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ARKANSAS GENERAL ASSEMBLY

Senator Cecile Bledsoe
Chair

Representative Jack Ladyman
Chair

HOUSE & SENATE PUBLIC HEALTH, WELFARE, & LABOR COMMITTEE

November 14, 2022

The Honorable Terry Rice, Co-Chair
The Honorable Jeff Wardlaw, Co-Chair
Arkansas Legislative Council
State Capitol Building, Room 315
Little Rock, AR 72201

Dear Senator Rice and Representative Wardlaw:

In accordance with Act 802 of 2021, the following report of the Arkansas Legislative Study on Mental and Behavioral Health is being submitted to the Arkansas Legislative Council.

This report was submitted by Rep. DeAnn Vaught to the House and Senate Public Health, Welfare, and Labor Committees. Rep. Vaught knew very quickly that she needed help to conduct this study and, as a result, she formed a large group of as many as 60-80 legislators, educators, mental health providers, medical professionals, and behavioral health stakeholders. This group met seven times over the past few months and quickly divided into seven working groups to concentrate on specific areas and mental and behavioral health. These working groups met dozens of times over the last nine months to discuss specific issues and recommend changes and improvements in the delivery of services.

Rep. Vaught said on several occasions that these working groups have built bridges that needed to be built for many years. This sentiment was echoed by many of the mental and behavioral health providers in testimony before the committee. She also noted that there is more work to be done in this public policy area, which will take several years to improve.

Respectfully submitted,

Cecile Bledsoe

Senator Cecile Bledsoe

Jack Ladyman

Representative Jack Ladyman

CC: Anne Cornwell, Secretary, Arkansas Senate
Marty Garrity, Director, Bureau of Legislative Research
Amber Pool, Assistant Coordinator/Assistant to the Speaker, House of Representatives
Jill Thayer, Legal Counsel to the Director, Bureau of Legislative Research

Draft Arkansas Legislative Study on Mental and Behavioral Health

November 15, 2022

Activities and Findings

Representative DeAnn Vaught sponsored Act 802 of 2021 which required a study of the Mental and Behavioral Health conditions in Arkansas. Representative Vaught thought the best way to approach the study was to convene a group of legislators, mental health providers, medical professionals and behavioral health stakeholders. This quickly became a large group of 60-80 people who discussed the various services offered to persons suffering from mental health issues by different organizations some public and some private. These mental health providers spoke out about the difficulty in proving mental health services without a professionally-trained workforce. They commented about the low reimbursement from Medicaid for these services and the difficulty in these services being available in rural areas of the state because of the low reimbursement rates.

The legislators in the working group related the experiences from their constituents which children and adults had experienced major problems with being transferred from one organization to another. This was done and not enough information about their conditions were shared with the receiving organization. This resulted in patients being misdiagnosed and being put under renewed pressure to explain their circumstances when many could not do that.

The Department of Human Services participated in these working groups and provided better context for the discussion about the things they could change by policy and the things that they needed approval from the federal government to change. Also, the Provider-led Arkansas Shared Savings Entities (PASSEs) met with the working groups since the State of Arkansas adopted a modified managed care policy for behavioral health in 2017.

The Mental Health/Behavioral Health Working Group met seven times as a large group of 60-80 persons. Rep. Vaught quickly realized that the large group was helpful for a broad understanding of the entire mental health situation in the state, but the group needed to be divided into smaller working groups to focus on various aspects in the mental and behavioral health area.

The minutes from five of the meetings are included in Attachment 1. These are helpful in understanding the complexity of the treatments of these persons and the interrelated nature and availability of these services.

March 15, 2022

April 18, 2022

May 16, 2022

June 20, 2022

July 17, 2022

August 15, 2022

September 12, 2022

There were seven subgroups formed which met over a dozen times to discuss various facets of mental and behavioral health. The subgroups are listed below and the membership is listed in Attachment 2:

Workforce Development

Access to High Quality Services

Prevention & Early Intervention

Suicide Prevention

Services for Special Populations Substance Abuse/Co-Occurring Disorders

Rates, Regulations, Efficiencies & Bed Availability

Recommendations

Administratively DHS has agreed to do several things such as

- Update Physician's Manual to allow behavioral health integration.

- Update Infant Mental Health services.

- New service with professionals as team lead for high need PASSE members

- Funding for recruitment and retention of mental health professionals.

- New certification for PASSE members with specialized training for PASSE sub-populations.

- Allow substance abuse licensed counselors to provide Substance Use Disorder (SUD) services in Medicaid OBH Manual.

- Rate changes and new provider for high need, complex Medicaid beneficiaries in PASSE.

- Rates for Outpatient counseling, Psychiatric Residential Treatment Facility (PRTF), team-based Home & Community Based Service (HCBS) approach.

- Addressing quality in Under 21 Inpatient Psychiatric Hospital (PRTF) manual.

Legislation

Legislation is being drafted, studied and considered which will:

- Increase the number of Psychological Examiners practicing in the state.

- Combine the Boards which license Mental Health Professionals in the state.

- Establish an enhanced reimbursement rate through Medicaid and other payers for medical homes that provide universal, team-based enhanced primary care services for young children.

- Reimburse screenings for American Academy of Pediatrics recommended early childhood development/autism, maternal depression, behavioral health, and family needs through Medicaid and other payers to improve screening and referral to community resources through medical homes.

- Enhance opportunities to train behavioral health clinicians on early childhood mental health and develop expertise in evidence-based approaches to supporting young children and their families.

- Create a DHS position charged with increasing collaboration across key state agencies to identify and implement best practices for mental health promotion, prevention and early intervention for young children and their families.

- Enhance the availability to treatment for young children and adolescents that need intensive treatment.

- Depression/Anxiety screenings need to be covered by insurance.

- Advocate for school counselors to be trained on suicide awareness/prevention.

- Explore federal funding available on cell phone providers ways to sustain call centers.

- Better educate Pediatricians with suicide awareness/prevention.

- Examine safe storage of available suicide means for guns, drugs, and chemicals.

- Request an Interim Study Proposal focused on approaches to identification of children with early emerging emotional and behavioral concerns through the expansion of routine standardized screening.

- Request an Interim Study Proposal on the development of a network of Family Resource Centers consistent with the models which have been shown to reduce the risk of maltreatment, and based on the nationally-adopted Standards of Quality for Family Strengthening and Support.

ATTACHMENT 1

Mental Health / Behavioral Health (MHBH) Working Group

Meeting Notes

March 15, 2022 – 1:30 P.M. – State Capitol, Room 138 – Little Rock AR 72201

Present: Sen. Kim Hammer, Rep. DeAnn Vaught, Rep. Frances Cavenaugh, Rep. Brian Evans, Rep. Jimmy Gazaway, Rep. Spencer Hawks, Rep. Lee Johnson, Rep. Jack Ladyman, Rep. Tippi McCullough, Rep. Les Warren, Rep. Aaron Pilkington, Leo Hauser - Bi-Partisan Strategies, Jay Hill - DHS, Caitlyn Johnson - ABHIN, Michael Keck - UAMS, Michelle Kitchens - ACHI, Tabrina Bratton - AR DOC, Patricia Gann - DHS/DAABHS, Gavin Lesnick - DHS/Communications, Casey Nichols - Ashdown Schools, Sheena Olsen - ACH, Marvin Parks - Bi-Partisan Strategies, Elizabeth Pitman - DHS, Joel Landreneau - AR Behavioral Health Council, Kim Shuler - ABHI, Mark White - DHS, Tammy Alexander - DHS, Laura Dunn - UAMS Dept. of Psychiatry, Nikki Edge - UAMS Dept. of Family Med., Lisa Evans - UAMS Dept. of Psychiatry, Carol Moore - ABHC, Brad Holloway - ABHC - BirchTree Communities, Paula Stone - DHS, Nicole May - AR Total Care, Dawn Stehle - DHS, Tyler West - American Foundation for Suicide Prevention, Van (Marq) Golden - UAMS, Priscilla Faulkner - Impact Counseling, Patti Halter - Impact Counseling, Clint Shackelford - ARcare, Susanna Watt - JCD Consulting, Justin Allen - AR Healthcare Alliance, Cory Cox - CareSource, Beth Tody - Horatio, Anna Strong - American Academy of Pediatrics (AR Chapter), and Joe Thompson - ACHI.

Representative DeAnn Vaught opened the meeting stating that the focus of the working group will be to gather information on the mental health services and resources available in Arkansas, where they are lacking, where expansion is needed and on opportunities to build bridges. The group will determine where funding is needed and how best to utilize that funding and make people aware of the services available. Introductions took place around the room. Rep. Vaught opened the room for attendees to provide a brief overview of the services they offer.

University of Arkansas for Medical Sciences (UAMS) A handout was provided to attendees. UAMS's services include a full range of adult, child and adolescent services, including inpatient and outpatient for both adults and children in the Child Study Center, drug treatment/medication management, methadone treatment, interventional psychiatry, medication-assisted therapies, a crisis stabilization unit (CSU) under the leadership of Dr. Evans, a range of research (detailed in the handout), and the Trauma Resource Initiative for Schools (TRIS) program which focuses on trauma-informed approaches to screen and respond to trauma in kids and adolescents. They do not currently have services for acute children, intensive outpatient or a partial hospitalization program.

Arkansas Behavioral Health Integration Network (ABHIN) Caitlyn Johnson stated that ABHIN is a nonprofit created because of behavioral health needs unmet in the health care system. The focus of what they do is placing behavioral health into the primary care setting as supporting research shows the need for a one-stop shop. They encourage universal screenings and focus on prevention. This model of care supports specialty behavioral health services by screening early and when there is an acute need, triaging that and moving it out into primary care. Current projects focus on opioid-use disorder and suicide. They provide suicide training to primary care teams and providers and have a focus on education for team-based care across the state, in rural counties. Their suicide prevention training included the development of a manual of resources in nine targeted counties which had information on screeners, how to interact when individuals test positive, how to interact with families, developing a crisis response plan and getting the resources they need. They had a great response from providers that participated.

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American Foundation for Suicide Prevention (AFSP) Tyler West stated that AFSP would like to help build stronger and safer communities. They have the funding to provide trainings and can come in and do capacity building trainings, talk to first responders, provide intervention training, and train superintendents and others in the schools. They worked closely with Cabot to create a tiered system several years ago. Instead of reacting and responding, they hope to get ahead of that by utilizing a four-level system. They will offer two days of training to deescalate: train counselors and teachers on how to identify at-risk individuals, train students how to recognize at-risk peers, and train parents too. This is a free service, and they just need schools to open their doors to them. Anyone in the working group is welcome to get with him and introduce him to their responders. They can also train community members to present these programs for sustainability down the road.

Arkansas Behavioral Health Council (ABHC) Joel Landreneau stated that their members provide a variety of mental health services, such as outpatient behavioral health, and that includes crisis intervention with professional and home/community-based services. They have members who are community mental health centers that have contracted with the state, several which do the Certified Community Behavioral Health Clinic (CCBHC) grant from SAMHSA, a model that integrates behavioral health and primary care under a single roof with a mobile crisis component; members who provide substance abuse treatment services both inpatient and outpatient, including medication assisted treatment of opioid addicts and a treatment program for pregnant women; members who are therapeutic communities which is a residential program for seriously mentally ill adults; members who are psychiatric residential treatment facilities for children; and members who provide acute inpatient hospitalization for adults and children. They are working to compile information for the group on the number of member centers they have of various types.

An independent licensed practitioner practicing in Southwest Arkansas stated that she provides individual therapy tier 1, outpatient, crisis, and family services therapy sessions, through Medicaid.

Arkansas Center for Health Improvement (ACHI) Michelle Kitchens stated that ACHI can offer data analysis and policy evaluation (most notable might be the crisis stabilization unit (CSU) evaluation they did after the legislature established), and they are able to do those things through health transparency initiative created by General Assembly.

Arkansas Department of Corrections (ADC) Tabrina Bratton stated ADC provides services for institutional populations which include substance abuse programming and treatment, behavioral health treatment and some one-on-one counseling for individuals. They are aware of other needed programs and treatment and are looking to expand.

Arkansas Behavioral Health Council (ABHC) Ruth Allison Dover provided an update on their progress working hand-in-hand with DHS on funding for CCBHCs and how to bring in needed services as well as addressing the workforce shortage and crisis, lack of professionals, and its effects on providers all across the state. The demand for services has never been higher and the needed credentials to provide those services has never been lower.

