Behavioral Health Treatment Access Legislative Task Force

Preliminary Report

Legislative Members

Senator Scott Flippo, Co-Chair

Representative Clarke Tucker, Co-Chair

Non-Legislative Members

Ms. Carole Baxter
Ms. Ann Brown
Mr. Dan Honey
Mr. Kevin Murphy
Mr. David Sterling
Mr. Mark Thurman
Mr. David Williams

Thanks

The Task Force wishes to thank the following entities that, along with numerous individuals, provided consultations, presentations and information that proved valuable in the development of this report.

Arkansas Department of Human Services, Division of Behavioral Health Services
Arkansas Insurance Department
Arkansas Public Policy Panel
Arkansas Sheriffs' Association
Arkansas Substance Abuse Treatment Providers Association
Council of State Governments Justice Center
Department of Human Services, Division of Medical Services
HISTECON Associates, Inc.
Judicial Equality for Mental Illness Coalition
Mental Health Council of Arkansas
Mickelson Consulting Group, LLC
Policy Research Associates
SAS (software company)
The Stephen Group Report – A "Blueprint for Action"
UAMS, College of Medicine, Department of Family and Preventive Medicine

---

Review of Charge

Act 895 of 2015 created the Behavioral Health Treatment Access Legislative Task Force. The Task Force is charged with ensuring that persons in the criminal justice system who have demonstrated a need for behavioral treatment have access to treatment and to:

- Facilitate access to behavioral health treatment programs;
- Coordinate with other public and private entities to develop and promote access;
- Take steps to reduce costs and encourage evidence-based care;
- Assess feasibility and make recommendations for changes to state programs to improve access.

Population(s) to Target: Options and Comments

Services for pre-incarceration, as an alternative to incarceration and perhaps pre-charged offenders

One recommendation was to select those incarcerated for low barrier crimes (Judicial Equality for Mental Illness Coalition). Statistics would be quickly (maybe monthly) available to provide level of accountability relative to the success of the efforts. A direct measure of cost reduction could be extrapolated with this population that could be compared to a direct measure of cost.

Services for those currently incarcerated

Thoughts expressed are that this may be a task for subsequent stages.

Services for those as re-entry from Prison

Thoughts expressed are that this may be a task for subsequent stages.

Statistics Supporting and Justification of Need for a Plan

- The cost to incarcerate low-risk mentally-ill offended is 20 times higher than the cost to provide crisis treatment and counseling centers (HISTECON)
- Arkansas' prison population increased 34% between CY 2005 – 2015 and is expected to climb an additional 44% by 2025.
- Approximately 3,500 adults and 100 juveniles currently incarcerated have a mental illness.
- More than 80% of state prisoners, 72% of federal prisoners and 82% of jail inmates meet the criteria for having either a mental health or substance use issue (DBHS)
- 449,000 Arkansans have behavioral health symptoms each year (projections from SAMHSA)
- 187,000 Arkansans abused or were dependent on illicit drugs or alcohol (projections from SAMHSA)
- 130,000 Arkansans needed but did not receive treatment for alcohol problems in the past year (Projections from SAMHSA)
- 60,000 Arkansans needed but did not receive treatment for illicit drug use in the past year (Projections from SAMHSA)
- 9.6% of the Arkansas operating budget (excluding federal funds) goes to expenditures related to the consequences of substance addiction (2011 analysis of Arkansas budget by Columbia University). This further noted that of every dollar spent on the consequences of substance use, only 4 cents goes to prevention and treatment.

- Cost benefit analyses consistently show cost-savings associated with investments in treatment (typical estimates range from 1.5 to 5+ dollars saved per dollar spent).
- Average comparison based on national data indicate that the costs of keeping prisoners with mental illness are more expensive than average prisoners; this ratio could be 25:1.
- 2009 study showed about 3,500 adults with serious mental illnesses are incarcerated in prisons in Arkansas, or about 20% of the average DCC population
- Department of Justice report found that more than half of all prison and jail inmates have a mental health problem compared with 11% of the general population, yet only 1 in 3 prison inmates and 1 in 6 jail inmates receive mental health treatment
- The cost of inpatient psychiatric hospitalization is $500 per person per day as opposed to a cost of an estimated $252 per person per day for Outpatient Stabilization. (mental health council)
- Referrals for substance abuse treatment often, particularly from the criminal justice system, come when the progression of the illness is such that 1) probability of success is low and 2) cost for treatment is at the highest level. These two things combined often are interpreted as supporting the belief that treatment is ineffective.

