“A Problem Unpleasant to Mention, Easy to Postpone”

Mental Health Access in Arkansas

James Owen, Hendrix College

HENDRIX ARKANSAS POLICY PROGRAM AN UNDERGRADUATE THINK TANK

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Executive Summary

Act 895 of the 2015 session of the Arkansas General Assembly marks an opportunity not only to reform the criminal justice system in Arkansas, but also to implement changes to the mental health system. Arkansas has consistently earned a near-failing or failing grade in statewide mental health services (Aron, Honberg, and Duckworth 2009; Grading the States 2006). The state also consistently ranks above the national average in key behavioral health areas, including percentage of adults having suicidal thoughts and serious mental illness. Only slightly more than half of those persons with any mental illness receive treatment (Behavioral Health Barometer: Arkansas 2014). Act 895 creates and charges the Behavioral Health Treatment Access Legislative Task Force with the task of assessing the state of behavioral health in Arkansas before reporting back to Governor Asa Hutchinson by December 1, 2015, and each subsequent year. This report seeks to help inform the committee about the historical as well as the present mental health situation in Arkansas. It also offers solutions to move the state forward by maximizing efficiency of already in-use systems of care while simultaneously increasing points of access to promote a community-based continuum of care.

There are two pieces of legislation that are integral to understanding the current mental health system in Arkansas. Passed by Congress in 1963, the Community Mental Health Act helped to shift the treatment of mentally ill persons from institutionalized hospitalization to a community-based approach. This legislation broke up Arkansas into 13 different regions, each with an independent, nonprofit counseling service to treat the region. These community-based counseling services take the form of Community Mental Health

Centers (CMHC) and meet the provision of the Arkansas Constitution in Article 19, Section 19: "It shall be the duty of the General Assembly to provide by law for the support of institutions for . . . the treatment of the insane" (Constitution of the State of Arkansas of 1874 1874). Despite being over 60 years old, the CMHC model still persists as one of the only providers in many regions of the state. In rural areas, there are only four points of access to mental health care services: the CMHC, emergency rooms, private practice mental health professionals, and jails or correctional facilities. Some areas add inpatient care to the equation for five points of access; Little Rock and northwest Arkansas also have the University of Arkansas for Medical Sciences (UAMS) and Veterans Health Administration (VA) facilities.

The second policy change that is important to the current mental health care system is the Affordable Care Act (ACA) and, in particular, the "private option," Arkansas's distinctive expansion of Medicaid eligibility under the ACA. In 2014, the first full year of the private option, it proved to be invaluable in replacing revenue lost after $8 million in cuts prior to its implementation. In addition, rates of the uninsured have fallen since the implementation of the private option and Medicaid expansion.[1] The rate of uninsured patients visiting one of the CMHCs is down to 3 percent after implementation of the private option.[2] Another CMHC's number of uninsured patients has fallen from 2,800 to 800.[3]

There are two varieties of challenges facing mental health care in Arkansas. First is lack of access to mental health care; second is a shortage of mental health professionals. Although the private option has provided increased coverage, access to mental health care services needs to be increased, and innovative solutions are available. Crisis Intervention Team (CIT) training should be available to police officers, sheriffs, and communities in each of the 13 CMHC catchment areas around the state. This would add another level of access to care for mentally ill persons in Arkansas. Regional crisis centers – places where mentally ill persons can get medication adjusted, crises stabilized, and a follow-up appointment at a CMHC – are another way to increase access to mental health care. If crisis centers are coupled with CIT, the combination could provide an important level of care between CMHCs and an acute inpatient stay while also maximizing efficiency existing health care infrastructure. This combination of services is represented pictorially in Figure 3.

The lack of mental health professionals is just as important as more points of access. There is a severe shortage of mental health professionals in Arkansas, especially in more rural areas of the state.[4] While the CIT and regional crisis centers can maximize efficiency from existing resources, innovative practices such as telemedicine and use of Licensed Practical Nurses (LPNs) and Physicians Assistants (PAs) should be encouraged. There are avenues that pave the way to more mental health care access. Implementing CIT teams would be an efficient and relatively simple solution to a problem that is increasingly complex.

There are actions that can address both the lack of access and the physician shortage problem in Arkansas. In the short term, a good first step would be requiring that some police officers are CIT trained in each catchment region across the state. Not only does this action have the potential to reduce stigmatization, but it will also help citizens get the treatment they need. To meet the need for points of access, regional crisis centers could be established in a central part of each congressional district. In conjunction with treatment from CMHCs, regional crisis centers could help to avert the need for acute inpatient stays, reducing strain on inpatient hospitalization centers like the Arkansas State Hospital. Additionally, increased use of telemedicine and incentives for students to pursue careers as social workers, LPNs, and PAs would help to maximize the efficiency of the current psychiatrists in Arkansas. By taking these steps as soon as the 2017 session of the Arkansas General Assembly, Arkansas could set a solid foundation for future growth of mental health care services while also improving access in the short term.