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ARcare ARcare has 56 ambulatory clinics providing primary care, behavioral health, MAT therapy, and special services treating Hep C and HIV, pharmacy and longevity services, as well as tele-med services to several school districts and homeless shelters in LR. They are a federally qualified heath center.

Birch Tree Communities Inc. Brad Holloway stated that they provide therapeutic community services which are residential services for seriously mentally ill adults. There are just two of these programs in the state (Birch Tree & Mid-South Health Systems), and they have 350 members in approximately 12 sites across the state. Most referrals are from the state hospital and help with overcrowding and transitioning into independent living. They are looking to expand with additional sites as more are needed.

AR Healthcare Alliance They have 13 providers around state in dozens of counties providing behavioral health services to adults and children, developmental disability services, substance abuse services, autism services. They are working on a more comprehensive overview of the providers, their services, and the issues facing them. Tens of thousands of kids and adults are served by these providers.

Pinnacle Point Outpatient Behavioral Health Carol Moore stated that they are one of two members of the association that do have an inpatient residential acute hospital for adolescents and children. They also have 12 outpatient clinics where staffing has become a major issue. They serve the most needy populations in their outpatient clinics, and it is difficult to hire and maintain the staff that is needed to handle them. This is having a major impact on providers, families, children, adults and schools. The need is great.

American Academy of Pediatrics - AR Chapter Anna Strong stated that primary care pediatricians are, for the most part, serving as front line staff for many of the kids with these issues. They are hearing about the challenges families are facing with kids from birth to adolescence. They hear a lot about the desire for integrated behavioral health in primary care and know pediatricians would love to have social workers on their teams and be able to be reimbursed for those services.

Representative Lee Johnson stated that front line providers are seeing a lot of challenges in the ER with getting placement for those people with mental health issues. He knows stories of people spending weeks or months in the ER while waiting for placement.

Representative Les Warren shared a story of a developmental and mentally disabled individual, approx. 20 years old, who was in a facility. His parents had adopted him from the state as a little child. He had been in a facility and something happened that required him to go to the hospital. The facility then would not take him back. The hospital tried to care for him, but he was very combative, and so there was nowhere to put him. He stayed in the ER for 45 days, and they had to remove everything in the ER except for a pallet on the floor and had to keep him basically sedated because he would attack the nurses. They had to give him an IV to hydrate and feed him and one day he awoke while a nurse was working with his IV, and he attacked the nurse. The nurse was asked to file a charge so that they could finally get something done. She did, and he was placed in the county jail. The mother's heart was broken, and it had reached a point where the parents were discussing discontinuing guardianship of him because they felt they could not handle the liability. Jails are not equipped to handle disabilities in that setting. They were finally able

to get him into the Booneville Human Development Center but it was like an act of congress to find a place. Adequate facilities are needed for people in these type situations. Rep. Warren stated that he is committed to begin fighting for her and others with similar stories.

Representative Jimmy Gazaway stated that he has talked with Rep. Vaught over the last couple of terms about mental health issues and is glad see the formation of this group. He has had constituents approach him with concerns, and through his past professional experience as a deputy prosecutor for nine years, he handled mental commitments. He has seen people found not guilty due to mental disease or defect, some that were dangerous, sent to the state hospital, but they do not keep people long term anymore so it is common to see them back in court a few months later. Some have serious charges including rape and terroristic threatening. We need more long-term facilities or to find the money to do the follow-up care needed to keep these people from entering back into the criminal justice system. This is an area of focus for him. He shared a constituent story: a constituent's daughter, suffering from mental illness, turned 18 and her mom could not do much once she was an adult. She was seen in the ER more than 30 times and they could not place her in a long-term facility because there are essentially none and any long-term beds that did exist were full. A bed was finally found but she jumped out of the back of the ambulance during transport, dying tragically by suicide which should have never happened. Both short and long-term bed shortages are a concern. Another constituent's middle school aged daughter was bullied and died by suicide. He stated there is a need be more vigilant about bullying in schools and suicide. Rep. Gazaway discussed anti-bullying legislation he sponsored and passed in 2019, other legislation he has sponsored that criminalized encouraging another person to commit suicide, and legislation he passed while working in conjunction with UAMS, for a crisis line text app to be available to all school kids in Arkansas and which was unfortunately never funded. This app would give a portal to children in crisis. Utah has something like this, which is called Safe UT. He would like get some constituents to come testify and shine a light on these types of things. He is interested in looking at the intersection between mental health and criminal law, and how we treat people with mental health issues who need long-term intervention.

Representative Frances Cavenaugh shared that there is a children's shelter in her district with more children with mental health issues than they've ever had. These children are a danger to themselves and others, including the workers. They now have to ask specific questions to find out if they are a danger before accepting them, because that information is not always shared with them up front. The issue is that the shelter is not set up to accept and help those kids and so they are having to turn more and more away, leaving them nowhere to go. Long-term facilities are needed, as 30 days or less does not always do it. She believes we are at a crisis point when shelters cannot accept kids in need, because they don't have workers or or workers with the right expertise, and it is time to take control of the situation.

Representative Vaught shared that she and Representative Aaron Pilkington met with DHS recently about a hotline issue involving children not getting attended to in a timely matter or getting reported multiple times. A hotline model in Missouri is being looked at in which children are seen within 24 hours or less. This came about when a child near Rep. Vaught's district died after not being seen within 72 hrs of being reported. She said we have to tackle the hotline as well, prepare those taking the calls, and also make reporting available online.

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Representative Tippi McCullough shared that she worked with Tyler West of AFSP with putting the suicide hotline information on student ID cards last session, but she also wants to see if the hotline is fully funded. Tyler stated that it is fully funded, and per statute, ADH houses the crisis hotline. He has tested it and determined it is working. It does need more money though, and he would like to discuss that with her at some point.

Representative Brian Evans said he has served for ten years on the Cabot School Board and ten years ago no one ever talked about mental health because it was not really an issue like it is now. Issues began surfacing approximately five years ago, and he realizes now too much responsibility is put on guidance counselors, teachers, and coaches in this regard, as they are not trained in mental health. He said AFSP has done phenomenal work in the district in regard to student mental health. Their tiered system is great, but high performing students who are very involved form different relationships with teachers, counselors and coaches because they believe these are the people who will help get them into college, an honors program, a trade school, or help them get to the next level in sports, and so the last thing they want to do is admit to that person they have a problem. The hope that those students will go to a guidance counselor with abuse/social/emotional issues is not realistic because they don't want to breach those relationships. Students who are not as high performing fly under the radar and don't have that same relationship. He believes we need to figure out how to get quick access for students to someone trained to help them immediately, because he is concerned that even 24 hours might not be soon enough. There is a new youth council in Cabot made up of students concerned about the mental health of their peers, and they say 24 hours is too long. A student in crisis should not need a parent's permission to talk to someone, they need capability of getting assistance right then online with someone trained to help them. Rep. Evans said he is committed to working with the group to bridge that gap. Right now, most states require students to be 18 to receive help without parental consent. Some states have lowered this to 14. We need to fix that as well.

DHS ARHOME Mark White said that ARHOME places a renewed emphasis on behavioral health. It is a Medicaid expansion program serving individuals under 138% of the federal poverty level; around 333,000 Arkansans are in the program, but that is inflated somewhat because of the federal health emergency which may expire soon. Once that happens, ineligible individuals will roll off. ARHOME is doing several things to help increase the focus on behavioral health. Some key elements include working with rural hospitals to pay them to have beds for individuals in a mental health crisis which is good for hospitals as a revenue source but also helps the community by giving people a place to get treatment. Also, they are working with individual participants who are susceptible to mental health issues such as young adults, who are veterans, in DHS custody, in foster care in the past, or were incarcerated to make sure they get resources.

Arkansas Department of Human Services (DHS) Patricia Gann provided an overview of DHS's strategic behavioral health plan for the next three years. They are shifting to a client centered approach to service delivery across all populations to include integration of nonmedical services into client plans, increased and effective client interactions, robust spectrum of services available and utilized, and a client centered approach in programs. This will improve the health and wellbeing of Arkansans. They want to focus on a

recovery-based model, helping individuals live their best lives and transform the delivery of services. Their vision for the state's public behavioral health system is to ensure that Arkansas has a comprehensive and coordinated approach to the delivery of mental health and substance abuse services that allow Arkansans of all ages to have access to services at the right time and a place to meet their needs regardless of where they live. They are going to strengthen the behavioral health team and its integration with other divisions and agencies which is critical to their three-year plan. Director Jay Hill has named Patricia Gann the deputy director of behavioral health, and she will move over totally into behavioral health as chief and someone else will take over the aging program. Asst. Director Tammy Alexander will lead adult services and will focus on forensics and court involved adults, Medicaid PASSE clients, Medicaid tier 1 clients, and mental health crisis and prevention programs. Paula Stone was introduced as interim lead of Children and Youth Services which focuses on children and youth with complex behavioral health needs, court involved children and youth, Medicaid PASSE clients, Medicaid tier 1 clients, and mental health crisis and prevention programs. Paula has an immense amount of knowledge and love and care for that population. The strategic focus of DHS is to identify gaps in services and service availability in both the public and private behavioral health system, as Arkansas continues to strengthen and develop mental health and substance abuse services, both government paid and private paid. Information should be readily available to policy makers and the public to understand service gaps. They want to ensure an ongoing analysis of publicly and privately paid behavioral health services available in AR in order to identify the gaps and the effectiveness of efforts to fill the gaps. They want to address gaps in services and service availability for children and youth in the behavioral health system by: strengthening PASSE services and supports for at risk children; addressing the shortage of community-based treatment providers; serve at-risk youth with complex behavioral health needs; incentivize community-based treatment options for court involved youth to reduce the number of youth who require secure residential treatment by getting more supports and services into the communities in order to keep children in their communities and homes with those supports; expand diversion supports for youth with mental health or substance abuse issues through use of the peer community (currently have four peers employed by DHS who are amazing and are probably one of the greatest resources moving forward as they are able to walk the walk with individuals with substance abuse issues); and expand the use of provider provision of infant and toddler mental health services. There is a need to start looking at prevention, so moving forward they want to look at how they can expand the infant mental health program which works with families and children 0-4 to help deal with mental health issues and also will look at family dynamics programming and get people actively involved in infant mental health services so that both the back end and the front end are covered, and they are getting those services before some of this stuff happens. They plan to expand tier 1 services for children and youth, including targeted case management to make sure children who are at risk have support; and expand early intervention and prevention services. They want to strengthen outcomes for adults entering the forensic system and increase diversion supports for adults at risk of entering the forensic system by: addressing placement options for adults with serious mental illness requiring a secure community-based treatment setting while undergoing forensic restoration services (want to make sure they have a secure place to go and are getting treatment to get better); creating a secured community based residential placement option for adult Medicaid PASSE beneficiaries with complex behavioral health needs who no

longer require treatment in an acute setting and have been found unrestorable following forensic services; piloting use of behavioral health peers in courts to divert individuals into treatment instead of forensic assessment (once they get forensic assessment a legal process starts so the peers in courts will help divert away from that and instead get them into treatment); and working with the judicial system to increase use of treatment diversion. They also want to address whole health by integrating social determinants of health (SDOH) supports into case plans by: providing intensive support services to address SDOH for individuals with mental illness through Life360 Homes targeting rural Arkansans and those returning from incarceration or military service, formerly in foster care or the juvenile justice system or at risk of long-term poverty due to mental illness; increasing access to intensive in-home family support programs that provide family centered treatment for struggling families at risk of entering the child welfare system with a goal of having intensive in-home family support programs available in every county by 2024; and strengthening reentry services for DYS involved youth through intensive in-home services contracts that support a youth and his or her family post-custody. They want to make sure we are not just sending people home but sending them home with the appropriate supports to make sure they are as successful as possible when reentering the community. The want to address the gaps in mental health emergency and crisis response service availability. They plan to look at how quickly services are accessed and their availability by: expanding access to mental health crisis services delivered in acute crisis units (ACU) and all regions in Arkansas by incentivizing rural hospitals to establish and maintain ACU bed availability so that services are available and people don't have to go far away to get services; expanding mental health crisis emergency response capability statewide by providing mental health crisis response training to EMS and other emergency responders; expanding crisis emergency response capability through use of telemedicine deployed through ambulances and other EMS emergency response vehicles which has been successful in other states and DHS is looking at how they can connect EMS with a licensed professional when going out into the community; developing a robust mental health crisis response system in coordination with the Arkansas PASSES, Department of Health, and the 911 and 988 system; and developing an easy one-stop portal on the DHS website. With regard to workforce development and service quality, they plan on: in conjunction with providers and beneficiaries, developing a statewide strategic plan to build a quality future HCBS workforce; addressing shortages and improve quality of behavioral health workforce in rural Arkansas and all over the state; developing, in conjunction with PASSEs and providers, a high quality and skilled workforce to serve dually-diagnosed beneficiaries in a home or community based setting (this is a special population of people with developmental delays as well as mental health issues); developing workforce to support recovery from mental illness and substance abuse by establishing a fully integrated peer program for behavioral health (nothing works better than a peer to help people see how they can live their best life and they can recover and live well with mental illness); improve quality of mental health services by promoting the use of evidence-based services and development of staff training in evidence-based practices so that we know we are moving forward with quality systems that use practices that we know work; and strengthening the monitoring of behavioral health services and quality of those services.

