Secure Residential Treatment Facilities White Paper

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Executive Summary

According to the National Institute of Mental Health (mental illness, n.d.), Serious Mental Illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment that substantially interferes with or limits one or more major life activities. This white paper details Arizona's complex landscape of mental health care, particularly for the Chronically Mentally Ill (CMI) population. People with CMI are defined in this paper as that subset of the SMI population who experience a chronic inability, for one reason or another, to interact with or benefit from our current Behavioral Health system. Ariz. Rev. Stat. § 36-425.06. specifies CMI the individuals as "determined to be seriously mentally ill, who are chronically resistant to treatment for a mental disorder and who are placed in the facility pursuant to a court order issued pursuant to section 36-550.09." Further information regarding the criteria for admission is available in Appendix F.

The burden of mental illnesses borne by society is particularly concentrated among those who experience disability due to CMI. The inability of the current system to adequately treat the CMI population has led to a vicious cycle of incarceration, homelessness, and insufficient medical care, as well as costing our society a sizable financial burden (estimates are that 5 -10% of people with SMI that are CMI are responsible for up to 70% of behavioral health expenses) which could be mitigated by treating people with CMI appropriately. Arizona law restricts long-term psychiatric beds to only 117 statewide (Maricopa County is limited to only 55 beds of the 117 beds). Other counties in Arizona do not have any limits.

Behavioral Health Residential Facilities (BHRF) are unlocked community treatment homes that are staffed 24/7. However, because they are unlocked, many individuals leave

precipitously and start the destructive cycle over again. Secure Behavioral Health Residential Facilities (SBHRF), which are authorized under Arizona law and for which licensing exists, have been identified as a potential solution for treating this vulnerable population. However, to date, no SBHRFs have been licensed or built.SBHRF will be discussed further below. Both BHRFs and SBHRFs are considered medically necessary treatment; they are not housing. The SBHRF setting can provide sufficient time on the correct medication and psychotherapy for individuals to gain insight into their illness and begin their road to stability. The majority will step down to a less restrictive community setting.

Introduction

Mental illness is a widespread and often misunderstood problem that affects millions of people worldwide. The Treatment Advocacy Center (TAC), a nationally recognized authority on mental illness, provides an illustration (shown below) that highlights the substantial impact of SMI prevalence and treatment rates, along with the significant costs and consequences involved. One of the most contentious debates in the mental health field is whether involuntary treatment should be employed for individuals with CMI. Most, if not all, persons who fall into the category of CMI are affected by a condition known as anosognosia, which causes them to lack insight into their condition. It is a symptom commonly seen in 60% of individuals with schizophrenia, 50% of individuals with bipolar disorder, and, to a much lesser extent, (20-30%) in other severe mental illnesses where the affected person is not able to recognize their illness (*Anosognosia - Treatment Advocacy Center* 2023). This paper seeks to argue that, in specific circumstances, involuntary treatment is necessary, justifiable, and, above all else, humane for individuals with CMI who lack insight into their illness. Often, these individuals are (1) at risk to themselves and others and (2) at risk for deterioration of their mental and physical health.

First, individuals with CMI often struggle to maintain their daily lives and may inadvertently pose a risk to themselves or others. For instance, someone with severe schizophrenia may experience hallucinations or delusions that lead them to harm themselves or others. If individuals with CMI are not aware of their illness, they are unlikely to seek help or adhere to a treatment plan, increasing the risk of harm. In such cases, involuntary treatment may be the only way to ensure the safety of the individual and the community.

Second, the mental and physical health of individuals with CMI often deteriorates without proper treatment. This decompensation can lead to various negative outcomes, including homelessness, incarceration, and even death. Involuntary treatment can prevent this downward spiral by ensuring individuals receive the necessary care and support to manage their illness.

Between jail, prison, and life on the streets, people with chronic mental illness (CMI) are caught in a never-ending cycle of interaction with police, fire, emergency rooms, and our civil commitment systems. Individuals with CMI go to the emergency room at five times the general population's rate, and their hospital stays are four times as long (Navas et al., 2022). An increasing percentage of police calls now involve the mentally ill (an increase of 40% from 2014 to 2021) (Salonga et al., 2023). Furthermore, those calls are increasingly dangerous to both the officer and the person with the mental illness. 80% of all people killed by police have a mental illness (Salonga et al., 2023); 50% of all attacks on officers are perpetrated by the mentally ill (Walsh, 2017). Because of limitations in our present behavioral health system due to insufficient resources, many will be petitioned for involuntary treatment 20 times a year or more without success.

The reason for the constant cycling and failure is a combination of idiosyncrasies about illness, treatment limitations, and systemic realities. Nearly all those in the CMI population have

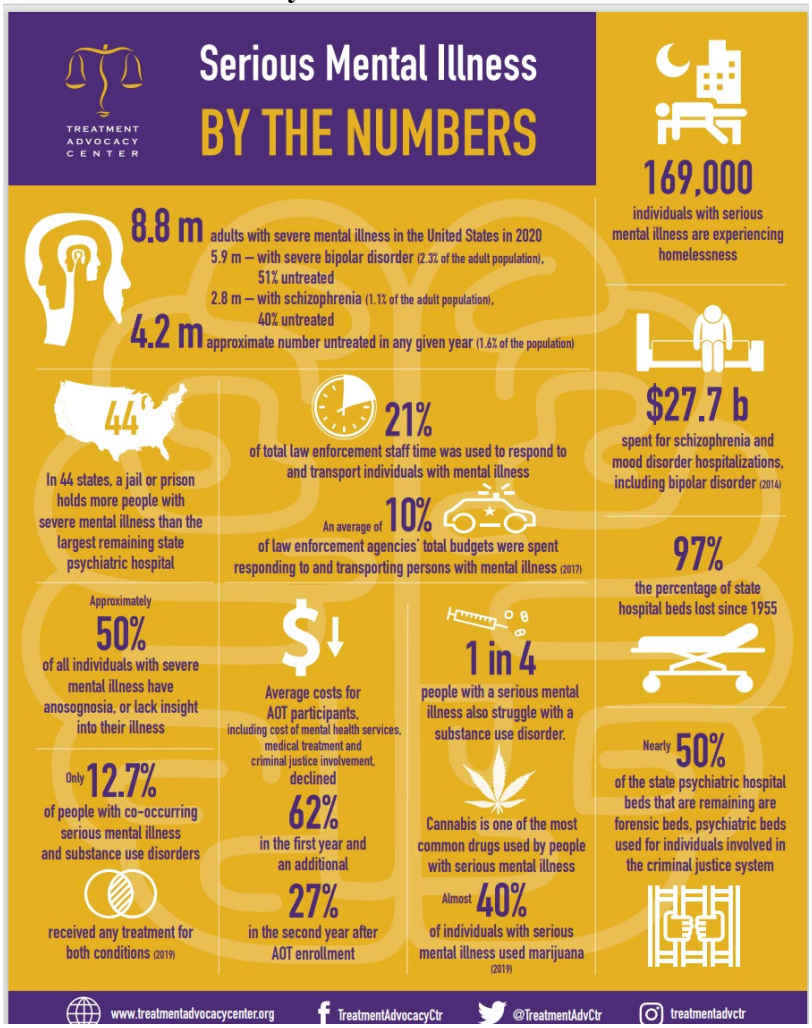
a psychotic disorder and, if treated, are treated with antipsychotic medications. Antipsychotic medications take up to six months to take effect (*Antipsychotics,* n.d.). Moreover, many have anosognosia; therefore, they resist taking medication. This would not be problematic if they could stay at a hospital long enough for the medication to take effect and hopefully gain at least some insight into their disease. According to Arizona Health Status and Vital Statistics 2019,

> The top five conditions with the longest length of inpatient stay were: Schizophrenic disorders (11.8 days), psychoses (8.6 days), manic-depressive disorders (8.8 days), congenital anomalies (8.7 days), and depression (7.7 days) (*Inpatient Discharges From Short Stay Hospitals By First-Listed Diagnosis And Patient Characteristics* 2020).

However, rather than staying the necessary length (usually many months) in a hospital, it would be less costly, more therapeutic, and more humane for the person to spend this time in a secure, home-like setting that a SBHRF would provide. Patients not effectively stabilized leave the hospital, quickly stopping the antipsychotic medication, becoming symptomatic once again, and the cycle starts again. Continuous cycling in psychosis is a serious humanitarian and public health and safety issue. The longer time an individual experiences psychosis, the more damaged the brain is, and their baseline is lowered (Andreasen et al., 2013). Nevertheless, we have watched this tragedy play out for decades. The public and those we elect have known this problem year after year, yet there has been no significant progress. The answer for the CMI population is a treatment environment that can be sustained for a more extended period. To obtain longer-term treatment with this population, considering our lack of level 1 inpatient psychiatric availability, that treatment could be completed in a SBHRF.

As Arizona contemplates expanding the continuum of residential treatment settings for this population, reimbursement is important. Thus, whether a secured residential is an inpatient facility, an IMD, or neither is a question that must be answered.

Figure 1: Treatment Advocacy Center SMI Prevalence and Treatment Rates



(Our impact: By the numbers 2023)

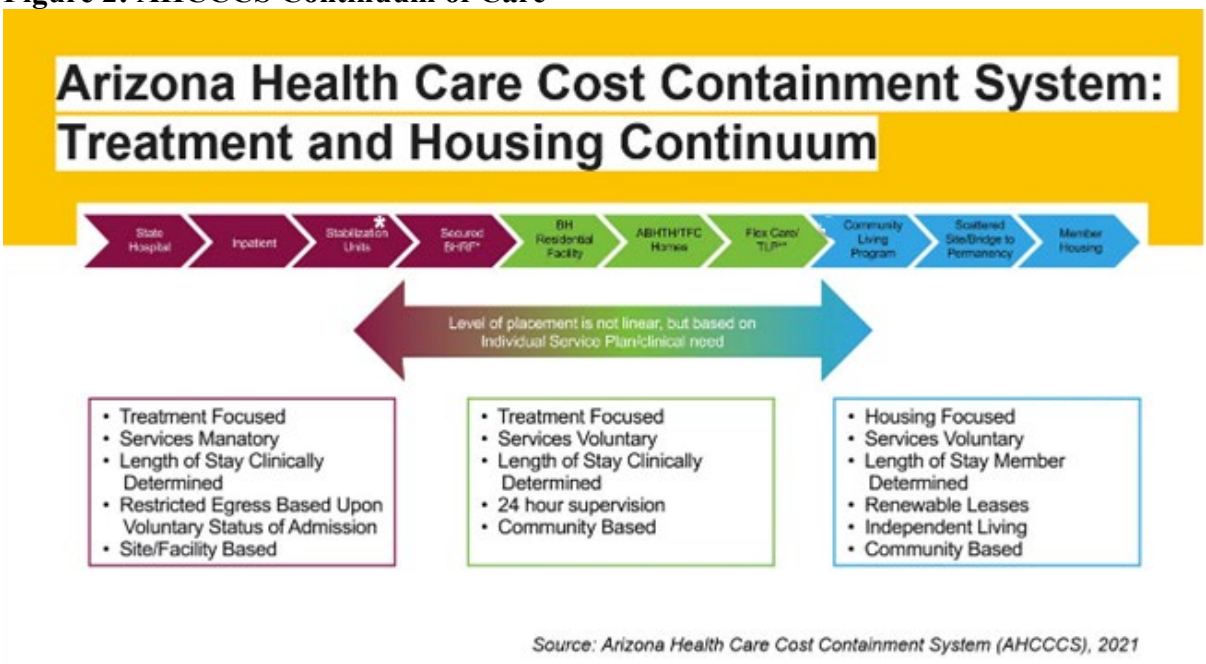
The Continuum of Care

Research shows that treatment for CMI, including medication and psychotherapy, can effectively manage symptoms and improve quality of life. However, as mentioned above, individuals who need more insight into their illness are less likely to seek or adhere to treatment voluntarily. Involuntary treatment can ensure these individuals receive the necessary care, leading to improved outcomes and a better quality of life. Involuntary treatment should always

be a last resort and conducted with strict legal safeguards to protect the individual's rights. A court-ordered involuntary treatment order (COT) includes a thorough assessment by a qualified mental health professional, judicial oversight, and regular review of the individual's condition and treatment plan. While COT is undoubtedly a contentious issue, it is sometimes necessary and justifiable for individuals with CMI who have not been successful with voluntary treatment options. With strict legal safeguards in place, COT can ensure the safety and well-being of the individual and the community, prevent the deterioration of mental and physical health, and improve the overall quality of life for the affected individual. Therefore, it is essential that mental health professionals, policymakers, and the wider community carefully consider the benefits and potential risks of involuntary treatment and work together to develop a framework that prioritizes the safety and well-being of all involved.

