202 E. MCDOWELL RD., SUITE 153
PHOENIX, ARIZONA 85004
(602) 258-8850
(602) 258-8757 (FAX)
WWW.ACLPI.ORG

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Mr. Robert J. Sorce
Attorney General's Office
1275 West Washington
Phoenix, Arizona 85007-2926

Logan T. Johnston
Johnston Law Offices, PLC
One North First Street, Suite 250
Phoenix, Arizona 85012

Re: DHS Three-Year Plan

Dear Bob and Logan:

At the close of mediation the Plaintiffs agreed to provide the Defendants with their concerns with the Three Year Plan. We write to renew our concerns with those sections in the DHS Three-Year Plan that address matters that Plaintiffs view as critical to the implementation of the Defendants' obligations under the Settlement Agreement. We apologize for sending this so close to our scheduled meeting but delayed in order to incorporate some of the critical information which we received late last week concerning increases in case management and direct supports.

Background

In Plaintiffs' view, Defendants have not moved with dispatch to develop the system of services required by the Settlement Agreement. The current Three-Year Plan raises many of the concerns previously expressed both with strategies and pace.

In December of 2005, Plaintiffs met with BHS and shared with them a draft of our letter invoking the dispute resolution provisions of the Settlement Agreement. To get *J.K.* implementation on track, Plaintiffs asked the State to develop an implementation plan agreeable to Plaintiffs and also extend by at least three years the term of the Settlement Agreement. The three year extension, coupled with a meaningful implementation plan, was intended to place Plaintiffs in the same position they would have been had Defendants moved "as quickly as practicable" to develop the system required by the Settlement.

As required by the Settlement Agreement, the parties entered mediation, eventually producing an agreement memorialized in an exchange of letters. Pursuant to the agreement, a team of BHS staff met intensively with Plaintiffs and family organizations in April-June 2006 to develop an implementation plan. In early June, the team produced a draft plan. Ultimately, the proposed plan was not accepted by DHS leadership. Mediation was tried again and Defendants agreed to a three-year extension of their obligations under the Settlement Agreement. The parties also exchanged views about a draft DHS Three-Year Plan shared with Plaintiffs.

The DHS Three Year Plan

While it has positive features, the DHS Three-Year Plan is not adequate to ensure compliance with the Settlement Agreement. An implementation plan should describe: an approach to implementation that is likely to succeed, the actual steps that will be taken, the dates by which these steps will be completed, and an effective approach to holding responsible parties accountable for implementing the plan.

The DHS Three-Year Plan is an improvement over previous annual action plans. It includes a number of specific strategies and deadlines that, if properly implemented, will promote the system's fidelity to the Principles. It requires that a system be created for evaluating the fidelity of practice to the Principles and that direct supports be expanded. However, in places instead of identifying effective solutions to problems that have long plagued the system, it identifies a process by which solutions will be developed, or it relies on approaches that are plainly inadequate to bring about needed reforms.

We recently set out our concerns about the State's plan for creating a system for evaluating the fidelity of practice to *JK* Principles (at the parties' February 2007 meeting and in a February 12, 2007 letter). We also recently described our concerns about the State's plan for expanding direct supports (in a March 21 letter). In both areas, we continue to be concerned by the pace of the State's efforts and the substance of its plan. In addition, it is of concern that at this late date Defendants still lack basic information required to move forward, for example, the number of children with high needs, and the availability of, and scope of the need for, direct supports.

Below, we set out concerns about the State's plan for building other core elements of the service system required by the Settlement Agreement.

Accountability

To date, the State has not imposed a performance expectation that children be served according to the Principles. By performance expectation, we mean an expectation that has teeth. A RBHA or provider that meets the expectation is rewarded, and one that fails to meet the expectation suffers consequences.

One reason for this failure is DHS' restricted view of its authority under existing contracts to enforce an expectation of *JK* compliance. Another reason is that the State lacks essential tools for holding RBHAs and providers accountable: a process for evaluating whether children are being served according to the Principles, and a comprehensive implementation plan that specifies the steps RBHAs and providers will take, and by when, to transform themselves into agencies that are capable of serving, and that actually serve, children according to the Principles.

There will not be compliance with the Settlement Agreement until this situation changes. To secure compliance, the State must establish an enforceable expectation that RBHAs and providers will serve children according to the Principles. This expectation could be phased in over a period of years. For example, the State could require that by December 31, 2007, 60% of children will be so served, and that by December 31, 2008, 80% of children will be so served.