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Recapping their strategic focus, they want to:

- Identify gaps in services and service availability in both the public and private behavioral health system
- address gaps in services and service availability for children and youth in the public behavioral health system
- strengthen outcomes for adults that enter the forensic system and increase diversion supports for adults at risk of entering the forensic system
- address whole health by integrating SDOH supports into case plans
- address the gap in mental health emergency and crisis response service availability
- focus on workforce development and service quality

Three key things in the DHS strategic plan:

- provide services at the right time in the right place is critical: need for expanding capacity because so many individuals in the state are struggling with these issues that can live and work in the community productively with the right support without having to be confined to an institution.
- want to leverage Medicaid dollars as much as possible. State dollars are limited so we need to take the steps necessary to leverage those federal dollars.
- want to reduce the gap between developmentally disabled treatment and mental health treatment because of efficiency and also because the number of people with both issues is growing.

Discussion took place on whether DHS's strategic plan is a proposed roadmap to getting help for the issues that were previously discussed. It was confirmed to be roadmap of where DHS wants to get, starting today and moving forward. They need data on what gaps exist, where they are and what they need to do to fill those gaps. Practitioners commented in follow up to this. Those that talked about issues within the schools were asked to follow up with Elizabeth Kindall and Beth Mathys with ADE, as Pinnacle Point recently participated in training with them for mental health first aid.

Peer reviewed research data was shared from three years ago that shows:

- 3.4% of Americans suffer from serious mental illness, yet psychiatric beds have decreased by 14%
- Arkansas has over 3,000 seriously mental ill adults in prison and incarcerates more individuals with serious mental health issues than it hospitalizes at a rate of 3:1
- AR State Hospital is the only acute psychiatric hospital operated by the state, and with only 185 adult beds in the state, Arkansas ranks 46th nationally with 7.5 beds per 100,000 population while a minimum of 50 beds per 100,000 people is considered necessary to provide adequate

treatment. The problem is that 86% of the beds at the state hospital (at the time of this study) are occupied by court ordered forensic patients so the hospital's hands are tied. We need to get some of them out of there and into programs.

- The cost of acute psychiatric hospitalization is approximately $825/day. The cost of placement at the Arkansas State Hospital is approximately $650/day and the median is about $737/day for psychiatric hospitalizations. This shows the need for residential places to put people, like therapeutic communities and similar programs. The cost of therapeutic communities is approximately $175/day. The study was based on 78 new clients that Birch took in and over one calendar year, they looked at the number of acute psychiatric hospitalization days they had one year prior to the Birch admission and the cost of that was $20,982,000.00 ; the cost of those same members one year post Birch admission was $4,982,00.00 so there are ways to open more programs to provide these services but we cannot open and operate anymore programs with the current rates. The last rate change was a decrease and not an increase. Creating more programs or physical places for them to go is not possible because no one can afford to open programs like these, because they can't build the infrastructure to do it.

An independently licensed practitioner shared that there are a lot of therapists getting burnt out. She stated that while many don't want to go to the primary care doctor, her caseload has doubled in size. There is a big push for nurses to go back to school because nurses are needed, but we also need psych majors and others to go back to school and get into this field because if we open new facilities they will be needed in order to see the patients.

Ashdown School District Superintendent Casey Nichols addressed the group and shared stories from within the district. They currently have mental health awareness and education programs as well as suicide prevention awareness and education programs because there is a strong need. This has been done through grant funding and locally. COVID19 has brought this issue to the forefront. Earlier in his career they received a call and were asked to come to a home by police. When they arrived, their job was to identify the student because she had hung herself. The child never reached out and never had any signs of mental health issues. There were no outcries but because of a family matter, she made that choice. We need to figure out what things could have gone into place in the public education setting in the 10 years prior to that to be able to recognize that and identify that risk. We look at the reactive measure to take care of current issues but it's equally important to front load the initiative to be able to catch the kids when they are very influenced and make a difference in their lives that would not perpetuate them being in a system of failure and loss. An example is the discussion on the infancy program and what that might look like in terms of 20 years down the road if something like that is done. He said this is a critical piece in all of this, and we must be visionary to make differences that will be sustainable to the future and not continue to take care only as an emergency. Follow up discussion took place in regard to integrative behavioral health as it can help with those issues where you put a trained licensed mental health professional in a care team with primary care doctors and they will have constant access to individual patients. LCSWs see firsthand the high no-show rates because of stigma, concerns, barriers, transportation issues, etc. and after leaving community mental health, she went to work as a

behavioral health consultant in an FQHC, seeing a lot of the same type of patients but they were keeping their appointments because they had a health issue and needed to get that addressed and the behavioral health consultants were available onsite so they had a one-stop shop. It's critical to do universal screenings to identify problems right away and triage these patients to specialty health. This model will promote better care.

Information was provided on a new school initiative for schools recently launched with funding from the Blue and You Foundation. One thing they do is provide consultation to administrators and school counselors after a school crisis and have learned that the story the superintendent shared is not rare. We have to deal with crisis as it is happening and back that up but also support DHS partners and their expulsion prevention efforts from birth to five. They receive hundreds of teacher referrals every year for three and four year olds who are about to be expelled for exhibiting extreme challenges with emotions and behavior, and while they can't control those emotions, we can change their trajectory pretty easily when they are three and four. Parents can be equipped with the skills they need to support kids after difficult situations. There needs to be balance meeting crisis intervention with prevention, early intervention and identification. It is much easier to make the change in children than adults.

Representative Les Warren discussed the challenge with getting mental health professionals in the schools. Discussion followed on the need to incentivize people to go into and remain in the mental health profession.

Senator Kim Hammer recommended having the Department of Education (DOE) in the room next time to coordinate with what they have in terms of required seat time and providing time to students to have mental health time within the school setting. When he was a case manager working for a mental health firm, they went in and provided school-based mental health services to the kids but the problem they ran into was DOE holds the superintendents of schools accountable for keeping the kids in classrooms for the specified amount of time and so they ran into resistance from teachers when they wanted to pull a student out. Today, ten years later, maybe the landscape has changed enough that we better understand that if the child is not mentally healthy then you can't teach them and so we are going to have to have that conversation on how to hit a balance. Sen. Hammer asked Superintendent Nichols how he felt about that, and he said that seat time takes place still; however, he believes most superintendents are less concerned with seat time and more concerned with the well-being of a child, stating that if we are not meeting the most basic needs than there is no way the child can be educated and be a productive member of society.

Tyler West (ASPF) talked about expanding the workforce and the number of mental health professionals in schools. He also discussed the role telemedicine might play going forward. One thing he said he learned during COVID is that telemedicine is more effective than in-person visits. Dr. Dunn agreed that there has been a turn to tele psychiatry and tele behavioral health, and no-show rates have dropped. She said the AR-Connect program started at UAMS during pandemic and people could call a phone number and get hooked up immediately and referred as needed. Part of the chancellor's vision for UAMS is digital health as a way to bridge the rural/urban divide and she thinks that mental health needs to be a huge part of

that. She wants to be a major leader in that field so anything they can do to partner with anyone in the room is welcomed.

Arkansas Children's Hospital (ACH) Sheena Olson stated that primary care and behavioral health integration today at ACH does not include a large behavioral health service but does have a huge primary care practice and also has Arkansas Children's Clinical network and those organizations. There are still so many barriers to integrating, but it is something we need to talk about and figure out how to make that happen and how to incentivize that. The same is true with acute crisis units, as they get kids in the ED with no place to go for various reasons. Thinking through the gaps in care for children specifically, what do we do with some of those that need partial hospitalization or stepdown or something like that, and how can we make that capacity available? They have talked about telemedicine as well. These things are on their radar, and they want to be engaged with this group and figure out what is keeping a primary care practice from having mental health professionals; is it: reimbursement, workforce, or possibly education. There is a lot of opportunity, and they are willing to work on it as it was paramount before the pandemic and has increased since.

ARcare Clint Shackelford said ARcare is putting a huge focus on behavioral health. They have hired many LCSWs and are thankful now LPCs can bill for services. They partner with a lot of school districts with primary care but haven't really offered behavioral health and now see that is where the need is. It is going to drive their efforts to make that available. He stated the need to be conscientious of not migrating back to archaic rules that were barriers to telehealth and be cognizant of the doors that have opened for telemedicine that has launched it 20 years from where it was and maybe further. He mentioned a data survey showing that 53 year old men were surprisingly the most common user, so telehealth has the potential and we just need to figure out a roadmap to make it the efficient route to go.

Representative Ladyman shared a couple of stories from his time as mayor. Police officers would find people on the street, maybe not violent at the time, but with nowhere to go. A man in his 40's who was a high school friend of the police chief, lived in his parent's house after they passed away and couldn't take care of himself. He would come into town and sit on the curb every day, which was a personal safety issue so they'd call the police chief and he'd come take him home. The only other option was take him to jail. Eventually he had to take him to jail because he could not keep taking him home every day. This demonstrates the need for facilities where we can take these adults. He also shared that his son has been in many programs and he has worked through that with him. His son has been able to stay home a lot, but not too many years ago he would have flare ups and get violent for various reasons. One night, while having to restrain his son, his wife called 911, the police came, and their only option was jail or the ER. He went to ER and over a24 hour period he was able to get to where he could come home and eventually to the Jonesboro HDC. He said there has to be somewhere more appropriate to take people. There are crisis units like the one in Jonesboro now that allow them to be taken there for 36 hours max, but that's short term and we need long term. He said we have to fund facilities for the people that don't belong in a human development center or jail or prison, but that is where they will end up because there is no place for them currently.

Mental Health / Behavioral Health (MHBH) Working Group

Meeting Notes

March 15, 2022 – 1:30 P.M. – State Capitol, Room 138 – Little Rock AR 72201

Representative Evans stated that ARcare is a tremendous partner to their school district in what they offer in primary healthcare for students and faculty, and he knows they are committed to working on a telehealth option for mental health. He shared that in the past week a young lady in junior high made the decision, with no triggers or markers, to attempt to hang herself in the bathroom between class transition. Groups of students walked in and out while she was in the process, and finally a student reported it and they got the girl down before she took her life. She is a straight A student with no behavior issues and a star athlete. She likely didn't go to her guidance counselor or coach because she didn't want to breach those relationships. If there was a telehealth option, that might have been an option for her and could that have stopped this. Discussion took place then on what role community health centers could play in helping to facilitate DHS's three-year plan. Ruth Allison Dover stated that community mental health is a safety net for those in crisis and plays a vital part in the state's crisis response system. The focus now should be on how to do more prevention and not get to the crisis point. CCBHCs are a possible solution for Arkansas as they have demonstrated outcomes in multiple states. Missouri is a successful CCBHC state. They want to have more dialogue with UAMS on how CMHCs can fit into the ARHome structure, because it will take a collaboration between hospitals, local CMHCs and FQHCs. Part of the CCBHC effort is to integrate primary care as previous discussed.

