwide mandate for the implementation of electronic health records, it is critical that any system adopted in Arizona must be seamless between primary care and behavioral health care.
4. Arizona must continue to support greater education and advocacy efforts around integrated health for rural residents. These efforts must involve policymakers, funders, the healthcare community, consumers, and family members.
5. AHCCCS and ADHS/DBHS need to work together to decrease barriers to partnerships between RBHAs and FQCHCs in order to leverage the state's scarce resources and serve the greatest number of rural residents in need.

Recommendation C: Addressing Rural Behavioral Health Workforce Issues

Current Status

Throughout the course of the interviews for this review, challenges facing the rural behavioral health workforce emerged as an overriding theme. While recruiting and retaining a strong workforce can be difficult

in both rural and urban behavioral health settings, key informants stated that workers in Arizona's rural areas are further challenged by lower remuneration, less desirable housing stock, large caseloads, long distances, and fewer colleagues to turn to for support.

Recommendations

1. Retention of rural behavioral health workers across all levels of staffing is important to the quality of care received by behavioral health recipients. The ADHS should create contractual incentives for the RBHAs to increase staff retention at their provider agencies. This will allow the RBHAs and providers the flexibility to determine, on their own, how to best accomplish this goal.
2. Mental Health Professional Shortage Areas exist across the state, allowing rural agencies to access federal dollars to help recruit providers. The ADHS/DBHS should help these rural agencies to identify and obtain the funds needed to strengthen the workforce.
3. The large amount of federal funds currently available to FQCHCs can help increase the number of licensed behavioral health workers in the state's rural areas served by such clinics. The ADHS/DBHS should work with the FQCHCs to develop methods to increase the licensed behavioral healthcare workforce in Arizona.

Recommendation D: Improving the Transfer of RBHA Management of GSAs

Current Status

Anecdotal reports from GSA 3 and the history of the GSA 6 switches suggests that RBHA changeovers are extremely disruptive to both behavioral health recipients and providers. Given the fact that every RBHA contract is up for bid every three years with an option to renew

up to five years, such changeovers are inevitable and need better management.

Recommendations

1. ADHS/DBHS should conduct a study of the recent RBHA transition in GSA 3 to learn about disruptive impacts. Such a study could be conducted at minimal cost by utilizing master and doctoral level students at The University of Arizona, Mel and Enid Zuckerman College of Public Health.
2. The study should be used to inform the development of RBHA transfer protocols that would guide future changeovers and reduce disruptions to service provision.

Recommendation E: Addressing the Continuing State Budget Reductions

Current Status

Arizona is experiencing an unprecedented fiscal crisis that has already led to a 47 percent decrease in the overall ADHS/DBHS budget. These cuts have also had the effect of shifting responsibility for the mentally ill from the state, in the form of treatment and supportive services, to the counties, in the form of jails, and emergency rooms. Rural hospitals, justice systems, and counties are even less equipped than Pima and Maricopa Counties to absorb these costs. Given that rural areas already faced substantial challenges in the form of transportation and lack of housing/support services, the state must take a more measured approach with its next round of cuts. Arizona is in danger of reversing course in its commitment to serving residents with a mental health diagnosis in the community. The current trend could lead to warehousing mentally ill individuals in settings less able to appropriately address their behavioral health needs.

Recommendations

1. The Arizona Legislature should not enact across the board behavioral health cuts that

will disproportionately impact services to rural behavioral health recipients. Services, such as transportation, may appear non-critical but are vital to the provision of services to isolated rural populations.

2. In order to better identify the most efficient services in light of funding challenges, the ADHS/DBHS should conduct impact and cost-effectiveness studies.

Recommendation F: Coordinating Prevention Efforts Statewide

Current Status

There are many agencies both at the state and local levels involved in prevention efforts around substance abuse, suicide, sexual and domestic violence, and early identification of developmental delays among children. The plethora of agencies and community coalitions involved in these efforts is on the one hand to be applauded, but on the other hand makes coordination of efforts difficult.

