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Underserved Arizonans: Mental Health and Developmental Disabilities



September 2016

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With support from ASU'S Center for Health Information and Research

Underserved Arizonans: Mental Health and Developmental Disabilities

We don't often think about people with intellectual or developmental disabilities (I/DD) having mental health issues, but some do. In fact, they are at greater risk of developing mental health issues¹ than the general population. Overall, they experience social rejection, stigmatization, and a lack of acceptance that contributes to greater stress. Many have limited coping skills for dealing with this stress, due to language difficulties, inadequate social supports, and/or other disability-related issues.² As a result, some are also more vulnerable to substance abuse. But despite these complex issues, they are less likely to receive any treatment, or they are offered services that don't match their needs.³

This report introduces the under-discussed topic of mental health and substance abuse and how it impacts people with I/DD and their families. It will also share the findings of focus groups conducted in 2015 with 39 adults with lifelong mental health issues and their families in Phoenix, Flagstaff, and Tucson to better understand the day-to-day experiences of living with a mental health issue, the barriers they confront, and how they have successfully overcome them.

Impact of Mental Health on I/DD

Mental health issues are not commonly viewed as developmental disabilities – but they can be. The federal Developmental Disabilities Act defines the term developmental disability as a severe, chronic disability of an individual that is lifelong and attributable to a mental or physical impairment manifested before the age of 22 that results in substantial functional limitations requiring supports in three or more of the following areas of major life activity:⁴

- Receptive and expressive language
- Learning
- Mobility
- Self-direction
- Capacity for independent living
- Economic self-sufficiency

Accordingly, some mental health issues fall under the umbrella of developmental disability.

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I'm bipolar, and I'll have episodes where I get really frustrated or, you know, I just can't always function correctly socially. Then it's more of a personal battle. I don't really know how I would be able to ask anyone for help per se.

-22-year-old male

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But increasingly, mental health issues are diagnosed in people with unrelated I/DD, which is often referred to as dual diagnosis.⁵ Persons with a dual diagnosis can be found at all ages and levels of intellectual and adaptive functioning. Estimates of the frequency of dual diagnosis vary widely, however, the National Association for the Dually Diagnosed (NADD) has adopted the estimate that 30-35% of all persons with I/DD have a psychiatric disorder. Very high rates of co-occurring emotional disorders are also found among children who have autism (41-70%), cerebral palsy, and epilepsy.⁶

The co-existence of I/DD and a psychiatric disorder can have serious effects on the person's daily functioning. It can interfere with educational and vocational activities, jeopardize housing options, and disrupt family and peer relationships. Therefore, it is imperative that accurate diagnosis and appropriate treatment be obtained in a timely manner.

Mental Health Access among People with I/DD



On Employment...

I had medication changes or stability changes if something, if, if I went unstable, then there wasn't the space or the time to get stable again. Like you can't take that much time off...

-39-year-old female with dual diagnosis



Programming for developmental disabilities and mental health issues are administered in the state of Arizona through two different departments/divisions: the Division of Developmental Disabilities (DDD) under the Department of Economic Security (DES), and as of July 1, 2016, Arizona's Health Care Cost Containment System (AHCCCS or Medicaid) provides Arizona's mental health care. AHCCCS contracts with the Regional Behavioral Health Authorities (RBHAs), and Tribal Regional Behavioral Health Authorities (TRBHAs), to administer managed care delivery services in six distinct geographic service areas throughout the State.⁷ This regionalized system allows local communities to provide services in a manner appropriate to meet the unique needs of individuals and families in those areas. There can be some variation in the services delivered by each RBHA.

These regional agencies are required by AHCCCS to maintain a comprehensive network of behavioral health providers that deliver prevention, intervention, treatment and rehabilitative services, including employment, to a variety of populations. This includes: children and adolescents, adults diagnosed with a Serious Mental Illness (SMI), adults diagnosed with General Mental Health Disorders (GMH), and adults diagnosed with Substance Use Disorders (SUD/SA). According to prior Arizona Division of Behavioral Health Services (DBHS) data, there were 118,228 members enrolled in January 2013, but only 6,790 were also enrolled with DDD,⁸ representing about 20% of DDD's overall caseload. This is a lower percentage than the 35%

national dual diagnosis prevalence rate, indicating there may be statewide impediments to recognizing co-occurring developmental and mental health disabilities. Some groups are receiving more attention than others. The most common I/DD diagnosis among the members enrolled in both DBHS and DDD in 2013 was intellectual disability (46.8%) followed by autism (36.3%).⁹

In addition, the majority are disconnected from work and education opportunities. Out of the 3,712 working age adults enrolled in both of Arizona's DDD and DBHS systems, at least 73% of them were not working or attending school.¹⁰ The 2015 focus group data reveal that barriers to work among this population include discrimination and a lack of understanding of their disabilities, fear of losing Social Security and health benefits, and the lack of scheduling flexibility at some job sites.