A representative of the UAMS Crisis unit stated that during the pandemic the unit received calls from people needing help for loved ones with various issues and it's very hard to help people even with all the knowledge they have. They know the challenges to getting people the help they need. At the crisis unit, they take people in, get them stabilized, and then feed them out for the various services into evidence based practices that they know work. Their problem is not all of those services are well funded and they are not always there to help people after they are done with the crisis. One of the things they do as a crisis unit is train officers, such as specialty mental health officers, so that they can respond. Access to care and funding of programs is important. We need to improve access to care and quality of care. Good things are in place, and we can start building out on them.

Representative Warren shared a story of a child in his son's class that killed himself and a cheerleader who hung herself. He also shared a story of a veteran who had go from the nursing home where he was living to a VA hospital, and once released from the hospital found that the nursing home wouldn't let him come back because he had tried to set his bed on fire. He had nowhere to go and was dropped off in the streets of Morrilton, AR. We need to invest in some type of home where mentally ill people can be contained, taken care of, and have a decent existence as opposed to being out on the streets. Addressing mental health in children through the older population, the whole mental health picture, is going to require facilities for those who don't have family members or anywhere to go.

Senator Hammer asked for a comprehensive list of all providers that have their fingers in the mental health field in Arkansas and in what particular area they provide services to figure out where services are needed. DHS said they are working on a list like that. Based on current caseloads, by discipline, what would it take to staff up fully? We need an idea of what number we are shooting for (i.e. how many psychiatrists, psychologists, etc. are needed?).

Mental Health / Behavioral Health (MHBH) Working Group

Meeting Notes

March 15, 2022 – 1:30 P.M. – State Capitol, Room 138 – Little Rock AR 72201

Representative Gazaway requested information on the number of beds we currently have total in the state for juveniles, number of beds broken down by the number of days (i.e. long term beds, 30 day beds, 10 day beds etc.) and for each population and the length for which they serve them. He would like for anyone in the room that has knowledge on the history of mental institutions in the state to provide information on where we have been and why we find ourselves where we are today.

Caitlyn Johnson (ABHI) discussed the need to also take these conversations to the payers. She said we continue to ask why we don't have mental health clinicians or why we can't keep them staffed and one reason is because we can't pay them. In school they are commonly told not to expect to earn a lot of money in the field. There is a significant disconnect between what they are asking for as clinicians, as superintendents and everyone else vs. what the payers are paying. This is something that needs to be taken to the payers as they have a huge influence on who sees the patients and when they see them.

Representative Ladyman followed up on Representative Gazaway's comments. There was a move to take people out of institutions years ago and get them out in the community, but he believes what that has done from his perspective is created a gap because the serious cases go the state hospital to live and the others that can, go out and live on their own; however, there are people that fall in the middle who need to be somewhere. We need to be able to meet people at their level of need.

Representative Vaught recognized the need for these meetings to be long based on the content. She said she would like for all entities to do a PowerPoint presentation and each take a turn, providing a digital copy as well. Any information that was asked for, such as that requested by Senator Hammer and Representative Gazaway, can be sent to robin.voss@arkansashouse.org. Meeting attendees were asked to review the copies of sample legislation that were distributed which show some of the ways mental health issues have been addressed in other states. We will also be looking into whether states have done anything to provide an alternative pathway similar to what Arkansas did with teacher licensure several years ago. Discussion followed on whether we might see people take that path to licensure as a financial incentive but then move to private practice because there is more money in it. We need to find a way to incentivize staying where the services are needed as opposed to going to where the money is. The move to private practice is one of the contributors to the shortage, reinforcing that rates must be addressed.

Representative Vaught would like to see the group break down into silos but first would like them to present their PowerPoints. She asked they send the services they provide, what age groups/populations they serve, and in what areas of the state they serve to Robin so that the group can figure out how to build bridges.

The meeting was adjourned.

Mental Health / Behavioral Health (MHBH) Working Group

Meeting Notes

April 18, 2022 – 1:30 P.M. – State Capitol, Room 138 – Little Rock AR 72201

Present: Sen. Kim Hammer, Sen. Greg Leding, Rep. Harlan Breaux, Rep. Frances Cavenaugh, Rep. Nicole Clowney, Rep. Cameron Cooper, Rep. Brian Evans, Rep. Denise Garner, Rep. Jimmy Gazaway, Rep. Michelle Gray, Rep. Spencer Hawks, Rep. Lee Johnson, Rep. Jack Ladyman, Rep. Julie Mayberry, Rep. Tippi McCullough, Rep. Aaron Pilkington, Rep. Keith Slape, Rep. Stu Smith, Rep. DeAnn Vaught, Rep. Les Warren, Bess Ginty - AR Healthcare Alliance, Cory Cox - Care Source, Ruth Allison Dover - ABHC/MidSouth Health, Nikki Edge - UAMS Dept. of Family Medicine, Kathryn Griffin - Governor's Office, Brad Nye - Summit Community Care, Beth Mathys - ADE, Lisa Evans - UAMS Dept. of Psychiatry, Priscilla Faulkner - DHS/DAABHS, Van Golden - UAMS, Patti Halter - Impact Counseling, Jay Hill - DHS, Jack Hopkins - AR Total Care, Stacy Smith - ADE/DESE, Michael Keck - UAMS, Michelle Kitchens - ACHI, Joel Landreneau - AR Behavioral Health Council, Nicole May - AR Total Care, Cale Turner - Bi-Partisan Strategies, Elizabeth Pitman - DHS, Joey Miller - ARcare, Christie Green - Empower, Amy Cobb - Empower, Stacy Crawford - Empower, Laura Prondzinski - Arkansas Healthcare Alliance, Paula Stone - DHS, Anna Strong - American Academy of Pediatrics AR Chapter, Susanna Watt - JCD Consulting/ACH, Ritchie Thomas - Life Within Counseling, Mary Meacham - AFSP AR, Michele Snyder - Soul Shop Movement, Betsy Kindall - ADE, Teresa Hudson - UAMS, Lenett Thrasher - AAEA, and Matt Gilmore - ADH.

Jenny Walden, a guest of State Representative Jimmy Gazaway, was introduced and shared with the group the story of her latedaughter Kelsey who dealt with a variety of mental health related issues and the challenges their family encountered in their efforts to access the services she needed. Based on those experiences, she sees great need for access to long-term beds, services for those in the 18 - 20 year age group as a service gap is present, help for caregivers with getting guardianship of adults with severe mental health issues, and improvements to how the transportation of individuals to mental health facilities is managed. Discussion followed regarding emergency rooms not being equipped to treat mental illness, the need to look at the investments we are making in long-term mental health services, age-related service gaps, guardianship assistance, mental commitment issues, and IQ requirements.

Arkansas Behavioral Health Council Joel Landreneau provided a PowerPoint presentation to the group and discussed the need for the reevaluation of the rate structure in behavioral health, stating that rates were cut in outpatient behavioral health reform enacted in 2018 and describing the large disparity that existed between what individual therapists were paid and agencies were paid prior to 2018. This was addressed in the 2019 changes by making no change at all which is unjustifiable because the level of acuity of the patients seen in agencies is higher. A rate increase is needed for therapeutic communities as these tend to be longer term stays. A rate increase has been promised to allow them to staff properly, but this increase has yet to be seen. The needed higher level programs that don't now exist can exist if the policy decisions are made to fund them. They are asking the working group to examine a rate increase to therapeutic communities level one and two as soon as possible, allow for the creation of a level 0 as well to care for chronically mentally ill adults at a higher level of intense care, and review behavioral rates overall because there is now an unjustified disparity between Medicaid and private pay. Examples of disparities were given. With regard to the workforce shortage, mental health professionals have too many other options and places they can go. He stated that when you create new provider types without creating an increased workforce size, all you are doing creating more people competing for the same size

workforce. The workforce issue can be addressed in the short term by addressing reciprocity (which is still an issue), addressing issues with Medicaid refusing to pay LPCs who see Medicaid/Medicare dual eligible clients simply because they also have Medicare, which he believes is fixable at the state level with a policy change (the policy change request has been asked of DHS but was previously denied), and policy changes to approve Medicaid payment of LADACs to see people with substance abuse disorders to free up LCSWs to see other clients. Proposed workforce development solutions include, creating a rate differential between agencies and independent practices, raising everyone's rates so the differential between Medicare and private insurance isn't so stark, enabling LPCs to bill Medicaid for duals, enabling LADCs to bill Medicaid services rendered to Medicare beneficiaries who have a primary diagnosis of substance use disorder, and finally enacting legislation to make Arkansas the 10th state to join the Counseling Compact for LPCs. Additional reforms include adopting the CCBHC model into AR Medicaid as it is a national model of complete care under one roof allowing for one clinic to provide all a patient needs and it has a payment reform mechanism in it that establishes reimbursement rates, and adopting a cost-base reimbursement model. A longer-term ask he would like see is for the legislature to reexamine the wisdom of using 1915(i) as the payment mechanism for behavioral health, as he believes it works well for IDD and not as well for behavioral health. In summary, he would like see increased availability of inpatient placements for the chronically mentally ill through increased rates in therapeutic communities and the creation of the new level type in therapeutic communities; increased incentives for therapists to work with patients with more complex needs, and decreased incentives for therapists to leave agencies. Examples were cited from a sampling of paid claims provided by Empower which were paid by provider type: of 90,499 claims, 631 were done by an IOP, 89,000 were done by agency therapists and this shows that agencies are seeing PASSE members and PASSE members are the ones with higher needs and therefore it is agencies that are seeing the sicker patients. Of those 90,000 claims, 40,000 were paid to provider type 19s which have already fulfilled their supervision requirement, 49,000 were paid to those that still need those requirements fulfilled which demonstrates how our workforce skews in the direction of the inexperienced. He said people believe we don't have therapists but there are actually a lot of therapists and the question is why aren't there enough therapists willing to take Medicaid; this is a public policy question that needs to be addressed in the next session. Discussion followed. Mark White with DHS said federal law says that Medicaid can't pay for services for individuals that can access that service at an agency with Medicare, and federal law also prevents those agencies from using LPCs. There are bills in congress to fix that but until that happens, DHS doesn't have the option to change it. Sen. Hammer asked if a waiver would be an option in the meantime while congress deliberates this. Discussion followed, and Mark White stated he will check to see if any other states have had a waiver. Status of the Optum assessment was also discussed as well as the lack of continuity of care illustrated by Ms. Walden's story of her daughter having over 100 admissions and perhaps if we didn't have such aggressively short authorizations and had longer term options, continuity of care could be less of an issue. Rep. Garner, the House sponsor of Act 623, the social work licensing reciprocity legislation, asked what the issue is with this and discussion followed regarding Arkansas making a distinction between an unsupervised and a supervised license, because Arkansas is presently not willing to issue a license to an individual still needing supervision. Also, in the case of an individual's coursework not aligning exactly with what Arkansas

requires is preventing Arkansas from issuing a license. More discussion followed regarding licensing issues/compacts.