Mental Health Care in Arkansas: Yesterday

In 1953, the University of Arkansas partnered with the Arkansas State Hospital to produce a report on rural mental health care. Two conclusions of "A Note on Mental Illness in Rural Arkansas" remain relevant today. First, the report found 10.2 out of every 10,000 people in urban areas were able to receive mental health care while only 6.1 per 10,000 received care in rural areas (Stewart 1953). Secondly, people in rural areas generally waited longer to access care, presumably because there was neither community support nor access to facilities (Stewart 1953). While the report was not comprehensive, it highlighted problems that continue to plague Arkansas: stigmatization of mental illness and lack of access to treatment.

Ten years after "A Note on Mental Illness in Rural Arkansas" was published, Congress, prodded by the Kennedy Administration, began investigating the state of mental illness across the entire United States. This investigation culminated in the Community Mental Health Act, passed in 1963. In justifying the need for better ways to treat mental illness, Kennedy gave a special address to Congress in which he described the attitude towards mental health issues as "a problem unpleasant to mention, easy to postpone, and despairing of solution." Kennedy then offered his solution by outlining three objectives for the Community Mental Health Act: research on the causes of mental illness, more skilled workers and doctors to fight mental illness, and strengthening and improving the programs and facilities that serve mentally ill persons.[5] The Community Mental Health Centers (CMHCs) created by this act sought to shift the focus on care taking place in institutions to a community-based approach (Frank and Glied 2008). The focus of the legislation was construction grants for outpatient centers along with operating funds for the first few years of their existence (Frank and Glied 2008).

Because of changes in presidential administrations, the program was not wholly implemented as originally envisioned. Nevertheless, the CMHC model became the backbone for outpatient care in Arkansas. The implementation of the CMHC model in Arkansas splits the state into 13 catchment areas, each with differing geographic sizes and obstacles. They range from a portion of one county to 15 counties in size.

Although the creation of CMHCs did signal a shift from institutionalization to community-based care, the number of hospital "beds" has remained a metric to measure the availability of care. That said, the demographics of patients occupying the beds within Arkansas have changed. A "forensification" has occurred within the Arkansas State Hospital, a major source of beds within Arkansas.[6] For instance, the Arkansas State Hospital has 222 beds available for inpatient treatment, but 96 are reserved for the forensic population. Only 90 adult beds and 36 adolescent beds are available for the general population ("Arkansas State Hosptial" n.d.). In other words, defendants accused of a crime awaiting evaluation or inmates being treated occupy the majority of the beds available for inpatient acute stay.

It is a combination of CMHC and remnants of the idea of institutionalization that remains at the center of the Arkansas mental health system to this day. Two main services are provided: outpatient and acute inpatient services. While the CMHC model provides outpatient services to each of the 13 state catchment areas, the rest of the mental health care system has been slow to change, as inpatient acute care is only available in the more urban parts of the state. If the CMHC model is the backbone of Arkansas's mental health system, Little Rock is the heart.

Mental Health Care in Arkansas: Today

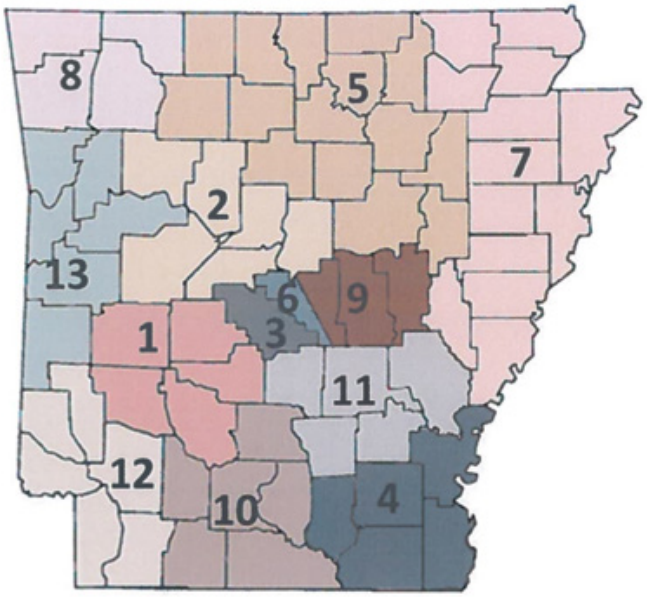
Arkansas's mental health system is antiquated and limited. The inpatient care that is available comes from a few providers that cluster in central and northwest regions of the state. While CMHCs do provide outpatient services in each of the 13 catchment areas in Arkansas, inpatient care is nonexistent in the south-central and Delta counties. Many mentally ill persons

receive medication and treatment in correctional facilities. Especially in the more rural areas of the state, physician recruitment is an issue, only adding to the disparity between access to care in urban and rural areas of the state.