According to the DHS Three Year Plan, BHS will "incorporate additional requirements into T/RBHA contracts including incentives and penalties for performance based on minimum performance expectations and benchmarks" in July 2007 (goal 2.3.1) and will "determine the appropriate course of action" for RBHAs not making "adequate" progress in October 2007(goal 2.3.3). Appropriate actions might include improvement plans, corrective action plans, and notice to cure and/or sanction. The process will be repeated in later years.

This plan is sound as far as it goes. However, the plan makes no commitment to including among the "additional requirements" that will be incorporated into contracts and expectation that children will be served according to the Principles, and Defendants have repeatedly expressed discomfort with doing so. Indeed, the plan gives no hint of what performance the State would consider "adequate" five years into the Settlement, or what performance it will consider "adequate" when October 2007 arrives. Moreover, while the State recognized the need to impose "additional"

requirements when it issued its Three-Year Plan in the summer of 2006, under the Plan "additional" requirements will not be imposed until July 2007 at the earliest.

Finally, we urge the State to take swift and decisive action in the face of poor performance. For too long, the State has tolerated RBHAs inattention to, *inter alia*, developing direct supports, case management services, and competent clinical services. In these and other recognized areas of deficiency, the State should be developing performance improvement plans with RBHAs *now,* providing technical assistance and tight oversight.

Case Management

There continues to be too few case managers, and too little case management services, to allow for the delivery of services according to the Principles.

After negotiations with Plaintiffs, Defendants announced their intention to ensure that by December 31, 2008, all children with high needs would have a case manager (and the case manager's only job would be case management). We applaud the State's embrace of this reform. We also applaud Defendants' efforts to identify which children will be considered "high need." We are in agreement with Defendants that the following children should be considered high need: children who have been in a Level I, II, or III placement; children referred by child welfare or juvenile justice for mental health services; children at risk of placement in a Level I, II, or III placement; children on parole or probation; children receiving special education; and children on whom at least $5,000 has been spent by the behavioral health system. The State may want to also include children who score over certain thresholds in particular assessments, for example, on the CANS.

The State also plans to establish caseload standards for case managers serving high need children. We have long urged this step. Case managers cannot do their job unless their caseloads are controlled. Consistent with national standards, we have proposed an average case load of 12 to 15 cases for case managers serving high need children. We understand that in its recent proposal to the legislature the State reported that its research supports case loads of no larger than 12 to 15 and that current case loads are much higher.

Our understanding is that the State estimates approximately one-third of class members have high needs. We agree with this assessment and that assigning them

case managers should be a high priority. We are concerned that in its presentation to the legislature it estimates that if the requested rate increases are approved they will only provide case managers with low case loads to 4% of the children served.

The State must also make it a priority to provide needed case management services to all children, including those who may not be high need. To date, the State has failed to develop an effective approach to meeting the case management needs of children who are not high need.

The plan developed last spring by the BHS team with whom Plaintiffs and family organizations met addressed case management. We urge the State to implement its recommendations that:

- Beginning in July 2006, contracts be amended to require 35% of all children be assigned a case manager. The 35% of class members assigned case managers would be those with the highest needs.

- In the next fiscal year, children entering the system be assigned a case manager who would follow them through the intake process and become their case manager on an ongoing basis, unless they were high needs, in which case they would be assigned to a high needs caseload.

- Thereafter, all children in the system have a case manager.

- ADHS replace the Clinical Liaison system with (a) behavioral health case managers and (b) a network of clinical consultants providing clinical support to child and family teams.

- ADHS move toward using free standing case management agencies, according to steps outlined in the plan.

In implementing the above, the State should continue to expand case management services until (a) the supply of case managers satisfies the demand from child and family teams and (b) practice reviews, including in depth reviews, indicate that children are receiving the case management services they need.

18-21 Year Olds

There are an estimated 6,000 class members aged 18 to 21. These youth face several critical problems. Youth may be dropped from services when they reach the age of 18, despite their still being eligible for services under the Settlement Agreement and EPSDT. If enrolled in the adult system, they are often not served according to the Principles. Among other reasons, the adult system lacks services these youth require.

The State developed a "practice improvement protocol" for serving 18 to 21 year olds, which it recently updated. However, it has done little to ensure its implementation or that youth aged 18 to 21 receive the benefits of the Settlement.

The DHS Three Year Plan provides for training and technical assistance on the protocol, measuring compliance with the protocol (although not until January 2008), reviews of the fidelity of practice to the Principles for 18 to 21 years olds (although not until July 2008), improving employment and housing services for this population (although not until mid and late 2008), and improving training for therapeutic foster parents. (Goal 3). While positive steps, they are unlikely to ensure compliance with the Settlement Agreement in a timely manner.