Below is the system of care existent in Arizona for individuals with SMI/CMI. Arizona's continuum of care offers many levels of treatment, from secure hospitalizations to independent community living. Additionally, there is a sub-level of care provided to the mentally ill by other agencies not part of the Arizona Health Care Cost Containment System (AHCCCS) system of care, which is typically not considered in the Behavioral Health Treatment system; nonetheless, these other agencies provide some level of care for a significant number of people with CMI. Note that individuals enter at differing entrance points and interact with all the levels of care on the continuum and frequently on the sub-continuum.

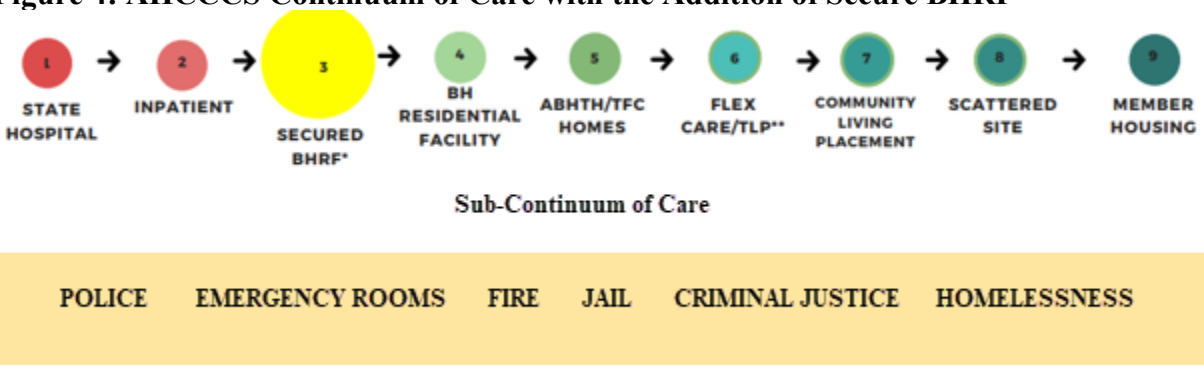
Figure 2: AHCCCS Continuum of Care



SBHRFs in the chart above (*AHCCCS Medical Policy Manual (AMPM)* 2023)

Figure 3: AHCCCS Continuum of Care Before 2019

Figure 4: AHCCCS Continuum of Care with the Addition of Secure BHRF*



Note: A Secure BHRF is a licensed facility in the state of Arizona; they have not been built and are not available at the time of this report (*AHCCCS Medical Policy Manual (AMPM)* 2023).

Case Studies

Individual One- A Success Story

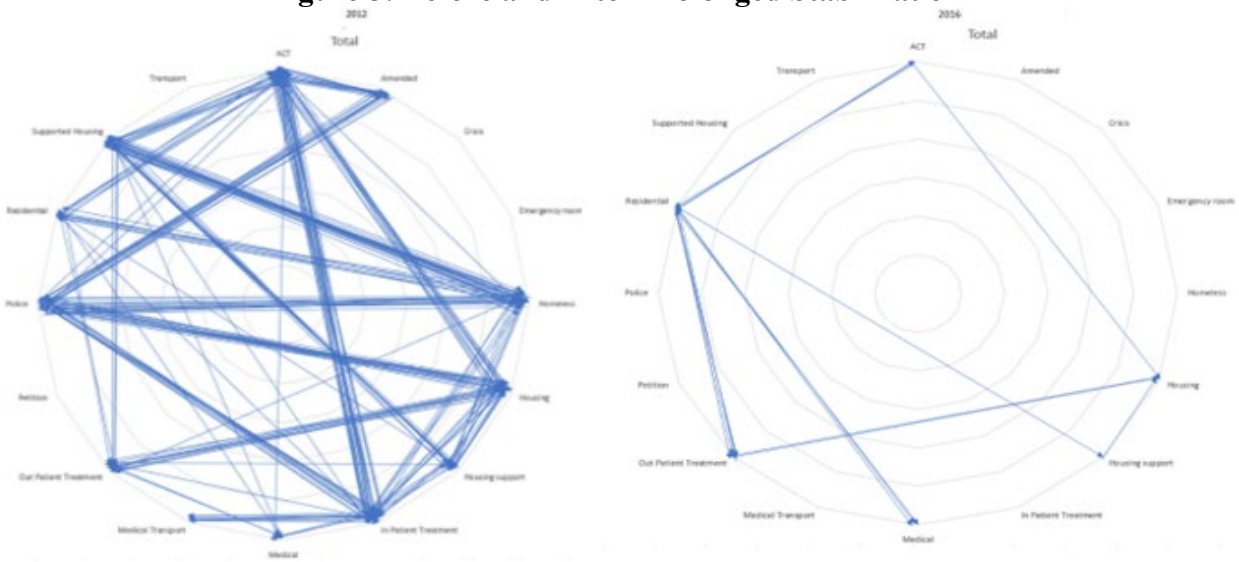
Allen, now 33 years old, has had difficulty all his life. He set furniture on fire in his home at age 4, had socialization problems, laughed inappropriately, used marijuana at age 14, and

brought strangers with guns into the family home (his "new best friends"). He disappeared into the streets at age 18 and was assaulted multiple times, destroyed apartments and condos provided for him, punched holes in walls to stop the voices, tore a sink out of a wall, discarded fresh food as "poisoned," and was ejected from fifteen dual diagnosis programs as too mentally ill (i.e., "he needs a higher level of care"). He was hospitalized many times and frequently denied care due to his use of illicit substances. Diagnosis: Schizoaffective disorder and substance use disorder.

He had been in 15 different dual-diagnosis treatment programs, all of which had been unsuccessful. His parents' unrelenting advocacy resulted in Allen's 2.5-year stay in two level 1 psychiatric hospitals where he was off illicit substances and on psychiatric medication. He was stabilized sufficiently to step down to a "Lighthouse" (Copa community-based living with 24/7 supervision). This 2.5-year involuntary inpatient treatment period was crucial in improving Allen's well-being and giving him insight into his disease. He has subsequently rebuilt his life, enjoys playing guitar, working part-time, and has not been hospitalized for several years. Long stabilization periods in Level One psychiatric hospitals are not available to many people due to, among other things, the Arnold v. Sarn settlement agreement (see below). Similar outcomes may be achieved by combining an inpatient stay for stabilization with a step down to an SBHRF for some time.

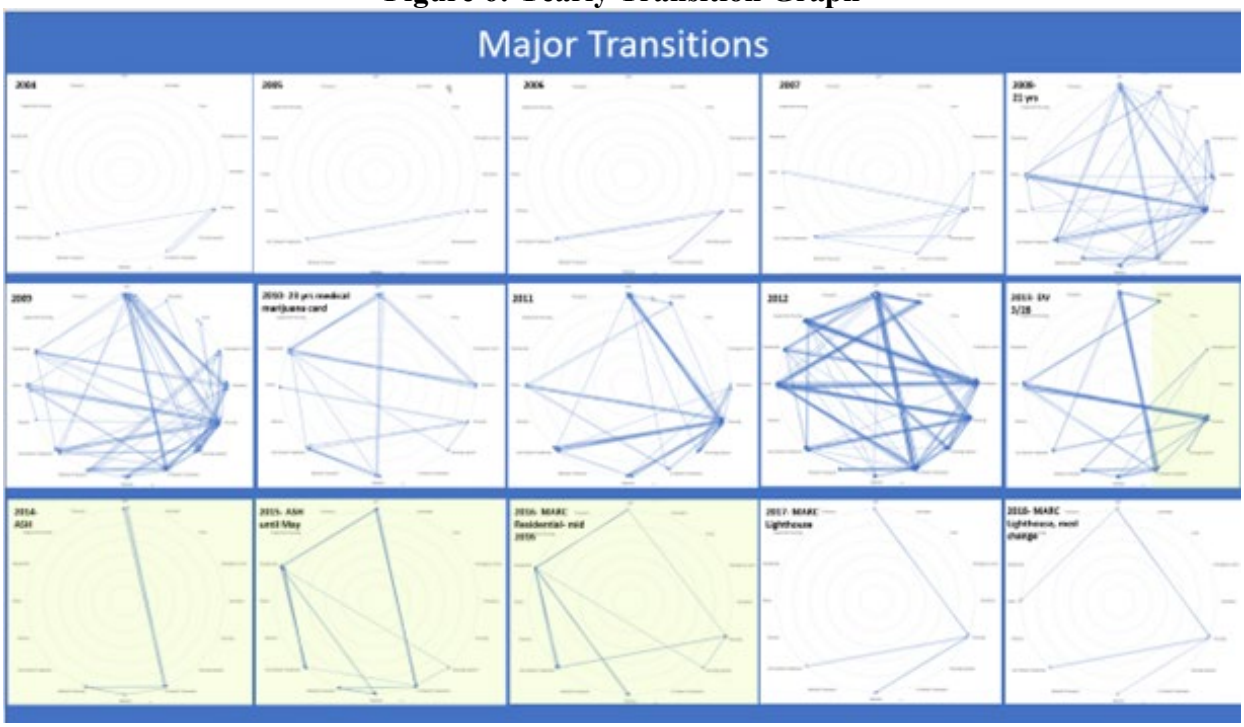
Below is a visual representation of the chaos that Allen and his family experienced before he was finally afforded a long-term stay in an involuntary hospital—the transitions between various entities in the system. The time in the hospital permitted him to gain insight into his mental illness and recover. He remains stable today with the support provided by a Copa Health "Lighthouse" community-based home with 24-hour supervision.

Figure 5: Before and After Prolonged Stabilization



Note: This shows each point of interaction between public/private services and one clinically ill individual over one year (2012- left, 2015- right). The transition reductions on the right were obtained after long-term stabilization in a secure facility.

Figure 6: Yearly Transition Graph



This shows each point of interaction between public/private services and one clinically ill individual over 15 years.

Note: The diagram above shows the lack of chaos after Allen experienced prolonged stabilization in a secure setting (long-term inpatient highlighted in green) and was provided with appropriate community housing upon release.

Individual Two- A Behavioral System Failure

Matt, now 42 years old, had socialization problems throughout his childhood, appeared to have ADHD, and spent his 13th and 14th birthday in a psychiatric hospital for depression and bipolar disease. He began using marijuana at age 14, then "spice" in his 20s, then methamphetamine in his 30s. At age 17, he undertook a "devotional path" by meditating for 2 to 4 hours timespans and restricting his food and water intake. At 6 feet 4 inches tall and 120 pounds, he was hospitalized for malnutrition and severe psychosis. He was diagnosed with schizoaffective disorder. Over 28 years, Matt has cycled countless times through residential treatment programs (repeatedly ejected for "lack of engagement"), apartments (evicted for "bizarre behavior"), emergency rooms, hospitals, halfway houses, streets, and jails. He believed hospitals were doing experiments on him.

Through his parents' persistent advocacy, Matt now lives in a "Lighthouse" (24-hour supervised enhanced community setting home with wraparound services provided by an Assertive Community Treatment (ACT) team, leaves the "Lighthouse" whenever he wants to, use methamphetamine, engage in bizarre and risky behavior, and get taken to an emergency room or get arrested and jailed. His only options are the "Lighthouse" (Copa Health Enhanced Community Living Home with 24/7 staffing), the streets, or jail. He left the unlocked community home and was hit by a car, suffering two broken legs while in a highly psychotic state, and continues to get arrested for bizarre behaviors associated with his mental illness. He was enrolled in diversion programs that are difficult to complete with his ongoing psychiatric issues. He would benefit from being civilly committed to a SBHRF for a prolonged period to stabilize him and then step back down to a BHRF, Lighthouse, or other community living.

Individual Three- A Behavioral System Failure

Tammi is a 31-year-old woman with a long history of schizophrenia, along with a long history of failed treatment. She has been determined SMI. She is not willing to consistently engage in care, nor does she tell her doctors her actual symptoms or situations, and is constantly homeless, living on the streets because her case manager tells her there is nothing available for her. Because she is homeless, she is assaulted continuously. The police contact her parents as they file missing person reports and try to encourage her to go with them, but she refuses. She has been psychiatrically hospitalized more than 20 times and arrested several times. She is appropriate for residential services and an ACT team but rejects the services because of a delusion that the residential staff and ACT teams "are fronts for the FBI." She refuses to complete a Power of Attorney (P.O.A.). She will not stay in any unlocked treatment center. She continuously cycles through psychosis, further damaging her brain. She would benefit from a prolonged stay in a secure setting in a level 1 locked hospital or a SBHRF.

Individual Four- A Behavioral System Failure

David is a 31-year-old man with a long history of schizophrenia. He has been determined SMI since he was 21. He has paranoid and delusional thoughts, and his behavior is bizarre. He dropped out of school after a psychotic break. He also cannot keep a job. He also has medical conditions he does not follow up on. He refuses all mental health treatment and has never received treatment for his illness. He is increasingly aggressive and confrontational. After a particularly aggressive encounter with his parents, he took the family car, drove 90 mph on a city street, and hit a curb. The car flew into an open field and crashed. Police petitioned him. He is currently at a psychiatric hospital; the family is inquiring about obtaining guardianship to begin

involuntary treatment. He also will need a secure environment for an extended time to begin gaining insight and begin his recovery.