A regional approach was taken in order to assess the current situation in Arkansas. Interviews were conducted with stakeholders in eight of the 13 catchment areas. Catchment areas were used as the unit of analysis because each area has a different CMHC, yet each also has unique demographic and geographic characteristics that are best analyzed on a region-by-region basis. These stakeholders included CEOs of CMHCs, private providers, and advocacy groups, among others. Each interview was focused on assessing access to care by asking stakeholders region- and organization-specific questions. Taking a catchment area approach instead of a statewide approach allows for comparison of practices across geographical areas with distinctive demographic patterns. By approaching the problem from this perspective, commonalities and variances across the state can be assessed. Figure 1 presents a map of the catchment areas for community mental health services.

In order to measure where each region stands, three tiers of access were created as a metric to compare the access between regions (See Table 1). For the purposes of this report, a point of access is any physical location where a person can receive mental health care. A point of access can be for outpatient care, day treatment, or inpatient care. The metric was designed to answer two questions: what kind of care is available in each catchment area, and where can this care be accessed? This is by no means a perfect measurement of access to care; however, it does illustrate the major points of access to a layperson on the subject of mental health. For a metric to be completely accurate in illustrating access to care, each individual clinic, psychiatrist, hospital, and other health system infrastructure would need to be listed. A comprehensive list of mental health care infrastructure could be a topic for further research and inquiry.

Figure 1: The 13 Mental Health Care Catchment Regions in Arkansas



Source:(Arkansas Department of Human Services: Division of Behavioral Health Service 2014)

REGIONAL EVALUATIONS

Catchment Area 6: This area consists of the greater Little Rock area. Specifically, it covers the south side of the Arkansas River to the western edge of Pulaski County. Catchment area 6 serves as the best available model of what care should look like. Between 20 and 40 Pulaski County and Little Rock Police participated in crisis intervention team (CIT) training in September of 2015.[7] The greater Little Rock area also ranks in the first tier of access to mental health care. One can access care through Little Rock Community Mental Health Center, Inc., emergency rooms, private practices, jails, University of Arkansas for Medical Sciences (UAMS) Psychiatric Research Institute, Veterans Administration (VA) Hospital, and other private hospitals with inpatient care.[8] Although it is located in Little Rock, the Arkansas State Hospital serves citizens throughout the state.

Catchment Area 8: Combining the four Northwest Arkansas counties of Washington, Benton, Carroll, and

Table 1

Tier	Points of Access to Mental Health Care
First	1. Regional Community Mental Health Center 2. Emergency Rooms 3. Private Practices 4. Jails/Correctional Facilities 5. Inpatient Acute-Stay Capacity (Private or Public) 6. Veterans Administration Hospital 7. University of Arkansas for Medical Sciences - Psychiatric Research Institute 8. Arkansas State Hospital*
Second	1. Regional Community Mental Health Center 2. Emergency Rooms 3. Private Practices 4. Jails/Correctional Facilities 5. Inpatient Acute-Stay Capacity (Private or Public)
Third	1. Regional Community Mental Health Center 2. Emergency Rooms 3. Private Practices 4. Jails/Correctional Facilities

**The Arkansas State Hospital is located in Little Rock. This provides catchment areas 6 and 9 with an extra point of access.*

Madison, catchment area 8 most closely resembles the greater Little Rock area as far as access to mental health care. It is served by Ozark Guidance Center CMHC, which has seven offices located across its four-county catchment area that provide outpatient behavioral health services. Beyond Ozark Guidance Center, UAMS-PRI staffs and collaborated with other local entities to open a 28-bed adult mental health unit as part of the Northwest Medical Center (Parham 2014a). Catchment area 8 ranks as a first-tier region for access, with points of access through Ozark Guidance Center, UAMS, a VA Hospital, emergency rooms, private practices, jails, and inpatient acute-stay capacity.[9]

Catchment Area 9: The borders of catchment area 9 run from the north side of the Arkansas River east across Lonoke to Prairie County. This area combines a mix of urban and rural areas. However, it is close enough to Little Rock that it can fully utilize the mix of treatment options available in the capitol city.[10] Professional Counseling Associates, Inc., serves this region with locations in North Little Rock, Jacksonville, Cabot, Sherwood, and Lonoke. There is not a physical outpatient center in Prairie County. Catchment area 9 receives a first-tier designation due to its location close enough to Little Rock to take advantage of the services across the Arkansas River.

