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VIA HAND DELIVERY

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Re: *JK*

Dear Bob and Logan:

Plaintiffs hereby invoke the dispute resolution provisions of Section IX of the Settlement Agreement ("Disputes Regarding Implementation"). Over the course of the implementation period, we have repeatedly raised concerns with Defendants, seeking needed relief through collaborative negotiation. We are now at a critical juncture. Unless bold action is taken, the promise of the Settlement Agreement will never become a reality.

As required by Paragraph 59 of the Settlement Agreement ("Written Statement of Issues in Dispute"), which we now specifically invoke, we reprise our concerns below. We also identify corrective actions we believe are needed. We look forward to meeting with you to try to resolve these matters through collaborative negotiation.

As you know, Plaintiffs have carefully followed Defendants' implementation activities. In addition to periodic meetings with Defendants, we stay in close touch with knowledgeable individuals at all levels of the behavioral health system. We also participate in key committees and processes in Maricopa County where the majority of class members reside.

We recognize Defendants have taken important steps toward implementation, including: the covered services initiative, training curricula, national coaches, and Practice Improvement Protocols and Technical Assistance Documents. We also acknowledge the individuals at ADHS, RBHA's, and providers who have worked to implement *JK*. Yet as detailed in prior meetings and correspondence, serious issues remain in dispute.

Issue 1: Defendants have failed to meet their core obligations under the Settlement Agreement. Defendants will be unable to develop by July 2007, a Title XIX behavioral health system that delivers services according to the *JK* Principles. Defendants have not moved as quickly as practicable to develop such a system. As is detailed below, Defendants have not made changes to "contracts, decisions, practice guidelines and other policies" needed to achieve the Principles for class members. As a result, few children are now receiving services in accord with the *JK* Principles. Sadly, this is also true of children with complex needs who have long been the focus of ADHS' implementation effort. Delivery of services according to the *JK* Principles (including an adequately functioning child and family team) is the exception, not the rule. In Maricopa County for example, a recent review found that in only 19% of cases were services delivered according to the *JK* Principles.

Issue 2: ADHS has failed to create appropriate performance expectations to ensure *JK* implementation and to hold RBHA's and providers accountable to those expectations.[1] Far too many managers and supervisors at the RBHA and provider level do not give appropriate priority to *JK* implementation. Until ADHS creates and enforces appropriate performance expectations, this circumstance is unlikely to change

ADHS and the RBHA's have long lacked two essential tools for imposing accountability: (a) a comprehensive implementation plan -- for ADHS, RBHA's and providers -- setting out steps and deadlines sufficient to ensure that necessary changes are made,[2] and (b) a mechanism for reviewing the fidelity of front-line practice to *J*K

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[1] By contrast, ADHS has held RBHA's accountable for meeting for various expectations not closely related to, and in some cases in conflict with, developing a behavioral health system that delivers services according to the *JK* Principles.

[2] National experts said recently of written implementation plans prepared by the seven comprehensive service providers (CSP's) in Maricopa County that "the quality of the plans raises questions about the true understanding of the CSPs of the changes needed...."

Principles, and for reflecting back to service providers areas where performance was inadequate and improvement necessary.

The State Action Plan recently adopted by ADHS does not adequately address systemic deficiencies reflecting little understanding of why front-line practice is not changing or how to ensure that it does. In mid-April 2005, Plaintiffs met with DBHS' new leadership, Dr. Jerry Dennis, and asked that ADHS finally develop a meaningful implementation plan. A commitment was made to speedily convene an implementation plan meeting that would include Plaintiffs and to complete an implementation plan by mid-July for Maricopa County and then complete plans for other areas of the state. The meeting was postponed as a result of another leadership change. While there have been two Implementation Planning Meetings in Maricopa County, both led by the RBHA, an implementation plan for Maricopa County has not been developed. Neither have implementation plans been developed in the rest of the state.

ADHS has been slow to change the quality management and improvement system so that it measures whether services to class members are consistent with and designed to achieve the *JK* Principles. Essential to such a system is an in depth case review of a sample of individual children's cases that include interviews of relevant individuals in the child's life. Yet, there appear to be no plans for ensuring that such in depth case reviews are integral to ADHS' system.