Recommendations

1. A study should be done to identify all the rural prevention agencies and coalitions in the state and determine the name(s) for each, full contact information, membership, mission, and current activities and programs being supported.
2. This study should be co-sponsored by the ADHS/DBHS, ASAP, DES, DOE, and the ADHS/Office of Women's and Children's Health. The initial study could be accomplished with a small amount of funding by utilizing one or more Master of Public Health interns from The University of Arizona, Mel & Enid Zuckerman College of Public Health.
3. Posting of the information on a website and annual maintenance of current information should be done by the above agencies.

Recommendation G: Increasing Quality and Evaluation of Rural Health Prevention Programs

Current Status

While the ADHS/DBHS has specific requirements for the evaluation of prevention programs that are funded through the T/RHBAs, there are many prevention programs conducted in rural communities by other agencies and coalitions that are not adequately evaluated. This is often due to the fact that these projects are never funded amply enough and the first aspect of the project to be sacrificed is evaluation. Unfortunately, this can result in the waste of funds on projects that are not achieving prevention or the desired changes in behavior.

Recommendations

1. ASAP should employ a variety of strategies to encourage prevention programs that utilize an integrated model of dealing with the whole person, the family, and the community.
2. In collaboration with The University of Arizona, Rural Health Office and Mel & Enid Zuckerman College of Public health, ASAP should begin a strong program evaluation initiative that provides training for rural prevention agencies and coalitions about the vital need for evaluation; the necessity for incorporating evaluation planning at the beginning of planning any project – not at the end; how and where to obtain help with evaluation questions, planning, and implementation; and ways in which to accomplish thorough, but inexpensive, prevention program evaluation activities.
3. This training should be conducted in different rural areas of the state, as well as by webinar.

4. A portion of the ASAP website should also be devoted to providing the evaluation information given in the training sessions.

Recommendation H: Increasing Behavioral Health Residential Treatment Facilities in Rural Arizona

Current Status

There are insufficient behavioral health residential treatment facilities in rural Arizona for rural adults, practically none for rural youth, and those that do exist are only for the treatment of substance abuse. While Arizona's focus on having children receive community and home-based services is to be commended, choosing to treat complex substance abuse issues in this way may not take into the account all of the challenges faced by rural families. It could be an example of an urban solution resulting in a smaller, under-resourced rural version of an urban program that does not adequately account for rural realities.

Recommendations

1. A study should be done by ADHS/DBHS to identify the strengths and challenges within rural families related to meeting the demands and pressures placed on them by the expectation that rural substance abusing youth or adults can be treated in their homes.
2. Results of the study should lead to a determination of different and/or additional support that may be needed by rural families, as compared to urban families. Such support might include some short-term residential facilities or in-home care available to provide respite to rural families dealing with the treatment of a substance abusing youth or adult in the home.

Recommendation I: Providing Leadership and Developing Policies for Improved Rural Behavioral Health Care in Arizona

Current Status

The challenges to providing an adequate amount and scope of rural behavioral health have remained constant over the past 20 years. Mounting needs, rural issues of stigma, diverse language/culture, lack of adequate transportation and low socioeconomic status, a lack of available behavioral health providers, and restricted/limited resources strain existing services and limit access to rural residents in need. Only policies aimed at resolving the large array of issues that have caused these long-standing challenges can make any headway toward terminating them.

Recommendations

1. Leadership is critically needed in Arizona to develop comprehensive policies that: a)

adequately account for rural realities regarding access to behavioral health care, b) do not result in smaller, under-resourced versions of urban programs, and c) do not perpetuate the tendency to seek single policy solutions to the panoply of issues that surround the provision of quality behavioral health for America's rural residents.

2. A major collaborative effort needs to take place to develop a long-term strategic plan for rural behavioral health with key targets and outcomes that set direction, regardless of leadership change at the state level.
3. The Arizona Rural Health Office is ready to provide this leadership on behalf of Arizona's rural residents, and invites all who wish to participate in this effort to join us. We will begin by distributing this report to numerous agencies, organizations, and people who we hope will join us in our endeavors.