Catchment Area 1: As seen in Figure 1, catchment area 1 is comprised of five counties: Garland, Hot Spring, Clark, Montgomery, and Pike. Community Counseling, Inc. is the Community Mental Health Center provider for the catchment area. While the more urban areas of Hot Springs, Malvern, and Arkadelphia all have access to care through satellite offices of Community Counseling, the more rural

areas in Pike and Montgomery Counties do not have outpatient services unless patients are willing to drive to Hot Springs or Arkadelphia.[11] Overall, however, catchment area 1 ranks in the second tier for access to mental health care. This means that mentally ill persons have the following points of access: emergency rooms, Community Counseling, Inc. (CMHC), private practices, jails, and inpatient acute capacity.[12] Catchment area 1 is a good example of the challenges of urban and rural areas. The cities have access to care while those living in less populous counties have much fewer places to get mental health care.

Catchment Area 2: Anchored by Russellville in the west and Conway in the east, catchment area 2 consists of six counties: Yell, Perry, Faulkner, Conway, Pope, and Johnson. It is served by Counseling Associates, Inc., which has offices in every county except Yell and Perry. Similar to Montgomery and Pike counties in catchment area 1, patients in the rural Yell or Perry counties must be willing to drive to a more urban area for treatment at a CMHC.[13] This catchment area ranks in the second tier as well. There are five main points of access to the mental health system: emergency rooms, Counseling Associates, Inc. (CMHC), private practices, jails, and inpatient acute capacity.[14]

Catchment Area 7: This is the second largest catchment area in terms of the number of counties of any CMHC. Mid-South Health Systems, Inc. provides mental health services for a region that stretches from the Arkansas-Missouri border in the north to the Helena-West Helena area in the south. It stretches as far west as Monroe County. Of the 13 counties included in the catchment area, the CMHC provides outpatient services in 12, the only exception being Poinsett County; most of the treatment there is outsourced to Jonesboro.[15] Overall, catchment area 7 ranks in the second tier of access to care, as they have Mid-South Health Systems, emergency rooms, jail facilities, private practices, and access to inpatient acute-stay facilities.[16]

There are two important caveats to this assessment. First, the further south one travels in the district, the harder it is to find care within Arkansas. Helena-West Helena does not even have a jail facility as a point of access, and the closing of the Crittenden County Hospital eliminates an emergency room as a point of access.[17]

On the other hand, Mid-South Health Systems should be commended for their commitment to mental health courts as evidenced by their continued financial investment.[18] These courts allow a mentally ill person to enroll in a treatment program to avoid serving time or get a reduced sentence. While the legal counsel at Mid-South Health Systems acknowledged that there is a risk with every client that walks through the door, "the hope's that the person stays in treatment long enough for you to get some type of benefit that will eventually pay for the services."[19] In short, this program requires financial and social buy-in from the local government, CMHC, police, and jails for it to work effectively. However, the return on investment can be a reduced rate of recidivism.

Catchment Area 11: Comprised of Grant, Jefferson, Arkansas, Cleveland, and Lincoln Counties, catchment area 11 is served by Southeast Arkansas Behavioral Health Systems (SABHS). There is no physical outpatient location in Cleveland County, but SABHS does operate offices in Pine Bluff, Star City, Stuttgart, and Sheridan. SABHS has started a pilot program to use telemedicine to administer behavioral health services to children and adults in jails that has been successful.[20] Because of the inpatient acute care services available via a contract with Jefferson Regional Medical Center, catchment area 11 receives a second-tier designation for mental health services.

Catchment Area 4: This catchment area, in the heart of the Delta, covers five counties: Ashley, Bradley, Chicot, Desha, and Drew. The CMHC that covers catchment area 4 is Delta Counseling Associates, Inc. (DCA). Outpatient treatment is available from offices DCA operates in Crossett, Dumas, Lake Village, McGehee, Monticello, and Warren. Like many other districts across Arkansas, catchment area 4 has trouble recruiting physicians to their area.[21] To combat the physician shortage, DCA has been trying telemedicine to provide increased access; telemedicine is only