Individual Five- A Behavioral System Failure

Crystal is a 32-year-old female who had a psychotic break in her first year of college. She decompensated quickly and began having paranoid delusions. Her loving, supportive family could not convince her to stay on medication. She lived on the streets of Phoenix, Arizona, in the "Zone" (an area in Phoenix where homeless people congregate on the perimeter of the homeless shelter) and self-medicated often. She was beaten up, raped, and victimized for years. The Phoenix police would contact her family during crises, but she refused to participate in treatment. After her parents took guardianship and she was on court-ordered treatment (COT), she gained insight into her disease after involuntary confinement in a psychiatric facility; this insight has enabled her to step down to community living with supervision. Unfortunately, when she moved to an unsupervised apartment, she stopped taking her medication, began using illegal substances, and is now cycling through psychosis. Her parents cannot make her stay at a BHRF even with guardianship. She would benefit from a longer stay at a SBHRF.

These five individuals were repeatedly denied appropriate care for their chronic mental illnesses, as their families were told: "They need a higher level of care." People with serious mental conditions and substance use disorders are routinely rejected from dual diagnosis facilities. Presently, such "higher levels of care" are not available for most individuals. Individual one- Allen "won the lottery" in a sense by being afforded a long period of time in a secure, long-term environment. Since that level of care is not available to thousands of CMI, they live in streets and jails because of the lack of long-term secure stabilization. Family members, guardians, and judges would like to place some CMI persons in SBHRFs.

Healthcare Case Study Summary - Making the case for Secure Residential Facilities

In cases like Allen and the others we have discussed, CMI individuals would only be considered for SBHRF after multiple failures at voluntary community treatment in non-secure settings. After an agreement with the individual's clinical team, a judge must approve COT (court-ordered treatment), including a secure facility placement as part of COT. This infringement on an individual's civil liberties warrants serious consideration. The authority and corresponding criteria for individuals being court-ordered to an SBHRF are found within ARS section 36-550.09 (*Title 36- Public Health and Safety* 2023). If a judge with appropriate jurisdiction finds that a patient meets the criteria for court-ordered treatment pursuant to section 36-540, subsection A, the court may approve the patient's placement in a SBHRF that is licensed by the Department of Health Services pursuant to section 36-425.06. The provider must be willing to accept the patient if the patient has been determined to be seriously mentally ill, and the court finds that the patient is chronically resistant to treatment, as set forth in this section. Placement in a SBRHF for treatment is not considered a period of inpatient treatment for the purposes of section 36-540, subsection F (*Title 36- Public Health and Safety* 2023).

This paper provides a legal foundation for addressing the urgent need for secure behavioral residential health facilities (SBRHF) within Arizona's community-based treatment system. Based on statutory authority, AHCCCS has added this level of treatment to Arizona's continuum of care for people with SMI, particularly to those individuals whom the court finds to be CMI who are failing in non-secure settings. Arizona stakeholders need to understand the critical distinctions between mental healthcare facilities. This paper provides a robust argument for implementing SBHRF to deliver effective mental health care to those most in need without conflicting with existing federal and state laws. The recognition of the inability of the current

behavioral health system to adequately provide for those with CMI underscores the importance of providing appropriate treatment and support for a vulnerable population whose existing behavioral health service offerings have failed.

Analysis of the Law

Arnold v. Sarn Settlement Agreement

In 1981, a class action lawsuit, Arnold v. Sarn, was initiated against the State of Arizona. The lawsuit alleged that the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS) and Maricopa County had failed to provide a comprehensive community mental health system as mandated by statute. The legal process unfolded over many years. In 1986, the trial court found that the State (ADHS) and Maricopa County had breached their statutory obligations. The AZ Supreme Court reaffirmed this decision in 1989. The lawsuit was finally resolved by a Settlement Agreement approved by the court in 2014. Although the agreement created essential community services to varying degrees, it significantly reduced the availability of public long-term psychiatric hospital beds in Arizona (55 for Maricopa County with 117 total for Arizona). This is one of the reasons why the establishment of SBHRF is essential. From ASH (Arizona State Hospital) Report 2023, "Arizona has the fewest number of state-operated psychiatric beds reserved for individuals under a civil commitment order, per capita, in the nation. As shown in Table 1 below, as of the most recent census, Arizona has 117 total inpatient civil psychiatric beds for approximately 7.2 million or just 1.6 beds per 100,000 residents" (Sheldon, 2023). This is despite the fact that 40 – 60 long-term psychiatric inpatient beds are considered necessary per 100,000 based on conclusions drawn from well-regarded empiric studies (Fuller et al., 2016).

Table 1: State Psychiatric Beds

State Operated Civil Commitment Inpatient Beds per 100k Residents (Psychiatric Only)						
	AZ	MN[19]	CT	NM	WA	MT
Population	7.2M	5.6M	3.6M	2.1M	7.8M	1.1M
Adult Civil Beds	117	110(206)	132	121	531	117
Beds per 100k	**1.6**	**2.0 (3.7)**	**3.7**	**5.8**	**6.8**	**10.6**

(Sheldon, 2023)

In January 2014, officials from ADHS, Maricopa County, and the Office of the Governor reached an agreement with the plaintiffs, referred to as the "Stipulation for Providing Community Services and Terminating Litigation," which was signed into law in January 2014. This agreement laid out specific terms: It mandated an increase in community services across four key areas: Assertive Community Treatment (ACT), Supported Employment (SE), Permanent Supportive Housing (PSH), and Consumer Operated Services (COS), also known as Peer and Family Support Services.

Additionally, the agreement stipulated the use of various tools by the parties to evaluate the services provided in Maricopa County. These tools included a quality service review, a service capacity assessment, and a review by the Substance Abuse and Mental Health Services Administration (SAMHSA) to assess fidelity to their guidelines. As part of the exit stipulations, the Arizona Department of Health Services (ADHS)/Division of Behavioral Health Services (DBHS) and the State of Arizona committed to the following actions:

1. Expanding the number of ACT teams from 15 in fiscal year 2014 to 23 by the end of fiscal year 2016.
2. Increasing the capacity for supported employment services in Maricopa County. By the end of fiscal year 2016, the system aimed to accommodate an additional 750 individuals in need of supported employment services.

3. Enhancing the availability of supportive housing slots in Maricopa County. By the end of fiscal year 2016, an additional 1,200 individuals with serious mental illnesses were expected to receive supportive housing services.
4. Expanding access to support services for peer and family members in Maricopa County. By the end of fiscal year 2016, space would be made available for an additional 1,500 peer and family members to receive these support services.

Since 2016, AHCCCS has continued to support the implementation of these four services within the community (*Arnold v. Sarn,* n.d.). While these are worthy goals, the system continues to fall short of adequately achieving these goals for the SMI population.

Olmstead Case Law

US Reports: Olmstead v. LC, 527 US 581 (1999)

In the case of Olmstead v. LC (1999), the symptoms of SMI, which include but are not limited to schizophrenia, present significant challenges for treatment. These symptoms encompass hallucinations, delusions, paucity of thought, lack of motivation, poor socialization, impulsivity, and *anosognosia*, making it challenging for individuals suffering from SMI/CMI to receive appropriate care. It is important to note that there have been instances of misinterpretation or omission of crucial information when discussing the arguments related to the Olmstead case, especially the opinion of the court regarding placing people with SMI/CMI in the "least restrictive environment."

The case originated with two women from Georgia who had been confined for psychiatric treatment at Georgia Regional Hospital. After receiving treatment, their treating doctors determined that they had improved to the point where they could transition to community-based care. However, instead of releasing them, the state continued to keep them

institutionalized. The women filed a lawsuit, asserting that the state had violated Title II of the Americans with Disabilities Act (ADA) by failing to place them in a community-based program once their medical professionals deemed it appropriate. The Supreme Court ruled in favor of the two women, asserting that the ADA was indeed violated when individuals capable of living safely in the community were held in institutions (Olmstead v. LC, 1999).

However, it is essential to recognize that the judicial arguments also emphasize that not everyone can safely live in the community. In particular, Justice Ginsberg, in her opinion, stated that the ADA does not mandate states to phase out institutions that are necessary for individuals requiring close care and protection. Moreover, it is not the ADA's intention to push states to place institutionalized individuals into inappropriate settings, such as homeless shelters. The case was never meant to advocate for relocating individuals to the streets or unsuitable environments based on their conditions.

Justice Ginsberg further pointed out that some individuals, whether mentally retarded or mentally ill, may never be suitable for placement outside the institution. There are situations where institutional settings remain necessary and must remain available for the well-being and safety of these individuals. Therefore, when accurately understood, the Olmstead case supports the provision of secure treatment when it is deemed necessary for the individual in question.

In summary, the Olmstead v. LC case underscores the importance of individualized assessments and treatment plans for those with CMI, ensuring that they receive the appropriate care, whether in the community or in institutional settings, based on their unique needs and circumstances. Further information on this case is located in Appendix D.

Analysis of Statutory Law

In 2019, by adding ARS section 36-550.05 (B) (3), the Arizona Legislature, for the first time, recognized the need for a secure behavioral health residential facility (SBHRF) program as part of the continuum of care in our community residential treatment system. This section mandates that "This program shall provide secure twenty-four-hour on-site supportive treatment and supervision by staff with behavioral health training only to persons who have been determined to be seriously mentally ill and chronically resistant to treatment pursuant to a court order issued pursuant to section 36-550.09 (*Title 36- Public Health and Safety* 2023). Arizona Revised Statute 36-550.09 outlines the criteria and procedures for placing a person in a secure behavioral health residential facility. It is a step that a court can take when a person has been determined to be seriously mentally ill and chronically resistant to treatment (*Title 36- Public Health and Safety* 2023). A more precise explanation of the revised statute is in the appendix.

The IMD Exclusion: Federal Statutory Law

The Medicaid IMD exclusion has created barriers to accessing long-term care in locked hospitals for individuals with mental health conditions covered by Medicaid (AZ AHCCCS). This has led to challenges in providing appropriate and sustainable care for individuals who require extended treatment in these settings, and it has prompted a shift towards alternative models of community-based mental health care. Policy reforms and waivers in some states address these challenges and improve access to appropriate care for this vulnerable population.

The Institutions for Mental Diseases (IMD) exclusion (a part of Medicaid law dating back to the 1960s) has had a significant impact on long-term stays in locked hospitals for individuals with mental health conditions. Here is how this exclusion has influenced the behavioral health system in Arizona: a) It limits access to Medicaid funding by not providing federal funding for services rendered to Medicaid-eligible individuals in IMDs. This means that

individuals with mental health needs whom Medicaid covers may not have access to the financial support needed for long-term care in in-patient psychiatric hospitals; b) community hospitals are overcrowded and treat patients for inadequate lengths of time because of financial concerns due to lack of federal funding. A practice known as "boarding" occurs when individuals are held in emergency rooms or other non-specialized facilities while waiting for a bed to become available in an in-patient psychiatric hospital; c) It impacts treatment quality and continuity of care. Longer-term stays in locked hospitals can be crucial for individuals with severe and persistent mental illnesses, allowing them to receive comprehensive treatment, stabilization, and rehabilitation.

What is the IMD Exclusion

The IMD exclusion is a well-established policy within the Medicaid framework that prohibits the federal government from allocating federal Medicaid funds to states for healthcare services provided to Medicaid-eligible individuals who are receiving treatment in Institutions for Mental Diseases (IMDs). This policy is outlined in §1905(a)(30)(B) of the Social Security Act (SSA) (Houston, *Medicaid's institution for mental diseases (IMD) exclusion - CRS reports* 2023). When an individual eligible for Medicaid is under the care of an IMD, they are ineligible to receive Medicaid coverage for services provided within or beyond the IMD premises. This restriction on federal funds for long-term treatment is closely linked to the common occurrence of short stays in community psychiatric hospitals, typically falling below the 15-day limit. It's important to note that, as explained in the "Legislative History" section, the IMD exclusion specifically applies to individuals between the ages of 21 and 64 (Houston, *Medicaid's institution for mental diseases (IMD) exclusion - CRS reports* 2023).

The term "institution for mental diseases" as per SSA §1905(i) refers to a facility, such as a hospital or nursing facility, with more than 16 beds, primarily dedicated to diagnosing, treating, or caring for individuals with mental illnesses. This encompasses medical attention, nursing care, and associated services (Houston, *Medicaid's institution for mental diseases (IMD) exclusion - CRS reports* 2023).

According to 42 CFR 435.1010, an Institution for Mental Diseases (IMD) is further clarified as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for individuals with intellectual disabilities is not considered an institution for mental diseases" (*The Federal Register,* 2023).