Funding has exacerbated the problem. While Arizona ranks high in the amount of federal dollars received for mental health per capita spending on community-based programs, they don't fare so well in state spending. Since 2008, there has been a 42% decline in state funding per capita for mental health services in Arizona.¹¹

Subsequently, Mental Health America released its 2016 report on the state of mental health care and ranked Arizona 50 out of 51 in the country for its high prevalence of mental illness and overall poor access to care among youth and adults.¹²

A mental health diagnosis is often overlooked in people with I/DD. There is often a tendency to recognize only the developmental delay and attribute any behaviors to that condition. This phenomenon, known as overshadowing, blinds the clinician to the possibility a mental illness could be the cause of the behaviors for which the person is being referred.¹³ Moreover, standard clinical graduate programs and medical schools do not include dual diagnosis in their training curriculum.¹⁴

Another impediment to the recognition of mental illness in persons with I/DD has been the tendency for the administration and funding of mental health and I/DD services to be separate. Each system may expect the other to serve the person with a dual diagnosis. There is confusion among interagency agreements over their respective roles when a child is dually diagnosed. Specifically, is a child's behavioral health diagnosis related to a developmental disability or a separate emotional disability? The answer to this critical question draws on different funding, programs, and services.



[The behavioral health clinic] said, well, you know, we can't take him. He needs to go to be socialized. He can't even get in a place to socialize. He doesn't socialize anyway. He can't hear.

-Parent of an adult with dual diagnosis

To address this fragmentation, AHCCCS utilizes a "systems of care" approach to planning and service delivery which engages families as well as the child welfare, developmental disability and juvenile justice systems. While families continue to receive services from independent agencies, planning and coordination are intended to ensure each family has one integrated service plan meeting their goals. These multiple programs across I/DD and behavioral health agencies include care coordination or case management, resulting in unnecessary complexity for families. The 2014 focus group findings from the families of high school youth with behavioral health issues showed they have to manage the care coordinators across these systems, which becomes burdensome and overwhelming.¹⁵ Staff at these agencies also may feel ill-equipped to provide adequate services to people who have a dual diagnosis.¹⁶

There is a great need to train qualified personnel in the diagnosis and treatment of psychiatric disorders among individuals with I/DD in all systems who interact with them, but especially in the DDD and AHCCCS system. Furthermore, the more the general public is educated on dual diagnosis, the more people with I/DD will receive access to behavioral health services. Figure 1 provides some sample screening questions developed by NADD to determine if an individual with I/DD may have behavioral health needs.

Figure 1: Screening questions for behavioral health issues among people with I/DD

1. Is there a significant change in the person's behavior or mood that occurs in all settings rather than some settings?
2. Is there little or no improvement in the person's behavior despite the availability of consistent, high-quality supports?
3. Has the person experienced deterioration in his ability to take care of himself?
4. Has the person experienced decreased involvement with other people (by her choice)?
5. Has the person lost interest in formerly preferred activities?
6. Has the person shown some impairment in his or her perception of reality (e.g., is responding to internal voices, or professes beliefs that are obviously false)?