Issue 3: ADHS has been hamstrung by its failure to acknowledge the poor performance of the behavioral health system. Despite ADHS' protestations to the contrary, the behavioral health system is not performing at the level expected at this stage. Its poor performance is not part of a "developmental" process, but instead the predictable result of deficient and ineffective implementation activities, including the failure of ADHS and RBHA's to hold providers accountable. ADHS cannot correct failures it will not acknowledge. Neither have implementation plans been developed in the rest of the state.

Issue 4: The behavioral health system cannot deliver services according to the *JK* Principles without ready access to direct supports, home-based respite, and therapeutic foster care. Although this was universally acknowledged at the beginning of the implementation period, ADHS and the RBHA's were slow to develop these resources, which are now not adequate to meet the need. Indeed, for years no meaningful effort was undertaken to develop direct supports, home-based respite, and therapeutic foster care. This has hobbled the ability of front-line providers (and of child and family teams) to deliver needed services to class members. It has also

resulted in children being needlessly placed into institutional care such as group homes and RTC's.[3] Neither ADHS nor the RBHA's have an effective plan to ensure that class members get the direct support, home-based respite, and therapeutic foster care that they need.

Issue 5: An effective training program is essential to the success of *JK* implementation. The existing program, created by ADHS and RBHA's, is not effective to ensure that services are provided according to the Principles. The training program fails to meet specific requirements of the Settlement Agreement. There are not qualified trainers in sufficient numbers to train front-line staff and supervisors. The training program does not provide front-line staff and supervisors with sufficient knowledge and skills to enable them to plan and provide services consistent with the *JK* Principles. In particular, it lacks a sufficient on-the-job "hands-on" component in which trainers, coaches and mentors teach effective techniques and approaches, including unified service planning and implementation, the involvement of parents as partners, and how to access and use wraparound supports. It also lacks effective tools for evaluating the ongoing effectiveness of the training program. Moreover, staff that have gone through the training program have been stymied in delivering services consistent with the *JK* Principles, due to leadership and structural problems at the provider level (*e.g.*, inappropriate restrictions placed on child and family teams).

Issue 6: Adequate case management is required to deliver services according to the Principles, especially for the children with complex needs who comprise at least one-third of the Plaintiff class. ADHS and the RBHA's have been reluctant to invest in case managers and been slow to develop needed case management. There is no functioning system -- and there has never been one -- for identifying children who need intensive case management or ensuring they get this service. There are not nearly enough case managers for children with complex needs, turnover remains a serious problem, and ADHS and the RBHA's have no plan for correcting this situation. Since there are too few case managers, providers deny needed case management to children with complex needs or give case managers caseloads that are far too high.

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[3] In Maricopa County, approximately $20,000,000 is spent on some 175 children in congregate care. 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.

Issue 7: Clinicians find it difficult to comply with ADHS' intake policies (which Plaintiffs have consistently decried as inconsistent with *JK* implementation) while also ensuring adequate clinical participation in child and family teams. Another reason: providers still reflexively provide office-based therapy to class members, at considerable expense, although it has become increasingly clear that for a very significant number of class members, office-based therapy is neither effective nor indicated.

Issue 8: The behavioral health system lacks enough clinicians with appropriate expertise. ADHS and RBHA's have no plan for correcting this problem. In addition, the RBHA's have not strategically employed clinicians with appropriate expertise for maximum effect (in, *e.g.*, developing the system required by the Settlement Agreement).

Issue 9: Child and family teams are central to implementation of the Settlement Agreement. However, there is no clear vision of how child and family teams will function for children with less complex needs, nor of what training and support will be needed by those who perform the facilitation role. If current clinical staff will perform this role, their job descriptions need to be rewritten to include these responsibilities and their encounter obligations adjusted accordingly.

Issue 10: Current intake policies encourage and in practice often require front-line practice that is inconsistent with the *JK* Principles, including: the 30-day assessment is often performed by someone outside the child and family team, and a clinical liaison who is not a member of the team (and before a team is even formed) often dictates the child's service plan.