What Arkansas currently has

. . .in Mental Health Treatment Services

- **Crisis Intervention** (this is a Medicaid reimbursable service)– The Mental Health Council shows 13,916 such services in FYE 2014 with 5,917 hospitalized (42.5%) and the remainder referred to Mental Health Treatment Programs and/or Substance Abuse Treatment Programs.
- **Acute care at Arkansas State Hospital or other hospitals for indigents who have exhausted any other reimbursement benefits utilizes state General Revenue Funding –** The state has a system to have unspent such funds placed in a reserve category that remain with the mental health center allocated those funds.
- **Crisis Service Requests** to Mental Health Centers have a contractually mandated response time of 15 minutes: Crisis as defined as "homicidal, suicidal or gravely disabled"
- **911 program** provides oversight to individuals who are adjudicated to be not-guilty by reason of mental insanity

. . .in Substance Abuse Treatment Services

The Division of Behavioral Health Services (DBHS) was allocated $10,078,119 under the Substance Abuse Prevention and Treatment Block Grant (SAPT) for Substance Abuse treatment for Federal Fiscal Year 2016. This is the main source of funding for substance abuse treatment for indigent individuals in Arkansas.

DBHS allocates these funds to 8 Substance Abuse Providers throughout the state through competitively procured contracts.

Available Services:

- **Detoxification**
- **Residential Treatment**
- **Outpatient Treatment**
- **Intensive Outpatient Treatment**
- **Methadone Maintenance**
- **Drug and Alcohol Safety Education Program**

In State Fiscal Year 2015, these dollars and contracts provided services for 12,488 individuals. From comparing Medicaid claims data to data regarding individuals receiving contracted services, DBHS has ascertained that 35% of individuals receiving contracted services are Medicaid eligible.

Overarching Ideas Identified as Needed for Success in Plan

- Strong leadership
- Broad stakeholder engagement
- Comprehensive data analysis
- Use of Evidence Based practices
- Provide incentives for positive outcomes

Ideas/Concerns/Questions/Points for Consideration

- **Accountability**

  What is reasonable to expect for the length of time a person is to receive crisis services? How often should someone need crisis services and how do we reward not needing it? Can we design a program that will reinforce outcomes, not services, e.g. "recovery management"?

  The evaluation component should include independent, pre-identified standardized data as a means to quantify the success of efforts and foster its sustainability. Evaluation protocols for reporting to governance, legislative, agency and other stakeholder constituencies. Measures used within the Access to Recovery concept that might be workable for this include 1) decrease in justice involvement 2) increase in employment 3) decrease in drug use and 4) decrease in children in CPS custody.

  A recommendation was to legislate an ongoing statewide task force as well as regional task forces for oversight.

- **Benefits retention/expansion**

  Allow retention of Medicaid/SSI by suspending rather than terminating benefits during incarceration and help people who lack benefits apply for them prior to release.

- **Care Coordination**
  Care coordination (assists adults and children with behavioral health needs) is not a Medicaid or 3rd party insurance reimbursable service.

- **Communication and public perception**
  Communication/coordination between local police, community and service providers needed.

- **Crisis Units**
  Components to be considered for inclusion vary greatly, with corresponding cost variances. Differentiating such units from homeless shelters where there is typically no outcome expectation is important.

- **Expansion of Current Services**
  Enhance the level of intensive community based services in order to reduce inpatient and residential admissions, theoretically preventing or decreasing the number of crisis situations.

- **Housing**
  It was recommended that constraints be removed that exclude persons formerly incarcerated from housing, services and employment.