High Prevalence of Mental Health Issues among Arizona's Foster Youth

Over the past 20 years, some studies have found children and youth with disabilities are at least 3.4 times more likely to experience maltreatment than children and youth without disabilities¹⁷ and are disproportionately represented in the child welfare system. In 2013, 4,001 (30%) of children in Arizona's Department of Child Safety (DCS) system had a disability,¹⁸ which is significantly higher than the 4.1% of all of Arizona's children who have disabilities.¹⁹ Of these

children with disabilities in the DCS system, 40% had a medical condition, 33% had behavioral issues, 20% had a vision or hearing impairment, and 7% had a learning disability.²⁰

Arizona's SB 1375 report²¹ released last year join findings from previous studies that indicate youth with disabilities have a higher average number of out-of-home placements and are less likely to have a concurrent plan for their permanency outcomes than their non-disabled peers, and make up the majority of older youth in care. The average number of placements for all children in DCS is two. But some children are so impacted by the severity of the abuse, they become unable to form meaningful relationships or to respond to services, e.g., they have emotional disabilities. These children tend to go through multiple placements with numerous individuals and agencies. One child had been placed 42 times - in fact, of the 751 children who aged out of the system in 2013, over half had at least four different placements, and 35% were in more than five placements.²² Moreover, in 2013, almost half (45%) of individuals enrolled in DBHS and DDD were under the age of 18.²³

In Arizona, children who enter the DCS system are required to be referred by DCS to Rapid Response within 72 hours. The Rapid Response referral alerts the RBHA to send a behavioral health service provider to enroll the child and assess their immediate needs. In addition, to affirm children receive the services they need, HB 2442 (known as Jacob's Law), allows foster and adoptive parents to contact regional behavioral health authorities directly to enroll children in care.

A Word on Substance Abuse

Mental and substance use conditions often appear alongside each other. In FY 2014, 22.1% of Arizona's substance abuse clients had a co-occurring GMH, while 31.2% also had a SMI, in addition to a substance use disorder.²⁴ Furthermore, in 2014, Arizona ranked at the bottom with a drug overdose rate of more than 18 deaths per 100,000 people.²⁵ Substance abuse is especially acute among Arizona youth. When compared to other states, Arizona is tied with Colorado for having the eighth-highest rate of fatal overdoses in the country – 10.2 per 100,000 people, verses 7.3 per 100,000 nationally.²⁶ This number has been rising for the past 10 years. Addressing youth substance abuse is important because more than 90% of adults who develop a substance use disorder began using before they were 18.²⁷

But where do youth and adults with I/DD fit in? They are not part of any current prevention strategy, although their inclusion is sorely needed. For example, substance abuse prevention programs are common in traditional classrooms across the country, but there are few matching the learning needs of special education students. Just as there is overshadowing of mental illness diagnoses because clinicians only see the I/DD, a similar process can occur with

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...off medication I don't care about my fiancée or parents or family's feelings on me selling drugs and guns and breaking into houses and, you know, doing ecstasy and whatever. All my crazy stuff that I would do. I didn't care. But on medication I care enough not to do it. So I don't hurt them.

-25-year-old male with bipolar disorder and psychosis

substance abuse. About 25% of people with I/DD are believed to use substances and that number is growing with more people living independently.²⁸

Arizona's DDD recognized this as an issue in 2014.²⁹ With the high number of people with I/DD living the community, many suffer from higher rates of victimization, isolation, and other barriers that make them vulnerable to drugs and alcohol.³⁰ In fact, people with physical and cognitive disabilities are more likely to have a substance use disorder and less likely to get effective treatment for it than those without such a coexisting disability.³¹ There is a significant need for substance abuse screening and treatment for people with I/DD – many of whom also have mental health issues.

However, there are a small number of trained professionals available to treat for substance abuse, and even fewer who are trained in I/DD. A 2015 study shows Arizona has the sixth-lowest number of providers at 20 providers per 1,000 non-elderly adults with a drug or alcohol addiction – the U.S. average is 32.³² That affects who receives services.

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Arizona State University's Center for Health Information and Research reviewed Arizona's Medicaid service utilization data from July 2014 – June 2015. The findings suggest there is a much lower percentage of individuals with I/DD seen or treated for substance abuse than the non-I/DD population. It's not much better for those without I/DD. Nationwide, only about 11% of those who need treatment get it.³³

Individuals and Families Recount Their Experiences with Arizona's Behavioral Health System

Individuals and families were asked to discuss service gaps, strengths, barriers, and supports to living the life they desired. Many reported that they valued their clinics. The clinics that performed well shared one trait in common – the personalized relationship they had with clients. Individuals with mental health issues want to feel understood, listened to, and they

belong. The more satisfied participants talked about the strong relationship they had with their case managers and the clinic administration.