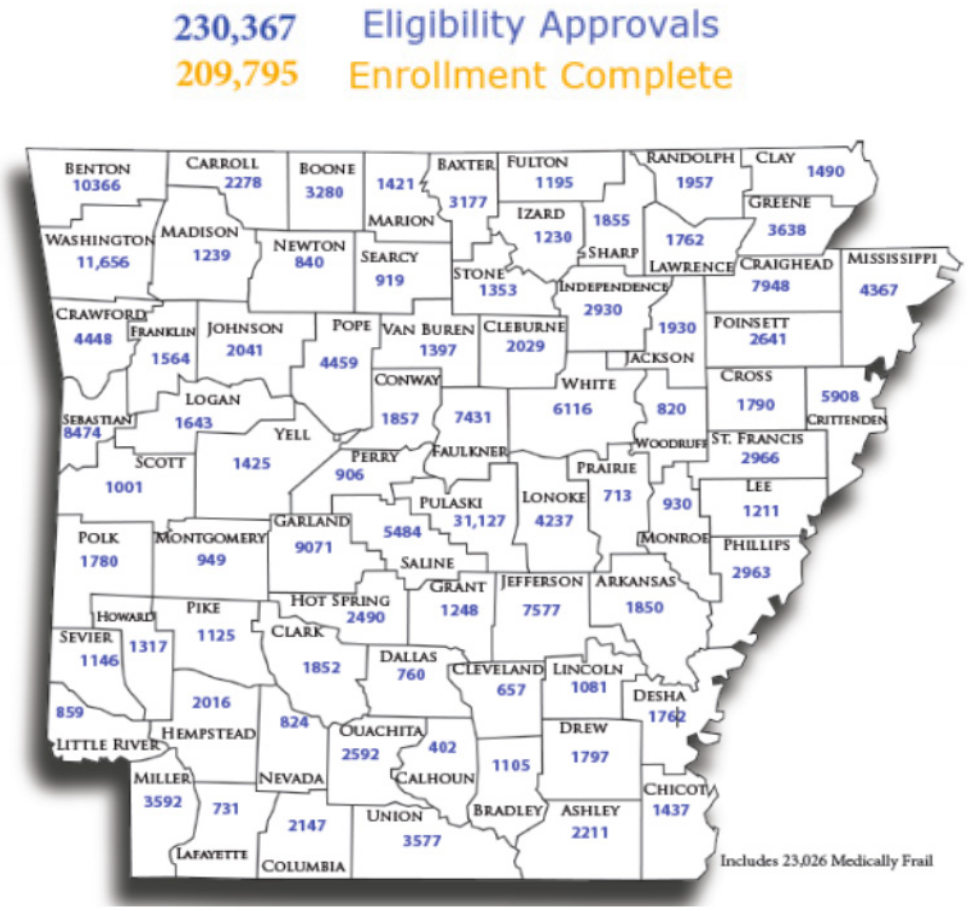
available at the offices in each county operated by DCA.[22] Transportation to the offices for telemedicine services can still be an impediment to access. This area of the state is classified as third-tier in access to care, with the following points of access available: emergency rooms, DCA, private practices, and jails.[23] The closest place with acute care inpatient capacity is Jefferson Regional Hospital in Pine Bluff.

Catchment Area 10: South Arkansas Regional Health Center serves the six-county area of south-central Arkansas that includes Calhoun, Columbia, Dallas, Union, Nevada, and Ouachita Counties. There is not a physical location for service by the CMHC in Calhoun or Dallas County. While the CMHC does provide same-day walk-in services, there is a clear lack of mental health services available to residents of south-central Arkansas. Much like catchment area 4, there are the basic four points of access to mental health services: South Arkansas Regional Health Center, emergency rooms, private practices, and jails.[24] This ranks catchment area 10 in the third tier for access to mental health care.

REGIONAL TRENDS IN ARKANSAS

Each region of Arkansas presents its own challenges and unique methods employed to best serve its population. However, some core trends that have developed across the eight CMHCs profiled are increasing use of telepsychiatary to meet an increasing caseload, and use of physician extenders such as Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs). Another innovative approach is the mental health court programs that Mid-South Health Systems offers to help treat the root of the mental illness while also helping to reduce prison crowding. Walk-in, same-day service like that at South Arkansas Regional Health System should be implemented around the state to insure that if a patient gets to the CMHC, they receive treatment in a timely manner.

Figure 2: Enrollees in Arkansas's Unique Expansion of Medicaid as of December 30, 2014



Source: (Arkansas Department of Human Services 2014)

CMHCS AND THE PRIVATE OPTION

One of the ten essential benefits included in Medicaid expansion through the Affordable Care Act is that mental health services must be included. As of December 2014, after one full year of the private option, over 209,000 have received mental health care benefits through Medicaid. Of the population who are now covered under the private option, according to Figure 2 (above), 18,614 live in South Arkansas or the Delta - an area that already is designated in the third tier for access to care in Arkansas.

When the private option was passed in 2013, nearly $8 million was cut from the budget of CMHCs due to the expected increase in revenue that the private option would provide.[25] The logic was that with less uninsured people coming through the doors expecting treatment, the CMHCs would be able to sustain the cut through Medicaid reimbursement. There is evidence that this logic has been proved correct. From 2013 to July of 2015, Professional Counseling Associates, Inc. has seen a decrease of 27 percent in their rate of uninsured.[26] From 2013 to 2014, Counseling Associates, Inc. saw a decrease of 11.7 percent in their rate of uninsured.[27] Two other CMHCs, Community Counseling Inc. and Southeast Arkansas Behavioral Systems, recorded uninsured rates after the private option of 6.75 percent and 3 percent, respectively.[28] Anecdotally, Mid-South Health Systems went from about 2,800 uninsured clients per year before the private option to approximately 800 after the private option.[29] According to one director of a CMHC, the private option has had a positive effect and "opened a big door" especially for individuals that need outpatient, short-term medical care.[30] In this way, the private option can be seen as opening up access to care to a new group of mentally ill persons that might not have sought or received treatment in the past.