The US Dept. of Health & Human Services (HHS) policy guidance related to the IMD exclusion can be found in the State Medicaid Manual, Part 4, §4390. HHS states that the exclusion "was designed to assure that States, rather than the federal government, continue to have principal responsibility for funding inpatient psychiatric services." (*The state Medicaid Manual Chapter 4 Services section 4270 to section 4390.1: Guidance portal* 2015). When determining whether a facility is an IMD, the most important criteria used for CMS determination reflect two key measures: the services that the facility provides and the prevalence (more than 50%) of individuals with "mental diseases." (*The state Medicaid Manual Chapter 4 Services section 4270 to section 4390.1: Guidance portal* 2015).

Identifying Behavioral Health Residential Facilities

A Behavioral Health Residential Is Not An Institute of Mental Disease (IMD)

A Behavioral Health Residential Facility (BHRF) in Arizona is a treatment facility licensed under Title 9, Chapter 10, Article 7 of the Arizona Administrative Code. It provides mental health services, offering a structured treatment environment with 24-hour supervision and counseling or therapeutic activities for individuals with mental illnesses who do not require on-site medical services under the direct supervision of a medical professional. It is important to note that 100% of the individuals treated at a BHRF have a mental illness. Despite this, it is not classified as an Institution for Mental Diseases (IMD) or an inpatient facility.

The primary reason for not designating a BHRF as an IMD is that it lacks key characteristics associated with an IMD, particularly the requirement for "medical attention and nursing care." Federal IMD statutes and regulations specify that an IMD includes a necessary medical component, and BHRFs are not overseen by medical practitioners. Medical practitioners are not required to be on-site or on-call, and residents are not admitted based on orders from medical practitioners. Additionally, the presence of a registered nurse (RN) is not mandatory at all times, and federal restraint and seclusion regulations do not apply to BHRFs. BHRFs are classified as "community residential" settings rather than "inpatient" settings, as defined by ARS 36-550, which describes a "Community residential treatment system" for individuals with serious mental illness (*Arizona legislature ARS 36-550. Definitions* 2023).

According to federal and state law, a Behavioral Health Residential Facility ("BHRF"), which includes secure premises and is licensed under AAC Title 9, Chapter 10, Article 7, is also **not** considered an *Institution for Mental Diseases* ("IMD") or an inpatient facility.

A Behavioral Health Residential Facility is Not An Inpatient Facility

Federal Statute 42 CFR 435.1010 defines an inpatient facility as a "Medical Institution," which is an institution organized to provide medical care and nursing services, equipped to meet the healthcare needs of individuals on an ongoing basis, authorized by state law to provide medical care, and staffed by professional personnel responsible for medical and nursing services. The focus on medical care and oversight is essential in determining whether a facility qualifies as an inpatient facility, such as a hospital or medical institution (*42 CFR § 435.1010 - definitions relating to institutional status.* n.d.). State law, the Arizona Administrative Code in particular, further emphasizes the requirement for medical oversight and continuous medical practitioner availability in hospitals, sub-acute facilities, and residential treatment centers (RTC). These facilities must also have 24/7 registered nurse (RN) staffing and admit patients based on orders from medical practitioners. An RTC is a facility staffed by certified healthcare professionals offering 24-hour care in a community setting; depending on size, they may be considered an IMD.

In contrast, BHRFs do not provide medical care as federal and state regulations mandate. BHRFs do not require physician oversight, continuous medical practitioner availability, or round-the-clock nursing services. Admission to BHRFs does not depend on orders from physicians or medical practitioners; nursing services are provided as needed rather than continuously. Instead, BHRFs require a Behavioral Health Professional (B.H.P.) to oversee care to ensure residents are appropriately admitted; nursing services are not continuous and may be provided on an as-needed basis. Because BHRFs are not Medical Institutions as defined by federal law and regulation, they cannot be considered inpatient facilities.

Table 2: Inpatient & Institute of Mental Disease Vs. Behavioral Health Residential Facilities

Differences between IMD and BHRFs/ SBHRFs

Inpatient and IMD	***Behavioral Health Residential Facility***
Under the direction of a Medical Practitioner	Behavioral Health Care Provider (BHP) oversees care
Physician order for admission	BHP approves admission
Medical Practitioner on-site or on-call	BHP on-site or on-call
24/7 RN on-site	RN is present or on-call
Federal Restraint & Seclusion regs apply	Federal Restraint & Seclusion regulations do not apply
Contains a Seclusion Room	Does not contain a seclusion room
Room & board included in service rate	Room & board not included in service rate

A Secure Behavioral Health Residential Is Not An Institute of Mental Disease

Whether a non-secured BHRF is an IMD or an inpatient facility is not up for debate. We know it is neither. The question is whether a SBHRF would trigger either categorization. It would not. First, as seen above, medical services must be provided in an inpatient facility. A SBHRF, like a non-secured BHRF, would not provide medical services. Therefore, it is not an inpatient facility.

Behavioral Health Assisted Living Facilities providing "directed care" have "secure" premises. These settings have been allowed by both ADHS and AHCCCS as community-based settings that are "secure if they are the least restrictive setting capable of meeting the person's treatment needs." (*AHCCCS Medical Policy Manual (AMPM)*). Arizona has allowed the premises of Assisted Living Facilities delivering directed care services, an AHCCCS home, and community-based settings (HCBS) to be "secure" since 1998. Assisted living is a higher level of care than a secure BHRF, has locked doors, but is not an IMD. Therefore, because behavioral health assisted living is not an IMD, it cannot be argued that a secure BHRF is.

County attorneys in AZ have expressed a need for SBHRF settings to address the needs of individuals with SMI who have committed dangerous crimes but are not competent to stand

trial. These individuals are determined to be non-restorable and dangerous. SBHRF can be specifically designed to provide secure and therapeutic environments for individuals deemed non-restorable and dangerous. SBHRF are a solution for county attorneys who must release these dangerous, incompetent individuals into the community.

Other Secure Residential Facilities

Nationally, states are recognizing the need for SBHRF. There are some already in operation and some under construction. Below are a few examples.

Hope House, NY

Hope House, located in the Bronx, New York, on Crotona Park, is expected to open in early 2025 as an Alternative to Incarceration (ATI) for those with serious mental illness accused of a felony-level crime(s). Admission to Hope House will depend upon an eligible defendant knowingly entering into a voluntary plea agreement to reside at Hope House as an Alternative to Incarceration. Thereafter, the plea agreement is mandated by the judge presiding over the felony case. Hope House will offer a long-term (up to one-to-two years of stay) residential program for 16 adults, 18 years or older, in a NYS Office of Mental Health licensed congregate residential facility. Hope House will have daily and evening residential services with overnight residential and security staff on site 24 hours a day to provide continuous services in a safe, therapeutic environment. Hope House will also offer on-site mental health treatment through a Continuing Day Treatment Program (CDTP) offered by Argus Community. Hope House will be open to anyone residing in one of New York City's five boroughs at the time of their arrest, with four beds reserved for people residing in the Bronx at the time of arrest. Preference will also be given to veterans when possible. People accused of a sex offense are not eligible for admission to the Hope House Crotona Park North location (*Hope House on Crotona Park a 6-year pilot project in*

Bronx, New York 2024). If clients are violent or if clients leave against court-ordered treatment, they will return to court for further proceedings. This will not be considered an IMD due to its number of beds limited to 16. Further information is available in Appendix H.

Grace Secure Forensic Residential, New Orleans, Louisiana

Grace Secure Residential is located in New Orleans, Louisiana. It is called a Forensic Supervised Transitional Residential & Aftercare (FSTRA). The patients come directly from a level one psychiatric hospital or from jail. This facility has been operating for 30 years and has the capacity for 80 people. The patients are both forensically involved and court-mandated. Due to its size, it is considered an IMD. Grace Secure Residential has a contract with the State; the money is all state dollars with no federal revenue. They are on a fee-for-service model. Their group homes do have doctors, nurses, and social workers on site. Their services include inpatient, housing, and outpatient. Some people are there for an extended period of time; one person has been there for seven years, but the typical stay is six months to one year. Louisianna has two FSTRA units; the larger one is 125 beds. All referrals are from jails and hospitals. They do not take people who are actively violent as they find it is too dangerous. They will manage an outburst if a resident escalates and needs to go to the hospital for a medication adjustment then after that patient regains stability and is no longer aggressive, he or she will return to the facility. Key outcomes have shown reduced recidivism, reduced hospitalizations, and reduced police interactions. They take anyone who is not currently aggressive or violent; they have people convicted of murder and sex offenses. Everyone is court-ordered. They take the history from the psychiatric hospital or jail. Most have been in a level 1 psychiatric hospital prior to the program. They also operate a Mental Health Rehab (MHR) program, an outpatient facility, where they assist the person with life skills such as getting a job, living successfully in their apartment, and

keeping them on medications. Grace MHR acts as their case manager. They will petition them immediately if they fail to keep appointments or take medication, and a probation officer is sent out to pick up the person for more intensive treatment. The outcomes of recidivism are impressive; their members stay out of the hospital and jail. Outcome metrics will be added.

Secure Residential San Mareo, California

San Mateo County designed and remodeled the existing facility, which was constructed in 1952 and originally served as a tuberculosis hospital. It was adapted in 1978 for its current use in the treatment of people with mental illness. Designated as a Mental Health Rehabilitation Center (MHRC) that is licensed to serve San Mateo County residents 18 years old and older with long histories of mental illness.

The new Cordilleras campus replaces a 117-bed facility with a campus composed of five secure residential units with 16 individuals and a supportive housing unit for another 57 residents. A different behavioral health provider will run each of the 16-bed housing units. Due to this size limit, it will not be designated as an IMD. The new campus will open in Spring 2024; the old one is still operational during construction. Each MHRC has three residential wings that splay out at an angle from the rest of the building, pointing towards the central green. Two residential wings contain five beds each, and the third one contains six. Between the splayed wings are fenced courtyards of varying sizes for client use. The rectangular block of the building, located against the hillside, contains communal functions and staff support areas. An open staff station, positioned at the center of a large open activity space, provides clear lines of sight down the living room of each residential wing. The dining room, entered from the open activity space, has views and access to a private courtyard. Entry for clients and visitors is from the curbside drop-off via a covered walkway to a private entry patio for each MHRC. Staff and service

providers enter via a separate door to a staff/service corridor to avoid disruption to the residents. The Supported Housing unit is a modified "L" plan. Entry for visitors and clients is from a drop-off area on the loop road to a central waiting and reception area on the first floor. Campus Center rooms, such as the art room, retail space, chapel, and wellness room, adjoin the lobby. One has an uninterrupted view of the central green space from the lobby, and double doors lead out to it. From these doors, visitors can walk under cover to the large community room in the separate one-story pavilion to the south. Service entry and loading dock, in a walled enclosure, occur at the west side of the building, with kitchen and other building support spaces adjacent. Administrative offices are situated in the south wing of the "L" on the first floor. Each of the three upper floors of the building contains two residential wings connected by shared spaces, including a central dining/activity room with a private balcony and a broad view of the central green space (*Cordilleras Health System Replacement* 2018). Outcomes in the new Secure residential campuses are expected after one year of operation and thereafter.

Telecare Corporation

Telecare operates in Washington, Oregon, California, Arizona, and Nebraska. The Telecare Rochester, Washington campus has been open for about five years. This is not considered an IMD due to its number of beds limited to 16. There are three more homes in Vancouver, Washington, including a new one opening in 60 days. An additional campus is under construction in Stanwood, Washington, and will open in one year. These residential homes provide an alternative to higher levels of care, such as state psychiatric hospitals or other IMDs (larger institutions). The secure residential treatment facilities (SRTFs) and MHRCs offer a homelike setting while also treating the behaviors and issues that put them at elevated risk for institutional placement. The SRTF's focus is on skills development and community integration.

They offer many therapeutic services, including community-based transitional services, recovery-focused groups and activities, medication management, education, transportation, and intensive case management. The typical length of stay is up to 18 months. They also offer Longer-Term Residential, which provides individual treatment planning focusing on repairing family and social relationships and honing daily living skills. They help create crisis intervention plans, and Staff also teach and assist with medications (*Program Types* n.d.). The chart below is for overall outcomes; the report will be updated when secure outcome numbers are differentiated—further reading in Appendix I.

Figure 7- Telecare Measurements

(*Outcomes & results* n.d.)

Conclusion

A Secure Behavioral Health Residential Facility (SBHRF) provides a safe environment for stabilizing individuals with severe mental illness (SMI), especially those with chronic and severe conditions (CMI). Currently, available facilities such as community psychiatric inpatient hospitals often cannot effectively stabilize CMI individuals due to constraining medical necessity protocols and regulatory constraints, which contribute to short-duration stays. These individuals may have experienced homelessness and involvement with the justice system.