Peer support is also a strength; similar to other states, it is an inherent part of the behavioral health model in Arizona.³⁴ Fully one-third (34.5%) of members with SMI statewide receive peer-support.³⁵ Many participants were already peer support recovery specialists, strived to become one, or were engaged in peer support with someone helping them through recovery.

Individuals learn about recovery and how to advocate for themselves from others who have successfully recovered from a crisis. Peer support specialists are trained and certified, and paid to facilitate support groups, teach classes, and mentor others in their recovery. Peer mentors provide positive role modeling, exhibit strong coping and problem-solving skills, and share the benefit of their knowledge about community resources. They are critical to helping individuals and families feel supported.

In addition to these strengths, there were some gaps consistently reported by the 39 individuals and families who participated in the focus groups. Addressing some of these issues may strengthen mental health in Arizona.

Significant confusion surrounds Title XIX (19) versus non-Title XIX (19) services

Individuals and families are confused about what they are able to receive if they are not eligible for the state's Medicaid program through AHCCCS, also called Title XIX (19). For people with a designation of SMI who are eligible for Medicaid, Title 19 Medicaid-funded services are comprehensive. They include:

- Behavioral Health Day Programs
- Prevention Services
- Support Services
- Rehabilitation Services
- Medical Services
- Treatment Services
- Crisis Intervention Services
- Inpatient Services
- Residential Services

People with SMI ineligible for Medicaid are still able to access some of these non-Title 19 services, but they are limited, and typically funded through federal block grants, state appropriations, and county or city funding. The 2014 Mental Health Parity and Addiction Equity Act mandated insurance companies could no longer treat behavioral health care differently than primary care by charging higher co-pays or limiting the number of treatments patients can receive. However, non-Title 19 people with SMI are ineligible for counseling or residential treatment services. While Title 19 has low co-pays for clinic visits, the cost is high for some who are privately insured. For example, some private insurance plans have high co-pays for therapists, which are greatly needed in the SMI community.

Lack of coordination of care and staffing issues top complaints

Families and individuals stated primary care and behavioral health systems aren't fully



I think that you, you will not get your needs met if you aren't a loud squeaky wheel. Nobody's going to say, oh, man, for you, let's hand you all these services, let's get the right meds. You really have to fight - You have to have an advocate...You have to be willing to go to a supervisor, willing to go up the ladder - willing to file an appeal, willing to take the next step and not be scared.

-Parent



lack of information and how to advocate successfully adversely impacts people in transition.

For example, many youth who are transitioning into an adult system have a difficult time because they don't know how to advocate for themselves effectively. They do not understand the current system well enough to know how to solve problems with the current barriers in service delivery. As a result, some wind up "falling between the cracks" with no doctors, no insurance, and no support. Many participants had no faith in the system. One family member

coordinated. Some doctors will only treat physical issues before addressing behavioral health issues, and some clinics won't see a member unless their physical issue is resolved. Furthermore, some clinics are inconsistent in the quality of care offered, and some are disorganized.

Families discussed court-ordered treatment that was never acted upon due to lost paperwork, and prescribed outpatient services never delivered. Much of this could be due to staff shortages experienced by many of the clinics, or coordination issues with police departments in charge of carrying out those orders.

There is a significant shortage of psychiatrists and turnover of case managers in the behavioral health system; often individuals are seen by nurse practitioners. Many people experience coordination difficulties related to transitions. Participants described difficulties in securing appropriate services when released from prison, when aging out of foster care, or when relocating. For some, these constant changes create anxiety, even more so among those who are dually diagnosed.

In light of these circumstances, individuals and families frequently complain of not having one central location for information – or knowing where to go if something gets dropped. They often hear information that is incorrect and are unsure where to turn to obtain accurate information. This

said, “If you're a person who is living with mental illness, and does not have an advocate fighting for them, they will be lost.”

Crisis response gaps

More than one in four people with SMI (26.7%) had to access crisis services in 2015.³⁶ Crisis response is critical for some families; however, there are some obstacles to receiving needed help. Families report not always being able to admit their family member when they are in crisis. They often have to go to the emergency room, which will confer with the clinic and make a decision about what to do. On the other hand, there is a gap in services for people in distress who do not need to be hospitalized. There is little availability for emergency psychiatrist appointments. Families often must take an individual to the hospital to get help. Individuals and families consistently reported there was just no “in-between.”