- **Jail diversion programs**
  Establish jail diversion programs for those with mental illnesses and expanding jail diversion programs for people with substance use disorders. This would include the development of mental health courts . Also recommended for this is to clarify legislated powers for civil and specialty courts to do outpatient commitments where necessary for personal and public safety.

- **Legal Options**
  The question of how to legally provide treatment services to an individual who does not desire those services must be addressed. Specialty courts may provide an alternative-to-sentencing option. However, this does not provide the immediate relief law enforcement is requesting for local jails. Current civil commitment laws differ for mental illness and substance abuse but both are time-consuming and again unlikely to provide the immediate relief that is desired.

- **Substance Abuse Treatment Expansion**
  Expand the populations eligible for substance abuse services within traditional Medicaid to address the overwhelming number of individuals who burden the state general revenue designation – Arkansas Medicaid has requested a waiver to allow this expansion. The request is supported by the Division of Behavioral Health Services.
  If Medicaid covered an expanded population and enhanced array of services, federal grant money would become available to focus on high risk and criminal justice involved populations.

DBHS proposes the enhancement of the current Medicaid reimbursable substance abuse treatment service array to include:

- Accessible Outpatient Counseling Services
- Substance abuse assessment
- Individual substance abuse counseling
- Group substance abuse counseling
- Marital/family substance abuse counseling
- Multi-family substance abuse counseling
- Intensive Rehabilitative and Residential Services
- Supportive Housing
- Supportive Employment
- Short Term Substance Abuse Residential
- Acute crisis units
- Detoxification

To provide access to the substance abuse treatment services listed above and **ensure cost neutrality**, the current behavioral health system must be rebalanced. The establishment of a behavioral health system that ensures the efficient and effective provision of services would result in savings that could fund the proposed expansion of substance abuse programming in the state. This model could be supported through multiple program and funding options through the Centers for Medicaid and Medicare (CMS).

Systemic Barriers

- There is a potential conflict between the interests of corrections/treatment staff vs. interests of insurers.
  Given the high consequences of relapse for a person on probation or parole, treatment providers may advocate for more intensive services upon release from prison, with services tapering down over time.
  Insurers typically approve the least intensive service first, with more intensive services available only if violations (revocations of probation/parole due to substance use) occur.
- Co-pays and deductibles could be a significant barrier to services
- Many of those needing services are not covered by Medicaid. . .so a system will need to include how to pay for those otherwise uncovered individuals. The current rate for residential substance abuse treatment for income eligible residents of Arkansas is $62 per day.
- Medicaid currently only reimburses for a small subset of those with substance abuse disorders (pregnant/postpartum women and juveniles)
- Private option insurance plans vary in their coverage for substance abuse treatment with many treatment programs refusing to accept insurance due to: difficulty receiving prior authorization and a slow reimbursement process.

Training

Critical Intervention Training for mental health and substance abuse offenders and for Law Enforcement as initial responders was recommended.

Workforce Development

- Two schools of thought were expressed: 1) there are an inadequate number of individuals in the workforce trained and licensed to provide services particularly knowledgeable of substance abuse issues and 2) the reimbursement rates for working in substance abuse treatment are so low that individuals adequately trained are not electing to work in this area.
- Insurance requirements for residential substance abuse services in many cases are more consistent with in-patient hospitalization requirements (e.g. 24/7 medical emergency coverage) when placement and reimbursement does not support that level of care. This may result in an increase in more costly hospitalization services when outpatient services are not adequate.
- Ensure that all systems and services are culturally competent, individually specific and trauma informed- with specific interventions for women, men and veterans.

Programming Ideas (listed alphabetically and not necessarily mutually exclusive)

1) Assertive Community Treatment

ACT is a team-based approach to delivering comprehensive and flexible treatment, support, and services to help people stay out of the hospital and develop skills for living in the community. ACT offers services that are customized to the individual needs of the consumer, delivered by a team of practitioners, and available 24 hours a day for an unlimited amount of time. This type program is most useful for individuals with chronic mental illnesses who may or may not have a co-occurring substance abuse disorder. It is evidence-based and costly. There is one such program in the state. According to the Division of Behavioral Health (who provided much more detail for additional years), in the 2014 fiscal year the total number of unduplicated clients served in that program was 133. Of that 133, 77 did not have Medicaid or Medicare to offset the cost of their treatment and DBHS provided $758,067 to provide ACT programming to these high need individuals.