Arkansas Department of Education Jerri Clark, ADE Health Services Director, and Betsy Kyndall, who oversees the Arkansas Aware program for ADE and helps coordinate school-based mental health services for school districts, addressed the group regarding on-campus mental health services from a prevention standpoint. They informed the group of the support they provide to school districts, what they see happening on campuses, barriers that exist and what solutions they recommend. Their team works to help implement prevention strategies including equipping teachers with the tools and resources they need to manage classrooms and identify mental health concerns, make sure they are implementing access to equitable, quality mental health services, and provide a Medicaid team to work with school districts on getting reimbursements. Thirty-thousand Arkansas children get mental health services at school. About 90% of Arkansas school districts contract with mental health agencies and ADE assesses and provides technical assistance to those school districts with the contracts, assisting both the school district and the agency, showing them best practices and how to partner with a mental health agency. They look at what the space looks like in the school, and if its confidential. The remaining 10% employ their own clinicians and these are only protected by FERPA not HIPAA. They also coordinate services because school districts are only able to provide Tier 1 level services and many kids need additional services. Some schools do a hybrid model, an example being Bryant. In the hybrid, the district contracts with ILPs and then ILPs will see kids for a flat rate and the school district bills on their behalf. These are the three main models. AR Aware has a $9 million SAMSHA funded grant and does a lot of training for educators, specifically mental health first aid. Legislation passed last session requires SROs to be mental health first aid certified which is a great foundational tool because educators are not equipped for what they are seeing in the schools. They also provide training in trauma informed practices, adverse childhood experiences, resiliency for teachers, donate to the THRIVE academy for deep training in mental health for high level administrators, provide mental health screeners at the counseling and school nurse level to support counselors and school nurses in making referral decisions, have a collaborative partnership with the UAMS TRIS program that provides follow up and training to those staff members. For treatment on campus, schools are considered providers but typically schools collaborate with an agency. ADE recommends the hybrid as a best practice model, where school districts hire a staff therapist to provide some Medicaid billable services but mainly provide non-billable services necessary to students and coordinate the agencies that are coming onto campus. ADE promotes that because school districts are excluded from the PASSE so those that hire their own therapist and get reimbursement for the therapist are completely excluded. They collaborate with DHS for school districts that do want to set up mental health services. The districts will come through ADE- DESE first and they will do ground work and vet them in their readiness to set up a school-based mental health model. They will certify the school district for school-based mental health which helps streamline the process. Another benefit of this model is the free care rule meaning school districts are recognized as a provider billing beyond an IEP, which is not the case in many states which makes mental health services available to all students. 90% use agencies though, so this won't apply to 90% of the students that get care on campus. Telehealth was discussed and the waivers that were put through by DHS, and it was stated that some waivers were made permanent but some not, and will damper services

when they go away. School based health centers are a stop gap for students that need PCP referrals. ADE recommends school districts have school based mental health coordinators, but it is not mandated and not enough have them. The employee assistance program makes free counseling services available to teachers and has been promoted by ADE diligently over the last 12 months, but there has been a decrease in the number of sessions available to teachers from 8 sessions to 3 which is not good. Teachers are less than thriving right now. They would suggest looking into that. The barriers they see are: PCP referrals are still a problem in terms of problems getting the referral, students being underinsured with deductibles for behavioral health that are not affordable or without mental health coverage, inconsistencies within the PASSE in terms of client eligibility/prior authorization requests and requirements/credentialing requirements/modifiers, discontinuance of telehealth upon expiration of the public health emergency, and quality of care. Legislation to allow for 10 sessions prior to a PCP referral instead of three sessions is not enough. ADE put together a needs list which included the need for key policies among PASSE entities that need to be streamlined to alleviate access to service delays, modification of policies related to PCP referrals to remove barriers, and lastly a study of the copay and deductible requirements for mental health services for private insurance because this is an issue at the student level they see every day. Michael Poore, Superintendent of the Little Rock School District, elaborated on the barriers. He pulled together information representing 25 school districts across the state to share with the group and will send copies of the reports following the meeting. He shared a story of a colleague with a foster child who ran away and was later put in a residential center but was sent home after five days and has run away again. Throughout this ordeal, the mother has not even been able to find a place to send her daughter in Little Rock, which Mr. Poore pointed out that if this is an issue in Little Rock, "think of what that means within small school districts." He shared that schools have things they need to do on their part as well. Schools can get better at finding ways to provide access to the providers and also need to provide training to help employees with de-escalation approaches. Schools have been priced out from being able to hire social workers so that is not really a possibility right now. He asked legislators to micromanage this situation because it is a problem. Rep. Vaught shared a story of a student in her district who was in the middle of a mental health crisis that resulted in being out of school for several days and upon return was greeted by teachers who had no idea where the child had been and questioned him as to where he had been and why he had not gotten online and completed his assignments. This caused him to struggle again resulting a continuous cycle of being in and out of school. There was poor communication between the school, teachers and parents and the parents were not made aware of the scope of issues that had occurred at school. ADE stated this is an example of what should not have happened, and it seems that in addition to clear communication, the missing component in that situation would be a "trauma informed lens," which is training ADE can provide and is set up where teachers understand when students have experienced trauma and can then move forward with that in mind. They said they want educators and kids alike to feel safe at school and ADE is doing their part to provide them with those tools and trainings to allow for that. ADE is working on a multi-tiered system of support for students to make sure there are open lines of communication and everyone is on the same page. This is something they are doing through their THRIVE academy to train high level administrators in this. Discussion followed regarding school based intervention teams and the importance of a line of communication with teachers, students and also

parents. Carol Moore stated a problem that also exists is while a child (or adult for that matter) is in acute or residential care, outpatient providers are not allowed to provide any services to the families who are trying to prepare for moving their child (or adult family member) back home and this is another significant issue. Family services are provided at the inpatient facility but in the cases where the patient is only there for a limited number of days, there may not be an opportunity to have a family session before they are discharged and outpatient providers and school-based providers need the ability to be able to work with those families to prepare for the homecoming and to understand the patient's situation. School counselors are not allowed to tell anyone why someone has missed school and many times when the student comes back, counselors aren't even given any information on the student's situation. This is a problem and teachers need to know what to do when a student comes back. Rep. Gazaway talked about access in school-based settings, referring to Act 1064 of 2019 to create an Arkansas School Safety and Crisis Line which was never funded. It was modeled after SafeUT that provides students access to contact someone for services through a free app who can guide them through a crisis to a point when they can be referred out to a provider. AR Connect is sort of outgrowth of the planned AR School Safety and Crisis Line idea and he would like to look at how AR Connect is working and how we can expand that. Discussion followed on AR Connect, now named AR Connect Now, which is a program providing urgent mental health care. They can take calls from anyone in the state and the individual can talk with a nurse who'll make sure they are not suicidal and if not, will gather basic info and offer to make them an intake appointment, within usually 1 working day, with a licensed professional to assess the person and determine the needed treatment. They have social workers, LPCs and psychiatrists available to meet the varying needs. Patients will be seen at no cost to them up to six times (if they have insurance, the insurance must be billed) and the grant funding pays the copay. They have money to continue this until early 2023. BCBS has given them some funds to push this out to make schools aware the program is available including to, parents, children and employees of the school. Rep. Garner added that until we take care of providing mental health, nutrition and brain development in the prenatal to three age group, we are placing band aids on a huge problem. She also pointed out that we are expecting our teachers to act as social workers or counselors, and we cannot and should not continue to do that nor can we or should we train them to do so. She suggested taking the money being spent on professional development and training in this area, and instead paying for the salary of a social worker in every school or school psychologist in every school district because school counselors are not trained to take care of these problems. More discussion followed. Sen. Tucker suggested that consideration be given to whether CIT training would be a good idea statewide for teachers. Rep. Evans asked about the need for parental consent when a child contacts AR Connect, as he said it would be concerning if a student reaches out for help but there is not a way to help them at that time because we have to first track down their parents. Discussion followed. Sen. Hammer mentioned an issue with the hotline regarding multiple mandated reporters calling in on one student which results in duplicate reports and asked if there is a way around that. Discussion followed on this as well as long-term care needs and facilities and the data needed to support the decision to increase the access to longer term care and to make sure we get better outcomes.

Rep. Vaught informed the group that a plan has been identified for creating separate sub-groups of the working group moving forward. She asked those in the room to email to Robin ideas for action that can

be taken with policy changes instead of legislation. Next month signups will begin for the sub-groups, and the sub-groups will do their work going forward and come back to the working group to present their progress.

The next meeting will be Monday, May 16th, 10:30 a.m. The meeting was adjourned.

Mental Health / Behavioral Health (MHBH) Working Group

Meeting Notes

May 16, 2022 – 1:30 P.M. – State Capitol, Room 138 – Little Rock AR 72201

Present: Rep. Frances Cavenaugh, Rep. Nicole Clowney, Rep. Denise Jones Ennett, Rep. Brian Evans, Rep. Denise Garner, Rep. Jimmy Gazaway, Rep. Tippi McCullough, Rep. Aaron Pilkington, Rep. Johnny Rye, Rep. DeAnn Vaught, Tammy Alexander - DHS, Cyndi Coleman - Methodist Family Health, Bess Ginty - AR Healthcare Alliance, Cory Cox - Care Source, Stacy Crawford - Empower, Ruth Allison Dover - ABHC/MidSouth Health, Netlla Cureton - Paris Schools, Laura Dunn - UAMS, Nikki Edge - UAMS Dept. of Family Medicine, Kathryn Griffin - Governor's Office, Brad Nye - Summit Community Care, Lisa Evans - UAMS Dept. of Psychiatry, Van Golden - UAMS, Jay Hill - DHS, Michael Keck - UAMS, Michelle Kitchens - ACHI, Joel Landreneau - AR Behavioral Health Council, Sarah Lasiter - Paris Schools, Nicole May - AR Total Care, Carol Moore - ABHC, Sheena Olson - ACH, Laura Prondzinski - Arkansas Healthcare Alliance, Kim Shuler - ABHI Network, Dawn Stehle - DHS, Paula Stone - DHS, Susanna Watt - JCD Consulting/ACH, Betsy Kindall - ADE, Teresa Hudson - UAMS, Mike Mertens - AAEA, Mark White - DHS, Alan McClain - AR Insurance Dept., Patty Gibson, ABHI Network, David Kuchinski - The Centers, Amy Stephenson - ACCN, Lecole White - ACCN, Kelsi Ballard - ACH, Jenn Goldman - Mercy, Janna Brown - CareSource, CaSandra Glover - AR Advocates for Children, Loretta Alexander - AR Advocates for Children, Bridge Adkins - DHS, Jacy Gardner - Empower, Bill Paschall - The Centers, Lindsey Bowers - White River Medical Center Behavioral Health, Fredricka Tabor - WRMC Behavioral Health, Angela Dover - BCBC, Angela Duran - Excel by Eight, Serena McKnight - Life Within, Misty Jones - Life Within, Riley Pate - Life Within, Ann Patterson - Partners for Inclusive Communities, Sarah Moore - AR Justice Reform Coalition, Nicole Fairchild - Arkansas Aware, Jerri Clark - DESE, Erin Franks - ADE, and Heather Callaway - parent.

Sarah Lasiter, mental health coordinator with Paris Schools, was introduced and spoke to the group about the gaps she sees in access to health services and shared an example dealing with a student in the district with multiple issues who is not thriving. Safety for the student and those around the student is an issue, and because of the many issues, there have been problems with providers not wanting to accept the youth. The school therapist's hands are tied because no one will take the student, and getting on a PASSE is not an option because no providers will take this on due to the student's aggressive behavior. This is a barrier the parents have dealt with for over 10 years. Providers in the room were asked to reach out to Sarah if they believe they can provide help. Discussion followed.

Heather Callaway, a parent, shared her son's story with mental health issues and examples of instances when he has been a danger to himself and others, and how this has impacted their family. She gave an overview of what day-to-day life looks like for those with mental illness and their loved ones. She sees issues with communication between parents and providers. The process for getting appointments with providers is very complicated and creates additional barriers. She stated that a massive overhaul of our insurance and healthcare system is needed. Discussion followed.

Life Within Counseling Thomas Ritchie provided a PowerPoint presentation to the group. Life Within is an outpatient counseling clinic providing a variety of services to both Medicaid and private insurance clients. Taking care of clinicians is his first priority, because if they aren't cared for, they may not want to be clinicians much longer. He provided examples of individual cases that illustrate the challenges clinicians face and the hoops they must jump through. He stated that the ability to focus on the client rather than compliance will approve outcomes. They believe quality care could reduce quantity care, so he stated we

must protect clinicians from burnout. Caseload issues were discussed. Clinicians are able to focus on quality of care when not having to focus on administrative tasks. The independent licensure program has been a game changer. He acknowledged some of the great work done by several in the room from DHS. They also are working on a program to assess the parent's own mental health as a part of the overall treatment process and believe this is something that is overlooked. He discussed opportunities moving forward to address service shortfalls by increasing opportunities for LACs and LMSWs, reopening the possibility for Masters level psychological examiners to address the waitlist of those waiting for testing, reducing reimbursement rate disparities between private insurance vs. Medicaid, children vs. adults, and family vs. individual services, and reducing regulations that increase administrative hurdles that decrease time spent on client care. Discussion followed.