In some cases, families have to call the police. Some family members stated they were afraid to call the police because they were unsure of who would respond. As a result, one father suffered multiple contusions from his son beating him up while in crisis.

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“He [the police officer] was like, yeah, we’re taking you to the hospital. You’re going to be okay. He was actually talking to me.”

-24-year-old male with bipolar disorder

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Police have many interactions with people with mental health issues – some of whom are dually diagnosed. While many officers around the state are now receiving basic mental health training, training in other disabilities such as autism, epilepsy, and I/DD is still lacking. However, police are required by state law to pick up individuals who have a court order for treatment. In some situations, by-standers call police when a person is in crisis.

As a result, individuals reported numerous experiences of police interactions – some good, some bad. Some in crisis reported police officers laughed at them or provoked them when they were in psychosis. On the other hand, there were stories of officers who helped individuals in crisis by listening to them, showing respect, and talking to them.

Additionally, some short-term respite group homes available to transition individuals out of crisis lack staff training and may not share information with individuals and families. A parent reported her autistic son was not allowed to sleep with his shoes on; another parent stated the site made the residents stay in their rooms throughout the entire stay. Whether there were valid reasons or not for these rules, individuals and families were not aware of them.

Families feel unsupported by the behavioral health system

A lack of information from the mental health system was a common barrier shared by families who don't have guardianship over their adult children. They wanted to help them, but often didn't know how or didn't have enough information to be successful. They cited the Health Insurance Portability & Accountability Act (HIPAA) as the main obstacle, which requires the protection and confidential handling of protected health information. Only the patient is able to access the information unless he or she signs a release. Many will not.

Furthermore, for some families there is not enough training once individuals are diagnosed. One spouse shared her frustration when her husband was released from the hospital with no information about bipolar disorder. She stated, "I was left basically dealing with my husband trying to have him explain it to me. Of course that was practically impossible cuz he's in the throes of bipolar disorder and constant medication changes."

Families felt as a whole the mental health system did not recognize them or appreciate they were an inherent piece of the individual's support system.

Promising Practices

There are a number of promising practices that can ensure people with dual diagnoses and their families receive the support they need. Arizona has been working diligently to offer more community-based options to those with mental health issues since the Arnold vs. Sarn class action lawsuit filed in 1981 against the State. This suit alleged that ADHS and Maricopa County did not provide a comprehensive community mental health system as required by statute. In January 2014, officials at ADHS, Maricopa County, and the Office of the Governor reached an agreement with plaintiffs to provide an increase in certain community services by the end of fiscal year 2016 and terminate the litigation. Other Arizona counties are looking towards Maricopa County to monitor the outcomes.

While progress has been made, there is still work to do. The following are recommendations and best practices advanced by family members and community professionals to better serve individuals with I/DD and their families:

- **TRAINING, TRAINING, AND MORE TRAINING:** An increase in training and awareness among all I/DD, substance abuse prevention and treatment, and behavioral health providers (including job coaches) of dual diagnosis is essential. Training will ensure individuals with I/DD are screened adequately so they have their mental health and/or substance abuse needs addressed, and they are able to live life as independent and healthy as possible.

- **SOCIAL SECURITY EDUCATION:** There continues to be a lack of awareness that individuals can work and receive Social Security and Medicaid. Arizona DB101 (<https://az.db101.org/>) is an online tool that introduces individuals, family members, and agency and support staff to work-incentive programs that help individuals with disabilities keep and earn more assets without losing all of their benefits. It also calculates how employment may affect health insurance and Social Security benefits so individuals are fully aware of their options.
- **SYSTEM COORDINATION:** The system lacks an integrated-care navigator to help coordinate and train both I/DD and behavioral health systems. This navigator also could help alleviate confusion for individuals and families who have to work with multiple systems and provide them access with correct information. Examples of these navigator programs exist in states such as Pennsylvania. These navigators are especially helpful when a person is transitioning from one program to another. In addition, system integration entails locating medical, psychiatric, substance abuse, and I/DD services in one location for easier access and better coordination. States integrating substance abuse and mental health services have also undertaken a variety of activities to promote shared data capacity, including linking data from different systems and adopting data standards.