Although evidence is not complete, it does seem to indicate that there is a negative relationship between the expansion of Medicaid and the rate of uninsured in CMHCs. Expansion of Medicaid leads to lower rates of uninsured seeking mental health care services. This additional revenue from more insured patients has been able to make up for the loss of the approximately $8 million from CMHC budgets.[31] However, with the cuts still in place to CMHCs, the state's distinctive expansion of Medicaid becomes a necessary piece of revenue to keep the CMHCs financially afloat.

HEALTH REFORM LEGISLATIVE TASK FORCE AND THE PRIVATE OPTION

Vital to the continuation of the private option, the unique expansion of Medicaid in Arkansas, are the findings of the Health Reform Legislative Task Force created by Governor Hutchinson. With the stated goal of suggesting reforms to the private option for 2017, the task force has approved two major objectives. However, the tactics for reaching the objectives have yet to be determined. The results of the task force are important to the future of mental health care in Arkansas because many patients and providers rely on Medicaid to make treatment possible.[32]

The two objectives approved by the Task Force include that Arkansas should continue the private option, and that the state will try to save $835 million in traditional Medicaid reforms over the next five years (Ramsey 2016). These objectives developed from statements from both Governor Hutchinson as well as the Stephen Group report that was commissioned by the task force. While the Stephen Group's report does not lay out specific proposals, it does indicate that the state could save significant amounts of money by implementing best practices, using more coordinated care, more personal responsibility, and enhanced eligibility and program integrity (The Stephen Group 2015). In short, the Stephen Group report leaves the decision on tactics up to the legislature while outlining possible strategies to save the state money.

There are two competing ideas for how to reform Medicaid in a way that saves the state money. One option is to embrace a managed-care approach as outlined in the Stephen Group report; a second option is to let state agencies and health care providers carry out and oversee the services provided. The Stephen Group report claims that using managed care companies could save Arkansas $2 billion over five years. Achieving the same objective through state agencies would save $700 million (Ramsey 2016). If both options prove to be equally effective, using private managed care companies seems to make more sense both economically and in terms of accountability. It remains to be determined which path the state will follow. Ideally, the state will be able to provide better care for the Medicaid population while reducing the price tag for those services in the future. This is possible and should be the goal.

Mental Health Care in Arkansas: Tomorrow

For the Arkansas Legislature and the Behavioral Health Access Task Force to identify mental health access solutions for tomorrow, it must be asking the right questions and trying to solve the correct problems. Arkansas faces two distinct, yet interconnected, obstacles to obtaining multiple levels of access to care throughout the state. Those obstacles are a shortage of mental health providers and a lack of points and levels of access. There are simply not enough psychiatrists and psychologists to meet the need for patients. Looking at the state as a whole by examining each of the aforementioned catchment areas, there are only two levels of access: outpatient sessions or inpatient acute stays. In the words of one mental health professional with over 20 years of experience in Arkansas, the two biggest mental health problems facing the state are access to care and a continuum of care for patients.[33] The good news is that solutions exist for each of these problems.

There is a shortage of psychiatrists in most of the CMHCs discussed here. For example, Delta Counseling Associates only has one full-time psychiatrist.[34] The shortage of psychiatrists inspires competition between entities such as UAMS and the VA for the same psychiatrists.[35] While demand is high for psychiatrists, supply is not keeping up. UAMS produces about 10 psychiatrists each year; however, only eight can be retained in Arkansas through the residency program at UAMS.[36] Of those eight, not all will choose to stay in Arkansas. This leads to an inevitable brain drain, and helps to explain the shortage of psychiatrists.

To make up for this disparity between patients and psychiatrists, many CMHCs have already begun to use physician extenders. Psychiatric physician extenders can take many forms such as an APRN, PA, LCSW, or licensed professional counselor. In order to make up for the shortage of physicians, Arkansas should invest in physician extenders. Having a PA or an APRN can as much as triple the amount of patients that can be seen by a psychiatrist in a day.[37] One way of producing more physician extenders would be to offer incentives for students to pursue degree programs such as Arkansas State's Bachelors and Masters of Social Work (MSW). This would facilitate efficiency for the psychiatrists already serving in Arkansas by maximizing the number of patients that can be seen in one location each day. It should also be noted that expansions of UAMS to include other campuses, like the 2009 expansion into northwest Arkansas, could help produce more psychiatrists (Parham 2014b).

