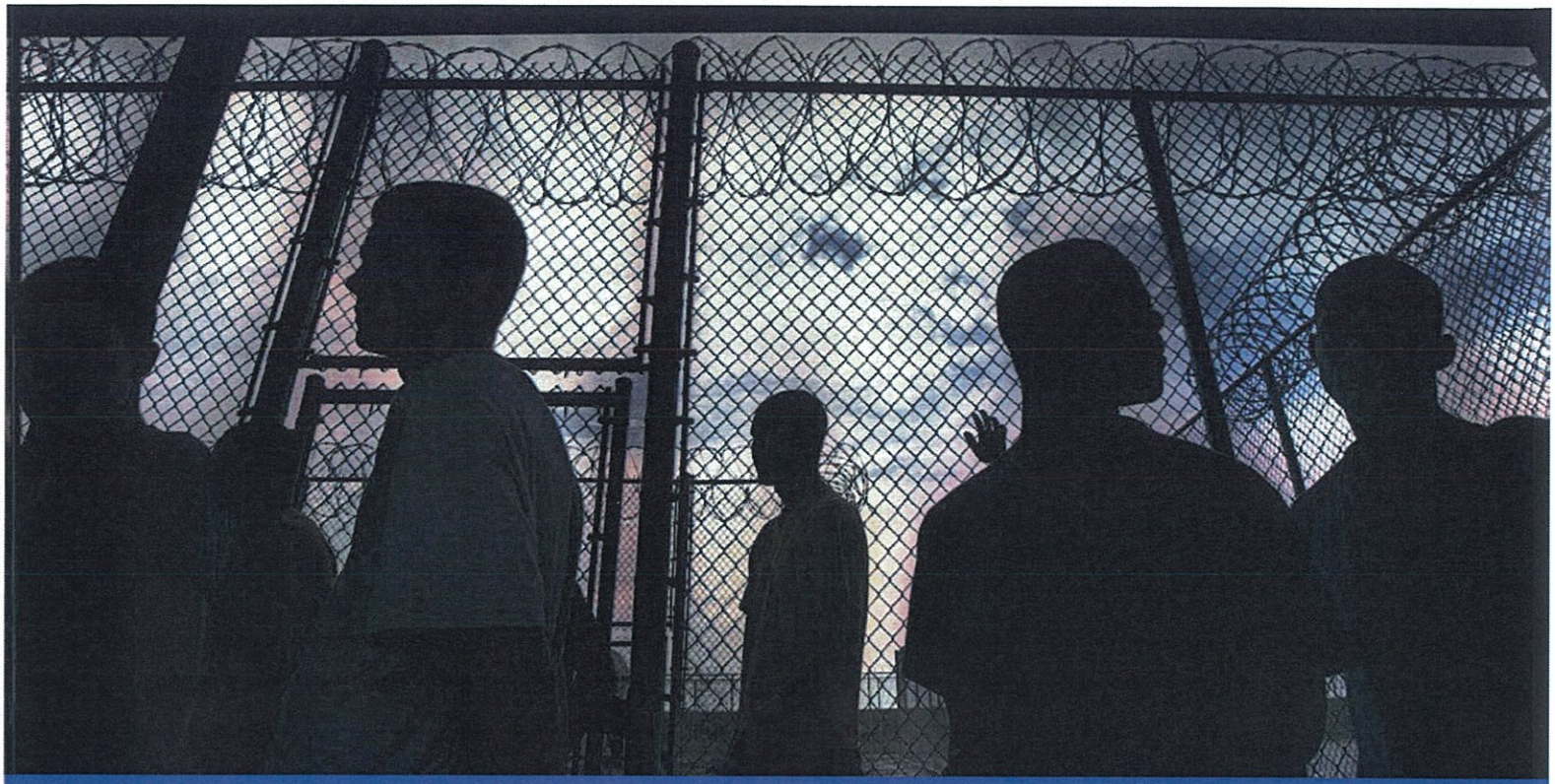

A Brief Cost Analysis of Arkansas Mental Health and Prison Reform

Arkansas Public Policy Panel, April 2015

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Judicial Equality for Mental Illness

1. Introduction and Background

The past decade has begun to see a shift in the system of incarcerating mentally-ill persons in Arkansas and across the nation. Based on a number of empirical studies and public-policy reviews, states have begun to question the long-standing reliance on secure confinement of offenders with mental-health issues, its effect on public safety, and on the person's ability to join society as productive and contributing members of their community in the future.

In Arkansas a wide cross-section of those involved with administering both criminal justice and mental-health care – judges, prosecutors, police, state agency heads, mental-health advocates, families, and the patients themselves – have been able to meet and agree on a number of changes to the former system of "arrest and commit." A primary focus of their efforts has been the design of a diversion process that places a mentally-ill offender in a treatment program rather than the criminal-justice system. This reform approach would increase the use of community-based alternatives like probation, community service, smaller therapeutic residential programs, and crisis centers.