To achieve compliance, the State must create an enforceable performance expectation in the children's and adult systems that youth aged 18 to 21 will be served according to the Principles, and then hold RBHAs accountable. Moreover, to address transition issues consistent with the Settlement Agreement:

- The State should allow 18-21 year olds to keep their child and family team, facilitated by the children's system. The team would decide when, between the ages of 18-21, the youth would transition into the adult system.

- The adult system should have dedicated, trained case managers for youth transitioning into the adult system.

- Case loads for staff working with this age group should be lowered to allow them to effectively work on housing, employment/education, and benefits.

- These youth should be able to access services from the children's and adult systems.

- Transition planning for youth in foster care should include a focus on finding family.

Intake and Initial Assessment

The *JK* Principles require that the child and family team conduct the assessment and develop the service plan. The current intake process does not allow this. It was not developed to comply with *JK*, and while there have been significant efforts to harmonize the policy with the Principles, ultimately this effort has failed. All too often, the 30-day assessment is performed by someone outside the team, a service plan is developed without a team being formed, and/or a clinician outside the team dictates the initial service plan.

Our understanding is that the State is planning to correct this problem by, *inter alia*, adopting a new intake policy by October 2007. While Anne has not been included in this work group, she reports that the group seems to be working toward a new policy that will ensure the initial assessment is performed by the team and is of quality. We have some concerns that the substance of the group's recommendations may not survive the many levels of review called for by the Three-Year Plan.

Substance Abuse Treatment

As the State knows, there has long been inadequate substance abuse services for children. The problem is two-fold. There is too little capacity, and many of the existing providers deliver services in archaic and ineffective ways. Little has been done to assure that substance abuse providers practice according to the Principles or comply with the Substance Abuse Treatment Practice Protocol.

We support the State's long overdue plan to identify existing capacity and the ways in which it fails to meet children's needs. We also support including expectations for substance abuse services in contracts. We are unclear, however, on what expectations the State plans to include and whether they will meaningfully address the problems identified above, including by shifting funding from ineffective services to effective ones. There must be an aggressive effort to reach, assess and treat children with substance abuse issues.

Also, consistent with SAMHSA' consensus document, we urge the State to revise the Substance Abuse Treatment Practice protocol to emphasize direct supports

as essential to effective substance abuse treatment for children. This might be done in the planned updating in May 2007.

Clinical Expertise

The children's system lacks a sufficient number of clinicians with appropriate expertise, including in the treatment of high need children such as children with challenging behaviors including maladaptive sexual behaviors, substance abuse issues, or an intellectual disability.

The State made some progress by developing practice improvement protocols, but it has done little to ensure that RBHAs and providers improve clinical expertise through recruitment and/or training. Clinicians continue to pursue ineffective approaches to trauma (including abuse and neglect), runaway behavior, substance abuse, sexual issues, and children with intellectual deficits.

One strategy that Plaintiffs have consistently urged is requiring RBHAs and providers to strategically employ skilled clinicians for maximum effect, for example, by deploying them to clinically supervise case managers and direct supports and to consult with child and family teams on special populations.

The DHS Three-Year Plan indicates that the State will revise existing practice protocols in some areas and issue new ones. Additionally, the State will "[p]rovide technical assistance as needed ... for special children's populations, including child welfare involvement, substance abuse problems, children birth to five, developmental disabilities, and juvenile justice involvement." While positive steps, these strategies have not been successful in the past in fixing the problem. In our view, stronger medicine is required.

The State should establish, and hold RBHAs and providers to, a performance expectation that they will have a sufficient number of clinicians with expertise in serving high need children, and should require measurable increases in the number of such clinicians. Furthermore, the issue of clinical expertise should receive attention in practice reviews.

Reducing Congregate Care

The State spends a disproportionate amount of money on congregate care[1] for a relatively small number of children. These children could be better served in family settings at far less cost. The money saved could be reinvested in expanding direct supports, home-based respite, and therapeutic foster care.

We have urged that the RBHAs be required to undertake a focused effort to avoid placement in congregate facilities and to facilitate discharge of children already placed. We commend to you the plan developed by the BHS team with whom Plaintiffs and family organizations met last spring. Under that plan, the State would:

- Require RBHAs to reduce both the number of children in congregate facilities and children's length of stay.

- Tighten the authorization process, and prohibit placement of children under the age of 12.

- Ensure rapid intervention with child and family teams requesting congregate care, including working with the team to develop alternatives.

- Have sufficient crisis stabilization teams, similar to the CPS Stabilization Teams and Special Assistance Teams, that would target children at risk of placement in congregate care, including users of the crisis system and children for whom congregate care has been requested.