SBHRF, licensed by the Department of Health Services (DHS), offers secure 24-hour supervision by trained staff, contributing to the continuum of care. CMI individuals have not been successful in other settings and often will have experienced homelessness and justice system involvement. This newly licensed secure setting adds to the continuum of care. It requires the DHS to license secure behavioral health community-based facilities to provide secure 24-hour on-site supportive supervision by staff with behavioral health training. DHS already licenses "secure" settings for adolescents, children, and individuals with dementia and Alzheimer's disease. SBHRFs are distinct from inpatient facilities or institutions for mental diseases, lacking medical oversight, on-site nursing, restraint/seclusion capabilities, and including room and board. According to federal oversight and approval, they are considered community-based settings, not inpatient or medical institutions.

Expanding SBHRF as community-based secure living can give CMI individuals the time they need to stabilize on medications, gain insight, and break the cycle of repeated psychosis. Several other states use SBHRF as a step down from level 1 and have realized respectable results.

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APPENDIX

APPENDIX A- BEHAVIORAL HEALTH RESIDENTIAL FACILITIES LICENSING

Covers the Arizona State licensing requirements for a Secure Behavioral Health Facility.

APPENDIX B- ARS 36-550, TITLE 36- CIVIL COMMITMENT

Covers the civil commitment process.

APPENDIX C- TITLE 13- FORENSIC COMMITMENT

Covers the Forensic Commitment process.

APPENDIX D- OLMSTEAD ACT

Covers the Olmstead Act, expanded below

APPENDIX E-42 CFR 435.1010, INSTITUTION FOR MENTAL DISEASES

Covers the Institution for Mental Diseases exclusion from Medicare Dollars.

APPENDIX F-ARS 36-550.09, SECURE RESIDENTIAL FACILITIES ADMISSION CRITERIA criteria expanded below.

APPENDIX G- SMI PREVALENCE AND TREATMENT RATES

Covers SMI prevalence and treatment rates.

APPENDIX H- ARIZONA HEALTH STATUS AND VITAL STATISTICS 2019

APPENDIX I- HOPE HOUSE SUMMARY AND FAQs

APPENDIX J- TELECARE CORPORATION

APPENDIX D- OLMSTEAD ACT

Olmstead Case Law
US Reports: Olmstead v. LC, 527 US 581 (1999)

The symptoms of CMI (mainly, but not exclusive to, schizophrenia) are hallucinations, delusions, paucity of thought, lack of motivation, poor socialization, impulsivity, and anosognosia (a symptom of a high percentage of persons with psychotic disorders that makes it difficult for individuals to realize they are sick) make treatment difficult. There is also misinterpretation or omission of relevant information in the arguments referring to the Olmstead case. The peer community and the American Civil Liberty Union (ACLU) have misinterpreted or omitted some arguments. The Olmstead vs. LC (1999) case began with two women from Georgia who were confined for psychiatric treatment at Georgia Regional Hospital. After receiving treatment, both women improved to the point where treating doctors concluded they could receive community-based care. However, rather than releasing the women, the state kept them institutionalized. The women filed suit, alleging that the state violated Title II of the Americans with Disabilities Act ("ADA ") in failing to place them in a community-based program once their treating professionals determined that such placement was appropriate. The Supreme Court agreed with the two women. Because their doctors concluded they could safely live in the community, the ADA was violated when they continued to be held in an institution (Olmstead v. LC, 527 U.S. 581, 1999).

However, judicial arguments also made clear that not everyone can live safely in the community. Justice Ginsberg wrote, "The ADA is not reasonably read to impel States to phase out institutions, placing individuals in need of close care at risk" (*Olmstead v. L. C.*, 527 US 581 at 605). She went on, "[n]or is it the ADA's mission to drive States to move institutionalized individuals into an inappropriate setting, such as a homeless shelter . . ." (*Id.* at 606). Booting an individual to the street or a setting not appropriate for their condition was never contemplated in this case. However, Ginsberg also noted that "[f]or other individuals, no placement outside the institution may ever be appropriate" (*Id.* at 605). Additionally, "some individuals, whether mentally retarded or mentally ill, are not prepared at particular times – perhaps in the short run, perhaps in the long run – for the risks and exposure of the less protective environment of community settings; *for these persons, "institutional settings are needed and must remain available*" (Id., *emphasis* added). Thus, when read accurately, Olmstead provides support for secured treatment if it is needed for that individual.

APPENDIX F-ARS 36-550.09, SECURE RESIDENTIAL FACILITIES ADMISSION CRITERIA

Here's a breakdown of the section:

Section A describes under what circumstances a court can order a patient's placement in a secure behavioral health residential facility. This can happen when the court determines that a patient meets the criteria for court-ordered treatment (pursuant to section 36-540, subsection A), is seriously mentally ill, and is chronically resistant to treatment. The court can place the patient in a facility that is licensed by the department (as per section 36-425.06) and willing to accept the patient. It also specifies that placement in such a facility is not considered inpatient treatment under section 36-540, subsection F.

Section B outlines how a court can determine if a person is "chronically resistant to treatment." For this to happen, the court must find that within the 24 months prior to the court order (excluding time hospitalized or incarcerated), the person persistently or recurrently refused or failed to participate in or adhere to treatment for their mental disorder despite being offered, prescribed, recommended, or ordered treatment. The evidence must meet the following criteria:

1. The person received treatment in less-restrictive settings (including unsecured residential treatment with 24-hour support from staff with behavioral health training) in the past 24 months. That treatment was unsuccessful or likely to be unsuccessful due to the person's unwillingness to cooperate with such treatment.
2. The person's nonadherence to treatment in the past 24 months resulted in one or more of the following consequences: serious self-harm; harm or threats of harm to others; recurrent homelessness due to the mental disorder; recurrent serious medical problems due to poor self-care or failure to follow medical treatment recommendations; or recurrent arrests due to behavior resulting from the mental disorder.
3. The court can consider any other relevant evidence about the person's willingness or ability to participate in treatment or their need for treatment in a licensed, secure residential setting to ensure compliance with court-ordered treatment.

Section C states that a person's placement in a licensed secure behavioral health residential facility must be part of a written treatment plan presented to and approved by the court (as required by section 36-540, subsection C, paragraph 2). The court order must confirm that placement in a licensed, secure behavioral health residential facility is the least restrictive environment to ensure compliance with the person's treatment plan.

The Secure Behavioral Health Residential Facility setting is designed to cater to the needs of civilly committed individuals who:

1. Have been diagnosed with serious mental illnesses.
2. Consistently struggle with adherence to treatment or support for mental disorders while in the community.
3. They are placed in the facility under an Arizona court order for mental health treatment, as per current Court Ordered Treatment (COT) regulations.
4. Experience frequent admissions to inpatient settings due to dangerous behaviors that pose a risk to themselves or others, negatively impacting their health and well-being.

5. Suffers from repeated relapses that have detrimental effects on their overall psychiatric, physical, and medical health.
6. No longer meet the medical necessity criteria for inpatient care.
7. Have a history of incarceration and involvement with the legal system, stemming from untreated mental illness or symptom exacerbation.
8. Have a history of homelessness or a pattern of leaving treatment facilities against medical advice (AMA).
9. Experience challenges related to substance and alcohol use.
10. They are not deemed to pose a significant risk of violence toward others while living in a secure setting with round-the-clock support and supervision.
11. They have demonstrated an inability to live safely in an unsecured environment, exhibiting tendencies like "wandering off" or "eloping," which result in engaging in dangerous behaviors harmful to their health, well-being, and safety.

The SBHRF setting is also essential for addressing the needs of individuals with SMI who have committed dangerous crimes but are not competent to stand trial. These facilities are specifically designed to provide a secure and therapeutic environment for individuals deemed non-restorable and dangerous. The individuals who have been determined non-restorable and deemed dangerous after committing a dangerous crime can be court-ordered to a SBHRF. SBHRFs can be tailored to the needs of "forensic people," e.g., those who have committed dangerous crimes and have SMI may need more staff due to the violent tendencies of this population. The provider of SBHRFs must be willing to accept the person. It is thought to be best practice not to intermingle these populations (i.e., "forensic" and "civil") for the best outcomes. The County Prosecutors in rural counties have had trouble housing this population (forensic) and have often released them to the public, which can endanger the community.

The statute endeavors to:

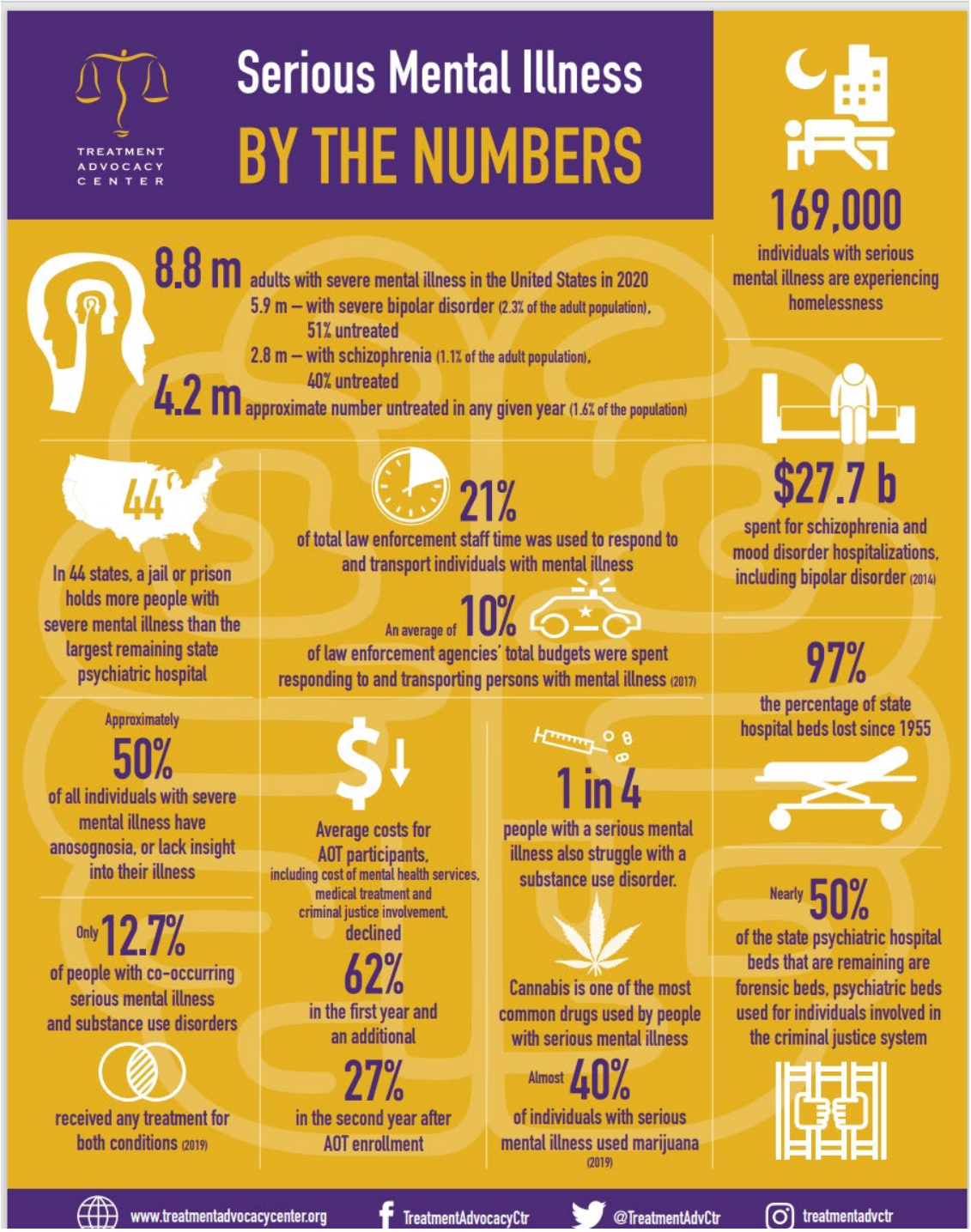
1. balance the safety and well-being of individuals with serious mental illness who resist treatment,
2. while protecting their rights by requiring the least restrictive environment for treatment court
3. approval of the treatment plan

ensuring community and public safety.

APPENDIX G- SMI PREVALENCE AND TREATMENT RATES

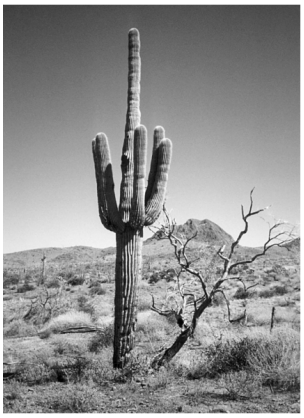
Covers SMI prevalence and treatment rates.