Some of Arizona's jurisdictions have improved coordination with the criminal justice system by implementing mental health courts. Mental health courts typically involve judges, prosecutors, defense attorneys, and other court personnel who have expressed an interest in or possess particular mental health expertise. The courts generally deal with nonviolent offenders who have been diagnosed with a mental illness or co-occurring mental health and substance abuse disorders. The goal of these courts is to decrease the frequency of clients' contacts with the criminal justice system by providing courts with resources to improve clients' social functioning and link them to employment, housing, treatment, and support services.

- **BETTER EDUCATE FAMILIES AND INDIVIDUALS:** There is a lot of information and support available to families to assist them in advocating for themselves; however, many don't know about it, and much of the information available is not specific to I/DD. The National Alliance for Mentally Ill Arizona (NAMI) and Mental Health America (MHA) of Arizona offer information and referral, support groups, and education classes, among other services to help navigate the system and learn about specific mental health issues. The NAMI organization also includes some information on developmental disabilities, including autism and Tourette's syndrome.

- **PREPARING FOR CRISES:** Individuals, families, and first responders all have parts to play in ensuring a crisis does not turn into a tragedy. Individuals and families should know the number of their local crisis response team. They should also develop a mental health crisis plan – a short-term written plan designed to address behaviors and help prepare for a crisis.³⁷ This plan should be stored on the individual’s phone or kept with him or her, as well as shared with anyone who may be involved in a crisis, including doctors, providers, family members, and police.

Figure 2: Mental Health Crisis Plan Checklist

- ✓ Phone numbers for the therapist, psychiatrist and other healthcare providers, helpful family members and friends, and local crisis line
- ✓ Addresses of walk-in crisis centers or emergency rooms
- ✓ Emergency contact’s address and phone number(s)
- ✓ Diagnosis and medications
- ✓ Previous psychosis or suicide attempts
- ✓ History of drug use
- ✓ Triggers
- ✓ Things that have helped in the past
- ✓ Mobile Crisis Unit phone number in the area (if there is one)

In addition, family members, police, first responders, and community members can take Mental Health First Aid.³⁸ It is an eight-hour course that introduces participants to risk factors and warning signs of mental health concerns, builds understanding of their impact, and overviews common treatments. The course uses role-playing and simulations to demonstrate how to assess a mental health crisis, select interventions and provide initial help, and connect persons to professional, peer and social supports, as well as self-help resources. Participants are introduced to local mental health resources, national organizations, support groups, and online tools for mental health and addictions treatment and support.

The Crisis Intervention Team (CIT) Training is a program developed in a number of U.S. cities, including in Arizona, to help police officers react appropriately to situations involving mental illness or developmental disability. Police involvement in this training has resulted in fewer police injuries, fewer

arrests, and increased diversion into mental health treatment. It is a 40-hour training, but only a small percentage of patrol officers are trained.

CONCLUSION

Arizona is taking steps to address system gaps, but some of these barriers are not easily corrected. The shortage of psychiatrists and substance abuse providers across the nation persists, and without adequate state support, there will continue to be limited services offered to individuals who need them. Expanding the current system’s capacity requires innovative community-based solutions. The assistance of faith-based and other non-profit organizations are targeted by federal Substance Abuse and Mental Health Services Administration (SAMHSA)

grants to assist in substance abuse and mental health programs. However, programs targeted to individuals with I/DD continue to be excluded from these community-based options. Future programs and funds should target these gaps so that Arizona individuals with I/DD and families don't continuously feel like they are "running into a brick wall," but they are overcoming it.

NOTES

¹ Mental health problems are characterized by severe disturbances in behavior, mood, thought processes and/or interpersonal relationships that negatively impact quality of life. They can include disorders such as anxiety, bipolar, personality, schizophrenia, obsessive-compulsive, ADHD, depression, among many others.

² National Association for the Dually Diagnosed (NADD), <http://thenadd.org/resources/information-on-dual-diagnosis-2/>

³ Linda Henderson-Smith, Diane Jacobstein, (2015 September). Youth with Co-occurring Intellectual/Developmental Disabilities and Mental Health Disorders. National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development. http://thenadd.org/wp-content/uploads/2013/10/MHDD_Report-1.pdf

⁴ http://www.acl.gov/Programs/AIDD/DDA_BOR_ACT_2000/p2_tl_subtitleA.aspx

⁵ Dual diagnosis is also a term used for people with substance abuse and mental health issues.