BIBLIOGRAPHY

- Arizona Criminal Justice Commission. (n.d.). *Arizona Community Data Project*. Available from <http://www.bach-harrison.com/arizonadataproject/Default.aspx>
- Arizona Department of Health Services. (2010, August 30). *2011 Annual Network Development and Management Plan*. Available from http://www.azdhs.gov/bhs/pdf/plans/2011_Annual%20Network%20%20Management%20Plan.pdf
- Arizona Department of Health Services. (2010, December 31). *Annual report on substance abuse treatment programs*. Available from http://www.azdhs.gov/bhs/pdf/FY10_SA_PROG_FINAL.pdf
- Arizona Department of Health Services. (n.d.). *Arizona Vision*. Available from <http://www.azdhs.gov/bhs/principles.pdf>
- Arizona Department of Health Services. (2010). *Contractor Annual Audited Financial Reports*. Available from <http://www.azdhs.gov/bhs/finance/reports/annual.htm>
- Arizona Department of Health Services. (n.d.). *Division of Behavioral Health Services funding at a glance*. Available from <http://www.azdhs.gov/bhs/updates/BHSFundingInfo.htm>
- Arizona Department of Health Services. (n.d.). *Domestic Violence services*. Available from <http://www.azdhs.gov/phs/owch/domviolence.htm>
- Arizona Department of Health Services. (2010, October). *Enrollment-penetration report*. Available from http://www.azdhs.gov/bhs/pdf/enroll_pen/Enrollment_Penetraton_2008_2010SFY_201009.pdf
- Arizona Department of Health Services. (2010). *FY 2010 Capitation Rates*. Available from <http://www.azdhs.gov/bhs/pdf/>
- ADHSDBHSFY2010CapitationRates.pdf
- Arizona Department of Health Services. (2010, May 26). *FY 2010 PATH Application*. Available from <http://www.azdhs.gov/bhs/pdf/Final%20Application%20to%20Feds%205.27.2010.pdf>
- Arizona Department of Health Services. (n.d.). *Guiding principles for recovery-oriented adult behavioral health services and systems*. Available from <http://www.azdhs.gov/bhs/pdf/Adult%20Guiding%20Principles.pdf>
- Arizona Department of Health Services. (n.d.). *History of Arizona State Hospital*. Available from <http://www.azdhs.gov/azsh/history.htm>
- Arizona Department of Health Services. (2010, March 12). *Letter regarding Arnold v. Sarn lawsuit from Arizona Department of Health Services/Division of Behavioral Health Services Director Laura Nelson*. Available from <http://www.azdhs.gov/bhs/pdf/3-12-10%20stakeholder%20letter.pdf>
- Arizona Department of Health Services. (2010, September 13). *News release: Behavioral health services contract to start Dec. 1st*. Available from http://azdhs.gov/news/2010-All/20100913%20GSA_3_agreement.pdf
- Arizona Department of Health Services. (2010, May 10). *News Release: New Guidance for Behavioral Health Services Released; ADHS Collaborates With Regional Behavioral Health Authorities*. Available from <http://www.azdhs.gov/news/2010-All/100510%20Joint%20News%20Release.pdf>
- Arizona Department of Health Services. (2010, August 31). *State plan: Community mental health services block grant*. Available from <http://www.azdhs.gov/bhs/pdf/CMHS%20Arizona.pdf>
- Arizona Department of Health Services. (2010, September 30). *Substance abuse prevention and treatment block grant*. Available from http://www.azdhs.gov/bhs/pdf/FY2011_SAPT_Final.pdf
- Arizona Department of Health Services. (2009, October 8). *System of Care Network Development and Management Plan*. Available from http://www.azdhs.gov/bhs/ntwrk_plan.pdf
- Arizona Governor's Office for Children, Youth and Families. (2008, April). *Substance Abuse Treatment Services Capacity Report*. Available from <http://gocyf.az.gov/SAP/documents/SubstanceAbuseTreatmentServicesCapacityAssessment.pdf>
- Arizona Rural Health Office. (2010, December). *Cochise County Rural Health Policy Assembly*. Available from <http://www.rho.arizona.edu/Publications/Documents/CochiseCountyAssemblyFinalReport.pdf>
- Arizona State Legislature. (n.d.). Arizona Revised Statute 36-550.01: Statewide plan for community residential treatment. Available from <http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/36/00550-01.htm&Title=36&DocType=ARS>
- Arizona Substance Abuse Partnership. (2010, March 13). 2010 Strategic plan. Available from <http://gocyf.az.gov/SAP/documents/ASAP/ASAPEABPlanning2010TPR.pdf>
- Bazelon Center for Mental Health Law. (n.d.). *History of J.K. v. Humble case*. Available from <http://www.bazelon.org/In-Court/Current-Cases/J.K.-v-Humble.aspx>
- Cenpatico of Arizona. (n.d.). Available