Treatment Advocacy Center SMI Prevalence and Treatment Rates



(Our impact: By the numbers 2023)

APPENDIX H- ARIZONA HEALTH STATUS AND VITAL STATISTICS 2019



4A. INPATIENT DISCHARGES FROM SHORT STAY HOSPITALS BY FIRST-LISTED DIAGNOSIS AND PATIENT CHARACTERISTICS

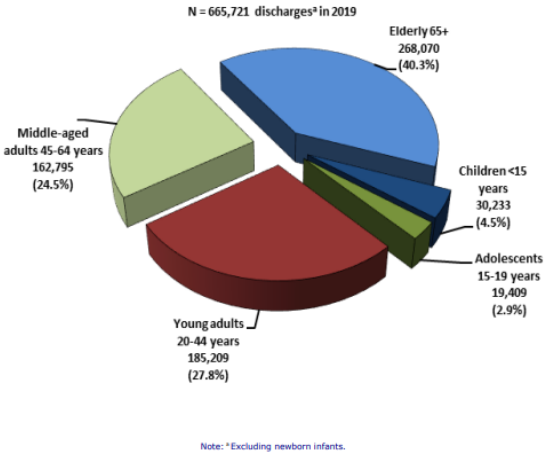
An inpatient discharge occurs when a person who was admitted to a hospital leaves that hospital. A person who has been hospitalized more than once in a given calendar year will be counted multiple times as a discharge; thus, the numbers in this report are for discharges, not persons. Federal, military, and Department of Veteran Affairs' hospitals are excluded. Beginning in 2010, the psychiatric hospitals also are required to report to the Arizona Department of Health Services. All discharges are for residents of Arizona. Discharges of out-of-state residents are not included in this report. Discharges of inpatients in this report exclude newborn infants.

Beginning in 2016, diagnostic groupings and code numbers are based solely on the International Classification of Diseases and Related Problems, 10th Revision, Clinical Modification (ICD-10-CM). ICD-10-CM incorporates greater details about medical diagnosis and represents a substantial increase in number of diagnostic codes, with more than 69,000 codes compared with about 14,000 under ICD-9-CM. Due to fundamental changes in the coding system caution should be exercised in comparing current inpatient data to that of years prior 2016. For further explanation of this new coding system, please refer to "The Implementation of the International Classification of Disease, Tenth Revision," Introduction page ix.

The change in the Arizona reporting requirements increased the number of diagnoses that are coded for each discharge from nine to twenty-five. In this section, discharges are presented by principal diagnosis, which is the first one listed on the discharge summary of the medical record. The number of first-listed diagnoses is the same as the number of discharges. For comparability with the national data* , the discharge rates are presented per 10,000 population. The groupings of ICD-9-CM and ICD-10-CM codes used to identify specific diagnostic categories can be accessed at: http://pub.azdhs.gov/health-stats/hip/cat/icd9-10primary.xlsx.

*Findings of the National Hospital Discharge Survey are available in bound reports of the National Center for Health Statistics and online at http://www.cdc.gov/nchs/nhds.htm

Figure 4A-1
Hospital Inpatient Discharges[a] by Age Group, Arizona Residents, 2019



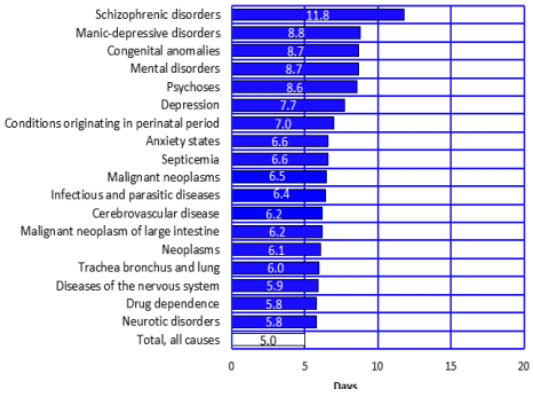
Note: [a]Excluding newborn infants.

In 2019, there were 665,721 inpatients discharged, excluding newborn infants, from non-Federal short stay hospitals in Arizona (**Table 4A-1**). Patients who were elderly (65 years or older) accounted for 40.3 percent of hospital discharges (**Figure 4A-1**), followed by young adults (20-44 years old) who comprised 27.8 percent of discharges, and middle-aged adults (45-64 years old) with 24.5 percent of all inpatient discharges.

Diseases of the circulatory system were the most common diagnoses (14.4 percent of all discharges), followed by *mental disorders* (10.4 percent), and *injury and poisoning* diagnoses (10.0 percent; percentages based on data in **Table 4A-1**).

Note: Excluding newborn infants.

Figure 4A-2
Average Length of Hospital Stay for Discharges with Selected First-listed Diagnosis, Arizona Residents, 2019

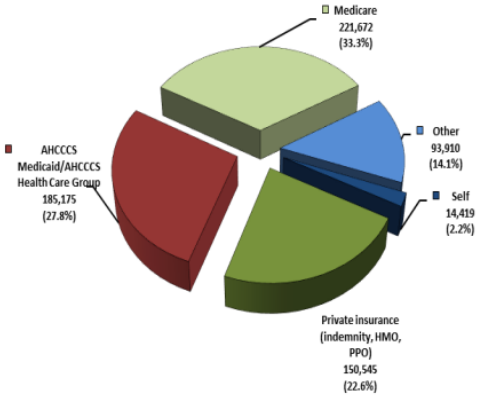


Based on the data from the National Hospital Discharge Survey, the longest continuously running nationally representative survey of hospital utilization, the length of stay for inpatients has changed dramatically from 1970 through 2010. In 1970, the average length of stay was 7.8 days, with one-third of patients hospitalized for 8 days or more. In 2010, the average length of stay nationally was 4.8 days.

In 2019, the average length of hospital stay for Arizona inpatients was 5.0 days (**Figure 4A-2**, **Table 4A-5**). The percent of patients hospitalized for three days or less was 54.01 percent, with 17.2 percent of inpatients staying eight days or more.

The top five conditions with the longest length of inpatient stay was: *Schizophrenic disorders* (11.8 days), *psychoses* (8.6 days), *manic-depressive disorders* (8.8 days), *congenital anomalies* (8.7 days), and *depression* (7.7 days).

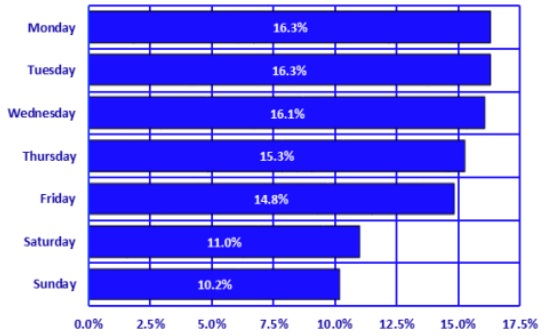
Figure 4A-3
Hospital Inpatient Discharges by Payer, Arizona Residents, 2019



Medicare paid for 33.3 percent of all discharges (**Figure 4A-3**) and 70.0 percent of inpatient discharges of persons aged 65 years or older (**Table 4A-4**). The Arizona Health Care Cost Containment System (AHCCCS; the State's Medicaid Program) was the second most frequently recorded expected source of payment, accounting for 27.8 percent of inpatient discharges. Private insurance accounted for 22.6 percent of hospital inpatient discharges.

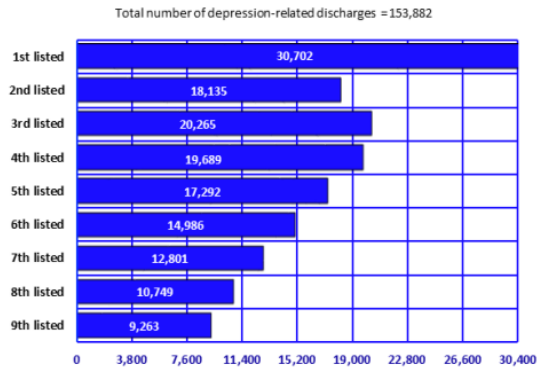
Note: The Arizona Health Care Cost Containment System is the State's Medicaid Program.

Figure 4A-4
Percent of Hospital Inpatient Admissions by Day of the Week, Arizona Residents, 2019



The rhythm of hospital births by day of the week (see **Figure 1B-14**) reveals that the daily average of resident live births in 2019 was substantially lower on weekends than on weekdays. The same pattern applies to hospital inpatient admissions excluding newborn infants (**Figure 4A-4**).

Figure 4A-5
Number of Depression-Related Inpatient Discharges and Emergency Room Visits of Arizona Residents, 2019

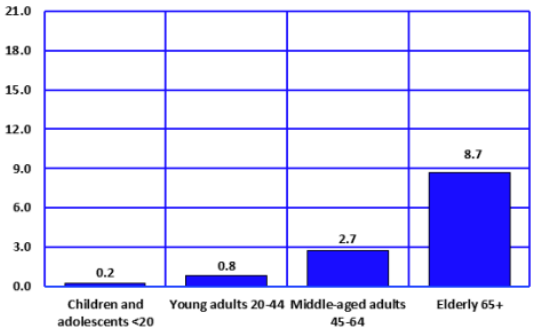


In 2019, *depression* accounted for 24,369 inpatient discharges and 6,333 emergency room visits as the first-listed diagnosis (for a total of 30,702 hospital encounters; **Figure 4A-5, Table 4A-1, Table 7C-1**).

The extent to which the first-listed diagnosis is the principal reason for hospitalization ought not to be overestimated. More often than not, the first-listed diagnosis is the immediate, but not necessarily the underlying cause of hospitalization.

However, when we count all entries of this code within the nine diagnostic fields, depression was mentioned on 153,882 inpatient discharges and emergency room records (**Figure 4A-5**). When hospital data are used to estimate the prevalence of depression, it makes sense to include all mentions of this disorder in all diagnostic fields, not just the first one.

Figure 4A-6
Inpatient Hospitalization Rates for Enterocolitis due to *Clostridium difficile* By Age Group, Arizona Residents, 2019



Note: Number of visits per 10,000 population

In 2019, 1,791 Arizonans were hospitalized with the diagnosis of enterocolitis due to *Clostridium difficile*, a bacterial inflammation of the intestines (**Table 4A-1**). The disease is of growing public health concern because it is often acquired in hospitals and other health care institutions with long-term patients as residents.

The hospitalization rates associated with enterocolitis due to *Clostridium difficile* tend to increase with age. The rate for the elderly 65 years or older (8.65/10,000) was the highest of all age groups (**Figure 4A-6**).

In 2019, 112 Arizonans died from enterocolitis due to *Clostridium difficile*. Elderly 65 years or older accounted for 82.1 percent of these deaths (**Table 2C-27**).

APPENDIX I- HOPE HOUSE SUMMARY AND FAQs (Cheryl Roberts, 2023)

Hope House on Crotona Park
849 Crotona Park North
Bronx, New York

A Project of the Greenburger Center for Social and Criminal Justice
Scheduled to Open Early 2025

Hope House on Crotona Park, anticipated to open in early 2025, is an Alternative to Incarceration (ATI) for those with Serious Mental Illness (SMI), including those with cooccurring Substance Use Disorders (SUD) accused of felony level crimes. People charged with misdemeanors only are not eligible for Hope House. Hope House will offer a longer-term (one-to-two-year expected length of stay) residential program for 8 men and 8 women operated by the Greenburger Center for Social and Criminal Justice, Inc. (GCSCJ or Hope House), with an on-site treatment program provided by an outside provider and residential and security staff on-site 24/7.

Hope House is a first-of-its-kind model in the nation because of its use of bond agency authority to provide security in a voluntary ATI program and its co-located integrated residential and therapeutic treatment services. These features are discussed in more detail below. Whenever possible, veterans will have preference. Preference will also be given to individuals living in the Bronx at the time of their arrest as follows: up to 4 beds will be reserved for people residing in the Bronx at the time of their arrest where such bed is available and more than one candidate is being considered, one of whom is a Bronx resident. Hope House will serve anyone, ages 18 and older, residing in New York City's five boroughs though at the request of the local community board, Hope House will not accept people accused of sex offenses at this location.

A Voluntary Program for those Determined Mentally Competent to Participate

Admission to Hope House is on a voluntary basis with advice of counsel and consent of the Court. In cases where sentencing law mandates incarceration, Hope House will require district attorney (DA) consent before enrollment including acknowledgment and agreement by the DA that such charge will be dropped and replaced with a lower charge including agreement that a non-incarceral sentence should be imposed, where the terms of the Plea Agreement are

met. Where the client is unable to complete the terms of the Plea Agreement, a DA must also agree that any time spent at Hope House can reduce the sentencing determination by an equivalent amount should a term of incarceration ultimately be imposed.

A client's competency to make this voluntary decision will be carefully considered. A client not able to demonstrate a rational and factual understanding of the elements and consequences of the decision and the services offered at Hope House will not be enrolled in the program. Clients actively violent or threatening violence are also not eligible.