Representatives Cavenaugh and Vaught discussed rate change needs with representatives of the PASSEs, the processes they use in negotiating a rate with a provider, and the concerns that have been expressed with regard to PASSEs. They hear there is a disconnect with providers saying the PASSEs won't negotiate with them until they know what the rate is going to be from Medicaid and DHS saying they aren't involved in negotiating prices which creates a catch 22 and so there is a need to understand what that process is. Representatives of the PASSEs were asked to get with their teams to get an answer to that as soon as possible, because this is at a crisis level. Discussion followed regarding the delays. Rep. Cavenaugh requested the following from the PASSEs:

- financial statement
- balance sheet
- profit & loss statement for the last year
- profit & loss statement for the current year

Arkansas Children's Hospital Representatives of ACH discussed behavioral health integration in primary care and shared issues that they have seen. National stats are reflective of what is happening in AR. Mental Health/Behavioral Health (MHBH) issues can start in early childhood and no child is immune. Disparity in adult and child services exists. Assessing MHBH at earlier ages can turn an escalating problem into a de-escalating problem. They have seen over the last 5-10 years a need for telehealth services in pediatrics. Telehealth services are helpful in getting the right level of service to children and can help relieve the waitlist of those needing services. MHBH is a priority for ACH. They want to work on this through partnerships with MHBH providers across state. There has been a 25% increase in MHBH diagnosises since Covid started, and the acuity of those needs is higher than in past. In 2018, they saw 300 suicide ideation cases, and this year they are on track to hit 550. ACH is most focused on early detection and intervention and believe primary care is a good place to expand that. Discussion followed regarding the types of patients they are seeing. Figuring out a way to integrate behavioral health will be a huge win for Arkansas children. The three areas they see for opportunities to show innovation are: 1) expanding policy to support integrated care, 2) investing in innovative solutions to acute crisis interventions, and 3) creating new models to meet needs of dual diagnosis patients. Primary care physicians are in a unique position to provide initial services within clinics and can make the family more

comfortable. The more we can capture issues in the age 0-3 range, the more money we will save down the road. ACH is happy to partner with and support the work of this group. Discussion followed. Rep. Garner stated that taking care of issues in this age group would serve to take care of many issues seen in schools, the work place, and the jail system. She asked, given the state's billion dollar surplus, what could be done to take care of those issues and support this effort to avoid these issues down the road. More discussion followed, and it was agreed that investing in early childhood care would be a long-term savings to our state.

University of Arkansas for Medical Sciences Dr. Laura Dunn, chair of the Dept. of Psychiatry, spoke on behalf of UAMS. She talked about opportunities to work together and improve the lives of Arkansans and firmly believes in the need to start early in the lives of children. According to the CDC, Arkansas has the highest proportion of children, ages 2-8, with diagnosed emotional/behavioral health disorders and estimates show that 36,000 adolescents in Arkansas have had major depressive episodes in the last year. Mental health workforce shortages exist in most areas of the state, resulting in unmet needs, and research shows the impact this has on MHBH issues into adulthood. UAMS wants to be a partner in this effort. They offer a range of MHBH services. They currently have school-based programs, integrated care (with room to grow), outpatient care, telehealth, subspecialty programs both outpatient and in, education programs, and a hub for innovation in MHBH research. Additionally they are studying risk and resilience across the lifespan. She shared information on Project Play, a childhood MHBH consultation program funded by DHS and ADE as part of Arkansas's expulsion prevention system for success. They help parents and teachers support children and keep them in the educational system. An example was shared. The ARBest program improves outcomes for children who have experienced trauma as well as their families. They train MHBH professionals to deliver evidence-based treatments to patients with trauma across their lifespan. Science shows that trauma impacts children, making it difficult to succeed in the classroom. Through the TRIS program, they work in partnership with ADE to help schools support students and staff, provide training, share resources to support administrators and counselors after traumatic events impacting the school community, and help students in need of trauma treatment. TRIS is funded by a Blue and You grant. She also shared information on a new program, AR Connect Now, a new way to address access issues, which is essentially is an urgent virtual MHBH clinic to connect patients to services for longer term care. They have reached a wide range of Arkansans through this program. It is currently supported by a limited time grant through SAMSHA, and will now be up to us to work together to find ways to sustain these types of programs and expand them in the future. Information was also shared on the crisis stabilization units (CSUs), which serve an important population and are alternatives to jails and emergency rooms for those in crisis. Discussion followed.

Rep. Vaught explained that the working group will be breaking out into seven subgroups going forward, and Robin Voss will send out the list. The overall working group will continue to meet monthly, and the subgroups will work in coordination with the working group.

The next meeting will be Monday, June 20th. The meeting was adjourned.

Mental Health / Behavioral Health (MHBH) Working Group

Meeting Notes

June 20, 2022 – 1:30 P.M. – Big Mac Bldg. Rm. A – Little Rock AR 72201

Present: Sen. Kim Hammer, Rep. Lee Johnson, Rep. Julie Mayberry, Rep. Les Warren, Cyndi Coleman - Methodist Family Health, Cory Cox - CareSource, Ruth Allison Dover - MidSouth Health, Rachael Marx - WRMC, Nikki Edge - UAMS, Lisa Evans - UAMS, Patricia Gann - DHS, Brad Holloway - BirchTree, Teresa Hudson - UAMS, Michelle Kitchens - ACHI, Joey Miller - ARcare, Carol Moore - ABHC, Brad Nye - Summit Community Care, Sheena Olson - ACH, Elizabeth Pitman - DHS, Laura Prondzinski - AR Healthcare Alliance, Paula Stone - DHS, Anna Strong - AAP, Lanett Thrasher - AAEA, Marlo Lowe - AR Substance Abuse Certification Board, Lisa K. Ray - AR Substance Abuse Certification Board, Sarah Moore - AR Justice Reform Coalition, Jon Comstock - AR Justice Reform Coalition, Debbie Malone - Child Care Aware, Geania Dicky - Dot2Dot Consulting, Ann Patterson - Partners for Inclusive Communities, Jenna Goldman - Mercy Health, Loren Miller - ARcare, Kelley Linck - WSG Consulting, David Kuchinski - Centers, Max Greenwood - AR BCBS, Tammy Keech - Safe Babies Court Team, Bert Price - ABCBS, Sarah Lasiter - Paris Schools, Shawna Clayton - Paris Schools, Jonathan Taylor - Governor's Council on Developmental Disabilities, CaSandra Glover - AR Advocates for Children and Families, Mike Poore - Little Rock Schools, Robin Lipton Ingram - Partners for Inclusive Communities, and Karan Burnette - Partners for Inclusive Communities.

Rep. DeAnn Vaught opened the meeting and advised the group that they will be dividing into subgroups going forward. Subgroups will work on developing legislation / policy changes and will be looking at what is working in other states. Anyone interested in serving on a subgroup can email Robin Voss. The MHBHWG group will still come together as a big group for the purpose of continuing the flow of information.

Priscilla Faulkner with Impact Counseling, an Independently Licensed Practitioner (ILP), spoke to the group about the struggles and challenges she sees. She works with children, adolescents, and adults. She shared examples of challenges she has seen in dealing with high risk clients, including juvenile repeat offenders. She spoke on some of the concerns she has which included: how lack of access can lead to safety concerns for the clients, their caregivers and their family members when the client is denied services or placement; instances where a juvenile is recommended for long term care but is denied by PASSE due to lack of consistent QBHP (Qualified Behavioral Health Provider) sessions; the struggle of clinicians with making contact due to a lack of service for Optum Assessments; post-COVID, the increase in clients with mental health issues who had no pre-existing issues; agencies struggling to find clinicians due to the reimbursement disparity; clinicians feeling undervalued and overworked due to paperwork and caseloads from state and federal regulations which results in clinicians wanting to move over to independent practice because compliance requirements are less burdensome than with an agency. She asked for a call to action to create one manual for compliance with the PASSES instead of separate ones for each. She discussed the possibility of creating a Behavioral Health Crisis Response Council similar to that in the state of Utah and recommended the council should: implement crisis response teams in each area of the state and train, network and provide education and support to schools, agencies and police, and also meet regularly to review procedures and ensure effectiveness. She also suggests they recruit from university counseling programs for interns to assist in their districts, recruit psychiatric nurse practitioners needing clinical hours, and offer student loan forgiveness for counselors, psychologists, psychiatric nurse practitioners, degreed qualified behavioral health providers, social workers, and psychological examiners.

She spoke on the reimbursement disparity, explaining what the average work week and payout looks like for her. With the 4,360 counselors in Arkansas, the practice is expected to grow but patients are seeing long wait times to get in with counselors so growth is a must. Discussion followed regarding: the different compliance rules for each PASSE; the different certification requirements for agencies vs. ILPs; work being done to align the ILP and agency manuals to decrease paperwork level issues (the primary reason why the difference exists in the ILP and agency manuals is that the agency manuals are more rigorous due to national accreditation); the educational requirements for ILPs; clarification of the issues surrounding the differing PASSE manuals; the care coordinator process; benefits and barriers for crisis response teams in rural communities; the relevance of the required national accreditation which largely contributes to the disparity concerns; and the impact of the ILP pathway since it was put in place.

Kim Shuler, CEO for AR Behavioral Health Integration Network (ABHIN), and Patty Gibson, CMO of ABHIN, discussed integrated behavioral health (IBH). Patty emphasized the importance of addressing this overwhelming problem. She said that IBH is about working as a team and there are a lot of models and research that support it and taking care of the whole person. She discussed the divide between medical providers and mental health providers and ABHIN's mission to increase integrated care in Arkansas. There are clinical trials that show this model of care has better outcomes than usual care. She discussed what it would look like: it can include mental health specialists in a medical setting or medical specialists in a mental health setting. She said it would allow for helping people "upstream" before they might need to get admitted to the hospital and shared examples of that. The goal of IBH is to get the right level of care to the right people at the right time and place. She discussed the various levels of care involved with IBH and how they work together and collaborate. Evidence shows a strong link between mental health/behavioral health (MHBH) conditions and chronic illness. More than half of all MHBH treatment occurs in the primary care setting already. PCPs are providing 60-80% of the MHBH care but don't have the training. In her work within primary care, she has seen they are struggling with the demands of MHBH, and drowning or overwhelmed. They also struggle with not being able to get the help needed for patients due to long waiting lists and other barriers. The integration of medical and behavioral health would produce savings in healthcare expenditures down the road. It is believed that the outcomes from IBH will be 1)improved population health, 2)improved patient satisfaction, 3) improved provider satisfaction and 4) reduced cost of care. She discussed the 5% of patients that are using 50% of the health resources and the estimated two trillion dollar projected costs in the next 10 years if this type of model is not adopted. She shared data on common co-morbid conditions and comparison data of the cost for that condition compared with the total cost when a comorbidity exists with MHBH. ABHIN is working on the issue through: monthly webinars with speakers on IBH to bring education and training resources to AR; suicide prevention care coordination, funded by a 3-year grant, in primary care clinics to provide more training and education; Rural Health Network Planning supported by a 1-year federal grant to look at needs and develop a strategic plan to bring resources to areas in need; Rural Community Opioid Response Program supported by a 3-year federal grant providing education to primary care teams for increased screening and treatment; and workforce training, through UA/UALR supported by an endowment from BCBS, that will launch an internship in IBH and provide skills to master-level students so that when they graduate they understand and will feel comfortable in primary care settings. ABHIN recommendations include: 1)

reviewing other states' innovative primary care programs and alternative payment models, 2) developing statewide collaboration to assess needs of primary care teams, health systems, MHBH systems and communities, 3) bringing primary care and MHBH providers together for discussion and planning, 4) providing statewide training on IBH, and 5) developing physical and MHBH outcome measures that can be used in identifying gaps in the current payment system. She stated that the take away is they know these models work and are able to address MHBH in primary care, and will help identify issues early and equip patients with the skills needed to avoid bogging down the MHBH system. Discussion followed regarding where the support for this model presently exists, its effectiveness and potential return on investment, areas where this has already been done, ABHINs role in this, what they believe the issues will be, and the importance of communication in the success of integrating.

Dr. Gerry Jones, CMO of St. Vincent Infirmary, spoke to the group as a representative of Little Rock's COVID-19 Response Task Force. Through that work, they are now dealing with not just COVID needs but issues related to all health care needs in Central Arkansas including MHBH. He discussed the inpatient setting, stating they are seeing patients presenting as suicidal, psychotic, or homicidal, i.e. the most sick with MHBH issues. He has seen how MHBH patients are underserved and saw a marked increase in acute care needs during the pandemic and decrease in available resources, especially among those shelter and food challenged. This is burdening hospitals and EMS providers. The number of MHBH patients awaiting acute care continues to rise. He cited just yesterday, there was zero availability of adult MHBH beds in central Arkansas. Emergency Rooms (ERs) are not equipped to deal with these problems, and patients have to wait there for a bed to become available, taking up resources while in our ERs. He stated that incidents of nurses, staff, etc. being harmed by these patients are no longer just rare events. He sees a need for: access to early intervention services, addressing the sheltered and food challenged population as these challenges exacerbate MHBH issues, and looking at how MHBH services are reimbursed.