While widespread agreement about the need for mental-health and prison reform has been achieved, less is known about the exact costs and benefits of these reforms. How will different actions by the courts or state agencies affect the state's budget for mental-health care and for processing offenders? If cost savings are achieved, how much money may be available for more effective alternatives that help mental-health patients become reestablished in their communities?

Our research found that one year's worth of trial and jail time for each mentally-ill person costs the state about 20 times as much as crisis treatment and counseling for the same person with mental problems. These are average comparisons, and the national data indicate that the costs of keeping prisoners with mental illness are more expensive than average prisoners; this ratio could be 25:1 or higher. Based on the current jail and prison populations, this could mean savings of millions of budget dollars from the costs of adjudication and incarceration by local and state agencies.

It appears that Arkansas has thousands of prisoners with mental-health issues who are receiving less than appropriate care when better medical and mental-health care could be provided at a fraction of the current cost per inmate.

Before we address the financial issues of prison reform and the mentally ill, the next chapter highlights some of the issues that have been addressed by other cities, counties, and states that have been restructuring their mental-health systems to address these problems.

2. The Experience of Other Notable States with Mental Health Reforms

Concerns about quality of care and the cost of incarceration have led a number of other states to address the issue of reform. Most notable has been the experience of San Antonio, Texas with a program of local crisis treatment centers. Also, neighboring states like Oklahoma and others have enacted important changes in their approach to incarceration and mental health.

San Antonio, Texas

Mental-health officials and police alike recognized that jailing patients is an expensive and not very effective way of dealing with many episodes of low-impact crimes like domestic disputes, petty larceny, and public disorder. By pooling their resources, five years ago city leaders were able to fund the Restoration Center, which is a full-time facility with mental and physical health services available. The Center has become the focus of the city's jail-diversion program, which involves over 4,000 persons each year.[2]

In addition, law enforcement embarked on a thorough training program in dealing with mental-health issues, after recognizing that many arrests involved the same individuals who needed but did not receive proper care after a previous arrest. San Antonio's response was to require all officers to take a 40-hour course called Crisis Intervention Training, to learn how to handle mental health crises. With this training and a place to take offenders who are in need of treatment, the city has offered an alternative to a revolving door of arrest, jail, bail, and rearrest. Of course, suspected felons still go to jail and people in need of medical care are taken to the hospital, but officers have an alternative for the many people who don't fit a normal pattern.

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. Altogether, more than 18,000 people use the Center each year, and officials say the coordinated approach has saved the city more than $10 million annually (for details, see Table 1 in Chapter 3).

Oklahoma

In recent years, a number of states had significant drops in the number of beds allocated for mental-health hospitals.

2 "Blueprint for Success: The Bexar County Model -- How to Set Up a Jail Diversion Program in Your Community," The Center for Health Care Services, San Antonio, Texas, 2008.

Oklahoma was one of the states to realize this problem and take comprehensive action. Coupled with inadequate increases in community-based facilities and dwindling mental-health resources, a considerable number Oklahoma's mentally ill were, by default, treated by the criminal justice system once they came into contact with the Oklahoma Department of Corrections (ODOC).

In 2000, the chief medical officer of the ODOC initiated a plan to ascertain the services necessary to meet the challenge in a cost-effective way. This challenge was especially urgent because of the medically necessary needs of the inmate population of the ODOC, as mandated by the state constitution. A taskforce developed guidelines and assessment criteria to determine specifically what level of service was needed to treat the inmates. The taskforce recommendations were put forth in the form of a management tool for mental-health services. One key recommendation that Arkansas might want to consider was: "Criteria for assessing treatment needs that focus on post-release reintegration rather than institutionalization."[3]

In 2007, ODOC in collaboration with Oklahoma Department of Mental Health and Substance Abuse Services launched Re-entry Intensive Care Coordination Teams (RICCT). This innovative approach was implemented in four locations, two each in Tulsa and Oklahoma counties. The RICCT program is intended as a way to transition inmates – with mental illness and co-occurring disorders – from the penal system into other areas of treatment for substance abuse and mental illness. Other services include assistance with housing, vocational programs, medical care, and various other community-based programs and resources.

The results of this Oklahoma-based program are promising; the RICCT program has served 626 offenders since February 2014.[4] The ODOC reports that 55 percent (14,625) of all prisoners have mental health needs and of those with mental illness, 55 percent are in jail for non-violent crimes. At any single time, an average of more than 800 inmates are mentally ill in Oklahoma's two largest counties.

A major goal of the RICCT program is to reduce the rate of re-incarceration and to assure that this population gets proper treatment, including appropriate psychiatric medications and community support. Of the people enrolled in the program when compared to non-enrollees, 92 percent fewer arrests were reported after one year of the program, 80 percent fewer days were spent in jail, and 80 percent fewer days were spent as inpatients in area hospitals.

3 "Re-entry Intensive Care Coordination Teams," Oklahoma Department of Mental Health and Substance Abuse Services, Oklahoma City, August 2014.