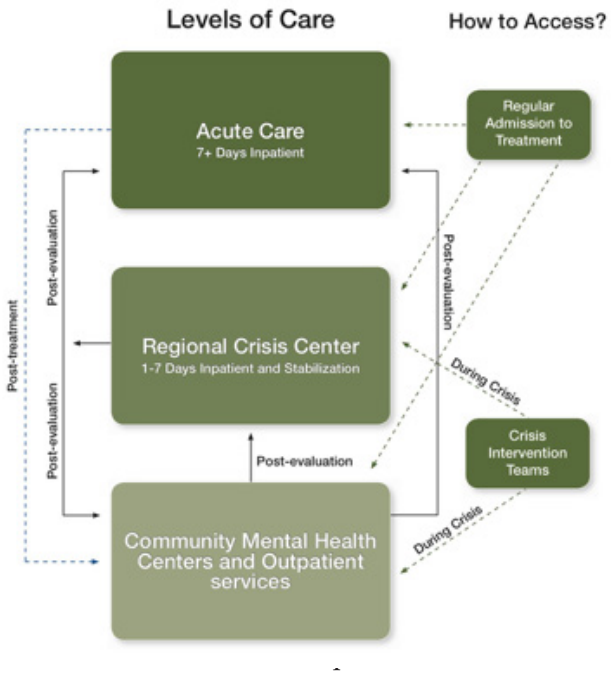
The final piece to combat the psychiatrist shortage in Arkansas is by employing telepsychiatry practices. Through this strategy, a psychiatrist in Little Rock could help to serve patients in the Delta or other counties such as Montgomery, Pike, Perry, or Yell where a physical location is not present. This would eliminate the need for a large capital investment for an office location in more rural areas of the state.

To address the lack of levels and types of access, the discussion must move from individual doctors to the greater health care infrastructure present in Arkansas. Areas in the first tier with the most access to care are the exception to the rule. Most counties in Arkansas do not have more than outpatient services, with the occasional availability of inpatient treatment. Data from the Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that the current institutions provide insufficient coverage of the population. Only 45.9 percent of Arkansans with any mental illness receive treatment or counseling (Behavioral Health Barometer: Arkansas 2014).

Throughout the country, there are many different methods that have worked to increase access to mental health care. These include Assertive Community Treatment (ACT), Crisis Intervention Team (CIT) training, and Crisis Care Centers (CCC). When used in conjunction in places such as Memphis, Tennessee, and Bexar County, Texas, CIT and CCC units have ultimately saved money by diverting mentally ill

persons away from prisons (Evans 2007). In addition to saving taxpayer money, these programs also increase the points of access while reducing stress on other points of access such as hospital emergency rooms. The combination of CIT and CCC as far as increasing access to care can be seen in the following diagram.

Figure 3: Points of Access to Mental Health Care with CIT and CCC



CIT teams are a critical first step in increasing efficiency of the few resources already available in Arkansas. Even without complimentary CCCs, CIT can help law enforcement be able to identify those people that are mentally ill before they commit a crime. Then, law enforcement officers trained in CIT can take mentally ill persons to the proper treatment facility, either emergency room, CMHC, or to an acute inpatient facility such as the Arkansas State Hospital.

Even more progress is made when Crisis Care Centers are involved in the points of access at the disposal of police officers. CCCs allow law enforcement a place where they can drop off a mentally ill patient at any hour of the day and return to duty in 15 minutes (Baldwin et al. 2015). Not only can CCCs act as a place for mentally ill persons to sober up or have their medication assessed, but it can also be used as a check-in center for an initiative like South Dakota's 24/7 sobriety program (Mickelson 2015). In addition, CCCs provide a place where the proper referral to mental health professionals can be made, whether to an acute stay facility or to a CMHC. This critical step would maximize efficiency of the 13 CMHC's in Arkansas while also only putting those who need inpatient stays into those facilities.

Using Crisis Centers and CIT training addresses the lack of access to care; however, it only begins to address the continuum of care. Two additional steps can be taken to help lower rates of recidivism and make sure that mentally ill persons stay on-course throughout their treatment plan. Just as a patient must go to physical rehabilitation for a muscle tear, mental illness requires more than an intervention to treat. Therefore, a same-day treatment policy, such as that already implemented at Southern Arkansas Regional Health Center CMHC in El Dorado, would be very important to make sure that people stay in treatment. Under this model, anyone who walks through the door seeking mental health care would be seen the same day.[38] Having same-day treatment also allows a CCC to refer a patient straight to a CMHC where that patient could have continuing appointments. Secondly, ACT programs should be considered. By implementing ACT, a caseworker, psychiatrist, and patient can all stay on the same page regarding treatment options and completion. In addition, ACT programs are evidence-based models that provide support services in the client's home or other community settings ("Assertive Community Treatment" n.d.). The result of ACT programs is that patients spend fewer days in a hospitalization setting, are more often employed, live independently, and have fewer symptoms of mental illness ("Assertive Community Treatment" n.d.). The costs of treatment for ACT are high, but the net economic benefits are positive, as the government spends less on hospitalization and jails while receiving taxes from the patient who is now able to work.