Mr. Greg Thompson, executive director for MEMS, gave the EMS perspective. He said MEMS gets approximately 100,000 calls per year and this is increasing. 10% of those have a MHBH connection. EMS is the access to health care for the most vulnerable population who don't have normal types of care. Currently there is no treatment model other than take to these patients to the ER. At times because they can't be left unsupervised and placement has not yet been made, there is no choice but to leave these patients on the ambulance cot which means the ambulance is tied up when someone calls. Things MEMS is currently working on include: looking at "frequent fliers" to figure out what they need; working on a pilot with Children's Hospital to find way to take patients less than 18 directly from scene to a MHBH facility bypassing the ER (when they have a previous connection with a facility), and looking at the age and the circumstances of those patients that are time intensive to see if there is a better pathway for them.

With respect to hospitals and emergency services, Greg Thompson was asked if he could include repeats in his data mining. Dr. Jones provided clarification on the absence of available beds, stating that his meaning when he referenced the lack of beds in central Arkansa was that there were "physically no beds." He went on to state that the established dollar costs for those beds are approx. $800/day. Discussion

followed regarding the need to remove barriers that prevent patients from being transported to non-hospital facilities,

With regard to IBH, discussion took place on cost/benefit of IBH and the potential challenges in relation to that, how IBH might affect revenue downstream, whether there are enough people to have IBH, the expected impact of IBH on providers in small rural communities, and the need to also focus on substance abuse in IBH because this is a common co-occurring disorder with MHBH.

Rep. Vaught announced the next meeting will be July 18th, at 9:30am in Big Mac A. The subgroup meetings were announced as follows:

Workforce Development - July 5th - 1:30pm - Rep. Brian Evans & Sen. Greg Leding
Access to High Quality Services - TBD - Rep. Les Warren and Sen. Breanne Davis
Prevention & Early Intervention - July 5th - 10am - Rm 138 - Rep. DeAnn Vaught, Rep. Denise Garner and Sen. Clarke Tucker
Suicide Prevention - July 6th - 10am - Rm 149 - Rep. Tippi McCullough
Services for Special Populations - TBD - Rep. Aaron Pilkington and Sen. Kim Hammer
Substance Abuse & Co-Occurring Disorders - TBD - Rep. Jimmy Gazaway
Rates, Regulations, Efficiencies & Bed Availability - July 18th - 3pm -Rm 138 - Rep. Frances Cavenaugh

The meeting was adjourned.

Mental Health / Behavioral Health (MHBH) Working Group

Meeting Notes

July 18, 2022 – 9:30 a.m. – Big Mac Bldg. Rm. A – Little Rock AR 72201

Present: Sen. Breanne Davis, Sen. Kim Hammer, Sen. Greg Leding, Sen. Clarke Tucker, Rep. DeAnn Vaught, Rep. Fran Cavanaugh, Rep. Nicole Clowney, Rep. Denise Jones Ennett, Rep. Denise Garner, Rep. Jimmy Gazaway, Rep. Ashley Hudson, Rep. Julie Mayberry, Rep. Tippi McCullough, Rep. Les Warren, Tammy Alexander - DHS, Bridget Atkins - DHS, Faith Bedwell - Veterans of American, Tabrina Bratton - AR Department of Corrections, Michael Cluts - SWACMHC, Cyndi Coleman - Methodist Family Health, Tisha Deek - UAMS, Matthew DeSalvo - Salvation Army of Central AR, Jarrod Bridges - Youth Home Inc., Ruthie Bain - Social Work Licensing Board, Stacy Crawford - Empower, Ruth Allison Dover - ABHC MidSouth Health, Lisa Evans - UAMS, Patricia Gann - DHS, Patty Gibson - ABHIN, Syrna Bowers - AR Dept. of Corrections, Matt Gilmore - ADH, Bess Ginty - AR Healthcare Alliance, Jenna Goldman - Mercy Health, Max Greenwood - AR BCBS, Jay Hill - DHS, Brad Holloway - ABHC BirchTree Communities, Lindsay Bowers - WRMC, Melissa Weatherton - DHS, Teresa Hudson - UAMS, Michael Keck - UAMS, Michelle Kitchens - ACHI, David Kuchinski - The Centers, Joel Landreneau - AR Behavioral Health Council, Sarah Lasiter - Paris Schools, Alye Johnson - WRMC, Kristin Koenigsfest - DHS, Marlo Lowe - AR Substance Abuse Certification Board, Debbie Malone - Child Care Aware NWA, Nicole May - AR Total Care, Jeanna Pennington - Empower, Stephanie Andrews - Empower, Ryan Childers - Empower, Pamela Bagwell - Empower, Ann Patterson - Partners for Inclusive Communities, Elizabeth Pitman - DHS, Bert Price - AR BCBS, Lisa Ray - AR Substance Abuse Certification Board, Ritchie Thomas - Life Within Counseling, Kyndall Rogers - DHS, Booth Rand - AID, Mitch Morris - Empower, Paula Stone - DHS, Anna Strong - American Academy of Pediatrics, Jeremy Wooldridge, Paul Schandevel - Children's Homes Inc., Lindsay Wallace - AR DOC, Fredricka Tabor - WRMC, Lori Poston - MidSouth/Arisa.

Rep. DeAnn Vaught announced that the next meeting of the MHBH Working Group will be August 15, 2022, at 9:30 a.m. in Big Mac Building - Rm. A, and she added that working group members who would like to present at an upcoming meeting should let Robin Voss know. She also informed the group that all presentations will be held and the opportunity to ask presenters questions would follow. She has been to several conferences over the past month and has had the opportunity to share what Arkansas's MHBH Working Group is doing. She reported that other states have shown interest in the work, and said she appreciates everyone taking time to help tackle the issue. She would like to see Arkansas as one of the states leading the issue. With regard to subgroups, she said that subgroup members should attend in person if possible but opportunities to attend via Zoom will be arranged when necessary. Subgroups will be provided a bit more time to delve into their work before needing to report back to the working group, but she would like to see legislation coming out of the subgroups by October.

Shawna Burns, representing Seed Digging Wellness Center, spoke to the group on the history of mental health, barriers she has seen through her work in this field, and possible solutions to removing those barriers. She has been a counselor for over 17 years and prior to that was a school teacher. She has seen a lot of change in mental health over the past two decades. She shared that suicide is now the second leading cause of death among middle school, high school and college age youth in Arkansas, and is a huge problem that must be addressed with a focus and study on quality and trauma informed programs. She said the shortage of providers is a huge barrier and discussed the factors that contribute to that including

the closing of agencies leaving schools without services, the dilemma of Behavioral Health Agencies (BHAs) vs. ILPs, and the extensive requirements for Medicaid/PASSE providers. With schools being one of the safest places for students, she said we need to equip them with funding to help offset the effects of the therapist shortage by training teachers, administrators, school counselors, janitors, bus drivers, etc. to see the signs, make the necessary connections, and use the information to aid in prevention. She said children are capable of overcoming trauma, but we must treat the infection not just the symptoms. She sees need for regulation change and explained the current problem with the DHS certification manual. She believes it would be helpful to allow all licensed mental health professionals to practice as ILPs as it would allow mental health professionals additional opportunities to provide services in rural schools and communities without BHAs. She also recommends removing the burden of requiring ILPs to provide clients their own personal suicide hotline number as this requirement is causing burnout, as it requires the therapist to answer the call at any time of day or night and to personally go and meet the client within a two hour window if they believe there is a threat of suicide. It is a heavy load to be on call 24-7, and she said private insurance companies do not even require that. She believes a simple fix would be to let providers use the national crisis #998 or text line 741-741. She shared personal experiences that allow her to relate to the problem and show proof that children can get better and become a part of helping to change the system in the future.

Paul Schandevel with Children's Homes Inc. addressed the group. He is a LCSW in Arkansas and has been working with kids and families for 35 years. Children's Homes, Inc. has been building their program since 1993. The program is unique in that they have an 80% reunification rate for families. They are not residential treatment or congregate care, but rather an experiential learning academy (with no income requirements). They serve youth from all over the country, from foster care and the juvenile justice system. They are also used by residential treatment centers as a "step down" for other treatment centers when the child is not ready to go home or the family is not yet ready for the child to come home. They are a unique option and are very similar to the largest children's home in the nation, Hershey School for Boys and Girls, which is also a residential education system. Children's Homes, Inc. intentionally makes an effort to serve families in the Delta. He explained that they fall in a category somewhere between foster care and a residential treatment center. The experiential learning approach intentionally sets up experiences that teach kids real-life lessons they can then apply in real life. Their campus is a 30-acre private residential neighborhood with nine single family homes. Each home is managed by "houseparents." Six students, age 11-16 of same gender, live in each family home and each child has their own bedroom. Their pledge is to "work with guardians and their children as a team dedicated to mentor youth while safely allowing natural and simulated experiences, mature their attitude, behavior, intellect and relationships - equipping them with Adapt-to-life Skills and Bible Truths." They help youth who are: grieving a loss, struggling with poverty, rebelling against authority, disrupting adoption, being impacted by mental illness, in trouble with the law, living in an unsafe neighborhood, in spiritual crisis, experimenting with drugs/alcohol, needing alternatives to juvenile or foster care systems, needing a bridge between residential treatment and returning home, traumatized by an adverse childhood experience, or needing a home while a parent is in drug/alcohol rehab. They unfortunately cannot help with kids who have a record of being violent or abusing others as this could put their other clients in danger. Advantages to their program include: free

tuition/room/board, education and family-focused programming, the ability to learn through experience, access to mental health services if needed, availability of scholarships for college, trade school and certificate programs, no premature discharges when insurance doesn't pay, no risk of losing parental custody, proven high family reunification rate, trauma informed interventions, and a Christian environment. The average length of stay is 1-2 years. The five key ingredients of the experiential learning academy are: 1) increased faith in God and knowledge of right and wrong, 2) expanded self-awareness and acceptance, 3) improved academic performance and peer relationships, 4) preparation for family reunification and adulthood, and 5) greater love, forgiveness, hope in God and self and future. They also offer an equine-assisted learning program which focuses on relationships and what they are all about, Adventure Counseling which forces students out of their comfort zone, and a Pathfinders wilderness program, all of which assist with improving self-awareness and acceptance. Additionally, they partner with outside programs for traditional mental health services: *Open Book Wellness Center* which offers individual, family and group therapy; *Renew Mental Health and Wellness* which provides psychiatric medication services; and *Compact Psychological Assessment Center* which provides psychological evaluations (he added that he is frustrated with PASSEs not doing a good job with paying for evaluations). He spoke on their Balcom Learning Center, one of the top three alternative education programs in the country, which helps to improve academic performance and peer relations. In this program, there is a teacher/student ratio of 1:5 and they work to catch students up on academics but also work on goals, leadership and career investigation and prepare students to go to a regular school, return to families, and enter young adulthood. He shared that they work with a lot of angry students but want to help them to learn to live based on love instead of hate, move past their bitterness, and allow love to enter their lives.