- from http://www.cenpaticoaz.com/dbhsmmessage_072110p28.pdf
- Governor's Office for Children, Youth and Families. (n.d.). *Arizona Substance Abuse Partnership*. Available from http://gocyf.az.gov/SAP/BRD_ASAP.asp.
- Humble, W. (2010, May 14). Proposition 100. [Web log entry]. Available from <http://directorsblog.health.azdhs.gov/?p=282>
- Nelson, L. (2009, February 4). ADHS/DBHS Presentation to Joint Meeting of Senate Committee on Healthcare and Medical Liability Reform and House Committee on Health and Human Services. Available from www.azfbh.org/files/FINAL_presentation_2-5-09.ppt
- Nelson, L. (2010, July 21). Letter from Arizona Department of Health Services/Division of Behavioral Health Director Laura Nelson. Available from <http://www.azdhs.gov/bhs/updates/documents/msg/span/>
- Newton, C. (2009, March 12). Arizona's mental health system gets a C. *The Arizona Republic*. Available from <http://www.azcentral.com/news/articles/2009/03/12/20090312mentalhealth0312.html>
- Newton, C. (2009, August 30). County's mental health system failing. *The Arizona Republic*. Available from <http://www.azcentral.com/arizonarepublic/news/articles/2009/08/30/20090830mentalhealth0830.html>
- Northern Arizona Regional Behavioral Health Authority. (n.d.). Available from <http://www.narbha.org>
- Recovery Innovations (n.d.). History. Available from <http://www.recoveryinnovations.org/history.html>
- Southeastern Arizona Behavioral Health Services. (n.d.). Available from <http://www.seabhs.org>
- St. Luke's Health Initiatives. (1999, December). *Into the light, vol. 1*. Available from <http://www.slhi.org/IntoTheLight/Volume%20I/behavioral-main.html>
- St. Luke's Health Initiatives. (1999, December). *Into the light, vol. 2*. Available from <http://www.slhi.org/IntoTheLight/Volume%20II/volume2-main.html>
- St. Luke's Health Initiatives. (2003, January). *The Humpty Dumpty Syndrome: Integration and Behavioral Health*. Available from http://www.slhi.org/publications/issue_briefs/pdfs/ib-03winter.pdf
- U.S. Department of Health and Human Services. (2010, September 24). HHS awards nearly \$100 million in grants for public health and prevention priorities. Available from <http://www.hhs.gov/news/press/2010pres/09/20100924a.html>

APPENDIX A

The Arizona Rural Health Office would like to offer its thanks to Kirsten Yaffe, Agnes Attaki, and Elizabeth Ferris Costello for their help with the development of this document. We also must thank the key informants and reviewers who generously offered their time and valuable knowledge to help inform the review:

Key Informants:

Deanna Bellinger

National Alliance on Mental Illness
(Southeastern Arizona)

Teresa Bertsch

Northern Arizona Regional Behavioral
Health Authority

Becky Howard

Arizona Association of Community Health
Centers

Emily Jenkins

Arizona Council of Human Service Providers

Briana Kreibich

Division of Substance Abuse Policy, Governor's
Office for Children, Youth and Families

Brian Lensink

Children's System of Care, Planning and
Development, ADHS/DBHS

Tammany McDaniel

Community Initiatives, Arizona Youth
Partnership (Mohave County)

Vanessa Seaney

Community Partnership of Southern Arizona

Lisa Shumaker

Office of Prevention Services, ADHS/DBHS

Fred Trost

National Alliance on Mental Illness (Yavapai
County)

Cheri Wells

Northern Arizona Regional Behavioral
Health Authority

Behavioral Health Providers at six Arizona Community Health Centers (group interview)

Kevin Heaton (North Country Healthcare),
Michael Dattola (El Rio Health Center), Joanne
Sorenson (Marana Health Center), Bill Rosenfeld
(Mountain Park Health Center, Patricia Bruce
(United Community Health Center), and Dennis
Huff (Native Health)

Reviewers:

Stephen Michael

Arizona Smokers'
Helpline

Jeanne Blackburn

Arizona Substance
Abuse Partnership

Jack Beveridge

EMSYS, Inc.

