The Mental Health Council of Arkansas is made up of 12 Community Mental Health Centers and two specialty centers, Centers for Youth & Families and Birchtree Communities. We are the public mental health system and safety net for those diagnosed with serious and persistent mental illness and children diagnosed with serious emotional disturbance.

We do not support managed care for these two populations. There is no protection for these Arkansans as they will be competing for the same services as the general population in a managed care system. The Community Mental Health Centers serve all counties in the state. Developing supports in the community provides less intrusive, less expensive and less restrictive care.

Contracting with an out of state administrative management company automatically reduces available funds for direct services. There are other options for reducing costs without a managed care company; we assert that we can manage and enhance services with community supports in place.

I. Support the existing public mental health system through the development and enhancement of the following priority services:

A. Crisis Intervention services, including the establishment of crisis units.
The Mental Health Council of Arkansas supports and agrees with TSG:

The purpose of the Task Force would be to develop a Blueprint for Action and a way to provide sustainable support for local communities to address the issue of diverting adults with serious mental illness charged with low barrier crimes from jail and getting them into treatment in a timely way that addresses recovery and increased ability for self-responsibility. Specific elements of the proposed Blueprint for Action should include ways to identify and improve community based communication and coordination among local police and numerous stakeholders and community leaders during screening, assessment, and even pre-booking diversion. Critical Intervention Training for law enforcement, and accountability and support are also important factors.

We have such a Task Force in place that includes the community groups listed. We have toured Oklahoma, Bexar County Texas and scheduled to tour a state run crisis unit in Mississippi. We have conducted a pilot process of CIT Training.

The problems and issues are complex and funding is certainly a consideration. Our goal is to fundamentally change the system with far reaching and long term solutions to reduce the incarceration of persons with mental illness. This would change the overcrowding we currently face. This would free up our Sheriffs, police departments, and jail system to pursue violent criminals, thereby resulting in better utilization of limited staff resources and cost savings;

Bexar County: In the first year, nearly 1,000 people with mental illness were directed away from jail to a more appropriate treatment facility. Since that time, our program has quadrupled, diverting more than 4,000 individuals with mental illness from incarceration to

treatment and saving the county at least $5 million annually for jail costs and $4 million annually for inappropriate admissions to the emergency room.

Sequential Intercept Model

We recommend use of this model by the Criminal Justice Task Force in its planning efforts for improved access to community based behavioral health services.

II. Treatment Compliance

This is an important issue when considering cost savings and accountability.

Funding for Assertive Community Treatment (ACT) teams and increased intensive case management is much less costly than inpatient hospitalization or continued incarceration of prisoners with mental health or substance use diagnoses. Individuals' compliance with treatment is also a key component in the success of specialty courts, mentoring programs and other re-entry efforts.

. Care Coordination is a critical and necessary element to reduce higher levels of care utilization.

Enhanced Substance Abuse Treatment – Our primary funding stream in Arkansas does not reimburse for these services. Substance abuse treatment needs to be adequately reimbursed by Medicaid.

Enhance the level of intensive community based services in order to reduce inpatient and residential admissions. This includes a new admissions process with better-identified protocols for approval of inpatient and residential care.

II. The Payment Improvement Initiative cost millions of tax dollars to develop and should be implemented with the three Tier System. We do not agree with using the Inter-RAI. No other specialty must first have a screening to determine services. This results not only in a barrier to, and delay in treatment, but leaves out the fundamental clinical judgement of a professional.

III. Support and develop telemedicine policies and procedures to benefit access to care.

The shortage of psychiatrists is well documented throughout the country. Telemedicine restrictions in Arkansas should be reviewed. Many of the Community Mental Health Centers have developed this capability to serve mentally ill in jails and remote counties. Telemedicine is a critical component of the Mental Health Crisis Units. We observed this in our tour of Oklahoma and Texas units.

IV. Collect meaningful data to be used in analysis of services/costs.

As part of the public mental health system, the Community Mental Health Centers billing and other pertinent data is included with the Arkansas State Hospital and Arkansas Health Services. We suggest this data be separated ASH/AHS, inpatient, and CMHC's, outpatient for meaningful analysis of Medicaid services provided by the Mental Health Centers.