4 Ibid.

Georgia

Georgia has a comprehensive system and network of mental-health treatment services, providers, and mental-health professionals. The majority of these programs and services are under the auspices of the Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD). The state has been thorough and innovative in putting into place an infrastructure to address the problem of mental health, whether it is developmental disabilities, behavioral health, or imprisoned patients. Georgia's approach has been to deploy an array of state-based programs and community-based providers that offer treatment, assessment, intervention, and numerous other services.[5]

The Georgia Crisis Response System for the Developmental Disabilities (GCRS-DD), while not directed at mental illness per se, is a good example of the many state-based programs under this agency. This program has treatment options for both adults and adolescents. Within this GCRS-DD program, the Assertive Community Treatment (ACT) team is an example of a Community Service Provider. This program is funded in part by block grants designed to address mental health problems. The ACT team works within the community and provides services that address substance abuse, treatment, prevention, and training.

In many cases, providing this mental-health intervention, treatment, and stabilization at the community level has been shown to be effective in reaching the people who normally may not have access to the kinds of mental healthcare services needed.[6] This may be another model for the type of pro-active treatment that Arkansas may want to consider.

New Mexico

The state implemented the New Mexico Crisis and Access Line (NMCAL) in early 2013 to tackle the related problems of budgeting, treatment, finite resources, and effective plans of action. It is well known that states grapple with these issues in dealing with mental illness among their populations. Exacerbating the problem are arrays of systemic issues that keep state officials continually seeking the best methods and treatment options to meet the mental-health needs of their citizens.

During its first year of operation, the NMCAL answered almost 3,100 calls. An additional 3,700 calls were fielded by the core service agency (CSA) crisis lines during the same

5 "Adult Crisis Stabilization Units – Chapter 82-3-1," Department of Behavioral Health & Developmental Disabilities, Ga. Comp. R. & Regs. 82-3-1.XX. (n.d.).

6 "FY 2012 Provider Manual," Department of Behavioral Health & Developmental Disabilities, April 1, 2012.

period, bringing the total number of calls to approximately 6,800 during the first year of operation. Call volume jumped significantly as the program was publicized and more people became aware of the service.

The effectiveness of the CSA call line was based on several key factors. As an example, within the first year of operation the crisis line answered calls from 32 of the state's 33 counties. Also notable is the effectiveness of the clinicians answering the calls. For example, 95 percent of the callers were stabilized by the clinician and referred to community resources by the end of the call. It was reported that suicidal thoughts were mentioned by over 500 callers and 88 percent of them were stabilized by the clinician by the end of the call.[7]

NMCAL has proven its necessity and effectiveness for New Mexico. As more states seek better and complementary ways to alleviate the burden on law enforcement with respect to handling the mentally ill, perhaps the NMCAL approach could be an added option for Arkansas policy-makers to consider.

Oregon

Oregon has undertaken a major investment in improving the state's infrastructure, programs, and services offered to its citizens with mental health concerns. The Oregon Health Authority, Division of Addictions and Mental Health has taken the lead in coordinating the necessary expansion and updating of the current system.

During 2013, Oregon spent $4.95 million revamping the old system, and more than $7.4 million was allocated for the entire 18-month funding period. The method chosen to accomplish the overhaul is a service known as Mobile Crisis (MC) services.

The available services include but are not limited to assessment, intervention, placement for treatment, and continued support services. MC services have a shorter response time than the traditional programs and are meant to compliment the current system. An integral part of this approach is the coordination with the law enforcement agency.[8]

The overall goal of the new approach is two-tiered: 1) increase the number of people using the mobile crisis service; and 2) decrease the hospitalization of patients using the mobile crisis services and reduce the involvement of the police and the criminal-justice system. This reduces both the cost and severity of treatment for the mentally ill when they come in contact with law enforcement.

While these comparisons with other states are helpful in understanding the complex issues involved in treating mentally-ill prisoners, it should be recognized that these data are limited and do not exactly reflect the experience in Arkansas. Further analysis may be needed that involves surveys of the imprisoned population, interviews with state and local officials, people with mental illness about their treatment, and case studies of possible reforms that may alleviate some poor conditions. These studies are discussed in more detail in the conclusions in Chapter 4.

3. Estimating the Costs of Mental-Health and Prison Reform

Any analyst or interested observer of the mental-health system in Arkansas will notice how complex the various jurisdictions and processes can be. In this short paper, we do not attempt to examine every detail of the process to achieve an exact determination of the costs and benefits of reform in this area. However, it is possible to review the major components of the cost of full-time imprisonment and compare those with the costs of alternative methods of treatment, such as the Restoration Center used in San Antonio.

How big is the problem of incarcerating mentally-ill prisoners in Arkansas's jails and prisons? Definitive numbers are difficult to achieve, and will vary by the proportion of women and youth who are counted, since both groups appear to have higher rates of illness among people who are incarcerated.[9] However, a 2009 study indicated that about 3,500 adults with serious mental illnesses are incarcerated in prisons in Arkansas.[10] This would represent about 20 percent of the average Department of Corrections (DoC) population, based on recent records of the agency.[11]

In addition, U.S. Department of Justice studies have found that about 21 percent of the prisoners in local jails also have mental-health issues, meaning another 1,200 persons need

7 "New Mexico Crisis and Access Line Annual Report: 1-855-NMCRISIS," available on-line at www.nmcrisisline.com.