Laura Nelson

ADHS/DBHS

APPENDIX B

Availability of Adult Substance Abuse Treatment Services in Arizona Counties in Geographic Service Areas (GSA)												
	Outpatient Clinics		Specialty Providers		Residential Substance Abuse Beds		Detox Inpatient Beds		Detox Sub-Acute Beds		Stabilization Services	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
State Total	471	n/a	198	74	782	560	294	165	148	132	40	90
GSA 1												
Mohave	6	n/a	5	0	0	0	0	0	10	16	0	0
Yavapai	15	n/a	10	5	22	38	0	16	14	16	0	0
Coconino	13	n/a	6	6	16	16	39	16	0	0	24	24
Navajo	8	n/a	7	1	0	0	0	0	4	12	0	32
Apache	2	n/a	3	0	0	0	0	0	0	0	0	0
GSA 1 Total	44	n/a	31	12	38	54	39	32	28	44	24	56
GSA 2												
Yuma	4	n/a	11	5	12	12	0	0	16	16	16	16
La Paz	0	n/a	1	0	0	0	0	0	0	0	0	0
GSA 2 Total	4	n/a	12	5	12	12	0	0	16	16	16	16
GSA 3												
Greenlee	1	n/a	0	0	0	0	0	0	0	0	0	0
Graham	2	n/a	1	0	0	0	0	0	0	0	0	0
Cochise	13	n/a	4	2	30	12	0	0	16	3	0	0
Santa Cruz	2	n/a	5	0	0	0	0	0	0	0	0	0
GSA 3 Total	18	n/a	10	2	30	12	0	0	16	3	0	0
GSA 4												
Gila	13	n/a	8	1	8	8	0	0	0	0	0	18
Pinal	52	n/a	34	6	18	18	10	10	14	14	0	0
GSA 4 Total	65	n/a	42	7	26	26	10	10	14	14	0	18
GSA 5												
Pima	76	n/a	53	15	521	294	225	62	36	16	0	0
GSA 6												
Maricopa	264	n/a	50	33	155	162	20	61	38	39	0	0

**Availability of Youth Substance Abuse Treatment Services
in Arizona Counties in Geographic Service Areas (GSA)**

	General Outpatient		Intensive Outpatient		Residential Substance Abuse Facilities	
	2008	2009	2008	2009	2008	2009
State Total	36	51	22	16	51	13
GSA 1						
Mohave	1	1	1	1	1	0
Yavapai	3	3	1	1	4	1
Coconino	1	3	1	1	1	0
Navajo	1	0	1	2	0	0
Apache	0	1	0	0	0	0
GSA 1 Total	6	8	4	5	6	1
GSA 2						
Yuma	3	4	1	2	0	0
La Paz	1	0	0	0	0	0
GSA 2 Total	4	4	1	2	0	0
GSA 3						
Greenlee	0	0	1	0	0	0
Graham	1	0	1	0	0	0
Cochise	5	3	1	0	3	0
Santa Cruz	1	1	1	0	0	0
GSA 3 Total	7	4	4	0	3	0
GSA 4						
Gila	1	3	0	0	0	0
Pinal	6	7	3	0	4	2
GSA 4 Total	7	10	3	0	4	2
GSA 5						
Pima	2	11	5	3	19	2
GSA 6						
Maricopa	10	14	5	6	19	9

A publication of the
Arizona Rural Health Office
Mel And Enid Zuckerman College of Public Health
The University of Arizona

•••

1295 N. Martin Ave.
P.O. Box 245177
Tucson, AZ 85724-5117
(520) 626-5823
www.rho.arizona.edu



THE UNIVERSITY OF ARIZONA.