The Diversion Process

Once determined competent, a client's enrollment occurs at the point of a Court ordered Plea agreement, including the following five components:

• A plea of guilty to the agreed upon charge(s), with sentencing adjourned until either: completion of the mandated ATI residential treatment phase or early discharge from the ATI;
• Imposition by the Judge of nominal cash bail (i.e., $1.00), pursuant to NYS Criminal Procedure Law section 510.10(5), as a condition of the Plea and release to the ATI, to be enforced by an outside bond agent or other authorized person but specifically trained by Hope House;
• A commitment by the Court to a sentence requiring no further incarceration upon successful completion of the ATI program, but could include a period of post-release supervision, including, where appropriate, an agreement for term of probation;
• A stated sentence of incarceration that will be imposed if the client does not successfully complete the program, which sentence will be no greater than that which would have been imposed in the absence of program participation; and
• A commitment that, should the client be unable to successfully complete the ATI program, the sentence that the client receives will be reduced by one day for each day that the client spent in treatment.

Security Provided by Bond Agency Authority or Authorized Staff as per CPL Section 530.80

As part of the Plea agreement, Hope House will not accept a client unless the client voluntarily asks for and the Court imposes nominal cash bail on the client, allowing a bond agent retained by Hope House to return the client to Court should the client no longer wish to remain in the care of the ATI or where the client becomes an unmanageable risk such that the client must be returned to Court for further proceedings on the Plea as set forth above. The authority authorizing a bond agent to take a client into custody where forfeiture of bail is threatened is CPL 530.80. This bail bond supervision model was based upon successful work done by the Vera Institute of Justice with misdemeanor defendants. Learn more at: https://www.vera.org/publications/bail-bond-supervision-in-threecounties-report-on-intensive-pretrial-supervision-in-nassau-bronx-and-essex-counties

As part of the Plea Agreement, clients wishing to withdraw from the program will also agree to remain on-site for up to 24 hours to allow safe transport back to court during court hours. Clients will only be taken into custody by a bond agent as a last resort. If a client is taken into custody, custodial control will be exerted off Hope House property.

Use of cash bail avoids the need for and delay of securing and effectuating a bench warrant, a major obstacle for judges and DAs who have been hesitant to divert this population under currently available ATI options. As importantly, it also allows Hope House to require training of bond agents so that if needed, a client will be taken into custody by a person specifically trained to deescalate a mental health crisis situation rather than a police officer.

Access into the facility will be monitored. All doors exiting to the outside will either be

alarmed or locked, but locks will have an emergency panic bar to enable people to exit the building in an emergency. At no time will clients be locked in their rooms. Clients will also leave the building with peers or staff until such time as they can leave the building safely on their own without a peer or staff.

Treatment Philosophy & Licensure

Program and residential staff will provide evidenced based work-ordered-day programming, mindfulness and meditation, violence reduction, restorative justice programs, and life skills training, including job/education services. The residential component will be licensed as an NYS Office of Mental Health (OMH) 595-Congregate Care facility.

The Continuing Day Treatment Program (CDTP) and related staff will provide evidenced based trauma counseling; psychiatric and nursing care; medication management for psychiatric conditions; cognitive and dialectical behavioral therapy, where necessary; and opioid and substance use disorder treatment and management. CDTP services will be provided by Argus Community, Inc via an OMH CDTP Satellite license. The CDTP will be located in the same building as the residential program.

Re-Entry into the Community

Re-entry planning will comply with NYS Office of Mental Health licensure requirements and will begin at the time of enrollment. The goal of Hope House residential and therapeutic programming will be stabilization of any substance use disorders, management of psychiatric symptoms, and the treatment of underlying mental and physical disease. Upon stabilization, residential program staff will work to instill life and where possible, job skills which are essential to successful re-entry into the community.

Beginning in the second year of a client's stay, or as soon as possible, residential staff and a re-entry coordinator will work with clients and nonprofit organizations with extensive community experience with Hope House's target population to provide support in three major areas: 1) evaluation, motivational counseling, referral to residential programs; 2) family education, support, and reconciliation services; and 3) re-entry/recovery support and case management service.

FAQ Hope House on Crotona Park (Cheryl Roberts, 2023)

1) **What population does Hope House serve?**

Hope House will serve people accused of a felony-level crime and living with serious mental illness with or without a co-occurring substance use disorder. People convicted of a crime and already sentenced to prison are not eligible for Hope House. Hope House is a voluntary, Alternative to Incarceration (ATI) residential program open to defendants prior to trial or conviction.

2) **Will Hope House serve men and women?**

Yes, Hope House will serve up to 8 women and 8 men at a time.

3) What are the eligibility requirements for Hope House?

In addition to the requirements outline in FAQ#1, potential Hope House clients must be 18 years or older and live in one of the 5 New York City boroughs at the time of arrest to be eligible to enter Hope House. With respect to 4 beds, preference will be given to individuals living in the Bronx at the time of their arrest where a bed is available and more than one candidate is being considered, one of whom is a Bronx resident. This preference reflects the fact the Hope House on Crotona Park is located in Bronx, New York. Individuals accused of sex offenses or who are actively exhibiting violent behavior are not eligible for admission to Hope House. People accused of misdemeanors only are also not eligible for Hope House. A violent felony charge

does not automatically exclude an individual from admission. Each case will be examined on a case-by-case basis, but at no time will violence or the threat of violence be tolerated at Hope House. Violence or the threat of violence, are grounds for immediate expulsion from the program.

4) **How is a person admitted to Hope House?**

A Hope House resident must: 1) be accused of at least one felony charge; 2) have a serious mental illness with or without a co-occurring substance use disorder confirmed by a mental health assessment; 3) be competent to stand trial, understand the nature of a Plea agreement, and voluntarily sign the Plea agreement with the advice and consent of an attorney and with permission of the Court and the Prosecutor; and 4) voluntarily ask a Judge to set nominal ($1.00) bail as a condition of diversion to Hope House at the time of entering the Plea agreement.

5) **What is the length of stay at Hope House?**

Typically, up to 2 years.

6) **What kinds of services will Hope House Clients Receive?**

While at Hope House, clients will receive 24-hour residential care. Mental health treatment will be offered Monday through Friday, available 9 am – 5 pm through a Continuing Day Treatment Program (CDTP) offered by Argus Community Inc., on the second floor of Hope House, including medication management and treatment for opioid addiction if necessary. Clients will also receive daily program instruction in life management skills through a work-ordered day schedule in a modified therapeutic community setting.

7) **Can Clients leave the facility?**

While clients will be allowed to leave the premises with a peer or other staff, during the first 6 – 8 months of stay, a court may condition a participant's release on their voluntary commitment to remain on the premises until staff are sure the client will not engage in activities that are harmful to themselves or others, such as ingesting illegal substances or engaging in other criminal activity, particularly activity harmful to recovery and treatment.

8) **Is Hope House a private prison or is the program voluntary?**

Hope House is not a private prison. Private prisons are illegal in New York State. In consultation with their defense attorney, a person may voluntarily decide to enter Hope House. If a client wishes to be discharged from the program, Hope House staff will make arrangements to return the client back to court for further proceedings pursuant to the client's Plea Agreement.

9) **Will Corrections Officers or any other governmental personnel be on site to provide security?**

No. Hope House on Crotona Park it a project of the Greenburger Center for Social and Criminal Justice, Inc., a 501c(3) not-for-profit. All staff will be privately hired and trained.

10) Will clients ever be locked in rooms or cells? What happens in case of fire?

Clients will never be locked in a room and there are no cells on the premises. The City's Building Department has reviewed and approved the fire escape plans for Hope House. Doors to the outside of the facility will be locked at all times, but emergency escape bars will be placed on all doors, allowing emergency egress in case of fire. Once pushed, the emergency release bar will unlock the door within 15 seconds, as per the NYC Building Department.

11) **Who will provide residential and clinical services and what is the treatment modality?**

The Greenburger Center of Social and Criminal Justice, Inc., (GCSCJ) has partnered with Argus Community, Inc., to provide mental health treatment and substance use disorder recovery services. The Hope House treatment model will be based on Argus' modified therapeutic

community model. Residential services will be provided by the GCSCJ based on a work-ordered-day schedule inspired by the Fountain House clubhouse model.

12) **How will security be provided?**

Security staff will be on the premises 24 hours a day. A bond agent or someone with the ability to take a client into custody will be on call to provide these services off-site if necessary. Bond agents will be fully trained in Crisis Intervention Team (CIT) training and only called if a client leaves the facility or acts in another manner in contravention of a court order and must be returned to court pursuant to the court order. In these circumstances, the goal would be to take the client into custody without resorting to issuance of a bench warrant by a court for arrest of the client by the police. Where the client becomes violent or threatens violence, security staff may find it necessary to contact the local Sheriff's Department or police precinct to effectuate and arrest on-site and transport the client to court as necessary and proscribed by the court. Security staff will be fully trained to manage this population.

13) **Who determines whether a client is discharged from the program?**

The judge with jurisdiction over the case will determine whether a client should be discharged from the program for failure to adhere to the terms of the Plea agreement, except in cases where the client is violent, threatens violence or presents an immediate danger of serious harm or injury to self or others. Where a client is violent, threatens violence or presents an immediate danger of serious harm or injury to self or others, the Program Director will determine whether the client must be discharged from the program and will notify the court within one business day of such decision. Where a client is discharged by the program director, discharge protocol will be followed to the maximum extent practicable, given any requirements or responsibilities placed on the client or Hope House per the court order.

APPENDIX J- TELECARE CORPORATION

Provided by Jennifer Hinkel, Ed.D.| Vice President for Development **on January 26th, 2024.**

Opportunity House: A New Secure Residential Treatment Facility in Salem

Telecare Corporation is seeking a contracting opportunity with the Oregon Health Authority to operate a Secure Residential Treatment Facility (SRTF) that is currently under construction at 325 Lancaster Drive SE in Salem, Oregon. The program will offer 16 new subacute treatment beds in Marion County, serving the Aid & Assist and Civil Commitment populations. Telecare partnered with Community First Solutions to secure grant funding from Oregon Health Authority Health Systems Division to build this house which will be ready by June 2025.

Telecare has over 20 years of experience providing high quality, population-specific services to the Aid & Assist and Civil Commitment populations in Oregon, and 59 years of experience providing services to similar populations in California and other states Establishing 16 new beds for the Civil Commitment and Aid & Assist populations will provide a new referral resource to divert individuals from admission to Oregon State Hospital (OSH) which will positively impact the OSH backlog.

To enhance our service to the target population, we have the ability to flex the use of the beds between the two populations according to the changing needs of the community. Additionally, this facility will also serve individuals who do not need hospital-level care. Telecare's diversion program caters to individuals requiring Post-Acute Intermediate Treatment Services (PAITS), enabling f the Civil Commitment population to be diverted from OSH.

Facility Design

Telecare operates facilities that exemplify the principles of recovery and trauma-informed care. With this goal in mind, Telecare's residential treatment homes project a physical manifestation of the respect and dignity clients deserve. All of Telecare's facilities are designed to foster a safe, healing environment with a program culture that is sensitive to those who have histories of trauma. This approach often decreases the likelihood of assaultive behavior, thereby reducing the need for safety interventions. The facility design will include a myriad of amenities and features consistent with an environment of hope. Features will include outdoor space for recreation, stress reduction and other therapeutic activities including gardening, individual bedrooms and accessible restrooms, a wheelchair ramp, a laundry area, group/meeting spaces, consultation rooms, staff offices, full eat-in kitchen, dining area, and space for family visits (including family of choice). Additional amenities include calming artwork, comfortable upholstered furniture, natural veneers, and softer lighting and paint colors to create comforting settings. Decoration of the physical space will be kept minimal for safety.

Organizational Capability: Similar Telecare Programs

Our Secure Residential Treatment Facilities (SRTFs) in Oregon include residents under the jurisdiction of the Oregon Psychiatric Security Review Board (PSRB) designated as "guilty except for insanity" and originating from Oregon State Hospital. These low-scale, home-like programs provide the State with significant savings by delivering services and supports in a setting that is more therapeutic and less costly than the State Hospital.

Recovery Center at Gresham in Gresham, Oregon

The state of Oregon selected Telecare to deliver a Post-Acute Intermediate Treatment Service (PAITS) tailored to individuals diagnosed with serious mental illnesses. Established in 2002, the Gresham Recovery Center is specifically designed to house 16 residents. Referrals for long-term care are facilitated through the State of Oregon Office of Addictions and Mental Health. In instances where capacity permits, we also welcome direct referrals from the community.

72nd Avenue Recovery Center in Portland, Oregon
Developed in partnership with the State of Oregon Office of Mental Health and Addiction Services, the 72nd Ave Recovery Center offers a clinical approach that is dramatically different than the traditional sub-acute locked facility. Opened in 2005, 72nd Ave Recovery Center is a 16-bed inpatient sub-acute SRTF. The program embraces the recovery philosophy at all levels instead of focusing primarily on symptom and behavior management. Recovery is woven into and defines every aspect of the program, from assessments and interventions to the resident information system, the selection of staff, and the overall resident experience.