8 "RFP For Crisis Services Funding," Oregon Health Authority Division of Addictions and Mental Health, 2013.

9 "Identifying Target Populations for Diversion from the Criminal Justice System: Preliminary Evidence" (PowerPoint Presentation), Mindy Bradley, Dept. of Sociology and Criminal Justice, University of Arkansas-Fayetteville, 2014; see also H.J. Steadman, F.C. Osher, et al., "Prevalence of Serious Mental Illness among Jail Inmates," Psychiatric Services 60, June 2009.

10 Sabol, W. J., West, H. C. and Cooper, M., Prisoners in 2008, U.S. Department of Justice, Bureau of Justice Statistics, (2009); and James, D. and Glaze, L., Mental Health Problems of Prison and Jail Inmates, U.S. Department of Justice, Bureau of Justice Statistics, (2006).

11 Arkansas Department of Correction Annual Report 2014, June 30, 2014. See also "Prisoners in 2013," U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, BJS Bulletin NCJ 247282, September 2014.

treatment.[12] Furthermore, at least 20 percent of young people who are adjudicated in the juvenile-justice system have a severe mental illness, and 70 percent of these youth have at least one mental-health condition.[13] Based on recent counts, that places another one-fifth of incarcerated youth, or about 150 young people, at risk and in need of treatment.[14]

So without a thorough census of the prison and jail populations, a best estimate of the number of incarcerated people with mental-health issues is about 5,000 persons in Arkansas. Compared to many national estimates, this appears to be a conservative number, as the following studies document.

- A recent study by the Department of Justice found that more than half of all prison and jail inmates have a mental health problem compared with 11 percent of the general population, yet only one in three prison inmates and one in six jail inmates receive any form of mental-health treatment.[15]
- Approximately 20 percent of inmates in jails and 15 percent of inmates in state prisons have a serious mental illness.[16]
- The nation's jails and prisons have replaced hospitals as the primary facility for mentally ill individuals. There are more seriously mentally ill individuals in the Los Angeles County Jail, Chicago's Cook County Jail, or New York's Riker's Island Jail than in any psychiatric hospital in the United States.[17]
- In fact, in every county in the US that has both a county jail and a county psychiatric facility, the jail has more seriously mentally ill individuals.[18]

In addition, the cost of care for mentally-ill inmates is a major concern for many other states, as these examples indicate.

- Mentally-ill inmates cost more than non–mentally ill inmates for a variety of reasons, including increased staffing needs. In Broward County, Florida, it costs $80 a day to house a regular inmate but $130 a day for an inmate with mental illness.[19]
- In Texas prisons "the average prisoner costs the state about $22,000 a year," but "prisoners with mental illness range from $30,000 to $50,000 a year." Psychiatric medications are a significant part of the increased costs.[20]

Clearly, Arkansas has thousands of prisoners with mental-health issues who are receiving 1) less than appropriate care while locked up in prisons and jails, and 2) high-cost incarceration when better medical and mental-health care could be provided at a fraction of the current cost per inmate. If other states have instituted reforms of their treatment of this population, including crisis centers and community-based care, Arkansas should consider similar reforms that would provide better treatment and reduce the costs of institutionalized care (see sidebar for details of an alternative care approach).

In addition, the state is not presently upholding its constitutional mandate of caring for those with a mental illness. This situation could conceivably present legal challenges for the relevant agencies similar to the well-known educational reform cases like the Alma and Lakeview suits. These are costs that the state would likely avoid by initiating reforms in the way it cares for prisoners with mental illness.

Potential Savings from Mental-Health Reform

Even in the absence of a detailed study of the many facets that reform could include in Arkansas, it is possible to trace the overall configuration of the necessary care improvements and the possible cost savings involved.

For example, the present cost of keeping a prisoner at a state facility is about $63 per day, or about $23,000 per year.[21] In addition, the average cost of adjudicating a criminal suspect through the law enforcement and court system is about $6,300 in 2014 dollars.[22] These costs include prosecuting

12 James and Glaze (2006); National Institute of Corrections, "Corrections Statistics by State," U.S. Department of Justice, 2006, available on-line at http://nicic.gov/statestats/?st=AR.

13 Skowyra, K.R. & Cocozza, J.J., Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System. The National Center for Mental Health and Juvenile Justice; Policy Research Associates, Inc., 2007.

14 "Statistical Briefing Book," U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 2015; available on-line at http://ojjdp.gov/ojstatbb/default.asp.

15 "Care of the Mentally Ill in Prisons: Challenges and Solutions," Anasseril E. Daniel, MD, J Am Acad Psychiatry Law 35:406–10, 2007.

16 "How Many Individuals with Serious Mental Illness are in Jails and Prisons?" Treatment Advocacy Center (updated November 2014); available on-line at http://www.treatmentadvocacycenter.org/problem/consequences-of-non-treatment/2580.

17 E.F. Torrey, A.D. Kennard, D. Eslinger et al., More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States, Arlington, Va.: Treatment Advocacy Center, 2010.