⁶ Jacobstein, D. (2014), Effective Strategies Checklist: Children and Youth with Developmental Disorders and Challenging Behavior at

<http://gucchdtacenter.georgetown.edu/publications/Effective%20Strategies%20Checklist%20FINAL.pdf>

⁷ As of July 1, 2016, the administration of DBHS will move under AHCCCS.

⁸ DDD information request received from Claudia Sloane, DBHS. Received June 18, 2013. Additional request made but no further responses.

⁹ Ibid.

¹⁰ Ibid.

¹¹ FY 2016 Appropriations Report, Arizona.

¹² <http://www.mentalhealthamerica.net/issues/state-mental-health-america>

¹³ Silka, V. R. & Hauser, M. J. (1997). Psychiatric assessment of the person with mental retardation. *Psychiatric Annals*, 27, 162-169.

¹⁴ Maria Quintero and Sarah Flick (2010 September). Co-Occurring Mental Illness and Developmental Disabilities. *Social Work Today*, 10, 5. <http://www.socialworktoday.com/archive/092310p6.shtml>

¹⁵ <https://morrisoninstitute.asu.edu/products/graduation-cliff-summary-full-report>

¹⁶ <http://thenadd.org/resources/information-on-dual-diagnosis-2/>

¹⁷ Sullivan, P.M. & Knutson, J.F. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse & Neglect*, 24, 1257-1274 .

¹⁸ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2015). Child maltreatment 2013.

Available from <http://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf>

¹⁹ U.S. Census, Sex by Age by Disability Status, 2009-2013 American Community Survey 5-Year Estimates

²⁰ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2015).

²¹ SB 1375 Report, October 1, 2015.

<https://www.azahcccs.gov/shared/Downloads/News/SB1375Report10-1-15.pdf>

²² https://dcs.az.gov/sites/default/files/SEMIANNUAL-REPORTING-REQUIREMENTS-10-14-3-15_FINAL-Revised-080515.pdf

²³ DDD information request received from Claudia Sloane, DBHS. Received June 18, 2013. Additional request made but no further responses.

²⁴ <http://www.azdhs.gov/bhs/pdf/reports/annual/2014-substance-abuse-treatment-programs-annual-report.pdf>

²⁵ <http://blogs.cdc.gov/nchs-data-visualization/drug-poisoning-mortality/>

²⁶ Ibid.

²⁷ Trust for America's Health (2015). Reducing Teen Substance Misuse: What Really Works, <http://healthyamericans.org/assets/files/TFAH-2015-TeenSubstAbuse-FnlRv.pdf>

²⁸ Jackson, K. (2013). Substance Abuse in People with Intellectual and Developmental Disabilities — Breaking Down Treatment Barriers. *Social Work Today*, 13, 5, 26. <http://www.socialworktoday.com/archive/091613p26.shtml>

²⁹ <https://cabhp.asu.edu/sites/default/files/panelist-substance-abuse.pdf>

³⁰ Jackson, K. (2013). Substance Abuse in People with Intellectual and Developmental Disabilities — Breaking Down Treatment Barriers. *Social Work Today*, 13, 5, 26. <http://www.socialworktoday.com/archive/091613p26.shtml>

³¹ Substance Abuse Disorder Treatment for People with Physical and Cognitive Disabilities

Treatment Improvement Protocol Series #29 SAMSHA (1998; most recently revised 2012)

³² <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/4/01/how-severe-is-the-shortage-of-substance-abuse-specialists>

³³ <http://www.samhsa.gov/data/sites/default/files/NSDUH-SR200-RecoveryMonth-2014/NSDUH-SR200-RecoveryMonth-2014.htm>

³⁴ Peer-support services are not part of I/DD state services like they are in state mental health services.

³⁵ Arizona Department of Health Services, Division of Behavioral Health Services, Individuals with a Serious Mental Illness (SMI), FY 2015 Annual Report.

³⁶ Arizona Department of Health Services, Division of Behavioral Health Services, Individuals with a Serious Mental Illness (SMI), FY 2015 Annual Report.

³⁷ <https://www.nami.org/Find-Support/Family-Members-and-Caregivers/Being-Prepared-for-a-Crisis>

³⁸ Mental Health First Aid USA is operated by the National Council for Behavioral Health in partnership with the Missouri Department of Mental Health. <http://www.thenationalcouncil.org/about/mental-health-first-aid/>



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