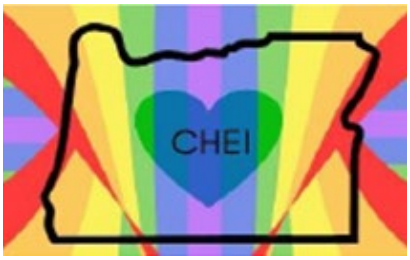
Recovery Center at Woodburn in Woodburn, Oregon
The Recovery Center at Woodburn is an SRTF designed to serve individuals who are under the jurisdiction of the PSRB. The Recovery Center at Woodburn opened in 2006 and offers a stable living environment for people found by the courts to be Guilty Except for Insanity . Services that are offered embrace the core concepts of Telecare's holistic approach to recovery where residents are provided with a safe, secure living environment.

Deschutes Recovery Center in Bend, Oregon
Opened in 2011, The Deschutes Recovery Center is a 16-bed residential treatment program providing services to eight individuals under the jurisdiction of the PSRB and eight individuals under the authority of civil commitment proceedings with the State of Oregon. The main purpose of the program is to provide a stable living environment for people who are transitioning from the state hospital or other secure facilities to a community-based program as a primary component of their mental health treatment.

Multnomah Crisis and Treatment Center in Portland, Oregon
Opened in 2011, Multnomah Crisis and Treatment Center is a 16-bed secure sub-acute crisis residential treatment program. This program provides comprehensive mental health and psychiatric treatment services in a safe, welcoming inpatient environment for adults with serious mental illness. We believe recovery starts from within, and that our job is to do whatever it takes to provide the support residents need on their recovery journey. Our facility includes a full team of peer supports, clinicians, a nurse, a psychiatrist, and recovery specialists who are here to provide support 24 hours a day.

Telecare's Approach to Services
Cultural responsiveness, trauma-informed, and person-centered care are the cornerstones of Telecare's service philosophy. Telecare's Cultural Humility, Equity, and Inclusion (CHEI) Committee guides their cultural competency efforts. Telecare's care team is staffed with certified Peer Support Specialists who may have once been disproportionately impacted by health inequities and understand the importance of compassionate care.

Cultural Humility, Equity, and Inclusion Committee



Telecare is committed to cultivating, respecting, and embracing cultural diversity practices, values, beliefs, interests, experiences, and the viewpoints of our staff, the individuals we serve, their families, and the communities in which we are located. This work is led by the organization's Cultural Humility, Equity, and Inclusion (CHEI) Committee with the Chief Human Resources Officer as the CHEI Executive Sponsor. The CHEI Committee is tasked with creating an annual Cultural Awareness Plan to better help Telecare improve its goals, policies, practices, and accountability efforts in creating a vibrant work environment—and a place where recovery can thrive.

Cultural Responsivity

Providing quality services that are culturally and linguistically appropriate to all clients grounds our programmatic approach. We recognize that only through services that are sensitive and tailored to individuals' diverse needs can we begin to positively impact outcomes and the communities we serve. Our staff work within each individual's self-defined cultural and linguistic framework to deliver services and foster hope for the future. Our person-centered clinical approach is designed to elicit information about issues of identity using open-ended questions through guided conversations (e.g. "How can we make sure that our services honor your culture?") and by doing as much listening and observing as possible to learn about the person we are serving. We make every attempt to follow the lead of each individual in respecting these cultural elements.

Recovery-Centered Clinical System

Telecare has developed a comprehensive Recovery-Centered Clinical System (RCCS), which we integrate within all aspects of our programs. RCCS offers a comprehensive, holistic, and richly personal approach to rehabilitation and recovery and incorporates Motivational Interviewing, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, trauma-informed care, and other person-centered therapeutic interventions. We work continually to make the RCCS curriculum both meaningful and accessible for individuals experiencing mental health crisis. We have found the insight-oriented therapeutic approach to be an excellent complement to the practices of positive behavior support and applied behavior analysis.

Whole Person Care

Because of the high prevalence of co-morbid chronic health and substance use conditions in the population with serious mental illness, Telecare has implemented a company-wide Whole Person Care initiative to ensure that clients with complex needs receive comprehensive recovery support. This holistic approach is especially valuable for high risk/high need populations because it addresses mental illness as only one of many barriers to health, wellness, and recovery.

About Telecare

Telecare is an employee- and family-owned corporation headquartered in California. Telecare operates over 161 programs in Oregon, California, Arizona, Nebraska, and Washington, serving over 41,500 unique individuals per year. Our spectrum of services includes inpatient acute, inpatient subacute, skilled nursing facilities, crisis, residential, and community-based programs.

Telecare has more than 59 years of experience providing services for people with severe mental illnesses in a spectrum of settings. Our mission is *to deliver excellent and effective behavioral health services that engage individuals with complex needs in recovering their health, hopes, and dreams.*

Descriptions of the Program Homes:

Recovery Center at Gresham | Multnomah County, Or. Opened in 2002, Recovery Center at Gresham is a 16-bed Gost-Acute Intermediate Treatment Services (PAITS) program in Gresham serving adults with a serious mental illness who may be under civil commitment or guardianship. The program was created to help divert individuals from state hospitalization, stabilize psychiatric symptoms that prevent people from being placed in less restrictive environments, reduce length of stay relative to state hospital stays, discharge residents into community placements and lower levels of care, enhance resident-focus, and to create cost-savings for the State.

72nd Ave. Recovery Center | Multnomah County, Or. Opened in 2005, 72nd Ave. Recovery Center is a 16-bed Secure Residential Treatment Facility (SRTF) in Portland serving adults with serious mental illness who have had extensive institutional experiences. The program was created in partnership with the Oregon Health Authority, Health Systems Division to offer a clinical approach dramatically different than the traditional sub-acute locked facility.

Recovery Center at Woodburn | Marion County, Or. Opened in 2006, Recovery Center at Woodburn is a 15-bed Secure Residential Treatment Facility (SRTF) program in Woodburn serving adults (ages 18+) under the jurisdiction of the Psychiatric Security Review Board (PSRB). The program was created as a first step in the transition of individuals from Oregon State Hospital's forensic unit. In addition to mental health and life-skills training, Recovery Center at Woodburn also provides vocational rehabilitation opportunities that allow residents to work in the community.

Deschutes Recovery Center | Deschutes County, Or. Opened in 2011, Deschutes Recovery Center is a 16-bed Secure Residential Treatment Facility (SRTF) in Bend serving adults with serious mental illness. This program serves both Psychiatric Security Review Board (PSRB) and non-PSRB residents. The program was created to provide a stable living environment for people who are transitioning from the state hospital or other secure facilities to a community-based program as a primary component of their mental health treatment.

Gladman MHRC | Alameda County, Ca. Opened in 1965, Gladman is Telecare's longest-running program. Gladman is licensed as a 40-bed Mental Health Rehabilitation Center (MHRC)

serving individuals whose psychiatric disabilities require extensive rehabilitation services beyond those provided in typical sub-acute settings.

Morton Bakar Center | Alameda County, Ca. Opened in 1980, Morton Bakar Center is a 97-bed SNF in Hayward for older adults, ages 57+, diagnosed with a serious mental illness. Under the direction of a multidisciplinary team, residents Telecare's sub-acute recovery programs are supportive, structured, and usually secure inpatient environments designed to help residents prepare to move to the community and/or lower levels of care. These programs provide psychosocial rehabilitation and emphasize skills-building. Where applicable, they also focus on building linkages to community supports. Services include individual treatment, therapeutic group activities, medication support, pre-vocational and social work support.

Sub-Acute Program Roundup *(revised 1/24/2024, Jennifer Hinkel)*

An Overview of Telecare's Rehabilitation Programs receive diagnostic evaluation and treatment to address their psychiatric and medical needs. The center provides a longer term recovery program within a supportive, structured, and secure inpatient environment designed to help residents prepare to move to the community and/or lower levels of care. In 2016, Morton Bakar Center was recognized by the American College of Health Care Administrators as being in the top 9% of high-performing SNFs in the nation.

Villa Fairmont MHRC | Alameda County, Ca. Originally opened in 1981, Villa Fairmont MHRC is a 97-bed licensed MHRC that serves adults with a history of severe mental illness and repeated hospitalizations. Most clients are referred by acute psychiatric hospitals. Villa Fairmont's major service goals are symptom stabilization, engagement in recovery and a rapid return to the community for persons recovering from an acute phase of illness.

Cordilleras | San Mateo County, Ca. Opened in 1982, Cordilleras is licensed as a 68-bed MHRC that offers three licensed adult residential facilities: Edgewood Suites, a 15-bed residential program, Magnolia Suites, a 14-bed residential program, and Willow Suites, a 20-bed residential program. Cordilleras MHRC primarily serves San Mateo County residents aged 18 and older with long histories of mental illness and multiple episodes of acute psychiatric hospitalization. The goal of Cordilleras is to allow residents who would otherwise be in a state hospital or an acute care setting to develop the skills and supports needed to live more independently in the community.

La Casa Mental Health Rehabilitation Center (MHRC) | Los Angeles County, Ca. Opened in 1987, La Casa MHRC is a 190-bed inpatient sub-acute program in Long Beach and serves adults in Los Angeles County with serious mental illness who would otherwise be in a state hospital or acute care. La Casa MHRC resides on a 9-acre site features a full-size gym and swimming pool and adjacent to La Casa Psychiatric Health Facility (PHF). Staff at La Casa MHRC provide training in social skills and community living, along with therapeutic and activity groups.

Garfield Neurobehavioral Center | Alameda County, Ca. Opened in 1992, Garfield Neurobehavioral Center is Alameda County's first neuropsychiatric program. Garfield provides medical, nursing, and rehabilitative services to individuals who have a neurological disorder as well as a mental illness. The center is one of the few facilities in California accepting individuals with this combination of disorders. Garfield provides a recovery-centered environment with individualized care plans and programs. The staff at Garfield monitor residents' improvement to ensure a pathway to success, self-improvement, and potential for discharge to lower levels of

care. Garfield primarily serves adults ages 18-64. The program currently provides services to numerous counties throughout California as well as to Regional Center clients.

Recovery Center at Sarpy | Sarpy County, Ne. Opened in 2006, the Recovery Center at Sarpy provides 24-hour psychiatric rehabilitation, support, and supervision in a community setting that serves adults with serious mental illness and a co-occurring substance use disorder who are unable to reside in a less restrictive setting due to the pervasiveness of the impairment. The Recovery Center at Sarpy tailors services to residents so they can successfully transition to their residential setting of choice. The program's goal is to engage residents in treatment, rehabilitation, and recovery activities with the intent of further stabilizing and transitioning them to the least restrictive setting as rapidly as possible.

Redwood Place | Alameda County, Ca. Opened in 2003, Redwood Place is a voluntary and unlocked 15-bed facility that was developed to provide integrated, recovery-centered services to individuals with developmental disabilities (DD) and serious mental illness (SMI), who have cycled repeatedly through acute hospitals and clinical settings. As a sub-acute program, it creates a new level of care between State Developmental Centers and community-based treatment which supports the gradual transition from institutional to community environments. Redwood Place provides a comprehensive array of services and supports that are greater than what clients would receive in either the DD or SMI system alone.

Sanger Place MHRC | Fresno County, Ca. Opened in 2010, Sanger Place MHRC is a 15-bed sub-acute, secure, psychiatric care facility that serves adults with serious mental illness as well as individuals with co-occurring mental health and substance use disorders. The focus of the program is to empower residents to explore effective choice-making and awaken hope.

Deschutes Recovery Center | Deschutes County, Or. Opened in 2011, Deschutes Recovery Center is a 16-bed Secure Residential Treatment Facility (SRTF) in Bend serving adults with serious mental illness. This program serves both Psychiatric Security Review Board (PSRB) and non-PSRB residents. The program was created to provide a stable living environment for people who are transitioning from the state hospital or other secure facilities to a community-based program as a primary component of their mental health treatment.

Horizon View MHRC | Ventura County, Ca. Opened in 2016, Horizon View is a 16-bed MHRC that serves adults with serious mental illness who are in need of longer-term recovery services in a secure setting. Horizon View MHRC provides recovery-based rehabilitation and activity programs and services aimed at assisting members in gaining skills and stability needed for prepare them for placement in the least restrictive environment possible. The primary goal of this project is to place members closer to home, with improved access to family support and familiar surroundings.

Riverside MHRC| Riverside County, Ca. Opened in 2020, the Riverside County Telecare MHRC is licensed as a 38-bed sub-acute residential program located in Riverside, CA. The program provides longer-term mental health recovery services within a supportive, structured, and secure inpatient environment designed to help clients prepare to move to the community and/or lower levels of care.