18 Ibid.

19 C.M. Miller and A. Fantz, "Special 'psych' jails planned," Miami Herald, November 15, 2007.

20 E. Bender, "Community treatment more humane, reduces criminal-justice costs," Psychiatric News, 2003, 38:28.

21 Arkansas Department of Correction, "Annual Report 2014," June 30, 2014; see also "Prisoners in 2013," U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, BJS Bulletin NCJ 247282, September 2014; also Christian Henrichson and Ruth Delaney, "The Price of Prisons: What Incarceration Costs Taxpayers," Vera Institute of Justice, January 2012 (Updated 7/20/12).

22 HISTECON Associates, Inc., "Cost Benefit Analysis of Arkansas Juvenile Justice Reforms" (unpublished report), Arkansas Advocates for Children and Families, Little Rock, AR, August 2012.

attorneys, judges, court clerks and reporters, and police time during arrests, arraignments, jail time, and testimony at trial. Thus, an estimate of the first-year costs of the criminal processing and imprisonment of mentally-ill suspects is about $30,000.

If we apply that figure to the 5,000 such inmates that are believed to populate the jails, prisons, and juvenile centers, the total cost to local and state governments would be $150 million for their first year – for incarceration and a treatment that most health professionals now describe as inferior, inappropriate, and unnecessarily expensive. (The total budget for Arkansas DoC alone in 2014 was more than $324 million for an average prisoner count of about 16,900 persons.)[23]

For a reform alternative, the experiences of San Antonio and Oklahoma in our region are notable in their approach. Each has created a separate intake process involving a "crisis center" that law enforcement and the community can rely on to both remove the offending party from an undesirable social situation and intercede with psychiatric and medical assistance for the individual involved. These types of centers have costs too, of course, but they are considerably lower than the costs of traditional incarceration, as Table 1 demonstrates.

Although direct comparisons across state boundaries and jurisdictions can be incomplete, the picture of across-the-board cost savings is very clear. In FY2010, San Antonio and Bexar County estimate that their reforms saved taxpayers more than $4,600 per episode that involved a person with a mental illness. These savings, in areas like reduced wait time in jails, hospitals, and courtrooms, have produced total savings in the region of about $50 million over the past five years.[24]

23 Arkansas Department of Correction, 2014.

24 Jenny Gold, "Mental Health Cops Help Reweave Social Safety Net In San Antonio," August 19, 2014; available on-line at www.npr.org/blogs/health/2014/08/19/338895262/mental-health-cops-help-reweave-social-safety-net. Prisoner numbers for Bexar Co. come from "Fiscal Year 2012 Statistical Report," Texas Department of Criminal Justice, prepared by Executive Services, Huntsville, Texas, 2012.

Table 1. Example of Cost Avoidance by Using Crisis Treatment Centers San Antonio and Bexar County, Texas (FY 2010) reduced to per prisoner per year basis*

Cost Category	City	Rest of Bexar Bexar County	Total Direct Cost Avoidance
Public Intoxification Diverted from Detention Facilities	$222	$1,010	$1,232 (@one-half for mental health)**
Injured Prisoner Diverted from ER at Hospital	$269	$645	$914 (@one-half for mental health)**
Mentally Ill Diverted from Courtroom/Jail Facility	$212	$378	$590
Reduction in Jail Time Awaiting Competancy for Hospital Admission	n/a	$260	$260
Reduction in Jail Time for Outpatient Competancy	n/a	$140	$140
Reduction in Jail Time for Competency Restoration on Bonds and Returns	n/a	$393	$393
Totals	$1,031	$3,614	$4,645

*Based on FY 2010 average prisoner population and percentage receiving mental-health treatment.
**Since many but not all of these two types of patients have mental illness, only one-half of the savings was attributed here. The exact proportion of these types with mental illness is not known at present.
Source: HISTECON Associates, Inc. Original data are from "Keeping the Mentally Ill and Serial Inebriates out of Jail, off the Street, and out of the Hospital by Providing Access to Treatment and Support Services," San Antonio, Bexar County, Texas, 2010 and "Fiscal Year 2012 Statistical Report," Texas Department of Criminal Justice, prepared by Executive Services, Huntsville, Texas, 2012.

An Assessment by Health Management Associates
(a consulting group for the state of Michigan) of Treatment Costs

Calculating the net savings from implementing an assisted outpatient treatment (AOT) program requires collecting various data elements to compare costs of treating the relevant population before the implementation of AOT and after. The potential savings include not only a reduction in the cost of providing health services – that is, the direct costs – but also indirect costs for non-health services that may be changed by the implementation of AOT. Relevant costs (not necessarily exhaustive) are listed below.