Issue 11: Youth aged 18-21 have been overlooked in the implementation effort. These youth are served by the adult behavioral health system, not the children's system. No effort has been made to ensure that the adult system is serving 18-21 year olds consistent with the *JK* Principles.

Issue 12: Financial incentives are not aligned to encourage or support practice according to the *JK* Principles. We have heard this repeatedly from providers. While we lack access to much of the relevant information, it is striking that ADHS has never engaged in a meaningful process to identify and address the financial concerns repeatedly stressed by providers.

Issue 13: The state has set an expectation that by the end of 2005, 50% of children will be served according to the Principles. We think this is a laudable goal,

but it is not feasible in light of the current limitations of the system. We believe it creates perverse and dangerous incentives for ADHS to declare that the system has met the goal, and to establish an expectation that by the end of 2006 all children will be served according to the Principles.

Issue 14: In order to make up for lost time – the time lost due to Defendants' failure to move as quickly as practicable and to make needed changes to contracts, decisions, practice guidelines and policies -- the term of the Settlement Agreement must be extended. We believe an extension of at least three years would be appropriate.

Issue 15: To get *JK* implementation back on track, ADHS must quickly develop and aggressively follow an implementation plan that describes the steps that will be taken at the state, RBHA and provider level to ensure the development of a behavioral health system that delivers services according to the *JK* Principles. The plan should acknowledge the current poor performance of the behavioral health system and use strategies both comprehensive and powerful enough to produce good performance. The plan should establish targets, deadlines, concrete steps, and a clear path for accountability, as well as identify the human resources required for each activity to be successful. The plan must ensure:

- By the termination date of the Settlement Agreement (as extended by agreement or the Court), the development of a behavioral health system that delivers services according to the *JK* Principles.

- Regular reviews of the fidelity of front-line practice to the *JK* Principles, based on in depth reviews of a sample of cases that include interviews of relevant individuals in the child's life.

- A method of holding RBHA's and providers accountable for their performance as measured by fidelity reviews, including in a method for rewarding and "consequencing" providers based on their success in delivering services according to the *JK* Principles (*e.g.*, by steering new business to better performing agencies). In addition, RBHA's will develop competitors to existing providers by, *inter alia*, giving "case management" responsibilities to highly performing direct support agencies and allowing these agencies to draw on newly created stand-alone agencies for quality psychiatry and therapy.

- Timely access to direct supports, home-based respite, and therapeutic

foster care, including in crisis situations (*e.g.*, where there is an imminent risk of placement in out of home or congregate care).

- Adequate clinical participation in child and family teams.

- An adequate number of case managers, as well as a functioning system for identifying children who need intensive case management and ensuring they get this service. Turnover among case managers must be addressed.

- An effective training program with sufficient hands-on coaching and mentoring.

- Appropriate caseloads for case managers.

- The intake process is consistent with the *JK* Principles. Initial assessments are done by child and family teams. Therapy is not reflexively provided before a child and family team is formed and the team develops a service plan.

- An increase in the number of clinicians with appropriate expertise and the strategic deployment of such clinicians.

- A targeted effort to avoid placement of class members in congregate facilities and to facilitate the discharge of class members now in congregate facilities.

- A clear vision of how child and family teams will function for children with less complex needs, and of what training and support will be needed by those who facilitate such teams.

- The alignment of financial incentives to encourage and support practice according to the *JK* Principles, including a process for addressing the financial concerns repeatedly raised by providers.

- Changing hiring practices, to ensure a workforce with a commitment to the delivery of services according to the *JK* Principles.

- The identification, promotion, and strategic deployment (*e.g.*, in management and supervisory roles) of champions of *JK* implementation (champions of service delivery according to the *JK* Principles).

· Serving youth 18-21 according to the *JK* Principles

We have confidence that, if Plaintiffs and Defendants approach these matters with an open mind and in good faith, we can negotiate a collaborative resolution of them.

Sincerely,

Anne Ronan
Ira A. Burnim

cc: Sue Gerard
Eddy Broadway
Michael Fronske
Brian Lensink