Conclusion

Changes to the Arkansas mental health system are needed. As far back as 1953, problems were found with the Arkansas mental health system. Even in more recent years, Arkansas has consistently ranked as one of the worst states for mental health care. The Arkansas Health Reform Task Force recommendations mark a commitment to improve upon Arkansas's unique Medicaid expansion. The report suggests many structural changes, such as more coordinated care, more personal responsibility, and enhanced eligibility and program integrity (The Stephen Group 2015). However, the Stephen's report and the Health Reform Task Force have not provided the concrete policy proposals and tactics related to improving behavioral health contained in this report. To be successful, changes will have to be implemented in both the short-term and the long-term.

In a normative sense, a long-term plan for mental health access in Arkansas would include three essential elements: a plan for the forensic population, a way to increase levels of access to care across the state, and a way to maintain a continuum of care. To manage and decrease the forensic population of mentally ill persons, two strategies would be employed. First, mental health courts would be put in place so that offenders can receive the treatment they need, and secondly, a program like ACT would be enacted to make sure that those with a mental illness continue to receive the support system, medication, and treatment needed. These two actions would help reduce recidivism while also integrating the ex-inmate back into the community. ACT programs would increase the levels of access across the state, but the changes should not end there. CIT-trained police officers should be available in each catchment area of Arkansas. Regional Crisis Care Centers would ideally be available in each catchment area, or at the very least every congressional district. These two changes would provide additional avenues to divert mentally ill persons from the Arkansas State Hospital or other inpatient facilities while providing more patient-centered care. To address the continuum of care, telemedicine programs would be coupled with programs that offer incentives to go into a career as a social worker, PA, APRN, or psychiatrist. This would increase the efficiency and quantity of care provided.

In the short term, several steps can be taken in the 2017 session of the Arkansas General Assembly to improve access to mental health. First, the private option must be continued without further cuts to the behavioral health budget. Eliminating Arkansas's unique version of Medicaid expansion or further budget cuts would effectively leave the CMHCs with very few financial resources. Secondly, CIT training should be incentivized across the state. In coordination with CIT training, regional crisis centers should be explored and implemented in a central location of each congressional district. Finally, Arkansas should help to encourage the use of telemedicine practices for mental health issues. Taking these steps to improve access to mental health care would establish a solid foundation for the future of the mental health care system especially for rural areas. President Kennedy's statement that mental illness is "unpleasant to mention, easy to postpone, and despairing of solution" no longer holds true. There are solutions. While the problem may remain unpleasant to mention and easy to postpone, there is a solution to the problem of access to care in Arkansas. All that is left to do is invest the social, political, and monetary capital to make that solution a reality.

Notes

1 Steve Newsome. Personal Communication. August 21, 2015; Jannie Cotton. Personal Communication. July 28, 2015.

2 Kathy Harris. Interview. July 6, 2015. Pine Bluff, AR. In this and other catchment areas, CMHCs are a primary provider of mental health treatment.

3 Bonnie White and Ruth Allison Dover. Interview. July 23, 2015. Jonesboro, AR.

4 Dr. Erick Messias. Interview. June 11, 2015. Little Rock, AR.; Stacey Davis. Interview. July 14, 2015. Monticello, AR.; Regina Pierce. Interview. July 14, 2015. El Dorado, AR.

5 John F. Kennedy. "Special Message to the Congress on Mental Illness and Mental Retardation.," February 5, 1963. Online by Gerhard Peters and John T. Woolley, The American Presidency Project. http://www.presidency.ucsb.edu/ws/?pid=9546

6 Dr. Larry Miller. Interview. June 29, 2015. Little Rock, AR.

7 Kim Arnold. Interview. June 24, 2015. Little Rock, AR.

8 Messias. Interview.

9 Dr. Justin Hunt. Interview. July 8, 2015. Fayetteville, AR.

10 Jannie Cotton. Interview. July 28, 2015. Professional Counseling Associates, Inc. North Little Rock, AR.

11 Dr. Rob Gershon. Interview. June 10, 2015. Community Counseling, Inc. Hot Springs, AR.

12 Gershon. Interview.

13 Newsome. Interview.

14 Newsome. Interview.

15 White and Dover. Interview.

16 White and Dover. Interview.

17 White and Dover. Interview.

18 White and Dover. Interview.

19 White and Dover. Interview.

20 Harris. Interview.

21 Davis. Interview.

22 Davis. Interview.

23 Davis. Interview.

24 Pierce. Interview.

25 Newsome. Interview; Pierce. Interview.

26 Cotton. Personal Communication.

27 Newsome. Personal Communication.

28 Dr. Rob Gershon and Diane Skaggs. Personal Communication. August 19, 2015; Harris. Interview.

29 White and Dover. Interview.

30 White. Interview.

31 Newsome. Interview.

32 Joe Messina. Interview. June 22, 2015. Hot Springs, AR.

33 Miller. Interview.

34 Davis. Interview.

35 Messias. Interview.

36 Messias. Interview.

37 Messias. Interview.

38 Pierce. Interview.

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