Total per-person costs for mental health services include:

- Total state inpatient psychiatric hospital costs
- Total outpatient mental health service costs
  - Evaluation/assessments
  - Crisis services
  - Assertive community treatment (ACT)
  - Case management/care coordination
  - Counseling
  - Medication management
  - Community/social supports

Total per-person costs for other medical services

- Total costs of inpatient psychiatric care in general hospital
- Total costs of non-psychiatric inpatient care
- Total hospital emergency department
- Total outpatient costs:
  - Physician
  - Facility diagnostic and treatment costs
  - Private duty nursing
  - Home health care
  - Rehabilitative therapies
  - Personal care
  - Durable medical equipment
  - Lab
  - X-ray
  - Pharmacy

Total per-person criminal justice costs

- Total general costs per inmate day
- Total general medical costs per inmate day
- Total psychiatric costs per inmate with SMI per day
- Average court costs (e.g., filing fees, courtroom, public defender, prosecutor) per individual
- Average per person costs associated with psychiatric evaluation

Total per-person homelessness services costs

- Emergency shelter costs per day
- Post AOT, policymakers may want to compare shelter costs with costs of permanent supportive housing

Total per-person legal and court costs

- Average court costs (e.g., filing fees, courtroom, attorney) per individual who has been civilly committed
- Average per person costs associated with psychiatric evaluation per individual who has been civilly committed.

-Adopted from "State and Community Considerations for Demonstrating the Cost Effectiveness of AOT Services: Final Report," Health Management Associates, Lansing, MI, presented to the Treatment Advocacy Center, Arlington, VA, February 2015.

The estimate of potential cost savings from reform is buttressed by recent research on prisoners with schizophrenia or bipolar disorders in Florida. The average cost of prison confinement was about $95,000, compared with non-institutional treatment with counseling, psychotropic drugs, and other community-based care that cost about $68,000 per patient. During a follow-up period of several years after incarceration or treatment, the average daily cost of treatment for those who were imprisoned was almost 27 percent higher than the cost of treatment for those who were diverted into community care from criminal sentencing.[25]

Of course, a crisis treatment center in Arkansas would entail some costs as well, but these expenses are minimal when compared to the costs of adjudication and prisons and jails. Not only would the costs be lower and the treatment of mental illness be more appropriate, but also many of the usage costs are reimbursable under Medicaid rules. This allows the state to share the burden of these costs with federal dollars.

Ohio has confronted this aspect of mental-health reform in a realistic yet compassionate manner, as described in a recent report:

> Failure to meet the needs of people with mental illness in a community setting has resulted in increased hospitalization, nursing home placements, and incarceration. Not only are these alternatives inappropriate – and in many cases inhumane – but they also are significantly more expensive. Though Ohio faces a crushing state revenue shortfall, more spending is needed now to stabilize the community mental-health system. This would not only improve the care of individuals with mental illness but would be prudent fiscal policy as it would stave off the need for future spending in other systems that are ill-equipped to provide long-term treatment and stabilization for people with mental illness.
>
> Caring for people with severe mental illness can be challenging. They often suffer from multiple chronic physical and/or behavioral conditions that require complex care from numerous providers in various health care delivery systems. In addition, they are more likely to be uninsured, unemployed, and/or homeless – making it difficult to maintain comprehensive care over the long term. As with physical health conditions, prevention and early intervention can reduce overall health care costs and lead to better outcomes such as quicker recovery and greater resiliency.[26]

Based on the experiences of several states that have introduced crisis centers – notably Florida, Minnesota, and Mississippi – an average treatment cost of $350-$400 per day can be projected. Treatment duration can vary from three to five days, based on reports from centers in Florida, Illinois, and Oklahoma. Using the maximum cost and duration to make a conservative estimate, the initial cost of treatment becomes about $2,000 per patient episode. While Medicaid reimbursement rates vary from state to state, it is possible that federal dollars would cover much of the daily cost of such care.[27]

Our earlier estimate of the population affected by this reform was about 5,000 people annually. For comparison purposes, the projected cost of one year's services at a crisis center would be about $10 million, plus some follow-up costs for maintaining contact with discharged patients.[28] DHS estimates that Medicaid would pay for between $2 million and $3 million during the next several years, leaving a net cost to Arkansas of about $7.5 million annually to provide better, more appropriate services to these people with mental illnesses. (This appears to be in line with the estimated cost of the Oregon CTC noted in a previous section.) Recall that if the state continues to place these same people in jails and prisons as criminal offenders, the current cost was estimated at $150 million annually.

While it must be recognized that these are rough approximations of the costs involved, the resulting cost ratio of 20:1 presents a powerful conclusion that crisis treatment centers should be seriously considered in Arkansas and elsewhere. (Since national data indicate that prisoners with mental illness are more expensive than average prisoners, this ratio could be 25:1 or higher.) Additional research into the many cost details would be a good starting point, such as a cost-benefit analysis (CBA) of substituting another type of care for current incarceration.

What makes CBA a powerful tool for analysts and policy-makers is that it combines knowledge about the imprisonment process with present-day costs of the different

25 Richard A. Van Dorn et al., "Effects of Outpatient Treatment on Risk of Arrest of Adults with Serious Mental Illness and Associated Costs," Psychiatric Services, September 2013 Vol. 64 No. 9; available on-line at ps.psychiatryonline.org.

26 Susan Ackerman, "Ohio's Community Mental Health System at a Crossroads," State Budgeting Matters, Volume 6, Number 3, The Center for Community Solutions, July, 2010.