2) Crisis Center(s)

Goal: 1) Triage what services are needed
2) Calm the person in crisis due to mental illness
3) Substance abuse – vague about what would be done with substance abuse other than refer – important to differentiate those with a need for detox as opposed to under-the-influence; important to avoid being revolving door for substance abusers to dry out and thus enabling rather than fostering accountability

Benefit:	1) Police would decrease time on crimes by the mentally ill/substance abuser 2) Provide location for individuals not requiring the more costly hospitalization
Logistics:	How many? Recommend for 3-5 crisis units of 16-beds each Where? Recommended for Central Arkansas and each corner of the state.
Cost:	Need projections for initial start-up cost per location identified Ongoing operational cost?
Resources:	Law enforcement funds? Decrease staffing needed? Mental Health centers general revenue for crisis? Substance abuse residential treatment programs may have available space and in the appropriate configuration to meet physical requirements.
Accountability:	Consider licensure as monitored by the Division of Behavioral Health Services; important for programs to differ from high dollar homeless shelters.

3) Georgia Model

"Assertive Community Treatment (ACT) teams funded that address mental health, substance abuse treatment, intervention and stabilization at the community level.

4) New Mexico Model

Developed a Core Service Agency (CSA) crisis line. 95 % of callers were stabilized by the clinician responding to the call and referred to community resources by the end of the call. It was reported that in 500 callers, 88% of them were stabilized by the clinician by the end of the call.

5) Oklahoma Model

"Criteria for assessing treatment needs that focus on post-release reintegration rather than institutionalization" – goal of this model is to reduce recidivism rates for criminal offences.

6) Oregon Model

Mobile Crisis (MC) services, coordinated with law enforcement and behavioral health personnel.

7) Recovery Homes

This is often used as a prison diversion model. Discussion included designing a diversion process that places a mentally-ill offender in a less-costly treatment program with a relatively low level of structure rather than the criminal justice system with high structure and high costs. Comments included: 1) To prevent exploitation of this population and exploitation of public resources it might be helpful to establish a licensing requirement with oversight for any recovery home and 2) Perhaps it would be necessary to establish Specialty Courts to require participation in such recovery homes if an individual selected this option rather than incarceration.

8) San Antonio Model

The "center" offers an inpatient psychiatric unit, outpatient services for psychiatric and primary care, drug or alcohol detox programs, a recovery program for substance abuse and some

housing for people with mental illnesses. Comments included: Concerns about the application of this model to a rural geographic area and concerns about the cost.

9) Sequential Intercept Model

This model identifies points of interception at which services can be provided to keep offenders with behavioral health disorders from penetrating deeper into the criminal justice system. "Diversion Programs" keep people with serious mental illness (and serious substance abuse disorders) who do not need to be in the criminal justice system in the community. "Institutional Services" provide constitutionally adequate services in correctional facilities for people with serious mental illness (and serious substance abuse disorders) who need to be in the criminal justices system because of the severity of the crime. "Re-entry transition Programs" link people with serious mental illness (and serious substance abuse disorders) to community-based services when they are discharged.

The points of interception include law enforcement and emergency services; initial detention and hearing; jails, courts, forensic evaluation and forensic hospitalizations; reentry from jails, prisons and hospitalization; and community supervision and community support services.

Actions required at the state level for this model:

- Provide crisis intervention training to law enforcement
- Pass legislation encouraging jail diversion programs
- Work to get Medicaid and SSI eligibility continued for those incarcerated rather than terminated at the point of incarceration as it currently is
- Remove constraints that exclude persons formerly incarcerated from housing; make criminal justice clients a priority for housing
- Expand access to evidence-based services within community-based services for those involved in the criminal justice system
- Create a criminal justice priority group; example provided was to petition HUD to allow the use of HUD funding for housing and Justice Assistance Grants
- Provide access to comprehensive and integrated treatment programs for persons with mental illness and substance use disorders diverted or released from the criminal justice system
- Legislate task forces/commissions made up of mental health/substance abuse/criminal justice stakeholders to legitimize issues
- Identify incentives to get mental health, substance abuse and criminal justice stakeholders to the table for discussion

There are five levels of "intercepting" problems. Actions required will be listed by level.