- Establish a very short term congregate care option, available if necessary to provide a reprieve and to reinvigorate the child and family team's efforts to develop a supportive plan for the child to remain in the community. The option could be fashioned after Maricopa's Group Home Without Walls or Tucson's Sendaro.

The most positive aspect of the Three-Year Plan is its call for setting utilization thresholds for congregate care. If the thresholds are rigorous, this could have far reaching impact. No thresholds have been set to date. However, the State has revised

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[1] RTCs and Level II & III facilities.

its prior authorization criteria. If it is enforced, the policy should make a difference in both the number of children approved for placement and the length of stay.

Other aspects of the plan, while beneficial, are unlikely to have similar impact. For example, "monitoring" the causes of over utilization will be helpful assuming there is clarity on what will be monitored, but must be followed by action. (To us, it seems pretty clear that the root causes of over utilization are tied to inadequate case management and direct supports). Increased collaboration with and education of DES and other stakeholders will help, but not necessarily lead to needed change. Revising the Out of Home Care Services Practice Protocol and developing a protocol on positive behavioral support and functional behavioral analysis will help if these protocols represent enforceable expectations to which RBHAs are held accountable. While the plan does not call for the revised protocol to be completed until March 2008, we understand that the Department is currently circulating a revision for comments. We have reviewed the revised protocol and, if it's enforced, it should make a difference.

Financial Incentives

Providers continue to insist that the State and RBHAs don't give them the money they need to serve children according to the Principles. The State has long said the opposite. We have urged the State to collaborate with providers to identify and address the financial concerns they repeatedly assert. The cap increase that BHS is requesting should ease this process.

If providers have sufficient funding to do their job, then it seems pretty clear that financial incentives in the system need to be realigned. The DHS Three-Year Plan calls for developing by July 2007 "a strategy to offer incentives for best/promising practice and Practice Protocol implementation." This is a step in the right direction.

Children With Less Complex Needs

Defendants have not had a clear vision for how to serve children with less complex needs, which has resulted in confusion and worse among RBHAs and providers.

The DHS Three-Year Plan calls for "clarification regarding team composition for children with complex behavioral health needs vs. children with lower behavioral health needs." This is a useful start, but a clear vision for serving children with

complex needs must go beyond the composition of child and family teams. There must be clarity, among other things, on how the child and family team process works and the Principles implemented for children with varying degrees of need, including the case management services to be provided children identified as having less complex needs. We suggest the State: (a) develop a protocol for regularly checking in with families with children identified as having less complex needs and for elevating services when needs increase, and (b) clarify that all children will be served by a case manager and establish case load standards for case managers serving children with less complex needs.

Training

An effective training program is essential to the success of *JK* implementation. A lot of money has been spent on training, and a lot of training activity has gone on, but it has not resulted in the desired outcome – to provide front line staff and supervisors with sufficient knowledge and skills to enable them to serve children according to the Principles

Among the problems: an insufficient number of qualified trainers; an inadequate on-the-job "hands-on" component in which trainers, coaches and mentors teach effective approaches; lack of effective tools for evaluating the ongoing effectiveness of the training program; and enormous staff turnover among those most intensively trained.

The DHS Three-Year Plan calls for "[t]raining supervisors to mentor, coach, and provide on-the-job training for personnel who facilitate or participate in CFTs," with an implementation date of August 2007. We assume this means as part of the formal training program required by the Settlement Agreement. We would appreciate your telling us more about your plans in this area and the extent to which they will address the above identified problems.

The DHS Three-Year Plan also calls for training on a variety of specific practice protocols and other initiatives, as well as including expectations about training in new and revised protocols. In the past, the State's practice of developing training specific to particular protocols or initiatives has led to a fragmented and inefficient training approach. We urge the State to consider developing a single unified training program for each type of personnel in the system (*e.g.*, case managers, direct support providers, clinicians, supervisors), including training for staff new to the system and

continuing education for existing staff. The training program could be modified as new protocols are issued or new initiatives undertaken.

The Plan also includes "initiatives for staff retention and turnover reduction strategies" but apparently not until July 2009.

An adequate training program would identify a core set of training requirements; focus heavily on supervision and management; require RBHAs and providers to identify their training budget and how it is spent; require RBHAs and providers to spend a minimum percentage of their training funds for coaching and mentoring; and use trainers who have practiced according to the Principles and can coach staff in this practice.

We hope that you will consider our concerns and suggestions in your efforts to ensure that class members get the services and supports that they need.

Sincerely,

Anne Ronan
Ira A. Burnim

cc: Tim Nelson