27 Current reimbursement rates for residential care in Arkansas are $350 per diem and $800 for acute care. A crisis center would provide a combination of these services.

28 These supervision costs tend to be minor. For example, for 2013 the active parole/probation caseload in Arkansas was about 35,000 offenders and the average cost for supervision per day per offender was $1.75. See Arkansas Community Correction, "Annual Report, FY 2013," June 30, 2013.

alternatives that may be used for mentally-ill offenders. This is especially informative when addressing those offenders entering the most restrictive and costly segments of the system. If used correctly, the CBA model's results will provide a clearer picture for reformers, budget planners, and agency managers of the cost implications of numerous treatment options for these offenders.

As an example, Figure 1 illustrates the key components of a CBA prepared recently for Arkansas juvenile-justice reforms. Essentially, it follows the adjudication and commitment process and focuses on the major fiscal components of that process: taxpayer costs, treated patient benefits in the future, future benefits for potential victims, and taxpayer benefits. It is important to note that benefits can include not only monetary savings – e.g., lower prison costs – but also non-monetary improvements like future reductions in victimization of family and community members.

Other positive changes would occur in the future, also. Research shows that community interventions have longer-term consequences that are highly beneficial to both the mentally ill and their communities. For example, lower recidivism rates and reduced criminal behavior in the future would create substantial benefits in the form of fewer crime victims and better economic prospects for the treated person later.[29] As Figure 1 represents, these positive effects could include fewer offenders who return to the prison system as repeat offenders, so that future prison-system costs would also be reduced.

4. Summary and Conclusions

This brief review of current research has examined the major issues related to mental health and prison reform, and listed the cost considerations that must be investigated more closely before serious public-policy changes can be made. However, even this summary assessment has touched on several key points that Arkansas should consider relative to its treatment of the mentally ill.

First, a large number of mentally-ill persons are caught up in the law enforcement, judicial, and prison system in Arkansas. This leads to three regrettable outcomes for the state: 1) people with mental illnesses are not receiving the proper care and treatment that will allow them to return to their families and communities for a more normal life, 2) the cost of adjudication and incarceration for these people is much higher than the cost of medical intervention, leading to overcrowding in the jails and prisons and larger than necessary budgets for the prison system, and 3) the state is not presently upholding its constitutional mandate of caring for those with a mental illness, and that could conceivably present legal challenges for the relevant agencies similar to the well-known educational reform cases like the Alma and Lakeview suits.

Second, based on estimates from a variety of sources about the cost of a system of crisis treatment centers for mentally-ill persons who enter the criminal-justice process, and the known costs of adjudication and incarceration in Arkansas, it appears that these costs may be widely different. One year's worth of trial and jail time for each person costs the state about 20 times as much as crisis treatment and counseling for the same person with mental problems. These are average comparisons, and the national data indicate that prisoners with mental illness are more expensive than average prisoners to house and caretake; this ratio could be 25:1 or higher.

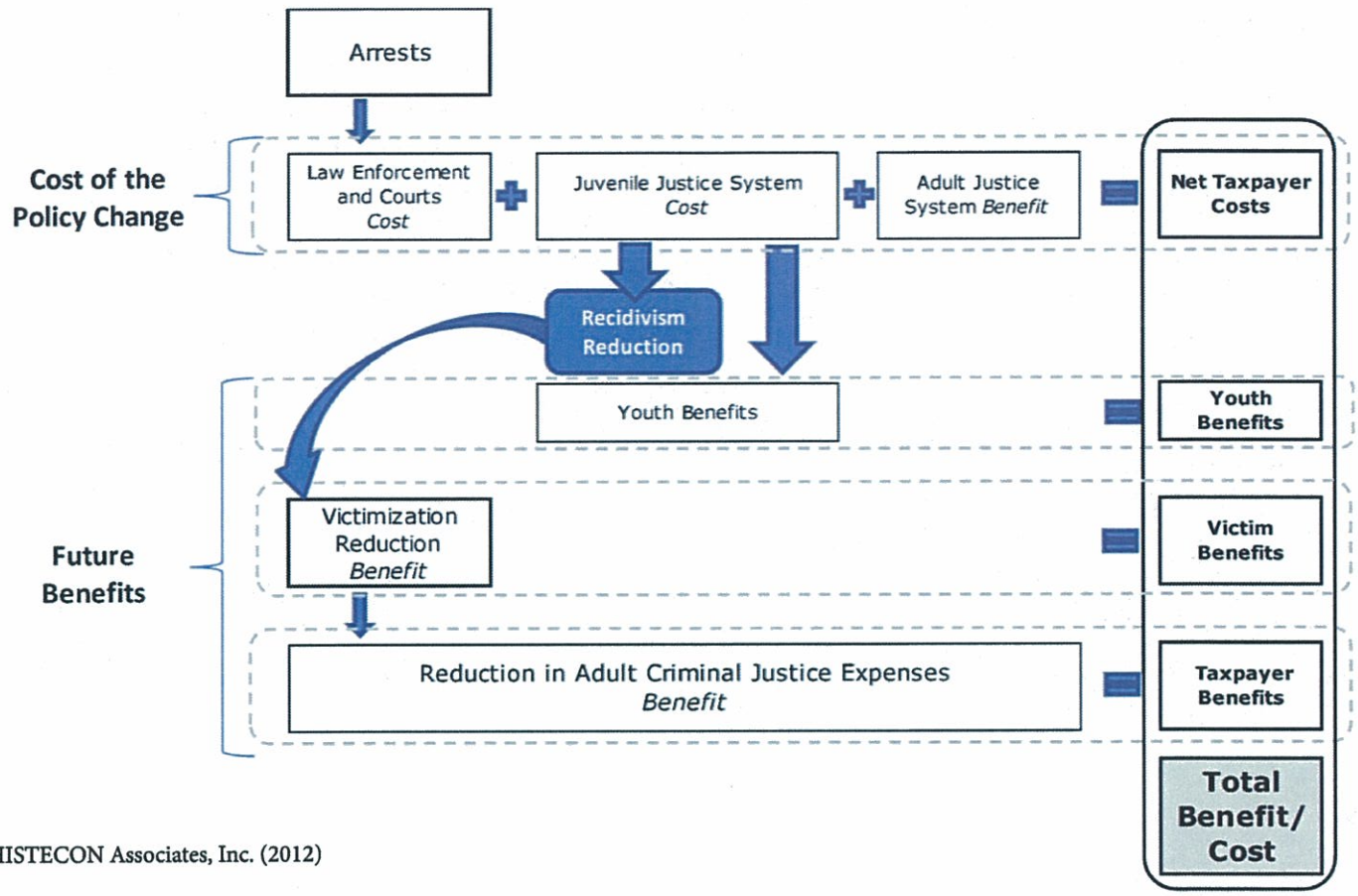
Third, the Department of Human Services has begun to consider the alternative of a crisis-treatment approach to divert many of these individuals from the criminal-justice system to community-based treatment centers. While these plans are preliminary at present, it is clear from the San Antonio experience that hundreds of persons who might otherwise become inmates could be treated more appropriately at this type of facility while saving the Arkansas taxpayers millions of dollars annually. San Antonio reports that more than $50 million has been saved in just two counties since the inception of its program about five years ago.