Intercepting at the community/law enforcement level – Intercept 1

- Train dispatchers to identify callers who may need trained law enforcement responders.
- On-scene assessment by trained officers to de-escalate

- Availability of drop off crisis centers who link to community services
- Collaboration between police and mental health to reduce frequency of subsequent contacts

Intercepting at initial detention and initial court hearings – Intercept 2

- Utilization of a standardized screening instrument statewide
- Legal counsel provided with access to mental health history, available community resources and legislation/case law of use in case resolution.
- Maximize the use of alternatives to prosecution.
- Maximize the use of pre-trial diversion.
- Link to comprehensive services including care coordination, access to medication, prompt access to benefits, health care and housing.

Intercepting at Jail/Courts – Intercept 3

- Develop an individualized treatment program plan
- Provide physical health and mental health care while incarcerated consistent with community and public health standards.
- Provide substance abuse treatment, provide services for families and children of inmates, e.g. educational and vocational programs, peer support, mentoring and basic living skills.

Intercepting at Re-entry – Intercept 4

- Refer inmates for mental health counseling upon release whose mental illness was identified following incarceration.
- Effect the safe and seamless transition of people with mental illness from prisons or jails to the community.
- Utilize a transition checklist to identify services needs and provide effective linkages to services upon transition back into the community.
- Ensure releases exit prisons or jail with ID and prior determination of eligibility and linkage to public benefits to ensure immediate access upon release from prison or jail.

Intercepting those involved in Community Corrections – Intercept 5

- Concentrate community supervision resources on the period immediately following the person's release from prison or jail and adjust supervision strategies as the needs of release, victim, community and family change.
- Connect inmates to employment, including supportive employment services, prior to release. Facilitate releases sustained engagement in treatment, mental health and supportive health services and stable housing.
- Ensure a range of options for community corrections officers to employ to reinforce positive behavior and effectively address violations or noncompliance with conditions of release.

10) 24/7 Sobriety Project

This program involves voluntary sobriety testing which is paid for by the offenders who wish to stay in society. It involves intensive (twice per day at highest level) alcohol/drug testing. Model is considered evidence-based and includes:

- A focus on personal responsibility and accountability of the offender
- A focus on change, behavior modification and choices made by the offender
- Continued poly-substance use testing and monitoring of the offender
- Daily data collection and communication using web-baased client management software
- Uses predetermined, immediate, measured and sure consequences for non-compliance by the offender
- All testing fees are paid by the participant and are low and affordable
- 24/7 is self-funding. Qualifies for grant funds through the Office of Highway Safety to help establish and grow programs.
- Requires the establishment of specialty courts and revision of sentencing guidelines

Cost Information Provided

- Estimated per day costs of crisis centers is $350 –$400 (APPP)
- Projected costs per year at crisis center is $10,000 million, plus some follow-up costs for maintaining contact with discharged patients (APPP); they estimate that Medicaid would pay $2.5-3 million of this with the state absorbing about $7.5 million annually
- See detailed cost-neutrality comment from Division of Behavioral Health relative to substance abuse Medicaid expansion proposal.

Recommendations for possible cost savings

- Decrease Medicaid treatment plan reviews from 90 days to 6 months
- Remove Medicaid requirement for annual psychiatric assessment
- Apply for a federal grant that would allow mental health centers to become Certified Community Behavioral Healthcare Centers. This is not currently an option (DBHS).

Groups eager to provide a service

- CNYPC – Central New York Psychiatric Center – wants to consult to help us identify where gaps exist in our current system
- HISTECON Associates – wants to do any research needed @ cost depending on requests
- Mickelson Consulting Group – want to do 24/7 training @ no cost; but cost for using model per person per day
- Policy Research Associates – want to do Sequential Intercept training @ $35,000
- SAS – wants to provide software for criminal justice agencies