Lindsay Wallace, ADC Chief of Staff, spoke to the group on behalf of the Arkansas Department of Corrections (ADC). She recognized Deputy Director of Residential Services Syrna Bowers with the Division of Community Correction, Deputy Director of Health Services & Programs Aundrea Culclager with the Division of Correction, and DOC Quality Improvement & Program Evaluation Administrator Dr. Tabrina Bratton. She spoke on what is being done to address mental and substance abuse health issues in the incarcerated population and the steps they are taking moving forward in the future. Their goal is to improve the services offered to the offender population. They have two divisions, the Division of Community Correction (DCC) and Division of Correction (DOC). They are likely the largest mental health providers in the state given the size of population they serve. She said, like everywhere, suicide rates are increasing within ADC. With regard to the DCC, she said they house nonviolent-nonsexual offenders who serve sentences in one of their six community correction facilities. These centers are licensed as substance abuse and drug treatment facilities and mental health services are provided by the contractor who provides medical services for the whole state. DCC staff members are trained and certified to provide substance abuse treatment, counseling, provide life and social skills, employment readiness training, health education, and referral services as needed. These services come in the form of individual sessions or group training sessions and may include referrals outside to meet mental health needs if they cannot be addressed internally. The centers provide substance abuse assessment and treatment plans which are individualized by background and experience. Assessments are ongoing throughout incarceration and treatment is revised as needed. The centers also offer medication-assisted treatment for opioid

dependent offenders. There is a focus on reentry into society. The West Memphis and Texarkana centers can provide programming for those with co-occurring disorders. The Osceola and West Memphis centers provide Cognitive Processing Therapy to treat PTSD. In terms of the DOC, they are continuing to evaluate programming in an effort to make sure they are offering the best treatment to those that need it. They currently offer residential programs, case management, medication management, individual and group services, and crisis prevention and intervention services. She shared information on a pilot program called Substance Use Rehabilitation Services (SURS) at the Grimes and McPherson units for offenders needing drug treatment. For many years, they used the therapeutic community model to offer the Substance Abuse Treatment Program at the Benton, Cummins, Randall Williams, and Wrightsville units, and the Therapeutic Community Program at the Tucker and Wrightsville units. Information was shared on the services offered in each program. They intend to replace both programs with the SURS program once the pilot is complete. She said it is challenging for them to increase services when they cannot find staff. ADC has a continuing problem with a staffing shortage, most notably within their mental health services positions. Data was provided on their staffing numbers. The East Arkansas Regional Unit in Mariana has seen the most significant shortage resulting in them contracting with an outside mental health provider to provide those services. Since entering into that contract, that facility now has 11 of 13 positions filled. She added that reducing recidivism is a top priority for them and addressing drug addicted behavior is a significant component of that effort as it is a major predictor of recidivism.

Prosecuting Coordinator Bob McMahan and Prosecuting Attorney Teresa Howell spoke on behalf of the AR Prosecuting Attorneys Association. Mr. McMahan spoke about the civil commitment process. He said his office is responsible for handling civil commitments which can be mental, alcohol, drug, and also criminal related. The major issue they see during court involvement is that there are not enough beds for individuals as they navigate their way through the criminal justice system. He said when a person is converted to voluntary status before the end of the seven day period, they end up back on the streets. With not enough beds, that is what they are seeing. Another issue involves those with a dual diagnosis, a situation where they come under court order from a judge where the individual is discharged from treatment and because the facility isn't equipped to handle due to their co-occurring disorder, there is nowhere to put them. Discussion followed regarding the issue of civil commitments who get stabilized and then released, and don't get the supportive care needed afterwards. Longer term bed availability would help with those who need the additional support after acute care, to prevent the cycle of getting released and ending up right back in acute crisis care. Teresa Howell addressed the criminal side of the issue, stressing care needed to be strong, firm and consistent. She cited the issues with long waits for fitness to proceed evaluations to be completed all the while they are being held in jail the whole time. She said they need more beds and more psychiatrists. The jails are overrun with people waiting for evaluations and taking up space needed for criminal purposes. Jails are not equipped to handle mental issues. Probation and parole staff are understaffed and overworked and cannot give the support needed to help them on the outside, so they end up back in the same cycle. She added that drug addiction is a significant component to the mental health issues they are seeing, is overwhelming, and is ruining our society which is why we must do something to address it.

Mental Health / Behavioral Health (MHBH) Working Group

Meeting Notes

July 18, 2022 – 9:30 a.m. – Big Mac Bldg. Rm. A – Little Rock AR 72201

Greg Parrish spoke on behalf of the Arkansas Public Defenders Commission and said he concurred with everything Bob McMahan and Teresa Howell said. He spoke on the involuntary commitment process for adults and children who are considered homicidal or suicidal, saying they are appointed to represent these individuals because of the loss of liberty during the commitment process. They try to get the ward to waive the hearing when possible to avoid damaging the relationship between the ward and the individual who requested the commitment. A majority of people who are incarcerated suffer from some type of mental illness. Whether or not they are fit to proceed is decided first and many are filed that probably should not be filed, but it is hard for an attorney not to file for assessment if they learn of information indicating a mental health issue. He discussed the challenges for public defenders with how the fitness to proceed process works, and shared story of an inmate in jail awaiting transport for two years, stating this long wait is unfortunately not uncommon while awaiting evaluation. He shared stories of others waiting a long time for evaluations. The Public Defenders Commission has good relationships with sheriffs and prosecutors. They sometimes have to use their own funds to expedite an evaluation and expediting costs the taxpayers money. Ultimately, the time delays caused by bed shortage is a major problem.

Scott Bradley spoke on behalf of the Arkansas Sheriffs Association. From the viewpoint of sheriffs, jails have become a catch all for the mentally ill, those on commitment orders, awaiting transport, etc. Jails are struggling because of the high numbers. Presently, he said 75 are on a wait list due to court orders. Jails are overwhelmed and understaffed just like everyone else. They recently had one jail half staffed. The average wait currently is over 200 days and that is hard on sheriffs and jails as they are not equipped, placing all in an unsafe setting. Jailers being injured is not uncommon. He said it is his understanding that there are only 188 beds at the state hospital and 1/3 are taken by long term people so not all of them are even assessable. He sees the need for more beds as a critical issue, and appealed to legislators for help. He said while more beds not the only answer, it will be a major piece to addressing the problem.

Questions were then asked of those that presented. Sen. Clarke Tucker asked presenters how many beds they currently have for mental health and substance abuse treatment and how many they believe they will need. Lindsay Wallace said ADC has 200 for the SURS program, and the SATP and TC programs have 431 total between the two. They need more still but staffing is going to be a barrier as well. It is estimated they will need about 9000 beds. Rep. McCullough asked how inmates are made aware of the options they have for treatment or services. Ms. Culclager stated that most information is provided during the intake process screening to identify what their needs are. For DCC each facility shares that info during the orientation program. Rep. McCullough asked what the waiting time is from the time of conviction to actually going to corrections. This fluctuates depending on bed availability, but on average a little over 200 days and maybe a bit shorter for DCC facilities. Lindsay Wallace was asked for details on probation/parole services. She said they have substance abuse counselors in probation/parole offices but any other needs are referred out and not provided on the probation/parole side. Rep. Cavenaugh asked Bob McMahan and Teresa Howell if they know how many mental health beds exist for adults, and for children and young adolescents. They believe around 200 - 230 for adults. As for children, approximately 46 juvenile beds. They can get the breakdown of the specific number of beds for the group. Discussion followed on how we are not set up to deal with children with acute mental needs and how this is

associated with acts of violence. Sen. Kim Hammer asked Paul Schandevel if they receive Medicaid or state funding. He responded that they are 100% private. Sen. Hammer would like to find out what the comparison is of their success rates vs. institutions that have limitations due to receiving federal dollars. Paul will get that information. Sen Hammer asked mental health professionals about evaluation delays and if there is anything in the process that could be changed without compromising state/federal funding or standards where individuals who are not as highly training could conduct evaluations. Discussion followed indicating that licensed clinicians cannot do psychological evaluations, and if they do this it would impact how deep of an assessment they would be permitted to do. Sen. Hammer suggested this be looked at. Discussion followed. Rep. Gazaway asked Paul Schandevel about the lack of bed space for juveniles, what kind of capacity Youth Homes has, and whether they take juveniles in state custody that need placement. Mr. Schandevel responded that kids that come there live in a family setting and are vetted. They cannot accept a child who would be a danger to the other children. Discussion followed. They will do what they can but ultimately have to protect the parents and their kids. Rep. Gazaway asked what kind of capacity they have currently. The current capacity level is 27 but their goal is to get it to 36. They are needing house parents. The public defenders and prosecuting attorneys were asked whether judges are receptive to them when they make recommendations on what needs to happen or do they believe judges might benefit from more education in this respect. It was discussed that education is always a good thing and judges probably would welcome information on best practices. Presenters were asked where they thought the breakdown is happening in the assessment process. It was stated that many times it is an issue of not having enough information. Discussion followed. The question was asked about what can be done in early childhood to make sure issues do not continue later in life and it was stated that proactivity and prevention is key, and we must change the way we teach, counsel, and parent children to better meet their needs early on. The public defenders and prosecutors were asked who does the contracts for the evaluations that are slowing things down. The contracts are mostly completed through Community Mental Health Centers. They are now looking at the evaluation process and working on a plan to get evaluations current. They are aware of the backlog and working to get caught up. Rep. Vaught asked for a list of the centers to be given to Robin. The question was asked as to why ILPs cannot bill Medicaid directly. It was explained that this would require a policy change and is being looked at. With regard to early childhood, legislation allowing for home visits for all new moms has passed in some other states and they are seeing huge benefits with postpartum depression, and fewer babies and children in foster care. Joel Landreneau shared information regarding the difficulty to get people to work in behavioral health agencies, and said if you allow Lip's to bill Medicaid directly, you will take away the last population of people willing to work for Behavioral Health Centers. He said this actually needs to go in the other direction. More discussion followed. Teresa Howell was asked if they had researched the capacity for doing mental health courts. She said there are some specialized courts that are addressing these things and this would require getting judges involved to manage those courts and could be looked at, but they have not done any studies on it yet. Kathryn Griffin of the Governor's Office was asked about Crisis Stabilization Units. She said there are four in the state and they are very successful where people are assessed, stabilized, treated, medication is started and they are then placed in inpatient or outpatient therapy in their communities if necessary.

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Rep. Vaught closed the meeting by inviting presenters to continue coming to meetings to contribute to the conversation. If anyone is wanting to join a subgroup or wanting to present, they should let Robin Voss know. The meeting was adjourned.

ATTACHMENT 2

Mental Health/Behavioral Health Working Group Subgroups
5/17/2022

Workforce Development
Focus will be on our state's capability to meet the growing need for mental health services, i.e. addressing the gap between need and providers.

- Rep. Brian Evans
- Rep. Michelle Gray
- Rep. Lee Johnson
- Sen. Greg Leding
- Rep. Austin McCollum
- Rep. DeAnn Vaught
- Rep. Carlton Wing

Access to High Quality Services
Focus will be on the removal of barriers to mental health services, integrated behavioral health services, crisis services and specialty psychiatric emergency care.

- Rep. Frances Cavenaugh
- Sen. Breanne Davis
- Rep. Denise Garner
- Rep. Jack Ladyman
- Rep. Tippi McCullough
- Rep. DeAnn Vaught
- Rep. Les Warren

Prevention & Early Intervention
Focus will be on the services needed to meet mental health needs early (birth through adolescence) and the support services that provide the best opportunity for good mental health.

- Rep. Keith Brooks
- Rep. Karilyn Brown
- Rep. Denise Garner
- Rep. Julie Mayberry
- Rep. Aaron Pilkington
- Sen. Clarke Tucker
- Rep. DeAnn Vaught

Suicide Prevention
Focus will be on efforts to prevent suicide through training and recognition of warning signs.

- Rep. Cameron Cooper
- Rep. Brian Evans
- Rep. Jimmy Gazaway
- Rep. Tippi McCullough
- Rep. Stu Smith
- Rep. Les Warren
- Rep. DeAnn Vaught

Services for Special Populations
Focus will be on the needs of high utilizers of mental health services, including those unsheltered, with frequent interaction with law enforcement, or in transition and crisis.

- Rep. Harlan Breaux
- Rep. Cameron Cooper
- Rep. Denise Garner
- Sen. Kim Hammer
- Rep. Spencer Hawks
- Rep. Austin McCollum
- Rep. Tippi McCullough
- Rep. Aaron Pilkington
- Rep. Keith Slape
- Sen. Clarke Tucker

Substance Abuse/Co-Occurring Disorders
Focus will be on access to evidence-based services for treatment of those in need or with a co-occurring disorder

- Rep. Nicole Clowney
- Rep. Jon Eubanks
- Rep. Jimmy Gazaway
- Rep. Keith Slape
- Rep. DeAnn Vaught

Rates, Regulations, Efficiencies & Bed Availability
Focus will be to consider the impact of rate changes on the provision of services, look at the opportunity for efficiencies and need for regulations, and address the issue of bed availability

- Rep. Frances Cavenaugh
- Sen. Breanne Davis
- Rep. Jon Eubanks
- Rep. Brian Evans
- Rep. Jimmy Gazaway
- Sen. Kim Hammer
- Rep. Lee Johnson
- Sen. Greg Leding
- Rep. DeAnn Vaught