Lastly, the long-term implications of this type of diversion are clearly positive for several reasons.

- One, crisis centers are better prepared to help mentally-ill persons who have been arrested for non-violent offenses. The types of treatment that such centers provide – e.g., evaluation and assessments; crisis services; dedicated community treatment; case management and care coordination; counseling; medication management; and community and social support – are immediately beneficial to resolve the underlying causes of many of these episodes. The short-term care regimes will also deliver the individuals back to their families and communities more quickly than a lengthy process of adjudication and confinement.
- Two, removal of a higher-cost but low-risk group of mentally-ill persons from jail and prison settings will allow law enforcement to concentrate their limited resources on higher-risk criminals who need to be incarcerated for society's protection at a lower overall cost to the taxpayers.
- Three, lowering the number of inmates in state prisons by diverting low-risk mentally-ill persons to treatment centers would create a beneficial trend in the long run.

29 "Identifying Target Populations for Diversion from the Criminal Justice System: Preliminary Evidence," Bradley, 2014.

Figure 1. Diagram of an Example of General Cost-Benefit Analysis Model For Juvenile Justice Reform



HISTECON Associates, Inc. (2012)

Current overcrowding means that county jails must provide expensive cells and supervision that add to the state's corrections budget. A lower prison population means not only lower costs for accommodating this overflow, but also lessens the need for more prisons in the future. At an estimated price tag of more than $100 million for a modern prison facility, this last point alone makes an alternative for mentally-ill persons a policy imperative.

Faced with these choices, many states and government agencies have used a cost-benefit analysis (CBA) to assess the financial issues involved. This CBA model allows analysts and policy makers to think about policy alternatives in a real-dollar comparison and to evaluate the future impacts and the best options for improving public safety and the future social and economic prospects for our mentally ill. As a recent report from the National Conference of State Legislatures (NCSL) described it, the analysis:

> ...allows lawmakers to weigh multiple options and determine which will achieve the greatest results for the lowest cost. ...it allows evaluators to compare programs that have different goals – for example, program A aims to reduce crime, while program B aims to curb substance abuse – in order to find the option with the greatest net societal benefit.[30]

Based on a summary of the available data from other states and the current costs of adjudication, incarceration, and treatment for mentally-ill persons in Arkansas, this study recommends that the state prepare a detailed cost-benefit analysis of the proposed Arkansas crisis treatment centers. If that research confirms the preliminary findings contained in this report, then the state should move forward immediately to institute these centers, both for the sake of those with mental illness and to help reform the costly prison system.

30 "Cost-Benefit Analysis of Juvenile Justice Programs," National Conference of State Legislatures, 2011.

The Arkansas Public Policy Panel is a statewide organization dedicated to achieving social and economic justice by organizing citizen groups around the state, educating and supporting them to be more effective and powerful, and linking them with one another in coalitions and networks. The Panel seeks to bring balance to the public policy process in Arkansas.

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